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# Medicare Advantage (MA) Provider Contracting Guidelines

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## Medicare Managed Care Manual

### Chapter 11 - Medicare Advantage Application Procedures and Contract Requirements

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This Chapter Last Updated - (Rev. 83, 04/25/2007)

This appendix only references an excerpt from Chapter 11 of the *Medicare Managed Care Manual*. To view the full chapter, refer to the Centers for Medicare & Medicaid Services (CMS) website at [cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs)

#### 100.4 - Provider and Supplier Contract Requirements

(Rev. 79, Issued 02-17-06, Effective Date 02-17-06)

Contracts or other written agreements between MA organizations and providers and suppliers of health care or health care-related services must contain the following provisions:

- Contracting providers agree to safeguard beneficiary privacy and confidentiality and assure accuracy of beneficiary health records;
- Contracts must specify a prompt payment requirement, the terms and conditions of which are developed and agreed to by the MA organization and its contracted providers and suppliers;
- Contracts must hold Medicare members harmless for payment of fees that are the legal obligation of the Medicare Advantage organization to fulfill. Such provision will apply, but will not be limited to insolvency of the MA organization, contract breach, and provider billing;
- Contracts must contain accountability provisions specifying:
  - That first tier and downstream entities must comply with Medicare laws, regulations, and CMS instructions (422.504(i)(4)(v)), and agree to audits and inspection by CMS and/or its designees and to cooperate, assist, and provide information as requested, and maintain records a minimum of 10 years;
  - That the MA organization oversees and is accountable to CMS for any functions and responsibilities described in the MA regulations (422.504(i)(4)(iii)); and
  - That MA organizations that choose to delegate functions must adhere to the delegation requirements - including all provider contract requirements in these delegation requirements - described in the MA regulations (422.504(i)(3)(iii); 422.504(i)(4)(i)-(v));
  - Contracts must specify that providers agree to comply with the MA organization's policies and procedures;

# Medicare Advantage (MA) Provider Contracting Guidelines

## 100.4 - Provider and Supplier Contract Requirements *(cont'd.)*

In addition to the provisions mentioned above, MA organizations must include certain MA-related provisions in the policies and procedures that are distributed to providers and suppliers that constitute the organizations' health services delivery network. The following table summarizes these provisions:

CONTRACT REQUIREMENTS THROUGH POLICIES, STANDARDS & MANUALS	CFR REFERENCE
Safeguard privacy and maintain records accurately and timely	422.118
Permanent "out of area" members to receive benefits in continuation area	422.54(b)
Prohibition against discrimination based on health status	422.110(a)
Pay for emergency and urgently needed services	422.100(b)
Pay for renal dialysis for those temporarily out of a service area	422.100(b)(1)(iv)
Direct access to mammography and influenza vaccinations	422.100(g)(1)
No copay for influenza and pneumococcal vaccines	422.100(g)(2)
Agreements with providers to demonstrate "adequate" access	422.112(a)(1)
Direct access to women's specialists for routine and preventive services	422.112(a)(3)
Services available 24 hrs/day, 7 days/week	422.112(a)(7)
Adhere to CMS marketing provisions	422.80(a), (b), (c)
Ensure services are provided in a culturally competent manner	422.112(a)(8)
Maintain procedures to inform members of follow-up care or provide training in self-care as necessary	422.112(b)(5)
Document in a prominent place in medial record if individual has executed Advance directive	422.128(b)(1)(ii)(E)
Provide services in a manner consistent with professionally recognized standards of care	422.504(a)(3)(iii)
Continuation of benefits provisions (may be met in several ways, including contract provision)	422.504(g)(2)(i); 422.504(g)(2)(ii); 422.504(g)(3)
Payment and incentive arrangements specified	422.208
Subject to laws applicable to Federal funds	422.504(h)(2)
Disclose to CMS all information necessary to (1) Administer & evaluate the program (2) Establish and facilitate a process for current and prospective beneficiaries to exercise choice in obtaining Medicare services	422.64(a); 422.504(a)(4); 422.504(f)(2)
Must make good faith effort to notify all affected members of the termination of a provider contract <i>30 calendar days before the</i> termination by plan or provider	422.111(e)
Submission of encounter data, medical records and certify completeness and truthfulness	422.310(d)(3)-(4), 422.310(e), 422.504(d)- (e), 422.504(i)(3)-(4), 422.504(l)(3)
Comply with medical policy, QM and MM	422.202(b); 422.504(a)(5)
Disclose to CMS quality & performance indicators for plan benefits re: disenrollment rates for beneficiaries enrolled in the plan for the previous two years	422.504(f)(2)(iv)(A)

# Medicare Advantage (MA) Provider Contracting Guidelines

CONTRACT REQUIREMENTS THROUGH POLICIES, STANDARDS & MANUALS	CFR REFERENCE
Disclose to CMS quality & performance indicators for the benefits under the plan regarding enrollee satisfaction	422.504(f)(2)(iv)(B)
Disclose to CMS quality & performance indicators for the benefits under the plan regarding health outcomes	422.504(f)(2)(iv)(C)
Notify providers in writing for reason for denial, suspension & termination	422.202(c)(1)
Provide 60 days' notice (terminating contract without cause)	422.202(c)(4)
Comply with Federal laws and regulations to include, but not limited to: Federal criminal law, the False Claims Act (31 U.S.C. 3729 et. Seq.) and the anti-kickback statute (section 1128B(b) of the Act)	422.504(h)(1)
Prohibition of use of excluded practitioners	422.752(a)(8)
Adhere to appeals/grievance procedures	422.562(a)

## 100.5 - Administrative Contracting Requirements

(Rev.79, Issued: 02-17-06 Effective Date: 02-17-06)

The MA administrative contracting requirements apply both to first tier contracts and to downstream contracts in the manner specified for provider contracts, as described above. At the same time, the responsibility of the MA organization is to assure that its contractor and any downstream contractors have the information necessary to know how to comply with the requirements under the MA program.

These requirements do not apply to administrative contracts that do not directly relate to the MA organization's core functions under its contract with CMS. For example, a contract between the MA organization and a clerical support firm would not need to contain these provisions. Similarly, a contract between the MA organization and a real estate broker to identify rental properties for office space would not be required to address these areas. CMS would, however, view contracts for administration and management, marketing, utilization management, quality assurance, applications processing, enrollment and disenrollment functions, claims processing, adjudicating Medicare organization determinations, appeals and grievances, and credentialing to be administrative contracts subject to MA requirements as articulated in the MA regulation and related guidance.

The following provisions must be addressed in the administrative service contracts:

- The person or entity must agree to comply with all applicable Medicare laws, regulations, and CMS instructions;
- The person or entity must agree to comply with all State and Federal confidentiality requirements, including the requirements established by the MA organization and the MA program;
- The person or entity must agree to grant DHHS, the Comptroller General, or their designees the right to inspect any pertinent information related to the contract during the contract term, for up to 10 years from the final date of the contract period, and in certain instances described in the MA regulation, periods in excess of 10 years, as appropriate;
- The contract must clearly state the responsibilities of the administrative services provider and its reporting arrangements;

# Medicare Advantage (MA) Provider Contracting Guidelines

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## 100.5 - Administrative Contracting Requirements *(cont'd.)*

- The contract must provide that the MA organization and any first tier and downstream entities has/have the right to revoke the contract if MA organizations do not perform the services satisfactorily, and if requisite reporting and disclosure requirements are not otherwise fully met in a timely manner;
- If the written arrangement provides for credentialing activities by a first-tier or downstream entity, the first-tier or downstream entity must meet all applicable MA credentialing requirements;
- If the written arrangement provides for the selection of providers by a first-tier or downstream entity, written arrangements must State that the MA organization retains the right to approve, suspend, or terminate any such arrangement;
  - Contracts between MA organizations and first tier entities, and first tier entities and downstream entities must contain provisions specifying MA delegation requirements specified at §422.504(i)(3)(iii) and §422.504(i)(4)(i)-(v). A written agreement specifies the delegated activities and reporting responsibilities of the entity and provides for revocation of the delegation or other remedies for inadequate performance. Contracts must indicate what functions have been delegated and must require the entity to comply with the requirements of these standards and of applicable law and regulations. When a function is only partially delegated, contract provisions must clearly delineate which responsibilities have been delegated and which remain with the organization. In the Quality Improvement area, for example, the organization might develop topics for projects in consultation with an affiliated medical group, but delegate the actual conduct of a specific project to the group. The agreement must specify how the delegate is to conduct Quality Improvement activities, at what points in the process decisions by the delegate (for example, on data collection methodologies) are subject to the organization's review, and how the delegate's activities will be integrated into the organization's overall Quality Improvement program (for example, through participation in an organization-wide committee).

## 100.6 - Implementation of Written Policies With Respect to the Enrollee Rights

(Rev. 79, Issued 02-17-06, Effective Date 02-17-06)

The organization must articulate enrollees' rights, promote the exercise of those rights, ensure that its staff and affiliated providers are familiar with enrollee rights, and treat enrollees accordingly. While most of the standards in this domain address basic procedural protections for enrollees, they are closely related to quality of care. Interpersonal aspects of care are highly important to most patients. Enrollees' interactions with the organization and its providers can have an important bearing on their willingness and ability to understand and comply with recommended treatments, and hence, on outcomes and costs. Policies are communicated to enrollees in the enrollee statement furnished in accordance with Chapter 2 of this manual, and to the organization's staff and affiliated providers, at the time of initial employment or affiliation, and annually thereafter.

Material on enrollee rights must be included in provider contracts or provider manuals, and in staff handbooks or other training materials.

# Advance Directives

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Federal law mandates requirements for specific Medicare and Medi-Cal providers related to patient self-determination – the right of individuals to make medical treatment decisions and to make advance directives, such as Living Wills and Durable Power of Attorney for health care. A summary of the requirements is as follows:

Every hospital, nursing facility, home health agency, hospice, and health maintenance organization (HMO) that receives funds under Medicare or Medi-Cal must:

1. Provide written information to each adult individual, as required, about the right to make decisions concerning medical care, including the right to accept, or refuse, medical or surgical treatment, and the right, under California law, to formulate advance directives.
2. Maintain and provide to individuals written information about their policies respecting the implementation of such rights.
3. Document in the individual's medical record whether or not the individual has executed an advance directive.
4. Not condition the provision of care, or otherwise discriminate based on whether or not the individual has executed an advance directive.
5. Ensure compliance with state law regarding medical treatment, decision making and advance directives.
6. Provide education to staff and the community on issues concerning advance directives. (Providers can demonstrate compliance with this Medi-Cal requirement by conducting educational campaigns, including newsletters, articles in the local newspapers, local news reports, or commercials.)
7. Revise and disseminate their informational materials when they receive information from the Department of Health Care Services (DHCS) regarding changes in state law which affect patients' rights related to patient self-determination. Materials must be revised as soon as possible, but no later than 90 days from the effective date of the change in state law.
8. Furnish written description of legal rights that includes a statement that the resident may file a complaint with their local Licensing and Certification district office, concerning non-compliance with their advance directives, resident abuse, neglect or misappropriation of resident property in the facility.

# Advance Directives

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## Advance Directives *(cont'd.)*

In addition to the above requirements, facilities *may*:

- Contract with other entities to furnish information concerning advance directive requirements and patients' rights to accept or refuse medical or surgical treatment. Despite the availability of information from other sources, providers are still legally responsible for ensuring that the statutory requirements are met, i.e., providers must, at a minimum, still provide the required brochure entitled “Your Right to Make Decisions About Medical Treatment”.
- Provide information about advance directives to family members, or a representative, when an adult individual is incapacitated at the time of admission and is unable to receive information (due to the incapacitating condition or mental disorder), or articulate whether or not he or she has executed an advance directive. If the individual regains his/her capacity, the facility is obligated to provide this information to the individual.

**The information required in 1 and 2 above must be provided to adult individuals as follows:**

- A hospital must give information at the time of the individual’s admission to inpatient.
- A nursing facility must give information at the time of the individual’s admission as a resident.
- A provider of home health care or personal care service must give information to the individual in advance of the individual’s coming under the care of the provider.
- A hospice program must give information at the time of initial receipt of hospice care by the individual.
- An HMO must give information at the time the individual enrolls with the organization, i.e., when the HMO enrolls or re-enrolls the individual.

To request copies of the California Advance Directive for Health Care, call Blue Shield Medicare Advantage Plan Member Services at (800) 776-4466 (TTY 711) 8 a.m. to 8 p.m., seven days a week, from October 1 through March 31, and 8 a.m. to 8 p.m., weekdays (8 a.m. to 5 p.m. Saturday and Sunday) from April 1 through September 30.

# Disaster and Contingency Planning Guide

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This quick reference chart is a tool for you to have available for addressing any natural disaster or systems failure. It is designed to be of assistance in assuring that members receive necessary care in the case of a disaster.

ISSUE	ACTION
<p><b>Eligibility:</b> You are unable to access the eligibility verification systems in place through your IPA/medical group.</p>	<p>Contact Provider Customer Services at (800) 541-6652, 8 a.m. to 5 p.m., Monday through Friday.</p> <p>Go to <a href="https://blueshieldca.com/provider">blueshieldca.com/provider</a> and click on <i>Eligibility &amp; benefits</i>.</p>
<p><b>Access-to-Care and Continuity of Care/Medical Records:</b> Your office is without power or damaged by a disaster.</p> <p>Each provider is required to maintain his or her own medical records. In case of a disaster, access to patient records from impacted provider may become impaired.</p>	<p>Emergency and urgently needed services should be appropriately directed to the nearest emergency room or urgent care facility.</p> <p>Routine care should be triaged, as appropriate, to other providers in your IPA/medical group. For extended disasters or where your IPA/medical group physicians are not available, members are entitled to appropriate access to care and may be routed to other providers to assure necessary care is provided.</p> <p>Should a provider office be damaged and records inaccessible, care should be provided as medically indicated.</p>
<p><b>Referral Authorizations:</b> Your IPA/medical group office is without power or damaged by a disaster and you cannot obtain either a written or verbal approval for necessary care.</p>	<p>Members who need urgent or emergency medical care should be referred as medically indicated. For routine referrals, should your IPA/medical group remain unavailable for more than 48 hours, contact the following for assistance in obtaining approval:</p> <p>Contact Provider Customer Services at (800) 541-6652, 8 a.m. to 5 p.m., Monday through Friday.</p> <p>Go to <a href="https://blueshieldca.com/provider">blueshieldca.com/provider</a> and click on <i>Authorizations</i>.</p>
<p><b>Capitation Payments:</b> Blue Shield experiences a major interruption.</p>	<p>Should a disaster occur, Blue Shield is committed to making payments based on current membership or estimated payments based on the prior month's membership.</p>

# Disaster and Contingency Planning Guide

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# Blue Shield Medicare Advantage Plan Required Billing Elements

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## Skilled Nursing Facility Discharges (SNF or TCU)

### Background

There have been longstanding federal regulations designed to protect member rights for Medicare Advantage (MA) enrollees. These regulations include the right to due process, with appeal rights when any service or item being denied or as cited in section 422.568(c) of the Balanced Budget Act, when a discontinuation of a service occurs and the member disagrees.

For skilled nursing facility discharges, discontinuation of service, continued stay beyond the maximum Medicare / Blue Shield Medicare Advantage plan covered benefit of 100 days per benefit period, a specific, regulatory notice is required to be provided to the beneficiary (member) (or legal representative) and said notice requires a signed acknowledgement of receipt.

### What constitutes a valid acknowledgement of receipt?

The Centers for Medicare & Medicaid Services (CMS) has external review performed through Maximus Federal Services (Maximus). We are summarizing from Maximus “Reconsideration Notes”, the guidelines for appropriate notice of receipt of the Notice of Non-Coverage (NONC) for SNF discharges. Signature validates receipt of the notice but does not imply any agreement. The notice ties to delivery of member rights and for a notice to be considered to have occurred, the following guidelines apply:

Delivery in person is preferable and the member must sign the actual notice. For appeals cases, the plan must provide a copy of the actual notice delivered, not a sample letter, along with the signature page, with the member signature, acknowledging receipt.

If a member refuses to sign an acknowledgment of receipt of the Notice of Non-Coverage, both the beneficiary’s medical chart and the “refusal to sign” page of the notice should reflect:

- The date the notice was delivered.
- The individual who delivered the notice.
- Specific reasons for the member’s refusal to sign the notice receipt acknowledgment form.
- If a witness is able to attest a patient’s refusal to sign, document the delivery of the notice and obtain the witness’s signature as attestation to the patient’s refusal to sign.
- If a witness is not available, the individual delivering the notice should sign the acknowledgment form to attest the attempted delivery of the Notice of Non-Coverage.

Enhancements to build on the acknowledgment of receipt in the case of a refusal to sign:

- Often, a verbal notice of a planned discharge occurs prior to delivery of the actual written notice. Although not required, if a verbal notice occurs, it can be easily noted on the Acknowledgment of Receipt page prior to delivery of the notice to the member. By noting the verbal notice on the acknowledgment of receipt, the case documentation is enhanced, should an issue be subsequently appealed. NOTE: Verbal notice does not meet the requirements for valid notice. Verbal notice can only be used to enhance the case documentation related to the actual delivery of a valid notice with a signed acknowledgement of receipt.

# Blue Shield Medicare Advantage Plan Required Billing Elements

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## Skilled Nursing Facility Discharges (SNF or TCU) *(cont'd.)*

### Guardians and Incompetent Patients

A Notice is not valid if delivered knowingly to an incompetent patient. Having a patient being discharged from skilled nursing care with a diagnosis of dementia is not likely to hold as a valid notice on appeal unless there are documented attempts to also deliver the Notice of Non-Coverage (NONC) to and secure a signed acknowledgment from any legal guardian or other family members.

Legal guardians include court appointed guardians, family members with Durable Power of Attorney for Health Care, or appropriate legal counsel/attorney representation. Additionally, it is also recognized that, as a practical matter, there are circumstances when appointment documentation cannot be obtained in a timely manner. If a member is not competent or is physically unable to sign the statement, and the representative is the spouse or next of kin, the notice acknowledgement that is signed by a default representative should be clearly documented by the facility as to the applicability of a state allowable person to be a default representative. In the event there is any controversy related to such default representation, only a representative as determined by the appropriate state court would be accepted.

If verbal or telephonic notice is provided to a representative, this is only as back up to the actual signed acknowledgement of written notice. The member officially receives notice when the written notice is delivered and a signed acknowledgement obtained or a clearly documented refusal to sign the acknowledgement occurs.

We are challenged when a guardian is unwilling to sign the acknowledgment of receipt of the notice and direct hand delivery is not viable. In such cases, document all attempts to both verbally inform and to physically deliver the notice carefully. If delivery of the notice to a guardian for an incompetent patient is via mail, keep all receipts from the courier service or certified mail (return receipt required) to demonstrate delivery of the notice. In such cases, the signed courier service or other confirmation of delivery can be submitted as valid acknowledgement of receipt.

- The patient's chart should document any verbal notice
- Document attempted delivery to member and guardian
- Obtain signed acknowledgement of receipt or document (and preferably witness) actual delivery of the notice, where there is a refusal to sign

*Note: In cases where care must be coordinated through an offsite guardian, provide adequate time for delivery of a valid notice. (A courier service delivery will delay notice and potentially discharge by only one day if they are able to deliver to the guardian. U.S. Certified mail is not as predictable.)*

# Blue Shield Medicare Advantage Plan Required Billing Elements

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## Skilled Nursing Facility Discharges (SNF or TCU) *(cont'd.)*

### Regulatory Changes and the Centers for Medicare & Medicaid Services

**Important Notice:** The Grijalva Final Rule 42 C.F.R. § 422.620 contains provisions required under the settlement agreement in the Grijalva v. Shalala litigation concerning appeal rights under the Medicare managed care program to Medicare Advantage (MA) enrollees at the time of discharge from an inpatient hospital stay. For the Grijalva portion, which relates to SNF, Home Health and CORF discharges, the effective date was January 1, 2004. The current requirement still in effect for IPAs is to deliver the Notice of Non-Coverage (NONC) within one day prior to the effective date of the discharge.

#### ***The Final Rule Requires:***

- The right to an immediate review of a Medicare Advantage Organization (MAO) discharge decision by an independent review body if the enrollee believes services should continue.
- Advanced written notice to all MA enrollees **at least two days before** the termination of certain services (before planned termination of Medicare coverage of their skilled nursing facility (SNF), home health agency (HHA) or comprehensive outpatient rehabilitation facility (CORF) services), with instructions on how to obtain a detailed notice and file an appeal.
- Upon request, a specific and detailed explanation of why services are either no longer medically necessary or are no longer covered by the health plan. The health plan also needs to describe any applicable Medicare coverage rule, MA policy, contract provision or rationale upon which the termination decision was based.

In addition, the final rule requires MAOs to provide detailed discharge notices only in those situations where enrollees indicate dissatisfaction with the health plan's decision. All Medicare beneficiaries who are treated in a hospital will continue to receive generic notices upon admission that will inform them of their appeal rights, but only those beneficiaries that disagree with the decision to be discharged must be issued a detailed written notice of non-coverage one day before their hospital coverage ends. If an appeal is filed, beneficiaries remain entitled to continuation of coverage for their hospital stay until the quality improvement organization renders a decision.

Enrollees then may request an independent review of the MA organization's decision to end coverage of SNF, HHA or CORF services. In the event of a timely appeal request, an MA organization must issue a second, detailed notice that explains the reasons why Medicare coverage should end.

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 MA organization must provide the second, detailed notice to both the QIO and the enrollee.

# Blue Shield Medicare Advantage Plan Required Billing Elements

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## Skilled Nursing Facility Discharges (SNF or TCU) *(cont'd.)*

### Regulatory Changes & the Centers for Medicare & Medicaid Services *(cont'd.)*

***Provider Notification of Termination.*** An important feature of the final rule provisions is that Medicare would charge providers with the actual delivery of the required notices. CMS believes that the providers themselves are in the best position to deliver the notices to enrollees, and that it would be placing an unreasonable burden on MAO's to require that they deliver the notices to affected enrollees. The MA organization would retain ultimate responsibility for the decision to terminate services and for financial coverage of the services, however. The services would remain covered until four calendar days after an enrollee receives the termination notice, or if the Independent Review Entity reviews the decision, until noon on the day after an Independent Review Entity decision upholding the MAO's decision. CMS believes that the requirement that providers issue these notices, in effect on behalf of MAO's, best ensures that beneficiaries receive these notices in a timely manner. To facilitate implementation of this policy, we are proposing under §422.502(I) that all contracts between MAO's and their providers must specify that the providers will comply with the notice and appeal provisions in subpart M of the federal requirements.

***Timing of Notices.*** Section 422.624(b)(1) addresses the timing of the required notices. In general, the provider would notify the enrollee of the MAO's decision to terminate covered services two calendar days before the scheduled termination. Again, the current requirement still in effect is within one day of the date of discharge. If the provider services are expected to be furnished to an enrollee for a time span of fewer than two calendar days in duration, the enrollee should be given the notice upon admission to the provider (or at the beginning of the service period if there is no official "admission" to a non-institutional provider, such as in an HHA setting). The notice must be given in all situations, regardless of whether an enrollee agrees with the decision that his or her services should end.

CMS would allow providers a full working "day" within which to deliver the termination notice, with any notification delivered during normal business hours on a given day serving to initiate the four-day standard on that day, even if the timing of the delivery of the notice resulted in fewer than 24 hours to ask for an Independent Review Entity appeal, and fewer than 96 hours between notification and the proposed termination of services. That is, a notice delivered to a member at 2 p.m., Monday, would indicate that the member has until noon, Tuesday, to appeal to the Independent Review Entity, with termination of services scheduled for noon, Friday.

# Blue Shield Medicare Advantage Plan Required Billing Elements

## Skilled Nursing Facility Discharges (SNF or TCU) *(cont'd.)*

### Regulatory Changes & the Centers for Medicare & Medicaid Services *(cont'd.)*

**Delivery of Notices.** §422.624(c) specifies that “delivery” of a notice is valid only if a member has signed and dated the notice to indicate that he or she both received the notice and can comprehend its contents. This policy is consistent with our requirements governing delivery of similar notices, such as the requirements set forth in HCFA Program Memoranda A-02-018 for HHA Advanced Beneficiary Notices. Under this concept, a member who is comatose, confused, or otherwise unable to understand or act on his or her rights could not validly “receive” the notice, necessitating the presence of an authorized representative for purposes of receiving the notice. Similarly, presenting the standardized notice to a person who is illiterate, blind, or unable to understand English would not constitute successful “delivery” of the notice. Such situations could be remedied either through use of an authorized representative if that person has no barriers to receiving the notice or through other steps (such as use of a translator or language accessible version of the notice) that overcome the difficulties associated with notification.

*Note: CMS would not interpret the requirement for successful delivery to permit an enrollee to extend coverage indefinitely by refusing to sign a notice of termination. If an enrollee refuses to sign a notice, the provider would annotate its copy of the notice to indicate the refusal, and the date of the refusal would be considered the date of receipt of the notice. Paragraph (c) describes what constitutes an effective delivery of a termination notice. The notice would have to be delivered timely, using standardized format and language, and include all of the elements required under §422.624(b)(2).*

### BLUE SHIELD OF CALIFORNIA APPEAL PROCESS FOR NOTICE OF NON-COVERAGE HHA, SNF, CORF

#	Responsible Party	Activity	Time Requirement
	MSO	Determines termination date and drafts Notice of Medicare Non-Coverage (NOMNC). Faxes to SNF, HHA, CORF. If SNF, HHA, CORF prepare their own notices then notification needs to be given for termination date.	No less than 2 days prior to termination of services
1.	SNF, HHA, CORF	Issues NOMNC and obtains member's signature. SNF- at least 2 days prior to termination If < 2 days of service, then on admission or first visit, if the enrollee’s services are expected to be fewer than 2 days in duration, the SNF, HHA, or CORF should notify the enrollee at the time of admission to the provider. If, in a non-institutional setting, the span of time between services exceeds two days, the provider should deliver the notice no later than the next to last time that services are furnished. If benefits are exhausted a notice is required, the member may appeal, however these are referred back to the health plan to review and respond to this appeal. If a HHA is going out for an evaluation only, the agency is not required to send a notice. Also when only partial services are being discontinued (i.e., PT ends, but HHC continues), no notice is needed until all services end.	2 days prior to termination of services

# Blue Shield Medicare Advantage Plan Required Billing Elements

#	Responsible Party	Activity	Time Requirement
2.	Enrollee	Disagrees with the discharge, the enrollee must contact the Quality Improvement Organization (QIO), Health Services Advisory Group, Inc. This request is made either in writing, telephone or fax, by noon the day after receipt of the NOMNC. The notice is still considered timely as long as Health Services Advisory Group, Inc. receives the appeal request no later than noon the day before the effective date that Medicare coverage ends.	No later than noon the day after receipt of notice
3.	QIO = Health Services Advisory Group, Inc.	Receives Appeal request from enrollee or representative. Immediately notifies Medicare Advantage and the provider of the enrollee's request for a fast track appeal by phone and fax.	Day 1 begins
4.	MA (Medicare Advantage) = Medicare Advantage plan	Receives notice of appeal from Health Services Advisory Group, Inc. (by phone & fax) requesting the following information for review: A copy of the advance notice of termination (NONMC), a copy of the detailed explanation of Non-coverage (DENC), a copy of enrollee's medical records, and a copy of other documents as requested.	Day 1
5.	Blue Shield Medicare Advantage plan	Contact CM at IPA/MSO and request the information above faxed to Health Services Advisory Group, Inc. for review. Advise of same day requirement for sending these records. Request coversheet confirming records were sent to Health Services Advisory Group, Inc., copy of NONMC and DENC faxed to Blue Shield Medicare Advantage plan. Also contact should be made to SNF requesting records & NOMNC be faxed to Health Services Advisory Group, Inc. for review with confirmation of this to Blue Shield. Health Services Advisory Group, Inc. needs the detailed chart notes that SNF's have for review.	Day 1
6.	Blue Shield Medicare Advantage plan	If IPA/MSO is unable to make Day 1 submission requirement, notify Manager, Director or Medical Director.	Day 1
7.	Blue Shield Medicare Advantage plan	Manager, Director or Medical Director then contacts IPA Director of UM/QM & or Medical Director to obtain documents.	Day 1
8.	IPA/MSO	Faxes records to: 1.) Health Services Advisory Group, Inc. Copy of NOMNC with member's signature or documentation of refusal to sign, copy of DENC and copy of enrollee's medical records. 2.) Member/representative: Mails DENC. Upon request, all documents sent to Health Services Advisory Group, Inc.	Day 1

## Blue Shield Medicare Advantage Plan Required Billing Elements

#	Responsible Party	Activity	Time Requirement
9.	Blue Shield Medicare Advantage plan	IPA makes decision to rescind the termination date and send new letter to member Fax copy of letter to Health Services Advisory Group, Inc.	Resolved Go to step 14
10.	Health Services Advisory Group, Inc.	Reviews documents Renders decision to uphold or overturn Notifies Blue Shield Medicare Advantage plan of decision by phone or fax. Mails letters of determination to Blue Shield Medicare Advantage plan and enrollee	Day 1 If Resolved Go to step 14
11.	Health Services Advisory Group, Inc.	If documents not received by Health Services Advisory Group, Inc., on Day 2, Health Services Advisory Group, Inc. sends to Blue Shield Medicare Advantage plan , "Notice: Failure to Comply" requesting documents again.	Day 2
12.	Blue Shield Medicare Advantage plan	Call IPA/MSO contact again to ensure all documents are faxed to Health Services Advisory Group, Inc. for review.	Day 2
13.	Health Services Advisory Group, Inc.	Review documents Render decision to uphold or overturn Notifies IPA & Blue Shield Medicare Advantage plan of decision by phone or fax. Mails letters of determination to Blue Shield Medicare Advantage plan and enrollee	Day 2
14.	Blue Shield Medicare Advantage plan	Logs all actions, dates & times in Notes document  Prepare file for each appeal with notes on left side of folder, all other documents are filed on right side of folder, latest on top Record case in Grijalva Appeals tracking log	Real time
15.	Blue Shield Medicare Advantage plan	Cases are filed away in a locked cabinet alphabetically	Conclusion

# Blue Shield Medicare Advantage Plan Required Billing Elements

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## Skilled Nursing Facility Discharges (SNF or TCU) *(cont'd.)*

### Contractual and Billing Requirements

Contracts already obligate providers to compliance with state and federal regulations. As part of the new CMS rule, contracted entities must comply with applicable notice and appeal provisions in subpart M, including but not limited to, the notification requirements in §§422.620 and 422.624 and the requirements in §422.626 concerning supplying information to an Independent Review Entity.

### Questions & Answers:

- **Is the provider or MA organization required to obtain an enrollee's signature on the advance termination notice or detailed termination notice?**  
The provider must obtain the enrollee's or authorized representative's signature on the advance termination notice (NOMNC), which ensures that the enrollee received the notice, and that financial liability may be properly transferred to the enrollee for any days beyond the effective date that Medicare coverage ends. The provider must place the original NOMNC in the enrollee's case file, and give a copy to the enrollee. In the event of an appeal, the provider must also provide a copy to the Quality Improvement Organization (QIO), since the QIO is responsible for verifying that the provider delivered a valid notice to the enrollee.  
  
The MA organization does not need to obtain the enrollee's or authorized representative's signature on the detailed notice, which is called the Detailed Explanation of Non-Coverage (DENC).
- **Suppose that an enrollee is receiving physical therapy, wound care, and IV in a SNF. If the SNF only discontinues the IV, is the SNF required to deliver an NOMNC to the enrollee two days prior to the IV ending?**  
No. A provider is not required to deliver the NOMNC two days prior to one service ending, while other Medicare-covered services continue. The fast-track appeals process applies only to situations when the enrollee will no longer receive Medicare-covered services from the provider. The scenario described would be considered a reduction, rather than a termination, of services.
- **Many patients receiving home health care only require a single visit. Can the NOMNC be given during the first (and last) visit?**  
Yes. In cases where the services or visits will be less than two days, the NOMNC may be given upon admission, or during the only visit.
- **If a member is in a SNF, gets pneumonia and subsequently needs to go to an acute setting, should the member receive the NOMNC?**  
No. The NOMNC is not intended or required for this situation.
- **Will SNFs, HHAs, and CORFs be required to retain copies of NOMNCs in patients' medical records? Will the MA organization need to obtain a copy?**  
The provider should retain a copy of the NOMNC as part of the patient's medical record; however, MAO's and providers should determine how and where the notices should be maintained to meet medical records' retention policies.

# Blue Shield Medicare Advantage Plan Required Billing Elements

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## Skilled Nursing Facility Discharges (SNF or TCU) *(cont'd.)*

### Contractual & Billing Requirements *(cont'd.)*

- **If a provider is discontinuing a previously authorized, discrete increment of services, e.g., the MA organization authorized 12 skilled nursing visits by an HHA nurse, does the provider still have to issue a NOMNC if the provider is planning to discharge the patient as scheduled on the last visit? Why?**  
Yes. The provider must deliver the NOMNC no later than the next-to-last visit in this example. Providing a notice to the enrollee not only conveys when the services are going to end, but also informs the enrollee of the right to appeal if the enrollee disagrees, and transfers liability to the enrollee if the enrollee continues to receive non-covered services.
- **Can you please clarify if whether the fast-track appeals process also includes psychiatric home health services?**  
Yes, the fast-track appeals process applies to psychiatric home health services.
- **How will providers know what their responsibilities are under the new fast-track appeals process?**  
CMS provides information to providers on their responsibilities under this new appeals process through CMS' Medlearn website, CMS' "list serve" of participating providers, outreach to provider trade associations, and CMS open door forums. In addition, we are instructing our fiscal intermediaries and carriers to include an article about the process in their next provider bulletins. QIOs also are required to provide education and training to the providers with whom they have agreements. MAO's must also do their part to ensure that their providers are educated about their responsibilities under the fast-track appeals process.
- **Will CMS release the NOMNC to providers, or will MAO's be required to distribute the notices to the providers directly?**  
The notices are available online at <https://www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices>. MAO's should work with their providers to determine whether direct distribution is necessary. The provider education material that we have distributed refers providers to the "appeals" website.

# Blue Shield Medicare Advantage Plan Required Billing Elements

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## CMS Model Letters:

- DETAILED NOTICE OF DISCHARGE (Attachment A)
- NOTICE OF MEDICARE NON-COVERAGE (Attachment B)

(Attachment A – CMS Model Letter – **SAMPLE** - Must be 12 point font)

Patient Name:  
Patient ID Number:  
Physician:

**OMB Approval No. 0938-1019**  
Date Issued:

**{Insert Hospital or Plan Logo here}**  
**DETAILED NOTICE OF DISCHARGE**

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You have asked for a review by the Quality Improvement Organization (QIO), an independent reviewer hired by Medicare to review your case. This notice gives you a detailed explanation about why your hospital and your managed care plan (if you belong to one), in agreement with your doctor, believe that your inpatient hospital services should end on \_\_\_\_\_ . This is based on Medicare coverage policies listed below and your medical condition. **This is not an official Medicare decision.** The decision on your appeal will come from your Quality Improvement Organization (QIO).

- Medicare Coverage Policies:

\_\_\_\_ Medicare does not cover inpatient hospital services that are not medically necessary or could be safely furnished in another setting. (Refer to 42 Code of Federal Regulations, 411.15 (g) and (k)).

\_\_\_\_ Medicare Managed Care policies, if applicable: \_\_\_\_\_  
**{insert specific managed care policies}**

Other \_\_\_\_\_  
**{insert other applicable policies}**

- Specific information about your current medical condition:
- If you would like a copy of the documents sent to the QIO, or copies of the specific policies or criteria used to make this decision, please call **{insert hospital and/or plan telephone number}**.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938- 1019. The time required to complete this information collection is estimated to average 60 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. CMS 10066 (approved 5/2007)

# Blue Shield Medicare Advantage Plan Required Billing Elements

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(Attachment B – CMS Model Letter – SAMPLE - Must be 12 point font)

OMB Approval No. 0938-0953

{Insert provider contact information here}

## NOTICE OF MEDICARE NON-COVERAGE

**Patient name:**

**Patient number:**

**The Effective Date Coverage of Your Current** {insert type}

**Services Will End:** {insert effective date}

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- Your Medicare provider and/or health plan have 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 services you receive after the above date.

### Your Right to Appeal This Decision

- You have the right to an immediate, independent medical review (appeal) of the decision to end Medicare coverage of these services. Your services will continue during the appeal.
- If you choose to appeal, the independent reviewer will ask for your opinion. The reviewer also will 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 services should no longer be covered after the effective date indicated above.
- Neither Medicare nor your plan will pay for these services after that date.
- If you stop services no later than the effective date indicated above, you will avoid financial liability.

### How to Ask For an Immediate Appeal

- You must make your request to your Quality Improvement Organization (also known as a QIO). A QIO is the independent reviewer authorized by Medicare to review the decision to end these services.
- Your request for an immediate appeal should be made as soon as possible, but no later than noon of the day before the effective date indicated above.
- The QIO will notify you of its decision as soon as possible, generally no later than two days after the effective date of this notice if you are in Original Medicare. If you are in a Medicare health plan, the QIO generally will notify you of its decision by the effective date of this notice.
- Call your QIO at: Health Services Advisory Group of California, Inc., 1-800-841-1602, TTY 1-800-881-5980, to appeal, or if you have questions.

# Blue Shield Medicare Advantage Plan Required Billing Elements

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See page 2 of this notice for more information.

Form CMS 10123-NOMNC (Approved 12/31/2011)  
H0504\_12\_095B File & Use 05052012

OMB approval 0938-0953

## If You Miss The Deadline to Request An Immediate Appeal, You May Have Other Appeal Rights:

- If you have Original Medicare: Call the QIO listed on page 1.
- If you belong to a Medicare health plan: Call your plan at the number given below.

Plan contact information:

Blue Shield Medicare Advantage Plan  
Attn: Medicare Appeals and Grievances Dept.  
P.O. Box 927  
Woodland Hills, CA 91365-9856

Ph: 1-800-776-4466  
TTY: 1-800-794-1099  
Fax: 1-916-350-6510

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Additional Information (Optional):

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Please sign below to indicate you received and understood this notice.

I have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision by contacting my QIO.

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Signature of Patient or Representative  
Form CMS 10123-NOMNC (Approved 12/31/2011)

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Date  
OMB approval 0938-0953

# Blue Shield Medicare Advantage Plan Required Billing Elements

## Optional Attachment to assist with documentation

Please fax completed (signed) Notice of Medicare Non-Coverage (NOMNC) to:

<b>CONFIRMATION OF NOTICE BY TELEPHONE</b>	
(Notification by telephone is done only in situations where the notice must be delivered to an incompetent enrollee in an institutional setting. See <i>Medicare Managed Care Manual</i> , Chapter 13, Section 60.1.3 for reference.)	
Name of person contacted:	
Date of contact:	Time: <input type="checkbox"/> AM <input type="checkbox"/> PM
_____	
Signature of Health Plan/SNF/HHA/CORF/Medical Group Representative	Date
<b>CONFIRMATION OF FOLLOW-UP NOTICE BY MAIL</b>	
(Notification by mail must also be done if telephone notification was made. This is done only in situations where the notice must be delivered to an incompetent enrollee in an institutional setting. See <i>Medicare Managed Care Manual</i> , Chapter 13, Section 60.1.3 for reference.)	
Mailing address:	
_____	
_____	
Date sent: _____	Via: <input type="checkbox"/> US Mail <input type="checkbox"/> Certified Mail <input type="checkbox"/> FedEx <input type="checkbox"/> Priority Mail
_____	
Tracking # (if applicable): _____	
<b>CONFIRMATION OF REFUSAL TO SIGN</b>	
<i>I confirm that the Notice of Medicare Non-Coverage was hand-delivered to the member or the member's authorized representative; however, the member or the member's authorized representative refused to sign the acknowledgment of receipt.</i>	
Name of person receiving notice:	
Date of delivery:	Time: <input type="checkbox"/> AM <input type="checkbox"/> PM
_____	
Signature of Person Delivering Notice	Date

# Blue Shield Medicare Advantage Plan Required Billing Elements

Guidance Checklist When Issuing NOMNC to Other Than Member (See Medicare Managed Care Manual, Chapter 13, Section 60.1.3)	Responsible Party		Initial Completed	Date	Time
	SNF	BSC/MG/ IPA			
Call patient's representative the day letter is issued. (Date of conversation is the date of the receipt of the NONMC). ID self and give organization, contact name and number, purpose of call (right to file an appeal) and describe the appeal right being discussed (e.g., QIO vs. expedited).					
Inform representative that skilled services will no longer be covered beginning on: (date) _____ and financial responsibility starts on (date) _____					
Advise representative of appeal rights. (You must read directly from the letter)					
Advise representative that an appeal must be phoned to HSAG by 12:00 p.m. the following day of receipt of the NOMNC or phone call.					
Provide the representative with the QIO name (HSAG) and phone number listed in the appeal section of the letter. Provide address, fax or other method of communication needed by representative for QIO to receive appeal in a timely fashion.					
Inform representative how to get a detailed notice describing why the enrollee's services are not being covered					
Provide at least one phone number of an advocacy organization or 1-800-MEDICARE					
Confirm the telephone contact by written notice mailed same day.					
If direct phone contact cannot be made, including leaving voice mail, mail the notice to the representative, certified mail, return receipt requested. (If the <b>Medical Group</b> is sending the certified mail, the Facility must notify the Medical Group immediately that certified mail is required.)  (If the <b>Facility</b> sent the certified mail, and HSAG is processing an appeal, the certified returned receipt must be submitted to HSAG. If not submitted, the appeal may be decided in favor of the member solely due to lack of the receipt which is the evidence of timely notification.)					
Document that representative understands the information provided.					