Health Services

, WI-544

Phone No:715- Fax: 715

Notice of Medicare Non-Coverage

Patient name: Patient number:

The Effective Date Coverage of Your Current **Skilled Nursing Facility** Services Will End: **07/20/2022**

- Your Medicare provider and/or health plan have determined that Medicare probably will not pay for your current Skilled Nursing Facility 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: LIVANTA 888-524-9900 or TTY 888-985-8775 to appeal, or if you have questions.

See page 2 of this notice for more information.

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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:
UnitedHealthcare
Appeals and Grievance
Mail Stop: CA124-0157
P.O.Box 6106
Cypress, CA 90630
Customer Service: 1-800-204-1002
TTY:711

Additional Information (Optional):

Once complete, please return this NOMNC to your naviHealth Care Coordinator on the same day it is issued (fax: 844-244-9482).

Telephone delivery does not require a signature and should only occur when the member is unable to understand the notice and the representative is not available to sign in a timely manner.

The following is to be completed by the provider delivering this notice by telephone (skip if in-person):

- Notice delivered by (print full name):_____ Title:_____
- Call date:_____Call time:_____ am / pm
- Spoke with:
  - Full name:_____
  - Telephone number:(_____)_____
  - Relation to member: ☐ POA ☐ AOR ☐ Other (specify):_____
  - Reason why member could not sign/understand:_____
- An explanation of this Notice of Medicare Non-coverage and the member's appeal rights were Provided as indicated above.
- Made aware of the effective date that skilled service(s) is ending is: _____and date financial liability to begin is: _____
- Last covered date:_____Service to end: Skilled Nursing Facility Services
- To file an immediate appeal, the QIO must be called by noon on (date):_____
- Your QIO name and telephone number is (as indicated above on page 1):
  LIVANTA: 888-524-9900, TTY: 888-985-8775
- If you miss this deadline, you may have other appeal rights and can contact your Health Plan.
- Your health plan name and telephone number is UnitedHealthcare 1-800-204-1002, or TTY: 711
- Provider's signature/title:_____Date:_____

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.

daughter P.O.A. July 18, 2022

Signature of Patient or Representative Date

Resident has activated POA and is unable to understand & sign. NOMNC. Daughter. POA signed 7/18/2022

The company does not treat members differently because of sex, age, race, color, disability, or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability, or national origin, you can send a complaint to the Civil Rights Coordinator.

Online: UHC_Civil_Rights@uhc.com

Mail: Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UT 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again. If you need help with your complaint, please call the member toll-free phone number listed on your ID card.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html

Phone: Toll-free: 1-800-368-1019 or Toll-free: 1-800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services
200 Independence Avenue. SW
Room 509F, HHH Building
Washington, D.C. 20201

We provide free services to help you communicate with us, such as letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the member toll-free phone number listed on your ID card.

ATENCIÓN: Si habla español **(Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 (Chinese)，我們免費您您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng Việt **(Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

알림: 한국어(Korean)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAALALA: Kung nagsasalita ka ng Tagalog (Tagalog), may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является русском (Russian). Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تنبيه: إذا كنت تتحدث العربية (Arabic)، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على معرّف العضوية.

ATANSYON: Si w pale Kreyòl ayisyen (Haitian Creole), ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

ATTENTION : Si vous parlez français (French), des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po polsku (Polish), udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

ATENÇÃO: Se você fala português (Portuguese), contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

ACHTUNG: Falls Sie Deutsch (German) sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises an.

ترجمه: اگر زبان شما فارسی (Farsi) است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفا با شماره تلفن رایگانی که روی کارت شناسایی شما درج شده تماس بگیرید.

ध्यान दें: यदि आप हिंदी (Hindi) बोलते हैं, आपको भाषा सहायता सेवाएं, निःशुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन नंबर पर कॉल करें।

DÍÍ BAA'ÁKONÍNÍZIN: Diné (Navajo) bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí ninaaltsoos nitł'izí bee nééhozinígíí bine'dę́ ę́ ' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

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BFCC-QIO DETERMINATION LETTER

July 20, 2022

Case:
Patient Name:
Patient Date of Birth:
Provider: Health Services
Service Date: May 11, 2022 **Medicare(HIC)#:**

Dear

Thank you for your patience while we completed a thorough review of your provider's decision to end services. We understand the appeal process can be stressful. We hope your experience with Livanta has been a positive one.

Livanta LLC is authorized by Medicare to review medical care and services to decide if medical services meet professionally recognized standards of health care, are medically necessary, and are delivered in the most appropriate setting. Livanta LLC is also mandated to conduct an expedited review when a beneficiary appeals a provider's decision to end Medicare covered services.

An independent, certified, licensed, practicing peer reviewer reviewed the provider's decision to end coverage for the medical services from Health Services. Based on a review of the available medical documentation, and the information you provided. the peer reviewer found that you no longer meet the Medicare coverage requirements for skilled nursing facility services. The peer reviewer offered the following comments:

A review of medical records received shows that the patient has had sufficient time in a Skilled Nursing Facility to achieve therapy goals. Based on the Physical and Occupational Therapy evaluations, the patient has achieved reasonable goals of care. The patient needs minimum assist for bed mobility, transfers and walking of 15 feet with a walker. Therapy can be safely transitioned to a different setting. Skilled services are no longer needed on a daily basis to maintain or prevent decline. There were no medical issues to support the need for ongoing skilled nursing care.

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You or your representative were notified by telephone on July 20, 2022 at 4:15 PM Eastern time that the decision to end these services was upheld. These services will no longer be paid for by the Medicare program beginning on July 21, 2022.

You will be responsible for the cost of all services continued at Health Services beginning on July 21, 2022, except for those that are covered (when applicable) by Medicare Part B. If medical services were stopped before July 21, 2022, you will be responsible only for applicable deductible or coinsurance amounts and convenience services and items not normally covered by Medicare.

: Health Services and Medicare have been informed of this decision. We encourage you or your representative to discuss arrangements for further health care with your physician or case manager. Please be aware that this decision should not affect your Medicare coverage for medically necessary and appropriate services that you may require in the future.

If you disagree with our decision, you may request that Livanta LLC reconsider its decision to uphold Health Services's end of Medicare covered services. Your request must be made by telephone or in writing no later than **sixty (60) calendar days** from the date of this notice to:

Livanta LLC
Attention: Expedited Determinations
6830 W. Oquendo Rd Suite 202
Las Vegas, NV 89118
888-524-9900

If you or your representative have any questions regarding this action please call Livanta LLC at 888-524-9900.

Sincerely,

Matthew Stofferahn, MD
Medical Director

The Livanta Medical Director signs all letters to maintain physician reviewer anonymity.

cc: Health Services
CARE IMPROVEMENT PLUS WISCONSIN INSURANCE COMPANY

Health Services
, WI-544
Phone No: 715· · Fax: 715·
TTY users dial 711.

Detailed Explanation of Non-coverage

Date: 07/19/2022

Member name: Member number:

This notice gives a detailed explanation of why your Medicare provider and/or health plan has determined Medicare coverage for your current services should end. ***This notice is not the decision on your appeal.*** The decision on your appeal will come from your Quality Improvement Organization (QIO).

We have reviewed your case and decided that Medicare coverage of your current Skilled Nursing Facility services should end.

The facts used to make this decision:

Your case was carefully reviewed by our Medical Director to determine you are now at a level where you can transition from daily skilled services to services that are provided intermittently. When you admitted to the skilled nursing facility, you needed total help to move around, and you needed total help with most self-care skills. After receiving skilled services in the facility, you can move around with moderate help and perform most self-care skills with a lot of help.

Detailed explanation of why your current services are no longer covered, and the specific Medicare coverage rules and policy used to make this decision:

According to Chapter 8 of the Medicare Guidelines specifically related to Skilled Nursing Facilities (Section 30; 30.2.2; 30.3; 30.4.1.1; 30.6; 30.7), you must have a need for daily skilled nursing or daily skilled rehabilitation to receive coverage for skilled nursing facility services. Our Medical Director reviewed the documentation of your entire stay and determined you no longer need skilled services on a daily basis. More inpatient days at the skilled nursing facility are not medically necessary. A safe discharge plan has been recommended. You are now at a point where you can receive part-time skilled services.

Plan policy, provision, or rationale used in making the decision:

Your plan's policy requires our Medical Director to exclusively utilize Medicare Guidelines to determine the medical necessity for skilled services. The additional review of your plan's policy guidelines along with Medicare Guidelines confirm that you no longer meet criteria for daily skilled services.

If you would like a copy of the policy or coverage guidelines used to make this decision or a copy of the documents sent to the QIO, please call us at: 1-800-643-4845

Quality Improvement Organizations
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BFCC-QIO DETERMINATION LETTER

August 1, 2022

Case:
Patient Name:
Patient Date of Birth:
Provider: Health Services
Service Date: May 11, 2022 **Medicare(HIC)#:**

Dear

Thank you for your patience while we completed a thorough review of your provider's decision to end services. We understand the appeal process can be stressful. We hope your experience with Livanta has been a positive one.

Livanta LLC is authorized by Medicare to review medical care and services to decide if medical services meet professionally recognized standards of health care, are medically necessary, and are delivered in the most appropriate setting. Livanta LLC is also mandated to conduct an expedited review when a beneficiary appeals a provider's decision to end Medicare covered services.

Based on a request for a reconsideration appeal, an independent, certified, licensed, practicing peer reviewer reviewed the provider's decision to end coverage for the medical services from Tomahawk Health Services. Based on a review of the available medical documentation, and the information you provided. the peer reviewer found that you no longer meet the Medicare coverage requirements for skilled nursing facility services. The peer reviewer offered the following comments:

A review of medical records received shows that the patient was admitted to the Skilled Nursing Facility (SNF). The patient is self feeding and requires minimal help for hygiene and grooming. The patient needs minimal help with dressing, bathing and toilet tasks. The patient can walk 15 feet with a walker. The patient needs minimal help for bed mobility and functional transfers. There are no acute medical issues. Daily supervised services are no longer required to maintain or prevent a decline in function. The patient is ready for a different level of care.

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You or your representative were notified by telephone on August 1, 2022 at 2:07 PM Eastern time of the determination that the decision to end these services was upheld. These services will no longer be paid for by the Medicare program beginning on July 21, 2022

You will be responsible for the cost of all services continued at lealth Services beginning on July 21, 2022, except for those that are covered (when applicable) by Medicare Part B. If medical services were stopped before July 21, 2022, you will be responsible only for applicable deductible or coinsurance amounts, and convenience services and items normally not covered by Medicare.

Health Services and Medicare have been informed of this decision. We encourage you to discuss other arrangements for further health care with your physician or case manager. Please be aware that this decision should not affect your Medicare coverage for all medically necessary and appropriate services that may be required in the future.

You may appeal the reconsideration decision to an administrative law judge. If you wish to appeal, please refer to the information provided in the attached document for more details.

Appeals must be made in writing within 60 days from receiving this letter. You may wish to consult with your primary physician or case manager before taking further action.

If you or your representative have any questions regarding this action please call Livanta LLC at 888-524-9900.

Sincerely,

Matthew Stofferahn, MD
Medical Director

The Livanta Medical Director signs all letters to maintain physician reviewer anonymity.

Information and questions about quality of care or appeals.
Contact Livanta at 888-524-9900

Complaints or concerns about Livanta's work?
Let CMS know at QIOCONCERNS@cms.hhs.gov.

cc: Health Services
CARE IMPROVEMENT PLUS WISCONSIN INSURANCE COMPANY

IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS

Your Right to Appeal this Decision

If you do not agree with this decision, you may appeal the decision to an Administrative Law Judge (ALJ) at the Office of Medicare Hearings and Appeals (OMHA). You or your representative may present your case to the ALJ at a hearing. You may file an appeal on the following issues:

1. The reasonableness of the services;
2. The medical necessity of the services; or
3. The appropriateness of the setting in which the services were furnished.

You must have $200 in dispute to appeal to an ALJ. A claim can be combined ("aggregated") with others to reach this amount if: (1) the other claims have also been decided by a QIO; (2) all of the claims are listed on your request for hearing; (3) your request for hearing is filed within 60 days of receipt of all of the QIO reconsiderations being appealed; and (4) you explain why you believe the claims involve similar or related services.

You can find more information about your right to an ALJ hearing at www.hhs.gov/omha or by calling 1 855-556-8475. This is a toll free call.

How to Appeal

To exercise your right to appeal, you must file a written request for an ALJ hearing within **60 days** of receiving this letter. If your request for hearing is being filed late, you must explain why your request is being filed late. After you file an appeal, you may check your appeal's status via the OMHA website at www.hhs.gov/omha (click on Appeal Status Lookup).

When preparing your request for hearing, please use **Form OMHA-100**, available at: www.hhs.gov/omha/forms/index.html

Your request for hearing must include the following:

1. The Beneficiary's name, address, and Medicare health insurance claim number;
2. The name and address of the person appealing, if the person is not the beneficiary;
3. The representative's name and address, if any;
4. The case number listed on the front page of this reconsideration notice (or send a copy of the notice);
5. The dates of service for the claims at issue;
6. The reasons why you disagree with the QIO's reconsideration; and
7. A statement of any additional evidence to be submitted and the date it will be submitted.

You must send a copy of your request for hearing to the other parties who received a copy of this decision (for example, the beneficiary or provider/supplier). Please **do not** send a copy of your hearing request to the QIO that issued this reconsideration.

Mail your request for hearing to (tracked mail is suggested):

OMHA Central Operations
1001 Lakeside Ave., Suite 930
Cleveland, OH 44114-1158

OMHA processes **Medicare Beneficiary** appeals on a priority basis. If you are a Beneficiary or you represent a Beneficiary, mail your hearing request to:

OMHA Central Operations
1001 Lakeside Ave., Suite 930
Cleveland, OH 44114-1158

If you are a Beneficiary or represent a Beneficiary, you can also call the OMHA Beneficiary help line at 1 844-419-3358 for assistance. This is a toll free call. For more information on the OMHA Beneficiary prioritization program, including limitations for Beneficiaries represented by a provider/supplier, or a shared representative, visit the OMHA website at www.hhs.gov/omha or call the Beneficiary help line.

Who May File an Appeal

You or someone you name to act for you (your **appointed representative**) may file an appeal. You can name a relative, friend, advocate, attorney, doctor,or someone else to act for you.

If you want someone to act for you, you and your appointed representative must sign and date a statement naming that person to act for you and send it with your request for hearing. Call 1-800-MEDICARE (1-800-633-4227) to learn more about how to name a representative.

Help With Your Appeal

You can have a friend or someone else help you with your appeal. If you have any questions about payment denials or appeals, you can also contact your State Health Insurance Assistance Program (SHIP). For information on contacting your local SHIP, call 1-800-MEDICARE (1-800-633-4227).

Other Important Information

If you want copies of statutes, regulations, and/or policies we used to arrive at this decision, please write to us and attach a copy of this letter, at:

Livanta LLC
10820 Guilford Rd, Suite 202
Annapolis Junction, MD 20701-1105

If you have questions, please call us at:

1-855-878-1720

Other Resources To Help You

1-800-MEDICARE (1-800-633-4227)
TTY/TDD: 1-800-486-2048

If you need large print or assistance, please call 1-800-633-4227

Department of Health and Human Services
Office of the Secretary

OFFICE OF MEDICARE HEARINGS AND APPEALS

Kansas City Field Office
601 E. 12th Street
Suite 221
Kansas City, MO 64106-2817
(844) 566-6258
(816) 321-7292 (Direct)
(816) 527-0051 (Fax)
(844) 566-6258 (Toll Free)

10/12/2022

NOTICE OF HEARING

Appellant
Enrollee
Medicare No.
Date(s) of Service
OMHA Appeal Number
Administrative Law Judge Robert Clarke

A hearing in the above appeal is scheduled for:

Hearing Date: THURSDAY, 11/10/2022
Hearing Time: 09:30 AM Central Time

You are scheduled to appear by:

- ☑ Telephone
- ☐ Video-Teleconference (VTC)
- ☐ In-Person

You are instructed to call our office on the hearing date at the time indicated above. Please call

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(833) 419-1926 and enter 43353523 when asked for a passcode or collaboration code. Failure to call at the scheduled time will be considered a failure to appear for the hearing.

The following parties, participants, and/or witnesses are also scheduled to appear at the hearing:

Name	Role	Appearing by
CARE IMPROVEMENT PLUS WISCONSIN INSURANCE COMPANY	Party	
Livanta		
LLC	Non-Party	

What do I do next?

You must respond to this notice within 5 calendar days of receipt. You are encouraged, but not required, to use the enclosed *Response to Notice of Hearing* (form OMHA-102) when responding. If you are a party to the appeal, your response must indicate whether you plan to attend the scheduled hearing, or whether you object to the proposed time and/or place of the hearing. If applicable, you must specify who else from your organization or entity plans to attend the hearing and in what capacity, and list any witnesses who will be providing testimony. If you are an employee of CMS or a CMS contractor and wish to attend the hearing as a participant, your response must indicate that you plan to attend the hearing and specify each individual who plans to attend.

What if I object to the type of hearing?

If you are a party to the appeal and you object to the type of hearing scheduled, please complete section 6 of the enclosed *Response to Notice of Hearing*, and indicate what type of hearing you would prefer (if you are also requesting to change the time of your scheduled hearing, see the section below titled "What if I can't attend my scheduled hearing?"). No explanation is required if you are an unrepresented beneficiary or enrollee requesting to appear by VTC. For all other requests for a VTC hearing, and any requests for an in-person hearing, you must explain why you object to the type of hearing scheduled. If the Administrative Law Judge changes the type of hearing, an amended notice of hearing will be sent to the parties and any potential participants who were sent a copy of this notice.

What if I can't attend my scheduled hearing?

If you are a party to the appeal and you cannot attend the hearing at the scheduled time and place, please call our office immediately at the direct dial phone number at the top of this notice. Please *also* complete section 4 of the enclosed *Response to Notice of Hearing* and explain why you are unable to attend the hearing at the scheduled time and place. If the Administrative Law Judge finds good cause to reschedule the hearing, an amended notice of hearing will be sent to the parties and any potential participants who were sent a copy of this notice.

What if I don't attend my scheduled hearing?

If you are the appellant and neither you nor your representative appears at the scheduled hearing, the Administrative Law Judge may dismiss your request for hearing unless good cause for the failure to appear is found. If you respond to this notice of hearing and fail to appear, you must contact the Administrative Law Judge within 10 calendar days after the hearing and provide a good cause reason for not appearing. If you do not respond to this notice of hearing and fail to appear, the Administrative Law Judge will send you a notice asking why you did not appear, and you will have 10 calendar days to respond. If you do not respond to the Administrative Law Judge's notice within 10 calendar days, or you do respond and the Administrative Law Judge determines you did not have good cause for failing to appear, your request for hearing will be dismissed. If the Administrative Law Judge determines that good cause exists, the hearing will be rescheduled and the time between the originally scheduled hearing date and new hearing date will not count toward the adjudication period.

What if I don't want a hearing?

If you are a party to the appeal, you have a right to appear at the hearing to present arguments in favor of your position, and offer testimony and evidence to the Administrative Law Judge. However, if you do not wish to present your case at a hearing, you may request a decision based on the written and other evidence in the record. To do so, please complete section 4 of the enclosed *Response to Notice of Hearing*. Please also complete and submit a *Waiver of Right to an Administrative Law Judge (ALJ) Hearing* (form OMHA-104). You can find a copy of this form online at www.hhs.gov/omha, or you may contact our office to receive a copy. Please note that your waiver does not affect the right of other parties to participate in the hearing and even if all parties waive the hearing, the Administrative Law Judge may still decide to conduct a hearing if it is necessary to decide the case. If a hearing is conducted and you do not attend, you may still offer written evidence to the Administrative Law Judge. Please see below for additional information regarding the submission of evidence.

What if I no longer wish to pursue this appeal?

If you decide that you no longer wish to pursue this appeal, you may withdraw your request for hearing in writing. You may do this by letter or by completing and submitting a *Withdrawal of Request for an Administrative Law Judge Hearing* (form OMHA-119). You can find a copy of

this form online at www.hhs.gov/omha, or you may contact our office to receive a copy. If you submit a written request for withdrawal and no other party has filed a valid request for hearing, your appeal will be dismissed. Your request to withdraw will not be honored if a decision, dismissal or remand has already been issued.

What issues will be addressed at the hearing?

The issues before the Administrative Law Judge include all of the issues brought out in the initial determination, coverage determination, or organization determination; redetermination; or reconsideration that were not decided entirely in a party's favor, for the claims or other appealed matters specified in the request for hearing.

What if I object to the issues listed above?

If you are a party and you object to the issues, you must notify the Administrative Law Judge in writing at the earliest possible opportunity before the time set for the hearing and explain your objections. You can either do this in section 6 of the enclosed *Response to Notice of Hearing* or at a later time, but no later than 5 calendar days before the date of your scheduled hearing. You must send a copy of your objections to all the parties who were sent a copy of this notice and to CMS or any CMS contractor that has elected to be a party to the hearing. The Administrative Law Judge will make a decision on your objections either in writing, at a prehearing conference, or at the hearing.

Can I have a representative?

Yes. You have the right to have a representative attend the hearing on your behalf or attend the hearing with you. You can be represented by an attorney or other person. If you have a representative and have not completed and submitted an *Appointment of Representative* (form CMS-1696), which can be found online at www.hhs.gov/omha, or other written statement authorizing your representative to act on your behalf, please call our office as soon as possible.

Can I request a copy of the case file?

Yes. If you would like a copy of all or part of your file before the date of the hearing, please contact our office for further instructions.

Can I submit additional evidence?

If you want to submit additional written or other evidence, please complete and submit a *Filing of New Evidence* (form OMHA-115). You can find a copy of this form online at www.hhs.gov/omha, or you may contact our office to receive a copy. Unless you are an unrepresented beneficiary or enrollee, you must submit all evidence by the date (if any) you have

specified in your request for hearing, or within 10 calendar days of receiving this notice. If evidence is submitted more than 10 calendar days after receiving this notice, any applicable adjudication period will be extended by the number of calendar days in the period between 10 calendar days after receipt of this notice and the day the evidence is received. Please note that although the 10-day submission time frame does not apply to unrepresented beneficiaries and enrollees, they may wish to submit any additional evidence as soon as possible to allow the Administrative Law Judge more time to consider the evidence before the hearing.

If you are a provider or supplier, or a beneficiary represented by a provider or supplier, and you are appealing a reconsideration issued by a Medicare Part A or Part B Qualified Independent Contractor (QIC), you must also submit a statement explaining why the evidence was not submitted prior to the issuance of the QIC's reconsideration. The Administrative Law Judge will determine whether you have good cause for submitting the evidence for the first time at the OMHA level of appeal.

Will any experts participate or testify at the hearing?

No experts are scheduled to testify at your hearing.

What happens at the hearing?

- The Administrative Law Judge will open the hearing and ask the parties, participants and any representatives to identify themselves and any witnesses they may be calling;
- The Administrative Law Judge will ask you and any other witnesses to take an oath or to affirm that the testimony is true;
- You will have the opportunity to present facts and arguments;
- If you are a party, you or your representative may present witnesses and may cross-examine the witnesses of the other parties;
- The Administrative Law Judge may question you and any other witnesses about the facts and issues;
- The Administrative Law Judge may allow you to submit additional written statements and affidavits about the matter in lieu of testimony or argument at the hearing. You must submit the additional statements and affidavits within the time frame designated by the Administrative Law Judge and provide a copy of them to the other parties to your hearing, if any, at the same time you submit them to the Administrative Law Judge;
- The Administrative Law Judge will review the issue(s) and entire record of your claim, independent of any determinations previously made on your claim; and
- The Administrative Law Judge will make an audio recording of the hearing.

How will I know the result of my case?

After the hearing, the Administrative Law Judge will issue a written decision, which will be mailed to all parties to the appeal, the relevant QIC or Independent Review Entity, and the Part D plan sponsor if you are appealing a Part D coverage determination. The decision will include findings of fact, conclusions of law, and the reasons for the decision. The Administrative Law Judge will base the decision on the evidence of record, including the testimony at the hearing.

Whom do I contact with other questions about my hearing?

If you have any questions about your hearing, please call or write our office. A direct dial phone number and mailing address are at the top of this notice. Please provide the Administrative Law Judge name and OMHA appeal number if you write to the office, or have the information available if you call the office.

cc:

CARE IMPROVEMENT PLUS WISCONSIN INSURANCE COMPANY
PO BOX 6106
MS CA124-0157
CYPRESS, CA 90630

Livanta
6830 W. Oquendo Road
Suite 202
Las Vegas, NV 89118

[redacted] LLC

[redacted]

Enclosures:
OMHA-102 Response to NOH
OMHA-001 Notice of Nondiscrimination

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of Medicare Hearings and Appeals

NOTICE OF NONDISCRIMINATION

The Office of Medicare Hearings and Appeals (OMHA) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. OMHA does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation.

OMHA:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - TTY calls that are initiated by the caller through a public relay service
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact (844) 419-3358.

If you believe that OMHA has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (844) 419-3358.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 (844) 419-3358.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (844) 419-3358.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (844) 419-3358.

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le (844) 419-3358.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (866) 207-4466

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (844) 419-3358 번으로 전화해 주십시오.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: (844) 419-3358.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (844) 419-3358.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele (844) 419-3358.

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। (844) 419-3358 पर कॉल करें।

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para (844) 419-3358.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero (844) 419-3358.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer (844) 419-3358.

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں - کال کریں (844) 419-3358

If you need large print, please call 1-844-419-3358

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of Medicare Hearings and Appeals

RESPONSE TO NOTICE OF HEARING

Instructions: Complete sections 2 through 8 below, as applicable, and return this form to the assigned Administrative Law Judge (ALJ) **within 5 days of receiving the notice of hearing**. For expedited Part D hearings, contact the ALJ at the telephone number provided at the top of the notice of hearing **or** complete and return this form to the assigned ALJ **within 2 days of receiving the notice of hearing.** The return mailing address and fax number are at the top of the notice of hearing. You do not need to include the notice of hearing with your response.

Please note that only a party to the hearing may call witnesses; object to the time, place, or type of hearing; object to the statement of issues to be decided at the hearing; or object to the assigned ALJ (sections 4 through 6 below). Non-party participants are not permitted to call witnesses and may not file objections.

Section 1: Hearing information. [TO BE COMPLETED BY THE OFFICE OF MEDICARE HEARINGS AND APPEALS]

OMHA Appeal Number	Appellant		
Type of Hearing ☒ Telephone ☐ Video-Teleconference (VTC) ☐ In-Person		Assigned ALJ Clarke	
Hearing Day of Week THURSDAY	Hearing Date 11/10/2022	Hearing Time 09:30 AM	
Telephone Hearing Call-in Number (*if applicable*) (833) 419-1926		Passcode or Collaboration Code (*for telephone hearing*) 43353523	
VTC or In-Person Hearing Address (*if applicable*)	City	State	ZIP Code

Section 2: What is the responding party's or participant's information? (*Representative information in next section*)

Name (*First, Middle initial, Last*)	Firm or Organization (*if applicable*)	Telephone Number	
Mailing Address	City	State	ZIP Code

If the respondent is an entity or organization, please list all individuals who plan to attend the hearing and the capacity in which they are attending *(attach a continuation sheet if necessary)*:

Section 3 : What is the representative's information? (*Skip if you do not have a representative*)

Name	Firm or Organization (*if applicable*)	Telephone Number	
Mailing Address	City	State	ZIP Code

Section 4: Will you be present at the time and place shown above? (*Check one*)

☐ **I will be present at the time and place shown on the notice of hearing.** If an emergency arises after I submit this response and I cannot be present, I will notify the ALJ at the telephone number shown at the top of the notice of hearing as soon as possible.

☐ **I cannot be present at the time and place shown on the notice of hearing and would like to request that my hearing be rescheduled.** I understand that the ALJ has the discretion to change the time and place of the hearing as long as my explanation for my request to reschedule meets the good cause standard for changing the time and place of the hearing. (For example, good cause may be found due to an inability to attend the hearing because of a serious physical or mental condition, incapacitating injury, or death in the family or if severe weather conditions make it impossible to travel to the hearing. *See* 42 C.F.R. sections 405.1020(f) and (g), and 42 C.F.R. sections 423.2020(f) and (g) for additional circumstances that may establish good cause.) I understand that if I am the appellant and the hearing is postponed at my request, the time between the originally scheduled hearing date and the new hearing date is not counted toward any applicable adjudication period.

I would like to reschedule my hearing for the following date and time, and I have good cause to reschedule my hearing because:

☐ **I want to waive my right to appear at the ALJ hearing.** (*Please complete form OMHA-104 and attach it to this response.*)

PSC Publishing Services (301) 443-6740. EF

Section 5: Do you intend to call any witnesses to provide testimony at the hearing?

☐ No.

☐ Yes, I intend to call the following witnesses *(attach a continuation sheet if necessary)*:

Section 6: Do you object to any of the following conditions? (*Check all that apply*)

☐ **I object to the type of hearing scheduled.** If you are an unrepresented beneficiary or enrollee, and a telephone hearing is scheduled, you have the right to request that a VTC hearing be held instead if VTC technology is available. For all other parties, if a telephone hearing is scheduled, the ALJ may find good cause for an appearance by VTC if he or she determines that VTC is necessary to examine the facts or issues involved in the appeal.

If a telephone or VTC hearing is scheduled and the party, including an unrepresented beneficiary or enrollee, requests that an in-person hearing be held instead, the ALJ, with the agreement of the Chief ALJ or designee, may find good cause for an in-person hearing if VTC or telephone technology is not available, or if special or extraordinary circumstances exist.

I object to the type of hearing scheduled and request a (*check one*) ☐ VTC ***or*** ☐ in-person hearing because:

Note: No explanation is required if you are an unrepresented beneficiary or enrollee requesting a VTC hearing.

☐ **I object to the issues described in the notice of hearing.** I understand that I must send a copy of my objection to the issues to all the other parties who were sent a copy of the notice of hearing, and to CMS or a CMS contractor that elected to be a party to the hearing (if you do not have these addresses, please contact the ALJ's adjudication team at the telephone number shown in the letterhead of the notice of hearing). I understand that the ALJ will make a decision on my objection either in writing, at a prehearing conference, or at the hearing.

I object to the issues described in the notice of hearing because:

☐ **I object to the ALJ assigned to my appeal.** I understand that an ALJ cannot adjudicate an appeal if he or she is prejudiced or partial with respect to any party or has an interest in the matter pending for decision, and that I may object to the ALJ assigned to my appeal for these reasons. I understand that the ALJ will consider my objection and decide whether to proceed with the appeal or withdraw. I understand that if I object to the ALJ assigned to my appeal, and the ALJ subsequently withdraws from the appeal, another ALJ will be assigned, and any applicable adjudication time frame will be extended by 14 calendar days.

I object to the assigned ALJ because:

Section 7: If you are the appellant, do you want to waive or extend the time frame to decide your appeal? (*If yes, check one*)

☐ **I want to waive the time frame for the ALJ to decide my appeal.** I understand that by waiving this time frame, the ALJ does not have to decide my appeal within any applicable adjudication period that would otherwise apply.

☐ **I want to extend the time frame for the ALJ to decide my appeal.** I want the time frame to be extended _____ calendar days beyond any applicable adjudication period.

Section 8: Sign and date this form.

Party, Participant or Representative Signature	Date

Privacy Act Statement

The legal authority for the collection of information on this form is authorized by the Social Security Act (section 1155 of Title XI and sections 1852(g)(5), 1860D-4(h)(1), 1869(b)(1), and 1876 of Title XVIII). The information provided will be used to further document your appeal. Submission of the information requested on this form is voluntary, but failure to provide all or any part of the requested information may affect the determination of your appeal. Information you furnish on this form may be disclosed by the Office of Medicare Hearings and Appeals to another person or governmental agency only with respect to the Medicare Program and to comply with Federal laws requiring the disclosure of information or the exchange of information between the Department of Health and Human Services and other agencies.

If you need large print or assistance, please call 1-855-556-8475

Skilled Nursing Facility

nH Predict | Outcome

DOB: [redacted], Gender:
Admit Date: 06/03/2019

Likelihood of Hospital Admission from SNF in less than 30 days: 28% (High)

Patient Evaluation

Impairment Group: Orthopedic Conditions
Diagnostic Group: Upper Extremity Fracture
Primary Dx: S42.212A-UNSP DISP FX OF SURGICAL NECK OF LEFT HUMERUS, INIT
Usual Living Setting: Home Alone
Medical Complexity: 3 - Active, system disease limiting function
Grouper(s): None

	Basic Mobility	Daily Activity	Applied Cognition	Total Average Score
	E.g. Transfers, ambulation, stairs, wheelchair skills	E.g. Bathing, toileting, dressing, eating (ADL/IADL)	E.g. Memory, communication, problem solving	Average of Basic Mobility, Daily Activity, and Applied Cognition scores
Admission Function	32 (0–100) Max A to Mod A	33 (0–100) Mod A to Min A	65 (0–100) Close/Frequent Supervision	43 (0–100) Mod A to Min A
SNF Outcomes Prediction (+11 Avg. Gain)	44 Mod A to Min A	48 SU/Supervision/SBA to Mod I	69 Basic Decision/Problem Solving	54 Min A to SU/Supervision/SBA
Projected non-skilled caregiver needs post SNF	**3.75 Hours/Day**	**0.75 Hours/Day**	**None**	**4.5 Hours/Day**

Actual Discharge Setting After SNF of Similar Patients

Home Alone	9%
Home with Care	52%
Assisted Living	13%
Long Term Care	26%

Anticipated Length of Stay in Days*: 16.2 — **16.6 Avg.** — 17.0

Projected SNF Discharge: **6/20/2019**

Therapy:
Cycle: 15.3 Days on Average
561 Minutes per Week
5x/week: 112 minutes/day
6x/week: 93 minutes/day
7x/week: 79 minutes/day

Clinical Considerations: High (>25%) readmission alert. Home Alone unrealistic discharge plan.

naviHealth

This report was provided to your patient's health plan for conside care and treatment. The information contained in this report is n as or replace medical advice. All treating health care providers responsible for their own medical judgment.

EXHIBIT F

Admission Assistance Levels

Basic Mobility - e.g. Transfers, ambulation, stairs, wheelchair skills

May need a lot (mod/max) of assistance with:

- Advancing with his/her assistive device or wheelchair even short distances around the home
- Maneuvering the assistive device or wheelchair during transfers or walking
- Standing for even short time periods, for example, during transfers
- Transferring in/out of a car to attend any function outside the home
- Using his/her assistive device or wheelchair when transferring to chair, toilet or shower bench

May need total assistance with:

- Ascending or descending one step/curb with an assistive device or a wheelchair
- Going up/down ramps or steps with assistive device or wheelchair

Daily Activity - e.g. Bathing, toileting, dressing, eating (ADL/IADL)

May need a little (min/contact guard) assistance with:

- Basic activities of daily living (ADL) such as bathing and lower body dressing
- Completing simple housekeeping tasks around the home (simple dusting)
- Completing tasks that require fine motor coordination (snaps, buttons, sewing, slicing/dicing)

May need a lot (mod/max) of assistance with:

- Completing simple tasks around the home that require stamina, strength or balance (hanging curtains, simple above-the-head activities, etc.)
- Higher level activities of daily living such as medication administration and full meal preparation

Applied Cognition - e.g. Memory, communication, problem solving

May need partial to little assistance with:

- Figuring out a problem with a bill
- General household finances (managing checkbook)
- Navigating in the community
- Remembering calendar events/appointments

Applied Cognition - e.g. Memory, communication, problem solving (Continued)

May need total to partial assistance with communication, memory and social tasks including:

- Explaining/arranging household repairs
- Taxes, insurance and legal documents/transactions
- Understanding ingredients and portions

Predicted Assistance Levels upon Discharge from Skilled Nursing Facility

Basic Mobility - e.g. Transfers, ambulation, stairs, wheelchair skills

May need a lot (mod/max) of assistance with:

- Ascending or descending one step/curb with an assistive device or a wheelchair
- Going up/down ramps or steps with assistive device or wheelchair
- Standing from any chair or surface without an armrest, rail, or grab bar

May need a little (min/contact guard) assistance with mobility activities such as

- Advancing with his/her assistive device or wheelchair even short distances around the home
- Maneuvering the assistive device or wheelchair during transfers or walking
- Standing for even short time periods, for example during transfers
- Transferring in/out of a car to attend any function outside the home
- Using his/her assistive device or wheelchair when transferring to chair, sofa, toilet or shower bench

Daily Activity - e.g. Bathing, toileting, dressing, eating (ADL/IADL)

May need a little (min/contact guard) assistance with:

- Completing simple housekeeping tasks such as vacuming, cleaning sinks, etc.
- Completing tasks that require upper extremity strength (lifting boxes, moving light furniture, some gardening activities, etc.)

May need a lot (mod/max) of assistance with:

- Completing higher level activities such as running errands outside of the home
- Completing housekeeping tasks that require strength, stamina or balance (over-the-head activities of longer duration, moving heavy furniture, climbing step stool)

Applied Cognition - e.g. Memory, communication, problem solving

May need partial to no assistance with:

- Basic communication
- Following a recipe
- Remembering calendar events
- Remembering to do 4 to 5 errands

May need partial to little assistance with communication, memory and social tasks including:

- Getting household items repaired or installed
- Managing household finances
- Navigating in the community
- Shopping and doing price/budget calculations

DOB: [redacted] Gender:
Admit Date: 06/03/2019

The Report

Your goal is our goal – to return to the community as quickly and safely as possible. We have gathered your information and compared that against thousands of patients, similar to you, to understand what outcomes you may achieve with therapy. This report will give you an idea of what you may be able to do after therapy and how much assistance you may need.

Your Care Coordinator is: _____

Your Journey

Following therapy, patients like you have experienced the following:

Actual Discharge Setting After Skilled Nursing Facility of Similar Patients

Basic Mobility

You may need a little (less than 25%) physical assistance with such activities as walking, climbing stairs or transferring from a chair inside your home.

Caregiver Assistance Needs after Skilled Nursing Facility:
3.75 Hours/Day

Daily Activity

You may need a little (less than 25%) physical assistance with such activities as grooming, dressing or bathing.

Caregiver Assistance after Skilled Nursing Facility:
0.75 Hours/Day

Applied Cognition

You may be able to complete all complex tasks such as reading, counting money and conversing but you might have slight difficulty with such activities as completing a long insurance form or balancing a checkbook.

Caregiver Assistance Needs after Skilled Nursing Facility:
None

naviHealth

The information contained in this report was provided for consideration by your health plan in authorizing services. naviHealth is not a health care provider and this report is not intended to serve as or replace medical advice issued by a health care provider. Your treating health care provider is responsible for making decisions and recommendations regarding your care.

Your Care Skilled Nursing Facility

Your care will be based on your individual needs. Similar patients have experienced the following:

Target Discharge Date:	6/20/2019	Anticipated length of stay:	16 - 17 Days
Therapy:	9.5 Hours/Week	**High likelihood of hospital admission from the Skilled Nursing Facility within 30 days**	

Our Expertise

naviHealth works with your care team to help coordinate care and support clinical decision making. We draw upon the knowledge of experienced licensed clinicians. Using data from a patient database of over 3 million records, we help set realistic goals with you based upon what other patients like you have been able to achieve.

www.navihealth.com