17 of 1

Harkless, Bonnie (CMS/OSORA)

From: Harkless, Bonnie (CMS/OSORA)
Sent: Tuesday, March 06, 2007 5:24 PM
To: 'Tracie.L.Klingenberg@kp.org'
Subject: RE: Comment on a Revised Version of the Important Message from Medicare
Importance: High

Tracie,

Please refer to the process as noted in the January 5, 2007 Federal Register notice for submitting comments, " To be assured consideration, comments and recommendations for the proposed information collections must be received at the address below, no later than 5 p.m. on **[OFR—insert date 60 days after date of publication in the Federal Register.]**

CMS, Office of Strategic Operations and Regulatory Affairs

Division of Regulations Development - C

Attention: Bonnie L Harkless

Room C4-26-05

7500 Security Boulevard
Baltimore, Maryland 21244-1850"

Electronic comments are not accepted. Please overnight your comment to my attention. If I receive the comment tomorrow 3/7/07, with a postmark of 3/6/07, it will be accepted, otherwise it cannot be accepted. Please let me know if you have any additional questions.

Thank you.

Bonnie L. Harkless
PRA Analyst
Office of Strategic Operations and Regulatory Affairs
Centers for Medicare and Medicaid Services
(410) 786-5666
Bonnie.Harkless@cms.hhs.gov

From: Tracie.L.Klingenberg@kp.org [mailto:Tracie.L.Klingenberg@kp.org]
Sent: Tuesday, March 06, 2007 4:55 PM
To: Harkless, Bonnie (CMS/OSORA)
Subject: Comment on a Revised Version of the Important Message from Medicare

Kaiser Permanente appreciates the opportunity to review and comment on the revision to the Important Message from Medicare (IM) that was issued on January 5, 2007. Our comments are listed below. If you have questions or need further information, please contact me. Thank you for considering our comments.

- We would like to suggest moving the signature to the end of page 2 to ensure member reads all the information, including the appeal instructions.

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- We would like to suggest CMS specify a hour during the day as a deadline for the member filing the appeal – ie: noon of day of discharge. Without a reasonable deadline, the member can wait until 8 pm the day of discharge when there will not be support services in the hospital or at QIO to process the appeal request. This will delay records being sent and decisions being made and increase unnecessary lengths of stay in hospital.
- We would like to suggest CMS implement a time rule that the hospital needs to inform the member of discharge by. For example, the member must be notified by 6 PM on the day before the discharge date. This would ensure the member had enough time to consider whether to appeal the discharge by the filing deadline.
- We would like to suggest clearly defining the difference between "Original Medicare" and "Medicare Health Plan". Can CMS add the word Advantage or bracket a section to depict the type of MA plan the member is on, e.g. Medicare [Advantage] Health Plan?
- Does there need a place to note the date you gave a second copy of the notice to the member should they stay beyond 2 days?

Suggested changes to the actual IM:

Tracie Klingenberg
Project Manager, National Medicare Compliance
National Compliance, Ethics & Integrity Office
Kaiser Foundation Health Plan, Inc.
office (503) 813-4119 fax (503) 813-4912
Tracie.L.Klingenberg@kp.org

17/3

Harkless, Bonnie (CMS/OSORA)

From: Tracie.L.Klingenberg@kp.org
Sent: Tuesday, March 06, 2007 4:55 PM
To: Harkless, Bonnie (CMS/OSORA)
Subject: Comment on a Revised Version of the Important Message from Medicare
Attachments: suggeted changes.doc

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- Does there need a place to note the date you gave a second copy of the notice to the member should they stay beyond 2 days?

Suggested changes to the actual IM:

Tracie Klingenberg
Project Manager, National Medicare Compliance
National Compliance, Ethics & Integrity Office
Kaiser Foundation Health Plan, Inc.
office (503) 813-4119 fax (503) 813-4912
Tracie.L.Klingenberg@kp.org

OMB Approval No. 0938-0692

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AN IMPORTANT MESSAGE FROM MEDICARE

(Please Read Carefully)

Patient Name _____ Patient ID Number_____

Attending Physician _____ Date of Notice _____

YOUR RIGHTS AS A HOSPITAL PATIENT

- You have the right to receive necessary hospital services covered by Medicare or covered by your Medicare Health Plan (your "Plan") if applicable.
- You have the right to be involved in any decisions that the hospital, your doctor, your Plan or anyone else makes about your hospital stay.
- You have the right to receive services you need after you leave the hospital (that is, after you are "discharged"). Medicare or your Plan may cover some of these services if ordered by your doctor or your Plan. You have a right to know about these services, who will pay for them, and where you can get them.

YOUR HOSPITAL DISCHARGE AND MEDICARE APPEAL RIGHTS

Planning For Your Discharge: During your hospital stay, the hospital staff will be working with you and your doctor (and your Plan, if applicable) to plan for your discharge and arrange for services you may need after you leave the hospital. When your doctor or Plan decides you no longer need hospital care or can safely receive care in another setting, you will be informed of your discharge date.

If you think you are being discharged too soon:

- Talk to the hospital staff and your doctor (and your Plan, if applicable) about your concerns.
- You also have the right to request an appeal and have your hospital services covered during the appeal. An independent reviewer called a Quality Improvement Organization (QIO) will give you a second opinion about whether you are ready to leave the hospital.
- You should contact your QIO as soon as possible after you are informed of your discharge date, but before you leave the hospital. If you contact the QIO by your discharge date, your hospital services will continue to be paid during the appeal (except for charges like your coinsurance and deductibles) until noon of the day after the QIO notifies you of its decision.

Page 2 of this notice gives you more information about the appeal process and how to contact your QIO.

Please sign below to show that you have received this notice and understand it.

_____ _____

Signature of Patient or Representative Date

CMS-R-193 (Revision Date)

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HOW TO ASK FOR AN IMMEDIATE APPEAL OF YOUR DISCHARGE

- If you want to request an appeal, you should contact your Quality Improvement Organization (QIO) as soon as possible after you are informed of your discharge date, but before you leave the hospital. **If you request an appeal by noon of your discharge date, your hospital services will continue to be paid during the QIO review until at least noon of the day after the QIO notifies you of its decision.**

- Here is the contact information for the QIO: _____{insert name and number of the QIO}_____. The QIO accepts requests for appeals 24 hours a day, seven days a week and on holidays. You may also call the QIO if you have questions about the appeal process.

- If you request an appeal, you and the QIO will both receive a notice that explains the reasons that your doctor, the hospital, (and your Plan, if applicable) think you are ready to be discharged.

- The QIO will ask for your opinion and look at your medical records. You do not have to prepare anything in writing, but you or your representative have the right to give the QIO a written statement or any information you wish. You or your representative should be available to speak with the QIO.

- The QIO will notify you of its decision within one day after it receives all necessary information.

    - If the QIO finds that you are not ready to be discharged, Medicare will continue to cover your hospital services until further notice.

    - If the QIO finds you are ready to be discharged, you will be responsible for payment of your hospital services beginning noon of the day after the QIO notifies you of its decision.

YOU HAVE OTHER APPEAL RIGHTS:

Choose one and clearly explain the difference between "Original Medicare" and "Medicare Health Plan". Use the terminology that applies to your plan and delete the one that does not apply.

- **If you have Original Medicare:**
    - If you do not request an appeal by noon of your discharge date, you may still ask the QIO to review your case. However, the hospital can charge you immediately for any services you receive after your planned date of discharge. If the QIO decides your Medicare coverage should continue after you have made payments, you will receive a refund.
    - As for any Medicare services, a claim for your hospital services will be submitted to Medicare by the hospital. You will get a Medicare Summary Notice (MSN) regarding Medicare's decision on the claim and your right to appeal that decision.

- **If you belong to a Medicare [Advantage] Health Plan:** **Formatted:** Font color: Red
    - If you do not request an appeal by noon of your discharge date, you may still ask for a fast appeal from your Health Plan. However, if your health plan decides discharging you was the correct decision, you may be responsible to pay for any services you receive after your planned discharge date.

Consult your Medicare Handbook or call 1-800-MEDICARE (1-800-633-4227), or TTY: 1-877-486-2048 for more information about this notice and the Medicare claims appeal process.

INOVA HEALTH SYSTEM

18/1

rec'd 3/6/07

8110 Gatehouse Road
Suite 200, East Tower
Falls Church, Virginia 22042-1210
Tel 703 289-2000

Questions and Comments Regarding the Discharge Notice Important Message
Prepared by Linda Sallee, MS, RN, CMAC
Vice President, Case Management and Infection Control
Inova Health System
Falls Church, VA.

1. Since patients who are admitted from the emergency department are not re-registered by the admitting staff, the department who will issue the initial notice, we are requesting that we be allowed to give the notice to every emergency department patient so we will not miss providing a notice to any of these patients. The same issue does not apply to the observation patients because it is Case Management who works with physicians to make these status changes and can issue the notice when the status is changed. I am concerned we will miss the required timeframe if we do not have the ability to issue the notices to all ED patients.

2. We have begun designing our processes to meet this regulation and would like to pilot our new processes in June. We understand we would need to run dual processes in order to do this pilot but it would help us work out the bugs prior to the required implementation date.

3. This is a new process and has multiple points at which there may be a breakdown related t the timing. Will there be penalties for missing the timeframes even though we are trying to adhere to the requirements?

4. Based on information from our QIO, the continued stay HINNs will no longer be used. Does this also include the Preadmission and Admission HINNs? Will we need to keep any type of HINN log for the QIO? I believe we will continue to need these HINNs for those patients who never meet medical necessity criteria but will not cooperate with discharge planning or do not understand the 3 day rule for skilled nursing care. Physicians often do not understand this rule as well.

5. Currently, when a patient no longer meets medical necessity and our physician advisor concurs but the physician refuses to discharge the patient, we are able to ask the QIO for review and the patient becomes responsible for the bill if the QIO agrees with our findings. It appears that there is no longer a process for this type of review. The regulation as I understand it states that we are to give a copy of the notice to the patient no later than 2 days before discharge. Since only a physician is able to discharge a patient, must we wait until they agree to discharge? I believe we should be able to use medical necessity criteria in some way to assist us so that our length of stay does not increase significantly. We have physician advisors for our case managers and they do confer with the attending physicians but only the attending is able to discharge the patient.

6. When we have Medicare patients who move to or from acute rehab or behavioral health inpatient stays, the patient is discharged form one level of care and admitted to the other. Will we be required to give another letter when they move to this other unit, even if it is in the same building? Mental health patients may not be in a condition to understand the notice and giving them this notice could be detrimental to their progress in some instances. Since they are not paid DRG, is the requirement different? Would we continue to use the HINN in that case? I recommend that we continue to use the HINN process for admits to behavioral health and that the initial notice be accepted with the discharge notice criteria coming into play at the time of discharge (i.e. issue the copy) if the receiving unit is in the same building.

7. As I understand it, if the patient is issued an Important Message (IM) on the day of admission and is discharged on day 3 of the stay, a copy of the IM is not needed. If, however, they are discharged on day 4, a copy would be needed on day 2 of the stay.

8. On many occasions, the IM would be issued during the admission process and the physician and case manager would have discussed a discharge plan and date. The patient then improves more quickly than expected or they are appropriate for a Long Term Acute Care Hospital (LTAC). As the rule stands today, we would not be able to discharge the patient for 2 days until the copy of the notice can be issued. Not only does this increase our length of stay but may lead to the patients' recovery being delayed. For example, the patient is on a ventilator and not doing well with the weaning protocol. We know that the LTAC has a very aggressive weaning protocol with very good outcomes. We are proactive in our discharge planning and have an LTAC accept the patient and offer a bed tomorrow. Would we not be able to transfer the patient until 2 days due to our not providing the IM yesterday? In this case, the patient technically still meets inpatient medical necessity criteria but they can receive the care at an alternate level of care. Another example is a patient who is on multiple IV antibiotics. They received the IM on admission and today the physician discontinues 1 antibiotic, changes one to PO, and leave one at IV two times a day. The patient, with a capable and willing caregiver, could be managed at home or in a skilled nursing facility for the completion of the antibiotics. Based on the new rule, this patient must remain in the hospital for 2 more days.

9. With observation patients who are admitted to inpatient, I believe we should issue an IM on the day they become an inpatient. When we are counting days to issue the IM, does the observation day count at all?

10. Which languages will the IM be translated into? Will you post all the translated IMs on the website?

11. The current IM on the website asks for TTY numbers for the hospital and the QIO. We do not have anyone at the hospital who mans a TTY to know if a message is coming in other than in an emergency and the QIO does not normally provide a TTY, will the QIO and providers be required to have a TTY that is manned on a regular basis. This would be very hard to comply with as the staff who will be providing the copy of the IM within 2 days of discharge do not stay in an office but are up on the patient units. If we could use a fax number instead this would be helpful.

Thank you for your consideration of these questions and comments.

19/1

FAIRVIEW
Fairview Health Services
Patient Financial Services
P.O. Box 147
Minneapolis MN 55440-0147
(612) 672-6724 Fax: (612)-672-6454

Recd 3/6/07

Centers for Medicare and Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development – C
Attn: Bonnie L. Harkless
Room C4-26-05
7500 Security Blvd
Baltimore, MD 21244-1850

Re: Important Message from Medicare, Document CMS-R-193. Comment Request published in Federal Register January 5, 2007 (72 FR 568-569)

Dear Ms Harkless,

Fairview Health Services, which has seven hospitals in Minnesota, wishes to thank you for the opportunity to comment on the proposed changes to the process for the Important Message from Medicare. Our comments are as follows:

Initial delivery of notice:

Currently, the notice is given on admission or shortly thereafter by registration staff or hospital volunteers in some instances. Based on experience with this patient population, this notice will generate quite a bit of discussion, concerns, and questions that the staff may not be able or may not be the appropriate staff to answer, particularly during second and third shifts. This will push the notice delivery to nursing or day staff.

For admission staff to take a minimum of 13 minutes to get the signature and explain it to the patient and/or representative will back up the admissions process. It will delay other admissions/registration processes, causing dissatisfied patients, as well as dissatisfied staff who are waiting for the information in order to be able to start the processes necessary to start treatment.

The result is additional costs, such as more staff to avoid the backups on registration, or to push this to clinical staff, which is another administrative burden which interferes with their primary duty which is patient care.

We would like to point out that a signature does not necessarily mean comprehension. On admit, patients are sick and nervous, and family member are concerned. They may nod comprehension and then not even remember it, even if a copy is in their documents. These types of notices are often found in the trash.

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Comments to CMS
Important Message from Medicare

Timing prior to discharge:

We commented previously on the standard discharge notice. For all the same reasons, we cannot predict when the discharge will happen. Hospitals do not make this decision; physicians make the decision based on clinical criteria. When the patient meets criteria, the patient may be discharged. Some patients recover more quickly than expected. Some may be expected to go home and then do not. In short, discharge is impossible to predict. If we give the patient the notice and s/he does not go home as expected, we may end up having to give it again if the patient stays longer than two days past the time we gave them the copy. A patient who has already received the notice and then the discharge is delayed may require assurances that we are not going to send them home just because they did not meet the expected date or time.

Giving the patient the notice again will most likely generate the exact same questions they asked when they first got the notice, so we would expect at least another 13 minute conversation, using CMS' figures. Under the Conditions of Participation, we already are required to do discharge planning so that the transition to home or another facility or further care is smooth and patients understand next steps. Pushing this form in front of them again could cause patients and families to doubt the process, generating more questions, worry, and unnecessary delays, and causing further backup for other patients awaiting admission. For those who actually do decide to appeal to QIO, we will have unnecessary – and uncompensated – inpatient days while we wait for a QIO decision.

The process:

There is no proof that we actually gave the patient another copy without initials and some form of documentation and a place to put the date. Just giving it to the patient therefore serves no purpose, other than we can say it's our process.

We will not be able to get this form for emergency transfers. We anticipate that there will be other times when we cannot get this form, such as incapacitated patients with no family present. We anticipate that some people will simply refuse to sign the form. Assuming CMS goes ahead with some form of this notification, we would like guidelines for exception processing.

The handoff and tracking of this signed form so that it's available to the people at discharge is onerous. It will require that someone physically walk this over to the patient chart and place it there. There will be additional time involved in this process, which is hard to estimate since process flows for charts differ by hospital and probably by patient care unit. It will require a paper chart since this is not an electronic item, other than possibly it could be scanned, but considering that it may be needed within a short time frame, it could not be scanned in the normal process. It would have to be scanned immediately.

Comments to CMS
Important Message from Medicare

For a medium sized hospital with 20 to 25 admits a day and assuming 20 to 25 discharges per day, and using CMS' time figures, this will take the equivalent of one FTE per day. This assumes that there are no additional questions, and no QIO appeals.

Conclusion:
We feel that this is an unnecessary second step. If there are concerns about the discharge process, CMS should address them in discharge planning.

Thank you for the opportunity to comment.

Sincerely,

Stephanie McDonald
Compliance Specialist
Fairview Health Services
Corporate Office
400 Stinson Blvd
Minneapolis, MN 55413

University of Minnesota Medical Center, Fairview
Fairview Southdale Hospital
Fairview Ridges Hospital
Fairview Northland Regional Hospital
Fairview Lakes Regional medical Center
Fairview red Wing Hospital
University Medical Center, Mesabi

CDPHP™

500 Patroon Creek Blvd.
Albany, NY 12206-1057
www.cdphp.com

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February 28, 2007

rec'd 3/6/07

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

Dear Ms. Harkless:

As requested by CMS in its January 5, 2007 Federal Register request (Page 568), set forth below are comments concerning several sections of the proposed revised version of the "Important Message From Medicare" (IM) (CMS-R-193). For your ease, I have restated the relevant sections commented on in *italic typeface* and typed the language of concern in red typeface.

COMMENT 1

- *You have the right to receive services you need after you leave the hospital (that is, after you are "discharged"). Medicare or your Plan may cover some of these services if ordered by your doctor* or your Plan. *You have a right to know about these services, who will pay for them, and where you can get them.*

Discussion: We recommend deleting the words "or your Plan" in the third bullet point under the section entitled "Your Rights as a Hospital Patient". Use of those words implies that a Plan can order services. Health plans are not legally permitted to order services for patients. Suggesting to a patient that a health plan can order services creates confusion for patients in an area that health plans and practitioners have worked for years to clarify. It is detrimental to patients for them to believe that health plans can order services when only the physician can write an order for medical services.

COMMENT 2

Planning For Your Discharge: *During your hospital stay, the hospital staff will be working with you and your doctor (and your Plan, if applicable) to plan for your discharge and arrange for services you may need after you leave the hospital. When your doctor* or Plan *decides you no longer need hospital care or can safely receive care in another setting, you will be informed of your discharge date.*

20/2

Discussion: We recommend deleting the words "or Plan" because the Medicare Program; Notification of Hospital Discharge Appeal Rights; Final Rule, specifically states that physician concurrence is required, §422.620, (d), therefore it is the physician who determines that discharge is appropriate.

COMMENT 3

The Hospital Discharge Appeal Rights Final Rule states that prior to discharge the enrollee will be advised of discharge and receive a copy of the signed Important Message from Medicare. The Rule does not identify how receipt of this information is documented.

Discussion: We recommend adding a second signature line for the enrollee on the Important Message from Medicare form as well as a field for the discharge date so the enrollee can sign the form a second time thereby creating documentation that the enrollee received the copy of the signed notice and was advised of the intended discharge date.

Thank you for allowing us the opportunity to participate in this public comment. If you have any questions, please contact me at 518/641-3425.

Sincerely,

Deborah C. Manginelli

Deborah C. Manginelli, RN
Quality Coordinator
Medical Affairs Division
Capital District Physicians' Health Plan, Inc.