



CMA Weekly Alert – June 28, 2007

THE NEW MEDICARE HOSPITAL NOTICE: INSIGHT AND GUIDANCE FOR BENEFICIARIES

Starting July 1, 2007, hospitals participating in the traditional or Medicare Advantage Medicare program must provide beneficiaries with a new notice of discharge and appeal rights, as discussed in last week's *Weekly Alert*. This *Weekly Alert* describes the new notice as well as beneficiary rights to question and appeal hospital discharge decisions and to receive continued medical treatment.

The new notice, known as *An Important Message from Medicare about Your Rights* (IM) can be found at http://www.cms.hhs.gov/BNI/12_HospitalDischargeAppealNotices.asp#TopOfPage. The requirements for the new notice are discussed in Guidelines which were released by the Centers for Medicare and Medicaid Services (CMS) on May 25, 2007. In the Guidance, CMS explains when and how Medicare patients must be given information about their discharge and appeal rights. The Guidance is part of the CMS Medicare manual system,¹ and can be accessed at <http://www.cms.hhs.gov/Transmittals/downloads/R1257CP.pdf>.

Starting July 1, the IM must be given, in most cases, at least twice during a Medicare patient's hospital stay. First, upon admission, Medicare beneficiaries must receive the initial IM which they are to read, sign and date. The IM is to inform the beneficiaries of the process available to challenge a hospital's discharge decision. The CMS guidance document describes the events that trigger a hospital's duty to provide beneficiaries with an additional, follow-up IM notice. At or near the point of discharge, beneficiaries are to receive this second notice. The exception to the two-notice requirement is an individual who is in the hospital for just 3 days. One IM can be given on day 2, and suffice as both the initial and discharge IM.

Upon receipt of a hospital's discharge decision, beneficiaries may appeal the decision by requesting a timely review by the appropriate Quality Improvement Organization (QIO). When QIO review is requested, an additional notice called the *Detailed Notice of Discharge* (*Detailed Notice*) is to be given. The *Detailed Notice* is to explain the medical basis for the discharge decision. CMS has issued a Question & Answer document elaborating on the use of IM and the *Detailed Notice*. This CMS Q & A document can be found at: <http://www.cms.hhs.gov/BNI/Downloads/CMS-4105-FINAL%20RULE%20Qs%20and%20As%2004%2003%2007.pdf>.

What Basic Information Must the "IM" Contain?

The IM must contain the following essential pieces of information:

- The name(s) of the patient's physician(s) and the patient's ID number.
- A statement of the right to file an appeal or raise questions with a QIO about quality of care, including hospital discharge.
- The name and telephone number of the QIO that serves the area in which the hospital in question is located.
- A space for the beneficiary or representative to sign and date the document.
- The steps necessary to appeal a hospital discharge decision or to file a complaint about the quality of care.

What Basic Information Must the "Detailed Notice" Contain?

The *Detailed Notice* must contain the following essential pieces of information:

- The name(s) of the patient's physician(s) and the patient's ID number.
- The date the Notice was issued.
- The date the inpatient hospital services are to end.
- A statement that the *Detailed Notice* is not an official Medicare decision.
- Specific information about the patient's current medical condition.
- The hospital and/or Medicare plan telephone number for requesting copies of documents to be sent to the QIO.

When Must the "IM" be Distributed?

The patient must receive the original IM within two days of admittance to the hospital. The hospital must obtain the signature of the beneficiary or of his or her representative and provide a copy to that person at that time. If the patient or representative refuses to sign the IM, then the hospital is required to make a note to that effect; for purposes of requesting an appeal, the date of the refusal to sign is considered the date of notification. A follow-up copy of the signed IM should again be given "as far in advance of the discharge as possible, but not more than 2 calendar days before discharge." If discharge occurs within 2 days of the date the IM was given, no follow-up copy is required.

A beneficiary may be considered discharged when Medicare decides it will no longer pay for the medical services or when the physician and hospital believe that medical services are no longer required. The Medicare Claims Manual provides that a patient may be considered to have been discharged when s/he is either physically required to leave the hospital (not merely transferred to another inpatient setting) or when s/he remains in the hospital but at a lower level of care.

Discharge Decision Concerns

- **Four Hour Notice Requirement**

Notification of the beneficiary's discharge and appeal rights should not be hindered when the hospital cannot anticipate the date of discharge. According to CMS, if hospitals cannot anticipate the discharge date, the follow-up IM notice may be given on the day of discharge, at least four hours in advance of the actual discharge.

- **Problems With Four Hour/Same Day Notice**

Beyond requiring that the follow-up IM be given at a minimum of four hours in advance of discharge, CMS does not require the hospital to again obtain the patient's signature when this follow-up IM is given. The hospital may simply distribute a copy of the signed and dated IM that was given at admission. However, hospitals are not precluded from obtaining a new IM and verifying signature from the beneficiary. By allowing this practice, CMS has made it possible for hospitals to eliminate the need for a follow-up copy of the IM during inpatient stays of up to 5 days. This lack of timely notice may hinder the ability of Medicare patients to be fully aware of and exercise their appeal rights.

Appeals of Hospital Discharge

As previously discussed, when a hospital (with physician concurrence) determines that inpatient care is no longer necessary, the Medicare beneficiary has the right to request an expedited QIO review. The CMS guidelines provide that the appeal for expedited review must be made before the beneficiary leaves the hospital. Therefore, the beneficiary should not be discharged upon requesting the QIO review.

- **Timely QIO Review**

In order for the review request to be considered “timely”, beneficiaries must submit their requests in writing or by telephone no later than midnight of the day of discharge and before they leave the hospital. The beneficiary, therefore, should not be discharged upon requesting the QIO review, so long as the request is made on the same day.²

The beneficiary or qualified representative should be contacted by the QIO to discuss the case with the QIO and provide any necessary information that may be required. The hospital is required to submit all pertinent information to the QIO. The patient or his or her representative also has the ability to obtain the same information from the hospital and/or QIO. In addition, the QIO should obtain medical records from the hospital, including speaking to the patient’s physician(s). A timely request will trigger the QIO to render a decision within 1 calendar day after receiving all of the necessary information.

- **Detailed Notice of Discharge**

The *Detailed Notice* of discharge must be delivered “as soon as possible” after the beneficiary has requested a QIO review, but no later than noon of the day after the QIO notifies the hospital of the beneficiary’s request for the review. Under the CMS guidelines, hospitals are only required to deliver the *Detailed Notice* after the beneficiary has contacted the QIO for expedited review or when the beneficiary requests more detailed information from the medical care provider prior to requesting a QIO review.

The *Detailed Notice* is not an official Medicare decision. It is designed to give the patient further explanation about why the hospital and/or physician believe that the medical services are no longer necessary.

- **Financial Liability**

Beneficiaries are not financially liable for hospital costs incurred during a timely QIO review; they are responsible only for coinsurance and deductibles. Further, the burden of proof lies with the hospital to demonstrate that the discharge is the correct decision based on either medical necessity or other Medicare coverage policies. If the QIO decision is in agreement with the hospital (unfavorable to the patient), then the beneficiary becomes liable for the medical expenses incurred beginning at noon on the *day after* notification of the decision is given.

Conclusion

Medicare beneficiaries have the right to question the hospital’s and physician’s decision to discharge them from care; however the CMS Guidance on this subject continues to raise concerns. The Guidance lacks any requirement that hospitals obtain a signature from beneficiaries or their representatives attesting to their comprehension of the delivery of the follow-up IM. That follow-up acknowledgment is crucial, however, because the most important time for beneficiaries to understand their rights is before discharge. Notices are useless if they are delivered to patients who are being wheeled out the door. This deficiency also weakens CMS’s ability to monitor when the notices are delivered and to ensure that they are being provided in a timely and responsible manner.

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¹ Pub 100-04, Transmittal 1257, Change Request 5622

² If the beneficiary fails to request an expedited QIO review, s/he may still request one within 30 calendar days after receipt of the discharge notice or at any time for good cause. If the beneficiary stays in the hospital during this time, s/he will be liable for the charges incurred after the scheduled day of discharge unless the QIO review finds that discharge was inappropriate, thus agreeing with the beneficiary.