DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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**Center for Beneficiary Choices /Health Plan Policy Group**

Date: December 17, 2003

To: Medicare+Choice (M+C) Organizations

From: Robert Donnelly, Director

Subject: Implementation of the New Independent Fast-Track Appeals Process

This letter provides additional information to M+C organizations on the implementation of the new independent fast-track appeals process established in a final rule earlier this year. See 68 Fed. Reg. 16,652 (April 4, 2003). Beginning January 1, 2004, M+C enrollees must receive a notice at least two days before planned termination of Medicare coverage of their skilled nursing facility (SNF), home health agency (HHA) or comprehensive outpatient rehabilitation facility (CORF) services. Enrollees then may request an independent review of the M+C organization's decision to end coverage of SNF, HHA or CORF services. In the event of a timely appeal request, an M+C organization must issue a second, detailed notice that explains the reasons why Medicare coverage should end.

The Centers for Medicare & Medicaid Services (CMS) has designated Quality Improvement Organizations (QIOs) to conduct these fast-track reviews. QIOs are suitable for the fast-track appeals process in light of their experience in performing similar, immediate reviews of inpatient hospital discharges. The QIO that has an agreement with the SNF, HHA or CORF providing the enrollee's services will process the appeal. The M+C organization must provide the second, detailed notice to both the QIO and the enrollee.

**Standardized Notices**

The standardized notices to be used under the new fast-track appeals process are attached and will also be included in the next update to Chapter 13 of the M+C manual. The initial, largely generic notice is titled the "Notice of Medicare Non-Coverage" (NOMNC) and the follow-up notice to be used when an enrollee disputes a coverage termination decision is titled the "Detailed Explanation of Non-Coverage" (DENC). Both notices have been revised based on public comments, and thus the notices previously provided in the Appendix to Chapter 13 of the October edition of the M+C manual should not be used.

**Chapter 13 Provisions**

Since publication of Chapter 13 of the M+C Manual in October, CMS has had several opportunities to discuss some operational concerns posed by the public. As a result, we have revised sections 90.4 through 90.8, as described below. The revisions, which are attached, will also be reflected in an update to the M+C Manual.

- Section 90.4 establishes that the NOMNC is the standardized advance termination notice that M+C organizations and providers must use beginning January 2004. It also explains the circumstances and conditions under which M+C organizations, rather than providers, may issue the NOMNC. It also removes language that the M+C organization's regional office plan manager must approve the notice.

- Section 90.5 establishes that the DENC is the standardized detailed notice that M+C organizations must use beginning January 2004. It also removes language that the M+C organization's regional office plan manager must approve the notice.

- Section 90.6 explains when the NOMNC is issued, and discusses the need for flexibility and coordination among M+C organizations and providers in delivering the notice to plan for weekend discharges. It illustrates how coordinated planning with respect to notice delivery and discharge planning decrease potential financial liability for enrollees and M+C organizations.

- Section 90.8 defines a timely request for an appeal as one made no later than noon of the day following receipt of the NOMNC, or by noon of the day before coverage ends. The section clarifies that the QIO must "immediately" notify the M+C organization and provider of an enrollee's appeal request, and defines "close of business" as 4:30pm, in accordance with the guidelines of the Federal Acquisition Regulations. It also addresses the time line for M+C organizations to deliver necessary documentation, including explaining that if an enrollee requests an appeal earlier than required (that is, on the day of the provider notice as opposed to by noon of the following day), the M+C organization's deadline for documentation submission is unchanged (that is, no later than 4:30pm of the day prior to coverage ending). This maximizes an M+C organization's time to prepare and deliver the notices and case file information to the QIO and enrollee. Finally, this section also explains the responsibility of the M+C organization to coordinate the appeals process whenever: (1) the case file is misdirected by the M+C organization or the enrollee; or (2) an enrollee has exceeded the time line for requesting a fast-track review with the QIO.

**Requirements for Private Fee-for-Service Plans**

We recognize the PFFS model raises unique issues, but the regulations clearly apply to all M+C organizations. Organizations with PFFS plans can achieve compliance with the fast-track appeals process and hospital notice requirements by amending the terms and conditions on their provider websites to ensure that providers are delegated the responsibility to issue NOMNCs, DENCs and Notices of Discharge and Medicare Appeal Rights. Providers that seek deemed status with PFFS plans will thereby be obligated to comply with all notice and case submission requirements.

If M+C organizations have any questions regarding this letter, please contact Michele Edmondson-Parrott, Director, Division of Appeals Policy, at (410) 786-6478, or Chris Gayhead of her staff, at (410) 786-6429. Please contact your Regional Office Plan Managers for general operational issues associated with implementing the new fast-track appeals process.

Attachments