

BENEFITS IMPROVEMENT and PROTECTION ACT (BIPA) §521

Kansas Foundation for Medical Care, Inc.
Case Review Team

February 21st & 23rd, 2006

BENEFITS IMPROVEMENT and PROTECTION ACT (BIPA) §521

Federal Register, Friday, November 26, 2004

42 CFR 405.1200-1206

<http://www.cms.hhs.gov/BNI/>

BIPA is Often Referred to as Expedited Determinations

- The notices given for BIPA or expedited determinations are called:
 - Generic Notice or Notice of Medicare Provider Non-coverage
 - Detailed Notice or Detailed Explanation of Non-coverage

Affected Health Care Providers

- Home Health Agencies (HHAs)
- Hospices
- Skilled Nursing Facilities (SNFs)
- Comprehensive Outpatient Rehabilitation Facilities (CORFs)
- Swing Bed Facilities

Termination of Medicare Covered Services

- Discharge from a residential provider
- Complete cessation of coverage at the end of a course of treatment

Provider Responsibility

Medicare Beneficiary's Right

- Before any termination of services, the provider must deliver a valid written notice to the beneficiary of the decision to terminate services.

Information from the Beneficiary Notice Initiative Website

Step 1: Go to www.cms.hhs.gov/BNI/

Step 2: Click on *FFS ED Notices*

Step 3: Scroll down to the bottom of the page to *Downloads*

Address http://www.cms.hhs.gov/BNI/06_FFSEdNotices.asp#TopOfPage

U.S. Department of Health & Human Services www.hhs.gov

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Beneficiary Notices Initiative (BNI)

- [Overview](#)
- [FFS ABN-G and ABN-L](#)
- [FFS HHABN](#)
- [FFS SNFABN and SNF Denial Letters](#)
- [FFS HINNs](#)
- [FFS ED Notices](#)
- [MA Denial Notices](#)
- [MA NODMAR](#)
- [MA ED Notices](#)
- [ImportantMessagefromMedicare](#)
- [FFS NEMB](#)
- [FFS NEMB HHA](#)
- [FFS NEMB SNF](#)

FFS ED Notices

As of July 1, 2005, Home Health Agencies (HHAs), Skilled Nursing Facilities (SNFs), Comprehensive Outpatient Rehabilitation Facilities (CORFs) and Hospices with beneficiaries in Fee-For-Service Medicare are required to notify beneficiaries of their right to a new expedited review process when these providers anticipate that Medicare coverage of their services will end.

HHA, SNF, Hospice, CORF, and swing beds (under instruction) are required to provide a Generic Notice to beneficiaries to alert them that Medicare covered item(s) and/or service(s) are ending and give beneficiaries the opportunity to request an expedited determination from a QIO. A Detailed Notice is given when the QIO review is requested in order to provide more explanation on why coverage is ending.

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8

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for Medical Care, Inc.

Step 4: To Download the Generic Notice that you can modify to incorporate your provider information click on:

FFS Expedited Review Generic Notice in MS Word

Downloads

- [FFS Expedited Review Generic Notice CMS10123 \[pdf, 97kb\]](#)
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- [Generic Notice CMS10123 Instructions \[pdf, 33kb\]](#)
- [FFS Expedited Review Detailed Notice CMS10124 \[pdf, 32kb\]](#)
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- [Detailed Notice CMS10124 Instructions \[pdf, 14kb\]](#)
- [Expedited Determination Qs and As \[PDF, 106kb\]](#)
- [General Information \[PDF, 22kb\]](#)

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Model Notice that can be found at <http://www.cms.hhs.gov/BNI/>

CMB Approval No. 0938-0953

{Insert logo here}

NOTICE OF MEDICARE PROVIDER NON-COVERAGE

Patient Name:

Medicare Number:

THE EFFECTIVE DATE COVERAGE OF YOUR CURRENT {insert type}
SERVICES WILL END: {insert effective date}

- Your provider has determined that Medicare probably will not pay for your current {insert type} services after the effective date indicated above.
 - You may have to pay for any {insert type} services you receive after the above date.
-

YOUR RIGHT TO APPEAL THIS DECISION

- You have the right to an immediate, independent medical review (appeal), while your services continue, of the decision to end Medicare coverage of these services.
- If you choose to appeal, the independent reviewer will ask for your opinion and you should be available to answer questions or supply information. The reviewer will also look at your medical records and/or other relevant information. You do not have to prepare anything in writing, but you have the right to do so if you wish.
- If you choose to appeal, you and the independent reviewer will each receive a copy of the detailed explanation about why your coverage for services should not continue. You will receive this detailed notice only after you request an appeal.
- If you choose to appeal, and the independent reviewer agrees that services should

Note: We suggest you download, save, and review the following documents:

The screenshot shows a web browser window with the address bar displaying http://www.cms.hhs.gov/BNI/06_FFSEdNotices.asp#TopOfPage. The page content includes the following sections:

Instructions, please click on the appropriate link below.

Downloads

- [FFS Expedited Review Generic Notice CMS10123 \[pdf, 97kb\]](#)
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Related Links Inside CMS

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The browser's taskbar at the bottom shows the Start button, several application icons, and the taskbar itself with open windows for Microsoft PowerPoint and FFS ED Notices. The system tray on the right shows the Internet icon, a clock displaying 3:49 PM, and the logo for n for medical Care, Inc.

Provider Responsibility

Timing of Notice Delivery

- Issued no later than two calendar days before the proposed end of the services when applicable.
- If services fewer than two days in duration, the notice should be issued at the time of admission.

What if the Beneficiary's coverage ends abruptly?

- The regulation anticipates that the notice will be given at least two days in advance. When this goal cannot be met, such as when coverage ends abruptly, beneficiaries need to receive the notice as timely as possible to assure access to their right to QIO review.

Provider Responsibility

Content of Notice

- Beneficiary name and Medicare number
- Date that coverage of service ends
- Date that beneficiary's financial liability begins
- The type of services ending (ie skilled nursing, home health, hospice, etc.)
- Description of right to appeal
- Description of right to detailed information
- QIO contact information
 - Kansas Foundation for Medical Care
1-800-432-0407

Mandatory Content Elements: Form Instructions for Generic Notice

- Place logo in heading of notice
 - Name, Address, and telephone number of provider
- Patient name
 - Insert the patient's full name.
- Patient Medicare Number
 - Fill in the beneficiary's Medicare number.
- Effective date
 - The actual date Medicare covered services will end
 - Beneficiary cannot be held liable until two days after valid notice has been given.

Mandatory Content Elements: Form Instructions for Generic Notice

(continued)

- Type of services
 - Fill in the type of services ending (home health, skilled nursing, comprehensive rehabilitation services, or hospice).
- Name and number of QIO
 - Kansas Foundation for Medical Care
 - 1-800-432-0407

Provider Responsibility

Valid Notice

- Beneficiary or representative signed and dated notice.
- The timing of delivery was appropriate.
- The content of the notice is correct.

Notice Delivery

Beneficiary Refuses to Sign

- Annotate the notice to indicate the refusal.
- The date of the refusal is the date of receipt of the notice.

Notice Delivery (continued)

Notice Delivery to Authorized Representative

- If unable to deliver notice personally, the provider should telephone the representative.
 - Advise them of the termination of services, the effective date, their appeal rights, and the name and number for KFMC.
 - Document the telephone contact to include:
 - name of person initiating the contact
 - name of the representative contacted
 - date and time of the contact
 - telephone number called

Notice Delivery (continued)

Notice Delivery to Authorized Representative

- *(continued)*
 - The date of the conversation is the date of the receipt of the notice. Confirm the telephone contact by written notice mailed on that same date.
 - Place a dated copy of the notice in the beneficiary's medical file.

Notice Delivery (continued)

Notice Delivery to Authorized Representative

- When direct phone contact cannot be made, document appropriately and send the notice to the representative by certified mail, return receipt requested.
- The date that someone at the representative's address signs (or refuses to sign) the receipt is the date of receipt.

Amended Notice

- If the provider delivers a generic notice to beneficiary, but subsequently determines that services should continue beyond the effective date, the notice can be amended.
 - Provider must inform the beneficiary of the new effective date through either delivery of new notice or delivery of amended notice.
 - Delivery in an outpatient setting, or to an authorized representative, may be by telephone, followed by certified mail, return receipt requested.

Amended Notice *(continued)*

- Amended notice should be annotated to reflect:
 - Revised effective date
 - Date and time that provider contacted beneficiary
 - Name of person who initiated the contact
- If the beneficiary has requested an appeal based on the original notice, and the notice is amended, the provider should fax the amended notice to the QIO as soon as the beneficiary has been notified.

Financial Liability

- The provider is liable for continued services until two calendar days after the beneficiary received a valid notice, or until the service termination date, whichever is later.

Financial Liability Example

A notice was issued on 02-01-06 that was determined to be invalid. The provider has acknowledged that Medicare should not cover the service(s) beyond the effective date of 02-03-06. Providers were notified of valid notice requirements, therefore if a notice is found to be invalid there could be some days of provider liability. If a new valid notice was issued on 02-02-06 with an effective date of 02-03-06 (effective date will not change), beneficiary liability cannot begin until 02-05-06. Therefore, the provider could be held liable for services provided on 02-04-06. In these circumstances, the fiscal intermediary (FI) would be notified of dates that provider liability begins.

Medicare Beneficiary

May Appeal If:

- Non-residential provider (HHA or CORF)
 - Beneficiary disagrees with termination of service
and
 - Physician certifies that failure to continue the service may place the beneficiary's health at significant risk

Medicare Beneficiary (continued)

May Appeal If:

- Residential provider (SNF or hospice)
 - Beneficiary disagrees with discharge decision

Medicare Beneficiary (continued)

Appeal Request

- Appeal must be requested from QIO of state in which the care is being delivered.
 - Example: A MO hospice provider is providing the care in Kansas, the Kansas QIO would perform the review.
- The beneficiary (or representative) must request a QIO expedited appeal by noon of the day prior to termination of service(s).

Medicare Beneficiary (continued)

Untimely Appeal

- If a valid notice was issued, a non-expedited QIO review is performed.
 - Determination will be made in 7 days
 - If beneficiary is still receiving disputed services
 - Determination will be made in 30 days
 - If beneficiary is no longer receiving services

Physician Certification

(For appeals for HHAs and CORFs only)

- Beneficiary must have physician certification in order for QIO to proceed with appeal
 - The QIO will contact the physician for the beneficiary if they would like us to.
- Beneficiary may attempt to obtain certification on his/her own
 - If certification is obtained within 60 calendar days of effective date, QIO will accept appeal and make determination in the case.
 - In this case, QIO has 30 calendar days from receipt of certification to issue determination.

Provider Responsibility Expedited Review

- Send detailed notice to the beneficiary by close of business on the day of KFMC's notification of an appeal.

Model Notices can be found at
<http://www.cms.hhs.gov/BNI/>

- Click on FFS ED Notices

CMB Approval No. 0938-0953

Insert Logo here

DETAILED EXPLANATION OF [Insert type] NON-COVERAGE

Date:

Patient Name:

Medicare Number:

This notice gives a detailed explanation of why your provider has determined that Medicare coverage for your current {insert type} services should end. ***This notice is not the decision on your appeal.*** The decision on your appeal will come from your Quality Improvement Organization (QIO).

We have reviewed your case and decided that Medicare coverage of your {insert type} services should end.

- The facts used to make this decision:

- Detailed explanation of why these services are no longer covered, and the specific Medicare coverage rules and policy used to make this decision:

Provider Responsibility Detailed Notice Content

- Specific and detailed explanation why services are either no longer reasonable and necessary or are no longer covered
- Description of any applicable Medicare coverage rules, instruction, or other Medicare policy rules or information about how the beneficiary may obtain a copy of the Medicare policy

Provider Responsibility Detailed Notice *(continued)*

- Facts specific to the beneficiary and relevant to the coverage determination that are sufficient to advise the beneficiary of the applicability of the coverage rule or policy to the beneficiary's case
- Any other information required by CMS

Provider Responsibility Information to KFMC

- When notified of an appeal, supply all information requested including:
 - Generic Notice
 - Detailed Notice
 - POA paperwork if applicable
 - Medical Record – Documentation to support decision to terminate services
- For expedited appeals, this information should be furnished no later than by close of business of the day KFMC notified the provider of the appeal.

Provider Responsibility Information to KFMC (continued)

- The provider may be held financially liable in continued coverage if a delay results from the provider failing to supply requested information in a timely manner.

KFMC's Responsibility Expedited Review

- Immediately notify provider of appeal request
 - QIOs will be available to receive beneficiary's request for an expedited determination and will conduct review on weekends if necessary.
 - Providers need to be able to fax requested documentation for appeals through the week and on weekends, if requested.
- Determine if notice is valid

KFMC's Responsibility Expedited Review (continued)

- Examine medical and other records pertaining to services in dispute
 - Includes, if applicable, physician certification [HHA/CORF]
- Within 72 hours from receipt of an expedited appeal request, KFMC must make a determination on whether termination of Medicare coverage is the correct decision.

KFMC's Responsibility Determination

- Notify the beneficiary, beneficiary's physician, and the health care provider
 - Initial notification may be made by telephone
 - A written notification must follow

KFMC's Responsibility Written Notification

- Rationale for determination
- Explanation of the Medicare payment consequences and the date the beneficiary becomes fully liable for services
- Information about reconsideration rights, including how to request and the time period

Generic Notice Timing

On July 25, Mary Jane Jones begins to receive Medicare covered services from the provider. On August 2, the provider decides that Ms. Jones is well enough to stop receiving services. The provider delivers a generic notice (Notice of Medicare Provider Noncoverage) to Ms. Jones which indicates that her services will terminate on August 4. Ms. Jones decides to appeal.

| July 25 | August 2 | August 3 | August 4 | August 5 | August 6 |
|--|--|---|---|---|---|
| Ms. Jones begins to receive Medicare covered health care services. | <u>Issuance Date</u> Ms. Jones receives generic notice. The effective date is listed as August 4 | Ms Jones requests an appeal by noon of this day, qualifying for an <i>expedited</i> review. | <u>Effective Date</u> Ms. Jones may continue to receive services. | If the QIO determines termination of service was appropriate, Ms. Jones will be liable beginning with services provided on this date. | Because she qualified for an expedited review, Ms. Jones should receive a decision from the QIO on this date. |

Medicare Beneficiary Reconsideration

- If the beneficiary disagrees with KFMC's initial expedited appeal determination, he or she may request a reconsideration.
 - The beneficiary or authorized representative may ask for a reconsideration.

Coverage of Provider Services

- Coverage continues until the date designated on the termination notice, unless KFMC reverses the provider's service termination decision.

Coverage of Provider Services (*continued*)

- The provider should not bill the beneficiary for any disputed services until the expedited determination process (and reconsideration process, if applicable) has been completed.

Coverage of Provider Services (continued)

- If KFMC's decision is delayed because the provider did not supply necessary information or records timely, the provider may be liable for costs of any additional coverage.

Coverage of Provider Services (continued)

- If KFMC determines that the beneficiary did not receive a valid notice, coverage of provider services continues until at least two calendar days after a valid notice has been received.

Provider Responsibility

Releasing Information to Beneficiary

- At a beneficiary's request, the provider must furnish the beneficiary with a copy of, or access to, any documentation that it sends to KFMC.

Occasions Where a Notice is Not Required

- No notice is given when benefit days expire/have expired.
- No notice is given for transfers to comparable providers, including SNFs.
- No notice is given when beneficiary revokes the benefit.
- No notice is given if care in question is one-time or intermittent in nature, such as services available to all Part B beneficiaries independent of the setting of care/services.

Occasions Where a Notice is Not Required *(continued)*

- No notice is issued for a reduction in services
 - Notices are only to be issued with the complete cessation of Medicare Part A or Medicare Part B services
- No notice is given for a leave of absence
- No notice is required when a beneficiary's condition necessitates a higher/more intensive level of care
- If a provider ends services because it is not considered safe to enter a beneficiary's home, no notice is required

Reimbursement caps on PT, Speech Language Pathology, OT

- The therapy cap for now is considered an exhaustion of benefits.
 - Therefore, no generic notice needs to be issued and there will be no QIO review related to the FFS expedited review process.

Summary of Notification Requirements for FFS Expedited Determinations for Each Affected Provider Type

| Provider Type Subject to Expedited Determination | Medicare Payment Source for Covered Services | Affected Types of Bill (TOBs) | Triggers for Expedited Notice | Usual Service/Terminations Cases Not Triggering Expedited Notice* in Benefit** |
|--|--|-------------------------------|--|--|
| Swing Bed | Part A | 18x | End of Part-A covered level of care with benefit days remaining | <ul style="list-style-type: none"> ▪ No notice given when benefit days expire/have expired ▪ No notice given for transfers to comparable providers, including SNFs ▪ No notice given for leave of absence |
| SNF Prospective Payment System (PPS) | Part A | 21x | End of Part-A covered level of care with benefit days remaining | <ul style="list-style-type: none"> ▪ No notice given when benefit days expire/have expired ▪ No notice given for transfer to comparable provider ▪ No notice given for leave of absence |
| Other SNF | Part B | 22x, 23x | End of <u>all</u> Part B services on plan of care | <ul style="list-style-type: none"> ▪ No notice given if care in question is one-time or intermittent in nature, such as services available to all Part B beneficiaries independent of the setting of care/residence-- see list in Group 7, question 10. |
| Hospice | Part A | 81x, 82x | Provider discharge from hospice benefit for coverage reasons | <ul style="list-style-type: none"> ▪ No notice given when beneficiary revokes the benefit ▪ No notice given for transfer to other hospice |
| Home Health PPS | Part A and/or B | 32x, 33x | Provider discharge from home health benefit for coverage reasons | <ul style="list-style-type: none"> ▪ No notice given for transfer to other home health agency (HHA) ▪ No notice given for mid-episode hospitalization whether HHA discharges or not |

Table can be found at <http://www.cms.hhs.gov/BNI/>

Click on FFS ED Notices and download the Expedited Determination Qs and As. This table is on page 4 of the Qs and As.

| | | | | |
|-------------------|--------|-----|---|---|
| Other Home Health | Part B | 34x | End of <u>all</u> Part B services on plan of care, i.e., therapy plan of care | <ul style="list-style-type: none"> ▪ No notice given if care in question is one-time or intermittent in nature, such as services available to all Part B beneficiaries independent of the setting of care/residence; Examples: <ul style="list-style-type: none"> + DME provided when HHA is acting like an independent supplier + Roster billing of vaccines |
| CORF | Part B | 75x | End of all Part B services on plans of care | <ul style="list-style-type: none"> ▪ No notice given if care in question is one-time or intermittent in nature, such as services available to all Part B beneficiaries independent of the setting of care/residence |

**"Notice" only means expedited determination process requirements, NOT other notice requirements, such as for SNFs with the delivery of SNFABNs, denial or "cut" letters.

**Expedited Notice is not given in any benefit when termination of covered services is: (1) the result of a beneficiary, not a provider, deciding to end coverage; (2) when termination is for reasons other than medical necessity under Medicare coverage policy; and (3) when the beneficiary requires treatment at a higher level of care, such as transfer to an acute-care hospital.

NOTE: "Bolding", other than titles, represents significant change from current instructions.

Table can be found at <http://www.cms.hhs.gov/BNI/>

Click on FFS ED Notices and download the Expedited Determination Qs and As. This table is on page 4 of the Qs and As.

4

| PROVIDER 1: Discharging Beneficiary | PROVIDER 2: Receiving Beneficiary | PROVIDER 1: Issue Generic Notice? | Rationale |
|--|---|---|--|
| SNF Part A or Part B, or skilled swing bed | [Another] SNF | No | Transfers among providers of the same type do not require expedited notice. |
| SNF Part A or B, or skilled swing bed | HHA | Yes | Beneficiary has right to review of the loss of residential care and/or the change in level/frequency of services. |
| SNF Part A or B, or skilled swing bed | NF, non-skilled DPU or non-skilled swing bed | Yes | Beneficiary has right to review of the change in the level of services to noncovered care. |
| HHA | Hospice | No | Beneficiary's choice to elect the hospice benefit; could continue home health/other care instead even if terminally ill. |
| HHA | SNF | No | Notification is not required when the beneficiary condition necessitates a higher/more intensive level of care. |
| Any FFS provider required to give expedited notice | Acute stay hospital | No | Notification is not required when the beneficiary condition necessitates a higher/more intensive level of care. |
| Any FFS provider required to give expedited notice | NOT to a Medicare provider type; home settings including assisted living | Yes | Basic right to review of discharge/termination of covered care. |

Table can be found at <http://www.cms.hhs.gov/BNI/>

Click on FFS ED Notices and download the Expedited Determination Qs and As. This table is on page 8 of the Qs and As.

Kansas Foundation for Medical Care, Inc.
NOTICE OF MEDICARE PROVIDER NON-COVERAGE BENEFIT IMPROVEMENT
AND PROTECTION ACT OF 2000 (BIPA)
Federal Register, November 26, 2004
Effective 7/1/05

Provider:

- Determines when Medicare covered service will terminate.
- Issues a "Notice of Medicare Provider Non-coverage" (generic notice) no later than two (2) days before the proposed end of service,

Beneficiary/representative:

- Disagrees with notice
- Contacts KFMC

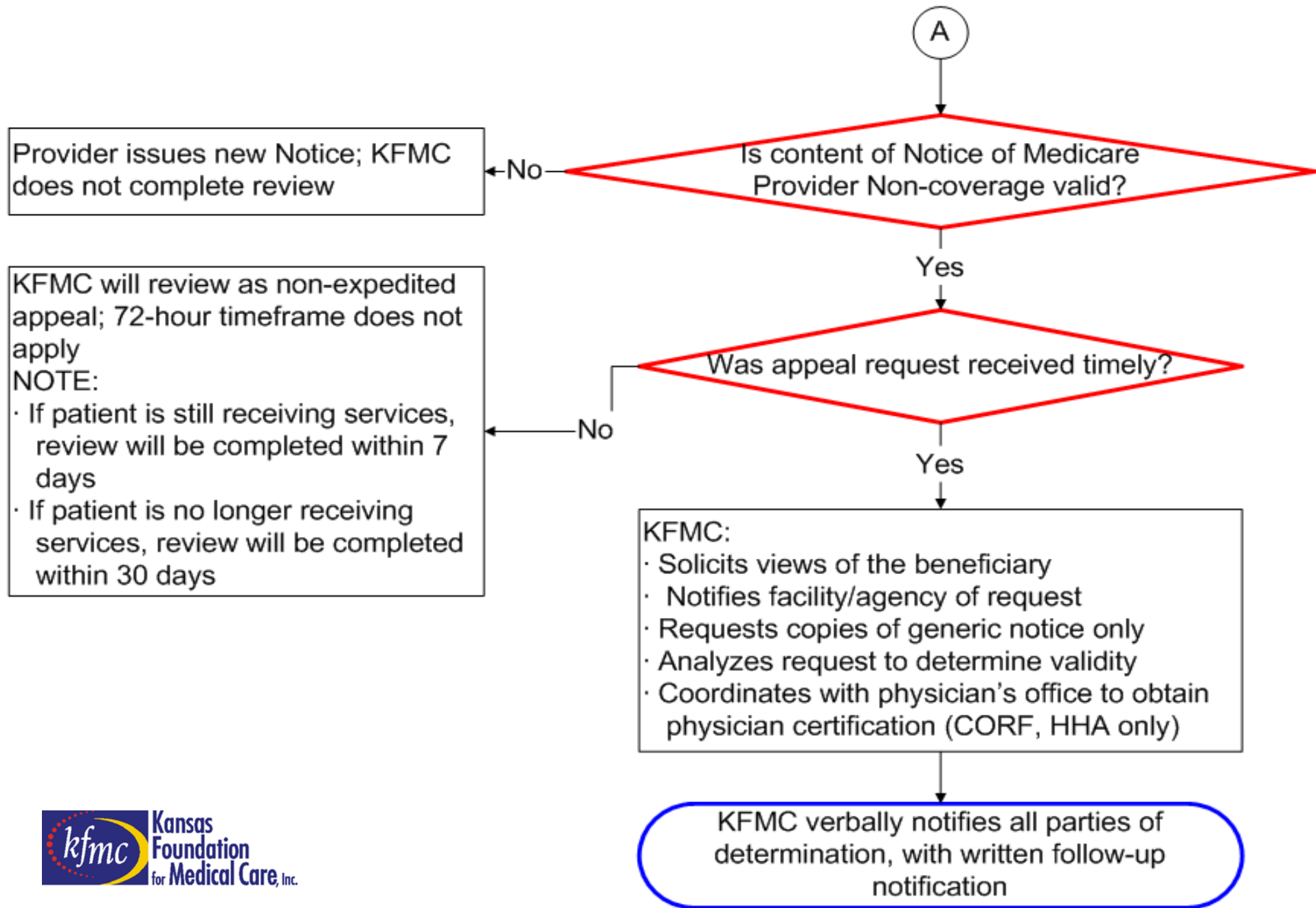
KFMC:

- Notifies facility/agency of request
- Requests copies of generic and detailed notices, and medical records
- Requests copies of physician certification (CORF, HHA only)

Provider:

- Submits documentation by close of business on date of KFMC notification

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For More Information Contact:

Angie Ginter, RN, BSN, CPUR, MBA

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1-800-432-0407

This material was prepared by the Kansas Foundation for Medical Care, Inc. (KFMC), the Medicare Quality Improvement Organization for Kansas, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. #8SOW-KS-CR-06-06

