ASANTE®
HEALTH SYSTEM

CMS, Office of Strategic Operations and Regulatory Affairs
Division of Regulations – C
Attention: Bonnie L. Harkless
Room C4-26-05
7500 Security Blvd.
Baltimore, Maryland 21244-1850

RECEIVED

9

R-193

Comments: Revised Version – Important Message from Medicare (CMS-R-193)

The following comments address the necessity and utility of the proposed information collection and the accuracy of the estimated burden on hospitals, pertaining to Revised Version of the Important Message from Medicare, as requested in a notice published in the January 5, 2007 issue of the Federal Register:

Medicare inpatients currently receive a copy of the Important Message from Medicare on admission. Requiring a signature from patient or family on the revised IM is a throwback to the 1980's, when the IM required a signature. This requirement was dropped in the 1990's, due to the excessive amount of time hospitals spent meeting that requirement for a variety of reasons – patient too ill, too painful, sedated, asleep, no family member present in room, etc. The majority of inpatients are admitted directly to the nursing units from the Emergency Dept., doctor's office, or home. The only scheduled inpatient admissions are generally for surgery or interventional procedures.

Coordinating the hand-off from the delivery of the initial IM from Patient Registration to Case Management for delivery of the IM copy will be an operational nightmare. Estimating discharge date two days in advance is particularly difficult, since most physicians cannot predict in advance that a patient will be stable enough for discharge. Often they do not know a patient will be ready for discharge until test results are available.

There is confusion as to how to handle situations where the primary insurance is a commercial carrier with Medicare as a secondary payor, when Medicaid is the secondary payor, or when the physician/UR Committee changes an inpatient to observation status, per condition code 44, prior to discharge.

Since there was no CMS pilot conducted, we question the accuracy of the time estimates to carry out the provisions of this rule. Three minutes per second IM copy to be delivered seems unreasonably low, considering it will take more than three minutes per case to decide who is to receive the copy.

Estimating that only 1% of inpatients will exercise their right to appeal pending discharge, based on the number of HINN's (Hospital Issued Notice of Non-Coverage) currently issued, is an exceedingly small percentage. Most hospitals have curtailed use of the HINN for continued stay, because it allows the patient 72 hours before assuming financial liability. Rather than serve a notice, Discharge Coordinators try to work with the patients and families to move them expeditiously to the next appropriate lower level of care.

CMS should consider delaying implementation until a hospital pilot is conducted to determine feasibility of projections and financial impact on hospital operations. This regulation will consume more hospital and QIO resources, increase length of stay, and will add one more thing to the rising cost of healthcare.

Sincerely,
Marie Chesnut RN
Resource Management