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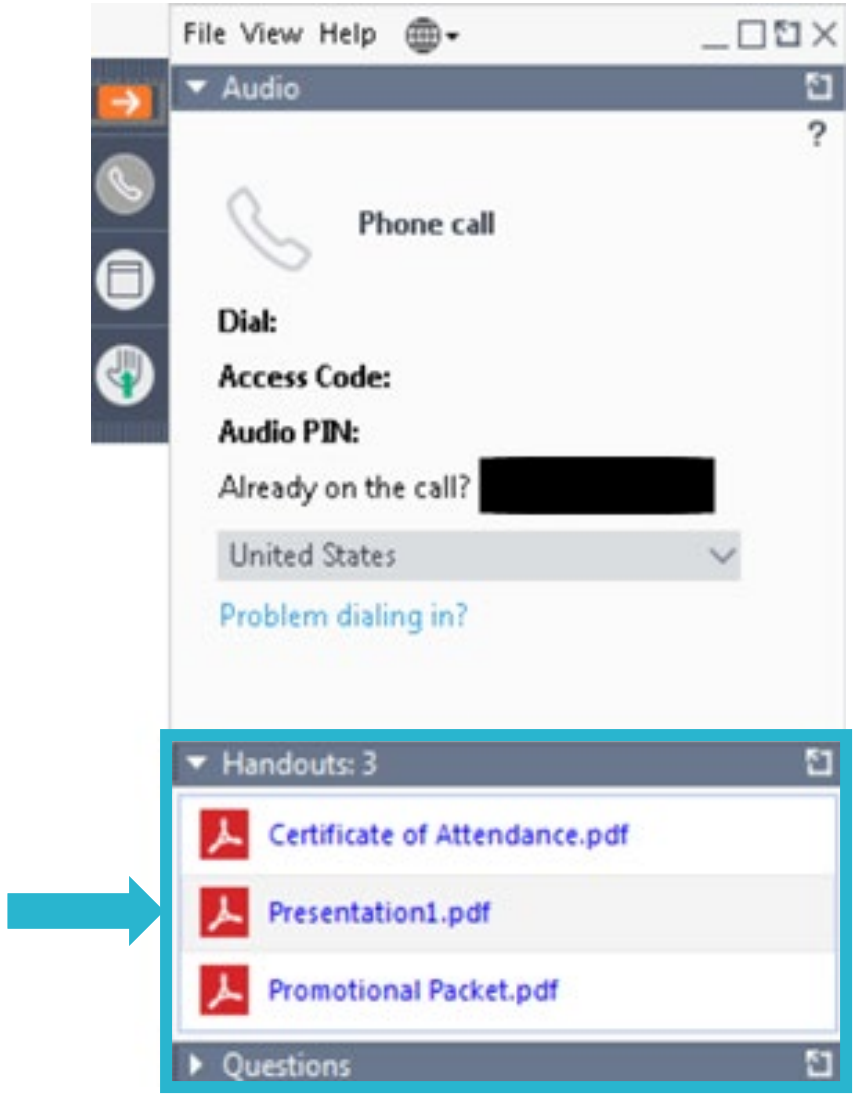

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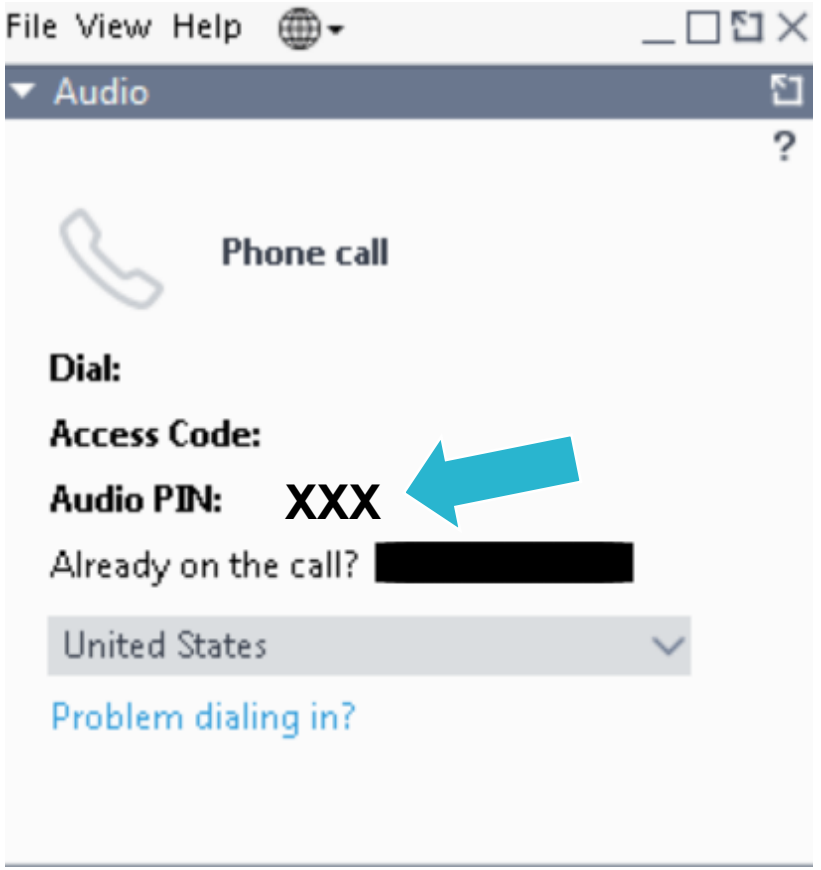

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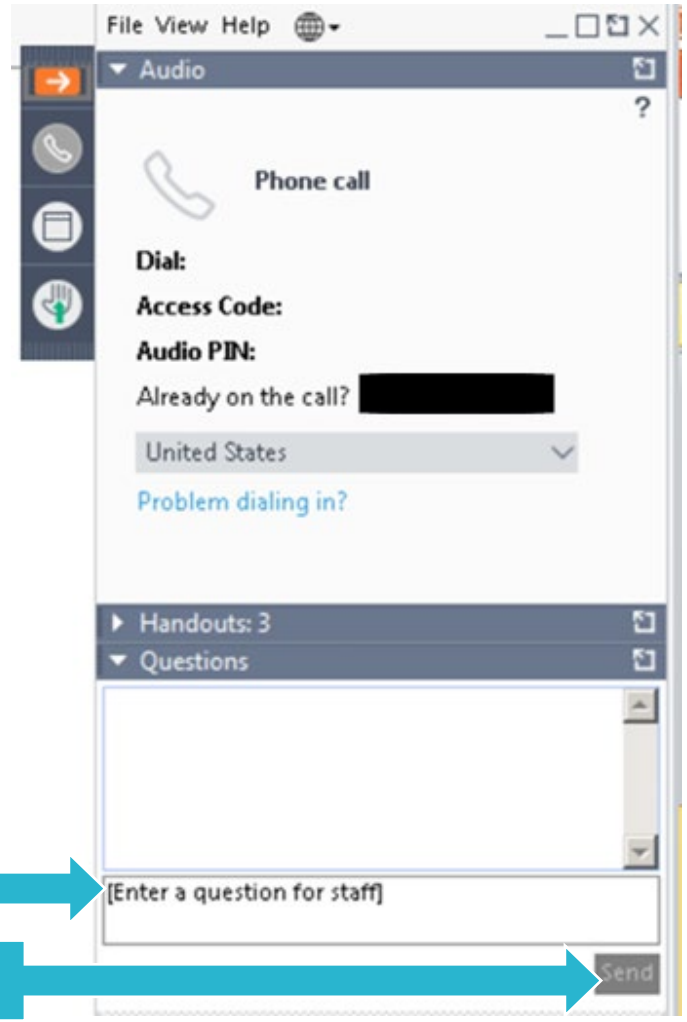

BFCC-QIO 101 for Healthcare Providers

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Bryan Fischer, Livanta LLC
Nancy Jobe, Kepro

September 2022

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Objectives

1. Describe the Beneficiary and Family Centered Care – Quality Improvement Organization (BFCC-QIO).
2. Discuss best practices for the issuance of Medicare beneficiary notices.
3. Discuss methods for transmitting medical records to the BFCC-QIO.
4. Review provider responsibilities.

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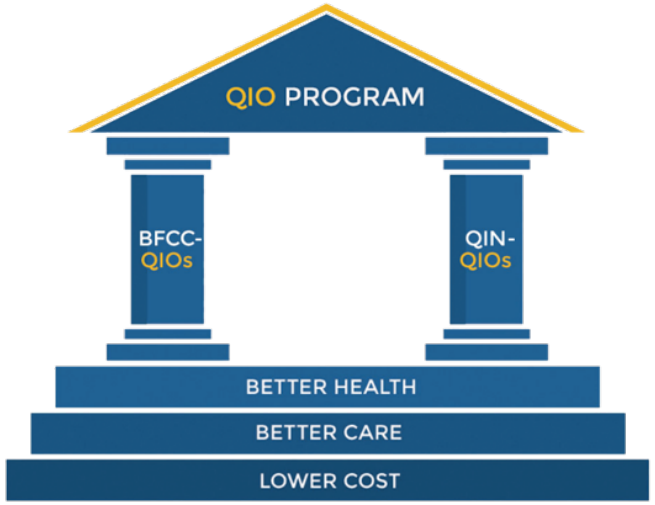
The Quality Improvement Organization (QIO) Program

- Medicare beneficiaries have the right to high quality healthcare.
- These rights are protected through physician (peer) review.
- Case Review Services
  - Discharge or Skilled Service Termination **Appeals**
  - Quality of Care **Complaints**
- **Immediate Advocacy:** Real-time assistance to resolve issues with care or Medicare-covered services.



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Two Contractors - National Coverage

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Quality Innovation Network – Quality Improvement Organization (QIN-QIO)

QIN-QIOs engage providers to participate in quality improvement projects, such as:

- Behavioral health outcomes
- Opioids
- Patient safety
- Chronic disease self-management
- Quality of care transitions
- Nursing home quality

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Beneficiary and Family Centered Care - Quality Improvement Organizations (BFCC-QIO)

- **Services provided by BFCC-QIOs:**
  - Case review for discharge and service termination appeals;
  - Case review for quality of care complaints; and
  - Beneficiary advocacy.
- **Medicare beneficiaries have the right to access BFCC-QIO services.**
  - All services provided by the BFCC-QIO are at no cost to Medicare patients and families.
- **Together, Kepro and Livanta provide BFCC-QIO services for all of the nation's Medicare beneficiaries.**

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Care Settings and Eligibility

Discharge or service termination appeals:

- Hospitals, hospices, home health agencies, skilled nursing facilities, and comprehensive outpatient rehab facilities (CORF)
- Applies to Medicare-covered inpatient or skilled services

Quality of care complaints:

- All care settings that accept Medicare
- Excludes dialysis facilities for end stage renal disease (ESRD) treatment

Immediate advocacy:

- All care settings that accept Medicare

Who is Eligible?

- Beneficiaries with Traditional Fee-for-Service Medicare and those who are Medicare and Medicaid dual-eligible
- Beneficiaries with Medicare Advantage plans

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BFCC-QIO Beneficiary Tasks

For Medicare Beneficiaries, the BFCC-QIO will:

Review Appeal Requests

Not ready for discharge or to end services? We'll review the case.

Review Quality of Care Complaints

Need to file a formal complaint about quality of care issues? Download the complaint form from our website.

Provide Advocacy Services

Ongoing issues can be addressed by Livanta's Immediate Advocacy program.

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What is Immediate Advocacy?

Immediate Advocacy is an informal complaint resolution service.

- A beneficiary or representative may request advocacy as a “real-time assistance” to resolve their issue.
- The complaint is received within six months of the date of service.
- Does not involve medical record review.
- Cases are usually closed in five days or less.
- Cases are only worked during business hours on weekdays.

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What is a Quality Complaint?

Beneficiary-reported complaints

- Examples: Medication errors, misdiagnosis, adverse events.
- Include review of medical record.

General quality of care

- Focused reviews
- Special studies
- External referrals

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Complaints - Getting a Decision

- **The beneficiary or their legal representative will receive a decision from Livanta over the phone *and* in writing (providers receive the decision in writing only.**
  - Livanta generally completes the case review within 30 - 45 days from receipt of the complaint form, although some cases may take longer.
  - Beneficiary decision letters are designed to be easy to understand and reference "Standards of Care."
- **Quality reviews are typically non-punitive.**
- **Re-consideration rights:**
  - Patient right to reconsideration (as of March 2017).
  - Provider has 3 days to request a reconsideration.

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What is a QIO Appeal?

- **In Medicare, a QIO appeal is a review action performed by a Medicare BFCC-QIO.**
  - QIO appeals ensure that providers are ending Medicare-covered services appropriately.
  - QIO appeals are not related to coverage denials or billing.
- **Medicare beneficiaries have the right to appeal discharge or service termination notices from:**
  - Hospitals
  - Skilled nursing facilities (SNFs)
  - Home health agencies (HHAs)
  - Hospice providers
  - Comprehensive outpatient rehabilitation facilities (CORFs)

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Appeals: Intake Process

- **Providers must issue the appropriate Medicare Beneficiary Notice when the decision is made to discharge or terminate Medicare-covered services.**
  - Hospitals issue Important Message when discharging.
  - Other providers issue the Notice of Medicare Non-Coverage (NOMNC) when terminating Medicare-covered services.
- **If a beneficiary or their representative appeals to the BFCC-QIO, the BFCC-QIO opens a case and:**
  - Notifies the provider an appeal has been filed.
  - Requests medical records by fax.
  - Receives the medical record and begins review.

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Appeals: Review Process

- **Once the BFCC-QIO receives the medical record :**
  - An independent Board-Certified Physician Reviewer (PR) evaluates the medical documentation submitted.
  - The PR determines if the medical documentation supports the decision to terminate the current level of Medicare-covered services.
  - BFCC-QIO establishes the date of potential patient financial liability.
- **The BFCC-QIO notifies the provider and beneficiary by phone of the review outcome.**
  - Verbal and written appeal determination is provided to the patient, the provider, and the Medicare Advantage Plan, if applicable.
  - Second-level appeal information is also provided.

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Levels of QIO Appeal

- **QIO Appeal**
  - Performed by the BFCC-QIO having jurisdiction for the state or territory where care was rendered
  - Conducted in 24-72 hours
- **Second-Level Appeal**
  - Performed by a Qualified Independent Contractor (QIC) or a BFCC-QIO
  - Conducted in 1-3 days for acute care and 1-14 days for non-hospitals
- **Third-Level Appeal: ALJ Hearing**
  - Assigned to a regional Administrative Law Judge (ALJ)
  - May take several weeks or months to be heard
- **Fourth-Level Appeal: Medicare Appeals Council**
  - Final level of appeal

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QIO Appeals: Limitations

QIO appeals are not used to dispute:

- Medicare benefit limitations
- Billing issues
- Denial of emergency room care (EMTALA)
- Observation status versus admission
- Transfers within the same level of care (hospital to hospital etc.)
- Outpatient services
- For non-QIO matters, call 1.800.MEDICARE

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BFCC-QIO Tasks - Other Review Types

- **Emergency Medical Treatment and Labor Act (EMTALA) violations**
  - Federal law regulates how hospitals must treat patients with an emergency medical condition.
  - Applies to hospitals that accept Medicare and Medicaid patients.
- **Hospital Higher Weighted Diagnosis Group (HWDRG) Claim Reviews and Short Stay Reviews (SSRs)**
  - Livanta is the national contractor, conducting this work in all states and territories.
  - Applies to hospitals only.

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Medicare Beneficiary Notices

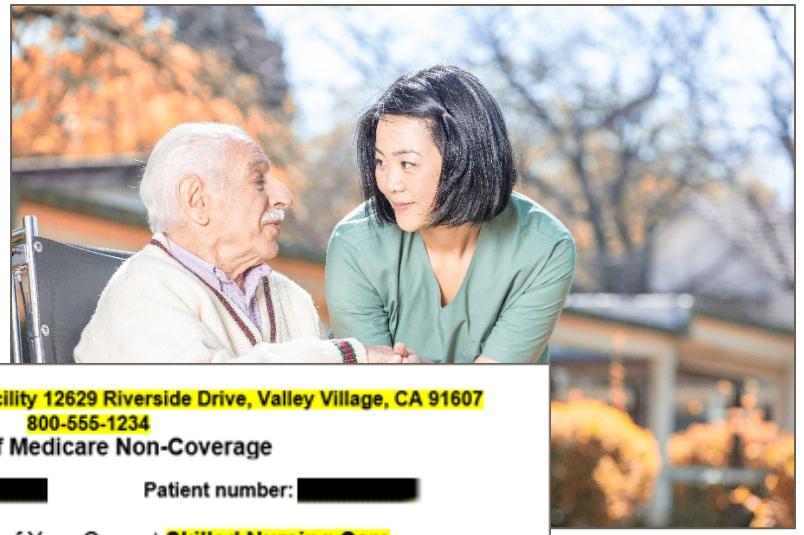
Sacred Heart Hospital 12629 Riverside Dr. Valley Village, CA 1-800-555-1234

Important Message from Medicare

Patient name: [redacted] **Patient number:** [redacted]

Your Rights as a Hospital Inpatient:

- You can receive Medicare covered services. This includes medically necessary hospital services and services you may need after you are discharged, if ordered by your doctor. You have a right to know about these services, who will pay for them, and where you can get them.
- You can be involved in any decisions about your hospital stay.
- You can report any concerns you have about the quality of care you receive to your QIO at: **Livanta LLC, 1-877-588-1123, TTY 855-887-6668** The QIO is the independent reviewer authorized by Medicare to review the decision to discharge you.
- You can work with the hospital to prepare for your safe discharge and arrange for services you may need after you leave the hospital. When you no longer need inpatient hospital care, your doctor or the hospital staff will inform you of your planned discharge date.
- You can speak with your doctor or other hospital staff if you have concerns about being discharged.



Sacred Heart Skilled Nursing Facility 12629 Riverside Drive, Valley Village, CA 91607
800-555-1234

Notice of Medicare Non-Coverage

Patient name: [redacted] **Patient number:** [redacted]

The Effective Date Coverage of Your Current **Skilled Nursing Care** Services Will End: **July 30, 2019**

- 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.

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IM Notice Example

Sacred Heart Hospital 12629 Riverside Dr. Valley Village, CA 1-800-555-1234

Important Message from Medicare

Patient name: [redacted] **Patient number:** [redacted]

Your Rights as a Hospital Inpatient:

- You can receive Medicare covered services. This includes medically necessary hospital services and services you may need after you are discharged, if ordered by your doctor. You have a right to know about these services, who will pay for them, and where you can get them.
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- You can work with the hospital to prepare for your safe discharge and arrange for services you may need after you leave the hospital. When you no longer need inpatient hospital care, your doctor or the hospital staff will inform you of your planned discharge date.
- You can speak with your doctor or other hospital staff if you have concerns about being discharged.

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IM Notice Example cont.

How to Ask For an Appeal of your Hospital Discharge

- You must make your request to the QIO listed above.
- Your request for an appeal should be made as soon as possible, but no later than your planned discharge date and before you leave the hospital.
- The QIO will notify you of its decision as soon as possible, generally no later than 1 day after it receives all necessary information.
- Call the **QIO Livanta LLC, 1-877-588-1123** to appeal, or if you have questions.

If You Miss The Deadline to Request An 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 **Kaiser Permanente Senior Advantage, 1-877-852-5081**

For more information, call 1-800-MEDICARE (1-800-633-4227), or TTY: 1-877-486-2048. CMS does not discriminate in its programs and activities. To request this publication in an alternate format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov .

Additional Information (Optional): Your planned discharge is scheduled for January 29, 2020 at 3PM. If you have additional questions about your discharge, please contact the care transitions team at ext. 2125.

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

Notice of Medicare Non-Coverage (NOMNC)

Sacred Heart Skilled Nursing Facility 12629 Riverside Drive, Valley Village, CA 91607
800-555-1234

Notice of Medicare Non-Coverage

Patient name: [redacted] **Patient number:** [redacted]

The Effective Date Coverage of Your Current **Skilled Nursing Care** Services Will End: **July 30, 2019**

- 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.

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: **Livanta LLC, 1-877-588-1123, TTY 1-855-887-6668** to appeal, or if you have questions.

See page 2 of this notice for more information.

Form CMS 10123-NOMNC (Approved 12/31/2011) 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: **Sample Medicare Advantage Plan, 1-888-321-5555**

Additional Information (Optional):

To discuss your discharge with the care transitions team, please call ext. 2125 to discuss your discharge plan.

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.

Signature of Patient or Representative Date

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Detailed Notice of Discharge/ Detailed Explanation of Non-Coverage

- **If a patient requests an appeal of their discharge, a Detailed Notice of Discharge (DND) or the Detailed Explanation of Non-coverage (DENC) must be issued.**
- **A well-written detailed explanation enhances communication which may in turn result in the withdrawal of the appeal by the patient.**
  - May improve health literacy of the patient and family.
- **Best practice:**
  - Always download latest version of Medicare notices from https://cms.hhs.gov/bni.

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Detailed Notice Example

Patient Name: [redacted]
Patient ID Number: [redacted]

OMB Approval No. 0938-1019
Date Issued : [redacted]

DETAILED NOTICE OF DISCHARGE

- 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:

  ☐ Other

- Specific information about your current medical condition:
  You were admitted to the hospital on [redacted] for care and treatment of Asthma with COPD exacerbation overlap. You underwent several diagnostic tests to determine an appropriate treatment plan. It was determined that you had Asthma with COPD exacerbation overlap. During your hospital course, you received IV antibiotics and fluids. Your medical condition has been fully assessed and treated. Your pain management, blood pressure, heart rate, respiratory rate and temperature are now stable. You no longer require constant 24 hour a day treatment and monitoring including, hospitalization management by physicians or assessment by licensed professionals. Additionally, you no longer require medication at a hospital level of care. Your physician has now determined that you can safely discharge Home with Home Health, if applicable.

- 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 Utilization Management at [redacted] or the [redacted] by dialing [redacted]

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Action for Providers: Appeals

- **CMS's Website for Beneficiary Notices** https://www.cms.hhs.gov/bni
  - Important Message (IM) and the Notice of Medicare Non-Coverage (NOMNC), HINN letters
  - Latest version of the forms and regulatory references
  - Notices can be downloaded with instructions
- **Use of the IM or the NOMNC to give patients their appeals rights**
  - Livanta's Helpline telephone and TTY numbers **MUST** be included
  - Provider logo may appear in the IM header
  - Font size must be no less than 12 point
  - Applies to traditional Medicare and Medicare Advantage patients

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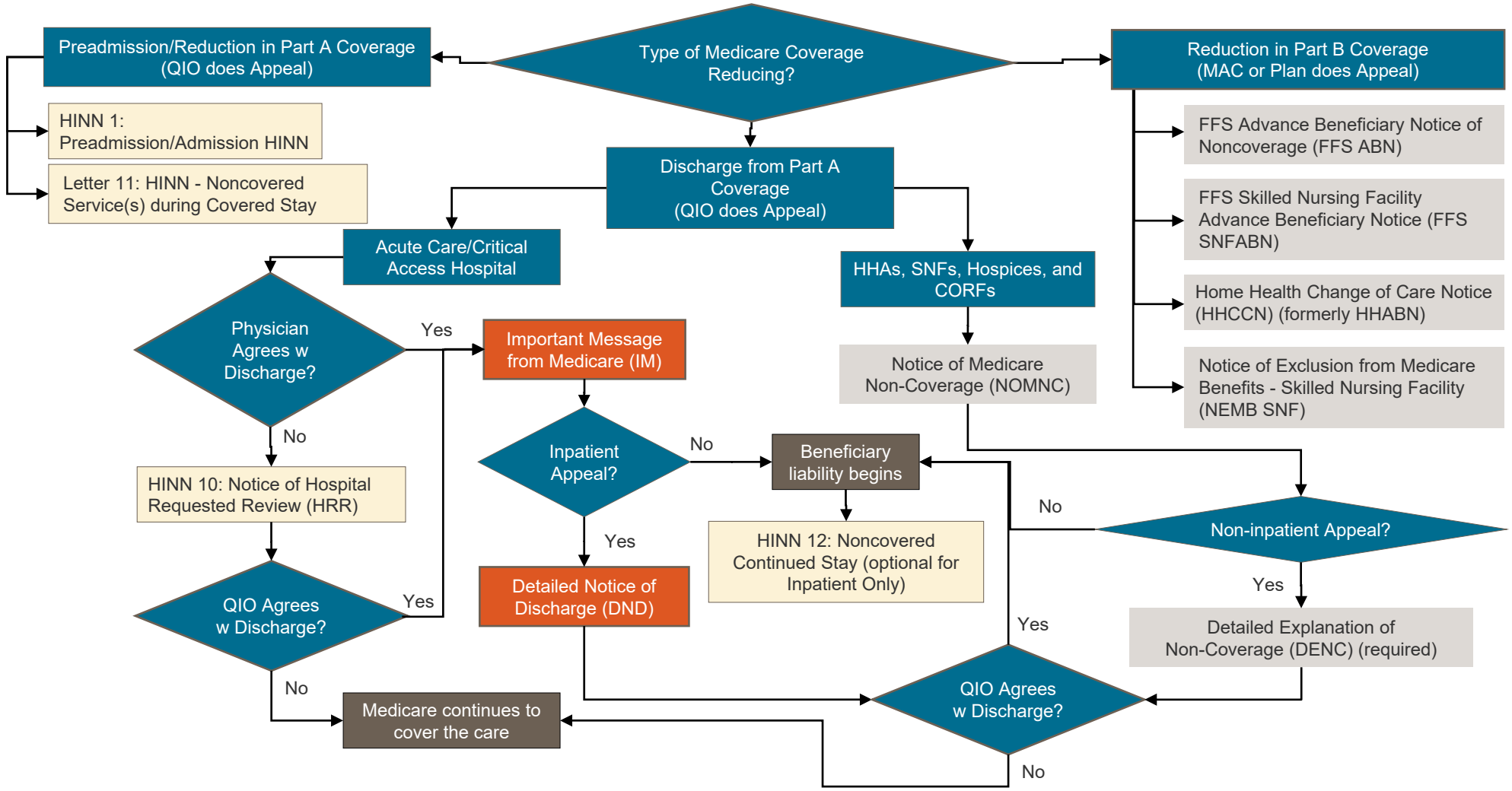
Beneficiary Notice Decision Tree



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Regulatory Requirement: Submit Medical Records to the BFCC-QIO Electronically

42 CFR § 476.78 (b)(2)(ii)(A) requires providers to submit medical records to the QIO in electronic format.

- In effect since October 1, 2020.
- Regulation allows reimbursement for electronic submission of medical records to the QIO for the first time.
- Livanta and Kepro support online submission of medical records.

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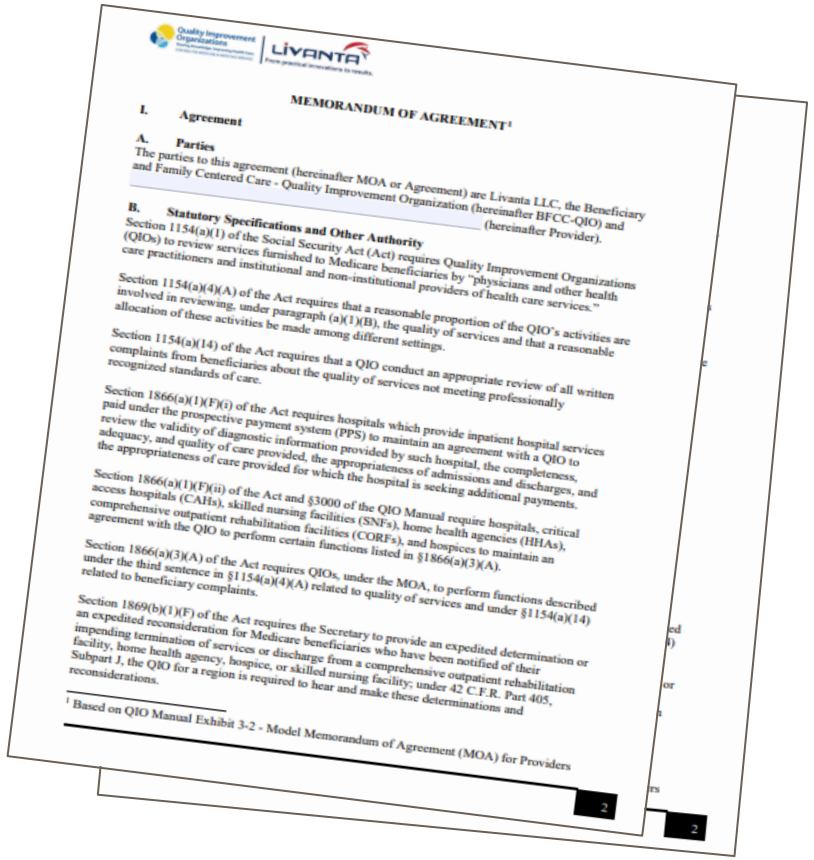
Memorandum of Agreement (MOA)

- Establishes the legal relationship between the BFCC-QIO and providers
- Required under Medicare law
- Points of contact
- Updates are the responsibility of the provider
- Online-only for Livanta and Kepro



MEMORANDUM OF AGREEMENT[1]

I. Agreement

A. Parties

The parties to this agreement (hereinafter MOA or Agreement) are Livanta LLC, the Beneficiary and Family Centered Care - Quality Improvement Organization (hereinafter BFCC-QIO) and (hereinafter Provider).

B. Statutory Specifications and Other Authority

Section 1154(a)(1) of the Social Security Act (Act) requires Quality Improvement Organizations (QIOs) to review services furnished to Medicare beneficiaries by "physicians and other health care practitioners and institutional and non-institutional providers of health care services."

Section 1154(a)(4)(A) of the Act requires that a reasonable proportion of the QIO's activities are involved in reviewing, under paragraph (a)(1)(B), the quality of services and that a reasonable allocation of these activities be made among different settings.

Section 1154(a)(14) of the Act requires that a QIO conduct an appropriate review of all written complaints from beneficiaries about the quality of services not meeting professionally recognized standards of care.

Section 1866(a)(1)(F)(i) of the Act requires hospitals which provide inpatient hospital services paid under the prospective payment system (PPS) to maintain an agreement with a QIO to review the validity of diagnostic information provided by such hospital, the completeness, adequacy, and quality of care provided, the appropriateness of admissions and discharges, and the appropriateness of care provided for which the hospital is seeking additional payments.

Section 1866(a)(1)(F)(ii) of the Act and §3000 of the QIO Manual require hospitals, critical access hospitals (CAHs), skilled nursing facilities (SNFs), home health agencies (HHAs), comprehensive outpatient rehabilitation facilities (CORFs), and hospices to maintain an agreement with the QIO to perform certain functions listed in §1866(a)(3)(A).

Section 1866(a)(3)(A) of the Act requires QIOs, under the MOA, to perform functions described under the third sentence in §1154(a)(4)(A) related to quality of services and under §1154(a)(14) related to beneficiary complaints.

Section 1869(b)(1)(F) of the Act requires the Secretary to provide an expedited determination or an expedited reconsideration for Medicare beneficiaries who have been notified of their impending termination of services or discharge from a comprehensive outpatient rehabilitation facility, home health agency, hospice, or skilled nursing facility; under 42 C.F.R. Part 405, Subpart J, the QIO for a region is required to hear and make these determinations and reconsiderations.

[1] Based on QIO Manual Exhibit 3-2 - Model Memorandum of Agreement (MOA) for Providers

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Stay in touch with the BFCC-QIO

- Sign up for Kepro's **email list** to receive Special Bulletins and Case Review Connections, a quarterly newsletter: https://www.keproqio.com/email
- YouTube: Kepro BFCC-QIO https://www.youtube.com/channel/UCTkXEqL9DsS8Cr-6GTO7yKg
- More information can be found on Kepro's website: https://www.KeproQIO.com
- Subscribe to Livanta's **Provider Bulletins** and weekly e-Journal, the *Livanta Compass* https://livantaqio.com/en/Provider/Provider
- LinkedIn: https://www.linkedin.com/company/livanta-bfcc-qio
- Livanta's BFCC-QIO website: https://www.LivantaQIO.com

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Knowledge Check

1. **True or False? A QIO, or Quality Improvement Organization, is a government contractor that ensures quality protection for Medicare patients and families.**
2. **What services are provided by the BFCC-QIO to Medicare Beneficiaries and Families?**
3. **True or False: QIO services are free to Medicare beneficiaries.**

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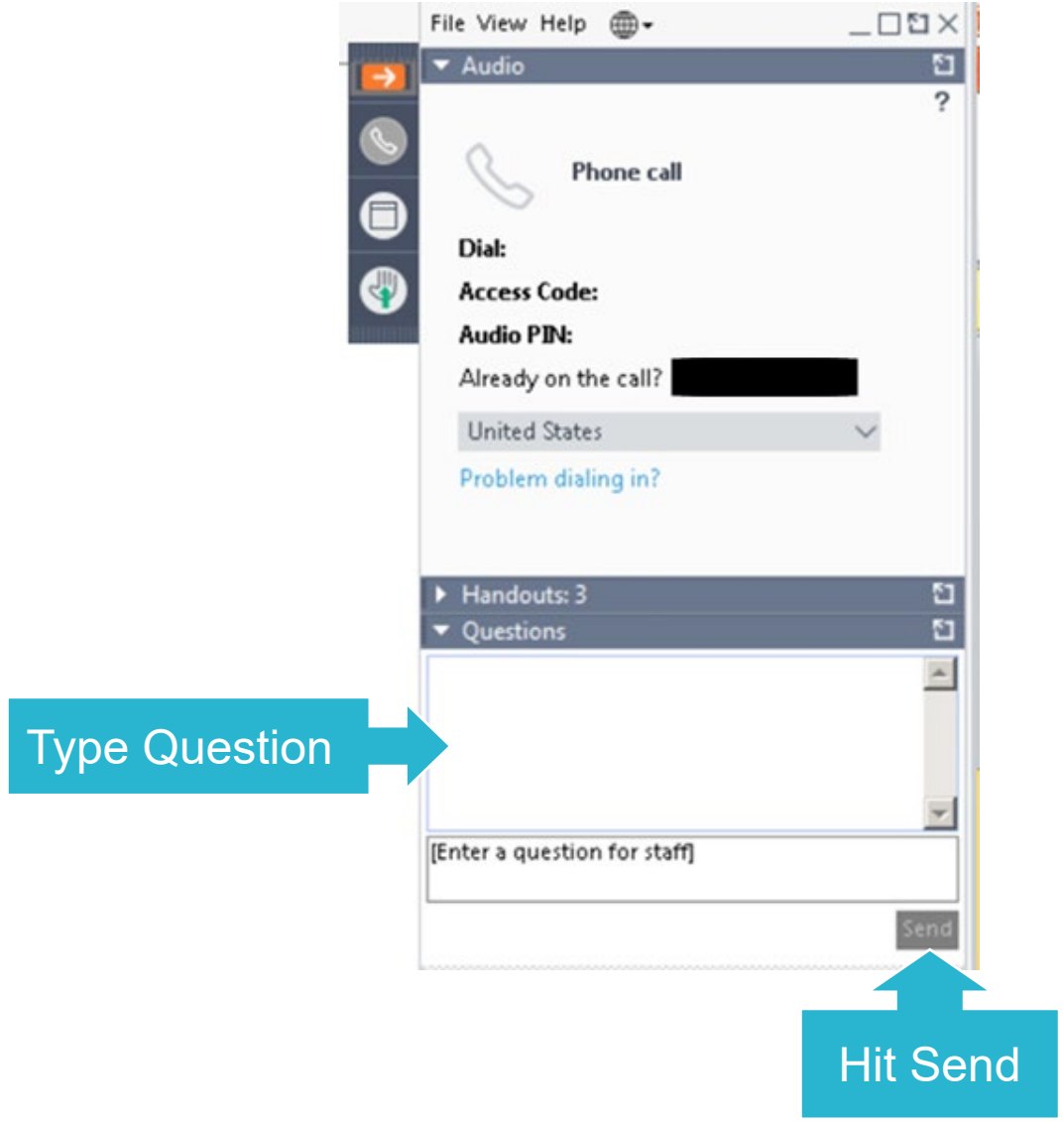
How to Participate Today

To ask a question by using the **Question Box**



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- Electronic Mailing List page at: https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Electronic-Mailing-Lists
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J15 Part A

Customer Support & myCGS Help: 866.590.6703

IVR: 866.289.6501

J15 Part A Contact Information:
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J15 Part B

Customer Support & myCGS Help: 866.276.9558

IVR: 866.290.4036

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https://www.cgsmedicare.com/partb/cs/index.html

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Thank You!

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