Supporting Statement – Part A
Fast Track Appeals Notices: NOMNC / DENC
CMS-10123/24 OMB approval #0938-0953

Introduction

The Centers for Medicare & Medicaid Services (CMS) requests a revision of two Office of Management and Budget (OMB) -approved Medicare notices: the Notice of Medicare (Provider) Non-Coverage (NOMNC) and the Detailed Explanation of Non-Coverage (DENC). This information collection results from the fast appeal process available to Medicare beneficiaries in Original Medicare and enrollees in Medicare health plans who receive notice that their Medicare-covered services are being terminated. Medicare beneficiaries and health plan enrollees are permitted by law to request that an independent review entity decide whether Medicare-covered services should continue.
For purposes of these provisions;

- The term "Medicare providers" includes skilled nursing facilities (SNFs), home health agencies (HHAs), and comprehensive outpatient rehabilitation facilities (CORFs),
- The term "Medicare providers" also includes hospices when referring to beneficiaries in Original Medicare,
- The term "Medicare health plans" includes Medicare Advantage plans and cost plans, and
- "Beneficiaries" refers to Medicare beneficiaries in Original Medicare and "enrollees" refers to Medicare beneficiaries enrolled in Medicare health plans.

Previously, collections were separate for the Original Medicare (OM) and Medicare Advantage notices required for fast appeals. In order to simplify the process for providers we are combining the OM and MA notices and related documents beginning this collection cycle.

A. Background

The Office of Management and Budget (OMB) previously approved the NOMNC and DENC under 0938-0953 for Original Medicare and 0938-0910 for Medicare health plans. The purpose of the NOMNC is to help the beneficiary/enrollee decide whether to pursue an immediate appeal by a Quality Improvement Organization (QIO) and, if so, when and where to file a request. Consistent with 42 CFR 405.1200 and 42 CFR 422.624, SNFs, HHAs, CORFs, and hospices must provide notices to all beneficiaries/enrollees whose Medicare-covered services will end, no later than two days in advance of the proposed termination of service. This information is provided to the beneficiary/enrollee through the NOMNC.

If the beneficiary/enrollee appeals the termination decision, the QIO and the beneficiary/enrollee, consistent with 42 CFR 405.1200(b) and 405.1202(f) for Original Medicare, and 42 CFR 422.624(b) and 422.626(e)(1)-(5) for Medicare health plans, will receive a detailed explanation of the reasons services should end. This detailed explanation is provided to the beneficiary/enrollee using the DENC, the second notice included in this revision package.

B. Justification

1. Need and Legal Basis

Section 521 of BIPA, Pub.L.106--554, amended section 1869 of the Social Security Act (the Act) to require significant changes to the Medicare appeals procedures. Among these changes is a requirement under section 1869(b)(1)(F) of the Act that the Secretary establish a process by which an individual may obtain an expedited determination and reconsideration with respect to the termination of provider services. The NOMNC and the DENC fulfill these regulatory requirements.

- §405.1200(b) – Prior to any termination of covered service, the provider of the service must deliver valid written notice to the beneficiary of the provider's decision to terminate services.
- §405.1202(f) – When an QIO notifies a provider that a beneficiary has requested an expedited determination, the provider must send a detailed termination notice to the beneficiary by close of business of the day of the QIO’s notification.

Pursuant to 42 CFR 422.624 (b)(1), providers must deliver to Medicare health plan enrollees a 2-day advance notice of termination of services. Per requirements at 42 CFR 422.626(e)(1), plans must deliver detailed notices to the QIO and enrollees whenever an enrollee appeals a termination of services. The NOMNC and the DENC fulfill these regulatory requirements. Additionally, 42 CFR 417.600(b) provides that cost plans must follow these same fast appeal notification procedures for their enrollees in the covered providers.

- §422.624(b) – Prior to any termination of service, the provider of the service must deliver valid written notice to the enrollee of the Medicare health plan’s decision to terminate services.
- §422.626(e)(1) – When an Independent Review Entity (IRE) notifies a Medicare health plan that an enrollee has requested a fast track appeal, the Medicare health plan must send a detailed

notice to the enrollee by close of business on the day of the IRE's notification.

- §417.600(b)(1) – The rights, procedures, and requirements relating to beneficiary appeals and grievances set forth in subpart M of part 422 of this chapter also apply to Medicare contracts with HMOs and CMPs under section 1876 of the Act.

2. Information Users

Providers will deliver a NOMNC to beneficiaries/enrollees no later than two days prior to the end of Medicare-covered services in SNFs, HHAs, CORFs, and Hospices. Beneficiaries/enrollees will use this information to determine whether they want to appeal the service termination to the QIO in their state. If the beneficiary/enrollee decides to appeal, the Medicare provider/health plan will send the QIO and appellant a DENC detailing the rationale for the termination decision.

3. Use of Information Technology

SNFs, CORFs, HHAs or Hospices generally deliver advance written notices to beneficiaries/enrollees, in person or by mail on behalf of providers and Medicare health plans. Providers and plans must deliver detailed written notices whenever those beneficiaries/enrollees request appeals. There is no provision for alternative uses of information technology for these notices.

4. Duplication of Efforts

The requirement that providers supply plan enrollees in HHA, SNF, CORF, and Hospice settings with advance notice of service terminations does not duplicate any other effort and the information cannot be obtained from any other source.

5. Small Businesses

This requirement will not adversely affect small businesses.

6. Less Frequent Collection

Consumer research supports providing information close to the time an individual needs to make a decision. In the case of an individual receiving provider services, he or she needs to decide whether the services continue to be medically necessary. (Providing the information other than during the receipt of services would significantly reduce the effectiveness.) In addition, providing the notice two days in advance of coverage ending decreases potential financial liability in the event the beneficiary/enrollee wants to appeal. Providing advance notices to less than 100% of all individuals who

are facing service terminations would not afford all beneficiaries/enrollees equal protection of their rights.

7. Special Circumstances_

There are no special circumstances to report. No statistical methods will be employed. The regulations at §422.1202(b) and §422.624(c) require that the notices be validly delivered to either beneficiaries/enrollees or their representatives. Given the short timeline for notice delivery in plan and provider settings, valid delivery means that providers must ensure that the beneficiary/enrollee understands the notice or arranges to have the notice delivered to the representative. For Medicare enrollees, providers are required to deliver the NOMNC on behalf of the plan. Note: CMS holds the Medicare health plan responsible for delivery of all notices, and compliance with the regulations governing this activity.

8. Federal Register Notice/Outside Consultation_

Not applicable.

9. Payments/Gifts to Respondent

Not applicable.

10. Confidentiality

Not applicable; CMS does not collect information. The provider and plan will maintain records of the notices, but those records do not become part of a federal system of records.

11. Sensitive Questions

Not applicable. We do not ask any question of the enrollee.

12. Burden Estimates

- The total hourly burden for the NOMNC is: **885,699 hours**
- The total hourly burden for the DENC is: **42,232 hours**
- The total wage burden for the NOMNC is: **$25,561,273**
- The total wage burden for the DENC is: **$1,219,674**

In 2009 35.2 million Medicare beneficiaries in OM requested 15,289 fast appeals. Thus, .04 percent of beneficiaries in OM used the fast appeal process in 2009.

In 2009 10,894,000 MA enrollees, in 740 health plans, requested 18,497 fast appeals. Thus, 0.17 percent of MA enrollees used the fast track appeal process in 2009.

In 2009, we estimate that providers delivered 5.3 million notices to Medicare beneficiaries and health plan enrollees based on the number of persons receiving home health services and persons discharged from SNFs (CMS Data Compendium 2009).
Note that the amount of Medicare business with CORFs is so small that Medicare statistical summaries do not include a separate line item for patient encounters with these facilities. Similarly, we do not have a precise estimate for of hospice discharges, but the number is considered to be an extremely small percentage of the total number of annual hospice patients. Accordingly, our analysis is necessarily limited to HHA and SNF services.

To arrive at the combined hourly and wage burden for OM and MA we made the following assumptions and calculations for the individual notices:

Provider staff spend 10 minutes per NOMNC.

Issuing the 5,314,194 NOMCS to OM beneficiaries and health plan enrollees results in a total annualized burden of 885,699 hours (10 minutes x 5,314,194 NOMNCs/60 minutes), or 36 hours per provider (885,699 hours/24,915 providers).

Provider and health plan staff spend 75 minutes per DENC.

Note that because Original Medicare providers are responsible for delivering the DENC to beneficiaries and health plans are responsible for delivering the DENC to health plan enrollees, we are breaking out the burden for the two Medicare programs. The burden breakdown is as follows:

- The number of DENCs issued per year by OM providers is 15,289 and the number of DENCs issues per year by health plans is 18,497. This equates to.6 notices per OM provider (15,289 divided by 24,915 providers) and 25 notices per health plan (18,497 divided by 740 plans).

- Issuing the OM DENCs results in an annualized burden of 19,111 hours (75 minutes x 15,289 DENCs/60 minutes).

- Issuing the MA DENCs results in an annualized burden of 23,121 hours (75 minutes x 18,497 DENCS/60 minutes).

We estimate that these notices would most likely be prepared by a staff person with professional skills at the GS-12 Step 1 with an hourly salary of $28.88.

- The wage burden is $4.81 per NOMNC ($28.88 x 10 minutes/60 minutes) and the wage burden is $36.10 per DENC ($28.88 x 75 minutes/60 minutes).

- Thus, we estimate a total wage burden of $25,561,273 for the NOMNC ($4.81 x 5,314,194 NOMNCs) and $1,219,675 for the DENC ($36,10 x 33,786 DENCs).

13. Capital Costs

There are no capital costs associated with this collection.

14. Cost to Federal Government

There is no cost to the Federal Government for this collection.

15. Changes to Burden

Our revised methodology for calculating the NOMNC burden is responsible for the increase in our estimated managed care burden. We now calculate the managed care NOMNC burden based on the actual number of HHA and SNF services and discharges. This is consistent with how we have calculated the burden for Original Medicare NOMNCs in the previous two OMB collections.

In addition, we are now including SNF data in our calculations for Original Medicare.

Changes to NOMNC burden (in hours)

	Current	Previous	Difference
Original Medicare	673,131	392,666	280,465*
Medicare Advantage	212,568	20,157	192,411**

Total	885,699	412,823	**472,876**

* Inclusion of SNFs in calculation accounts for 253,333 burden hours of the difference.
**Adjustment to the calculation methodology accounts for the burden difference.

16. Publication and Tabulation Dates

CMS does not intend to publish data related to the notices.

17. Expiration Date

CMS would like to display the expiration date.

18. Certification Statement

No exception to any section of the I-83 is requested.