

Overview Of Fast Track Appeals (Medicare Advantage) and Expedited Appeals (FFS) Process in Arizona

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What is Grijalva and BIPA?

- 1993 class action lawsuit brought by beneficiaries enrolled in the Medicare risk-based managed care organization program.
- Challenged the adequacy of the managed care appeals process and lack of appeals process for FFS patients in settings other than hospitals.

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Grijalva vs Shalala

- As a result of the lawsuit, CMS established an independent review entity to conduct fast-track and expedited review of appeals of decisions to terminate services.

Settings Affected by the New Appeal Rights

- Skilled nursing facilities (SNFs)
- Home health agencies (HHAs)
- Comprehensive outpatient rehabilitation facilities (CORFs)
- Hospice (for FFS only)

Medicare Advantage (MA) Enrollee's Right

- All MA enrollees have the right to request a Quality Improvement Organization (QIO) fast-track review to appeal the MA organization's decision to terminate coverage of services.

Fast-Track Appeal

- Enrollee or representative must request a Fast-Track Appeal by noon of the day before the effective date that Medicare coverage ends.
- QIO must make a decision and notify enrollee, the organization, and the provider by close of business the day after it receives information necessary to make a decision.

FFS (BIPA) Enrollee's Right

- All FFS enrollees have the right to request a QIO-expedited review to appeal the provider's decision to terminate coverage of services.

Expedited Appeal

- Enrollee or representative must request an Expedited Appeal
- QIO must make a decision and notify enrollee

Sounds Like a Great Thing!

- The beneficiary now has expanded appeal rights
- The managed care organization or the provider no longer makes decisions about appeals
- The beneficiary has the QIO to review their case.
- The beneficiary will not be financially liable if the Fast-Track Appeal is requested in a timely manner and until the QIO makes a decision.
- Beneficiary could be liable if requests Expedited Appeal after termination date.

What Does this Mean to HSAG, the Arizona QIO?

- Must have ability to take and review Fast-Track and Expedited Appeals seven days per week
- Must monitor the Notice of NonCoverage and the Detailed Explanation for accuracy and report Invalid notices to the Regional Office
- Provide education and support to the beneficiary
- Provide education and support to the providers
- QIO must make a decision on the Fast-Track Appeal no later than the day the Medicare coverage will end

What Does this Mean to You?

- Must give valid Notice of NonCoverage no later than two days before coverage of the beneficiary's services will end
- Must give detailed explanation of why the services are no longer necessary or covered
- The managed care plan is financially liable until a decision is made by the QIO
- For FFS, the provider may be liable until the QIO reaches a decision
- Managed care plan must provide weekend coverage

What Does It Mean to SNFs, HHAs, and Hospice

- Additional staff available seven days per week for record requests
- Additional training and implementation procedures
- Advance planning for discharge notices
- Possible additional \$\$ to carry out new Fast-Track and Expedited Appeals process

What Does this Really Mean?

- New rules for everyone to learn
- New financial implications for the managed care plans, QIO, HHAs, SNFs, and Hospice
- More time on administrative duties
- Mass confusion on the part of all involved

Late Breaking News

- April 5, 2006 Federal Register **proposes all** discharges from an acute setting will **require** a Notice of Discharge and Medicare Appeal Rights (NODMAR) or Hospital-Issued Notice of Non-Coverage (HINN).
- Applies to MA and FFS
- Period of comment: Deadline June 5, 2006.

QUESTIONS???

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