

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1257	Date: MAY 25, 2007
	Change Request 5622

SUBJECT: Important Message from Medicare (IM) and Expedited Determination Procedures for Hospital Discharges

I. SUMMARY OF CHANGES: The procedures for delivery of the Important Message from Medicare, a statutorily required notice, were revised with publication of the Final Rule CMS-4105-F. This notice informs beneficiaries who are hospital inpatients of their right to an expedited review by a Quality Improvement Organization (QIO) of a discharge.

NEW / REVISED MATERIAL

EFFECTIVE DATE: *July 1, 2007

IMPLEMENTATION DATE: July 2, 2007

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
D	2/80/Required Hospital Notice to Beneficiary
D	2/80/80.1/Notice to Beneficiaries of QIO Review of Care
D	2/80/80.2/Notice to Beneficiaries of QIO Review of Need for Continued Hospitalization
D	2/80/80.3/QIO Monitoring of Hospital Admission Notice to Beneficiaries
N	30/200/Expedited Review Process for Hospital Inpatients in Original Medicare
N	30/200/200.1/Scope of the Instructions
N	30/200/200.2/Special Considerations
N	30/200/200.3/Notifying Beneficiaries of their Right to an Expedited Review
N	30/200/200.3.1/Delivery of the Important Message from Medicare
N	30/200/200.3.2/The Follow-Up Copy of the Signed Important Message from Medicare

N	30/200/200.4/Rules and Responsibilities when a Beneficiary Requests an Expedited Review
N	30/200/200.4.1/The Role of the Beneficiary and Liability
N	30/200/200.4.2/The Responsibilities of the Hospital
N	30/200/200.4.3/The Role of the QIOs
N	30/200/200.4.4/Effect of a QIO Expedited Determination
N	30/200/200.5/General Notice Requirements
N	30/200/200.5.1/Number of Copies
N	30/200/200.5.2/Reproduction
N	30/200/200.5.3/Length and Page Size
N	30/200/200.5.4/Contrast of Paper and Print
N	30/200/200.5.5/Modification
N	30/200/200.5.6/Font
N	30/200/200.5.7/Customization
N	30/200/200.5.8/Retention of Notices
N	30/200/200.6/Completing the Notices
N	30/200/200.6.1/Translated Notices
N	30/200/200.6.2./Exhibit 1 - An Important Message from Medicare (CMS-R-193) and Form Instructions
N	30/200/200.6.3./Exhibit 2 - The Detailed Notice of Discharge (CMS 10066) and Form Instructions
N	30/220/Hospital Requested Expedited Review
N	30/220/220.1/Responsibilities of the Hospital
N	30/220/220.2/Responsibilities of the QIO
N	30/220/220.3/Effect of the Hospital Requested Expedited Determination
N	30/220/220.4/General Notice Requirements
N	30/220/220.5/Exhibit 3 - Model Language Notice of Hospital Requested Review (HRR)
N	30/240/Preadmission/Admission Hospital Issued Notice of Noncoverage (HINN)
N	30/240/240.1/Delivery of the Preadmission/Admission HINN
N	30/240/240.2/Notice Delivery Timeframes and Liability
N	30/240/240.3/Timeframes for Submitting a Request for a QIO Review
N	30/240/240.4/Results of the QIO Review
N	30/240/240.5/Effect of the QIO Review

N	30/240/240.6/Exhibit 4 - Model Language Preadmission/Admission Hospital Issued Notice of Noncoverage
N	30/260/Expedited Determination Process for Provider Services Terminations [placeholder]
N	30/300/Expedited Reconsiderations
N	30/300/300.1/The Role of the Beneficiary and Liability
N	30/300/300.2/The Responsibilities of the IRE
N	30/300/300.3/The Responsibilities of the QIO
N	30/300/300.4/The Responsibilities of the Provider
N	30/300/300.5/Coverage During an Expedited Reconsideration

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:

**Business Requirements
Manual Instruction**

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1257	Date: May 25, 2007	Change Request: 5622
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SUBJECT: Important Message from Medicare (IM) and Expedited Determination Procedures for Hospital Discharges

Effective Date: July 1, 2007

Implementation Date: July 2, 2007

I. GENERAL INFORMATION

A. Background:

Currently, at or about the time of admission, hospitals must deliver the “Important Message from Medicare” (IM), as required by Section 1866(a)(1)(M) of the Social Security Act (the Act), to all hospital inpatients with Medicare to explain their rights as a hospital in-patient, including their right to an expedited review by a QIO of a discharge. In addition, a hospital must provide a Hospital-Issued Notice of Non-coverage (HINN), as required by Section 1154 of the Act to any beneficiary in original Medicare that expresses dissatisfaction with an impending hospital discharge. Similarly, MA organizations are required to provide enrollees with a notice of non-coverage, known as the Notice of Discharge and Medicare Appeal Rights (NODMAR), when a beneficiary disagrees with a discharge decision (or when the individual is not being discharged, but the organization no longer intends to cover the inpatient stay).

The Weichardt v. Leavitt class action lawsuit filed in 2003 contested the legitimacy of the current hospital notice procedures. A settlement agreement was signed on October 28, 2005 whereby CMS agreed to publication of a proposed, and then a final rule setting forth revised discharge notice requirements for hospital inpatients who have Medicare. The Final Rule CMS-4105-F was published on November 27, 2006.

Beginning July 1, 2007, hospitals must deliver 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. For beneficiaries who request an appeal, the hospital, or health plan, if applicable, will deliver a Detailed Notice.

B. Policy: The authorization for these requirements are Section 1866(a)(1)(M) and Section 1154(e) of the Social Security Act and CMS- 4105-F, 42 CFR Parts 405.1204, 405.1205, 405.1206, and 405.1208.

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A / B M A C	D M E M A C	F I 	C A R I E R	D M R C	R H I	Shared-System Maintainers				OTH ER
							F I S S	M C S	V M S	C W F		
	their provider community in billing and administering the Medicare program correctly.											

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
N/A	

B. For all other recommendations and supporting information, use this space:

V. CONTACTS

Pre-Implementation Contact(s): Tim Roe, Timothy.Roe@cms.hhs.gov, 410-786-2006.

Post-Implementation Contact(s): Tim Roe, Timothy.Roe@cms.hhs.gov, 410-786-2006.

VI. FUNDING

A. For Fiscal Intermediaries, Carriers, and the Durable Medical Equipment Regional Carrier (DMERC), use only one of the following statements:

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

B. For Medicare Administrative Contractors (MAC), use the following statement:

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). 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.

Medicare Claims Processing Manual

Chapter 30 – Financial Liability Protections

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Hospital Issued Notice of Noncoverage*

*260 – Expedited Determination Process for Provider Services Terminations
<placeholder>*

300 – Expedited Reconsiderations

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200 - Expedited Review Process for Hospital Inpatients in Original Medicare

(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

Medicare beneficiaries who are hospital inpatients have a statutory right to appeal to a QIO for an expedited review when a hospital, with physician concurrence, determines that inpatient care is no longer necessary. The instructions that follow stem directly from regulations at 42 CFR 405.1205 and 405.1206 and are effective July 1, 2007. These regulations are also referenced at 42 CFR 489.27 and 412.42 (c)(3). The authority for these instructions stems from Sections 1866(a)(1)(M), 1869(c)(3)(C)(iii)(III), and 1154(e) of the Social Security Act. Instructions for managed care will be located in Chapter 13 of the Medicare Managed Care Manual.

Hospitals must notify Medicare beneficiaries who are hospital inpatients about their hospital discharge appeal rights. Hospitals will use a revised version of the Important Message from Medicare (IM) a statutorily required notice, to explain the beneficiary's rights as a hospital patient, including discharge appeal rights. Hospitals must issue the IM within 2 calendar days of admission, must obtain the signature of the beneficiary or his or her representative and provide a copy at that time. Hospitals will also deliver a copy of the signed notice as far in advance of discharge as possible, but not more than 2 calendar days before discharge.

For those beneficiaries who request a QIO review, hospitals must deliver a Detailed Notice of Discharge as soon as possible, but no later than noon of the day after the QIO's notification. Both the IM and the Detailed Notice must be the standardized notices provided by CMS.

200.1 Scope of the Instructions

(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

These instructions implement 42 CFR 405.1205 and 405.1206 which require hospitals to inform Medicare beneficiaries who are hospital inpatients of their right to a QIO review. These instructions delineate the expectations of beneficiaries (or their representative, if applicable), responsibilities of hospitals, and the role of the QIOs when the beneficiary requests an expedited review by a QIO of the discharge decision. For purposes of this instruction, the term "beneficiary" means either beneficiary or representative, when a representative is acting for a beneficiary.

Hospitals Affected by these Instructions. *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. Swing beds in hospitals are excluded, because they are considered a lower level of care. Religious nonmedical health care institutions are also excluded.

Hospital Inpatients who are Medicare Beneficiaries. *These instructions apply to beneficiaries in original Medicare who are hospital inpatients. Hospital outpatients who are receiving Part B services, such as those in observation stays or in the emergency department, do not receive these notices, unless they subsequently require inpatient care. Medicare beneficiaries in hospital swing beds or custodial care beds do not receive these notices when they are receiving services at a lower level of care.*

Definition of Discharge. *The term “discharge” is defined as a formal release of a beneficiary from an inpatient hospital. This includes when the beneficiary is physically discharged from the hospital as well as when the beneficiary is discharged “on paper” – meaning that the beneficiary remains in the hospital, but at a lower level of care (for example, the beneficiary is moved to a swing bed or to custodial care).*

200.2 - Special Considerations

(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

Other Insurers. *Section 1866(a)(1)(M), delivery of the Important Message from Medicare, applies to each individual who is entitled to benefits under Medicare Part A. Therefore, these requirements apply if a beneficiary is eligible for both Original Medicare and Medicaid (a dual eligible), is eligible for Original Medicare and another insurance program or payer, or has Medicare as a secondary payer. No matter where in the sequence of payers Medicare falls, these requirements still apply.*

Inpatient to Inpatient Transfers. *Beneficiaries who are being transferred from one inpatient hospital setting to another inpatient hospital setting, do not need to be provided with the follow-up copy of the notice prior to leaving the original hospital, since this is considered to be the same level of care. Beneficiaries always have the right to refuse care and may contact the QIO if they have a quality of care issue. The receiving hospital must deliver the Important Message from Medicare again according to the procedures in these instructions.*

Preadmission/Admissions for Services that are Not Reasonable and Necessary. When a Medicare beneficiary is planning to be hospitalized for services that Medicare usually pays for, but are not considered to be reasonable and necessary in this particular situation, hospitals must deliver a Preadmission/Admission Hospital Issued Notice of Noncoverage (HINN). (See Section 240 of this Chapter.) The Important Message from Medicare would be delivered only if the stay became a covered stay.

Admissions for Services that Medicare Never Covers. When a Medicare beneficiary is admitted for hospital services that are never covered by Medicare, hospitals may deliver the Preadmission/Admission HINN. The IM would be delivered only if the stay became a covered stay.

Change of Status from Inpatient to Outpatient. When a hospital utilization review committee determines that an inpatient admission does not meet the hospital's inpatient criteria, the hospital may change the beneficiary's status from inpatient to outpatient. See CR 3444 (Use of Condition Code 44) and MedLearn Matters article, SE0622, published on March 22, 2006, for notification requirements in this situation.

End of Part A days. For purposes of this instruction, the term discharge does not include exhaustion of Part A days, therefore, when a beneficiary exhausts Part A days, these requirements do not apply.

Hospital Requests QIO Review when the Physician does not Concur. There are separate existing requirements under 405.1208 for notifying a beneficiary when the hospital requests a QIO review. Hospitals should deliver the Notice of a Hospital Requested Review (HRR). (See Section 220 of this chapter.)

200.3 - Notifying Beneficiaries of their Right to an Expedited Review

(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

Hospitals must notify Medicare beneficiaries who are hospital inpatients about their hospital discharge appeal rights. Hospitals will use a revised version of the Important Message from Medicare (IM) a statutorily-required notice, to explain the beneficiary's rights as a hospital patient, including discharge appeal rights. Hospitals must issue the IM within 2 calendar days of admission, must obtain the signature of the beneficiary or his or her representative and provide a copy at that time. Hospitals will also deliver a copy of the signed notice as far in advance of discharge as possible, but not more than 2 calendar days before discharge.

200.3.1 - Delivery of the Important Message from Medicare.

(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

Hospitals must follow the procedures listed below in delivering the Important Message from Medicare (IM). Valid Notice consists of:

Use of Standardized Notice. *Hospitals must use the standardized form (CMS-R-193), see Section 200.6.2. The notices are also available on www.cms.hhs.gov/bni at the Link for Hospital Discharge Appeal Notices. Hospitals may not deviate from the content of the form except where indicated (see Section 200.6 on Completing the Notice). The OMB control number must be displayed on the notice.*

Delivery Timeframe. *Hospitals must deliver the original copy of the IM at or near admission, but no later than 2 calendar days following the date of the beneficiary's admission to the hospital.*

Hospitals may deliver the initial copy of the notice if the beneficiary is seen during a preadmission visit, but not more than 7 calendar days in advance of admission. If a beneficiary receives and signs the initial copy of the IM as part of the preadmission process, the follow-up copy of the notice must be delivered if delivery of the initial copy occurred more than 2 calendar days prior.

In-Person Delivery. *The IM must be delivered to the beneficiary in person. However, if the beneficiary is not able to comprehend the notice, it must be delivered to and signed by the beneficiary's representative.*

Notice Delivery to Representatives. *CMS requires that notification of a beneficiary who is not competent be made to a representative of the beneficiary. A representative is an individual who, under State or other applicable law, may make health care decisions on a beneficiary's behalf (e.g., the beneficiary's legal guardian, or someone appointed in accordance with a properly executed "durable medical power of attorney").*

Otherwise, a person (typically, a family member or close friend) whom the beneficiary has indicated may act for him or her, but who has not been named in any legally binding document may be a representative for purpose of receiving the notices described in this section. Such representatives should have the beneficiary's best interests at heart and must act in a manner that is protective of the beneficiary and the beneficiary's rights. Therefore, a representative should have no relevant conflict of interest with the beneficiary. A notifier (including the notifier's employees) that has a conflicting interest (such as shifting financial liability to the beneficiary) is not qualified to be a representative. (Note: If the beneficiary wishes to appoint a representative to file an appeal on his/her behalf, a valid Form 1696 or a conforming written instrument must be signed by both the beneficiary and the prospective representative and filed with the appeal request. See Medicare Claims Processing Manual, Publication 100-4, Ch. 29, Section 270 for specific instructions related to the use of Form 1696 and the appointment of representatives).

Notification to the representative may be problematic because that person may not be available in person to acknowledge receipt of the required notification. Hospitals are required to develop procedures to use when the beneficiary is incapable of receiving or incompetent to receive the notice, and the hospital cannot obtain the signature of the beneficiary's representative through direct personal contact.

Regardless of the competency of a beneficiary, if the hospital is unable to personally deliver a notice to a representative, then the hospital should telephone the representative to advise him or her of the beneficiary's rights as a hospital patient, including the right to appeal a discharge decision.

The information provided should include the following at a minimum:

- The name and telephone number of a contact at the hospital;*
- The beneficiary's planned discharge date, and the date when the beneficiary's liability begins;*
- The beneficiary's rights as a hospital patient, including the right to appeal a discharge decision;*
- How to get a copy of a detailed notice describing why the hospital and physician believe the beneficiary is ready to be discharged;*
- A description of the steps for filing an appeal;*
- When (by what time/date) the appeal must be filed to take advantage of the liability protections;*
- The entity required to receive the appeal, including any applicable name, address, telephone number, fax number or other method of communication the entity requires in order to receive the appeal in a timely fashion;*
- Direction to the 1-800-MEDICARE number for additional assistance to the representative in further explaining and filing the appeal; and*

The date the hospital conveys this information to the representative, whether in writing or by telephone, is the date of receipt of the notice. Confirm the telephone contact by written notice mailed on that same date. Place a dated copy of the notice in the beneficiary's medical file, and document the telephone contact with the beneficiary's representative (as listed above) on either the notice itself, or in a separate entry in the beneficiary's file or attachment to the notice. The documentation should indicate that the staff person told the representative the planned discharge date, the date the beneficiary's financial liability begins, the beneficiary's appeal rights, and how and when to initiate an appeal. The documentation should also include the name of the staff person initiating the contact, the name of the representative contacted by phone, the date and time of the telephone contact, and the telephone number called.

When direct phone contact cannot be made, send the notice to the representative by certified mail, return receipt requested, or other delivery method that requires signed verification of delivery. The date that someone at the representative's address signs (or refuses to sign) the receipt is the date received. Place a copy of

the notice in the beneficiary's medical file, and document the attempted telephone contact to the members' representative. The documentation should include: the name of the staff person initiating the contact, the name of the representative you attempted to contact, the date and time of the attempted call, and the telephone number called.

If both the hospital and the representative agree, hospitals may send the notice by fax or email, however, hospitals must meet the HIPAA privacy and security requirements.

Ensuring Beneficiary Comprehension. *Hospitals must make every effort to ensure the beneficiary comprehends the contents of the notice before obtaining the beneficiary's signature. This includes explaining the notice to the beneficiary if necessary and providing an opportunity for the beneficiary to ask questions. The hospital should answer all the beneficiary's questions orally to the best of its ability. The beneficiary should be able to understand that he or she may appeal a discharge decision without financial risk, but may have to pay for any services received after the discharge date if he or she stays in the hospital and does not appeal. Notices should not be delivered during an emergency, but should be delivered once the beneficiary is stable.*

These instructions do not preclude the use of assistive devices, witnesses, or interpreters for notice delivery. Thus, if a beneficiary is able to comprehend the notice, but either is physically unable to sign it or needs the assistance of an interpreter to translate it or an assistive device to read or sign it, valid delivery may be achieved by documenting use of such assistance.

Beneficiary Signature and Date. *The IM must be signed and dated by the beneficiary to indicate that he or she has received the notice and can comprehend its contents, unless an appropriate reason for the lack of signature is recorded on the IM, such as a properly annotated signature refusal (see below).*

Refusal to Sign and Annotation. *If a beneficiary refuses to sign the notice, hospitals may annotate the notice to indicate the refusal, and the date of refusal is considered the date of receipt of the notice. The annotation may be placed in the unused patient signature line, in the "Additional Information" section on page 2 of the notice or another sheet of paper may be attached to the notice, if necessary. Any insertions on the notice must be easy for the beneficiary to read in order for the notice to be considered valid. See also Section 200.5.6 - Insertions in Blanks.*

Notice Delivery and Retention. *Hospitals must give the original copy of the signed or annotated notice to the patient. Hospitals must retain a copy of the signed notice and may determine the method of storage that works within their existing processes, for example, storing a copy in the medical record or electronically.*

200.3.2 - The Follow-Up Copy of the Signed Important Message from Medicare.

(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

A “follow-up” copy of the signed IM must be delivered to the beneficiary using the following guidelines:

Delivery Timeframe. The follow-up copy must be delivered as far in advance of discharge as possible, but **no more** than 2 calendar days before the planned date of discharge. Thus, when discharge seems likely within 1- 2 calendar days, hospitals should make arrangements to deliver the follow-up copy of the notice, so that the beneficiary has a meaningful opportunity to act on it. However, when discharge cannot be predicted in advance, the follow-up copy may be delivered as late as the day of discharge, if necessary. If the follow-up copy of the notice must be delivered on the day of discharge, hospitals must give beneficiaries who need it at least 4 hours to consider their right to request a QIO review. Beneficiaries may choose to leave prior to that time, however, hospitals must not pressure a beneficiary to leave during that time period. If the hospital delivers the follow-up copy, and the beneficiary status subsequently changes, so that the discharge is beyond the 2-day timeframe, hospitals must deliver another copy of the signed notice again within 2 calendar days of the new planned discharge date. Hospitals may not develop procedures for delivery of the follow up copy routinely on the day of discharge.

Alternative to Delivery of the Signed Copy. A hospital may choose to deliver a new copy of the IM (not a copy of the signed IM) during the required timeframes; however, the hospital must obtain the beneficiary’s or representative’s signature and date on the notice again at that time.

Exception to Delivery of the Follow-Up Copy. If delivery of the original IM is within 2 calendar days of the date of discharge, no follow-up notice is required. For example, if a beneficiary is admitted on Monday, the IM is delivered on Wednesday and the beneficiary is discharged on Friday, no follow-up notice is required.

If a beneficiary receives and signs the initial copy of the IM as part of the preadmission process, the follow-up copy of the notice must be delivered if delivery of the initial copy occurred more than 2 calendar days prior.

Documentation. Hospitals must document timely delivery of the follow-up copy of the IM in the patient records, when applicable. Hospitals are responsible for demonstrating compliance with this requirement. If hospitals have processes in place to document delivery of other information related to discharge that includes a beneficiary signature and date, hospitals may include the follow-up copy of the notice in those documents. If there are no other existing processes in place, hospitals may use the “Additional Information” section of the IM to document

delivery of the follow-up copy, for example, by adding a line for the beneficiary's or representative's initials and date.

200.4 - Rules and Responsibilities when a Beneficiary Requests an Expedited Review

(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

A beneficiary has a right to request an expedited review by the QIO when a hospital (acting directly or through its utilization review committee), with physician concurrence, determines that inpatient care is no longer necessary.

200.4.1 - The Role of the Beneficiary and Liability

(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

Submitting a Request: *A beneficiary who chooses to exercise the right to an expedited review must submit a request to the QIO that has an agreement with the hospital where the beneficiary is an inpatient. In order to be considered timely, the request must be made no later than midnight of the day of discharge, may be in writing or by telephone, and must be before the beneficiary leaves the hospital. The beneficiary, upon request of the QIO, should be available to discuss the case. The beneficiary may, but is not required to, submit written evidence to be considered by the QIO.*

Timely Requests: *When the beneficiary makes a timely request for a QIO review – that is, requests a review no later than midnight of the day of discharge – the beneficiary is not financially responsible for inpatient hospital services (except applicable coinsurance and deductibles) furnished before noon of the calendar day after the date the beneficiary receives notification of the expedited determination from the QIO. Liability for further inpatient hospital services depends on the QIO decision:*

- **Unfavorable determination:** *If the QIO notifies the beneficiary that the QIO did not agree with the beneficiary, liability for continued services begins at noon of the day after the QIO notifies the beneficiary that the QIO agreed with the hospital's discharge determination, or as otherwise determined by the QIO.*
- **Favorable determination:** *If the QIO notifies the beneficiary that the QIO agreed with the beneficiary, the beneficiary is not financially responsible for continued care (other than applicable coinsurance and deductibles) until the hospital once again determines that the beneficiary no longer requires inpatient care, secures the concurrence of the physician responsible for the beneficiary's care or the QIO, and notifies the beneficiary with a follow-up copy of the IM.*

Untimely Requests: When the beneficiary fails to make a timely request for an expedited review, and remains in the hospital, he or she still may request an expedited review at any time, but the beneficiary may be held responsible for charges incurred after the day of discharge, or as otherwise stated by the QIO. If the QIO finds that the patient should have remained an inpatient, the hospital will refund the beneficiary any funds that were collected. When the beneficiary fails to make a timely request for an expedited review and is no longer an inpatient at the hospital, he or she may still request a QIO review within 30 calendar days of the date of discharge, or at any time for good cause.

200.4.2 - The Responsibilities of the Hospital.

(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

Provide the Detailed Notice of Discharge: When a QIO notifies the hospital that a beneficiary has requested an expedited review, the hospital must deliver a Detailed Notice of Discharge (the Detailed Notice) to the beneficiary as soon as possible but not later than noon of the day after the QIO's notification. If a beneficiary requests more detailed information prior to requesting a review, hospitals may deliver the detailed notice in advance of the beneficiary requesting a review.

Use of Standardized Notice. Hospitals must use the standardized form (CMS-10066), see Section 200.6.2. This notice is also available on www.cms.hhs.gov/bni at the Link for Hospital Discharge Appeal Notices. Hospitals may not deviate from the content of the form except where indicated (see Section 200.6.2 on Completing the Notice). The OMB control number must be displayed on the notice.

The Detailed Notice must be the standardized notice provided by CMS and contain the following:

- A detailed explanation why services are either no longer reasonable and necessary or are otherwise no longer covered.
- A description of any applicable Medicare coverage rule, instruction, or other Medicare policy, including information about how the beneficiary may obtain a copy of the Medicare policy. (See instructions for the Detailed Notice of Discharge at Section 200.6.3, Exhibit 2)
- Facts specific to the beneficiary and relevant to the coverage determination that are sufficient to advise the beneficiary of the applicability of the coverage rule or policy to the beneficiary's case.
- Any other information required by CMS.

Hospitals must follow requirements in Section 200.5.6 on Insertions in Blanks and Section 200.6. on Completing the Notices.

Provide Information to the QIO. Upon notification by the QIO of the beneficiary's request for an expedited review, the hospital must supply any and all information that the QIO needs to make the expedited determination, including copies of both the IM and the Detailed Notices. The hospital must furnish this information as soon as possible, but no later than noon of the day after the QIO notifies the hospital of the request. At the discretion of the QIO, the hospital may make the information available by telephone or in writing. A written record of any information not transmitted in writing should be sent as soon as possible. If the hospital fails to provide the needed information, the QIO may make a decision based on evidence at hand or defer the decision until it receives the necessary information. If this delay results in extended coverage of an individual's hospital services, the hospital may be held financially liable for those services, as determined by the QIO.

Burden of Proof. The burden of proof lies with the hospital to demonstrate that discharge is the correct decision, either on the basis of medical necessity or based on other Medicare coverage policies.

Provide the Beneficiary with Documentation if Requested. At the request of the beneficiary, the hospital must furnish the beneficiary with a copy of, or access to, any documentation that it sends to the QIO, including written records of any information provided by telephone. The hospital may charge the beneficiary a reasonable amount to cover the costs of duplicating the documentation and/or delivering it to the beneficiary. The hospital must accommodate the request by no later than the first day after the material is requested.

200.4.3 - The Role of the QIOs

QIO Availability. The QIO should have methods in place to accept requests for reviews outside of normal business hours, such as an answering machine message. QIOs will issue decisions within one calendar day after it receives all pertinent information.

Notify the hospital of the beneficiary's request for an expedited review. When the QIO receives the request from the beneficiary, the QIO must notify the hospital of the request immediately, or immediately in the morning if the request is received after the QIO's business hours.

Receive and Examine records. The QIO will examine medical and other records that pertain to the services in dispute.

Determine if the hospital delivered valid notice. The QIO will determine whether the hospital delivered valid notice, meaning that the notice is the standardized notice published by CMS, meets the notice delivery timeframes, and has been signed and dated by the beneficiary. If the QIO determines that the hospital did not deliver valid notice, the QIO will instruct the hospital to reissue the notice if

necessary, proceed with the review, and educate the hospital retrospectively. If the beneficiary or representative makes an untimely request for a review, and the QIO determines that the beneficiary did not receive valid notice, the QIO will determine the date the beneficiary becomes fully liable for the services.

Solicit the views of the beneficiary. *The QIO must solicit views of the beneficiary who requested the expedited review.*

Solicit the views of the hospital. *The QIO must provide an opportunity for the hospital to explain why the hospital and physician believe discharge is appropriate. The QIO may develop guidelines as to the form and extent of this opportunity.*

If needed information is not received. *If the QIO does not receive the information from the hospital needed to sustain the discharge decision, it may make its determination based on the evidence at hand or it may defer a decision until it receives the necessary information. If this delay results in extended Medicare coverage of an individual's hospital services, the hospital may be held financially responsible for these services as determined by the QIO.*

QIO Determination. *QIOs make their determinations based on criteria in §1154(a) of the Act, which specifies that QIOs will determine whether:*

- the services are reasonable and medically necessary,*
- the services meet professionally recognized standards of care, and*
- the services could be safely be delivered in another setting.*

Notification following a timely request. *When the beneficiary makes a timely request for an expedited review, the QIO must make its determination and notify the beneficiary, the hospital, and the physician of its determination within one calendar day after it receives all requested pertinent information. When the QIO issues an expedited determination, the QIO must notify the beneficiary, the hospital and the physician of its decision by telephone, followed by a written notice that must include the following information:*

- The basis for the determination.*
- A detailed rationale for the determination.*
- An explanation of the Medicare payment consequences of the determination and the date a beneficiary becomes fully liable for services.*
- Information about the beneficiary's right to an reconsideration of the QIO's determination, including how to request the reconsideration and the timeframe for doing so.*

Notification following an untimely request. *When the beneficiary makes an untimely request for an expedited review, and remains in the hospital, the QIO will make its determination and notify the beneficiary, the hospital, and the physician of its determination within 2 calendar days after it receives all*

requested pertinent information. When the beneficiary makes an untimely request for an expedited review, and is no longer an inpatient in the hospital, the QIO will make its determination and notify the beneficiary, the hospital, and the physician of its determination within 30 calendar days after it receives all requested pertinent information.

200.4.4 - Effect of a QIO Expedited Determination.

(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

The QIO determination is binding on the beneficiary, the physician, and hospital except in the following circumstances:

Right to pursue a reconsideration. *If the beneficiary is still an inpatient in the hospital and is dissatisfied with the determination, he or she may request a reconsideration according to the procedures described in 405.1204.*

Right to pursue the general claims appeal process. *If the beneficiary is no longer an inpatient in the hospital and is dissatisfied with this determination, the determination is subject to the general claims appeal process (See Chapter 29 of this manual.).*

200.5 - General Notice Requirements

(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

Since the Important Message from Medicare and the Detailed Notice of Discharge are OMB approved, standardized notices, hospitals must comply with the following General Notice Requirements:

200.5.1 - Number of Copies

(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

The Important Message from Medicare: *In most cases, a minimum of three copies of the Important Message from Medicare, including the original, will be needed. The beneficiary keeps the original signed notice and will receive a follow-up copy of the signed notice, except when delivery of the original notice falls within two days of discharge. The hospital must retain a copy of the signed IM and may do so electronically.*

The Detailed Notice: *A minimum of two copies of the Detailed Notice, including the original, will be needed. The beneficiary keeps the original notice. The hospital must retain a copy of the signed document and may do so electronically.*

Providing Copies to the QIO: *In addition to the above, if a beneficiary requests a review, hospitals are required to provide copies of both notice described in this section to the QIO.*

200.5.2 – Reproduction

(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

Hospitals may reproduce the notices by using self-carbonizing paper, photocopying the IM, or using another appropriate method. All reproductions must conform to applicable instructions.

200.5.3 - Length and Page Size

(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

***The Important Message from Medicare:** The IM must NOT exceed two sides of a page in length. The IM is designed as a letter-sized form. If necessary, it may be expanded to a legal-sized page to accommodate information hospitals insert in the notice, such as the hospital's name or logo.*

***The Detailed Notice:** The Detailed Notice must NOT exceed one side of a page in length. The Detailed Notice is designed as a letter-sized form. If necessary, it may be expanded to a legal-sized page to accommodate information hospitals may insert in the notice. Hospitals may attach applicable Medicare policies to the notice.*

200.5.4 - Contrast of Paper and Print

(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

A visually high-contrast combination of dark ink on a pale background must be used. Do not use reversed print (e.g., white on black), or block-shade (highlight) notice text.

200.5.5– Modification

(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

The notices described in this section may not be modified, except as specifically allowed by these instructions. In no case may either notice be condensed.

200.5.6– Font

(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

The IM and the Detailed Notice must meet the following font requirements in order to facilitate beneficiary understanding:

- ***Font Type:** To the greatest extent practicable, the fonts as they appear in the notices on the CMS Web site should be used. Any changes in the font type should be based solely on software and/or hardware limitations of the notices. Examples of easily readable alternative fonts include: Arial, Arial Narrow, Times New Roman, and Courier.*

- **Font Effect/Style:** Any changes to the font, such as italics, embossing, bold, etc., should not be used since they can make the notices more difficult to read.
- **Font Size:** The font size generally should be 12 point. Titles should be 18 point, but handwritten insertions in blanks of the IM can be as small as 10 point if needed.
- **Insertions in Blanks:** Information inserted by hospitals in the blank spaces on the IM and the Detailed Notice may be typed or legibly hand-written using the guidelines above.

200.5.7 - Customization:

(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

Hospitals are permitted to do some customization of IM or the Detailed Notice such as pre-printing agency-related information to promote efficiency and to ensure clarity for beneficiaries. Guidelines for customization are:

- Maintaining underlines in the blank spaces is not required.
- Information in blanks that is constant can be pre-printed, such as the hospital's name, QIO name and telephone number. Note the TTY phone number also needs to be entered.

200.5.8 - Retention of the Notices:

(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

Hospitals are required to retain copies of the signed notices and may do so either in hardcopy or electronically.

200.6 - Completing the Notices

(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

When completing the Important Message from Medicare and the Detailed Notice of Discharge, hospitals must utilize the following instructions:

200.6.1 - Translated Notices

(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

Both the "Important Message from Medicare" and the "Detailed Notice of Discharge" are available at <http://www.cms.hhs.gov/BNI/>. The notices will be available in English and Spanish, and in PDF and Word formats, under a dedicated link on the left hand margin: "Hospital Discharge Appeal Notices".

Hospitals should choose the appropriate version of the Important Message from Medicare and the Detailed Notice of Discharge based on the language the beneficiary best understands. When Spanish-language notices are used, the hospital should make insertions on the notice in Spanish. If this is impossible, additional steps need to be taken to ensure that the beneficiary comprehends the content of the notice.

**200.6.2 Exhibit 1 - Important Message from Medicare
(CMS-R-193) and form instructions
(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)**

Patient Name:

DEPARTMENT OF HEALTH & HUMAN SERVICES

Patient ID Number:

Centers for Medicare & Medicaid Services

Physician:

OMB Approval No. 0938-0692

AN IMPORTANT MESSAGE FROM MEDICARE ABOUT YOUR RIGHTS

AS A HOSPITAL INPATIENT, YOU HAVE THE RIGHT TO:

- *Receive Medicare covered services. This includes medically necessary hospital services and services you may need after you are discharged, if ordered by your doctor. You have a right to know about these services, who will pay for them, and where you can get them.*
 - *Be involved in any decisions about your hospital stay, and know who will pay for it.*
 - *Report any concerns you have about the quality of care you receive to the Quality Improvement Organization (QIO) listed here _____ {Insert Name and Telephone Number of the QIO} _____.*
-

YOUR MEDICARE DISCHARGE RIGHTS

Planning For Your Discharge: *During your hospital stay, the hospital staff will be working with you to prepare for your safe discharge and arrange for services you may need after you leave the hospital. When you no longer need inpatient hospital care, your doctor or the hospital staff will inform you of your planned discharge date.*

If you think you are being discharged too soon:

- *You can talk to the hospital staff, your doctor and your managed care plan (if you belong to one) about your concerns.*
- *You also have the right to an appeal, that is, a review of your case by a Quality Improvement Organization (QIO). The QIO is an outside reviewer hired by Medicare to look at your case to decide whether you are ready to leave the hospital.*
 - ***If you want to appeal, you must contact the QIO no later than your planned discharge date and before you leave the hospital.***

- *If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).*
- *If you do not appeal, but decide to stay in the hospital past your planned discharge date, you may have to pay for any services you receive after that date.*
- ***Step by step instructions for calling the QIO and filing an appeal are on page 2.***

To speak with someone at the hospital about this notice, call

_____.

Please sign and date here to show you received this notice and understand your rights.

Signature of Patient or Representative

Date

STEPS TO APPEAL YOUR DISCHARGE

- **STEP 1:** You must contact the QIO no later than your planned discharge date and before you leave the hospital. If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).
 - Here is the contact information for the QIO:
 {insert name of QIO in bold}
 {insert telephone number of QIO}
 - You can file a request for an appeal any day of the week. **Once you speak to someone or leave a message, your appeal has begun.**
 - Ask the hospital if you need help contacting the QIO.
 - The name of this hospital is {insert the name of the hospital and the provider ID number}.
- **STEP 2:** You will receive a detailed notice from the hospital or your Medicare Advantage or other Medicare managed care plan (if you belong to one) that explains the reasons they think you are ready to be discharged.
- **STEP 3:** The QIO will ask for your opinion. You or your representative need to be available to speak with the QIO, if requested. You or your representative may give the QIO a written statement, but you are not required to do so.
- **STEP 4:** The QIO will review your medical records and other important information about your case.
- **STEP 5:** The QIO will notify you of its decision within 1 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.
 - If the QIO finds you are ready to be discharged, Medicare will continue to cover your services until noon of the day after the QIO notifies you of its decision.

IF YOU MISS THE DEADLINE TO APPEAL, YOU HAVE OTHER APPEAL RIGHTS:

- You can still ask the QIO or your plan (if you belong to one) for a review of your case:
 - If you have Original Medicare: Call the QIO listed above.
 - If you belong to a Medicare Advantage Plan or other Medicare managed care plan: Call your plan.
- If you stay in the hospital, the hospital may charge you for any services you receive after your planned discharge date.

For more information, call 1-800-MEDICARE (1-800-633-4227), or TTY: 1-877-486-2048.

Additional Information:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0692. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Notice Instructions
The Important Message from Medicare (OMB #0938-0692) (CMS-R-193)

Completing the Notice

PAGE 1 of the Important Message from Medicare

A. Header

Hospitals must display “DEPARTMENT OF HEALTH & HUMAN SERVICES, Centers for Medicare & Medicaid Services” and the OMB number.

The following blanks must be completed by the hospital. Information inserted by hospitals in the blank spaces on the IM may be typed or legibly hand-written in 12-point font or the equivalent. Hospitals may also use a patient label that includes the following information:

Patient Name: *Fill in the patient’s full name.*

Patient ID number: *Fill in an ID number that identifies this patient. This number should not be, nor should it contain, the social security number.*

Physician: *Fill in the name of the patient’s physician.*

B. Body of the Notice

Bullet # 3 Report any concerns you have about the quality of care you receive to the Quality Improvement Organization (QIO) listed here _____.
Hospitals may preprint or otherwise insert the name and telephone number (including TTY) of the QIO.

To speak with someone at the hospital about this notice call: *Fill in a telephone number at the hospital for the patient or representative to call with questions about the notice. Preferably, a contact name should also be included.*

Patient or Representative Signature: *Have the patient or representative sign the notice to indicate that he or she has received it and understands its contents.*

Date: *Have the patient or representative place the date he or she signed the notice.*

PAGE 2 of the Important Message from Medicare

First sub-bullet - Insert name and telephone number of QIO in BOLD: *Insert name and telephone number (including TTY), in bold, of the Quality Improvement Organization that performs reviews for the hospital.*

Second sub-bullet – The name of this hospital is: Insert/preprint the name of the hospital, including the Medicare provider ID number (not the telephone number).

Additional Information: Hospitals may use this section for additional documentation, including, for example, obtaining beneficiary initials to document delivery of the follow-up copy of the IM, or documentation of refusals.

**200.6.3 Exhibit 2 – The Detailed Notice of Discharge (CMS 10066)
and form instructions**

(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

Patient Name: _____ OMB Approval No. 0938-1019
Patient ID Number: _____ Date Issued: _____
Physician: _____

{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}.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1019. The time required to complete this information collection is estimated to average 60 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10066 (approved 5/2007)

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 HICN number.*

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.

220 – Hospital Requested Expedited Review

(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

When a hospital determines that a beneficiary no longer needs inpatient care, but is unable to obtain the agreement of the physician, the hospital may request a QIO review. Hospitals must notify the beneficiary that the review has been requested. These instructions stem directly from Section 1154(e) of the Act and 42 CFR Part 405.1208.

220.1 – Responsibilities of the Hospital

(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

The hospital must comply with the following procedures when requesting a QIO review:

Notify the Beneficiary. *Hospitals must notify the beneficiary that the hospital has requested a review using a model language notice called the Hospital Requested Review (HRR) described in this section. See Section 220.4 for General Notice Requirements.*

Supply information to the QIO. *Hospitals must supply any pertinent information the QIO needs to conduct its review and must make it available by phone or in writing, by close of business on the first full day immediately following the day the hospital submits the request for review.*

220.2 – Responsibilities of the QIO

(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

The QIO's responsibilities are as follows:

Receive request and examine records. *The QIO must notify the hospital that it has received the request for review and must notify the hospital if it has not received pertinent records, examine the pertinent records pertaining to the services, and solicit the views of the beneficiary.*

Issue a determination. *QIOs make their determinations based on criteria in §1154(a) of the Act, which specifies that QIOs will determine whether:*

- the services are reasonable and medically necessary,*
- the services meet professionally recognized standards of care, and*
- the services could be safely be delivered in another setting.*

The QIO will make a determination and notify the beneficiary, the hospital, and the physician of its decision within 2 days of the hospital's request and receipt of any pertinent information submitted by the hospital.

Notification. When the QIO issues the determination, it must notify the beneficiary, the hospital, and the physician of its decision by telephone and subsequently in writing. The written notice of the expedited initial determination must contain the following:

- The basis for the determination;
- A detailed rationale for the determination;
- A statement explaining the Medicare payment consequences of the expedited determination and the date of liability if any; and
- A statement informing the beneficiary of his or her appeal rights and the timeframe for requesting an appeal.

220.3 – Effect of the Hospital Requested Expedited Determination (Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

The expedited determination is binding on the beneficiary, physician, and hospital, except in the following circumstances:

When the beneficiary remains in the hospital. When the beneficiary is still an inpatient in the hospital and is dissatisfied with this determination, he or she may request a reconsideration according to the procedures described in Section 300 of this Chapter.

When the beneficiary is no longer an inpatient in the hospital. If the beneficiary is no longer an inpatient in the hospital and is dissatisfied with this determination, this determination is subject to the general claims appeal process (See Chapter 29 of this manual).

220.4 – General Notice Requirements (Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

Providers should use the HRR to notify a beneficiary that it has requested a QIO review. This notice can be found at www.cms.hhs.gov/bni. Since the HRR uses model language, providers have some flexibility in the preparation of this notice. However, it is highly recommended that hospitals use the model language provided in this instruction, or by their QIO, in order to avoid questions of invalid notice. Providers should utilize the General Notice Requirements in Section 200.5 and the Translation requirements in Section 200.6.1 when preparing the notice.

240 – Preadmission/Admission Hospital Issued Notice of Noncoverage (HINN).

(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

*Regulations found at 42 CFR Part 476.71 require QIOs to review the medical necessity of hospital discharges **and admissions**, in addition to other requirements specified in that section of the regulation. Therefore, a beneficiary has a right to request an expedited review by the QIO when a hospital (acting directly or through its utilization review committee) has determined at the time of preadmission or admission, that the beneficiary is facing a non-covered hospital stay because the services are not considered to be reasonable and necessary in this case, the services could be safely provided in another setting, or the care is considered custodial in nature.*

The utilization review committee or the hospital may issue a preadmission/admission HINN. QIOs may also issue such notices after having been contacted by a hospital regarding care believed to be medically unnecessary, inappropriate, or custodial. The hospital need not obtain the attending physician's concurrence, or the QIO's, prior to issuing the preadmission/admission HINN. This also applies to direct admissions to swing beds (i.e., the beneficiary is admitted to the swing bed when the hospital determines that the beneficiary does not need hospital-level care, but instead needs only skilled nursing (SNF) or custodial nursing (NF) level services services).

240.1 – Delivery of the Preadmission/Admission HINN

(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

When delivering the Preadmission/Admission HINN, hospitals must follow the notice delivery requirements in Section 200.3.1 regarding

- *In-Person Delivery,*
- *Notice Delivery to Representatives,*
- *Ensuring Beneficiary Comprehension.*
- *Beneficiary Signature and Date.*
- *Refusal to Sign.*
- *Notice Delivery and Retention.*

240.2 - Notice Delivery Timeframes and Liability

(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

Preadmission: *In preadmission situations, the beneficiary is liable, if admitted, for customary charges for all services furnished during the stay, except for those services for which he or she is eligible to receive payment under Part B.*

Admission: *If the admission notice is issued at 3 p.m. or earlier on the day of admission, the beneficiary is liable for customary charges for all services furnished after receipt of the notice, except for those services for which the beneficiary is eligible to receive payment under Part B.*

If the admission notice is issued after 3 p.m. on the day of admission, the beneficiary is liable for customary charges for all services furnished on the day following the day of receipt of the notice, except for those services for which the beneficiary is eligible to receive payment under Part B.

240.3 – Timeframes for Submitting a Request for a QIO Review
(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

Preadmission: *In preadmission situations, a beneficiary who chooses to exercise the right to a QIO review should request immediately, but no later than 3 calendar days after receipt of the notice, or if admitted, at any point during the stay, an immediate review of the facts related to the admission.*

Admission: *In admission situations, a beneficiary who chooses to exercise the right to a QIO review should request immediately, or at any point in the stay, an immediate review of the facts related to the admission.*

240.4– Results of the QIO Review.
(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

If the QIO disagrees with the hospital’s determination and says the stay is reasonable and necessary, the beneficiary will be refunded any amount collected except applicable coinsurance and deductibles, and convenience items or services not covered by Medicare.

If the QIO agrees with the hospital determination and says the stay is not reasonable and necessary, the beneficiary will be responsible for all services on the date specified by the QIO.

240.5 – Effect of the QIO Review
(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

The QIO will send the beneficiary a formal determination of the medical necessity and appropriateness of the hospitalization determination is binding on the beneficiary, the physician, and hospital except in the following circumstances:

Right to pursue a reconsideration. *If the beneficiary is still an inpatient in the hospital and is dissatisfied with the determination, he or she may request a reconsideration according to the procedures described in §405.1204 (See Section 300 of this chapter.)*

Right to pursue the general claims appeal process. *If the beneficiary is no longer an inpatient in the hospital, the determination is subject to the general claims appeal process (See Chapter 29 of this manual.)*

**240.6 – Exhibit 4 – Model Language for Preadmission/Admission
Hospital Issued Notice of Noncoverage.**
(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

Hospital Identifier

Preadmission or Admission Hospital-Issued Notice of Noncoverage (HINN)
Model Language

Name of Patient: _____ Name of Physician: _____
Patient ID Number: _____ Date Issued: _____

We believe that Medicare is not likely to pay for your admission for
_____ (specify service or condition) _____ because:

_____ it is not considered to be medically necessary

_____ it could be furnished safely in another setting

_____ other _____.

However, this notice is not an official Medicare decision.

If you disagree with our finding:

- You should talk to your doctor about this notice and any further health care you may need.
- You also have the right to an appeal, that is, an immediate review of your case by a Quality Improvement Organization (QIO). The QIO is an outside reviewer hired by Medicare to make a formal decision about whether your admission is covered by Medicare. **See page 2 for instructions on how to request a review and contact the QIO.**
- **If you decide to go ahead with the hospitalization, you will have to pay for:**

CONTINUED ON PAGE 2

¹ For preadmission notices, insert: "customary charges for all services furnished during the stay, except for those services for which you are eligible under Part B."

For admission notices issued not later than 3:00 P.M. on the date of admission, insert: "customary charges for all services furnished after receipt of this hospital notice, except for those services for which you are eligible under Part B." (If these requirements are not met, insert the liability phrase below.)

For admission notices issued after 3:00 P.M. on the day of admission, insert: "customary charges for all services furnished on the day following the day of receipt of this notice, except for those services for which you are eligible to receive payment under Part B."

If you want an immediate review of your case:

_____ (insert one of the following as appropriate)

Preadmission:

- Call the QIO immediately at the number listed below, but no later than 3 calendar days after you receive this notice. If you are admitted, you may call the QIO at any point in the stay.

Admission:

- Call the QIO immediately at the number listed below or you may call the QIO at any point during your stay.
- You may also call the QIO for quality of care issues.

QIO Contact Information: _____ (insert name of QIO in bold)
_____ (insert telephone number of QIO)

If you do not want an immediate review:

- You may still request a review within 30 calendar days from the date of receipt of this notice by calling the QIO at the number below.

Results of the QIO Review:

- The QIO will send you a formal decision about whether your hospitalization is appropriate according to Medicare's rules, and will tell you about your reconsideration and appeal rights.
 - IF THE QIO FINDS YOUR HOSPITAL CARE IS COVERED, you will be refunded any money you may have paid the hospital except for any applicable copays, deductibles, and convenience items or services normally not covered by Medicare.
 - IF THE QIO FINDS THAT YOUR HOSPITAL CARE IS NOT COVERED, you are responsible for payment for all services beginning on _____ (specify date) _____. (see footnote¹ on page 1).

For more information, call 1-800-MEDICARE (1-800-633-4227), or TTY: 1-877-486-2048.

Please sign your name, the date and time. Your signature does not mean that you agree with this notice, just that you received the notice and understand it.

Signature of Patient or Representative

Date

Time

260 – Expedited Determination Process for Provider Services Terminations

(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

<Placeholder>

300 – Expedited Reconsiderations

(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

A beneficiary who is dissatisfied with a QIO determination can request a reconsideration by an independent review entity (IRE). Such reconsiderations are codified in regulations effective July 1, 2005 (42 CFR 405.1204) but are familiar to inpatient hospital providers as the process previously available under §1155 of the Act. This reconsideration process is the same for hospital and non-hospital providers.

300.1 - The Role of the Beneficiary and Liability

(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

Submitting a Request: *A beneficiary who chooses to exercise the right to an expedited reconsideration must submit a request to the appropriate IRE in writing or by telephone no later than noon of the calendar day following the initial notification (whether by telephone or in writing) of the QIO's determination. The beneficiary, upon request of the QIO, should be available to discuss the case or supply information that the IRE may request. The beneficiary may, but is not required to, submit written evidence to be considered by the IRE.*

Untimely Requests: *When the beneficiary fails to make a timely request for an expedited reconsideration subsequently may request a reconsideration under the standard claims appeal process (See Chapter 29 of this Manual), but the coverage protection described in Section 300.5 would not extend through this reconsideration, nor would the notification timeframes or the escalation process described in Section 300.2 apply.*

300.2 – The Responsibilities of the IRE

(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

Receipt of the Request. *On the day the IRE receives the request for an expedited reconsideration, the IRE must immediately notify the QIO that made the expedited determination and the provider of services of the request for the expedited reconsideration.*

Examine Records and Other Information. *The IRE must offer the beneficiary and the provider an opportunity to provide further information.*

Notification. *Unless the beneficiary requests an extension (see below), the IRE must notify the QIO, the beneficiary, and the provider of services of its decision no later than 72 hours after receipt of the request for an expedited reconsideration, and any such records needed for the reconsideration. The initial notification may be done by telephone followed by a written notice that includes:*

- *The rationale for the reconsideration decision,*
- *An explanation of the Medicare payment consequences of the determination and the beneficiary's date of liability,*
- *Information about the beneficiary's right to appeal the IRE's reconsideration decision to an ALJ, including how to request an appeal and the time period for doing so.*

Escalation. *Unless the beneficiary requests an extension, if the IRE does not issue a decision within 72 hours of receipt of the request, the IRE must notify the beneficiary of his or her right to have the case escalated to the ALJ hearing level if the amount remaining in controversy is \$100 or more.*

Extensions. *A beneficiary who requests an expedited reconsideration may request (either in writing or orally) that an IRE grant such additional time as the beneficiary specifies (not to exceed 14 days) for the reconsideration. If an extension is granted, the deadlines described above under notification, do not apply.*

300.3 - The Responsibilities of the QIO.

(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

When an IRE notifies the QIO that a beneficiary has requested an expedited reconsideration, the QIO must supply all information that the IRE needs to make its expedited reconsideration as soon as possible, but no later than by close of business of the day that the IRE notifies the QIO of the request for the reconsideration.

At the beneficiary's request, the QIO must furnish the beneficiary with a copy of, or access to, any documentation that it sends to the IRE. The QIO may charge the beneficiary a reasonable amount to cover the costs of duplicating the documentation and/or delivering it to the beneficiary. The QIO must accommodate the request by no later than close of business of the first day after the material is requested.

300.4 - The Responsibilities of the Provider.

(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

The provider may, but is not required to, submit evidence to be considered by an IRE in making its decision. If a provider fails to comply with an IRE's request for additional information beyond that furnished by the QIO for purposes of the expedited determination, the IRE makes its reconsideration decision based on the information available.

300.5 – Coverage During an Expedited Reconsideration.

(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

When a beneficiary makes a timely request for an expedited determination, the provider may not bill the beneficiary for any disputed services until the IRE makes its determination. Beneficiary liability for continued services is based on the QIO's decision.