

**Final Rule: Notification of Hospital Discharge Appeal Rights (CMS- 4105-F)**  
**Qs And As**  
**(April 3, 2007)**

**I. General**

Q1. Why is CMS revising the process for notifying Medicare beneficiaries about their discharge appeal rights? When will CMS-4105-F go into effect, what processes and notices should hospitals use in the interim, and where can I find more information on the new notice requirements?

A1. Consistent with section 1154 of the Social Security Act, Medicare beneficiaries have a longstanding right to request QIO review of a discharge decision. Hospitals continue to be responsible for notifying beneficiaries of this right. However, in part as a result of the Weichardt v. Leavitt lawsuit, CMS published final regulations on November 27, 2006, that established revised requirements for how hospitals must notify Medicare beneficiaries who are hospital inpatients about their discharge appeal rights. Notice is required both for Original Medicare beneficiaries and for beneficiaries enrolled in Medicare Advantage (MA) plans and other Medicare health plans subject to the MA regulations.

The new notice requirements will go into effect on July 1, 2007. Consistent with the Office of Management and Budget (OMB) Paperwork Reduction Act (PRA) process, CMS will publish both the Important Message from Medicare (IM) and the Detailed Notice of Discharge (DN) for a 30-day public comment period in early April. Until these notices are made final, hospitals should continue to follow existing procedures and use current notices.

More information on the final rule and the proposed notices can be found on [http://www.cms.hhs.gov/BNI/12\\_HospitalDischargeAppealNotices.asp](http://www.cms.hhs.gov/BNI/12_HospitalDischargeAppealNotices.asp). This page will be updated as the notices and instruction are finalized. Providers are asked to check the website frequently for updates.

Q2. What are the notice requirements set forth in CMS-4105-F?

A2. The final rule requires hospitals to use a revised version of the Important Message from Medicare (IM), CMS-R-193, which is an existing statutorily required notice, to explain discharge appeal rights. Hospitals must issue the IM within 2 calendar days of the day of admission, and obtain the signature of the beneficiary or his or her representative to indicate that he or she received and understood the notice. The IM, or a copy of the IM, must also be provided to each beneficiary within 2 calendar days of the day of discharge. Thus, in cases where the delivery of the initial IM occurs more than 2 days before discharge, hospitals will deliver a follow up copy of the signed notice to the beneficiary as soon as possible prior to discharge, but **no more** than 2 days before. (See Section IV of these Qs and As

for further detail regarding delivery of the follow-up copy of the notice.) For beneficiaries who request an appeal, the hospital, or health plan, if applicable, will deliver a Detailed Notice.

## **II. Scope**

Q1. Do the Important Message from Medicare and the Detailed Notice need to be given to all patients, regardless of payment source? Do they need to be delivered to beneficiaries who have Medicare as a secondary payer? What about those dually eligible for both Medicare and Medicaid?

A1. This rule applies to all Medicare beneficiaries, including enrollees in Medicare Advantage (MA) plans and other Medicare health plans subject to MA regulations. Section 1154 of the Social Security Act applies to all patients who are under Medicare, regardless of where Medicare falls in the sequence of payment. Thus, all Medicare beneficiaries, no matter where in the sequence of payers Medicare falls, must receive these notices.

Q2. Are hospitals such as Critical Access Hospitals, Long Term Care Hospitals and Psychiatric Hospitals included in the rule?

A2. Yes, 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. This means all hospitals paid under the Inpatient Acute Prospective Payment System (IPPS), sole community hospitals/regional referrals centers or any other type of hospital receiving special consideration under IPPS (for example, Medicare dependent hospitals, Indian Health Service hospitals); hospitals not under IPPS, including, but not limited to: hospitals paid under State or United States territory waiver programs, hospitals paid under certain demonstration projects cited in regulation (§489.34), rehabilitation hospitals, long-term care hospitals, psychiatric hospitals, critical access hospitals, children's hospitals, and cancer hospitals.

Note however that religious nonmedical health care institutions are excluded, as are hospital “swing beds” when used as skilled nursing beds (because they are then considered to be, and paid at, a lower level of care).

## **III. Delivery of the Initial Copy of the Important Message from Medicare**

Q1. When should the initial copy of the IM be delivered? What if a patient is in observation status, or is a patient in the Emergency Department (ED)? What if the patient is admitted on a Monday, the hospital has not delivered the IM, and the doctor discharges the patient the next day?

- A1. The initial copy of the IM must be delivered within 2 calendar days of a Medicare beneficiary's admission as a hospital inpatient. If a beneficiary is in observation status, the IM should be given within two calendar days of the actual admission to the inpatient hospital level of care. Similarly, if a beneficiary is first admitted to the Emergency Department (ED), then later admitted as an inpatient, the IM must be delivered within 2 calendar days of the admission as an inpatient, not within 2 calendar days of the admission to the ED.

If a beneficiary is suddenly ready for discharge on the day after admission, and has not received the initial copy of the IM, the hospital should deliver the initial copy as early as possible on the day of discharge to ensure that the beneficiary has adequate time to consider and act on his or her right to a QIO review of the discharge. Hospitals should allow beneficiaries at least several hours to consider their rights, although a discharge need not be delayed if a patient clearly consents.

- Q2. Who can sign the initial IM on behalf of the patient? If the patient refuses to sign the initial IM, can the admitting staff make a note on the form? If the patient refuses to sign the initial copy, should he or she sign the follow up copy?
- A2. This form is no different from any other form that the hospital has deemed may be signed by a 'responsible' person acting on behalf of the patient. If the patient or representative refuses to accept or sign the notice, hospitals should annotate the notice indicating the refusal, and must retain a copy of the notice. The date of refusal is considered the date of receipt of the notice. If the beneficiary refused to sign the initial copy, he or she should be given a copy of the annotated notice as the follow up copy. The follow-up copy does not have to be signed.

#### **IV. Delivery of the Follow up Copy of the Important Message from Medicare**

- Q1. When is a follow-up copy of the IM necessary and when does the follow-up copy of the signed IM need to be delivered? Is there a minimum number of days that a patient has to stay in the hospital following admission to be given the follow-up copy?
- A1. The purpose of the follow-up copy is to help ensure that beneficiaries are aware of their discharge appeal rights at the time they are most relevant, that is, during the period leading up to discharge. Thus, the regulations require that the follow-up copy of the IM be delivered as far in advance as possible, but **no more** than 2 days prior to discharge. When a hospital can anticipate the discharge, it should give the follow up copy of the notice 1 or even 2 days before discharge. When the hospital cannot anticipate the discharge, it should deliver the follow up copy as soon as the discharge can be anticipated. If necessary, the notice may be delivered on the day of discharge, again, as early as possible, and at least several hours before the time of discharge. Hospitals may not establish policies that allow the follow up copy of the IM to be delivered routinely to patients on the day of discharge. Again, beneficiaries should have adequate time to consider all of their

options.

If delivery of the initial IM falls within 2 calendar days of discharge, no follow up copy is needed. Here are some examples of how the 2-day requirement will work:

- If a beneficiary is admitted on Monday and the initial copy of the IM is delivered on Monday, no copy needs to be given if the beneficiary is discharged on Tuesday or Wednesday.
- If a beneficiary is admitted on Monday and gets the IM on Wednesday, a follow up copy is not needed if he or she is discharged on Thursday or Friday because delivery of the IM on Wednesday constitutes delivery within 2 calendar days of both the admission and discharge.

Q2. Does the follow-up copy of the IM need to be signed again? If the follow-up copy is delivered and the patient ends up staying several more days, does another follow up copy need to be delivered?

A2. The regulations do not require that the follow-up copy be signed. It serves as a reminder of the information that was given on the initial IM. However, while the beneficiary's signature is not required, a hospital must be able to document that the notice has been delivered. One way to accomplish this would be to have the beneficiary initial the form to indicate that he or she has received it. We intend to provide an "Additional Information" area for an entry on the latest version of the IM. If the follow-up copy of the IM has been delivered and a beneficiary remains in the hospital for more than 2 additional calendar days, another follow-up copy should be issued according to the required timeframes.

Q3. If a patient is transferred to another acute care hospital, is a follow-up IM required prior to transfer? When the patient is transferred to another acute care hospital, does the receiving hospital need to issue an IM? If a patient is discharged and readmitted the same day to the same facility, does another IM need to be issued?

A3. A follow-up copy is **not** required prior to transfers from one inpatient hospital setting to another inpatient hospital setting, for example, a short term acute care hospital to a long term acute care hospital. A follow-up copy of the signed notice **is** required prior to discharge to a lower level of care, such as a swing bed or SNF. We expect that these issues related to a hospital-to-hospital transfer will be resolved through continued communication among the physician, the hospital staff and the patient. A beneficiary always has the right to refuse care or to file a quality of care complaint with a QIO, if necessary.

When a beneficiary is transferred to another inpatient hospital setting, the notice delivery timeframes start again. Thus, the receiving hospital must issue an initial IM within 2 calendar days of the day of admission and a follow-up copy no more

than 2 days prior to the day of discharge. When a beneficiary is discharged and readmitted the same day to the same facility, he or she should be given the IM again since this is a new admission.

## **V. Retention of Copies**

- Q1. Will the hospital be required to retain a copy of the IM in medical record? If not, how will they be expected to maintain this information? Does the hospital need to keep a copy of the follow-up copy? How should the hospital document that the follow-up copy of the IM was given, when it was given and to whom it was given?
- A1. Hospitals must retain a copy of the signed IM and may do so wherever it makes sense given their record retention system. Scanning and electronic storage of notices is acceptable. Hospitals also must be able to demonstrate compliance with the requirement for delivery of the follow-up copy of the notice. However, as noted above, hospitals have some flexibility in terms of methods for documenting delivery of the follow-up copy, such as obtaining the beneficiary's initials on an "Additional Information" area that we intend to add to the notice.

## **VI. QIO Review**

- Q1. Is attending physician concurrence with the discharge required, is documentation of concurrence required? What is the process by which a provider can request QIO review of a discharge if the attending physician does not discharge a patient who is no longer receiving Medicare covered acute care services? Which notice should be used?
- A1. As has always been the case for both FFS and MA, physician concurrence with discharge is required. However, documentation of physician concurrence is not necessary before hospitals provide the Important Message from Medicare or for the patient to request QIO review.

There is an existing process in Original Medicare for hospitals to request QIO review if the physician does not concur with a hospital's determination that a patient no longer qualifies for Medicare covered inpatient hospital services. See 42 CFR 405.1208, and Transmittal 594, dated July 1, 2005 (see Section V.) In this case, hospitals currently issue HINN # 10 to the beneficiary. This process and use of HINN #10 remain the same under the new rule.

- Q2. Can the patient request a QIO appeal on the day of discharge? If the patient is given the follow-up copy of the IM at the time of discharge, and the patient chooses to appeal the discharge, should the patient be discharged anyway? Does the patient need to file an appeal before noon of the day of discharge?

- A2. The patient can appeal on the day of discharge and stay in the hospital without financial liability until at least noon of the day after the QIO notifies the hospital, the beneficiary and the physician of its decision. Therefore, a beneficiary who appeals to a QIO cannot be discharged without his or her consent.

The regulation requires the beneficiary's request for QIO review to be made no later than the day of discharge, so this means that the beneficiary has until midnight of the day of discharge to request an appeal.

- Q3. If a patient asks for QIO review of a discharge after he/she is discharged and leaves the hospital, and the QIO rules that the discharge was inappropriate, will the hospital be paid for the inpatient stay?

- A3. If a beneficiary leaves the hospital on his/her planned discharge date and later requests QIO review of the discharge, the QIO's decision about the appropriateness of the discharge would not affect Medicare's payment for the inpatient stay.

- Q4. How soon must a hospital supply information to the QIO following a request for an appeal?

- A4. The final rule requires the hospital to provide the QIO with all the information it needs to make its decision as soon as possible, but no later than noon of the day after the QIO notifies the hospital of the beneficiary's request for an expedited review.

## **VII. The Detailed Notice**

- Q1. When should the Detailed Notice be delivered?

- A1. The Detailed Notice should be delivered as soon as possible after an individual requests a QIO review, but no later than noon of the day after the QIO notifies the hospital of the beneficiary's request for a QIO review.

- Q2. Is there a 'format' for the detailed notice that is given to patients who appeal?

- A2. Yes, providers will be required to issue a standardized detailed notice. Again, the notices required by this rule are currently undergoing clearance through OMB's PRA public comment process. The Detailed Notice will be published for the second time in early April for a 30-day public comment period. (It was already displayed for a 60-day comment period last April 2006, at the same time as the proposed rule). During the upcoming public comment period for the Detailed Notice, we will carefully consider any timely suggestions on the format of the notice and for standardized language that could be pre-printed on the notice.

## **VIII. Existing Notices**

Q1. Does the hospital need to issue a Hospital Issued Notice of Noncoverage (HINN) before the follow-up IM? What should the hospital do if the patient stays in the hospital after the planned date of discharge and does not request a review, but requests a review a few days later? Will the new notification rules impact the manner in which Preadmission and Admission HINNs are currently issued? If so, how?

A1. In light of the new notice requirements under CMS-4105-F, we are currently reviewing all of the HINNs, and where it's appropriate, we intend to consolidate or eliminate certain HINNs. More information will be available prior to the July 1, 2007 implementation date. Since at the time of preadmission and admission, beneficiaries may not yet have received the IM describing their right to a QIO review, it is likely that the Preadmission/Admission HINNs, that describe both the right to a QIO review and patient liability, will remain in place.

The HINN will not need to be issued before the follow up copy of the IM. Currently, HINNs do two things –they inform beneficiaries of their right to a QIO review and they advise beneficiaries that they are facing liability (under 1879 of the Act). With this new process, we have separated these two functions. The IM delivery process informs beneficiaries of their right to a QIO review, and only those beneficiaries who face liability, such as a beneficiary who intends to stay in the hospital past the planned date of discharge and not request an appeal, will need to get a liability notice, similar to the current HINN.

If the beneficiary remains in the hospital after the planned date of discharge and then requests a QIO review, the beneficiary may be held responsible for charges incurred after the date of discharge or as otherwise stated by the QIO. Hospitals that believe a patient does not intend to, or has not requested a timely QIO review must deliver a hospital liability notice as explained in the paragraph above.

## **IX. Beneficiary Liability**

Q1. How will beneficiary liability be affected by the new regulation?

A1. As is the case today, Medicare beneficiaries who make a timely request for an expedited Quality Improvement Organization (QIO) review of a discharge decision will continue to be protected from financial liability (other than applicable coinsurance and deductible) until noon of the day after the QIO issues its decision. The QIO's determination will dictate liability after that point.

Q2. If a patient requires post-acute extended care services, has not met the 3 day qualifying stay requirement, requests an appeal, stays the 3<sup>rd</sup> day, and the QIO

finds the 3<sup>rd</sup> day was not medically necessary, how will it be known that the Skilled Nursing Facility (SNF) stay will not be covered by Medicare?

- A2. The new notification requirements do not affect the hospital's obligation to provide information about the qualifying stay to both the beneficiary and receiving SNF in the discharge process. Similarly, SNFs have the same obligation to confirm a qualifying stay has occurred as part of their admission process.

## **X. QIO Processes**

- Q1. QIOs currently review hospital stays Monday through Friday, but review non-hospital stays (BIPA expedited reviews) 7 days a week. Will QIOs now review hospital stays 7 days a week? Would the QIO business day be 8:00 am to 4:30 pm for appeal requests and receipt of medical records?
- A1. Hospital inpatients will be able to file requests for QIO review of discharge decisions 7 days a week. Thus, QIOs should have processes in place to accept requests for reviews outside their normal business hours and must ensure that they can process such requests 7 days a week.
- Q2. In the event the QIO determines that the notice is invalid, what is the process?
- A2. In this case, if necessary, QIOs will instruct the hospital to re-issue a corrected notice, but in all cases should proceed with the review. After the review the QIO should educate the hospital regarding the notice delivery process. A beneficiary who requests a review may remain in the hospital without liability until at least noon of the day after the QIO notifies the beneficiary of its decision, so it is in the best interest of the hospital to deliver a timely, valid notice.