Notification of Hospital Discharge Appeal Rights
QIO Handbook

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Prepared by the Beneficiary Protection Program
Quality Improvement Organization Support Center
# Notification of Hospital Discharge Appeal Rights Training Handbook

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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 in order to comply with the notice requirements.

Listed below is an overview of changes, including some important changes to the QIO and provider processes that are a result of the CMS-4105-F Final Rule for Notification of Hospital Discharge Appeal Rights.

- QIO and hospital processes are aligned for Medicare beneficiaries and MA enrollees who request expedited, timely appeal of inpatient discharge.
- Hospitals may request review for QIO concurrence for Medicare beneficiaries and MA enrollees when unable to obtain agreement for discharge from a physician.
- The QIO accepts and performs untimely requests for appeal for Medicare beneficiaries, both while still an inpatient in the facility and when the beneficiary is no longer an inpatient in the facility.
- Untimely requests from MA enrollees are referred to the MA plan.
- Valid delivery of the Important Message from Medicare notice is required.
- Valid delivery includes a process to follow for contacting a representative who can’t sign in person.
- “Responsible Person” is defined as someone who the hospital deems, under state law, as acting on behalf of the patient.
- QIOs should follow state guidelines regarding designation of representative.
- **Hospitals must take all steps necessary to ensure that notice is provided to the beneficiary or the beneficiary’s designated representative if necessary. Failure to give notice to a properly designated representative where required may result in the hospital being held liable.**
- “Hospital” is defined as any facility that provides inpatient care, including but not limited to short-term, long-term, acute or non-acute, prospective payment system or non-prospective payment system, critical access hospital, inpatient psychiatric and rehabilitation facilities.
- “Discharge” is defined as a formal release of a beneficiary from an inpatient hospital level of care. 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).
See Appendix A for an overview of the differences between the new and old processes.
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. It is strongly recommended that hospitals obtain the signature or initials of the patient when delivery of the follow-up copy is necessary, although a signature isn’t required. Providers may utilize other forms of documentation, such as inclusion in a discharge form checklist. Details of further requirements for valid delivery are found on page 8.

- 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 QIOs for monitoring.
- The specific QIO that is responsible for reviewing a particular discharge appeal is the QIO that has a Memorandum of Agreement with the hospital that is treating the Medicare beneficiary or MA plan enrollee.
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. See “Request for Preadmission/Admission Review and Hospital-Requested Review” (page 12) for changes related to valid delivery of the HINN.
- 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 deliver the IM during admissions for services that Medicare never covers or for exhaustion of Part A days, unless the stay subsequently becomes a covered stay.
- 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. This includes transfer from a short term acute care hospital to a long term acute care hospital, which is considered the same level of care. 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 the beneficiary is transferring to 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. More information regarding hospital-requested reviews can be found in “Request for Preadmission/Admission Review and Hospital-Requested Review” (page 12).
- Hospital inpatients who elect hospice coverage would not receive the follow up copy of the IM, if the hospice election occurs prior to discharge from acute care.
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
The QIO should have methods in place to accept requests for reviews outside of normal business hours, such as an answering machine or voice mail system. The QIO should 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 the QIO that has a Memorandum of Agreement (MOA) 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 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 the QIO receives the request for an expedited review from the Medicare beneficiary, MA enrollee, or representative, the QIO must 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 will 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, directly or by delegation to the hospital, will 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

If the provider or MA plan does not comply with delivery of a Detailed Notice to the patient, the QIO may go forward with the appeal process, if sufficient information is otherwise obtained (see “Provision of Information to the QIO” on page 7). If a QIO becomes aware of a pattern of noncompliance with delivery of the Detailed Notice, this should be reported to the CMS Regional Office.

See the appendices of this manual for copies of the Important Message from Medicare and instructions (Appendix B), and the Detailed Notice and instructions (Appendix C).

**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 follow up 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.

If the patient or family is uncooperative with arrangements for SNF placement, the provider should document the reasonable efforts that the provider has made and the lack of cooperation that prevented placement. The patient/representative should be informed of the planned discharge date and given the follow up copy of the IM. If an appeal is not requested within the time frame, or if the QIO agrees with the planned discharge, a liability notice should be given before billing the patient/representative for a continued stay.

**Geographic Area Concerns**

In the past, there has been CMS guidance that appropriate SNF placement would be within a geographic area of a 50-mile radius or one-hour drive, and that the Project Officer should be consulted for placements outside of the geographic area. However, placement within a
proscribed area, such as a state line, may not be attainable for patients with complex medical needs. The QIO should consider all of the issues involved in the case, and make a determination based on knowledge of what would be reasonable for a particular patient, and the types and availability of skilled nursing facilities in each state or area.

Court-Ordered Psychiatric Admission
The inpatient psychiatric admission of a Medicare beneficiary or MA plan enrollee may have a legal component that affects the circumstances of the discharge. The patient/designated representative should be informed of appeal rights and receive the IM within 2 days of admission. The patient may be discharged from acute care and remain in the facility for custodial or supervised care until an appropriate placement is found. If the patient is discharged from acute care and the facility is no longer billing Medicare, the IM should be delivered within 2 days of the discharge from acute care, and the patient/representative may request an appeal of this change in status. The facility must use the approved IM and can provide additional information in the comments section, or in a separate notice, regarding the placement plan for a particular patient. After providing the IM and appeal rights associated with the discharge from acute care, the provider may give notice and assign liability to the patient for subsequent custodial care.

Provision of Information to the QIO
- Upon notification by the QIO 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, in addition to copies of both the IM and the Detailed Notices.
- Upon notification by the QIO 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, in addition to 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 QIO contact the MA plan to request the information necessary to make the determination.)
- Information needed to make an expedited determination and copies of the notices must be furnished as soon as possible, but no later than noon of the day after the QIO 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 information needed to make an expedited determination is not provided, 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 (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 QIO, 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**
The QIO will determine whether the hospital delivered valid notice. This will include determining that the IM notice is the standardized notice published by CMS, meets the notice delivery timeframes (see page 3) and has been signed and dated by the beneficiary or a representative.

**In the rare situation where the QIO determines that the hospital did not validly deliver the IM, the QIO must instruct the hospital to 1) reissue the IM and 2) provide the QIO with a copy of the validly issued IM immediately after it is issued so that the QIO may complete the review. The QIO is not required to begin the substantive review of the appeal until it receives all requested pertinent information, which includes a copy of the validly issued IM. As required by the regulations, the QIO must make its determination and notify the beneficiary, the hospital, and the physician within one calendar day after it receives all requested pertinent information.**

See further instructions from the Medicare Claims Processing Manual, Chapter 30 (Appendix D) and the draft managed care instructions “Immediate Review Process for Hospital Inpatients in Medicare Health Plans” (Appendix E) for:

- What constitutes valid delivery of the notice to a representative who can’t sign in person
- The definition of a representative, either legally appointed or acting in the patient’s best interests, who may sign the IM for the patient and request an appeal
- Relevant conflict of interest by a representative who acts solely for the purpose of shifting financial liability to the patient
- Appointment of a representative using Form 1696

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.

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*
The QIO 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 the QIO, 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. The QIO 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
The QIO must provide an opportunity for the hospital and MA plan to explain why discharge is appropriate. QIOs should attempt to contact the attending physician for comments, prior to forwarding the case to the physician reviewer for a determination. This should mirror the process for non-hospital appeals, and the process previously followed for HINNs. The process shouldn’t be delayed to obtain the comments but the attending physician should be given an opportunity to comment. Who is responsible for contacting the attending physician would be an internal decision for each QIO. The QIO may develop guidelines as to the form and extent of these opportunities for comments.

Record Review
The QIO 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 for IPPS providers, including short term and long term acute care hospitals. Quality of care reviews should be done at the QIOs discretion.

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. The QIO may discontinue the appeal process.

Notification
The QIO notifies the Medicare beneficiary or MA plan enrollee or the representative of the results of the expedited review. QIOs should follow state regulations and guidelines for release of review findings to a representative. The QIO can request completion of Form CMS-1696 or similar designation if appropriate.
• If the QIO notifies the patient or representative that the QIO agrees with the discharge, liability for continued services begins at noon of the day after the QIO notifies the patient or representative that the QIO agreed with the discharge determination, or as otherwise determined by the QIO.
• If the QIO notifies the patient or representative that the QIO 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, the QIO notifies the hospital, the MA plan 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 parties should be notified by telephone, followed by a written notice. The written notice should be copied to the appropriate Fiscal Intermediary (FI). Both notifications should 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 QIOs determination, including how to request the reconsideration and the timeframe for doing so

See Appendix F for suggested letter templates. These letter templates may be modified as needed to comply with your QIO correspondence style, or to improve understanding.

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 (Medicare beneficiary) and 422.626 (f) (MA Plan enrollee). QIOs will continue 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 must be available to answer questions and provide information to the QIO.
• Additional evidence to be considered may be submitted by the patient and the provider, but is not required.
Original Medicare Beneficiaries

- The original Medicare beneficiary contacts the QIO by noon of the calendar day following receipt of the notice of an initial determination.
- Within 72 hours, the QIO notifies the original Medicare beneficiary, the hospital, and the physician of its reconsideration decision.
- The Medicare beneficiary may request an extension of up to 14 days for the reconsideration.
- If the patient requests an extension, the QIO should complete the review within 72 hours.
- The beneficiary may not be billed for disputed services until the QIO notifies the parties of the reconsideration decision.
- If the QIO does not issue a decision within 72 hours, the beneficiary must be notified of the right to have the case escalated to the ALJ hearing level if the amount remaining in controversy is $110 or more.
- If the beneficiary requests reconsideration after noon of the next day, the same general claims appeal process is followed, but the patient may be billed for the services prior to the QIO reconsideration determination, and the timeframes and escalation would not apply.

MA Plan Enrollees

- The MA plan enrollee may request reconsideration no later than 60 days after notification of the initial determination.
- If the enrollee is still an inpatient in the hospital, he or she may request a QIO reconsideration.
- If the enrollee is no longer an inpatient in the hospital, the determination is subject to the standard or expedited plan appeal process.
- The QIO must notify the MA plan enrollee, the hospital, the physician and the MA plan of the reconsideration decision as expeditiously as the enrollee’s health condition requires, but no later than 14 days within receipt of the request.
- If the enrollee remains hospitalized, it is recommended that the parties be notified within 72 hours.

Untimely Requests

Medicare Beneficiary

The Medicare beneficiary may contact the QIO for an untimely request for review.

- If the Medicare beneficiary remains in the hospital, the same time frames apply for QIO notification of the facility, delivery of the Detailed Notice and forwarding of pertinent information to the QIO. The QIO 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, the QIO 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. (See Appendix G for what constitutes good cause).
- The MA plan enrollee contacts the MA plan for untimely requests for discharge appeals.
Request for Preadmission/Admission Review and Hospital-Requested Review

Preadmission and Admission HINN
A hospital may determine that a Medicare beneficiary’s admission or planned admission is not considered to be reasonable and necessary, the services could be safely provided in another setting or the care to be delivered is considered custodial in nature. Regulations found at 42 CFR Part 476.71 require QIOs to review the medical necessity of hospital discharges and admissions.

QIO availability requirements to accept and perform preadmission/admission HINN reviews are unchanged by CMS-4105-F and the Weichardt rule. Therefore, QIOs are required to accept and perform these types of reviews during regular business hours.

The timeframes, liability and general appeal process for preadmission/admission HINNs are not changed. If a preadmission/admission HINN is issued, the initial IM to be given after admission should be held. However, the requirements for valid delivery of the preadmission/admission HINN are aligned with the requirements for valid delivery of the IM. Revised model language for preadmission/admission HINNs is found in the Medicare Claims Processing Manual, Chapter 30, 240.6 exhibit 4. Use of the model language will help providers to comply with requirements for valid delivery of these notices. If the QIO disagrees with the preadmission/admission HINN and the patient is subsequently admitted as an inpatient, a signed IM should be obtained within 2 days.

Hospital-Requested Review for Medicare Beneficiaries and MA Plan Enrollees
A hospital may determine that a Medicare beneficiary or MA plan enrollee no longer needs inpatient care but is unable to obtain the agreement of the physician. Previously, physician concurrence for discharge of MA plan enrollees was provided by the attending physician or the MA plan physician, prior to issuance of a NODMAR. After July 2, 2007, hospitals may request QIO concurrence when an enrollee no longer needs inpatient care. However, this should not occur until the hospital has consulted with the enrollee’s Medicare health plan. Plans should discuss the use of this procedure beforehand with contracted hospitals. These instructions stem directly from Section 1154(e) of the Act and 42 CFR § 405.1208. The hospital may not request QIO review if the MA plan determines that the enrollee no longer needs acute care, and the hospital and physician disagree. This would be considered a contractual matter, not subject to QIO review.

A revised notice containing model language for hospital-requested review can be found in the Medicare Claims Processing Manual, Chapter 30, section 225- Exhibit 3.

QIO availability requirements to accept and perform hospital-requested reviews are unchanged by CMS-4105-F and the Weichardt rule. Therefore, QIOs are required to accept and perform these types of reviews during regular business hours.

Process for Hospital-Requested Review
The hospital will notify the patient/representative and the QIO that a review is being requested. Delivery of the notice must comply with the same general notice requirements as for the IM. By close of business on the first full working day immediately following the day the hospital
submits the request for review, the hospital should provide any pertinent information needed by the QIO to make a determination.

The QIO will contact the hospital regarding the request for review and receipt of the records. The views of the patient/representative should be solicited and the records examined. The QIO will make a determination and notify the patient, the hospital, and the physician within 2 days of receiving the request and all information needed to complete the review.

Notification of Hospital-Requested Review Determination
The QIO notifies the patient, hospital, physician and MA plan of the determination by telephone and follows up in writing. QIO notification should include the basis for the determination, a detailed rationale, a statement of payment consequences and the date of liability, if any. **The patient becomes liable beginning at noon of the next calendar day following notification by the QIO.** The patient/representative should be informed by the QIO of appeal rights and the timeframe for requesting appeal, both by telephone and in writing. It is not necessary for the hospital to issue another HINN letter after QIO notification, as the patient is informed of liability and further appeal rights by the QIO.

Reconsideration
The QIO determinations are binding. However, the Medicare beneficiary or MA plan enrollee may request reconsideration of the QIO determination. The reconsideration procedures for preadmission/admission HINNs and for hospital-requested expedited reviews are the same as for expedited discharge appeal.

- **When the patient remains in the hospital.** When the beneficiary or enrollee is still an inpatient in the hospital and is dissatisfied with this determination, he or she may request reconsideration according to the procedures described in §405.1204 for Medicare beneficiaries or in § 422.626 for MA plan enrollees. (see “Right to Pursue Reconsideration” on page 10).

- **When the patient is no longer an inpatient in the hospital.** If the Medicare beneficiary or MA plan enrollee is no longer an inpatient in the hospital and is dissatisfied, the determination is subject to the reconsideration appeal processes described on page 10.

Model Language
Although providers have some flexibility in the use of suggested language, it is highly recommended that hospitals use the model language provided in the Medicare Claims Processing Manual, or by their QIO, in order to avoid questions of invalid notice. Providers should follow the General Notice requirements in Chapter 30, section 200.5, and the Translation requirements in section 200.6.1 of the Medicare Claims Processing Manual when preparing preadmission/admission or hospital-requested review notices.
Appendices

A. Notification of Hospital Discharge Appeal Rights – Comparison of New and Old Processes

B. Important Message from Medicare and Instructions

C. Detailed Notice and Instructions

D. Medicare Claims Processing Manual Chapter 30 – Financial Liability Protections

E. Managed Care Instructions: “Immediate Review Process for Hospital Inpatients in Medicare Health Plans” (Draft)

F. Letter Templates

G. Late Requests for Good Cause