Supporting Statement for the Detailed Notice and Supporting Regulations Contained in 42 CFR §§405.1206 and 422.622
CMS 10066/OMB Approval 0938-1019

Introduction

This application requests an extension of the Detailed Notice of Discharge (DND), Form CMS 10066, collection 0938-1019, in association with final rule CMS-4105-F, [Medicare Program; Notification of Hospital Discharge Appeal Rights.] This final rule, implemented on July 2, 2007, set forth requirements for hospitals to deliver a DND to beneficiaries who request review of a discharge decision by a Quality Improvement Organization (QIO). Hospitals and Medicare Advantage (MA) organizations are affected by this rule. The Office of Management and Budget (OMB) approved the new collection in 2007. In 2010, minor formatting revisions were made to the notice, and OMB approved an extension for use. The approved, current notice expires on July 31, 2013. No changes are being made to the notice or instructions with this submission.

A. Background

A beneficiary/enrollee who wishes to appeal a determination by a Medicare health plan or hospital that inpatient care is no longer necessary may request QIO review of the determination. On the date the
QIO receives the beneficiary's/enrollee's request, it must notify the plan and hospital that the beneficiary/enrollee has filed a request for an expedited determination. The plan (for a managed care enrollee) or hospital (for an original Medicare beneficiary), in turn, must deliver a DND to the enrollee/beneficiary.

B. Justification

1. Need and Legal Basis

The authority for the right to an expedited determination is set forth at §1869(c)(3)(C)(iii)(III) and §1154(a) of the Social Security Act.

42 CFR §405.1206 and 42 CFR §422.622 – When a QIO notifies a hospital or MA organization that a beneficiary/enrollee has requested an expedited determination, the hospital or MA organization must deliver a DND to the beneficiary/enrollee as soon as possible but no later than noon of the
day after the QIO's notification.

2. Information Users

According to the 2011 Medicare CMS Data Compendium (http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/DataCompendium/2011_Data_Compendium.html) Tables V.1 and VI.2, there were approximately 12.4 million Medicare hospital discharges in 2010 and 6,169 hospitals participating in Medicare that potentially would need to issue the notice.

The DND is required whenever a beneficiary requests a discharge appeal; thus, we can accurately determine the number of DNDs delivered by using QIO inpatient hospital appeals data. We collected calendar year
2010 QIO data from the Case Review Information System (CRIS), which is the results tracking system for all QIOs. In 2010, 9,075 fee-for-service (FFS) Medicare beneficiaries and 3,777 Medicare Advantage (MA)
beneficiaries requested a QIO review of their inpatient hospital discharge
decision for a total of 12,852 appeal requests requiring DND delivery in 2010.

Based on the above, we can deduce that .1036% of hospital discharges required DND delivery in 2010 (12,852 appeal requests ÷ 12.4 million inpatient discharges). In addition, we estimate that each hospital would deliver an average of 2.08 notices annually (12,852 appeal requests ÷
6,169 hospitals).

3. Improved Information Technology

Hospitals and MA organizations must deliver a hard copy of the DND whenever beneficiaries or enrollees request a review of the discharge decision by a QIO. There is no provision for alternative uses of information technology for the detailed notice, although hospitals may store a copy of the notice electronically.

4. Duplication of Similar Information

None.

5. Small Business

All hospitals are expected to give the DND in relevant situations. The requirement does not impose any greater burden on small businesses than on large businesses since there is no difference in the information collected.

6. Less Frequent Collection

None.

7. Special Circumstances

The regulations at 42 CFR §405.1206(b) and 42 CFR §422.622(b) require that the DND be delivered to either beneficiaries or their representatives when they request a QIO review. However, if the beneficiary or representative requests more information in writing to make a decision about whether to request a QIO review, providers may issue a DND prior to the beneficiary filing a QIO review request.

8. Federal Register Notice/ Outside Consultation

A 60 day *Federal Register* notice published on March 6, 2013 (78 FR 14555). Interested parties will have an opportunity to comment. Public comments will be considered carefully in making any necessary revisions to the notice and accompanying instructions.

9. Payment/ Gift to Respondent

We do not plan to provide any payment or gifts to respondents.

10. Confidentiality

We are not collecting information. The provider and QIO will maintain records of notices and decisions, but those records do not become part of a federal system of records. Therefore, this item is not applicable.

11. Sensitive Questions

We do not require beneficiaries to answer any sensitive questions. Therefore, this item is not applicable.

12. Burden Estimate

The regulation set forth at 42 CFR §405.1206(b) requires any beneficiary wishing to exercise the right to an expedited determination to submit a request, in writing or by telephone, to the QIO that has an agreement with the hospital. Section 405.1206(e) requires hospitals to deliver a DND to the beneficiary and to make available to the QIO (and to the beneficiary

upon request) a copy of that notice and any necessary supporting documentation. As specified in 42 CFR §422.622(e), Medicare health
plans are required to deliver the DND to the enrollee and to make a copy of that notice and any necessary supporting documentation available to
the QIO (and to the enrollee upon request).

Similar to the 2010 PRA submission for the DND, we are estimating that preparation of the DND and the patient's case file for the QIO will take approximately 1 hour. In addition, it is our expectation that the DND notices will be prepared by a staff person with professional skills equivalent to a GS-12, Step 1 (an hourly salary of $28.88, per the Office of Personnel Management). For the purposes of this package, and consistent with our
2010 submission, we will use a $30 hourly wage to determine the burden.

Based on the above, we can surmise the DND--

- Yields an annual burden of 12,852 hours
  (12,852 appeal requests (per section 2) x 1 hour);
- Costs $30 cost per notice
  ($30 hourly wage x 1 hour to complete the form);
- Total annual cost is
  $385,560 (12,852 hours x
  $30);
- On average, costs each hospital is $62.40
  (2.08 notices per hospital/per year (per section 2) x $30 hourly wage).

13. Capital Costs

There are no capital costs associated with this collection.

14. Costs to Federal Government

There is no cost to the Federal Government for this collection.

15. Changes to Burden Estimates

The DND is an existing collection that last received OMB approval in 2010. There are minor and expected differences in the hospital and QIO data used in this submission from the data used in the last PRA submission. These minor differences can be attributed to program and population variability and result in minimal change in the burden estimates. The annual hour burden of 12,852 hours is 366 less than the 13,218 annual hour burden estimated in the 2010 PRA submission. Thus, the annual cost burden of
$385,560 is $10,980 less than the estimated burden of $396,540

included in the prior submission.

16. Publication and Tabulation Dates

These notices will be published on the Internet; however, no aggregate or individual data will be tabulated from them.

17. Expiration Date

We are not requesting exemption.

18. Certification Statement

There are no exceptions to the certification statement.

C. Collection of Information Employing Statistical Methods

There are no statistical methods associated with this collection.