



An Important Message From Medicare *New Rules on July 1, 2007*

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Aunt Milly is an 84-year-old who lives alone. With two grown-up children who have little interest in assisting her, she has been doing a feisty job of caring for herself. She is an “occasional” flyer, rather than a “frequent” flyer, and is usually happy to go home. This time is different. Although weak, she appears to meet discharge criteria; but this time she “doesn’t feel up to going home” and “can’t she try that Medicare Appeal arrangement for a day or two?” The hospital staff listened with concern and replied, “OK, but if you lose the Appeal, you will be responsible for costs from now on, until you leave the hospital. It’s up to you....”

Now, YOU know—and I know—that this staff member could NOT have been a hospital case manager; but this story has been anecdotally told enough times to signal a disconcerting educational need about Appeal Rights for Medicare beneficiaries. And, if HINNs (Hospital Issued Notice of Non-Coverage), NODMARs (Notice of Discharge and Medicare Appeal Rights), and CoP (Conditions of Participation) have not caused enough confusion in the past, the whole process is in the midst of an overhaul. For purposes of this editorial, I will focus on the Medicare Discharge Notice policy changes that are currently being modified. Quotes directly from the 19-page, 3-column ruling are included.

How It Currently Works

When a patient enters a Medicare-approved hospital, he or she is given the *Important Message from Medicare* (IM). The IM has language that, among other subject matter, describes the beneficiaries’ right to appeal decisions about a continued stay in the hospital. Then, if a patient does not agree with a decision to be discharged, the beneficiary must ask for a HINN, which gives direction on how to exercise the right to Appeal the decision. If the patient is on a Medicare Advantage Plan, a NODMAR is provided, which explains why the beneficiary is being discharged; how to get a fast review; time frames to follow for an appeal; and what to do to pay if the choice is made to remain in the hospital after the appeal.

Effective July 1, 2007: Two Notices

The first notice, the *Important Message from Medicare*, has been around for many years. However, effective July 1, 2007, a revised *Important Message from Medicare*, amended rules, and a new process will be mandated. Please note that although the BONES of the rule have been worked out, we still do not know what the whole entity will look like. However, this ruling is important to case managers for good reasons:

- There is the distinct probability that many hospital case managers will be tasked with, at least, the discharge portion of this process. This also applies in critical access hospitals.
- Medicare (the largest insurance company in the country) is very serious about beneficiaries knowing, understanding, and being given their Medicare beneficiary appeal rights.
- Case managers, as patient advocates, desire the same.

Initially, hospitals will issue the IM within 2 days of admission, answer any questions, and get the beneficiary’s (or representative’s) signature. Then, hospitals will also be required to provide a *copy of the signed IM* before the patient leaves the hospital: “The notice should be given as far in advance of discharge as possible, but not more than 2 calendar days before discharge” (*Federal Register*, 2006, p. 68721). If the original IM was issued within 2 days of the patient’s discharge, as in short stays, the notice need only be provided once.¹

The *Important Message from Medicare’s* revised language will be standardized by CMS. Although at

¹Note that state law may supercede the federal law if it is more stringent. Some states still require hospital patients to receive a written discharge plan at least 24 hrs before leaving the hospital.

this time we do not know the exact wording, this is the gist. The IM will discuss the following:

1. The beneficiary's rights as a hospital inpatient and for posthospital services. The IM will provide Medicare inpatients with an advance written notice of their hospital discharge rights to try to minimize the potential for disputes.

To reflect the importance of discharge planning, we (CMS) intend to incorporate language into the revised IM about planning for discharge and encouraging beneficiaries to talk to their physician or other hospital staff if they have a concern about being discharged. If beneficiaries are still not satisfied with their discharge decision, they can request a QIO (Quality Improvement Organization) review. (*Federal Register*, 2006, p. 68713)

2. The beneficiary's right to request an expedited determination of the discharge decision, including a description of the process, and the availability of other appeals processes if the beneficiary fails to meet the deadline for an expedited determination.
3. The circumstances under which a beneficiary will or will not be liable for charges for continued stay in the hospital.
4. A beneficiary's right to receive additional detailed information.
5. Any other information required by CMS.

The beneficiary's signature indicates that he or she has received the notice and comprehend its contents. However, it is much easier to receive the notice than to comprehend its contents. If a beneficiary refuses to sign the notice, the hospital must annotate and date the IM to indicate the refusal; this is considered the date of receipt of the notice.

It is also possible that the beneficiary does not agree with the decision to discharge or go to a lower level of care (even in the same facility) and

requests a QIO review. In this case, a *second notice*—called a “*detailed notice*”—must be delivered to the beneficiary. The beneficiary must submit a request for a QIO review no later than the day of discharge. Note that the process for expedited reviews is beyond the scope of this editorial, but I encourage hospital case managers to be knowledgeable about the options and processes.

The detailed notice will provide a detailed explanation of why services are either no longer reasonable and necessary or are otherwise no longer covered; a description of any relevant Medicare (and Medicare health plan as applicable) coverage rule, instruction, or other Medicare policy, and information about how the beneficiary may obtain a copy of the Medicare policy; 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 his or her case; and any other information required by CMS. Hospitals and plans are presently responsible for providing the HINN or the NODMAR when a beneficiary disagrees with the discharge or he or she is being moved to a lower level of care (and the beneficiary must request the appeal). (*Federal Register*, 2006, p. 68720)

The detailed notice will essentially *replace* the HINN and NOD-

MAR by addressing *most* HINNs and NODMAR issues up-front.

Currently, hospitals or plans issue a HINN or NODMAR at discharge *only when the patient disagrees with the discharge decision (and requests an appeal)*. In this context, the HINN and NODMAR are used to tell a patient why a hospital or plan believes their stay will no longer be covered, to provide information about the QIO review process, and to describe the patient's potential liability. Under the process set forth in this final rule, *ALL* individuals will be provided with information upon admission about the QIO review process and associated liability, and individuals who disagree with the discharge decision will receive detailed information about why the hospital or plan believes their stay will no longer be covered. Thus, with this new process, the HINN and NODMAR will no longer be used to notify patients of their right to a QIO review of a stay. ... beneficiaries who disagree with the discharge decision will initiate a QIO review, *so that their stay can continue without liability until the QIO confirms the discharge decision or determines that the stay should continue.* (*Federal Register*, 2006, p. 68712)

Remember Aunt Milly? She was given incorrect information that likely frightened her into resigning

Three “Golden Rules”

1. Medicare beneficiaries shall not be told that they will have to pay for their hospitalization during the days of a Medicare Appeal. The beneficiary is not responsible until after the QIO has made a determination (and only if that determination was that the beneficiary should have been discharged).
2. Thou shalt not display an “attitude” when a Medicare beneficiary exercises his/her right to a formal Appeal. Although the case manager has (likely) had experience with at least one patient who used the Medicare Appeal process to “game the system,” this is not usually the situation.
3. Thou shall call your state's Quality Improvement Organization (QIO) with any questions about Medicare Beneficiary Rights, Appeals, etc. The entire process and possible outcomes are varied; however, the QIO is your resource.^a

^aTo find your state's QIO, go to <http://www.medicare.gov/dcs/ContentServer?cid=1094754859915&pagename=Medicare%2FGeneralPage%2FGeneralPageTemplate&c=MQGeneralPage>.

to go home (whether it was safe or not). See the “Three Golden Rules.”

What Can a Case Manager Do?

Although the final rule has been written and approved, the precise language of the revised IM and “detailed notice” will be subject to public review and comment; in fact, *many* notices that affect case man-

agement *and* our patients are routinely subject to public review. Case managers are a growing legion of patient advocates; with our unique vantage point, it is essential that the case management perspective be heard. If you feel that you have an “important message *for* Medicare,” consider the Public Review and comment period as an opportunity to be heard.

REFERENCES

Rules and regulations. 71(227) *Federal Register* (2006, November 27). Retrieved December 1, 2006, from <http://a257.g.akamaitech.net/7/257/2422/01jan20061800/edocket.access.gpo.gov/2006/pdf/E6-20131.pdf>

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