

# HEALTH LAW

## Update

NEWS FOR THE CLIENTS AND FRIENDS OF BASS, BERRY & SIMS PLC

## Coming July 1, 2007 – Changes to Hospital Discharge Appeal Rights

June 25, 2007

### Introduction

Effective July 1, 2007, new rules issued by the Centers for Medicare & Medicaid Services (CMS) will change how hospitals and Medicare Advantage (MA) plans notify certain Medicare beneficiaries of their rights to appeal discharge and non-coverage decisions.<sup>1</sup> Under the current rules, hospitals must deliver, at or about the time of admission, the “Important Message From Medicare,” Form CMS-R-193 (IM), to all hospital inpatients who are Medicare beneficiaries to explain their rights as patients, including their right to appeal discharge<sup>2</sup> decisions. Additionally, a hospital must provide a Hospital-Issued Notice of Non-Coverage (HINN) to any beneficiary with original Medicare coverage, i.e., non-MA coverage, who expresses dissatisfaction with an impending hospital discharge.<sup>3</sup>

CMS has reviewed the effectiveness of these current requirements and has concluded that they do not sufficiently inform Medicare beneficiaries of their right to a Quality Improvement Organization (QIO) review of a hospital’s discharge decision or of a health plan’s non-coverage of care. In adopting the final rule, CMS states that it has sought to balance a patient’s right to know how to appeal discharge and non-coverage decisions and a hospital’s practical ability to predict when a beneficiary will be discharged and to make appropriate discharge decisions. Consequently, CMS has revised the form of IM and indicates that it has adopted flexible standards that rely on a hospital to review the IM and any related questions with beneficiaries to ensure that Medicare beneficiaries understand their rights and liabilities under the law.

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<sup>1</sup> 71 Fed. Reg. 68707 (Nov. 27, 2006); *see also* CMS Transmittal 1257 (May 25, 2007).

<sup>2</sup> A discharge is the formal release of a beneficiary or enrollee from an inpatient hospital. This term includes both situations where a beneficiary is physically discharged and situations where a beneficiary is moved to a lower level of care in the hospital.

<sup>3</sup> Similarly, Medicare health plans, such as MA plans, are required to provide enrollees with a Notice of Non-Coverage, which is known as the Notice of Discharge and Medicare Appeal Rights (NODMAR), when an enrollee disagrees with the discharge decision (or when the individual is not being discharged but the Medicare health plans no longer intend to cover the inpatient stay).

## **Applicability**

These new rules apply to hospitals providing care at the inpatient hospital level. This level of care includes short-term and long-term care, acute or non-acute care, and critical access hospitals, regardless of reimbursement method. However, the rules do not apply to (a) hospital stays involving hospital swing beds when used as skilled nursing beds, (b) outpatient departments, or (c) religious non-medical healthcare institutions.

The IM must be provided by hospitals to certain Medicare beneficiaries. In particular, this final rule applies to the rights of beneficiaries of original Medicare, enrollees in MA and other Medicare health plans under MA regulations, dual eligibles, and beneficiaries with Medicare as a secondary payer.

## **Requirements Effective as of July 1, 2007**

### A. Hospital “Important Message From Medicare”

The IM must contain certain elements deemed to inform beneficiaries of their appeal rights. Almost all of the elements are required by Section 1866(a)(1)(M) of the Act, which includes a statement of the patient’s rights, information about when a beneficiary will and will not be liable for charges for a continued stay in a hospital, and a description of the QIO appeal process. The revised form of IM<sup>4</sup> elaborates on many of these elements by including step-by-step instructions for how to respond to an impending discharge and how to call the QIO to file an appeal. These changes inform the beneficiary of his or her need to remain involved in his or her medical care and to whom he or she can talk regarding decisions that affect his or her hospital stay. In addition, the revised form of IM simplifies the beneficiary’s burden by providing specific contact information for the appropriate QIO and hospital representative.

Where a Medicare beneficiary is not competent to comprehend the IM, the hospital must give notice to a representative. If the patient representative agrees, the hospital may e-mail the IM to the representative after a telephone call. Such electronic transmissions must meet HIPAA requirements. If the hospital cannot reach the representative by phone, the IM may be sent via certified mail.

The IM must be signed by the beneficiary (or representative if applicable) to indicate that he or she has received the IM and comprehends its contents. In addition, the revised form of IM includes language stressing the importance of discussing discharge planning issues with physicians, health plans, or hospital personnel to try to minimize the potential for disputes. Where a patient or representative refuses to sign the IM, the hospital must notate the refusal on the IM and retain a copy to document compliance.

Under the new rules, a hospital must deliver the IM within two calendar days of admission or at preadmission. In no circumstance can a hospital deliver the IM to a beneficiary more than seven calendar days before admission. The hospital must document delivery of each IM and must demonstrate compliance with these rules.<sup>5</sup> Once the hospital determines the date of a patient’s

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<sup>4</sup> This revised form of IM was issued by CMS on May 25, 2007, and can be found on the CMS Web site at: [http://www.cms.hhs.gov/BNI/12\\_HospitalDischargeAppealNotices.asp](http://www.cms.hhs.gov/BNI/12_HospitalDischargeAppealNotices.asp) (last visited June 22, 2007).

<sup>5</sup> CMS mandates only that the hospital retain a copy of the signed IM but does not prescribe a method or place for document retention.

discharge, the hospital must notify the patient as soon as possible and deliver a follow-up copy of the IM to the patient.<sup>6</sup>

The follow-up notice can be no more than two calendar days before the day of discharge. CMS acknowledges that discharge decisions often depend on diagnostic test results or, in situations where a patient has a complicated medical condition, on a decision agreed to by multiple physicians. However, a hospital should deliver the follow-up notice on the day of discharge only when unavoidable. Therefore, a hospital cannot adopt a policy to, or routinely, as a matter of practice, deliver the follow-up notice on the day of discharge. At the very least, a hospital must allow a patient to consider his or her appeal rights for four hours prior to discharge.

#### B. QIO Review of Appeals

The new rules also revise the procedures and standards for QIO reviews of beneficiary appeals. These revisions are intended to expedite the appeal process. Under the current rules, QIOs are required to provide reviews only on weekdays. Under the new rules, QIO must be available to review appeals seven days a week. In reviewing an appeal, the QIO is to consider medical records and whether valid notice delivery occurred.

A beneficiary must submit the request by phone or in writing to the QIO no later than the day of discharge. If the beneficiary requests the hospital's help in submitting an appeal, the hospital is obligated to assist. When a beneficiary does make a request for review by the QIO, the beneficiary must submit written evidence and be available to discuss the case with the QIO. After the Medicare beneficiary requests a QIO review, the beneficiary should not be discharged from the hospital.

Once the QIO receives a beneficiary's request for review, it notifies the hospital. As soon as possible, but no later than noon of the day after the QIO notifies a hospital of a patient's QIO review request, the hospital must take two actions. First, it must deliver the newly published Detailed Notice of Discharge using the standardized notice published by CMS on May 25, 2007.<sup>7</sup> Second, it must provide all information needed by the QIO by telephone or in writing, as requested by the QIO. The burden of proof rests with the hospital. Where the hospital fails to provide the requested information, the QIO may base its decision on the evidence at hand.

How quickly a QIO must conduct its review is determined by how timely a beneficiary submits a request to review a discharge decision. The QIO has one to 30 calendar days to make a decision regarding a patient's discharge after all relevant information is received. If the beneficiary submits his or her appeal to the QIO on or before the date of discharge, the QIO must issue its decision within one day. If the beneficiary remains in the hospital but does not submit his or her appeal to the QIO until after the planned day of discharge, the QIO must issue its decision within two days. Where a beneficiary leaves the hospital without submitting an appeal, the beneficiary retains the right to appeal the discharge decision for up to 30 days after the date of discharge. If the beneficiary waits to submit

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<sup>6</sup> Where a patient receives the initial IM within two days of discharge, a hospital is not obligated to deliver the follow-up IM to the patient.

<sup>7</sup> This Notice can be found on the CMS Web site at:  
[http://www.cms.hhs.gov/BNI/12\\_HospitalDischargeAppealNotices.asp](http://www.cms.hhs.gov/BNI/12_HospitalDischargeAppealNotices.asp) (last visited June 22, 2007).

his or her appeal until he or she has left the hospital, the QIO may issue its decision up to 30 days after receiving all of the relevant information.

C. Liability for Charges

Liability for the costs of a patient's hospital stay after the date of discharge depends on the timeliness of a beneficiary's request for a QIO review and the outcome of the QIO review. Specifically:

1. If a beneficiary timely files his or her appeal and the QIO agrees with the beneficiary that continued inpatient care is appropriate, the beneficiary is not liable for charges related to any Medicare covered services in excess of his or her deductibles and coinsurance.
2. If the beneficiary timely files his or her appeal, but the QIO agrees with the hospital's discharge decision, then the beneficiary will be liable for deductibles and coinsurance only for charges incurred prior to noon on the day following the QIO's notification of its decision and for all charges incurred after that time.
3. If a beneficiary does not file an appeal of the discharge decision on or before the date of discharge, the beneficiary may be liable for all charges incurred after the date of discharge. However, the QIO has discretionary power to set the date of liability.

**Conclusion**

CMS continues to post additional information to its Web site on Hospital Discharge Appeal Notices. In the coming weeks, CMS anticipates that it will publish a Spanish-language version of the IM, a revised inpatient stay Advanced Beneficiary Notice, and revised Questions and Answers. This information is available at [www.cms.hhs.gov/BNI](http://www.cms.hhs.gov/BNI). If you have any questions, or would like assistance in complying with these new requirements, please contact any of the attorneys in the Healthcare Practice Area listed at the end of this Update.

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