

Weichardt Frequently Asked Questions

1. Implementation

Q. Considering the operational impact on hospitals and Medicare health plans, can CMS extend the implementation date of these forms and regulatory changes to a later date until the forms (Important Message, Detailed Notice, and HINNs) can all be updated - and the entire process can be documented?

A. The regulatory implementation date was made public last November and the new Important Message from Medicare and Detailed Notice have been available since late May. CMS has no authority to delay implementation, particularly in light of the Weichardt lawsuit settlement agreement. Thus, we expect hospitals and Medicare health plans to make a good faith effort to implement this process in a timely fashion. Our HINN policy is addressed in a subsequent Q and A.

Q. For beneficiaries who are already inpatients on or after July 2, what notice do they receive if they appeal their discharge decision to the QIO?

A. Patients who are admitted on or after July 2 must receive a copy of the new IM within 2 days of admission. If discharge is more than 2 days after delivery of the initial IM, a follow-up copy of the signed IM must be provided at discharge, and if they request QIO review, the Detailed Notice must be provided as well.

Although hospitals are not required to go back and issue the new IM to Medicare beneficiaries who were already inpatients prior to July 2, they should issue a copy of the new IM to these patients when they are discharged, and if they request QIO review, a copy of the Detailed Notice should be provided.

2. Representatives

Q. When a patient is not competent, the representative cannot be located, and/or there is no current phone number and/or address, what process meets CMS requirements?

A. We recognize that any type of notice delivery requirement, particularly in the acute care setting, raises questions about authorized representatives. However, the need to identify appropriate individuals to deal with in these situations is not new or limited to these notices. Thus, hospitals should have processes in place for identifying an individual who can act on behalf of an incompetent patient. In some cases, State law addresses cases where hospital, nursing home administrators, or the like can act as representatives or guardians for purposes of making these decisions.

Q. A representative cannot be reached by phone, e-mail, or facsimile. For contact by certified letter, must a hospital keep the patient until it gets the signed card back from the US Mail?

A. Providers have the flexibility to select a means of delivery that is most appropriate for their operations (e.g. US mail, FedEx, UPS, or a phone/faxed response). If a representative is to be contacted using certified US mail, hospitals should initiate the process in a timely fashion that will allow return of the card before discharge. If the card indicates a refusal to sign or that the notice is undeliverable, the hospital may proceed accordingly. (Please refer to the Manual Instructions in Chapter 30, Section 200.3.1, Delivery of the Important Message from Medicare, subsection Notice Delivery to Representatives).

3. Documentation of the IM Follow-Up Copy

Q. Is it necessary to obtain the patient's signature on the follow-up copy of the CMS-R-193 that is given at discharge? Will documentation that the Important Message was given again and reviewed with the patient be sufficient without obtaining the patient's signature?

A. We strongly recommend that hospitals obtain the signature or initials of the patient when delivery of the follow-up copy is necessary. Although a signature is not required, we believe it constitutes the best method of documenting delivery of the follow-up copy of the IM. Other methods of documentation are acceptable (e.g., a discharge document check list), provided that surveyors can ascertain that the notice was delivered. Whatever method is used, hospitals must be able to demonstrate compliance with the rules requiring a timely delivery of a follow-up copy to a patient within 2 days before discharge.

Q. If hospitals use a new blank IM for the follow-up copy and obtain a signature on the form, do they keep that form in the medical record (permanent) or do they just give it to the patient?

A. You may either make a copy of the new signed IM and put the copy in the patient record, or keep the signed page 1 for the medical record and give page 2 to the patient.

4. Inpatient to Inpatient Transfers

Q. Two hospitals have different Medicare ID (provider) numbers. Patients are transferred from one facility to the other for other inpatient care. Sometimes, patients are returned to the initiating facility, while other times they remain at the second facility to later be discharged or moved to a lower level of care. Does the sending hospital need to issue a follow-up copy of the IM? Does the receiving facility need to issue a new IM?

A. Regardless of the hospital affiliation, the receiving hospital/unit would provide a new IM if the transfer involves different Medicare ID (provider) numbers. However, no follow-up copy is needed prior to leaving the sending hospital/unit if the transfer is an inpatient to inpatient hospital level of care. The hospital/unit ultimately responsible for discharging (releasing or lowering the level of care) the patient would provide the follow-up copy if more than 2 days have passed since the last IM was delivered.

Whenever the sending and receiving unit has the same provider number, no follow-up copy and no new IM is required. Hospitals would operate as if it is continual inpatient care from the same facility.

5. Payment and Placement Issues after Covered Inpatient Care Ends

Q. What if a patient no longer needs an inpatient level of care but there are no plans to discharge the patient? How would the patient know that they are financially responsible for the remaining days in the hospital?

A. When the hospital determines that a patient who is in a Medicare-covered stay no longer meets inpatient hospital criteria, the follow up copy of the IM should be given. If a review is requested, the QIO will determine if it is appropriate to end the inpatient level of care. If the QIO agrees with the hospital, the patient would receive a liability notice (ABN) to notify the patient that Medicare will no longer cover his or her stay.

Q. During a QIO review, a skilled bed once available before discharge is no longer available. Does hospital have any option other than to begin the skilled bed search again? Is there patient liability in this situation? If QIO review upholds the hospitals decision to end inpatient care, is the patient liable if the bed is still available but he or she refuses to accept it, but not liable if the bed is no longer available?

A. If the QIO review upholds the discharge decision, patient liability begins as soon as a SNF or swing bed placement is available. Note that the hospital may have up to two Medicare-paid grace days to find another skilled bed (See Chapter 30 of the Claims Processing Manual for more information).

6. HINNs

Q. Please clarify which HINNs will remain in use after July 2nd and which HINNs will be retired.

A. HINNs 1, 10, and 11 will continue to be used. See Section 240 of Chapter 30 for instructions on the use of the revised HINN 1. Also, please refer to Section 220 of Chapter 30 for the instructions on the use of HINN 10. The instructions for HINN 11 can be found in Transmittal CY 2006 982 (CR5070). HINNs 2 through 9 will be retired. Instructions for the new Section 1879 liability notice are forthcoming.

Q. Please clarify which notice(s) should be issued when moving patients from acute care to swing beds and also from swing beds to custodial care. Should hospitals continue giving HINNs for this purpose?

A. Effective July 2, only the follow-up copy of the IM would be required when moving a patient from an acute level of care to a covered swing bed level of care to inform the beneficiary of his/her right to a QIO review of the end of a covered inpatient hospital stay. When moving a patient from an acute level of care to a noncovered swing bed or custodial level of care, HINN 1 must be issued (see Section 240 of Chapter 30 for revised instructions on HINN 1).

Q. Please explain the difference between the new inpatient hospital stay ABN and the general ABN that is used for outpatient care.

A. The inpatient hospital stay ABN is used for patients receiving inpatient care. The general ABN is used for patients receiving outpatient care.

7. Managed Care

Q. Are Medicare Health Plans responsible for delivering the Important Message to their enrollees who are inpatients?

A. No, hospitals are responsible for delivering the Important Message to all Medicare inpatients, whether they are in original Medicare or enrolled in a Medicare health plan.

Q. When the Medicare health plan and physician want to discharge the patient but the hospital disagrees, how do the parties proceed?

A. CMS expects physicians, plans and hospitals to continue working together in developing appropriate discharge plans for patients. This is a normal part of the business coordination that takes place between plans and hospitals. Nevertheless, since the Medicare health plan is responsible for the Detailed Notice (DN) and can make the discharge decision in consultation with the attending physician, the reasons for the discharge should reflect the plan's determination, even if delivery of the DN is delegated to the hospital.

Q. What process can a patient use to appeal a discharge decision if the patient has exhausted Part A days but is utilizing inpatient days offered by the Medicare health plan as part of his or her benefit package?

A. In cases where a patient's Medicare Part A days are exhausted, the QIO does not have authority to review additional plan specific benefits beyond those guaranteed to all enrollees under Title XVIII. However, much like an optional supplemental benefit, the enrollee could file an expedited appeal with the plan, and, if necessary, subsequently appeal to CMS' independent review entity, and an ALJ.

Q. How will CMS monitor Medicare health plans for compliance?

A. In the new notice deliver process, the plans' primary responsibility is to deliver the Detailed Notice (DN) when enrollees request a QIO review. Thus, CMS will work with the QIOs to monitor timely delivery of the DN by plans.

Q. When a plan delegates delivery of the Detailed Notice (DN) to a hospital, does it delegate only the delivery or can it include the hospital giving its own information on the DN, including its own reasons for discharge? If the hospital is giving this notice to a plan enrollee, must it put the plan logo on the DN, or can it use its own logo?

A. The level of delegation is the decision of the plan and the hospital. Typically, plans delegate the entire process (developing and delivering the DN) and may continue doing so under the new process. CMS views a contracted hospital as part of the plan, since it is part of the enrollee's network. Thus, even when this responsibility is delegated, plans are ultimately responsible for the delivery and content of the notices, and financially liable for the inpatient stay. Therefore, plans have incentive to ensure that delivery of the DN is executed properly. However, nothing prevents a plan from developing its own DN, with its own letterhead and/or contact information, and delegating just the delivery of the notice to the hospital. Again, these details are contractual issues between the hospital and the plan.

8. Important Message from Medicare

Q. When the hospital delivers the Important Message at or near admission, does it keep the original IM signed by the patient, or does it keep the copy of the signed IM?

A. The hospital may decide who keeps the original and who keeps a copy of the signed Important Message.

We recognize that this is a change from the initial guidance provided in the manual instructions. However, based on hospital comments received following implementation, we believe that this change will make the process easier to administer. We will incorporate this change into the manual instructions for both original Medicare and managed care in the near future.

Q. Which ID number do hospitals put on page 2 of the Important Message from Medicare, the current hospital provider number or the new NPI?

A. Many QIOs have limited access to NPI numbers. Therefore, you should use either the current hospital provider number or both numbers, unless your QIO specifically instructs you to use only the NPI number.

9. Monitoring

Q. How will these requirements be monitored and what are the repercussions?

- A. State surveyors will monitor compliance with these requirements as part of the hospital survey process. To assess hospital compliance, surveyors will:
- review open medical records after inpatient admission and at the time of discharge;
 - interview staff regarding hospital policies and procedures related to providing patients with advance written notice of hospital discharge appeal rights and the follow up notification;
 - interview hospital staff about the actual implementation of these policies and procedures; and
 - interview patients to evaluate whether the hospital reviews the document with patients and answers any questions on admission as well as if the hospital conducts the follow up notification as required.

Non-compliance will be handled the same way any other areas of non-compliance are handled. Depending on the level of non-compliance, a hospital could be cited at either the standard or condition level, and the compliance issue would need to be addressed in the hospital's plan of correction. Continuing non-compliance could ultimately jeopardize a hospital's participation in the Medicare program. However, hospitals will be given ample opportunity to come into compliance before this course of action would be contemplated.

10. Documentation Rules During a QIO Review

Q. In the Detailed Notice Instructions, hospitals are asked to provide patients with an example of "policies used to decide discharge date". Criteria such as InterQual are proprietary and may not be copied. How do hospitals handle such a request? Also, if the patient requests a review by the QIO, what documents would the hospital provide? Copies of discharge orders and/or physician progress notes?

A. When asked to do so, hospitals should provide patients with all non-proprietary documentation that was sent to the QIO. For proprietary information, we expect hospitals and plans to describe the applicable criteria in plain language that is understandable by the patient.

Q. If a patient appeals, do hospitals provide 2 to 3 days of acute rehabilitation therapy until the QIO makes its decision?

A. Consistent with the hospital COPs, a patient who is awaiting a QIO decision should receive all appropriate care to meet the patient's medical needs.

11. Notice Instructions – Distribution

Q. Are the instructions (page 3 of the IM and page 2 of the DN) for hospital use only or do patients receive a copy of them?

A. The instructions are to help hospitals and plans complete the forms. Patients do not receive a copy of the instructions.

12. QIO Operations – Coordination with the Hospital

Q. How does a QIO know who to contact at the hospital and what means will they use to contact this person?

A. This will vary, depending on how much information the patient has in hand when they call the QIO and on each hospital's operational structure. Most QIOs contact the case management department initially. However, the new IM has a blank space for the provider to supply a name and number for the patient to get more information about their discharge, so the QIO may obtain this name and number from the patient. Otherwise, the main hospital number may be called and the case management department or on-call person contacted.

When requesting the medical record, the QIO will either fax a request to the case manager or other staff with whom they have been communicating, or contact the medical record department directly. However, many providers will not have a medical records person working regular hours on weekends and holidays, so this will have to be coordinated. Some QIOs and providers are discussing adding a Fast Track contact for discharge appeals to the provider contacts in the Program Resource System (PRS) database. QIOs maintain a list of authorized contacts in PRS for various functions, quality review, medical records, Task 1 activities, etc. As a last resort, the QIO would contact the designated liaison. It will be to the provider's advantage to have a contact person readily available for QIOs to use, to ensure there is no delay in sending the QIO the necessary information to perform the review.

13. Questions about the hospital and managed care instructions

Q. Section 200.5.1 of the Instructions states (Chapter 30 of the Medicare Claims Processing Manual) that “the hospital must retain a copy of the signed [detailed notice] and may do so electronically”. Is a signature required on the detailed notice?

A. No, while hospitals may obtain a signature on the detailed notice, it is not a requirement. We will correct this statement in the next update to the manual.

Q. The June 1, 2007 HPMS memorandum titled “Immediate Review Process for Hospital Inpatients in Medicare Health Plans” states, on page 5, that “an enrollee has the right to request an immediate review by the QIO when the Medicare health plan **and** (*emphasis added*) the hospital, with physician concurrence, determine that inpatient care

is no longer necessary”. Do the physician, plan, and hospital have to agree about the discharge decision?

A. As noted in a previous Q&A, CMS expects physicians, plans and hospitals to continue working together in developing appropriate discharge plans for patients. We further believe that in most cases the physician, plan, and hospital will agree about the appropriateness of the discharge decision. However, we acknowledge that hospital concurrence is not needed if the physician and plan agree that discharge is appropriate.