DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Beneficiary Choices
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Date: June 1, 2007

To: All Medicare Health Plans (MA and Cost Plans)

From: Anthony Culotta, Director
Medicare Enrollment and Appeals Group

Subject: Implementation of CMS-4105-F, "Notification of Hospital Discharge Appeal Rights"

The purpose of this memorandum is to remind you of the July 2, 2007 implementation of the new requirements for delivery of notices regarding hospital discharge appeal rights and to provide information about implementing the new notice process.

On November 27, 2006, we published in the *Federal Register* a final rule entitled "Notification of Hospital Discharge Appeal Rights." This rule revises the process for how hospitals and Medicare health plans must notify Medicare beneficiaries who are hospital inpatients about their discharge rights, as well as the process for adjudicating appeals based on those rights. The new requirements take effect July 2, 2007 and are set forth in revised 42 CFR 422.620 and 422.622 (see http://www.cms.hhs.gov/BNI/12_HospitalDischargeAppealNotices.asp).

The attached document explains how the new notice process is to be implemented. Later this year, we will modify sections 150 and 160 in Chapter 13 of the Medicare Managed Care Manual to incorporate instructions about this process.

For questions, please contact Timothy Roe at Timothy.Roe@cms.hhs.gov or (410) 786–2006.

Immediate Review Process for Hospital Inpatients in Medicare Health Plans

Note: *Although much of the guidance in this document primarily affects hospitals, it is important for Medicare health plans to be aware of these rules because they confer rights to plan enrollees and affect contracted hospitals. Some technical rules, primarily those involving hospital notice requirements, were purposefully omitted from these rules. The notice and review procedures for hospital inpatients are similar to those presently required for SNFs, CORFs, and HHA settings.*

Medicare enrollees who are hospital inpatients have a statutory right to appeal to a QIO for an immediate review when a hospital and a Medicare health plan, with physician concurrence, determine that inpatient care is no longer necessary (see Section 1866(a)(1)(M) and Section 1154(a) of the Social Security Act). The process described below stems directly from 42 CFR §§ 422.620 and 422.622 and is effective July 2, 2007.

Hospitals must notify Medicare enrollees who are hospital inpatients about their hospital discharge appeal rights. The term "enrollee" means either enrollee or representative, when a representative is acting for an enrollee. Hospitals will use a revised version of the Important Message from Medicare (IM) a statutorily required notice, to explain the enrollee's rights as a hospital patient, including discharge appeal rights. Hospitals must issue the IM within 2 calendar days of admission, must obtain the signature of the enrollee or his or her representative and provide a copy at that time. Hospitals will also deliver a copy of the signed notice as far in advance of discharge as possible, but not more than 2 calendar days before discharge.

For those enrollees who request a QIO review, Medicare health plans must deliver a Detailed Notice of Discharge (Detailed Notice) as soon as possible, but no later than noon of the day after the QIO's notification. Both the IM and the Detailed Notice must be the standardized notices provided by CMS.

Affected Hospitals. The term hospital is defined in the regulation as any facility providing care at the inpatient hospital level, whether that care is short term or long term, acute or non acute, paid through a prospective payment system or other reimbursement basis, limited to specialty care or providing a broader spectrum of services. This definition includes critical access hospitals. Swing beds in hospitals are excluded, because they are considered a lower level of care. Religious nonmedical health care institutions are also excluded.

Hospital Inpatients who are Medicare Enrollees. This rule applies to all Medicare managed care enrollees who are hospital inpatients. Hospital outpatients who are receiving Part B services, such as those in observation stays or in the emergency department, do not receive these notices, unless they subsequently require inpatient care.

Medicare enrollees in hospital swing beds or custodial care beds do not receive these notices when they are receiving services at a lower level of care.

Definition of Discharge. The term "discharge" is defined as a formal release of a enrollee from an inpatient hospital. This includes when the enrollee is physically discharged from the hospital as well as when the enrollee is discharged "on paper" – meaning that the enrollee remains in the hospital, but at a lower level of care (for example, the enrollee is moved to a swing bed or to custodial care).

Special Considerations

Other Insurers. Section 1866 (a)(1)(M), delivery of the Important Message from Medicare, applies to each individual who is entitled to benefits under Medicare Part A. Therefore, these requirements apply if an enrollee is eligible for both Medicare and Medicaid (a dual eligible), is eligible for Medicare and another insurance program or payer, or has Medicare as a secondary payer. No matter where in the sequence of payers Medicare falls, these requirements still apply.

Inpatient to Inpatient Transfers. Enrollees who are being transferred from one inpatient hospital setting to another inpatient hospital setting do not need to be provided with the follow up copy of the notice prior to leaving the original hospital, since this is considered to be the same level of care. Enrollees always have the right to refuse care and may contact the QIO if they have a quality of care issue. The receiving hospital must deliver the Important Message from Medicare again according to the procedures in this rule.

Admissions for Services that Medicare Never Covers. When a Medicare enrollee is admitted for hospital services that are never covered by Medicare, notice requirements in these this rule do not apply. Instead, Medicare health plans would deliver the Notice of Denial of Medical Coverage, guiding the enrollee through the standard or expedited appeals process.

End of Part A days. For purposes of this rule, the term discharge does not include exhaustion of Part A days, therefore, when a enrollee exhausts Part A days, these requirements do not apply.

Notifying Enrollees of their Right to an Immediate Review

Hospitals must notify Medicare enrollees who are hospital inpatients about their hospital discharge appeal rights. Hospitals will use a revised version of the Important Message from Medicare (IM) a statutorily-required notice, to explain the enrollee's rights as a hospital patient, including discharge appeal rights. Hospitals must issue the IM within 2 calendar days of admission, must obtain the signature of the enrollee or his or her representative and provide a copy at that time. Hospitals will also deliver a copy of the

signed notice as far in advance of discharge as possible, but not more than 2 calendar days before discharge.

Delivery of the Important Message from Medicare

Hospitals must follow the procedures listed below in delivering the Important Message from Medicare (IM). Valid Notice consists of:

Use of Standardized Notice. Hospitals must use the standardized form (CMS-R-193). The notices are also available on www.cms.hhs.gov/bni at the Link for Hospital Discharge Appeal Notices. Hospitals may not deviate from the content of the form except where indicated. The OMB control number must be displayed on the notice.

Delivery Timeframe. Hospitals must deliver the original copy of the IM at or near admission, but no later than 2 calendar days following the date of the enrollee's admission to the hospital. Hospitals may deliver the initial copy of the notice if the enrollee is seen during a preadmission visit, but not more than 7 calendar days in advance of admission.

In-Person Delivery. The IM must be delivered to the enrollee in person. However, if the enrollee is not able to comprehend the notice, it must be delivered to and signed by the enrollee's representative.

Notice Delivery to Representatives. CMS requires that notification of an enrollee who is not competent be made to a representative of the enrollee. A representative is an individual who, under State or other applicable law, may make health care decisions on a beneficiary's behalf (e.g., the enrollee's legal guardian, or someone appointed in accordance with a properly executed "durable medical power of attorney").

Otherwise, a person (typically, a family member or close friend) whom the enrollee has indicated may act for him or her, but who has not been named in any legally binding document may be a representative for purpose of receiving the notices described in this section. Such representatives should have the enrollee's best interests at heart and must act in a manner that is protective of the enrollee and the enrollee's rights. Therefore, a representative should have no relevant conflict of interest with the enrollee. A notifier (including the notifier's employees) that has a conflicting interest (such as shifting financial liability to the enrollee) is not qualified to be a representative. (Note: If the enrollee wishes to appoint a representative to file an appeal on his/her behalf, a valid Form 1696 or a conforming written instrument must be signed by both the enrollee and the prospective representative and filed with the appeal request. See Medicare Claims Processing Manual, Publication 100-4, Ch. 29, Section 270 for specific this rule related to the use of Form CMS-1696 and the appointment of representatives).

Notification to the representative may be problematic if he or she is not available in person to acknowledge receipt of the required notification. Hospitals are required to

develop procedures to use when the enrollee is incapable of receiving or incompetent to receive the notice, and the hospital cannot obtain the signature of the enrollee's representative through direct personal contact.

Regardless of the competency of an enrollee, if the hospital is unable to personally deliver a notice to a representative, then the hospital should telephone the representative to advise him or her of the enrollee's rights as a hospital inpatient, including the right to appeal a discharge decision.

If both the hospital and the representative agree, hospitals may send the notice by fax or email; however, hospitals must meet the HIPAA privacy and security requirements.

Ensuring Enrollee Comprehension. Hospitals must make every effort to ensure the enrollee comprehends the contents of the notice before obtaining the enrollee's signature. This includes explaining the notice to the enrollee if necessary and providing an opportunity for the enrollee to ask questions. The hospital should answer all the enrollee's questions orally to the best of its ability. Notices should not be delivered during an emergency, but should be delivered once the beneficiary is stable.

Enrollee Signature and Date. The IM must be signed and dated by the enrollee to indicate that he or she has received the notice and can comprehend its contents, unless an appropriate reason for the lack of signature is recorded on the IM, such as a properly annotated signature refusal (see below).

Refusal to Sign and Annotation. If an enrollee refuses to sign the notice, hospitals may annotate the notice to indicate the refusal, and the date of refusal is considered the date of receipt of the notice.

The Follow-Up Copy of the Signed Important Message from Medicare

A "follow up" copy of the signed IM must be delivered to the enrollee using the following guidelines:

Delivery Timeframe. Hospitals must deliver the follow up copy as far in advance of discharge as possible, but **no more** than 2 calendar days before the planned date of discharge. Thus, when discharge seems likely within 1- 2 calendar days, hospitals should make arrangements to deliver the follow up copy of the notice, so that the enrollee has a meaningful opportunity to act on it. However, when discharge cannot be predicted in advance, the follow up copy may be delivered as late as the day of discharge, if necessary. If the follow-up copy of the notice must be delivered on the day of discharge, hospitals must give enrollees who need it <u>at least 4 hours</u> to consider their right to request a QIO review.

Exception to Delivery of the Follow-Up Copy. If delivery of the original IM is within 2 calendar days of the date of discharge, no follow-up notice is required. For example, if

an enrollee is admitted on Monday, the IM is delivered on Wednesday and the enrollee is discharged on Friday, no follow up notice is required. Hospitals may not routinely deliver the follow-up copy on the day of discharge.

Documentation. Hospitals must be able to document delivery of the follow-up copy of the signed IM, when applicable.

Rules and Responsibilities when an Enrollee Requests an Immediate Review

An enrollee has a right to request an immediate review by the QIO when the Medicare health plan and the hospital (acting directly or through its utilization review committee), with physician concurrence, determine that inpatient care is no longer necessary.

The Role of the Enrollee and Liability

Submitting a Request: An enrollee who chooses to exercise the right to an immediate review must submit a request to the appropriate QIO as indicated on the IM notice. In order to be considered timely, the request must be made no later than midnight of the day of *discharge*, may be in writing or by telephone, and must be requested before the enrollee leaves the hospital. The enrollee, upon request of the QIO, should be available to discuss the case. The enrollee may, but is not required to, submit written evidence to be considered by the QIO.

Timely Requests: When the enrollee makes a timely request for a QIO review – that is, requests a review no later than midnight of the day of discharge – the enrollee is not financially responsible for inpatient hospital services (except applicable coinsurance and deductibles) furnished before noon of the calendar day after the date the enrollee receives notification of the determination from the QIO. Liability for further inpatient hospital services depends on the QIO decision:

- **Unfavorable determination:** If the QIO notifies the enrollee that the QIO did not agree with the enrollee, liability for continued services begins at noon of the day after the QIO notifies the enrollee that the QIO agreed with the hospital's discharge determination, or as otherwise determined by the QIO.

- **Favorable determination:** If the QIO notifies the enrollee that the QIO agreed with the enrollee, the enrollee is not financially responsible for continued care (other than applicable coinsurance and deductibles) until the Medicare health plan and hospital once again determine that the enrollee no longer requires inpatient care, secure the concurrence of the physician responsible for the enrollee's care, and the hospital notifies the enrollee with a follow up copy of the IM.

Untimely Requests: When the enrollee fails to make a timely request for an immediate review, he or she may request an expedited reconsideration by the Medicare health plan as described in § 422.584, but the enrollee may be held responsible for charges incurred after the day of discharge. If the enrollee receives a favorable reconsideration, the Medicare health plan must continue covering the care and/or refund the enrollee for any expenses the enrollee incurred during the review.

The Responsibilities of the Medicare Health Plan and the Hospital

Provide the Detailed Notice of Discharge: When a QIO notifies the Medicare health plan that an enrollee has requested an immediate review, the plan must, directly or by delegation, deliver a Detailed Notice of Discharge (the Detailed Notice) to the enrollee as soon as possible but not later than noon of the day after the QIO's notification. The plan is responsible for ensuring proper execution and delivery of the Detailed Notice, regardless of whether it has delegated that responsibility to its providers. If an enrollee requests more detailed information prior to requesting a review, plans may, directly or by delegation, deliver the detailed notice in advance of the enrollee requesting a review.

Use of Standardized Notice. Medicare health plans must use the standardized form (CMS-10066). This notice is also available on www.cms.hhs.gov/bni at the Link for Hospital Discharge Appeal Notices. Plans may not deviate from the content of the form except where indicated. The OMB control number must be displayed on the notice.

The Detailed Notice must be the standardized notice provided by CMS and contain the following:

- A detailed explanation why services are either no longer reasonable and necessary or are otherwise no longer covered.
- A description of any applicable Medicare coverage rule, instruction, or other Medicare policy, including information about how the enrollee may obtain a copy of the Medicare policy.
- Any applicable Medicare health plan policy, contract provision, or rationale on which the discharge determination was based.
- Facts specific to the enrollee and relevant to the coverage determination sufficient to advise the enrollee of the applicability of the coverage rule or policy to the enrollee's case.
- Any other information required by CMS.

Provide Information to the QIO. Upon notification by the QIO of the enrollee's request for an immediate review, the Medicare health plan and hospital must supply all information that the QIO needs to make its determination, including copies of both the IM and the Detailed Notices, as soon as possible, but no later than noon of the day after the QIO notifies the hospital of the request. In response to a request from the plan, the hospital must supply all information that the QIO needs to make its determination, including copies of both the IM and the Detailed Notices (if applicable) as soon as

possible, but no later than close of business of the day the plan notifies the hospital of the request for information. At the discretion of the QIO, the plan and the hospital may make the information available by telephone or in writing. A written record of any information not transmitted in writing should be sent as soon as possible.

Burden of Proof. The burden of proof lies with the Medicare health plan to demonstrate that discharge is the correct decision, either on the basis of medical necessity or based on other Medicare coverage policies.

Provide the Enrollee with Documentation if Requested. At the request of the enrollee, the Medicare health plan must furnish the enrollee with a copy of, or access to, any documentation that it sends to the QIO, including written records of any information provided by telephone. The plan may charge the enrollee a reasonable amount to cover the costs of duplicating the documentation and/or delivering it to the enrollee. The plan must accommodate the request by no later than close of business of the first day after the material is requested.

Coverage during the QIO expedited review. A Medicare health plan is financially responsible for coverage of services during the QIO review as provided for in these rules, regardless of whether it has delegated responsibility for authorizing coverage or discharge determinations to its providers.

The Role of the QIOs

QIO Availability. The QIO should have methods in place to accept requests for reviews outside of normal business hours, such as an answering machine message. QIOs will issue decisions within one calendar day after they receive all pertinent information.

Notify the Medicare health plan of the enrollee's request for an immediate review. When the QIO receives the request from the enrollee, the QIO must notify the Medicare health plan of the request immediately, or immediately in the morning if the request is received after the QIO's business hours.

Receive and Examine records. The QIO will examine medical and other records that pertain to the services in dispute.

Determine if the hospital or Medicare health plan delivered valid notice. The QIO will determine whether the hospital or plan delivered valid notice, meaning that the notice is the standardized notice published by CMS, meets the notice delivery timeframes, and has been signed and dated by the enrollee. If the QIO determines that the hospital or plan did not deliver valid notice, the QIO will instruct the hospital or plan to reissue the notice if necessary, proceed with the review, and educate the hospital or plan retrospectively. If the enrollee or representative makes an untimely request for a review, and the QIO determines that the enrollee did not receive valid notice (i.e. delivery of the IM was not valid), the QIO will determine the date the enrollee becomes fully liable for the services.

Solicit the views of the enrollee. The QIO must solicit views of the enrollee who requested the immediate review.

Solicit the views of the Medicare health plan and the hospital. The QIO must provide an opportunity for the Medicare health plan and the hospital to explain why the plan, hospital and physician believe the discharge is appropriate. The QIO may develop guidelines as to the form and extent of this opportunity.

If needed information is not received. If the Medicare health plan fails to provide the needed information, the QIO may make a decision based on evidence at hand or defer the decision until it receives the necessary information. If this delay results in extended coverage of an individual's hospital services, the plan may be held financially liable for those services, consistent with the requirements of this rule, as determined by the QIO.

QIO Determination. QIOs make their determinations based on criteria in section 1154(a) of the Act, which specifies that QIOs will determine whether:

- the services are reasonable and medically necessary,
- the services meet professionally recognized standards of care, and
- the services could be safely delivered in another setting.

Notification following a timely request. When the enrollee makes a timely request for an immediate review, the QIO must make its determination and notify the Medicare health plan, the enrollee, the hospital, and the physician of its determination within one calendar day after it receives all requested pertinent information. When the QIO issues a determination, the QIO must notify the plan, enrollee, the hospital and the physician of its decision by telephone, followed by a written notice that must include the following information:

- The basis for the determination.
- A detailed rationale for the determination.
- An explanation of the Medicare payment consequences of the determination and the date a enrollee becomes fully liable for services.
- Information about the enrollee's right to an reconsideration of the QIO's determination, including how to request the reconsideration and the timeframe for doing so.

Effect of an Expedited QIO Determination

The QIO determination is binding on the enrollee, the physician, the Medicare health plan, and the hospital, unless the enrollee requests a QIO reconsideration.

General Notice Requirements

Since the Detailed Notice of Discharge is an OMB approved, standardized notice, Medicare health plans must comply with the following requirements:

Number of Copies

The Detailed Notice: A minimum of two copies of the Detailed Notice, including the original, will be needed. The enrollee keeps the original notice. The Medicare health plan must retain a copy of the signed document and may do so electronically.

Providing Copies to the QIO: If an enrollee requests a review, Medicare health plans and hospitals together are required to provide copies of both notices described in this section to the QIO.

Reproduction

Medicare health plans may reproduce the notices by using self-carbonizing paper, photocopying, or using another appropriate method. All reproductions must conform to applicable formatting and font requirements.

Length and Page Size

The Detailed Notice: The Detailed Notice must NOT exceed one side of a page in length. The Detailed Notice is designed as a letter-sized form. If necessary, it may be expanded to a legal-sized page to accommodate information Medicare health plans may insert in the notice. Plans may attach applicable Medicare policies to the notice.

Contrast of Paper and Print

A visually high-contrast combination of dark ink on a pale background must be used. Do not use reversed print (e.g., white on black), or block-shade (highlight) notice text.

Modification

The IM and Detailed Notice may not be modified, except as specifically allowed by this rule. In no case may either notice be condensed.

Font

The Detailed Notice must meet the following font requirements in order to facilitate enrollee understanding:

- **Font Type:** To the greatest extent practicable, the fonts as they appear in the notices on the CMS Web site should be used. Any changes in the font type should be based solely on software and/or hardware limitations of the notices. Examples of easily readable alternative fonts include: Arial, Arial Narrow, Times New Roman, and Courier.

- **Font Effect/Style:** Any changes to the font, such as italics, embossing, bold, etc., should not be used since they can make the notices more difficult to read.

- **Font Size:** The font size generally should be 12 point. Titles should be 18 point, but handwritten insertions in blanks of the IM can be as small as 12 point if needed.

- **Insertions in Blanks:** Information inserted by plans in the blank spaces on the Detailed Notice may be typed or legibly hand-written using the guidelines above.

Customization

Medicare health plans are permitted to do some customization of the Detailed Notice, such as pre-printing agency-related information, to promote efficiency and to ensure clarity for enrollees. Guidelines for customization are:

- Maintaining underlines in the blank spaces is not required.

- Information in blanks that is constant can be pre-printed, such as the plan's or hospital's name, QIO name and telephone number. Note the TTY phone number also needs to be entered.

Retention of the Notices

Medicare health plans are required to retain copies of the Detailed Notice and may do so either in hardcopy or electronically.

Translated Notices

Both the "Important Message from Medicare" and the "Detailed Notice of Discharge" are available at http://www.cms.hhs.gov/BNI/. The notices will be available in English and Spanish, and in PDF and Word formats, under a dedicated link on the left hand margin: "Hospital Discharge Appeal Notices". Medicare health plans should choose the appropriate version of the Detailed Notice of Discharge based on the language the enrollee best understands. When Spanish-language notices are used, the plan should make insertions on the notice in Spanish. If this is impossible, additional steps need to be taken to ensure that the enrollee comprehends the contents of the notice.

Notices

Important Message from Medicare (CMS-R-193) and Form Instructions

http://www.cms.hhs.gov/BNI/12_HospitalDischargeAppealNotices.asp

When completing the Detailed Notice of Discharge, Medicare health plans must follow the attached instructions:

The Detailed Notice of Discharge (CMS 10066) and Form Instructions

http://www.cms.hhs.gov/BNI/12_HospitalDischargeAppealNotices.asp

Immediate Reconsiderations

An enrollee who is dissatisfied with a QIO determination can request a reconsideration from the QIO in accordance with § 422.626(f).

The Role of the Enrollee and Liability

Submitting a Request: If the QIO upholds a Medicare health plan's discharge decision in whole or in part, the enrollee may request, no later than 60 days after notification that the QIO has upheld the decision that the QIO reconsider its original decision.

Note: If the enrollee is no longer an inpatient in the hospital and is dissatisfied with the QIO's determination, the enrollee may appeal directly to an ALJ, the MAC, or a federal court.

The Responsibilities of the QIO

The QIO must issue its reconsidered determination as expeditiously as the enrollee's health condition requires but no later than 14 days of receipt of the enrollee's request for a reconsideration.

If the QIO Reaffirms its Decision

If the QIO reaffirms its decision, in whole or in part, the enrollee may to appeal the QIO's reconsidered determination to an ALJ, the MAC, or a federal court. If on reconsideration

the QIO determines that coverage of provider services should terminate on a given date, the enrollee is liable for the costs of continued services after that date unless the QIO's decision is reversed on appeal.

If the QIO’s Decision is Reversed

If the QIO's decision is reversed on appeal (by the QIO, ALJ, MAC or a federal court), the Medicare health plan must reimburse the enrollee, consistent with the appealed decision, for the costs of any covered services for which the enrollee has already paid the plan or provider.