

Original Medicare and Medicare Advantage Plan Discharge Appeals Process

Medicare beneficiaries and Medicare Advantage (MA) plan enrollees who are hospital inpatients have a statutory right to appeal to a Medicare Quality Improvement Organization (QIO) for an expedited review of a discharge decision.

The instructions that follow come directly from regulations at 42 CFR 405.1205 and 405.1206 for original Medicare and 42 CFR 422.620 and 422.622 for MA plans. These regulations 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 is section 1866(a)(1)(M), 1869(c)(3)(C)(iii)(III), and 1154 (a) of the Social Security Act. The Medicare Claims Processing Manual (Pub 100-04), Chapter 30, and the Medicare Managed Care Manual (Pub 100-16), Chapter 13, will be revised to include detailed instructions for providers to follow to comply with notice requirements.

Questions related to monitoring of delivery of notice should be directed to CBC/CMS mailbox at: Weichardt_ODF@cms.hhs.gov . QIOs will check for valid delivery of notices during an appeal, and address issues with provider education, but won't be involved in any other monitoring for notice delivery.

Important Message from Medicare

Hospitals must notify Medicare beneficiaries and MA enrollees who are hospital inpatients about their rights as a hospital patient, including discharge appeal and general liability rights. Hospitals will use a revised version of the Important Message from Medicare (IM), a statutorily required notice, to explain these rights.

Notice Delivery

Hospitals must issue an Important Message from Medicare notice within two calendar days of admission and obtain the signature of the patient or representative to indicate understanding. A copy should be provided to the patient/representative, and a copy of the IM should be kept by the facility. The initial copy of the IM may be delivered at the time of a preadmission or registration visit, but not more than 7 calendar days prior to the actual admission.

Hospitals will also deliver a follow-up IM as far in advance of discharge as possible, but not more than two calendar days before discharge. If the initial IM was received and signed as part of preadmission registration, and this occurred more than 2 calendar days prior to discharge, a follow up copy of the notice is required.

In cases in which the date of the delivery of the initial copy of the notice was within two calendar days of discharge, no follow-up copy is required. For example, if the patient is admitted on Monday, the IM needs to be given by Wednesday at the latest. If the notice is given on Wednesday and the patient is discharged on Friday, the follow up copy of the notice would not need to be delivered. Wednesday would be considered within two calendar days of admission **and** within two calendar days of discharge.

The copy of the IM that is associated with the patient's discharge may be either a new blank IM or a copy of the IM that was signed after admission; whichever is most convenient. Valid delivery requires that the hospital obtain a date and signature, provide a copy to the patient/representative and retain a copy.

- Hospitals may not alter the IM and must comply with General Notice Requirements as instructed in the Medicare Claims Processing Manual, Chapter 30, section 200.5.
- The IM should be delivered to each individual who is entitled to benefits under Part A or a MA plan. Therefore, delivery of the IM and the appeal process includes MA enrollees (for expedited timely appeal), and individuals who are dual eligible for Medicaid and Medicare, are eligible for Medicare and another insurance program, or have Medicare as a secondary payer.
- Hospitals are **not** required to provide a copy of each Important Message to the Kansas Foundation for Medical Care (KFMC) for monitoring.

Exclusions

- Swing beds in hospitals are excluded, because they are considered a lower level of care.
- Religious nonmedical health care institutions are excluded.
- 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.
- Preadmission/Admissions for services that are not reasonable and necessary will continue to be addressed with the Preadmission/Admission Hospital Notice of Noncoverage (HINN) review process, and the IM will not be issued unless there is a subsequent inpatient admission.
- Change of an inpatient admission to an outpatient admission by the utilization review committee would not require delivery of the copy of the signed IM, and would not trigger the appeal process. The hospital should follow the notification requirements in CR 3444 (Use of Condition Code 44) and MedLearn Matters article, SE0622.
- Hospitals should not use the IM and QIO appeal process to address admissions for services that Medicare never covers or for exhaustion of Part A days, unless the stay subsequently becomes a covered stay. The Hospital Stay Advance Beneficiary Notice would be appropriate for these situations or other liability notice.
- Transfer from one inpatient hospital setting to another inpatient hospital setting will **not** require delivery of the follow-up copy of the signed notice at the time of transfer, and will **not** trigger the discharge appeal process. A patient may always refuse care and contact the QIO if they have a quality of care concern regarding the transfer. The receiving hospital must deliver the IM again after transfer, and the notice requirements would begin again.

- For Medicare purposes, if the unit is billing with the same provider number, it would be considered a transfer within the facility and not a discharge. The IM would not have to be delivered again until within 2 days of discharge.
- If the hospital requests QIO review when the attending physician does not concur with the discharge, the copy of the signed IM associated with the discharge date would not be given.

Request for an Expedited Review – Patient or Representative

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

QIO Availability

KFMC has methods in place to accept requests for reviews outside of normal business hours, such as an answering machine or voice mail system. KFMC will be available to accept requests for appeals 24 hours a day and to perform reviews seven days a week.

Request Submission

A patient or representative who chooses to exercise the right to an expedited review must submit a request to KFMC. In order to be considered timely, the request must be made no later than **midnight** of the day of the planned discharge, and may be in writing or by telephone. The regulations say that the patient or representative, upon request of the QIO, should be available to discuss the case. Written evidence may be submitted by the patient or representative to be considered by the QIO.

Timely Requests

When the patient or representative makes a timely request for a QIO review—that is, requests a review no later than midnight on the day of the planned discharge—the patient 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.

Notification of Hospital or MA Plan

When KFMC receives the request for an expedited review from the Medicare beneficiary, MA enrollee, or representative, the KFMC will notify the hospital and MA plan of the request immediately (if the request is received during business hours) or immediately in the morning (if the request is received after business hours).

Delivery of the Detailed Notice of Discharge

- When a QIO notifies the hospital that a Medicare beneficiary has requested an expedited review, the hospital must deliver a Detailed Notice of Discharge to the patient or representative as soon as possible but not later than noon of the day after the QIO's notification.

- When an MA plan enrollee requests an expedited review, the MA plan must, directly or by delegation to the hospital, deliver a Detailed Notice to the MA plan enrollee or representative as soon as possible but not later than noon of the day after the QIO's notification.
- 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 (screening criteria may be used, but providers should provide specific Medicare coverage rules at the beneficiary's request)
 - 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

Burden of Proof

The burden of proof lies with the **hospital** (for a Medicare beneficiary) or with the **MA plan** (for an enrollee) to demonstrate that discharge is the correct decision, either on the basis of medical necessity or based on other Medicare coverage policies.

Skilled Nursing Facility Placement

For some patients, the discharge plan includes placement in a skilled nursing facility (SNF). Appropriate discharge planning for these patients would include arrangements and verification of an available SNF placement coordinated with the discharge order and delivery of the signed copy of the IM. If the SNF arrangement becomes unavailable during the appeal process, the QIO will complete the appeal process and determine if the patient is ready for transfer. The hospital should pursue another SNF placement as quickly as possible. However, the patient can't be penalized and held liable by the facility if the SNF bed becomes unavailable because of the exercise of appeal rights.

Provision of Information to the QIO

- Upon notification by KFMC of the Medicare 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.
- Upon notification by the KFMC of the MA plan enrollee's request for an expedited review, the MA plan 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 MA plan may request that the hospital furnish the

information to the QIO, but **regulations require that the KFMC contact the MA plan** to request the information necessary to make the determination.)

- Information must be furnished as soon as possible, but no later than noon of the day after KFMC notifies the hospital or MA plan of the request. At the discretion of the QIO, the information may be made 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 needed information is not provided, the KFMC 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 (for a Medicare beneficiary) or MA plan (for a MA enrollee) may be held financially liable** for those services, as determined by the QIO.

Provision of Information to the Patient or Representative

At the request of the patient or representative, the hospital or MA plan must furnish a copy of or access to any documentation that it sends to the KFMC, including written records of any information provided by telephone. The hospital or MA plan may charge a reasonable amount (the amount may be mandated by state regulations) to cover the costs of duplicating the documentation and/or delivering it to the patient or representative. The patient or representative is informed of this right on the Detailed Notice. The request must be accommodated by no later than the first day after the material is requested.

Determination if Hospital Delivered Valid Notice

KFMC will determine whether the hospital delivered valid notice, meaning that the IM notice is the standardized notice published by CMS, meets the notice delivery timeframes and has been signed and dated by the beneficiary or a representative. **If KFMC determines that the hospital did not deliver valid notice, KFMC will instruct the hospital to reissue the notice if necessary, but proceed with the review within the expedited timeframes, and educate the hospital retrospectively.**

- See further instructions from the Medicare Claims Processing Manual, Chapter 30

Delivery of the follow up copy of the IM notice as a part of the routine process on the day of discharge should be avoided. For example, if the medical record indicated that on Friday the discharge was planned to occur on Monday, the follow-up IM notice could have been delivered on Saturday, 2 days prior to the planned discharge date. When the follow-up copy is given on the day of discharge, patients should be given **at least 4 hours** to consider discharge appeal rights, without being pressured to leave. However, many patients are anxious to go home right away and do not need 4 hours to think about appeal rights.

If the follow-up copy of the IM is delivered, and the patient's condition changes so that they are not discharged within 2 days, another copy of the IM should be delivered for signature within 2 calendar days of the new discharge date.

QIO Appeal Process

Solicitation of the Views of the Patient or Representative

KFMC must solicit views of the patient or representative who requested the expedited review. As stated above, the hospital or MA plan must provide the patient or representative a copy of the documentation that was sent to KFMC, if requested. If such a request is not accommodated in a timely manner it may prevent the patient or representative from submitting reasons why the discharge is inappropriate. KFMC may make a decision based on the information at hand, or defer the decision until the documentation is provided to the patient or representative so that they can submit views regarding the case.

Solicitation of the Views of the Hospital or MA Plan and the Physician

KFMC must provide an opportunity for the hospital and MA plan to explain why discharge is appropriate. KFMC will attempt to contact the attending physician for comments, prior to forwarding the case to the physician reviewer for a determination.

Record Review

KFMC will examine medical and other records that pertain to the services in dispute.

Determination

The QIO physician reviews the medical records and any other information and renders an opinion regarding the patient's discharge status and the discharge plan. The QIO decision should be issued within one calendar day after receiving all pertinent information. The determination is 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
- The services could be safely delivered in another setting

CMS has indicated that in addition to determining if the notices were validly delivered and in addition to the discharge review, QIOs should do admission screening.

Change in Condition

Providers should inform the QIO as soon as possible if the patient's condition changes after the QIO is contacted and an appeal is requested. If the discharge is canceled, the follow up copy of the IM should be given again, prior to subsequent discharge. The QIO would contact the patient/representative and facility by phone to verify understanding of the situation. Because the patient is not informed of any specific liability until the QIO review is complete, there would be no need for notification in writing that the appeal process is being discontinued, or for the Detailed Notice to be rescinded.

Notification

The QIO notifies the Medicare beneficiary or MA plan enrollee or the representative of the results of the expedited review. KFMC will follow state regulations and guidelines for release of review findings to a representative. KFMC can request completion of Form CMS-1696 or similar designation if appropriate.

- If KFMC notifies the patient or representative that the KFMC **agrees** with the discharge, liability for continued services begins at noon of the day after the KFMC notifies the patient or representative that the KFMC agreed with the discharge determination, or as otherwise determined by the KFMC.
- If KFMC notifies the patient or representative that the KFMC **disagrees** with the discharge, the patient or representative is not financially responsible for continued care (other than applicable coinsurance and deductibles) until it is once again determined that the patient is ready for discharge. At that time, the patient or representative would be informed of the discharge plan and a copy of the signed IM would be given to the patient or representative for initialing.

In addition, KFMC will notify the hospital, the MA plan and the physician of its determination within one calendar day after it receives all requested pertinent information. When KFMC issues an expedited determination, the parties will be notified by telephone, followed by a written notice. The written notice will be copied to the appropriate Fiscal Intermediary (FI). Both notifications will include the following information:

- The basis for the determination
- A detailed, easily understood rationale for the determination
- An explanation of the payment consequences of the determination and the date the beneficiary or enrollee becomes fully liable for services
- Information about the right to a reconsideration of the KFMC's determination, including how to request the reconsideration and the timeframe for doing so

Reconsideration

Right to Pursue Reconsideration

The QIO determination is binding on the beneficiary, the physician, the MA plan and hospital, unless the patient requests reconsideration.

If the Medicare beneficiary or MA plan enrollee is still an inpatient in the hospital and is dissatisfied with the determination, he or she may request reconsideration according to the procedures described in 42 CFR 405.1204 and 422.626 (f). It is expected that on July 2, 2007, when the changes go into place, QIOs will be continuing to perform reconsiderations for original Medicare beneficiaries and MA Plan enrollees.

- If the initial determination is reaffirmed, the date of liability for the patient remains unchanged.
- The beneficiary or enrollee contacts KFMC by noon of the calendar day following receipt of the notice of an initial determination.

- The beneficiary or enrollee must be available to answer questions and provide information to KFMC.
- Additional evidence to be considered may be submitted by the patient and the provider, but is not required.
- Within 72 hours, KFMC notifies the Medicare beneficiary or MA plan enrollee, the hospital and MA plan, and the physician of its decision on the reconsideration request.
- The patient may request an extension of up to 14 days for the reconsideration.
- If the patient requests an extension, KFMC should complete the review within 72 hours.

Untimely Requests

Medicare Beneficiary

The Medicare beneficiary may contact KFMC for an untimely request for review.

- If the Medicare beneficiary remains in the hospital, the same time frames apply for KFMC notification of the facility, delivery of the Detailed Notice and forwarding of pertinent information to the KFMC. KFMC will make its determination and notify the beneficiary, the hospital, and the physician of its determination within two calendar days following receipt of the request and pertinent information.
- When the beneficiary makes an untimely request for an expedited review, and is no longer an inpatient in the hospital, KFMC will make its determination and notify the beneficiary, the hospital, and the physician of its determination within 30 calendar days after receipt of the request and pertinent information. The Medicare beneficiary can request a QIO review within 30 calendar days of the date of discharge, or at any time for good cause.
- The MA plan enrollee contacts the MA plan for untimely requests for discharge appeals.