Tufts Health Plan Medicare Preferred Organization Determination & Notice Instructions

Title	Definition	Written Notice Should be Sent When:	Written Notice Delivery Method & Timeframes	Written Notice Requirements
Important Message (IM) from Medicare CMS Standard Notice *OMB approval No.0938-0692 *Form No. CMS-R-193	The IM provides information to members about the Quality Improvement Organization (QIO) hospital appeal process, the members right to an expedited determination, associated liability regarding the discharge and the right to receive detailed information about the decision to discharge them from the hospital. **Note**: KEPRO is the QIO in this region.	• To all Medicare beneficiaries, including all Tufts Medicare Preferred members, admitted to a hospital, regardless of whether or not the member disagrees with the discharge decision. • The IM is issued by the hospital.	• Hospitals must issue the IM within 2 calendar days of admission, and must obtain the signature of the member or representative. • Hospitals must issue a copy of the signed notice as far in advance of discharge as possible, but not more than 2 calendar days before discharge.	• The name, address and telephone number (including TTY) of the hospital must be included in the header. • The member's name, ID number, attending physician and date of the notice must be included. • Physician concurrence is required. • The member or representative must sign and date the notice, and they retain the original. **Note**: The IM is a standardized notice. Hospitals are not allowed to deviate from the content of the notice except where indicated.
Detailed Notice of Discharge (DNOD) CMS Model Notice *OMB approval No.0938-1019 *Form No. CMS-10066	Detailed written notice issued to the member or authorized representative who appealed through KEPRO. The notices provides a detailed explanation of why both the hospital and Tufts Medicare Preferred are in agreement with the member's doctor, and believe that the member's inpatient hospital services should end on the date indicated on the notice.	• Member/authorized representative does not agree with the hospital discharge decision, and they have filed a hospital discharge appeal through KEPRO. • KEPRO will contact both the hospital and Tufts Medicare Preferred to notify them of the hospital discharge appeal request.	Delivered by the hospital to the member, authorized representative as soon as possible but *no later than 12:00 PM* the day after Tufts Medicare Preferred was notified of the appeal request by KEPRO.	The Detailed Notice of Discharge must: • Describe in simple terms the facts surrounding the decision to discharge the member • Explain why services are no longer necessary

Title	Definition	Written Notice Should be Sent When:	Written Notice Delivery Method & Timeframes	Written Notice Requirements
	Note: Upon admission and prior to discharge, hospitals are required to issue to members the IM (IM1, and IM2). The IM informs the member of their planned discharge date, and gives them their KEPRO appeal rights. If a member or their authorized representative files the hospital discharge appeal through KEPRO, Tufts Medicare Preferred must generate, and have the hospital issue to the member/authorized representative the Detailed Notice of Discharge (DNOD).	• Tufts Medicare Preferred Appeals & Grievances will contact the appropriate Case Manager (CM), Delegated Case Manager (DCM), and Mental Health Care Manager (MHCM) to inform them of the hospital discharge appeal. • The CM/DCM/MHCM will fill out a *Hospital Discharge Summary Form*, and return it to Tufts Medicare Preferred Appeals & Grievances so that the DNOD can be generated.	**Note**: If a hospital discharge appeal is requested through KEPRO, the member is protected from liability until 12:00 PM of the day following the day the KEPRO decision is rendered.	• Describe relevant Medicare coverage rules, instructions, or other policies • Use facts specific to the member and relevant to the coverage determination
Notice of Denial of Medical Coverage (NDMC) Standard Notice	Pre-Service/concurrent written notice to inform the member of a denied request for a not medically necessary, non-inpatient medical service. Denial reason can be not a covered service or not medically necessary.	• Member requests future/concurrent services and/or equipment • Member believes services should continue (including SNF exhaustion of benefits) • Medical Group has verbally informed member of their denial of coverage decision • Service requests to visit an out-of-plan/non-contracting specialist when there is a comparable in-plan/contracted specialist • Requests for non-covered DME items	**Instructions for Medical Group** Standard Request Timeframe: Verbally notify a member within 10-calendar days of the initial request. The Medical Group submits the Denial of Coverage & Expedited Approval Form, via fax, to Tufts Medicare Preferred Appeals & Grievances ASAP, but must be within 10-calendar days of the initial request. Tufts Medicare Preferred will mail the NDMC letter to the member within 14 calendar days, and provide copies to the Medical Group Medical Director, PCP and requested provider (if applicable).	Notice requirements: • Signature of physician who made the organization determination (stamp NOT acceptable) on the THP MP Denial of Coverage & Expedited Approval Form. • Member's appeal rights • Date of the last covered day must be clearly stated, if applicable • Specific and detailed explanation why the medical service or items are being denied

Title	Definition	Written Notice Should be Sent When:	Written Notice Delivery Method & Timeframes	Written Notice Requirements
		• Requests to rent or purchase durable medical equipment (DME) in a SNF • Homecare services when the Medical Group determines that the member does not meet the CMS criteria. **Note:** All UM denials should have supporting clinical documentation sent with them	Expedited Request Timeframe: Verbally notify a member of the decision within 24 hours of the initial request. The Medical Group submits the Denial of Coverage & Expedited Approval Form, via fax, to Tufts Medicare Preferred Appeals and Grievances ASAP, but must be within 24 hours of the initial request. Tufts Medicare Preferred will hand deliver if member is in facility or mail to members within 72 hours, and provide copies to the Medical Group Medical Director, PCP and requested provider (if applicable).	• Description of any applicable Medicare Coverage rule or any other applicable Tufts Medicare Preferred policy upon which the denial decision was based. Resources include: ./Medicare Coverage Issues Manual @ http://www.cms.hhs.gov/manuals/cmstoc.asp ./Medicare Intermediary Manual, Addendum A: section 3722.1 for SNF rationale codes ./Tufts Medicare Preferred benefit documents (Evidence of Coverage, Summary of Benefits)

Title	Definition	Written Notice Should be Sent When:	Written Notice Delivery Method & Timeframes	Written Notice Requirements
Notice of Medicare Non-Coverage (NOMNC) Standard Notice OMB approval # 0938-0953	Advanced written notice to inform the member, who is receiving services from a Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehab Facility (CORF), that covered care is ending.	• Physician has determined the member no longer meets the SNF/HHA/CORF criteria for coverage at a skilled level of care • Member agrees or disagrees with the discharge plan **Note**: NOMNCs should not be issued for SNF exhaustion of benefits. Tufts Medicare Preferred/Medical Group or provider should issue an NDMC, by filling out a Denial of Coverage & Expedited Approval Form and sending it to Tufts Medicare Preferred Appeals & Grievances.	Delivered by the SNF/HHA/CORF provider to the member or to the member's authorized representative. Notification is minimally: • Two (2) days prior to the last covered day for SNF/CORF • If admission is anticipated to be less than 2 days, provide notice on the day of admission. • Next to the last visit for HHA services **Member Receipt** If the member refuses to sign, the notice is still valid as long as the provider documents that the notice was given, and that the member refused to sign. The refusal should be witnessed on the signature page and filed, and a copy should be provided to the member.	The NOMNC must: • Accurately 'count' from date of notice to the effective date (minimum of 2 days prior notice to the last covered day). • Correctly display facility and/or plan name, address and phone number. • Identify the services being terminated. • Use at least 12-point font. • Be signed by the member/authorized representative or include notation that member/auth. representative refused to sign or was unable to sign. Authorized representatives may be notified by telephone if personal delivery is not immediately available.

Title	Definition	Written Notice Should be Sent When:	Written Notice Delivery Method & Timeframes	Written Notice Requirements
			If member is unable to sign, the notice must be delivered to and signed by the member's representative. If a representative is not available to receive and sign the notice the plan or provider must document the reason for employing an alternative to validate delivery to the member. • Verbal notification is considered "valid" when documentation in the medical record of the date & time of the telephone call to the authorized representative explaining the contents of the NOMNC and appeal rights is completed. The written notice must follow the verbal notification. • There must be 3 documented attempts to verbally notify the member or authorized representative followed by a certified mailing of the NOMNC letter on the date of the verbal notification. The effective date of the receipt is the date indicated on the return receipt. If no call back is received, resend the notice or make an additional attempt to verbally notify the member/ authorized representative.	In this case, the authorization representative must be informed of the contents of the notice, the call must be documented on the notice, a copy of the notice must be filed in the member's medical record and the original notice must be mailed to the authorization representative. The notice should: • Be dated • Describe the appeals process, including how to contact KEPRO. • Accurately indicate KEPRO's name and telephone number (1-888-319-8452) • Be delivered on time (on or before 2 calendar days prior to the effective date the coverage of services will end at the SNF or CORF or the next to last HHA visit. **Note**: All NOMNCs should be faxed within 7 days of being issued to the member to Tufts Medicare Preferred Appeals & Grievances Department 1-617-972-9516.

Title	Definition	Written Notice Should be Sent When:	Written Notice Delivery Method & Timeframes	Written Notice Requirements
Detailed Explanation of Non-Coverage (DENC) Standard Notice DENC H2256_2012_269 HMO OMB Approval No. 0938-0953	The DENC is a standardized written notice that provides specific and detailed information to the Medicare member of why their SNF, HHA, or CORF services are ending. Tufts Medicare Preferred is required to send a copy of the DENC to the member/provider (with a copy provided to KEPRO).	• Notice is provided when KEPRO accepts the request for a SNF/ HHA/CORF (Fast-Track) Appeal. • Tufts Medicare Preferred must submit a DENC along with the requested components of the member's medical record to KEPRO no later than the close of business the day KEPRO notifies Tufts Medicare Preferred that a Fast-Track appeal was filed, or close of business the day before the member's discharge, whichever is later. • Tufts Medicare Preferred Appeals & Grievances will contact the appropriate CM, or DCM to inform them of the SNF/HHA/CORF discharge appeal. • The CM/DCM will fill out a SNF/HHA/CORF Discharge Summary Form, and return it to Tufts Medicare Preferred Appeals & Grievances so that the DENC can be generated. **Note**: The SNF/HHA/CORF provider is required to submit the requested components of the medical record within the requested timeframe. If the provider fails to submit the requested components of the medical record within the required timeframe, THP MP may administratively deny the impacted days.	Delivered by an on-site CM/DCM, courier or contracted facility via fax to the member and KEPRO no later than close of business (typically 4:30 P.M.) of the day of KEPRO's notification of the appeal request, or the day before the effective date coverage ends, whichever is later. The delivery must be documented. **Note**: If the member is receiving non-residential services and requests that the organization provide the DENC through e-mail or facsimile, then Tufts Medicare Preferred will document and accommodate the request.	Notice requirements: • Type of Service denied • A specific and detailed explanation why services are either no longer reasonable and necessary or otherwise no longer covered; • Relevant facts to make the determination • Facts specific to the member and relevant to the coverage determination that are sufficient to advise the member of the applicability of the coverage rule or policy to the member's case. • Description of any applicable Medicare Coverage rule or any other applicable Tufts Medicare Preferred policy upon which the denial decision was based. Resources include: ./Medicare Coverage Issues Manual @ http://www.cms.hhs.gov/manuals/cmstoc.asp ./Medicare Intermediary Manual, Addendum A: section 3722.1 for SNF rationale codes ./Tufts Medicare Preferred plan benefit documents (Evidence of Coverage, Summary of Benefits)

Title	Definition	Written Notice Should be Sent When:	Written Notice Delivery Method & Timeframes	Written Notice Requirements
Medicare Advantage (MA) Reinstatement of Skilled Services Letter Reinstatement H2256-2006-127-HMO	Written letter to explain why denied SNF, Hospital, or Home Care services are being reinstated. (For the same benefit period).	Prospective, concurrent, or retrospective review of the member's medical record reveals: • Coverage of skilled care is/was medically necessary • Required notification timeframe(s) not met	Delivered by the Medical Group or THP MP to the member by mail.	Notice requirements: • Effective date of reinstatement • Date of original denial notice • Specific reason for reinstatement from the choices listed on the Addendum list which is attached to the MA Reinstatement of Skilled Services Letter (Insert only one paragraph that is specific to the services being reinstated) • Who to contact with questions
Extension and Did Not Meet Criteria Notices				
Standard Organization Determination Extension Letter Tufts Health Plan created, CMS approved MP Standard Part C Extension Letter H2256_2019_577_C	Written notice, when justified, to request an extension of up to 14-calendar days to make a standard (non-urgent) initial organization determination when additional information is needed.	Provided when justification can be demonstrated by: • Decision delay is in the interest of the member • Member requests extension • Need exists for additional information, diagnostic tests or medical evidence from a non-contracted provider	Delivered by Tufts Medicare Preferred Appeals & Grievances to the member/authorized representative by mail.	The Standard Organization Determination Extension Letter must include: • Reason for the delay • Time allotted to obtain additional information • Information about the member & THP MP plan responsibilities during the extension period

Title	Definition	Written Notice Should be Sent When:	Written Notice Delivery Method & Timeframes	Written Notice Requirements
		Note: Notice is used in a situation such as: • A request for a second opinion, or • A request for additional diagnostic testing.		
Expedited Organization Determination Extension Letter Tufts Health Plan created, CMS approved MP Expedited Part C Extension Letter H2256_2019_576_C	Written notice, when justified, to request an extension of up to 72-hours to make an expedited (urgent) initial organization determination when additional information is needed.	Provided when justification can be demonstrated by: • Decision delay is in the interest of the member • Member requests extension • Need exists for additional information, diagnostic tests or medical evidence from a non-contracted provider **Note**: Notice is used in a situation such as when information from an out-of-plan provider is not complete, or is not received within the allowed timeframe to decide upon a member's request for coverage.	Delivered by Tufts Medicare Preferred Appeals & Grievances to the member by courier, hand delivered by CM/DCM or faxed to facility with hand delivery to member.	Expedited Organization Determination Extension Letter must include: • Reason for the delay • Time allotted to obtain additional information • Information about the member & Tufts Medicare Preferred responsibilities during the extension period • Member grievance rights

Title	Definition	Written Notice Should be Sent When:	Written Notice Delivery Method & Timeframes	Written Notice Requirements
Does Not Meet Expedited Organization Determination Criteria Letter Tufts Health Plan created, CMS approved Expedited to Standard OD Response Letter H2256_2018_200_C	Written notice used to inform members, or their authorized representatives, that their request for an expedited organization determination does not meet the necessary time-sensitive criteria, and that it will be processed under the standard timeframe. **Note**: Medicare definition of 'time sensitive' is a situation where the time frame of the standard decision process could jeopardize the life or health of the member, or could jeopardize the member's ability to regain maximum function.	Provided when: • Organization determination request does not meet the Medicare time-sensitive criteria • Standard organization determination timeframe of 14-days is appropriate	Delivered by Tufts Medicare Preferred Appeals and Grievances to the member by courier, hand delivered by CM/DCM or faxed to facility with hand delivery to member, when applicable.	Notice requirements: • Member's right to file a fast grievance regarding the decision not to expedite • Member's right to resubmit the request with the support of a physician. If physician support received the request would be considered expedited at that time • Informs the member that the request will follow the standard organization determination timeframe • Medicare's definition of "time sensitive **Note**: Medicare definition of 'time sensitive' is a situation where the time frame of the standard decision process could jeopardize the life or health of the member, or could jeopardize the member's ability to regain maximum function.
Not Expedited Appeal Criteria Letter Tufts Health Plan created, CMS approved Not Expedited Appeal Criteria Letter H2256_2019_AG19_C H2256_2019_AG18_C	Written notice to inform the member, based on the information available, their expedited appeal request *did not meet* Medicare's definition of 'time sensitive' and thus will be processed through the standard appeals process.	Sent to a member or authorized representative to inform them that their expedited appeal request does not meet the 'time sensitive' criteria, will not be processed through the expedited appeals process, but will be processed as a standard appeal, and will follow the standard appeal timeframe.	Verbal notification provided, and then letter mailed within 2 days to the member/auth. representative.	Notice requirements: • Member's grievance rights • Medicare's definition of "time sensitive"

Title	Definition	Written Notice Should be Sent When:	Written Notice Delivery Method & Timeframes	Written Notice Requirements
	Note: Medicare definition of 'time sensitive' is a situation where the time frame of the standard decision process could jeopardize the life or health of the member, or could jeopardize the member's ability to regain maximum function.			**Note**: Medicare definition of 'time sensitive' is a situation where the time frame of the standard decision process could jeopardize the life or health of the member, or could jeopardize the member's ability to regain maximum function.

Refer to the Tufts Health Plan website for complete policy descriptions.