Compliance Responsibility of SNFs, HHAs and CORFs on Notice of Medicare Non Coverage (NOMNC)

The Medicare Modernization Act required that Medicare Health Plans, which include Medicare Cost plans like Kaiser Permanente, follow the organization determination, appeals and grievance regulations found in Subpart M of the Medicare Advantage regulations.

Medicare Health Plan enrollees receiving services from a Skilled Nursing Facility (SNF), Home Health Agency (HHA) or Comprehensive Outpatient Rehabilitation Facility (CORF) have the right to a fast appeal (expedited review by a Quality Improvement Organization-QIO) if they think their Medicare-covered services are ending too soon. These rules are similar to the existing right of a Medicare beneficiary to request a QIO review of a discharge from an inpatient hospital and can be found in the final rule published in 68 CFR 16652.

SNFs, HHAs and CORFs must provide an advance written notice of Medicare coverage termination to Medicare health plan enrollees no later than 2 days before the coverage of their services will end. If the patient does not agree that covered services should end, they may request an expedited review of the case by the QIO in the state. When this happens, the Medicare health plan, like Kaiser Permanente, must give a detailed notice to the patient and the QIO explaining why services are no longer necessary or covered. The QIO review process is generally completed within 48 hours of receipt of the request. Plans and providers have certain responsibilities related to notifying beneficiaries of Medicare’s fast appeals process.

The SNF, HHA and CORF notification and appeal requirements distribute accountability among four parties:

1. The Medicare Health Plan (like Kaiser Permanente) is responsible for:
   • Determining the discharge date
   • Providing the Detailed Explanation of Non-coverage (DENC) upon request

2. The provider is responsible for:
   • Providing medical information to the health plan upon request so that coverage determinations can be made in a timely manner
   • Delivering the Notice of Medicare Non-coverage (NOMNC) to all Medicare health plan enrollees no later than 2 days before their covered services will end.

3. The patient/enrollee (or authorized representative) is responsible for:
   • Acknowledging receipt of the NOMNC
   • Contacting the QIO within the allowable timeframe if they want an expedited review by the QIO
4. The QIO is responsible for:
• Immediately contacting the Medicare health plan and the provider if an enrollee requests and expedited review
• Making a decision on the case no later than the day Medicare coverage is predicted to end

CMS has strongly encouraged providers to structure their notice delivery and discharge patterns to make the process work as smoothly as possible. For example, SNFs may want to consider how they will assist patients who want to be discharged in the evenings or on week ends in the event the QIO agrees that coverage for services should end, and the patient does not want to incur additional financial liability. Examples given by CMS are ensuring follow up care is in place, scheduling equipment delivery if needed and writing orders or instructions in advance to facilitate a simpler discharge. Kaiser Permanente will work with providers on these needs.

More detailed information about this process can be found on the CMS website at www.cms.hhs.gov. The regulations are in 42 CFR 422.624, 626 and 489.27, and in Chapter 13 of the Medicare Managed Care Manual (at www.cms.hhs.gov/manuals).

In contracting with Kaiser Permanente, you agreed to follow all federal and state regulations as well as Kaiser Permanente policies. In working collaboratively to ensure member rights are safe guarded, the plan of care is well coordinated, clear, and timely communication occurs we request for you to:

1. Regularly inform us of the patient’s progress

2. Notify the health plan prior to the delivery of the NOMNC;

3. Verify the date services will end

4. Document and notify the health plan of the reason(s) that services are ending

5. Provide detailed information regarding the member’s clinical status

6. Send a copy of the NOMNC notice given to our members to Kaiser Permanente either by fax or by mail to the address below within thirty (30) days of delivery for our records. These are needed in the event of a QIO review, CMS audits, and Kaiser Permanente quality and compliance monitoring activities. Please send copies of the NOMNC to the following addresses:

**SNF NOMNCs:**
Fax: 301-625-6105
Mail: Kaiser Permanente
11921-D Bournefield Way
Silver Spring, MD 20904
Attn: SNF Department

**HHA NOMNCs**
Fax: 301 879-6122
Mail: Kaiser Permanente Provider Service Center
11921- B Bournefield Way
Silver Spring, Maryland 20904
Attn: Home Care Department

In addition to reviewing the copies of the NOMNCs sent to Kaiser Permanente by Providers, representatives from Kaiser Permanente will be conducting onsite audits at SNFs and HHAs to review the medical records of our members. This is being done to assure that NOMNCs are delivered to all Kaiser Permanente Medicare health plan enrollees no later than 2 days before their covered services will end and that the enrollee or authorized representative acknowledges receipt of the NOMNC through a valid signature.

If you have any questions regarding the NOMNCs, please contact:

**For SNF**
Cavella Bishop, Manager of SNF program
Phone: 301 625-6238

**For HHA**
Nancy Ambridge-Kawczynski
Manager of Referral Management and HH and DME
Phone 301 879-6135
How to Access Urgent Care or Emergency Room Services at Kaiser Permanente

The Kaiser Permanente Appointment and Advice Line will provide access to medical advice and facilitate the scheduling of a same day appointment or an appointment at a KP urgent care center. If an immediate appointment is not available or if the member is not near a KP urgent care center, the member may also be directed to contact a KP contracted urgent care provider.

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<th>Washington Metro Area</th>
<th>Outside Washington Metro Area</th>
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<tr>
<td></td>
<td>(703)359-7878</td>
<td>(800)777-7904</td>
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<tr>
<td></td>
<td>(703)359-7616 (TDD)</td>
<td>(800)700-4901 (TDD)</td>
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**URGENT CARE SERVICES**

Kaiser Permanente’s urgent care centers and telephone advice nurses provide an effective, safe and quality alternative to the long wait times patients often experience when they visit an ER. Certain injuries and illness can be seen at an urgent care facility. Additionally, with our electronic medical record system, our medical team has access to the member’s medical history at the touch of a button. The benefits for a member being seen at a Kaiser Permanente after hours care location include:

- Greater continuity of care when you seek medical advice before venturing to the ER
- Alerts regarding potentially harmful medication interactions so we can prevent them before you visit a non-Kaiser Permanente physician at the ER
- Patient safety systems that help reduce the possibility of errors

**EMERGENCY SERVICES**

Emergency Services are health care services that are provided by a Plan or non-Plan Provider after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in:

a) Placing the patient’s health in serious jeopardy;

b) Serious impairment to bodily functions;

c) Serious dysfunction of any bodily organ or part; or

d) In the case of a pregnant woman, serious jeopardy to the health of the mother and/or fetus.

If, due to the nature of the problem, the member must be directed to a Hospital Emergency Department (ED), the Participating PCP should instruct the member to go to the Emergency Department of the nearest hospital. The Participating PCP should notify the ED physician that the member has been referred.

Referrals to the Emergency Department must be called into the Provider Service Center Hotline at 1 (800) 810-4766. The hotline staff will document the referral when notified. Registered Nurses are available 24-hours a day, 7-days a week to facilitate discharge planning from an Emergency Department, or make urgent referrals to approved skilled nursing facilities or home health agencies.
Kaiser Permanente’s 2007-2008 Influenza Vaccine Campaign began in October. Your participation in this initiative is essential for the health of our members. We ask that you and your staff be on the alert during all interactions with our members in order to identify at-risk members and to inform, remind and encourage their influenza and/or pneumococcal vaccination.

Who should receive an influenza vaccine?

• Every Kaiser Permanente member who wants a vaccination
• Members aged 50 and over
• Members aged 6 months to 5 years
• Members who have a chronic illness or are immunocompromised
• Parents/caregivers of children under 5 years of age
• Family members/caregivers of members with a chronic illness or who are immunocompromised
• Pregnant women or women who plan to be pregnant during the flu season
• Health care workers

We mailed information about the influenza vaccine to all our high-risk members and encouraged them to walk-in to our weekend flu shot clinics in October for their vaccination. For the flu shot schedule for the remainder of the year, please refer members to 1-800-482-4738 or kaiserpermanente.org/flu.

Flu shot campaigns provide great opportunities also to vaccinate against pneumococcal pneumonia. Every member aged 65 years and older, as well as those under 65 years of age who have a chronic disease, should receive at least one pneumococcal vaccination in their lifetime.

Please note that there is no co-pay required unless the administration of these vaccines is associated with an office visit with a physician or practitioner. Please enter the appropriate CPT codes on your CMS-1500 forms as referenced in your Primary Care Agreement.

We value your participation as we partner together to provide medical care to the people of the Mid-Atlantic States. If you have any questions regarding this information, please contact the Provider Relations Department at 1-877-806-7470.
Approved Clinical Practice Guidelines

The following clinical practice guidelines have been approved in 2007. These guidelines are posted on https://mapmgonline.com under the Guidelines Group. If you would like to receive a hard copy of these or any other Clinical Practice Guidelines, please call Ana Vera at 301-816-6562.

- Pediatric Preventive Care
- Adult Immunization
- Adult Asthma in Primary Care
- Pediatric Asthma in Primary Care
- Coronary Artery Disease
- Osteoporosis
- Dyslipidemia
- Obesity screening
- Tobacco use screening
- Breast cancer screening
- Cervical cancer screening
- Colorectal cancer screening
- Chlamydia screening

Behavioral Health Case Management and Behavioral Health Acute Care Teams

Kaiser Permanente’s Behavioral Health Department wants you to know about two resources that offer additional support for KP members who are in your care.

Our Behavioral Health Case Management team is comprised of four licensed clinical social workers who support KP clinical teams in managing complex cases throughout Kaiser Permanente’s Mid Atlantic region. Their responsibilities include providing resource and referral support for patients and providers as well as being a liaison and providing linkage for members to services throughout Kaiser Permanente and the community. The case managers work in partnership with the BH Utilization Management team to coordinate care for members who have been hospitalized by confirming discharge plans and supporting medication and appointment adherence.

The Behavioral Health Acute Care Program is a new regional initiative developed to support members who may benefit from a more varied approach than that associated with traditional mental health services. This program is facilitated by small groups of Kaiser Permanente behavioral health practitioners who are located in each of our service areas. These providers work with members to develop individualized treatment plans that not only address their mental health diagnosis but also seek to remove barriers to treatment. Services may include but are not limited to: intense outreach, therapy, family support, life skills classes, and coordination of care with community services.

If you have questions or would like to refer one of our members to case management or to our acute care program, please call our Network Provider Line at (703) 208-6282 or (866) 311-0531. One of our BH Referral Management Assistants will follow up and assist you.

***** REMINDER *****

Don’t forget to call Provider Relations at 1-877-806-7470 for your Kaiser Permanente provider website enrollment package
Test Your OB-GYN HEDIS Knowledge

As network providers, you are valued members of our health care team at Kaiser Permanente Mid-Atlantic States (KPMAS) Region. We appreciate your vital role in assisting KPMAS to meet all Health Plan Employer Data Information Set (HEDIS) measures, including those measures impacting your OB-GYN members. Please see below for correct answers.

TRUE OR FALSE?

1. To be compliant with early prenatal care, a patient must be seen no later than 12 weeks after her last menstrual period.
   - True
   - False
2. Early OB lab work qualifies for meeting the HEDIS measure for early prenatal care.
   - True
   - False
3. Your patient is post Cesarean Section. She is evaluated during a routine postpartum follow-up appt on day 14. This appointment meets HEDIS standards.
   - True
   - False
4.) KPMAS recommends that the average risk woman have a pap test every 3 years
   - True
   - False
5.) A woman who has a positive pap history will be screened more frequently.
   - True
   - False

1. False [a patient must be seen in the first trimester or within 42 days of enrollment];  
2. False [to be eligible for meeting HEDIS, a prenatal appointment must accompany OB lab work];  
3. False [a postpartum patient must be evaluated between postpartum days 21 and 56];  
4. True;  
5. True.