CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 4250	**Date: March 8, 2019**
	Change Request 11165

SUBJECT: Update to Chapter 30 in Publication (Pub.) 100-04 to Provide Language-Only Changes for the New Medicare Card Project

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to provide language-only changes for updating the New Medicare Card Project-related language in Chapter 30 of Pub. 100-04. There are no new coverage policies, payment policies, or codes introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications.

EFFECTIVE DATE: April 8, 2019
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 8, 2019
Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	30/50.14/CMS Regional Office (RO) Referral Procedures
R	30/140.6.2/Initial Physician Notices
R	30/140.7/Processing Beneficiary Requests for Appeal
R	30/150.8/Processing Initial Denials
R	30/150.9/Processing Beneficiary Requests for Appeal
R	30/150.13/CMS Regional Office (RO) Referral Procedures
R	30/200.6.3/Exhibit 2 – The Detailed Notice of Discharge (CMS 10066) and Form Instructions

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 4250	Date: March 8, 2019	Change Request: 11165

SUBJECT: Update to Chapter 30 in Publication (Pub.) 100-04 to Provide Language-Only Changes for the New Medicare Card Project

EFFECTIVE DATE: April 8, 2019
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 8, 2019

I. GENERAL INFORMATION

A. Background: The CMS is implementing changes to remove the Social Security Number (SSN) from the Medicare card. A new number, called the Medicare Beneficiary Identifier (MBI), will be assigned to all Medicare beneficiaries. This CR contains language-only changes for updating the New Medicare Card Project language related to the MBI in Chapter 30 of Pub. 100-04.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires removal of the SSN-based Health Insurance Claim Number from Medicare cards within four years of enactment. There are no new coverage policies, payment policies, or codes introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications.

B. Policy: MACRA of 2015.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
11165.1	MACs shall be aware of the updated language for the New Medicare Card Project in Chapter 30 of Pub. 100-04.	X	X	X	X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Tracey Mackey, 410-786-5736 or Tracey.Mackey@cms.hhs.gov , Kim Davis, 410-786-4721 or kimberly.davis@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

50.14 - CMS Regional Office (RO) Referral Procedures

(Rev. 4250; Issued: 03-08-10; Effective: 04-08-19; Implementation: 04-08-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

Prior to submitting any materials to the RO, the Medicare contractor will contact the RO to determine how to proceed in referring a potential sanction case for violation of refund requirements. When referring these types of cases to the region, the contractor should include the following:

A. Background of the Subject

The subject's business name, address, Medicare Identification Number, owner's full name and Social Security Number, Tax Identification Number (if different), and a brief description of the subject's special field of medical equipment, supplies, or services.

B. Origin of the Case

A brief description of how the violations were discovered.

C. Statement of Facts

A statement of facts in chronological order describing each failure to comply with the refund requirements.

D. Documentation

Include copies of written correspondence and written summaries of any meetings or telephone contacts with the beneficiary and the supplier regarding the supplier's failure to make a refund. Include a listing of the following for each item or service not refunded to the beneficiary by the supplier (grouped by beneficiary):

- Beneficiary Name and *Medicare beneficiary identifier*;
- Claim Control Number;
- Procedure Code (CPT-4 or HCPCS) of nonrefunded item or service;
- Procedure Code modifier;
- Date of Service;
- Place of Service Code;
- Submitted Charge;
- Units (quantity) of Item or Service; and
- Amount Requested to be Refunded.

Include any additional information that may be of value to the RO.

140.6.2 - Initial Physician Notices

(Rev. 4250; Issued: 03-08-10; Effective: 04-08-19; Implementation: 04-08-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

Include in the notice to the physician the following:

- The patient's name and *Medicare beneficiary identifier*;
- A description of the service by procedure code, date and place of service, and amount of the charge;
- The same denial notice included on the beneficiary's MSN; and
- Depending on whether the beneficiary submitted a copy of an acceptable ABN with his/her claim, include in the notice to the physician one of the following:

Notice 1 - Advance Beneficiary Notice Received Prior to Initial Determination

(The service identified above has been denied because/although payment has been made to the patient for a less extensive service,) the information furnished did not substantiate the need for the (more extensive) service. Since you informed the beneficiary in writing prior to furnishing the service that Medicare was likely to deny payment for the (more extensive) service and the beneficiary signed a statement agreeing to pay, the beneficiary is liable for (this/the more extensive) service.

Or

Notice 2 - Advance Beneficiary Notice Not Submitted

(The service identified above has been denied because/Although payment has been made to the patient for a less extensive service,) the information furnished did not substantiate the need for the (more extensive) service).

If you have collected (any amount from the patient/any amount that exceeds your maximum allowable actual charge (MAAC) for the less extensive service), the law requires you to refund that amount to the patient within 30 days of receiving this notice. The law permits exceptions to this refund requirement in two cases:

- If you did not know, and could not have reasonably been expected to know, that Medicare would not pay for this service; or
- If you notified the beneficiary in writing before providing the service that you believed that Medicare was likely to deny the service, and the beneficiary signed a statement agreeing to pay for the service.

If you come within either exception, or if you believe the contractor was wrong in its determination that Medicare does not pay for this service, you should request an appeal of this determination by the contractor within 30 days of receiving this notice. Your request for appeal should include any additional information necessary to support your position.

If you request an appeal within this 30 day period, you may delay refunding the amount to the beneficiary until you receive the results of the appeal. If the appeal determination is favorable to you, you do not have to make any refund. If, however, the appeal is unfavorable, the law specifies that you must make the refund within 15 days of receiving the unfavorable appeal decision.

The law also permits you to request an appeal of the determination at any time within six months of receiving this notice. An appeal requested after the 30 day period does not permit

you to delay making the refund. Regardless of when an appeal is requested, the patient will be notified that you have requested one, and will receive a copy of the determination.

The patient has received a separate notice of this denial decision. The notice advises that he or she may be entitled to a refund of any amounts paid, if you should have known that Medicare would not pay and did not tell him or her. It also instructs the patient to contact your office if he or she does not hear anything about a refund within 30 days.

The requirements for refund are in §1842(1) of the Social Security Act. Section 1842(1) specifies that physicians who knowingly and willfully fail to make appropriate refunds may be subject to civil money penalties and/or exclusion from the Medicare program.

If you have any questions about this notice, please contact (Contractor contact, telephone number).

The contractor will ensure that the telephone number puts the physician in touch with a knowledgeable professional who can discuss the basis for the denial or reduction in payment.

NOTE: These procedures do not apply to claims the contractor automatically denies under the A/B link procedures. In those cases, the QIO is responsible for notifying the beneficiary and physician of the refund requirements of §1842(1) and making the refund determination where appropriate.

140.7 - Processing Beneficiary Requests for Appeal

(Rev. 4250; Issued: 03-08-10; Effective: 04-08-19; Implementation: 04-08-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

Where a beneficiary requests an appeal of the initial denial or reduction in payment, the contractor will process the appeal in the normal fashion except that, where the appeal results in a reversal to full or partial payment, the contractor will include the following special paragraph in the appeal notice sent to the beneficiary:

The doctor who furnished this service has been informed of this decision and advised that he/she may collect (his/her full charge for the service/up to the maximum amount he/she is allowed by law to charge under Medicare for the less extensive service for which payment has been made).

If the reversal is for the less extensive service, the contractor will incorporate in the notice the following:

You could have avoided paying $_____, the difference between the maximum amount the doctor is allowed to charge and the amount Medicare approved for the lesser service, if the claim had been assigned.

The contractor will send the physician who furnished the service a separate notice which clearly identifies the service for which full or partial payment is being made (i.e., includes the patient's name, *Medicare beneficiary identifier*, a description of the service billed by procedure code, date and place of service, and amount of the charge. Where only partial payment is being made, the contractor will clearly indicate the less extensive service for which payment has been made). The contractor will include the following language:

You were previously advised that Medicare payment could not be made for this service. However, after reviewing this claim, we have determined that payment may be made (for a less extensive

service). Therefore, if you have already refunded the amounts you collected from the beneficiary for this service, you may recollect (these amounts/any amounts which do not exceed your maximum allowable actual charge (MAAC) for the less extensive service for which payment has been made).

150.8 - Processing Initial Denials

(Rev. 4250; Issued: 03-08-10; Effective: 04-08-19; Implementation: 04-08-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

In any unassigned claim for medical equipment and supplies furnished on or after January 1, 1995, in which the contractor denies payment on the basis of §1862(a)(1), §1834(a)(17)(B), §1834(j)(1), or §1834(a)(15) of the Act, send separate notices to both the beneficiary (a Medicare Summary Notice (MSN)) and the supplier (a remittance advice (RA)).

NOTE: This instruction to send a remittance advice to the supplier in the case of denial of an unassigned claim is a specific requirement of §1834(a)(18)(C) of the Act, incorporated by reference into §1834(j)(4) and §1879(h) of the Act, applicable to denials of claims for medical equipment and supplies furnished on or after January 1, 1995.

If the beneficiary signed an ABN which satisfies the requirements in subsection II.6 and the supplier included a GA modifier on the claim to that effect, do not make an automatic finding that the claim should be denied on the basis of §1862(a)(1), §1834(a)(17)(B), §1834(j)(1), or §1834(a)(15) of the Act, merely because the supplier submitted a GA modifier. The fact that an ABN was given to the beneficiary will in no way prejudice the contractor's determination as to whether there is or is not sufficient evidence to justify a denial. In the case where there is an ABN, mail a standard denial MSN notice to the beneficiary. If the beneficiary did not sign an ABN and the supplier included a GZ modifier on the claim to that effect, include, in addition to one of the denial notices in Chapter 21, "Medicare Summary Notices," the following initial beneficiary notice in the MSN sent to the beneficiary.

A. Initial Beneficiary Notice

(MSN 8.54)

If the supplier knew that Medicare wouldn't pay and you paid, you might get a refund unless you signed a notice in advance. Refunds may be delayed if the provider appeals. Call your supplier if you don't hear anything within 30 days.

(MSN 8.54) - In Spanish

Si pagó por un servicio que su proveedor sabía Medicare no iba a pagar, usted tiene derecho a un reembolso, a menos de que haya firmado un aviso por adelantado. Los reembolsos se pueden demorar si el proveedor apela la decisión. Llame a su proveedor si no escucha nada en 30 días.

B. Initial Supplier Notice

Include in the notice to the supplier the following;

- The patient's name *Medicare beneficiary identifier*;

- A description of the item or service by procedure code, date and place of service, and amount of the charge;

- The same denial notice included on the beneficiary's MSN, (see Chapter 21, "Medicare Summary Notices"); and

- If the supplier submitted a GA modifier (signed ABN obtained), include in the notice to the supplier the following Notice 1. However, if the supplier submitted a "-GZ" modifier (a signed ABN was not obtained), include in the notice to the supplier the following Notice 2.

Notice 1. – Signed Advance Beneficiary Notice Obtained

(Remittance Advice Remark Code N124)

Payment has been (denied for the/made only for a less extensive) service/item because the information furnished does not substantiate the need for the (more extensive) service/item. The patient is liable for the charges for this service/item as you informed the patient in writing before the service/item was furnished that we would not pay for it, and the patient agreed to pay.

Remittance Advice Remark Codes cannot be reported without a Claim Adjustment Reason Code and a Group Code. For Notice 1 where ABN has been obtained, use CARC 96 - Non-covered charge(s), and Group Code – PR (Patient Responsibility).

Or

Notice 2. – Signed Advance Beneficiary Notice Not Obtained

(Remittance Advice Remark Code N125)

Payment has been (denied for the/made only for a less extensive) service/item because the information furnished does not substantiate the need for the (more extensive) service/item. If you have collected any amount from the patient, you must refund that amount to the patient within 30 days of receiving this notice. The law permits exceptions to this refund requirement in two cases: if you did not know, and could not have reasonably been expected to know, that Medicare would not pay for this service/item; or if you notified the beneficiary in writing before providing it that Medicare likely would deny the service/item, and the beneficiary signed a statement agreeing to pay.

Remittance Advice Remark Codes cannot be reported without a Claim Adjustment Reason Code and a Group Code. For Notice 2 where ABN has NOT been obtained, use CARC 96 - Non-covered charge(s), and Group Code – CO (Contractual obligation).

If an exception applies to you, or you believe the contractor was wrong in denying payment, you should request an appeal of this determination by the contractor within 30 days of receiving this notice. Your request for appeal should include any additional information necessary to support your position. If you request an appeal within 30-days, you may delay refunding to the beneficiary until you receive the results of the appeal. If the appeal determination is favorable to you, you do not have to make any refund. If the appeal is unfavorable, you must make the refund within 15 days of receiving the unfavorable appeal decision.

You may request an appeal of the determination at any time within 120 days of receiving this notice. An appeal requested after the 30-day period does not permit you to delay making the

refund. Regardless of when an appeal is requested, the patient will be notified that you have requested one, and will receive a copy of the determination.

The patient has received a separate notice of this denial decision. The notice advises that he or she may be entitled to a refund of any amounts paid, if you should have known that Medicare would not pay and did not tell him or her. It also instructs the patient to contact your office if he or she does not hear anything about a refund within 30 days.

The requirements for refund are in §1834(a)(18) of the Act (and in §§1834(j)(4) and 1879(h) by cross-reference to §1834(a)(18)). Section 1834(a)(18)(B) specifies that suppliers which knowingly and willfully fail to make appropriate refunds may be subject to civil money penalties and/or exclusion from the Medicare program. If you have any questions about this notice, please contact (contractor contact, telephone number).

Ensure that the telephone number puts the supplier in touch with a knowledgeable professional who can discuss the basis for the denial or reduction in payment.

NOTE: These procedures do not apply where the contractor automatically denies Part B services related to hospital inpatient services denied by the Quality Improvement Organization (QIO). In those cases, the QIO is responsible for notifying the beneficiary and supplier of the refund requirements of §§1834(a)(18), 1834(j)(4), and 1879(h) of the Act and making the refund determination where appropriate.

150.9 - Processing Beneficiary Requests for Appeal

(Rev. 4250; Issued: 03-08-10; Effective: 04-08-19; Implementation: 04-08-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

Where a beneficiary requests an appeal of the initial denial, process the appeal in the normal fashion except that, where the appeal results in a reversal, include the following special paragraph in the appeal notice sent to the beneficiary:

The supplier which furnished this item or service has been informed of this decision and advised that it may collect its full charge for the item or service.

Send the supplier which furnished the item or service a separate notice which clearly identifies the item or service for which payment is being made (i.e., include the patient's name, *Medicare beneficiary identifier*, a description of the item or service billed by procedure code, date and place of service, and amount of the charge. Include the following language:

You were previously advised that Medicare payment could not be made for this item or service. However, after reviewing this claim, we have determined that payment may be made. Therefore, if you have already refunded the amounts you collected from the beneficiary for this item or service, you may recollect these amounts.

150.13 - CMS Regional Office (RO) Referral Procedures

(Rev. 4250; Issued: 03-08-10; Effective: 04-08-19; Implementation: 04-08-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new

Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

Prior to submitting any materials to the RO, the contractor will contact the RO to determine how to proceed in referring a potential sanction case. When referring a sanction case to the region, include in the sanction recommendation (to the extent appropriate) the following:

Background of the Subject

The subject's business name, address, Medicare *beneficiary identifier*, owner's full name and Social Security Number, Tax Identification Number (if different), and a brief description of the subject's special field of medical equipment and supplies business.

Origin of the Case

A brief description of how the violations were discovered.

Statement of Facts

A statement of facts in chronological order describing each failure to comply with the refund requirements.

Documentation

Include copies of written correspondence and written summaries of any meetings or telephone contacts with the beneficiaries and the supplier regarding the supplier's failure to make refunds. Include a listing of the following for each item or service not refunded to the beneficiary by the supplier (grouped by beneficiary):

- Beneficiary Name and *Medicare beneficiary identifier*;
- Claim Control Number;
- Procedure Code (CPT-4 or HCPCS) of nonrefunded item or service;
- Procedure Code modifier;
- Date of Service;
- Place of Service Code;
- Submitted Charge;
- Units (quantity) of Item or Service; and
- Amount Requested to be Refunded.

Other Significant Issues

Include any information that may be of value to the RO while they review and possibly develop a case to impose sanctions.

200.6.3 - Exhibit 2 – The Detailed Notice of Discharge (CMS 10066) and Form Instructions

(Rev. 4250; Issued: 03-08-10; Effective: 04-08-19; Implementation: 04-08-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

Patient Name:
Patient ID Number:
Physician:

OMB Approval No. 0938-1019
Date Issued:

{Insert Hospital or Plan Logo here}

DETAILED NOTICE OF DISCHARGE

You have asked for a review by the Quality Improvement Organization (QIO), an independent reviewer hired by Medicare to review your case. This notice gives you a detailed explanation about why your hospital and your managed care plan (if you belong to one), in agreement with your doctor, believe that your inpatient hospital services should end on _____. This is based on Medicare coverage policies listed below and your medical condition.

This is not an official Medicare decision. The decision on your appeal will come from your Quality Improvement Organization (QIO).

- Medicare Coverage Policies:

  ____Medicare does not cover inpatient hospital services that are not medically necessary or could be safely furnished in another setting. (Refer to 42 Code of Federal Regulations, 411.15 (g) and (k)).

  ____Medicare Managed Care policies, if applicable: (insert specific managed care policies)

  ____ Other _____{insert other applicable policies}_____

- Specific information about your current medical condition:

- If you would like a copy of the documents sent to the QIO, or copies of the specific policies or criteria used to make this decision, please call {insert hospital and/or plan telephone number}.

Instructions for Completing the Detailed Notice of Discharge
(CMS 10066)

This is a standardized notice. Hospitals may not deviate from the content of the form except where indicated. Please note that the OMB control number must be displayed on the notice. Insertions must be typed or legibly hand-written in 12-point font or the equivalent.

Hospitals or plans may modify the following sections to incorporate use of a sticker or label that includes this information:

Patient Name: Fill in the patient's full name.

Patient ID number: Fill in the patient's ID number. This should not be, nor should it contain, the patient's social security or *Medicare beneficiary identifier*.

Physician: Fill in the name of the patient's physician.

Date Issued: Fill in the date the notice is delivered to the patient by the hospital/plan.

Insert logo here: Hospitals/plans may elect to place their logo in this space. However, the name, address, and telephone number of the hospital/plan must be immediately under the logo, if not incorporated into the logo. If no logo is used, the name and address and telephone number (including TTY) of the hospital/plan must appear above the title of the form.

BLANK 1: "**This notice gives you a detailed explanation of why your hospital and your managed care plan (if you belong to one), in agreement with your doctor, believe that your inpatient hospital services should end on _____.** In the space provided, fill in planned date of discharge.

Bullet # 1: **"Medicare Coverage Policies**:**"** Place a check next to the applicable Medicare and/or managed care policies. If necessary, hospitals may also use the selection "Other" to list other applicable policies, guidelines or instructions. Hospitals or plans may also preprint frequently used coverage policies or add more space below this line, if necessary. Policies should be written in full sentences and in plain language. In addition, the hospital or plan may attach additional pages or specific policies or discharge criteria to the notice. Any attachments must be included with the copy sent to the QIO as well.

Bullet # 2: **"Specific information about your current medical condition"** Fill in detailed and specific information about the patient's current medical condition and the reasons why services are no longer reasonable or necessary for this patient or are no longer covered according to Medicare or Medicare managed care coverage guidelines. Use full sentences and plain language.

Bullet # 3: **"If you would like a copy of the documents sent to the QIO, or copies of the specific policies or criteria used to make this decision, please call _____."** The hospital/plan should also supply a telephone number for patients to call to get a copy of the relevant documents sent to the QIO. If the hospital/plan has not attached the Medicare policies and/or the Medicare managed care plan policies used to decide the discharge date, the hospital should supply a telephone number for patients to call to obtain copies of this information.

Hospitals or plans may add space below this section to insert a signature line and date, if they so choose.