

8-2-113. Unlawful to intimidate worker - agreement not to compete.

(1) It shall be unlawful to use force, threats, or other means of intimidation to prevent any person from engaging in any lawful occupation at any place he sees fit.

(2) Any covenant not to compete which restricts the right of any person to receive compensation for performance of skilled or unskilled labor for any employer shall be void, but this subsection (2) shall not apply to:

(a) Any contract for the purchase and sale of a business or the assets of a business;

(b) Any contract for the protection of trade secrets;

(c) Any contractual provision providing for recovery of the expense of educating and training an employee who has served an employer for a period of less than two years;

(d) Executive and management personnel and officers and employees who constitute professional staff to executive and management personnel.

(3) Any covenant not to compete provision of an employment, partnership, or corporate agreement between physicians which restricts the right of a physician to practice medicine, as defined in section 12-36-106, C.R.S., upon termination of such agreement, shall be void; except that all other provisions of such an agreement enforceable at law, including provisions which require the payment of damages in an amount that is reasonably related to the injury suffered by reason of termination of the agreement, shall be enforceable. Provisions which require the payment of damages upon termination of the agreement may include, but not be limited to, damages related to competition.

Source: L. 05: p. 161, § 3. R.S. 08: § 400. C.L. § 4164. CSA: C. 97, § 92. CRS 53: § 80-4-13. C.R.S. 1963: § 80-11-13. L. 73: p. 940, § 1. L. 82: (3) added, p. 232, § 1, effective April 6.

Cross references: For the "Uniform Trade Secrets Act", see article 74 of title 7.

Health Facilities and Emergency Medical Services Division

6 CCR 1011-1

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES

CHAPTER XXVI - HOME CARE AGENCIES

6.8

Non-compete agreements

- (A) An HCA shall not coerce, threaten, or use any means of intimidation to prevent an employee from terminating the employment relationship and commencing employment at another HCA.
- (B) Non-compete clauses, agreements or contracts shall only be enforceable in accordance with Section 8-2-113, C.R.S.

Special Compliance Alert:

Expedited Appeal Review for Termination of Medicare Coverage

CMS is monitoring compliance with termination notices.

The Centers for Medicare & Medicaid Services (CMS) is evaluating data regarding provider compliance in issuing appropriate notices when services are being terminated for patients in traditional Medicare (fee-for-service) or Medicare Advantage programs. According to national data, Medicare beneficiaries in your state are displaying a lower percentage of appeals of service termination by comprehensive outpatient rehabilitation facilities (CORFs), home health agencies (HHAs), hospices and skilled nursing facilities (SNFs)/swingbed providers than in other states. In light of these facts, it is important for providers to fully understand the federal requirements related to termination of services for these beneficiaries.

Patients have the right to an expedited review process.

The Benefits Improvement and Protection Act of 2000 gives patients in traditional Medicare (fee-for-service) programs access to an expedited determination process when their Medicare-covered health care services are ending in a CORF, HHA, hospice or SNF/swingbed provider. This appeal right also exists for CORF, HHA and SNF/swingbed patients enrolled in Medicare Advantage programs.

Providers must issue a generic notice prior to termination.

Prior to terminating Medicare services, providers are required to deliver a generic notice (called a Notice of Medicare Provider Non-Coverage) to the Medicare beneficiary and obtain documentation of his/her signature and date. The intent of the generic notice is to inform the beneficiary of an end date for Medicare coverage of the services, allowing time for an appeal through the Medicare Quality Improvement Organization for your state, if they so choose. Providers must issue the notice no later than two days before the proposed end of services. *Termination of services* with regard to these regulations means the beneficiary has been discharged from a residential provider or there has been a complete cessation of services for his/her course of treatment, excluding when benefits are exhausted.

What happens if a beneficiary appeals the termination notice?

If the beneficiary contacts your state Quality Improvement Organization (QIO) and requests an expedited review of the decision to terminate services, your state QIO will notify the provider of the request. At this time the provider must deliver a detailed notice (called a Detailed Explanation of Provider Non-Coverage) to the beneficiary, which explains why the services are no longer required. The provider must also provide your state QIO with a copy of the generic notice, detailed notice and medical record or other documentation supporting termination of the services *by close of business of the day the appeal request was made*. When non-residential providers (CORFs and HHAs) are involved, your state QIO will ask the beneficiary to provide the attending physician's certification that the termination of the services would place the beneficiary's health at risk. Without the certification, your state QIO cannot process the appeal. Your state QIO will review all of the applicable information and render a decision within 72 hours of receiving an appeal request.

Make sure your notices meet CMS requirements.

There are very specific CMS requirements for the format/content of the notices issued by providers. Your state QIO will evaluate the notices and alert the provider to reissue if there are format/content problems. The state QIO phone number that providers should list on the generic notice is available. Templates for the notices and additional information about the expedited review process are available as noted below.

For More Information:

- www.cms.hhs.gov/bni: CMS Beneficiary Notices Initiative website
- www.cms.hhs.gov/qualityimprovementorgs, click on *QIO Directory* near the bottom of the page: QIO website for each state

BIPA Compliance

Benefits Improvement and Protection Act

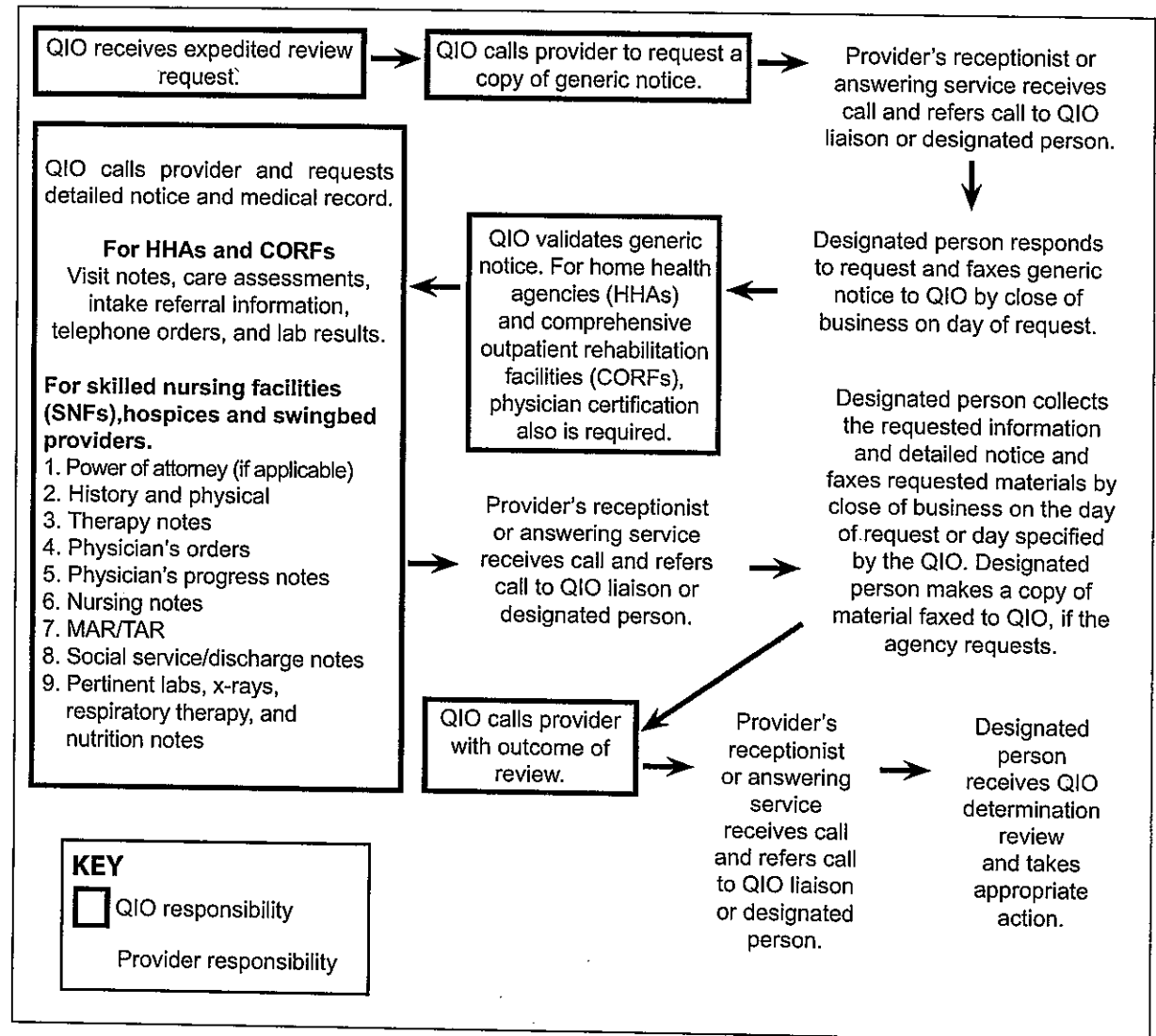
Provider Process for Expedited Reviews

BIPA Provider Checklist

The Medicare Quality Improvement Organization (QIO) for your state may call you on a weekday, weekend or holiday during their normal business hours.

Be sure your organization is prepared with this quick to-do list.

- Assign a designated person (QIO liaison) and at least one back-up person to respond to QIO requests for patient records and notices.
- Instruct the designated person on these matters:
 - The expedited review process
 - Accessing medical records
 - Material to be faxed
 - What to do with the QIO's review determination
- Provide your receptionist or answering service with instructions for handling expedited review requests:
 - Designated person(s) to contact in case of a review
 - Level of urgency
- Educate all staff about BIPA:
 - The expedited review process
 - Roles and responsibilities within your organization



Affected Providers

On July 1, 2005, new Medicare regulations (the Benefits Improvement and Protection Act §521) gave beneficiaries access to a new expedited determination process when their Medicare-covered CORF, HHA, hospice, SNF, or swing-bed provider services are ending.

Beneficiary May Appeal

- Beneficiary disagrees with termination and also, for HHA and CORF, the physician certifies that failure to continue the services may place the beneficiary's health at significant risk.

Financial Liability

- The provider is liable for continued services until two days after the beneficiary receives a valid notice, or until the service termination date, whichever is later.
- If the QIO upholds the notice, the beneficiary is financially liable for services received after the effective date.
- If the QIO overturns the notice, Medicare will continue to cover services.
- If the QIO determines the beneficiary did not receive a valid notice, coverage of provider services continues until at least two days after a valid notice has been received.

Notices—Provider Responsibilities

There are two notices required by these regulations.

1. The first is a generic notice (called a Notice of Medicare Provider Non-Coverage) that the provider will deliver whenever a beneficiary's Medicare coverage of current items and/or services is ending.
2. The second is a detailed notice (called a Detailed Explanation of Provider Non-Coverage) that the provider will deliver to the beneficiary and the appropriate QIO only if the beneficiary requests an expedited review by the QIO of the decision that coverage for items and/or services should end.

Effective Oct. 1, 2005, HHA, SNF, Hospice, CORF, and swing beds must use approved versions of the Expedited Determination Notices. To download the fee-for-service (FFS) Expedited Determination Notices and instructions, go to www.cms.hhs.gov/BNI and click the appropriate link.

Termination of Covered Services

- Discharge from SNF, hospice or swingbed, or
- Complete cessation of coverage at the end of a course of treatment
- Generic notification is not to be used for the following reasons:
 - Exhaustion of benefits
 - Reduction in services
 - Hospital transfer (i.e., patient has pneumonia and is transferred to acute care)
 - Refusal of care

Appeals

The beneficiary (or representative) must request a QIO expedited appeal by noon on the day prior to the termination of service(s). Expedited appeals will be conducted by your state QIO's Quality Review department as part of your state QIO's responsibilities as the Medicare QIO for your state. A copy of the beneficiary's medical record must be provided to your state's QIO no later than close of business on the day of request or as specified by the QIO.

Process

- Beneficiary requests appeal
- QIO notifies facility and requests copies of notices and medical record
- Provider faxes information to QIO; provider delivers detailed notice to the beneficiary on the same day
- QIO physician makes determination
- QIO notifies provider, physician, and beneficiary of determination within 72 hours of an expedited appeal request
- QIO mails written determination to provider, beneficiary, fiscal intermediary, and attending physician
- A beneficiary who disagrees may then request a reconsideration



... Leadership in Health Care Quality Improvement

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BIPA Quick Tips

Ensuring a Valid Notice of Medicare Provider Non-Coverage

A valid *Notice of Medicare Provider Non-Coverage* is essential if a beneficiary or authorized representative files an appeal. A notice that is not valid can delay the appeal process and increase provider financial liability.

How to make sure a *Notice of Medicare Provider Non-Coverage* is valid:

- *Notice* is delivered within the specified time frame:
 - At least two calendar days before proposed end of service
 - On admission, if duration of service is less than two days
 - Non-residential providers: If span of time between services exceeds two days, notice is issued by next-to-last time services are provided
- Contents of *Notice* are correct, including:
 - Name and Medicare number of beneficiary
 - Type of service being terminated
 - Date that coverage ends (effective date)
 - Description of right to appeal
 - Name **your state's Quality Improvement Organization (QIO)** and phone number
- Beneficiary/representative signs and dates *Notice*

BIPA/GRIJALVA NOTICES

(SNE, SWINGBED, HOME HEALTH, HOSPICE & CORF)

MEDICARE FEE FOR SERVICE

<http://www.cms.hhs.gov/BN/06/FFSEDNotices.asp>

MEDICARE ADVANTAGE

<http://www.cms.hhs.gov/BN/09/MAEDNotices.asp>

This material was prepared by CFMC, the Medicare Quality Improvement Organization for Colorado, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication No. RS-313-142 CO 2006



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What to do if a beneficiary/representative refuses to sign the *Notice of Medicare Provider Non-Coverage*:

- Write a note on the Notice indicating the refusal
 - The date of the refusal is the date of receipt of the *Notice*

What to do if in-person delivery is not possible:

- Call the beneficiary/authorized representative and document the telephone contact on the Notice. Include:
 - Name of person initiating the contact
 - Name of representative contacted
 - Date and time of contact
 - Telephone number called
- Document that you have told him/her the effective date for termination of services and have provided information about the right to appeal, including your state QIO's name, their toll-free phone number, and deadline for filing an expedited appeal
- Send the *Notice of Medicare Provider Non-Coverage* to the beneficiary/representative via certified mail or other traceable means

What to do if direct phone contact cannot be made:

- Document on the notice the dates and times of the attempted calls
- Send the notice to the representative by certified mail, return receipt requested

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BIPA/GRIJALVA NOTICES

(SNF, SWINGBED, HOME HEALTH, HOSPICE & CARE)

MEDICARE FEE FOR SERVICE

http://www.cms.hhs.gov/BNI/06_FFSEDNotices.asp

MEDICARE ADVANTAGE

http://www.cms.hhs.gov/BNI/09_MAEDNotices.asp

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