CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 594

Department of Health & Human Services

Center for Medicare and & Medicaid Services

Date: JUNE 24, 2005

Change Request 3903

Transmittal 577, CR 3903, dated June 3, 2005 is rescinded and replaced with Transmittal 594. In chapter 3, Exhibit 1-Hospital Issued Notices of Noncoverage-Ten Letters, was erroneously omitted from the transmittal page. The deletion of this exhibit is now being corrected via this transmittal. All other information remains the same.

SUBJECT: Preliminary Instructions: Expedited Determinations/Reviews for Original Medicare

I. SUMMARY OF CHANGES: This expedited review process, modeled on an existing Medicare managed care process, is effective under regulations July 1, 2005. It allows beneficiaries in specific care settings, home health, hospice, Comprehensive Outpatient Rehabilitation Facility (CORF), Skilled Nursing Facility (SNF) and swing bed, the right to appeal a pending discharge from a period of covered care to a Quality Improvement Organization (QIO). This process is similar to the QIO review of inpatient hospital discharges that has existed for some time.

NEW/REVISED MATERIAL :

EFFECTIVE DATE : July 1, 2005

IMPLEMENTATION DATE : July 1, 2005

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R = REVISED, N = NEW, D = DELETED – *Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
R	3/130 - Coordination With the Quality Improvement

	Organization (QIO)
D	3/130.1 - Limitation on Liability Provision
D	3/130.2 - General Responsibilities of Hospitals, Quality Improvement Organizations (QIOs), and FIs
D	3/130.3 - Placeholder for Instructions for FI/QIO Coordination - (Now in Discussion Within CMS)
D	3/130.4 - QIO Monitoring of Hospital Notices for Denial of Continued Stay of Inpatient Care Under PPS
D	3/130.5 - Issuance of Hospital Notices of Noncoverage
D	3/130.5.1 - Content of HINNs
D	3/130.5.2 - QIO Monitoring of HINNs
D	3/130.5.3 - Notices in Investigational/Experimental Procedures Situations
D	3/130.6 - Beneficiary Liability
D	3/130.7 - Provider Liability
D	3/130.8 - Right to a Reconsideration
D	3/130.9 - Model Hospital Issued Letters
D	3/Exhibit 1 - Hospital Issued Notices of Noncoverage-Ten Letters
R	30/20 - Limitation on Liability (LOL) Under §1879 Where Medicare Claims Are Disallowed
R	30/80 - Hospital-Issued Notices of Noncoverage (HINN)
D	30/80.1 - When and to Whom a Hospital ABN Should be Given
D	30/80.1.1 - Admission or Pre-Admission Hospital ABNs
D	30/80.1.2 - Continued Stay Hospitals ABNs
D	30/80.1.2.1 - Attending Physician Concurs
D	30/80.1.2.2 - Attending Physician Does Not Concur
D	30/80.1.2.3 - Advance Continued Stay Hospital ABN
D	30/80.1.3 - Combined Notices in Swing Bed Situations
D	30/80.1.4 - Combined Stay Hospital ABN in Swing Beds Treated as SNF Beds
D	30/80.1.5 - Delivery of Hospital ABN
D	30/80.1.6 - Qualified Recipients of Hospital ABNs
D	30/80.2 - Issuing the Appropriate Hospital ABN
D	30/80.3 - Hospital ABNs (HINNs)
D	30/80.3.1 - Hospital ABN Content Standards

D	30/80.3.2 - Hospital ABNs Model Language
D	30/80.3.3 - Hospital ABN Header Text
D	30/80.3.4 - Hospital ABN End Text
D	30/80.3.5 - Messages for Body of Hospital ABNs 1-9
D	30/80.3.5.1 - Hospital ABN 1 Message - Admission or Preadmission
D	30/80.3.5.2 - Hospital ABN 2 Message - Continued Stay (Attending Physician Concurs)
D	30/80.3.5.3 - Hospital ABN 3 Message - Continued Stay - Swing Bed Only (Attending Physician Concurs) (Patient Changes from Acute to NF Level of Care)
D	30/80.3.5.4 - Hospital ABN 4 Message - Continued Stay - Swing Bed Only (Attending Physician Concurs) (Patient Changes from Acute to SNF Level of Care)
D	30/80.3.5.5 - Hospital ABN 5 Message - Continued Stay (QIO Concurs)
D	30/80.3.5.6 - Hospital ABN 6 Message - Continued Stay - Swing Bed Only (QIO Concurs) (Patient Changes from Acute to NF Level of Care)
D	30/80.3.5.7 - Hospital ABN 7 Message - Continued Stay - Swing Bed Only (QIO Concurs) (Patient Changes from Acute to SNF Level of Care)
D	30/80.3.5.8 - Hospital ABN 8 Message - Continued Stay - Swing Bed Only (Patient Changes From SNF to NF or Custodial Care)
D	30/80.3.5.9 - Hospital ABN 9 Message - Direct Preadmission/Admission to NF Swing Bed
D	30/80.3.6 - Hospital ABN 10 Message - Hospital Notice to Beneficiary of QIO Review of Need for Continued Hospitalization
D	30/80.4 - Signature Requirements
D	30/80.4.1 - Acknowledgement of Receipt
D	30/80.4.2 - Beneficiary Signature Refusal
D	30/80.4.3 - Signature Requirements Under Special Circumstances
D	30/80.5 - QIO Review Authority for Hospital ABNs
D	30/80.6 - QIO Monitoring of Hospital ABNs
D	30/80.6.1 - Ongoing Monitoring
D	30/80.6.2 - Inappropriate Hospital ABN

D	30/80.7 - Notices in Investigational/Experimental Procedures Situations
D	30/80.8 - Beneficiary Liability
D	30/80.8.1 - Preadmission Hospital ABNs
D	30/80.8.2 - Admission Hospital ABNs
D	30/80.8.2.1 - Hospital ABN Issued on the Day of Admission
D	30/80.8.2.2 - Hospital ABN Issued After the Day of Admission
D	30/80.8.3 - Continued Stay Hospital ABNs
D	30/80.8.3.1 - For Hospital ABNs Issued With the Concurrence of the Attending Physician
D	30/80.8.3.2 - For Hospital ABNs Issued With the Concurrence of the QIO, or with the Concurrence of the Attending Physician
D	30/80.8.4 - Grace Days
D	30/80.9 - Provider Liability
D	30/80.10 - Right to a Reconsideration
D	30/80.10.1 - QIO Disagrees with the Hospital's Determination
D	30/80.10.2 - QIO Agrees with the Hospital's Determination
R	30/130.1.1 - Determining Beneficiary Liability in Claims for Ancillary and Outpatient Services
R	30/130.3 - Application of Limitation on Liability to SNF and Hospital Claims for Services Furnished in Noncertified or Inappropriately Certified Beds
R	30/130.4 - Determining Liability for Services Furnished in a Noncertified SNF or Hospital Bed

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2005 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

Unless otherwise specified, the effective date is the date of service.

Attachment - Business Requirements

Pub. 100-04	Transmittal: 594	Date: June 24, 2005	Change Request : 3903

Transmittal 577, CR 3903, dated June 3, 2005 is rescinded and replaced with Transmittal 594. In chapter 3, Exhibit 1-Hospital Issued Notices of Noncoverage-Ten Letters, was erroneously omitted from the transmittal page. The deletion of this exhibit is now being corrected via this transmittal. All other information remains the same.

SUBJECT: Preliminary Instructions on Expedited Determinations/Reviews for Original Medicare

I. GENERAL INFORMATION

A. Background: This expedited process, modeled on an existing Medicare managed care process, is effective under regulations July 1, 2005. It allows beneficiaries in specific care settings, home health, hospice, Comprehensive Outpatient Rehabilitation Facility (CORF), Skilled Nursing Facility (SNF) and swing bed, the right to appeal a pending discharge from a period of covered care to a Quality Improvement Organization (QIO). This process is similar to the QIO review of inpatient hospital discharges that has existed for some time.

B. Policy: The expedited process for original Medicare was enacted under BIPA and modified by MMA. The final regulation outlining the process was published in November 2004 and is effective July 1, 2005.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3903.1	Intermediaries shall amend user-controlled business processes as needed to account for this new process (i.e., there will be no Medicare/Shared system changes at this time).	X	X							

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3903.2	Contractors shall post this entire instruction, or a direct link to this instruction, on their Web site and include information about it in a listserv message within 1 week of the release of this instruction. In addition, the entire instruction must be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic.	X	X							

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: Paperwork Reduction Act Information Collection Clearance Package CMS-10123-10124.

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: July 1, 2005 **Implementation Date:** July 1, 2005 **Pre-Implementation Contact(s):** Elizabeth Carmody, 410-786-7533, elizabeth.carmody@cms.hhs.gov; Tom Kessler, 410-786-1991, thomas.j.kessler@cms.hhs.gov **Post-Implementation Contact(s):** Appropriate Regional Office	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2005 operating budgets.**

***Unless otherwise specified, the effective date is the date of service.**

ATTACHMENT: Preliminary Instructions: Expedited Determinations/Reviews for Original Medicare

Medicare Claims Processing Manual

Chapter 3 – Inpatient Hospital Billing

130 - Coordination With the Quality Improvement Organization (QIO)

(Rev. 594, Issued: 06-24-05, Effective: 07-01-05, Implementation: 07-01-05)

Instructions regarding hospital interactions with QIOs have been relocated as follows:

- *Instructions regarding HINNs are found in this instruction, CR 3903, which precedes the placement of full instructions in Chapter 30.*
- *Instructions regarding hospital billing for cases involving QIO review will be relocated to a new section in Chapter 1 of this manual in the near future. Current procedures should not change in the interim.*
- *Related instructions for QIOs can be found in the Medicare Quality Improvement Organization Manual, Publication 100-10, Chapter 7.*

Medicare Claims Processing Manual

Chapter 30 - Financial Liability Protections

20 - Limitation On Liability (LOL) Under §1879 Where Medicare Claims Are Disallowed

(Rev. 594, Issued: 06-24-05, Effective: 07-01-05, Implementation: 07-01-05)

Section 1879(a)-(g) of the Act provides financial relief to beneficiaries, providers, practitioners, physicians, and other suppliers by permitting Medicare payment to be made, or requiring refunds to be made, for certain services and items for which Medicare payment would otherwise be denied. This section of the Act is referred to as "the limitation on liability provision."

The basic purpose of this provision is to protect beneficiaries and other claimants from liability in denial cases under certain conditions when services they received are found to be excluded from coverage for one of the reasons specified in §20.1.

Medicare payment under the limitation on liability provision is dependent upon two primary factors. First, the claims for the services or items furnished must have been denied for one of the reasons specified in §20.1. The second factor in determining if Medicare payment is made under the limitation on liability provision is whether the beneficiary and/or the provider, practitioner, physician, or other supplier knew or could reasonably have been expected to know that the items or services (for which Medicare payment was denied on one of the bases specified in §20.1) were not covered. A determination of whether the protection under the limitation on liability provision can be afforded for a denied claim is made as a result of a prepayment medical review or a post-payment audit review. Unfavorable determinations may be appealed.

Where items or services are denied for one of the reasons specified in §20.1, and the other conditions described above are met, the Medicare program makes payment when neither the beneficiary nor the provider, practitioner, or supplier knew, and could not reasonably be expected to have known, that the items or services were not covered. When the beneficiary did not have such knowledge, but the provider, practitioner, or supplier knew, or could have been expected to know, of the exclusion of the items or services, the liability for the charges for the denied items or services rests with the provider, practitioner or supplier. When the beneficiary knew or could have been reasonably expected to know that the items or services were not covered, the liability for the charges rests with the beneficiary, i.e., the beneficiary is responsible for making payment to the provider, practitioner or supplier.

The limitation on liability provision requires the contractor to identify each claim for items or services denied for one of the reasons specified in §20.1. Such denials are processed in the normal manner except that a special message is entered on the notice to the beneficiary and/or provider, practitioner or supplier. Remittance Advices (RA) to

providers, practitioners, or suppliers indicate which items or services were denied for one of the reasons specified in §20.1 in a message included in the RA.

In some cases, the provider, practitioner, or supplier may submit a copy of an advance beneficiary notice (ABN) that satisfies the applicable requirements in §50 - §80. *However, if the reason liability is at issue coincides with the end of coverage for a period of care in specific settings--inpatient hospital, skilled nursing, home health, hospice or comprehensive outpatient rehabilitation facilities--notification under the expedited determination process will be required as of July 1, 2005. See CR 3903 for preliminary information on the expedited process, including its interaction with liability notice policy.*

> ***NOTE:*** *This chapter often uses the term "ABN" to signify all limitation of liability notices, not just a specific ABN form such as the CMS-R-131.*

Providers annotate claims to indicate an ABN was given. In these cases, the contractor should not make an automatic finding that the service is denied for one of the reasons specified in §20.1 merely because an acceptable ABN has been submitted. The fact that there is an acceptable ABN must in no way prejudice the contractor determination as to whether there is or is not sufficient evidence to justify a denial for one of the reasons specified in §20.1.

80 - Hospital-Issued Notices of Noncoverage (HINN)

(Rev. 594, Issued: 06-24-05, Effective: 07-01-05, Implementation: 07-01-05)

Instructions for the Hospital ABN have been retracted. Instructions related to HINNs have been relocated as follows:

- *Instructions regarding HINNs are found in this instruction, CR 3903, which precedes the placement of full instructions in Chapter 30.*
- *Instructions regarding hospital billing for cases involving QIO review will be relocated to a new section in Chapter 1 of this manual in the near future. Current procedures should not change in the interim.*
- *Related instructions for QIOs can be found in the Medicare Quality Improvement Organization Manual, Publication 100-10, Chapter 7.*

130.1.1 - Determining Beneficiary Liability in Claims for Ancillary and Outpatient Services

(Rev. 594, Issued: 06-24-05, Effective: 07-01-05, Implementation: 07-01-05)

A presumption will be made that the beneficiary did not know that items or services are not covered unless there is evidence to the contrary. Indication on the claim that the beneficiary received proper advance beneficiary notice before receiving the noncovered ancillary, outpatient, or rural health clinic services is evidence to the contrary which rebuts the presumption in the beneficiary's favor. The definitions of proper "advance beneficiary notice" to the beneficiary are set forth in §40.3. *Note that if the reason liability is at issue coincides with the end of coverage for a period of care in specific settings-- inpatient hospital, skilled nursing, home health, hospice or comprehensive outpatient rehabilitation facilities--notification under the expedited determination process will be required as of July 1, 2005. See CR#3903 for preliminary information on the expedited process, including its interaction with liability notice policy (i.e., ABNs).*

130.3 - Application of Limitation on Liability to SNF and Hospital Claims for Services Furnished in Noncertified or Inappropriately Certified Beds

(Rev. 594, Issued: 06-24-05, Effective: 07-01-05, Implementation: 07-01-05)

A - General

Payment for SNF and hospital claims may not be denied solely on the basis of a beneficiary's placement in a non-certified bed of a participating SNF or hospital. When requested by the beneficiary or his/her authorized representative, a provider must submit a claim to the FI for services rendered in a non-certified bed. When the FI reviews a claim for services rendered in a non-certified bed, it first determines whether the beneficiary consented to the placement. (See subsection C.) If the FI finds that the beneficiary consented, it denies the claim. If it finds that the beneficiary did not consent, it determines whether there are any other reasons for denying the claim. (See subsection D.) If there is another reason for denying the claim, the FI denies it. However, if none of the reasons for denial exist, beneficiary liability must be waived as provided under §1879(e) of the Act and a further determination must be made as to whether the provider, rather than the Medicare program, must accept liability for the services in question. (See "Coverage of Extended Care Services Under Hospital Insurance" in the Medicare Benefit Policy Manual, Chapter 8.)

B - Provider Notice Requirements

When a SNF or hospital places a patient in a noncertified or inappropriately certified portion of its facility because it believes the patient does not require a covered level of care, or for any other reason, it must notify the patient (or authorized representative) in writing that services in a noncertified or inappropriately certified bed are not covered.

The provider uses the *appropriate notice specified in §70 of this chapter for SNFs or swing beds, §80 for inpatient hospitals,* to advise the beneficiary of its decision to place him/her in a noncertified bed, using language such as:

> We are placing you in a part of this facility that is not appropriately certified by Medicare because (you do not require a level of care that will qualify as skilled nursing care/or covered hospital services under Medicare)/(or state any other reasons for the noncertified bed placement). Nonqualifying services furnished a patient in a noncertified or inappropriately certified bed are not payable by Medicare. However, you may request us to file a claim for Medicare benefits. Based on this claim, Medicare will make a formal determination and advise whether any benefits are payable to you.

(For related general billing requirements, see Chapter 1, §60 of this manual, or other chapters specific to the benefit being billed: Chapter 3 for inpatient hospitals and swing beds, Chapter 6 for swing bed PPS and inpatient SNFs, and Chapter 7 for outpatient SNFs.)

C - Determining Beneficiary Consent

The CMS presumes that the beneficiary did not consent to being placed in a noncertified bed. In order to rebut the presumption of *lack of* consent, the provider must indicate on

the bill the date it provided the beneficiary with an ABN notifying the beneficiary that the accommodations would no longer be covered; and requested the beneficiary's signed acknowledgement (on the ABN) of having received such a statement. Moreover, in any case in which a Medicare beneficiary gives his/her consent to placement in a noncertified bed, the provider must, if requested by the FI (contemplated only at an appeal level of claim processing), submit a copy of the ABN signed by the beneficiary to the FI, for a determination of the ABN's validity. The ABN must be signed by the beneficiary (provided he/she is competent to give such consent) or by the beneficiary's authorized representative. If the beneficiary or his/her authorized representative refuses to sign the form, the provider may annotate the file to indicate it presented the ABN to the beneficiary (or his/her authorized representative), but the beneficiary refused to sign. As long as the provider's ABN notifies the beneficiary of the likely Medicare noncoverage, the beneficiary's refusal to sign the ABN does not render it invalid. (See §40.3.4.6.) If any of the above requirements is not met, the FI automatically determines the ABN is defective.

When the FI receives *a claim* with an indication that the provider has provided the beneficiary or his/her authorized representative, *with* an ABN, the FI denies the claim and notifies the beneficiary that §1879 limitation on liability cannot be applied because of the beneficiary's valid consent to be cared for in a noncertified or inappropriately certified bed. If the FI determines that the ABN is not valid, the FI processes the claim in accordance with §130.4.

If the beneficiary appeals the initial denial, the FI obtains the ABN from the provider and determines whether it is valid. If the FI determines that the ABN is invalid, it notifies the provider and the beneficiary that payment **may** be made to the extent that all other requirements are met.

D - Determining Whether Other Requirements for Payment are Met

Denials still are appropriate for any of the following reasons. The FI must undertake the development needed to permit a determination as to whether:

- The patient did not receive or require otherwise covered hospital services or a covered level of SNF care;
- The benefits are exhausted;
- The physician's certification requirement is not met;
- There was no qualifying 3-day hospital stay (applicable to SNFs only); or
- Transfer from the hospital to the SNF was not made on a timely basis. (However, if transfer to an institution which contains a participating SNF is made on a timely basis, a claim cannot be denied solely on the grounds that the transfer requirement is not met because the bed in which the beneficiary is placed is not a certified SNF bed.)

The FI denies cases falling within these categories under existing procedures. Also, if the beneficiary receives care in a totally nonparticipating institution, denial on the grounds that the beneficiary was not in a participating SNF or hospital is still appropriate.

130.4 - Determining Liability for Services Furnished in a Noncertified SNF or Hospital Bed

(Rev. 594, Issued: 06-24-05, Effective: 07-01-05, Implementation: 07-01-05)

The FI presumes that the provider properly notified the beneficiary of noncoverage, and *that* the beneficiary assented, if the claim includes *the proper indicators of liability notification*.

The following development occurs only if the beneficiary appeals the FI's decision that the beneficiary may not have liability waived because the provider gave him/her timely notice that Medicare would not cover the accommodation; and that he/she consented to being placed in a noncertified bed.

A - Beneficiary Liability

If the FI determines that the beneficiary did not consent to placement in the noncertified bed within the participating facility (see §130.3.C), and that no other basis for denial of the claim exists (see §130.3.D), it finds the beneficiary not liable under §1879 of the Act.

B - Provider Liability

If the beneficiary is found not liable under §1879, liability may rest with the provider, or with the program. Liability rests with the Medicare program, unless any of the following conditions exist, in which case the provider is liable for the services.

- The provider did not give timely written notice to the beneficiary of the implications of receiving care in a noncertified or inappropriately certified bed as discussed in §130.3.B;
- The provider failed to provide the beneficiary with an appropriate ABN and/or did not attempt to obtain a valid consent statement from the beneficiary. (See §130.3.C.); or
- The FI determined from medical records in its claims files that it is clear that the beneficiary required and received services equivalent to a covered level of SNF care, or that constituted covered hospital services, and the provider had no reasonable basis for placing the beneficiary in a noncertified bed. Following are examples of situations in which it would be found that the provider did in fact have a reasonable basis to place a beneficiary in a noncertified bed:

EXAMPLES

- The FI, a QIO, or Utilization Review Committee had advised the provider that the beneficiary did not require a covered level of SNF care or covered hospital services *preadmission/admission*;
- The beneficiary's attending physician specifically advised the provider (verified by documentation in the medical record) that the beneficiary no longer required a covered level of care or services; *note that if covered care had previously existed, effective July 1, 2005, notification under the expedited determination process would be required (see §20 of this chapter);*

- A beneficiary not requiring covered services had a change in his/her condition that later required a covered level of care or services and the provider had no certified bed available (of course, the SNF transfer requirement must be met, see the Medicare Benefit Policy Manual, Chapter 8.); or
- The FI has other sufficient evidence to determine that the provider acted in good faith but inadvertently placed the beneficiary in a noncertified bed.

ATTACHMENT

(Rev. 594, Issued: 06-24-05, Effective: 07-01-05, Implementation: 07-01-05)

Preliminary Instructions: Expedited Determinations/Reviews for Original Medicare

I. Background and Summary

The Benefit Integrity and Protection Act of 2000 (BIPA), modified by the Medicare Modernization Act of 2003 (MMA), and implemented through a final regulation, CMS-4004-FC, effective July 1, 2005, conformed an existing Quality Improvement Organization (QIO) review process for inpatient hospitals, and created a new parallel process for hospices, home health agencies (HHAs), comprehensive outpatient rehabilitation facilities (CORFs) and skilled nursing level care at inpatient facilities (skilled nursing facilities (SNFs) and hospital swing beds), called expedited determinations/review, summarized in the following charts:

H O S P I T A L	**42 CFR 405.1206 - .1208**
• Previously existing process now codified in regulations • All inpatient services paid by Part A, including Critical Access Hospitals (CAHs) • Services submitted on institutional claims with type of bill (TOB)* 11x • Inpatient Part B services (12x TOB) remain categorized as outpatient hospital, not included • Existing QIO review right triggered by use of HINN form mostly unchanged, **EXCEPT:** o Now limited to discharges from hospital level care **ONLY** **Therefore, new process/notices for Swing Beds at skilled nursing level of care**	

→ NO NEW FISCAL INTERMEDIARY INSTRUCTIONS FOR 07/01/2005, HINN instructions updated, especially for swing bed change (attached)

N O N - H O S P I T A L

4 2 CFR 405.1200 - .1202

- New process, new notices - notification MUST use prescribed notices.
- "Discharge/Termination**" of all covered Skilled Nursing Facility (SNF), Hospice, Home Health and Comprehensive Outpatient Rehabilitation Facility (CORF) services
- **Swing Bed terminations change from existing hospital process to this process**

  Affected TOBs: 18x, 21x, 22x, 32x, 33x, 34x, 75x, 81x, 82x

NEW FISCAL INTERMEDIARY INSTRUCTIONS **++REQUIRED++** FOR 07/01/2005

*TOB is a field on the claim classifying the type of provider/service (see Medicare Claims Processing Manual Chapter 25)

**42 CFR 405.1200(a)(2)—reductions of services are not included.

Overview of Non-Hospital Expedited Determination Process for Original Medicare

RESIDENTIAL: ***No additional requirement beyond discharge (42 CFR 405.1202(a)(2)) 405.1202(a)(1))***	***NON-RESIDENTIAL:*** ***A physician must certify health risk* (42 CFR***
Hospice: 81x, 82x -- **Scope:** All care settings, even home -- **Triggering Event**: "Discharge" meaning coverage discharge ONLY on plan	**CORF: 75x** -- **Scope**: Exclusively CORF (i.e., no ORFs, no therapy at OPDs) -- **Triggering Event:** "Termination" meaning end of all covered services
SNF: 21x, 22x 34x -- **Scope:** All continuous A-B stays care, -- **Triggering Event**: "Discharge" meaning end of all covered services, including change to NF, NOT transfer /LOA* * plan	**Home Health (HH): 32x, 33x,** -- **Scope:** All coverage under a plan of home health OR therapy plan -- **Triggering Event:** "Termination" meaning end of all covered services on
Swing Bed: 18x -- **Scope:** All covered SNF-level services -- **Triggering Event:** "Discharge" meaning end of all covered services, including change to NF, **NOT** transfer/LOA**	

***** The certification may be provided by any physician, does not authorize the delivery of any services not previously ordered,

and may be provided by a QIO physician if the beneficiary wants to request an expedited determination but cannot find another physician.

****LOA = *Leave of absence.*** Transfers are not included if to other Medicare providers of same/similar type for comparable covered care in comparable setting (i.e., residential to other residential setting).

A. Explanation of Scope. In short, providers must give notice to eligible beneficiaries of their right to expedited determinations when their period of covered care ends. Expedited determinations allow beneficiaries to challenge/appeal their provider's decisions to discharge, whereas the standard appeal process available after a claim is adjudicated allows beneficiaries to dispute payment denials.

B. Duration. With expedited determinations, Medicare covered care must have been occurring for some type of duration, such as a stay in an inpatient facility, or a period of services delivered under a plan of care supported by a physician order. Therefore, when these criteria are met, expedited determinations are available for one of the specified benefits.

For example, home health services billed on a 34x TOB are included if there is a therapy plan of care, but not when the HHA is acting as a durable medical equipment supplier in one-time or sporadic delivery of equipment. Generally, intermittent items or services covered under Part B do not trigger the right to expedited determinations, since there is no continuous care to end. Therefore, TOB 23x claims for non-skilled nursing facility patients would never be included, since services covered on that TOB are incidental and paid under Part B for residents otherwise receiving custodial, and therefore Medicare noncovered, care. If previously at a skilled nursing level of care, that beneficiary would have gotten notice of the expedited right when that covered care ended. The rare instance of a one-visit home health episode, however, would trigger the expedited right, since home health is an integrated Part A-B benefit, and because orders were written anticipating more than one visit. The same principle would hold for CORFs under a therapy plan of care, even though paid exclusively under Part B.

C. Discharge for Other than Coverage Reasons. Expedited determinations do not occur when discharge is unrelated to coverage. For example, QIOs could not force provider staff to continue entering an unsafe environment by virtue of a decision disputing discharge. The issue of an unsafe environment most often occurs in HH and hospice, where delivery of care involves

going into beneficiary homes. In such cases, the provider's decision to discharge is independent of the beneficiary's qualification for coverage, so there is not an end of coverage to trigger an expedited review.

D. Hospice Scope. Even though revocation represents an end of covered hospice care, it cannot trigger an expedited determination since it is the beneficiary's, not the provider's, choice to revoke. Of hospice discharges, the ones related to qualification/coverage specific to the benefit would be rare cases where a beneficiary previously certified as terminally ill is judged no longer to be terminal. This limited use of expedited determinations for hospice has been anticipated and was discussed in the preamble of the expedited determination final rule.

E. Resources. The remainder of this document provides preliminary instructions on this review process for providers effective July 1, 2005. Under regulations, QIOs must have contracts with Fiscal Intermediaries (FIs) and Regional Home health Intermediaries (RHHIs), referred to as "intermediaries", that support this process. QIOs are assigned to cover specific States, and may directly contact providers to facilitate this new review process by that date. More detailed manualized instructions will follow this instruction, and other resources include:

- CMS-4004-FC can be accessed on the CMS website at: www.cms.hhs.gov/providerupdate/october2004/newregs.asp
- Frequently asked questions (FAQs) on the new review process can be found at: www.cms.hhs.gov/medicare/bni/default.asp
- A State QIO directory is found on the CMS website at: http://www.cms.hhs.gov/qio/

F. Relation of Liability Notices. Expedited determinations/reviews affect existing liability notification requirements. The following chart summarizes when the expedited determination (ED) process/notices, which address discharge, should be used, and when a liability notice, often generally referred to as an Advance Beneficiary Notice (ABN) would apply, since a beneficiary faces the possibility of responsibility for payment. [ABN instructions are in the on-line Medicare Claims Processing Manual, Publication 100-4, Chapter 30; the generic ABN, Form CMS-R-131, is used for CORF and hospice services (Section 50 of that Chapter), the HHABN for HH (Section 60 of that Chapter), the Hospital Issued Notice of Noncoverage (HINN) for

inpatient hospital services (see major section V. of this instruction), and a skilled nursing liability notice for that specific level of care (see Chapter 30, Section 70).]

In general, there is only one case when both notices are given, as listed in the following chart. Since the expedited notices do not necessarily give beneficiaries immediate information on the reason for noncoverage or costs of noncovered care, if there is a condition under which care could continue after coverage unexpectedly ends, current policy related to enforcement of limitation of liability under Section 1879 of the Social Security Act, and possibly conditions of participation applicable to a specific benefit, may require such additional information be provided, hence a need to provide both types of notice.

Original Medical Benefits: ED Notices and Relation to Other Liability Notices

TRIGGERING EVENT/ SCENARIO	Covered Care Reduction	Covered Care Discharge/ Termination	Covered Care Special Cases	Noncovered[i] Initiation, Reduction, Termination	Not Any Defined Medicare Benefit[ii]
Benefit/Type of Bill (TOB)	**1**	**2**	**3**	**4**	**5**
CORF **75x TOB** **(Part B)**	ABN	**ED Notice(s)** **AND** ABN **if** option to continue noncovered care	None	ABN	None, optional notice[iii]
HH **32x, 33x/ 34x*** **(Part A-B)/(Part B)** *** with therapy plan of care**	HHABN	**ED Notice(s**), unless special case, **AND** HHABN **if** option to continue noncovered care	End care for HHA business need – HHABN[iv]	HHABN	HHABN; if prior to accepting patient[v], HHABN-- phasing out optional notice
Hospice **81x, 82x** **(Part A)**	ABN, if any	**ED Notice(s)** **AND** ABN **if** option to continue noncovered care	None	ABN	None, optional notice
SNF **21x / 22x** **(Part A)/(Part B)**	Skilled Nursing Liability Notice [VI]	**ED Notice(s)**, unless special case, **AND** Skilled Nursing Liability Notice **if** option to continue noncovered care	At exhaustion of Part A benefits – Skilled Nursing Liability Notice	Skilled Nursing Liability Notice	None, optional notice
Swing Bed **18x** **(Part A)**	Skilled Nursing Liability Notice, if any	**ED Notice(s**), unless special case, **AND** HINN **if** option to continue noncovered care	At exhaustion of Part A benefits – Skilled Nursing Liability Notice	HINN	None, optional notice

i Meaning specific policy reason for limitation of coverage: care not reasonable/necessary, benefit requirement not met/exhausted.

ii Meaning always excluded from coverage under the original Medicare program by law (i.e., 1862), or not meeting the definition of a Medicare benefit.

iii Optional notices including specific Medicare Notice(s) of Exclusion from Medicare Benefits (NEMB).

iv Special requirement for home health under the Lutwin decision.
v HH COPs require notification if HHA intends charge potential patient for assessment when subsequently deciding not to accept patient.
VI Notice found in Publication 100-4, Chapter 30, Section 70.

A circumstance where two notices might be required is somewhat more likely to occur in home health. For example, a physician writes an order, and a plan of care is developed for services all normally covered under the home health benefit. Original Medicare pays this benefit in 60-day increments, and consequently, home health plans of care often cover 60 days. However, where covered care was expected to last at least 60 days, a beneficiary may no longer be homebound at Day 30, and therefore no longer qualifies for the benefit. An expedited determination notice would be given as soon as the failure to qualify for the benefit seemed likely, and a HHABN must be given because the items and services could be continued as noncovered care, for which the beneficiary would be liable. This is because the bundled payment unit, though lasting as long as 60 days, ends on the day coverage ends.

Somewhat similar is the need to give the skilled nursing liability notice (instructions are currently being amended in Chapter 30, Section 70) when the end of 100 days of Part A coverage is reached, since after that point the beneficiary will be liable for room and board. Generally, en expedited notice is not given when benefits exhaust. The expedited determination notice would only be given simultaneously to the other notice at that point if benefits exhausting coincided with the end of all covered care. More usually, the beneficiary continues into what is called a Part B stay where a skilled level of care is still delivered, and an expedited notice would not be given until the Part B stay ends.

The differentiation of which notice to use is most difficult for swing beds. With the advent of expedited determinations, in order to remain consistent with existing procedures for Medicare managed care, when covered skilled nursing level care is delivered, the notices that should be used should be the same as those used by SNFs delivering similar care, meaning either the skilled nursing liability notice or the non-hospital expedited review notices, as shown in the chart above. However, when care is noncovered such that level of care is not at issue, giving notice must reflect the setting of care instead, and therefore the HINN would be appropriate (see revised instructions for the HINN in major section V of this instruction).

G. Beneficiary Awareness. Beneficiaries who in the past have been in Medicare managed care may be aware of a similar review process on that side of the Program. Also, beneficiaries who have been hospital inpatients under original Medicare may have experienced QIO review of HINNs. The new expedited review process/ notices are particularly modeled on the existing

managed care process. Still, this process may be new to many beneficiaries. The most important aspect of the process for beneficiaries to understand is that they must make timely contact with the appropriate QIO as directed on the notice to trigger a timely expedited review. If a beneficiary in error contacts an intermediary, that intermediary should either instruct the beneficiary to use the information on the notice and call the QIO, or contact the provider to assist the beneficiary if confused by the notice, or, as a last resort, contact the QIO, making a link to the beneficiary. Intermediaries, and others like 1-800-Medicare call center staff, may have to work to make beneficiaries understand they have no active role in expedited review, and may have to stress to beneficiaries unaccustomed to QIOs that these entities must be contacted for this process.

H. Intermediary Role. The main duties for intermediaries in expedited reviews are to support beneficiaries and providers through an awareness of the process as explained in this instruction, and to perform routine duties potentially affected by this process-- liability notice oversight, claims processing and medical review-- with the same type of awareness. Effects on liability notices were presented above, and claims processing is discussed in major section III and IV of this instruction—particularly the need to coordinate with QIOs. Medical review should never repeat or contradict the results of QIO review, since this would be duplicative and QIO decisions are binding, and QIOs are bound by the same coverage policy in making their determinations-- even local policy. But the scope of these QIO decisions are limited to discharge, and medical review examines a much broader range of potential issues and periods of care. For example, a monthly SNF claim could include a discharge reviewed by a QIO, but it also contains other days of billing not related to discharge—the non-discharge period is not considered by the QIO, and would still be subject to medical review.

I. Process Overview. The expedited determination regulations lay out a review process involving beneficiaries, providers, QIOs and other entities. Usually, providers must give a "generic" notice to beneficiaries when the end of all covered care is foreseen, even if the beneficiary agrees with the discharge. The notice used is a prescribed CMS notice, which the provider works with the beneficiary to have him/her complete and sign, assuring the beneficiary understands the end of covered care is imminent. If the beneficiary accepts the provider's determination on termination, no additional action is required. However, if the beneficiary disagrees, the beneficiary contacts a QIO to request an expedited review. The provider must

then give a “detailed” notice explaining the reason for the initial notice on the termination of covered care. The QIO is responsible for establishing contact with the provider, so that the beneficiary’s medical records can used in making a determination, although QIOs can still make such decisions even if records are not available. The QIO makes a decision on coverage in answer to the beneficiary’s request for review, relaying this decision back to the involved parties. The following four tables provide more detail on this process.

J. Special Considerations Related to the Summary Charts. The summary charts on Pages 8, 9, 12 and 14 are intended as reference tools for providers. All key aspects of the regulation are summarized so that providers do not have to read the regulation, and related policy made through instruction is also integrated into the charts. However, additional explanation and policy appear in the rest of this section.

Milestone Charts. The milestone charts on Pages 8 and 9 are related, with the top row of both charts being the five key milestones of the review process. The first of these charts does nothing more than summarize the regulatory requirements of expedited reviews when **timely.** The second chart clarifies that there are some review rights when the process is **untimely** as well. Additionally, this chart lists statements in the regulation on provider liability, and clarifications made in instructions, relative to the milestone timing and conditions when the provider may be liable.

Milestones of QIO Expedited Determinations/Reviews under Regulation

STEP	1	2	3	4*	5**
Milestone	Provision of the **generic notice** to the beneficiary by the provider	Timely request by beneficiary to State QIO for expedited determination	QIO notification to provider of timely beneficiary request for expedited determination	Provision of the **detailed notice** to the beneficiary by the provider	Determination by QIO in timely process, with notification of beneficiary, beneficiary's physician and provider***
Reg Text Summary	No later than 2 days before the proposed end of covered services, but if services are fewer than 2 days in duration, give notification at the time of admission, or for non-residential providers, the next to the last time services are furnished	By no later than noon of the calendar date following receipt of the generic notice, and once the beneficiary requests the process, billing cannot occur until the QIO determines if coverage can continue.	On the day the QIO receives the request, it must immediately notify the provider	By close of business the same day as the QIO notifies the provider that a beneficiary has requested an expedited determination	No later than 72 hours after the receipt of the request for the expedited determination; Notification may initially be by telephone, but must be followed by a **written notice,** which includes information on reconsideration options. The QIO may make a decision even if not all requested information has been received.
Citation	42 CFR 405.1200 (b)(1)	42 CFR 405.1202 (b)(1) and (g)	42 CFR 405.102 (e)(1)	42 CFR 405.1202 (f)(1)	42 CFR 405.1202 (e)(6), (7) and (8)
Application	**All** SNF, swing bed, HH, hospice, and CORF beneficiaries ending a period of covered care.	SNF, swing bed, HH, hospice, and CORF beneficiaries **disputing** the end of covered care.	SNF, swing bed, HH, hospice, and CORF beneficiaries **disputing** the end of covered care.	SNF, swing bed, HH, hospice, and CORF beneficiaries the **disputing** end of covered care.	SNF, swing bed, HH, hospice, and CORF beneficiaries **disputing** the end of covered care.

* In between Steps 4 and 5, the provider should supply the QIO with requested records (42 CFR 405.1202 (d)), and the QIO will solicit the views of the beneficiary (42 CFR 405.1202(e)(4)).

** Subsequent to the determination process, the beneficiary can ask for a reconsideration (42 CFR 405.1204)

*** QIOs also intend to inform the payers(intermediaries).

Clarification to Milestones of QIO Expedited Determinations/Reviews, *Including* Untimely Review Option

STEP	1	2	3	4*	5**

Milestone	Provision of the **generic notice** to the beneficiary by the provider	Timely request by beneficiary to QIO for expedited determination	QIO notification to provider of timely beneficiary request for expedited determination	Provision of the **detailed notice** to the beneficiary by the provider	Determination by QIO in timely process, with notification of beneficiary, beneficiary's physician and provider
<u>Clarification</u> ======== **(Bolded text indicates clarification made through instructions.)**	The preamble of the regulation adds provision can be earlier than 2 days if the end of coverage can be foreseen. If the provider fails to give valid notice, beneficiary coverage continues for at least 2 days after valid notice is received (42 CFR 1202(c)). ========== **Provide notice simultaneous to service if conditions of coverage found suddenly no longer to be met.** **Provide applicable ABN if option for noncovered services exists; HHABN for HH.**	Expands to noon of the first day when QIO is available if not available immediately (42 CFR 1202 (b)(1)). There is an untimely QIO review option (42 CFR 405.1202 (b)(4)). The beneficiary may submit evidence for consideration by the QIO, and must be available to answer QIO questions (42 CFR 1202 (b)(2) &(3), and (d)(2)). ========== **No matter when the generic notice is given, the beneficiary still has until the day before coverage ends to request QIO review, or until 24 hours after the generic notice is given when coverage ends abruptly.**	If an untimely review is requested, beneficiaries do not have financial liability protection. ========== **The end of this liability protection means funds can be collected for noncovered services before a QIO determination, but must be refunded back to end of coverage effective date on the generic notice if the QIO finds coverage should have been extended.**	If an untimely review is requested, this requirement for provision of the detailed notice remains. Providers must also supply beneficiaries with copies of documentation sent to the QIO, if requested, by close of business after the first day after the request, but may charge a copying fee (42 CFR 405 (f)(3)). ========== **Providers should give the detailed notice after the generic to any beneficiary who requests it, even if a QIO has not been contacted.**	If an untimely review is requested, the QIO makes a determination "as soon as possible", not necessarily within the 72-hour limit.* The burden of proof rests with the provider to support the coverage termination decision, and should meet QIO requests for information**, ***and must supply copies of the generic and detailed notices, and must be allowed to explain termination decisions to QIOs*** (42 CFR 405.1202 (d), (e)(5) and(f)(2)). If the determination is delayed because the provider is slow in or fails to meet QIO information requests, the provider may be liable (42 CFR 405.102 (c)). QIOs will not require coverage to continue if posing a threat to the beneficiary's health and safety (42 CFR 405.102(c))—see II. B. below.

* QIOs will aim to make reviews within 7 calendar days of the request if services are still being delivered, within 30 calendar days if not still an inpatient

** By phone initially, by phone contact must be reflected in a written record.

Of particular note beyond the regulatory text:

- Providers may have to give multiple notices simultaneously:
    - Applicable liability notice/ABN if option for noncovered services exists (see Pages 4, 5 and 6);
    - Simultaneous generic and detailed expedited determination notices when coverage appears to have ended abruptly and it is apparent the beneficiary will seek an expedited determination (see Page 16, "Simultaneous Notification").
- No matter when in the covered period generic notice is given, the beneficiary still has until the day before the end of coverage to request QIO review, or until the first full 24 hour period after the generic notice is given when coverage ends abruptly, or longer in an exception case when the QIO is not available.
- Beneficiaries who receive the generic notice and request the generic notice should receive both notices, even if it is not clear the beneficiary has or will call the QIO to request review.
- The expedited review process, with or without reconsideration, occurs and is complete before a claim is filed, usually before discharge, but even in the case where the beneficiary request is untimely and services may not be being delivered anymore, there should be no billing until the process is complete; therefore, billing procedures do not change with this instruction – see major section IV below.

When the expedited review process is untimely, the end of liability protection means funds can be collected for noncovered services before a QIO determination, but must be refunded if the QIO finds coverage should have been extended. In general, the term "liability" in this regulation refers to a potential delay in the collection of funds due from the beneficiary subsequent to the effective date coverage ends provided in the generic notice; if the QIO decision extends coverage, however, there is nothing due from the beneficiary for the period in question. This is in contrast to the parallel review process for hospital inpatients, where liability means no

collection of funds until after the QIO decisions is received, not collection back to the effective date—see major section V of this instruction.

Other Impacts Related to Billing/The Collection of Funds. Providers are required to consider impacts beyond billing. Though QIOs are bound to consider the same Medicare coverage policy as providers and intermediaries, and therefore are somewhat likely to come to the same conclusions, it is possible these entities will disagree with the provider assessment of the patient.

- Consequently, providers should NOT discharge patients who are still under their care while the discharge is under dispute through the entire expedited review process. Providers should not conclude discharge paperwork, or lock or transmit applicable patient assessments, in addition to the hold on billing while the expedited review unfolds.

- Additionally, since providers usually communicate with the ordering physician when discharging patients—and if physician agrees that the patient can be discharged, then the agency no longer has orders-- the physician should be informed in contacts by the provider that the beneficiary will/is seeking an expedited determination or reconsideration, and also advised as to the possible impacts of this review process on coverage.

  NOTE: QIOs/QICs are not ordering/prescribing entities, even though they may provide the special certification needed for beneficiaries under the care of nonresidential providers. The expedited determination process does not override other regulatory requirements that orders be in place to deliver care. QIO decisions are made relative to a period where discharge, but not coverage, is at issue, since providers should be notifying beneficiaries whenever possible before coverage ends. That is, the expedited review process is designed to address only the remainder of what could be a covered period. If a QIO/QIC decision prolonging coverage impacts a period where orders do not exist, either because of the duration of the expedited review process, or because the physician has already concurred with the termination of orders, providers cannot deliver care. The QIO/QIC should contact an ordering physician if this occurs, preferably the same physician who has been ordering care in the case under consideration, and present

to that physician its decisions and the impact regarding reconsidering his/her own termination of orders-- or writing new orders. This is consistent with the regulations in noting the review process should not result in jeopardy to the beneficiary's health—see II. B. below. However, QIOs cannot force any physician to write orders.

Delivery of Services During the Review Process. Given the expedited review process begins at a point where a provider believes discharge is appropriate, assuming the patient's condition does not change, it is less likely there will be a medical need to deliver additional services while the review process unfolds. There is no obligation to deliver new services just because a beneficiary invokes the review process; the basic rule still holds that care must be medically necessary. The fact that the provider is expected to give the beneficiary the generic notice two days in advance of the end of coverage in most cases does not mean two additional days of services MUST be provided after that point, just that the beneficiary should be given the notice, and the association option to appeal, in advance of the end of coverage, while payment liability is not an additional concern, if at all possible.

Results/Appeal Option Chart. The last line of the chart on Page 8 segues to this subsequent chart. It expands on the information on the previous chart by putting expedited determinations and reconsideration in the context of claim-based or standard appeals (see V.F. below in this instruction for more information on reconsiderations).

Results of Expedited Determinations and Appeal Options

Scenario	**Beneficiary EITHER not eligible for expedited appeal, OR received generic notice and does not dispute discharge**	**QIO finds provider is correct - expedited process invoked timely, no reversal by QIC**	**QIO or QIC finds beneficiary is correct -expedited process, determination with or without reconsideration, invoked timely**	**Untimely Expedited Determin-ation**	**Timely Expedited Reconsideration**	**Untimely Expedited Reconsid-eration**	**Mitigating Factors**
Coverage *	Whether an ABN is given, services are covered or noncovered, if beneficiary receives services and files a claim, and an initial determination is made to deny when the claim is processed, an appeal can be made of that determination— this is **the standard appeal process**	Coverage ends as specified at the top of the generic notice (effective date)	Coverage continues until either orders end for care or until the provider again believes discharge notification is appropriate—in both cases, the generic notice must be given again when that point comes.	If an untimely review is requested, beneficiaries do not have financial liability protection (i.e., funds can be collected for noncovered care at after the effective date coverage ends)	The beneficiary must submit a request for this process by noon of the day following notification by the QIO of the expedited determination decisions (42 CFR 405.1204(b)(1)).		If the provider fails to give valid notice, beneficiary coverage continues for at least 2 days after valid notice is received (42 CFR 1202(c)).—see IV for billing If the provider is not timely in supplying information the QIO requests, the provider may be liable for the costs of additional coverage (42 CFR 405.1202(c) and (e)(7)—see IV for billing. QIOs will not require coverage to continue if posing a threat to the beneficiary's health and safety (42 CFR 405.1202(c)).
Further Beneficiary Appeal Options	None beyond the standard appeal process	Expedited Reconsidera-tion beyond QIO determina-tion (42 CFR 405.1204)	N/A – coverage continues, FI/RHHI** cannot reverse QIO/QIC determination to continue coverage	Expedited Reconsidera-tion (42 CFR 405.1204)	QIC decisions are binding, except can be subject to Administrative Law Judge (ALJ) review when requested by the beneficiary through the standard appeal process (Reg. Preamble II.B)	None beyond the standard appeal process (42 CFR 405.1204 (b)(4))	If the QIO is untimely with its decision under the reconsideration process, the beneficiary may escalate the appeal to an ALJ level as long as at least $100 is at issue (42 CFR 405.1204(c)(5)).

*** Neither the expedited review process nor decisions can change or extend existing Medicare coverage policy**. Rather, it is the QIO, not the FI or RHHI, that makes a determination under the expedited process as to whether or not the provider has correctly interpreted existing policy in the individual case.

** FIs/RHHIs still make non-coverage related determinations independent of discharge that could override the QIO—such as lack of beneficiary eligibility.

It is most important for providers to note that:

- The expedited review process, both determinations and reconsiderations, cannot change or extend existing Medicare coverage policy. Rather, in the process, it is the review entity, QIO or QIC, not the intermediary, which makes a decision as to whether or not the provider has correctly interpreted existing policy in the individual case.

- The use of the expedited review process does not remove standard appeal rights. However, it may impact the level at which this process begins, such as the references made to administrate law judges (ALJs) in the chart.

Review Entity Chart. Providers and intermediaries are not responsible for the performance of the QIO or QIC review, but are affected by the process. This final summary chart highlights the points of highest impact of QIO/QIC actions on both providers and beneficiaries.

> **NOTE:** Providers have a primary and recurring role in beneficiary education on the expedited review process. As the entities providing the expedited notices to beneficiaries, they are responsible for alerting beneficiaries to this appeal option, and for explaining the notices they provide in the context of the overall review process.

Review Entity Responsibilities in Expedited Determinations and Reconsiderations
Providers Should Know

<u>Under Expedited Determinations</u>, made at a beneficiary's request, QIOs decide:

- If notification is valid (42 CFR 405.1202 (e)(2)).
- If coverage should be continued, or that the provider's coverage termination decision is correct (42 CFR 405.1202(e)(6)).

<u>Under Expedited Determinations</u>, QIOs request:

- Records from providers (42 CFR 405.1202(c), (e)(7) and (f)(2)).
- Beneficiary opinions (42 CFR 405.1202 (e)(4)), and may accept beneficiary evidence (42 CFR 405.1202(b)(3)).
- Physician certifications of immediate health risk in non-residential settings (42 CFR 405.1202(a)(1)), though providers should make beneficiaries aware the QIO may provide the certification if the beneficiary cannot find another physician.

<u>Under Expedited Determinations</u>, QIOs deliver:

- Notification to beneficiaries, their physicians and providers, ultimately in writing, of their determinations (42 CFR 405.1202(e)(8)), which may include payment consequences, and the beneficiary's right to reconsideration when timely requests are made.

<u>Under Expedited Reconsiderations</u>, the reconsideration process primarily involves the beneficiary, QIO, and reconsideration entity (QIC). QICs are required to notify the beneficiary, the beneficiary's physician, and the provider of their decisions within 72 hours of the request for the expedited reconsideration and/or receipt of requested records (42 CFR 405.1204 (c)(3)):

- Beneficiaries may request the timeframe be lengthened to a maximum of **14 days** (42

CFR 405.1204(c)(6)).

- Providers may, but are not required to, submit evidence to the QIC, even when the QIC makes a specific request (42 CFR 405.1204(e)).
- Providers may not bill beneficiaries until the QIC makes its reconsideration determination (42 CFR 405.1204(f)), **or until the end of the 14-day period.**

II. Instructions for the Expedited Notices

Overview. This section of the instruction tells providers the basic information they need to obtain and deliver the notices appropriately. It is divided into 4 basic sections: getting the notices, delivering the notices, completing the notices and other instructions.

A. Getting the Notices

The generic and detailed expedited determination notices are subject to the Paperwork Reduction Act (PRA) since they collect information from the public. At the time this regulation becomes effective, the notices, which CMS intends to make mandatory, may not be finalized, but still will be available as drafts/model language. CMS will post the most recent version of the notices prior to or about July 1 so that providers can download the notices the CMS website. Links to the notices are found at the Beneficiary Notice Initiative (BNI) homepage on the CMS website or as a pre-finalization PRA package:

www.cms.hhs.gov/medicare/bni/ OR
www.cms.hhs.gov/regulations/PRA/

Providers should use the version posted at this location until the notices are finalized. The BNI website will note when the notices have been finalized and therefore become mandatory. CMS does not expect any major changes, and maybe not any changes at all, from the version of the notices posted in April 2005 at the PRA link above, however, there can be no guarantee until the clearance process is complete.

Providers should not change any aspect of the notices as downloaded, even prior to finalization, although minimal changes are permissible if required by hardware limitations at the provider's office (i.e., lack of a specific font). The generic notice must remain a two-sided, one page notice, and the detailed notice a one-sided, one-page notice. See the sections below on completing each notice for more detail.

B. Delivering the Notices

The generic notice should be delivered to the beneficiary prior to the end of the covered period, usually two days before the end of coverage, whenever possible, or as soon as the provider knows coverage has ended, if this occurs unexpectedly. The notice may be provided earlier than two days in advance, but should not be given so much in advance that the beneficiary fails to understand it is linked to discharge. There is no requirement for providers to give this notice when care is noncovered from start/admission. It is expected the notice will be delivered before or after a time when the provider is seeing the beneficiary for care. See Column 1 in the charts on Pages 8 and 9 of this instruction for more detail on the timing of delivery of the notice.

Delivery Other than In Person. The review process envisions giving notices in person because notification is anticipated as occurring when the provider would still be seeing the patient in the normal course of treatment. In non-residential settings where beneficiaries are not at hand, however, the process did not envision tasking providers with trips just to provide notice, since there is no reimbursement for notification. Therefore, while in person notification should be done whenever possible, with lead time for provision of both the generic and detailed notice during the covered period, it is not required to be in person if involving unavoidable additional costs.

Notification by other means should still occur in the required timeframes. While telephone or e-mail contact can substitute for an in person visit, and if e-mail is used a timely return message must be received, it must be followed up with delivery of a written notice in the mail. The generic notice must be prepared and mailed in duplicate, so that a beneficiary can sign and date two copies, keep one, and return a copy to the provider.

An example of the need for alternate delivery is when a provider goes to a beneficiary home far from the office and finds the copies of the notice at hand have either run out or are not legible for whatever reason. In such cases, the provider should still explain about the forthcoming notification of the expedited determination option verbally, and act if needed— such as by phoning the beneficiary with the QIO phone number as soon as possible if the beneficiary states a desire to appeal to the QIO. Another case is where the physician terminates orders without timely notification to the provider, so that the provider is unprepared for the end of covered care.

Who Gets the Notices. The generic notice is given to all beneficiaries eligible for the expedited review process. The detailed notice, however, is only given to beneficiaries who dispute their

upcoming discharge, and must be provided by the close of business the day of the QIO's notification (42 CFR 405.2002(f)(1)), or when requested by the beneficiary. See Column 4 of the charts on Pages 8 and 9 for more detail on provision of this notice.

> **NOTE:** Throughout this instruction, the term "beneficiary" should be understood to mean beneficiary or authorized representative, if applicable.

Business Hours of Operation Limitation. Regulatory timeframes requiring action within a given day can be extended in the case an event takes place shortly before a provider's close of business, since not all providers maintain 24-hour a day operations, and the expedited determination regulation was not intended to require new hours of operation. An example would be the case of QIO notification coming shortly before a provider's close of business. However, in such cases, the beneficiary still must be notified as soon as possible once business recommences, and it is recommended medical records be documented noting the limitation caused by routine hours of operation.

Simultaneous Notification. Usually, the generic notice will be given in advance of the detailed notice. However, if the provider, particularly a non-residential provider, can foresee that there will not be another service providing an opportunity to deliver the detailed notice, and the beneficiary makes clear he/she wants the detailed notice or will be asking for an expedited determination, both notices may be delivered at the same time. See also the chart on Page 9 for possible overlap with other notices. However, the timeliness of the expedited process still is determined by the beneficiary contacting the QIO, not delivery of the detailed notice, and this should be made clear to the requesting beneficiary.

Patient Leaves Before Coverage Ends/Review Process Not Applicable. Expedited determination policy envisions patients are under active care at the point of notification. In cases when a beneficiary leaves active care so that discharge cannot be done in person, whether for inpatient hospital re-admission as part of continuous care for the same spell or illness, or abrupt unforeseen patient departure, providers do not have a notification obligation, but should annotate records to reflect this circumstance. The regulation itself notes QIOs will not require coverage to continue if posing a threat to the beneficiary's health and safety (42 CFR 405.1202(c)), in seeming anticipation of the case where beneficiaries may have to re-enter the hospital for a more

intensive level of care. Note too that the expedited review process is not triggered when discharge occurs for reason other than the end of a period of covered care—see I.C. above.

C. Completing the Notices

Completing the Generic Notice. The generic notice is entitled: "Notice of Medicare Provider Non-Coverage", and is a two-sided, one-page notice. Providers may insert their logo or use letterhead at the top of the notice, as long as the notice remains one page, but otherwise should insert the name of the facility and minimum contact information (City and State, telephone number). The notice may be produced as a legal, rather than letter-size, page.

Blanks Requiring Completion – Generic Notice, Side 1. At the top of the notice, below the insert identifying the provider, providers must insert the patient name, Medicare Number (Health Insurance Claim Number - HICN), the type of coverage ("insert type"), and the effective date, with blanks for the type of coverage repeated twice immediately below the effective date. "Insert type" should be a general classification based on the type of provider giving care: skilled nursing facility, swing bed or residential skilled care; hospice, home health, or CORF. As with CORF, abbreviations are permitted, but must be verbally explained to the beneficiary. Home health agencies do not have to differentiate if care is either covered under a home health plan of care/paid under prospective payment/the home health benefit or administered under a therapy plan of care—all their care can be referred to as "home health/care". The "effective date" is the date on which coverage ends, whether or not this is a billed day or if/if not services – whether skilled or not-- are provided on that specific day. The provider must also insert the applicable QIO name and number in the blank in the first bullet under "How to Ask for an Immediate Review" at the bottom of the page.

Other – Generic Notice, Side 1. The rest of this side of the notice contains no blanks and is self-explanatory. The notice has been consumer tested, so language used should be readily understandable to beneficiaries.

Blanks Requiring Completion – Generic Notice, Side 2. This side of the notice has three basic areas to enter information: 1) the "Additional Information" box, 2) signature, and 3) date. Subsequent instructions on this notice will discuss the additional information box. For the

present time, there is no requirement to put information in this box, nor prohibition against using it. The signature should be that of the beneficiary, and the date should also be filled out by the beneficiary when signing with the current date.

Other – Generic Notice, Side 2. The limited other text on this side of the notice has been consumer tested and is largely self-explanatory. However, it may be necessary to emphasize that signing this notice only represents acknowledging the notice has been delivered, not necessarily agreement with the provider's coverage decision.

Other Requirements for the Generic Notice. The generic notice meets all the regulatory requirements for content given at 42 CFR 405.1200(b)(1)-(3). However, 42 CFR 405.1200(b)(3) also requires the beneficiary understand the notice. Therefore the provider, as the notifying entity, must assure this understanding is in place, by allowing additional time to explain the notice, if warranted, before the beneficiary signs.

> **NOTE**: In general as the notifying entity, providers are responsible for valid notification, including delivery and completion.

Complying with these instructions and using the CMS notice helps assure providers give valid notice. Note 42 CFR 405.1200(b)(5) states providers may be financially liable for continued services until 2 days after the beneficiary receives valid notice, or until the effective date for the end of coverage given on the notice-- whichever is later-- thereby creating an additional incentive to providers to assure notification is valid.

Completing the Detailed Notice. The detailed notice is entitled: "Detailed Explanation of [Insert Type] Non-coverage", and is a one-sided, one-page notice. Providers may insert their logo or use letterhead at the top of the notice, as long as the notice remains one page, but otherwise should insert the name of the facility and minimum contact information (City and State, telephone number). The notice may be produced as a legal, rather than letter-size, page. The "[Insert Type]" blank in the title should be completed as specified under the instructions for the generic notice for the same blank (see "**Blanks Requiring Completion – Generic Notice, Side 1 above**).

Blanks Requiring Completion – Detailed Notice. At the top of the notice, below the notice title, providers must insert the date, the patient name, and Medicare Number (HICN). The date should be the date on which this notice is given to the beneficiary.

In the next two paragraphs, complete "insert type" as instructed above. For the next two bullets, provide text relative to each of these bullets. For example, the first bullet, "The facts used to make this decision:", should pertain to the individual patient, such as: "You have recovered to the point you no longer need certain (intermittent skilled) services". The next bullet, "Detailed explanation of why these services are no longer covered, and the specific Medicare coverage rules and policy used to make this decision:", should be more general, pertaining to Medicare coverage policy. For example, in following the example for the first bullet, a HHA could enter: "Medicare requires you need intermittent skilled services in order to qualify for the home health benefit (and give a pertinent citation, in instructions, regulations or law, such as in this case, Title XVIII of the Social Security Act, Section 1814(a)(2)(C)).

In the last paragraph, the provider telephone number needs to be entered in the blank, in reference to beneficiaries obtaining copies of information the providers sends to the QIOs. Providers are allowed to charge beneficiaries for such copying, and also delivery of records if it cannot be done in person (42 CFR 405.1202(f)(3)). These charges must be reasonable and cannot exceed similar charges for the same services made in other cases.

Other Requirements for the Detailed Notice. The rest of the notice contains no blanks and is self-explanatory. This notice also has been consumer tested, so language used on the notice should be readily understandable to beneficiaries. Complying with these instructions and using the CMS notice helps assure providers give valid notice.

Note that providing the detailed notice is only one of two actions the provider must perform after hearing from the QIO that an expedited determination has been requested. The provider must also supply all information the QIO requests to make a determination as soon as possible, including a copy of the notices (42 CFR 405.1202(f)(2); see also the footnote on the chart on Page 8, and Columns 4 and 5 of the chart on Page 9).

Instructions Applicable to Completing Both Notices. As stated above, these notices cannot exceed their current number of pages, but legal-size paper instead of letter-size may be used. All information should also remain on the side of the page it appears on the CMS web site. Providers should use the exact font given in the notice if possible, though CMS recognizes some providers may have to use different fonts because of their own hardware limitations. In such cases, use a font as close to the font on the notice as possible. Do not use font effects, such as bolding, italicizing, or highlighting. The font should be at least 12 point in size, 18 point font for the title. A visually high-contrast combination of dark ink on a pale background must also be used.

> **NOTE**: The notice cannot be modified other than as specified in these instructions (i.e., replacement font if unavoidable, logo at top of notice, use of legal rather than letter-size paper).

Entries for all blanks on the notices can be hand-written, but handwriting must be legible. The handwriting should be no smaller than approximately font size 10. If typing entries to the notice, font size 12 is recommended over 10, but 10 is permitted.

Providers give a copy of the completed notice to beneficiaries. They may also give a copy to the beneficiary's physician, but are not required to do so under the regulation. They must also retain a copy of all expedited determination notices they give to beneficiaries in their records. If an expedited determination is requested, the provider will also have to give copies of the notices to the involved QIO.

D. Other Instructions

Valid Notice. Valid notice involves both delivery and completion. See the section on "Other Requirements" under both the generic and detailed notice in C. Completing the Notices, in the section immediately above.

Refusal to Sign. The regulation speaks to the situation when the beneficiary refuses to sign the generic notice (42 CFR 405.1200 (b)(4)). It recommends, and this instructions requires, the provider annotate the notice with the refusal, and place in the final date blank the date of the

refusal. While the detailed notice does not require a beneficiary signature, if in any way the beneficiary refuses to accept a copy of the notice, annotating this notice with that sort of refusal is recommended.

> **NOTE**: Beneficiaries who refuse to sign the generic notice are still entitled to an expedited determination.

Other Related Provider Obligations. The charts on pages 8-14 attempt to provide all information providers may need on the expedited review process and notices in a quick reference format. Review these charts in conjunction with this notice-specific section of the instructions in order to be familiar with all provider obligations and potential liability. In particular, consider Columns 1, 2, 3 and 5 of the chart on Page 9, and the last column on the right on the chart on Page 12.

III. Transitional Period Instructions

In order to assure claims are adjudicated in a manner consistent with expedited determinations or reconsiderations, when QIOs or QIOs/QICs decisions on coverage are made relative to part of the statement date periods of specific claims, current claims instructions need to be amended to require information appear on such claims relaying the applicable decision. However, due to a number of factors, the necessary changes in Medicare claims processing shared systems cannot be scheduled until January 1, 2006. The period from the regulatory effective date for the expedited determination process, July 1, 2005, until that January date, is the transitional period referred to in this section.

Medicare systems will permit some limited changes in claims submission in this interim period, and provider billing systems may also allow such changes. These changes are detailed in section IV. below.

Special actions are also likely to be required by intermediaries, meaning both FIs and RHHIs, and QIOs in the transitional period. CMS staff charged with oversight of QIOs will make this clear to the QIOs. Consequently, intermediaries should be aware of all expedited determinations/reconsiderations applicable to the claims they process in the transitional period.

CMS prefers to allow special services needed in the transitional period to be able to be uniquely defined in each QIO-intermediary relationship. Therefore, the remainder of instructions in this section suggest what types of actions may be needed, without requiring specific steps. QIOs who believe they need additional guidance on this matter should contact their usual CMS contacts. Intermediaries who believe they need additional information should go through their CMS Regional Office, and remind the Regions that questions they themselves cannot resolve should be sent to CMS Central Office, Center for Beneficiary Choices, Medicare Eligibility and Appeals Group, Division of Consumer Protection, attention Tom Kessler and/or Elizabeth Carmody.

Suggested Requirements. In short, intermediaries will have to be alerted by QIOs on a regular basis to expedited determinations/reconsiderations in a type of report that will then allow the intermediaries to track claims they process and make sure no actions are taken in adjudication

that would contradict QIO/QIC decisions. Intermediaries will have to do this in the interim period without any shared systems changes, using user-controlled tools like medical policy parameters, and should consider if the instructions in Section IV of this document can help facilitate this process.

> **NOTE**: Intermediaries have the authority to make or reverse denial decisions on claims based on the information relayed by QIOs in the transitional period based on this preliminary instruction.

Effective July 1, 2005 and indefinitely thereafter, such QIO/QIC determinations/reconsiderations are binding on intermediaries. However, after the January 1, 2006 Medicare claims processing shared systems release implements expedited review process changes for the affected types of institutional claims, all necessary information will be apparent on claims, and additional coordination with the QIOs just to obtain this information will not be necessary.

Timing of Information Exchange. CMS envisions QIOs and intermediaries exchanging information in a period of about every two weeks, or on another basis that still helps assure pertinent information gets to the intermediaries before applicable claims are finalized. This may be varied by provider type, since some providers, like HHAs under the home health benefit, have a long billing interval, and others, like CORFs may not.

Potential Report Contents. QIOs will have to convey enough information so that intermediaries can recognize affected claims. This will require identification of the beneficiary (i.e., name and HICN), identification of the involved provider (i.e., provider name and Medicare provider number and/or address), identification of the period in question (i.e., the beginning and ending dates of the period subject to the QIO/QIC decision relative to the effective date of the generic notice, or other period if specified by the QIO) and some type of indicator as to the decision (i.e., identified period is covered or noncovered).

Report Format and Exchange. CMS has no format recommendations other than noting that hopefully this would be discussed by both parties in an effort to facilitate automation, i.e., have the QIOs produce the report as an automated file readily usable by the intermediaries. Privacy

protections for beneficiary-specific information still apply, however, so that such information should never be transmitted via the internet.

Enforcement. CMS is well aware this review process is new to both beneficiaries and providers, and not much advance notice could be given to either because of the regulatory processes for finalizing both the regulation and notices. While all parties, including CMS, must make every attempt to meet these requirements, CMS realizes there will be many questions and possibly some missteps at the beginning. CMS will not seek to take punitive action in such cases as all involved parties become accustomed to the process, and encourages all involved to use QIO, intermediary and CMS resources to get timely support.

IV. Claim Instructions

As noted above, the outcome of expedited determinations and reconsiderations will be reported on Medicare claims to assure intermediary adjudication of claims is consistent with QIO/QIC decisions. Note that the expedited review process is always completed prior to billing, and therefore does not directly affect established billing procedures, even demand billing, other than the optional use of indicators presented below.

Due to limitations in Medicare systems, this reporting will be implemented in two phases. Initially, Medicare claims processing systems will allow reporting only of QIO/QIC decisions which authorize continued Medicare coverage. Reporting of QIO/QIC decisions that uphold the provider's decision to discharge the beneficiary from Medicare covered care will not be effective until January 1, 2006.

Special indicators will be used on claims to reflect the outcome of QIO expedited determinations and QIC reconsiderations. In the past, QIO related determinations were reflected only on hospital inpatient claims (type of bill—TOB-- 11x). A set of condition codes, reported in FLs 24-30 of the UB-92 or its electronic equivalent, were created to reflect these determinations. These codes, C1- C7, are known as the QIO approval indicator codes.

With the advent of the expedited determination process, these QIO approval indicators are relevant to types of bill other than inpatient hospital claims for the first time. With this instruction, certain QIO approval indicator codes will now be valid on the following TOBs:

18x, 21x, 22x, 32x, 33x, 34x, 75x, 81x, 82x.

Since QIO expedited decisions and QIC reconsideration decisions have the same effect on providers and beneficiaries, the same QIO approval indicator codes will be used to report either decision.

A. Reporting for Services Provided on or after July, 1, 2005. When providers are notified of QIO/QIC decisions that authorize continued Medicare coverage and do not specify a coverage ending date, they should submit a continuing claim for the current billing or certification period

according to all claims instructions for the applicable TOB, plus a single additional data element. Providers should (to the extent possible within the limits of their billing systems) annotate these claims with condition code C7, which is defined "QIO extended authorization." This indicator will alert FIs/RHHIs that coverage of the services on the claim has already been subject to review.

In the circumstance, expected to be rare, when providers are notified of QIO/QIC decisions which authorize continued Medicare coverage only for a limited period of time, they should submit claims as follows:

- If the time period of coverage specified by the QIO/QIC extends beyond the end of the normal billing or certification period for the applicable type of bill, submit a continuing claim for that period according to all applicable claims instructions plus two additional data elements. Providers should (to the extent possible within the limits of their billing systems) annotate these claims with condition code C3, which is defined "QIO partial approval" and with occurrence span code M0, which is defined "QIO approved stay dates", along with the following dates—the beginning date of the coverage period provided by the QIO/QIC, and the statement through date of the claim.

- If the time period of coverage specified by the QIO/QIC does not extend to the end of the normal billing or certification period for the applicable type of bill, submit a discharge claim according to all applicable claims instructions plus two additional data elements. Providers should (to the extent possible within the limits of their billing systems) annotate these claims with condition code C3, which is defined "QIO partial approval" and with occurrence span code M0, which is defined "QIO approved stay dates" and the dates provided by the QIO/QIC.

For the interim period prior to January 1, 2006, providers should not report any new indicators on claims when they receive notification of decisions which uphold the provider's decision to discharge the beneficiary from Medicare covered care. In these cases, providers shall submit a discharge claim according to all applicable claims instructions for the type of claim. Providers should also note that no new indicators are required on discharge claims in the case where a generic notice is provided and the beneficiary does not request an expedited determination.

CMS is aware not all provider billing systems will be able to make these changes at this time. Therefore, intermediaries will not take any action to require this coding. However, the use of the coding may aid in facilitating claim adjudication, so that all providers whose systems allow them to use these indicators are encouraged to use them effective July 1, 2005.

B. Reporting or after January, 1, 2006. Effective January 1, 2006, providers will be required to report the new indicators described above. They will also be required to report new indicators on claims when they receive notification of decisions which uphold the provider's decision to discharge the beneficiary from Medicare covered care. In these cases, CMS anticipates that providers will report condition code C4, defined as "Services Denied", on their discharge claims. In cases where untimely requests for determinations, or other delays in the determination process, result in beneficiary liability for certain dates of service, CMS anticipates the providers will also report occurrence span code 76, defined as "patient liability period," to identify those dates. Additional instructions defining the Medicare system changes required to allow the provider submission of condition code C4 will be published in the future and provide further detail of this process. Providers are encouraged to consider these future changes when modifying their billing systems to report the result of expedited determinations.

C. Billing Beneficiaries in Cases Subject to Expedited Determinations. Providers should note a significant difference between the use of expedited determination notices and the use of Advance Beneficiary Notices. As described in Claims Processing Manual, Chapter 1, section 60.3.1, in ABN or HHABN situations, all providers other than SNFs can bill beneficiaries for services subject to a demand bill while awaiting a Medicare determination on the coverage of the services. The same is not true in expedited determination situations. When a beneficiary requests an expedited determination timely, no funds may be collected until the provider receives notification of the QIO/QIC decision.

D. Provider Liability and Billing. Two specific parts of the expedited review process presented in the chart on Page 12 highlight cases where under the regulation providers may have to take liability: (1) if the provider is not timely in giving information to the QIO; and (2) if the provider does not give valid notice to the beneficiary. Since both these events occur after the point the provider has already determined discharge is imminent, there may be no actual liability,

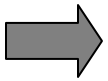
since there may be no medical need for additional care. However if services are required, and either of these liability conditions apply, such services should be billed as noncovered line items using the –GZ modifier, which indicates the provider is liable, consistent with billing instructions effective prior to July 1, 2005, and found in the Medicare Claims Processing Manual, Chapter 1, Section 60.4.2.

V. Revised Hospital Issued Notice of Noncoverage (HINN) Instructions

A. Overview

The section of this instruction seeks to make clear what notice of noncoverage inpatient hospitals have to use under different conditions, and give instructions for these notices. Expedited determination regulations applicable to original Medicare, effective July 1, will require some changes from current inpatient hospital processes.

For some time, inpatient hospitals have been required to issue notices of noncoverage, specifically called hospital issued notices of noncoverage or "HINNs", to beneficiaries, if the hospital determine that the care the beneficiary was about to receive or was receiving, was not covered, because it was not medically necessary, or was not delivered in the most appropriate setting, or was custodial in nature. HINNs used to be used for notification of noncoverage for either a hospital level of care or a skilled nursing level of care.



Effective with the regulation and this implementing instruction, HINNs will no longer be used for skilled care once it has begun in swing beds (continuous swing bed care, HINN Letter 8). QIOs were never required to make determinations in these cases, since the immediate review provisions of the Omnibus Budget Reconciliation Acts (OBRAs) of 1986 and 1987 do not apply to stays in SNF swing beds. These notices are also not subject to QIO review. HINNs will continue to be used, however, for changes from a hospital level of care to a skilled nursing or non-skilled (custodial) level within the hospital facility, even when this is a "paper transaction" if the patient is not physically moved/does not leave the facility.

The expedited review process requires current HINN instructions be updated to account for this change, and the concomitant change of notice for termination of Medicare covered resident skilled nursing services, even when provided in hospital swing beds. Now in these cases, the expedited determination process and notices used by SNFs (among other providers), not hospitals, will be used instead of HINNs. However, HINNs are otherwise used in the same manner as used in previous decades related to inpatient hospital level care, or noncovered

inpatient hospital care, with the same responsibilities shouldered by beneficiaries, hospitals, QIOs and intermediaries. **These instructions follow, and have been updated for codification of the existing process in new regulations in addition to the swing bed change**. As CMS finalizes other aspects of QIO review for inpatient hospital services, as affected by the recent expedited determination regulations for hospitals under original Medicare, further revisions in instructions will be made.

B. Beneficiary and Representative.

In this section, the term "beneficiary" is used to mean either beneficiary or authorized representative. Hospitals must comply with applicable State requirements on determining representatives. But generally, a hospital is responsible for determining whether the beneficiary, upon admission, is mentally competent and capable of transacting business (as opposed to being incapable of handling their own affairs, unable to sign and negotiate checks). It must have procedures in place to determine an appropriate representative when beneficiaries are incapable or incompetent. In these procedures, the hospital must anticipate situations such as when it cannot obtain the signature of the beneficiary's representative through direct personal contact. In such cases, when it mails the notice to the beneficiary's representative, it will simultaneously phone the beneficiary's representative. The date of the phone conversation is the date of receipt of the notice.

C. Changes to Current Manuals

CMS will strike H-ABN instructions from Chapter 30 of the Medicare Claims Processing Manual (100-4/30/80), and strike HINN instructions from 100-4/3/130, simultaneous to the release of this instruction/one-time notification. This instruction will be the temporary replacement to those instructions. The following text will appear at 100-4/3/130, with something similar at 100-4/30/80.

130 - Coordination with the Quality Improvement Organization (QIO)
(Rev.__)
A3-3674

Instructions regarding hospital interactions with QIOs have been relocated as follows:

- Instructions regarding HINNs are found in this instruction, CR #3903, which precedes the placement of full instructions in Chapter 30.
- Instructions regarding hospital billing for cases involving QIO review will be relocated to a new section in Chapter 1 of this manual in the near future. Current procedures should not change in the interim.
- Related instructions for QIOs can be found in the Medicare Quality Improvement Organization Manual, Publication 100-10, Chapter 7.

D. Citations and Authority for HINNs

The statutory authorities applicable to HINNs are found at §1154(e) and §1879 of the Act.

- 1879 applies broadly to original Medicare on specific protections from liability for payment. Related regulations are found at 42 CFR 411.404. Instructions are found in the Medicare Claims Processing Manual, Chapter 30.
- 1154(e) on QIO functions applies specifically to hospital inpatients:
    - If the hospital is paid under the Inpatient Acute Prospective Payment System (IPPS), related regulations on notices of noncoverage are found under 42 CFR 412.42(c).
    - If the hospital is reimbursed under State reimbursement systems under 1886(c) of the Act, or paid through a demonstration project under 402(a) of Public Law 90-248, or 222(a) of Public Law 92-603, noncoverage notices are addressed in regulations at 42 CFR 489.34, and must meet the conditions of 412.42(c)(1)-(4).

- For all other inpatient hospital services, including those paid on a reasonable cost basis, noncoverage notices are addressed under the general provisions of 42 CFR 411.404, related to 1879.

Note 1154(e)(2-4) was stricken by recent legislation, the Benefit Integrity Protection Act of 2000 (BIPA); however, it was referenced, in the same legislation, in 1869(c)(3)(C)(iii)(III), in effect keeping the requirements of 1154(e)(2-4) in place.

E. Statutory HINN Requirements and QIO Determinations

1. Types of Review. 1879 requires notification prior to noncoverage if beneficiaries under original Medicare are to incur financial liability. The related specific process for inpatient hospitals described under 1154(e) has existed for some time, but has been codified in regulations for the first time effective July 1, 2005 (42 CFR 405.1206 and .1208).

Hospitals are required to provide beneficiaries with notices of noncoverage for continued stays in two cases: (1) when the beneficiary's attending physician concurs inpatient care is no longer needed; and (2) when the attending physician does not concur, but the hospital still requests QIO review of its determination that inpatient care is no longer needed.

2. Hospital-Requested Review. In this second case, if the hospital requests such review, it will also notify the beneficiary that the review has been requested (HINN, Letter 10, see I. and J. below; 42 CFR 405.1208(b)(1), effective July 1). The QIO will still solicit patient input as part of the process.

The new regulations clarify that the requesting hospital must answer related QIO information requests, by phone or in writing, by close of business the first full working day after the date of the request (42 CFR 405.1208(b)(2)). The QIO must acknowledge the hospital request for review, notify the hospital if any requested records are missing, make a determination within two working days of the hospital request, or upon receipt of missing information requested from the hospital, if any; and finally, notify the beneficiary, hospital and attending physician of its decision, with an option for preliminary notification by telephone, but ultimately required to follow up in writing (42 CFR 405.1208(b)(3) and (4), (d)(1)). When this type of review occurs,

the hospital cannot charge the beneficiary until the date specified by the QIO (42 CFR 405.1206(f)(4)). Beneficiaries also have the same reconsideration options as mentioned immediately below (42 CFR 405.1208(e)(1)).

3. Beneficiary-Requested Review. QIOs are required to conduct similar reviews if requested timely by beneficiaries, meaning by telephone or in writing by noon of the first working day after receiving the hospital notice, when the attending physician concurs with the hospital. Such beneficiaries remain in the hospital with no additional financial liability until the QIO makes its determination (42 CFR 405.1206(a) and (d)(1)). Beneficiaries may also request two types of untimely review:

- When still an inpatient but not meeting the timeliness requirement (42 CFR 405.1206(c)(1));
- Within 30 calendar days after receipt of the notice of noncoverage (42 CFR 405.1206(c)(2)).

In both cases, liability protections under the timely process do not apply, meaning funds can be collected from beneficiaries if receiving noncovered services, but these funds must be returned if the QIO finds for the beneficiary. The QIO must then notify the hospital, and may request information from the hospital to make a determination. Hospitals must answer such requests by phone or in writing by close of business of the first full working day after the beneficiary receives notice of noncoverage (42 CFR 405.1206 (d)(2)). The QIO will examine this information, solicit beneficiary input, and provide notice of results of their review by telephone and/or in writing. QIOs must ultimately provide written notice, to the beneficiary, hospital and attending physician by close of business the first working day after it receives all pertinent information when a timely request was made. If an inpatient made an untimely request, the QIO makes its decision within 2, rather than 1, working days. When the beneficiary is no longer an inpatient and makes a request, the QIO will make a determination within 30 days after receiving all information (42 CFR 405.1206(d)(3) – (5)).

If the QIO finds for the beneficiary, he/she cannot be held liable for care until the hospital makes a new determination that noncoverage is imminent and discharge appropriate. Even if the QIO does not find for the beneficiary, if a timely request was made, he/she cannot be held financially

liable before noon of the calendar day after the date the beneficiary receives notification of the QIO determination. For untimely requests, the beneficiary may be held liable in accordance with the hospital's notice or as stated by the QIO (42 CFR 405.1206(f)(1)-(3)).

QIO determinations are binding on the notified parties. The QIO will inform the beneficiary of reconsideration options, including the timeframes for a timely request for further consideration. Such reconsiderations are now codified in regulations effective July 1, 2005 (42 CFR 405.1204). This reconsideration process is the same for hospital and non-hospital providers, therefore basic information is provided in this instruction in Section I., Background and Summary, and below in F.).

4. QIO Determinations. QIOs make their determinations based on criteria in §1154(a) of the Act, which specifies that QIOs will consider the following, and determine whether or not payment will be made:

- If services are reasonable and necessary under 1862(a)(1) or (a)(9) of the Act;
- If services meet recognized professional standards of care; and
- If the inpatient setting is appropriate to patient need.

42 CFR 412.42 (c), applying to hospitals paid under IPPS, follows the law, but specifies **custodial or medically unnecessary care** must be at issue when the hospital determines that inpatient care is no longer needed. It specifies that the hospital cannot charge beneficiaries until after the second day following the date the hospital gave notice that care would no longer be covered. 1154 states, for all hospitals, charges cannot be made before noon of the day after the QIO gives notice of its decision when the beneficiary requests that decision. Unlike under the new non-hospital process described in the other major sections of this instruction, that means funds are never collected if QIO review occurs until **after** the review is complete.

> NOTE: 42 CFR 489.34 extends this process to hospitals reimbursed under a waivered State system or as part of an applicable demonstration project. Also, since 1862 excludes payment of custodial care in all cases other than hospice, this prohibition would apply to all hospitals.

Exceptions to QIO determinations on hospital-level inpatient care are cases when:

- Payment can be made under 1879;
- Allowing for payment to be made for up to 2 more days to allow for post-discharge care when a provider **could not have known** care would not be covered under Title XVIII ("grace days").

General Liability. In general, after receiving the HINN, the beneficiary is considered to have knowledge as defined under 1879 in the Act that services are not covered, and he/she is liable. The provider is considered to have knowledge, as of the date of notice, that furnished (or proposed) services were noncovered, if it issued a notice (**see 42 CFR 411.406(d)**). Medicare indemnified both parties and makes payment when neither the hospital nor beneficiary has knowledge of noncoverage (see Chapter 30 of the Medicare Claims Processing Manual for more information).

Grace Days. Relatedly, §1154(a)(2)(B) of the Act recognizes what are called "grace days" may be provided only in cases where the hospital did not know and could not reasonably have been expected to know that payment would not otherwise be made for such services under Medicare. A hospital that issues a HINN has demonstrated knowledge that Medicare will not cover the services and, therefore, grace days are not applicable. While statute allows for payment by Medicare for a period in between knowledge of liability and discharge when placement at another provider is actively being sought as part of discharge planning (1861(v)(1)(G)), the QIO will not approve payment for additional days solely for the purpose of post-discharge planning when a beneficiary neither needs further care or can find placement at another appropriate facility.

Scope and Timing of Determinations. In all cases of appropriately requested review, QIOs will formally determine if the hospital notification was valid, if the hospital's findings were valid, and if beneficiaries will be liable should they remain in the hospital. The QIO also has to promptly notify the intermediary paying related claims if services are disapproved (42 CFR 476.80(e)), but not before the QIO has notified the provider and beneficiary of the right to reconsideration. If the right to reconsideration is exercised, final notification does not occur until the reconsideration is complete.

5. Other HINN Uses under Regulations or Instructions. There are three notable cases of the use of HINNs beyond those described above:

Exhaustion of Benefits. 42 CFR 412.42 (e) gives hospitals the ability to charge beneficiaries for noncovered services when benefits either do not apply or exhaust, but does not specify that notice is required. Yet hospitals are mindful of the general 1879 requirement to notify beneficiaries before they are held liable for noncovered care. As a consequence, many hospitals voluntarily use the HINN to notify beneficiaries when benefits are about to exhaust in addition to required uses of the notice. However, QIO review is not required and liability protections do not apply in these voluntary uses.

Preadmission/Admission. Regulations found at 42 CFR 476.71 require QIOs to review the medical necessity of hospital discharges **and admissions**, in addition to other requirements specified in that section of the regulation. Therefore, QIOs perform preadmission and admission review when requested for all inpatient hospital stays. Hospitals are required to use the HINN for this notification (HINN Letters 1 and 9, see J. below).

Unbundled Services. While the strict scope of 42 CFR 412.42 is limited to some, but not all, inpatient hospital services, general 1879 requirements apply to all hospitals. Therefore, hospitals which do not receive bundled payments for inpatient services, like IPPS hospitals, not subject to 42 CFR 412.42, still need to notify beneficiaries, and may have the added issue that some, but not all, services are noncovered. HINN language should be adapted to this situation, and a HINN should still be used for notification (see K. below for further guidance).

F. Right to a Reconsideration

A beneficiary who is dissatisfied with a QIO determination can request reconsideration by the QIC, the reconsidering body. Such reconsiderations are now codified in regulations effective July 1, 2005 (42 CFR 405.1204), but are familiar to inpatient hospital providers as the process previously available under §1155 of the Act. This reconsideration process is the same for hospital and non-hospital providers.

When a reconsideration is requested, 42 CFR 405.204(f) states the beneficiary may not be charged until the reconsideration determination is made. If requesting a reconsideration, the beneficiary must do so by noon of the calendar day after the first QIO decision is received, by phone or in writing. The beneficiary must be willing to answer questions for, and supply information to, the organization performing the reconsideration, and can submit additional evidence. If the beneficiary misses the timeframes, he/she can appeal the claim affected by the QIO determination through the general claim appeal process (42 CFR 405.1204(b)(1) – (4)). If the beneficiary has been discharged, he/she can seek further reconsideration only through the standard claim-based appeal process (42 CFR 405.1206(h)).

According to 42 CFR 405.1204(c)(1)-(6), the QIC, must immediately notify the QIO and provider of services when a request for a reconsideration is received, and may request records from both parties to be used in its determination. It must allow the beneficiary and provider an opportunity to provider further information, but these parties are not obligated to provide anything additional (re: the provider 42 CFR 405.1204(e)). 72 hours after either the original request is made, or all related requested records are received, the organization must make its determination, though the beneficiary may request up to 14 additional days. Note QICs and QIOs may make decisions without receiving records if not delivered as requested. The QIO, hospital, attending MD and beneficiary must all be notified of the QIC decision, ultimately given in writing, including:

- Explanation of its decision;
- Explanation of Medicare payment effects and the date of the beneficiary's liability, if liable, and
- The beneficiary's rights and process for appealing to an Administrative Law Judge if the amount in controversy is at least $100.

G. Limitations of HINN Use

Beneficiary Payment Responsibility. HINNs do not address every aspect of beneficiary responsibility for payment. Beneficiaries remain liable for applicable deductible and coinsurance amounts, and for charges for convenience items or services never covered by Medicare, even in periods where covered care is also delivered.

NOTE: Hospitals are not required to issue HINNs when the beneficiary will not be billed/liable.

Provider Evaluation Requirement. The HINN does not relieve the hospital or the attending physician of the responsibility for monitoring the beneficiary's condition/level of care, or for making appropriate discharge plans. If the beneficiary's condition changes after the notice is issued, the hospital may rescind the HINN, when warranted.

Swing Beds. The differentiation of when to use a HINN is most difficult for swing beds. With the advent of non-hospital expedited determinations, and in order to remain consistent with existing procedures for Medicare managed care, when covered skilled nursing level care has been being delivered, the notice that should be used should be the same as those used by SNFs delivering similar care, meaning either the skilled nursing liability notice or expedited determination notice(s). The skilled nursing liability notice is used when a reduction in covered care is occurring, which with the bundled swing bed prospective payment system (PPS), would probably occur rarely, or occur most in non-PPS swing bed facilities. The expedited notice(s) are used for terminations. However, when care is noncovered such that a covered level of care is not at issue, the notice must reflect the setting, and therefore the HINN would be appropriate (see J. below for specific HINNs for these cases; major section I. above for use of expedited determination notices for swing beds, and Chapter 30, Section 70 for skilled nursing liability notices).

H. Delivery of HINNs

Hospitals give HINNs to beneficiaries when issues of noncoverage arise for hospital-level inpatient care. The HINN may be given prior to admission, at admission, or at any point during the inpatient stay. It may be issued by hospital staff or utilization review committees based on Medicare instructions, including: coverage guidelines, notices, bulletins, or other written guides or directives from intermediaries or QIOs.

Refusal. Delivery of HINNs is only valid when the notice is signed and dated by the beneficiary, indicating the notice was received and understood. If a beneficiary refuses to sign a

HINN, the provider should annotate the notice to indicate the refusal, and the date of the refusal should be the date placed on the notice (42 CFR 405.1206(b)).

When direct phone contact cannot be made, the hospital must send the notice to the beneficiary by certified mail, return receipt requested. The date that someone receives (or refuses to sign), the HINN is the date of receipt. Each postal station may have different procedures for handling mail when return receipt is requested. In such cases, for an HINN sent by certified mail with return receipt requested, the hospital determines the beneficiary's liability as starting on the second working day after the hospital's mailing date (postmarked by the postal station), assuming there is no indication of a refusal date. The hospital may employ other procedures that have been reviewed and approved by the QIO, and when needed for review, will provide the QIO with proof of proper notification.

Preadmission/Admission Notices. The utilization review committee or the hospital may issue preadmission/admission HINNs. QIOs may also issue such notices after having been contacted by a hospital regarding care believed to be medically unnecessary, inappropriate, or custodial. The hospital need not obtain the attending physician's concurrence, or the QIO's, prior to issuing the preadmission/admission HINN. This also applies to HINNs related to direct admissions to swing beds (i.e., the beneficiary is admitted to the swing bed when the hospital determines that the beneficiary does not need hospital-level care, but instead needs only skilled nursing (SNF) or custodial nursing (NF) level services services).

Continued Stay Notices ("Cont. Stay" in J. below). The hospital may issue a continued stay notice of noncoverage when it determines that an admitted beneficiary no longer requires continued hospital-level inpatient care and either the attending physician or the QIO concurs. The hospital gives the notice to the beneficiary concurrently with requesting QIO review if the attending physician has not concurred with the hospital's assessment. Continued stay HINNs are normally issued no earlier than 3 days before the first noncovered day, but may be issued earlier, but the beneficiary should always understand the notice addresses discharge rights.

Before the hospital can issue this notice, it must consider the admission at issue, and project when acute care furnished to the beneficiary will end. If it is able to determine in advance that the beneficiary will not require acute inpatient hospital care as of a certain date, it may give the

HINN in advance of that date, but ordinarily no earlier than 3 days before the first noncovered day.

Combined Notices for Swing-Bed Hospitals ("Combo" in J. below). "Combined notices" apply to situations where a beneficiary is in an acute care hospital that has certified swing beds, but no longer requires an acute level of care, and instead only requires either SNF or NF-level care. The discharge from the acute care bed and admission to the (SNF or NF) swing-bed may be a paper transaction, with no physical movement of the beneficiary, and even if moved beneficiaries may require notice to understand the coverage distinction when staying within the same facility. The combined notice HINNs notify beneficiaries that either:

- The acute and SNF care is not medically necessary, only NF care is needed, or
- Acute care hospital services are not longer necessary, but SNF-level swing-bed services are appropriate and will be delivered.

  NOTE: Medicare covers SNF-level care, but never covers NF-level care.

The hospital issues the combined notice of noncoverage with either the attending physician's or the QIO concurrence. Post-discharge planning days are not applicable. Notifications of pending discharges from continuous SNF-level care are done with expedited determination notices, not HINNs, effective July 1, 2005 (HINN Letter 8 is discontinued, see J. below; see major sections I. and II. above in this instruction for guidance on use of the expedited determinations notices).

I. General Content Requirements of HINNs

Since HINNs use model language (see J. below), providers have some flexibility in the preparation of notices. It is highly recommended hospitals use model language provided in this instruction, or by their QIO, in order to avoid questions of invalid notice. But if providers choose to prepare their own notices, their HINNs must contain specific information for both their own, and the beneficiary's, protection, explaining:

- Description of the care at issue;

- Dates care is determined to be noncovered/point at which beneficiary becomes liable/effective date;
- Reason(s) why care is noncovered (e.g., admission noncovered because the services could be performed safely and effectively on an outpatient basis);
- Who made the determination (e.g., the hospital, with the concurrence of the attending physician, or the hospital with QIO's concurrence);
- Justification for the assessment of noncoverage (e.g., citation to specific Medicare policy);
- Description of subsequent financial liability/cost (payment will be due for what type of services);
- Clarification that the notice is not an official Medicare determination;
- Description of the beneficiary's review rights;
- The procedures for requesting QIO review; and
- The effects the notice and a QIO review request have on the beneficiary's liability, including exactly when liability begins.

J. HINN Letters

For some time, CMS instructions have offered different suggested HINNs, in the form of letters, for the different scenarios under which hospitals are obligated to notify beneficiaries of noncoverage of inpatient services. These letters are summarized in the table below, noting the discontinuation of Letter 8:

List of HINN Letters and Applicable Requirements

Letter #/Type	Situation	Statutory Require-ment*	Patient Liability Prior to/if no QIO/QIC Review**	Anticipated Result for Patient Care
Letter 1 – Preadmit. (a)	Preadmission: will not admit for covered stay – no concurrence required	1879, 411.404	Entire Part A stay upon receipt of pre-admission notice	No admission or noncovered admission
Letter 1-Admission (b)	Admitted as hospital inpatient, but notice of noncoverage given on or ***before*** 3PM same day – no concurrence required	1879, 411.404	All Part A services <u>after</u> receipt of the notice	Physical discharge or end of covered stay
Letter 1-Admission (c)	Admitted as hospital inpatient, but notice of noncoverage given ***after*** 3PM same day- no concurrence required	1879, 411.404	All Part A services for days following the date of the notice	Physical discharge or end of covered stay
Letter 2 - Cont. Stay	End of covered hospital inpatient stay when attending concurs	1154(e), 412.42 (IPPS+), 411.404	All Part A services: (1) Except as in (2), liability does not begin until the day following notice; (2) for IPPS and other hospitals subject to 412.42 ("IPPS+"), liability begins the third day following receipt of the hospital notice	Physical discharge or end of covered stay
Letter 3 - Cont. Stay /Combo	End of covered hospital inpatient stay when attending concurs	1154(e), 412.42 (IPPS+), 411.404	All Part A services: (1) Except as in (2), liability does not begin until the day following notice; (2) for IPPS+ hospitals, liability begins the third day following receipt of the hospital notice	End of covered hospital-level (acute) stay, discharge or start of noncovered swing bed stay (NF)
Letter 4 - Cont. Stay /Combo	End of covered hospital inpatient stay when attending concurs	1154(e), 412.42 (IPPS+), 411.404	N/A for Part A, as long as no insistence on continued hospital level services	Change to covered swing bed stay (SNF-level of care) or discharge
Letter 5 - Cont. Stay	End of covered hospital inpatient stay when QIO concurs	1154(e), 412.42 (IPPS+), 411.404	All Part A services: (1) Except as in (2) liability begins noon the day after the HINN is given; (2) for IPPS+ hospitals, liability begins the third day following receipt of the hospital notice	Physical discharge or end of covered stay

Letter #/Type	Situation	Statutory Requirement*	Patient Liability Prior to/if no QIO/QIC Review**	Anticipated Result for Patient Care
Letter 6 - Cont. Stay /Combo	End of covered hospital inpatient stay when QIO concurs	1154(e), 412.42 (IPPS+), 411.404	All Part services: (1) Except as in (2) liability begins noon the day after the HINN is given; (2) for IPPS+ hospitals, liability begins the third day following receipt of the hospital notice	End of covered hospital-level (acute) stay, discharge or start of noncovered swing bed stay (NF)
Letter 7 - Cont. Stay /Combo	End of covered hospital inpatient stay when QIO concurs	1154(e), 412.42 (IPPS+), 411.404	N/A for Part A, as long as no insistence on continued hospital level services	Change to covered swing bed stay (SNF-level of care) or discharge
Letter 8 **Cont. Stay**	**DISCONTINUED July 1, 2005** **Use expedited determination notices for end of covered swing bed stay**			
Letter 9 Preadmit. (a)	Preadmission: will only admit to noncovered swing bed (NF) – no concurrence required	1879, 411.404	Entire Part A stay upon receipt of pre-admission notice	No admission or noncovered swing bed admission
Letter 9 - Admission (b)	Admitted to NF swing bed ***before*** 3PM same – no concurrence required	1879, 411.404	All Part A services after receipt of hospital notice	Physical discharge or continued noncovered swing bed stay
Letter 9 - Admission (c)	Admitted to NF swing bed ***after*** 3PM same day – no concurrence required	1879, 411.404	All Part A services on days following the date of the hospital notice	Physical discharge or continued noncovered swing bed stay
Letter 10 – Notification of Hospital Request	Informs beneficiary QIO opinion is being sought by hospital on discharge, attending physician has not concurred	1154(e)(2) /405.1208 (b)(1)	N/A; note Letter 10 must precede Letters 5-7	N/A

* For reasons of space, regulation citations have dropped "42 CFR".

** Fills blank for effective date of notice. See E, and F. above in this section for impact of QIO/QIC review. Note that even if review occurs, the provider's notification on coverage in HINN may be upheld, but if the beneficiary requests the review, liability will not start until after

the QIO decisions as per 1154; if hospital requested review, the QIO will specify when liability begins.

K. Model Language/HINN Forms

Model Language. HINNs currently are notices with model language. Consequently, hospitals are allowed to make some changes, and several QIOs have also made suggestions for changes. Until further instruction from CMS, hospitals will continue to use model language. However, hospitals should be advised to meet all content requirements of the notice as set forth in this instruction, and would be wise to use the models from CMS attached to this instruction, or alternates developed by their QIO, since invalid notification may result in provider liability.

Partial Noncoverage. There are cases where existing model language is not adequate, such as hospitals for that do not receive bundled payments for inpatient services, unlike IPPS hospitals subject to 42 CFR 412.42. These hospitals still need to notify beneficiaries, even when some, but not all, services are noncovered. HINN model language should be adapted to this situation, in the sections addressing: (1) description of the care at issue, and (2) effective date by filling the blank as "N/A" if some covered care is continued. Other content requirements of the HINN would still apply. Use the HINN letter most appropriate to the overall situation.

Attached Letters/Format Requirements. Each of the 9 HINN letters still effective July 1, 2005 is attached to the end of this instruction. The text of the letters has been compacted so that the pages of the instruction could be minimized, and the bolded titles differentiating the 9 letters, and other bolded instructions to the notice preparer, are meant to be removed before use. Due to the use of model language, there are no format requirements for HINNs. Providers can therefore change spacing and extend the length of the letters as they see fit. However, hospitals must ensure beneficiaries understand the notice. Therefore, the letters should be easy for beneficiaries to understand (i.e., use of 12-point or large font, use of a visually high-contrast combination of dark ink on a pale background).

L. Acknowledgment of HINN Receipt/Retention.

The hospital must document the date and time of the beneficiary's receipt of the HINN in medical records, along with keeping a copy of the HINN itself. Hospitals may have to provide copies HINNs to QIOs if expedited review is requested.

M. Inappropriate HINNs

An inappropriately issued HINN would be any case where the QIO determines:

- The hospital's finding is invalid (e.g., where the admission was covered and where continued acute care was medically necessary)
- The content of the notice is not in compliance;
- The patient was charged for services without a notice;
- The patient requires SNF care and there was no available SNF bed (i.e., can't be used when placement is not available);
- A continued stay HINN is issued without the concurrence of the QIO or the attending physician ; and
- The beneficiary did not receive written notice when discharged from acute care and admitted to SNF or NF swing bed services.

  NOTE: In cases involving an admission HINN where the QIO determines that the beneficiary's condition changed from nonacute to acute, the QIO will assign a deemed date of admission.

N. Other Special HINN Considerations

Notices in Investigational/Experimental Procedures Situations. The hospital may charge a beneficiary for diagnostic procedures and studies, and therapeutic procedures and courses of treatment (e.g., experimental procedures) that are excluded from coverage as medically unnecessary, if it has informed the beneficiary in writing (42 CFR 412.42(d)). Since the hospital is required to submit investigational services/items to its intermediary for approval, it will follow these HINN instructions to provide notification and will consult the intermediary if further assistance if required.

Letter 1 - Model Hospital-Issued Notice of Noncoverage/HINN - Admission or Preadmission

Hospital Letterhead

_____

Date of Notice

_____ _____

Name of Patient or Representative Admission Date

_____ _____

Address Health Insurance Claim (HIC) Number

_____ _____

City, State, Zip Code Attending Physician's Name

YOUR IMMEDIATE ATTENTION IS REQUIRED

Dear _____:

The purpose of this notice is to inform you that we find that your admission for **(specify services or condition**) is not covered under Medicare **because (specify services to be furnished or condition to be treated) (specify)** is/are medically unnecessary **(or)** could be safely furnished in another setting. This determination was based upon our understanding and interpretation of available Medicare coverage policies and guidelines. You should discuss with your attending physician other arrangements for any further health care you may require. If you decide to **(be admitted to/remain in)** the hospital, you will be financially responsible for _____.[1]

This notice, however, is not an official Medicare determination. The **(name of QIO)** is the quality improvement organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of **(name of State)**, and to make that determination.

- If you disagree with our conclusion: **(Select as appropriate)**

  Preadmission:

_____

[1] For preadmission notices, insert: "all customary charges for services furnished during the stay, except for those services for which you are eligible under Part B."

For admission notices issued not later than 3:00 P.M. on the date of admission, insert: "customary charges for all services furnished after receipt of this hospital notice, except for those services for which you are eligible under Part B." (If these requirements are not met, insert the liability phrase below.)

For admission notices issued after 3:00 P.M. on the day of admission, insert: "customary charges for all services furnished on the day following the day of receipt of this notice, except for those services for which you are eligible to receive payment under Part B."

- Request immediately, but no later than 3 calendar days after receipt of this notice, or, if admitted, at any point in the stay, an immediate review of the facts in your case. You may make this request through us or directly to the QIO by telephone or in writing to the address listed below.

Admission:

- Request immediately, or at any point during your stay, an immediate review of the facts in your case. You may make this request through us or directly to the QIO by telephone or in writing to the address listed below.

- If you do not wish an immediate review:
  - You may still request a review within 30 calendar days from the date of receipt of this notice by telephoning or writing to the address specified below.
- Results of the QIO Review:
  - The QIO will send you a formal determination of the medical necessity and appropriateness of your hospitalization, and will inform you of your reconsideration and appeal rights.
  - IF THE QIO DISAGREES WITH THE HOSPITAL (i.e., the QIO determines that your care is covered), you will be refunded any amount collected except for any applicable amounts for deductible, coinsurance, and convenience services or items normally not covered by Medicare.
  - IF THE QIO AGREES WITH THE HOSPITAL, you are responsible for payment for all services beginning on **(specify date)**.[1]/

- QIO Address:

Name: _____

Address: _____

Telephone Number:_____

Sincerely,

_____

Chairperson of Utilization Review

Comm

ittee, Medical Staff, etc

[1]/ See footnote 1 on preceding page.

Letter 1 (Cont.)

ACKNOWLEDGMENT OF RECEIPT OF NOTICE

This is to acknowledge that I received this notice of noncoverage of services from the **(name of hospital)** at **(time)** on **(date)**. I understand that my signature below does not indicate that I agree with the notice, only that I have received a copy of the notice.

_____ _____ _____

(Signature of beneficiary or person acting on behalf of beneficiary) (Time) (Date)

cc: QIO

Attending Physician

Letter 2 - Model HINN Continued Stay (Attending Physician Concurs)

Hospital Letterhead

_____

Date of Notice

_____ _____

Name of Patient or Representative Admission Date

_____ _____

Address Health Insurance Claim (HIC) Number

_____ _____

City, State, Zip Code Attending Physician's Name

YOUR IMMEDIATE ATTENTION IS REQUIRED

Dear _____:

This notice is to inform you that we have reviewed the medical services you have received for **(specify services or condition)** from (date of admission) through **(date of last day reviewed)**. Your attending physician has been advised and has concurred that beginning **(specify date of first noncovered day)** further **(specify services to be furnished or condition to be treated) (specify)** is/are medically unnecessary **(or)** could be furnished safely in another setting. This determination was based upon our understanding and interpretation of available Medicare coverage policies and guidelines.

You are financially liable for all costs for the care you receive, except for those services for which you are eligible under Part B beginning on **(specify date).**[1]/ If you leave on **(specify date)**[1], you will not be liable for costs for care except for payment of deductible, coinsurance, or any convenience services or items normally not covered by Medicare. You should discuss other arrangements with your attending physician for any further health care you may require.

However, this notice is not an official Medicare determination. The **(name of QIO)** is the quality improvement organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of **(name of State)**, and to make that determination.

- If you disagree with our conclusion:
    - ° Request immediately, by noon of the first working day after receipt of this notice, an immediate review by telephone, or in writing. You may make this request through us or directly to the QIO at the address listed below.

_____

[1]/ For PPS hospitals and short term/acute care hospitals in waivered States, insert: the date of the third day following the date of receipt of the hospital notice.

For specialty hospitals and PPS exempt units, insert: the date of the day following the date of receipt of the notice.

- The QIO will request your views about your case and respond to you within one working day of receipt of your request and your medical records (sent by the hospital).

- If you do not request review by noon of the first working day after receipt of this notice:
  - You may still request QIO review at any point during your stay or within 30 days after you receive this notice, whichever is longer. Request this QIO review at the address listed below.
- QIO Review Results:
  - The QIO will send you a formal determination of the medical necessity and appropriateness of your hospitalization, and will inform you of your reconsideration rights.
  - IF THE QIO DISAGREES WITH THE HOSPITAL (i.e., it determines that your care is covered by Medicare), you will be refunded any amount collected by the hospital except for any applicable amounts for deductible, coinsurance, and convenience services or items normally not covered by Medicare.
  - IF THE QIO AGREES WITH THE HOSPITAL:
    - You are responsible for payment for all services beginning **on (specify date)**[1]/ unless you have requested an immediate review.
    - If you request an immediate review (i.e., you make your request for review by noon of the first working day after receipt of this notice), you will not be responsible for payment until noon of the next day after you receive the QIO's notification.

- QIO Address:

  Name: _____

  Address:_____

  Telephone Number: _____

Sincerely,

_____

Chairperson of Utilization Review

Comm

ittee, Medical Staff, etc

---

[1]/ See footnote 1 on preceding page

ACKNOWLEDGMENT OF RECEIPT OF NOTICE

This is to acknowledge that I received this notice of noncoverage of services from the **(name of hospital)** at **(time)** on **(date)**. I understand that my signature below does not indicate that I agree with the notice, only that I have received a copy of the notice.

_____	_____	_____
(Signature of beneficiary or person acting on behalf of beneficiary)	(Time)	(Date)

cc: QIO
Attending Physician

Letter 3 - Model HINN, Continued Stay-Swing Bed Only - (Attending Physician Concurs, Change from Acute to NF Level of Care)

Hospital Letterhead

_____

Date of Notice

_____ _____

Name of Patient or Representative Admission Date

_____ _____

Address Health Insurance Claim (HIC) Number

_____ _____

City, State, Zip Code Attending Physician's Name

YOUR IMMEDIATE ATTENTION IS REQUIRED

Dear _____:

This notice is to inform you that we have reviewed the medical services you have received for **(specify services or condition)** from **(date of admission)** through **(date of last day reviewed)**. Your attending physician has been advised and has concurred that beginning **(specify date of first noncovered acute care day) further (specify services to be furnished or condition to be treated) (specify)** is/are medically unnecessary **(or)** could be furnished safely in another setting. This determination was based upon our understanding and interpretation of available Medicare coverage policies and guidelines.

Upon receipt of this notice, the items and services you received will not be covered under Medicare. The care that you need now is not hospital or skilled nursing care and Medicare does not pay for it.

If you decide to stay in the hospital, you are financially liable for all costs of the care you receive except for those services for which you are eligible under Part B, beginning on **(specify date).**[1]/ If you leave the hospital on **(specify date)**, you will not be liable for costs of care except for payment of deductible, coinsurance, or any convenience services or items normally not covered by Medicare. You should discuss other arrangements with your attending physician for any further health care you may require.

- However, this notice is not an official Medicare determination. The **(name of QIO)** is the quality improvement organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of **(name of State)** and to make that determination.

_____

[1]/ For PPS hospitals and short term/acute care hospitals in waivered States, insert the date of the third day following the date of receipt of the hospital notice.

For specialty hospitals and PPS exempt units, insert: the date of the day following the date of receipt of the notice.

Letter 3 (Cont.)

Page 2 - Hospital-Issued Notice of Noncoverage

If you disagree with our conclusion:

- Request immediately, or at any point in the stay, an immediate review of the facts in your case. You may make this request through us or directly to the QIO at the address listed below.

- If you do not request an immediate review:
  - You may still request QIO review within 30 days after you receive this notice. Request this QIO review at the address listed below.
- QIO Review Results:
  - The QIO will send you a formal determination of the medical necessity and appropriateness of your hospitalization, and will inform you of your reconsideration rights.
  - IF THE QIO DISAGREES WITH THE HOSPITAL (i.e., it determines that your care is covered by Medicare), you will be refunded any amount collected by the hospital except for any applicable amounts for deductible, coinsurance, and convenience services or items normally not covered by Medicare.
  - IF THE QIO AGREES WITH THE HOSPITAL: You are responsible for payment for all services beginning on **(specify date)**[1]/

- QIO Address:

  Name: _____
  Address: _____
  Telephone Number: _____

Sincerely,

_____
Chairperson of Utilization Review
Committee, Medical Staff, etc

ACKNOWLEDGMENT OF RECEIPT OF NOTICE

This is to acknowledge that I received this notice of noncoverage of services from the **(name of hospital)** at **(time)** on **(date)**. I understand that my signature below does not indicate that I agree with the notice, only that I have received a copy of the notice.

_____ _____ _____
(Signature of beneficiary or person acting on behalf of beneficiary) (Time) (Date)

cc: QIO
Attending Physician

_____

[1]/ See footnote 1 on preceding page.

Letter 4 - Model HINN- Continued Stay-Swing Bed Only (Attending Physician Concurs, Change from Acute to SNF Level of Care)

Hospital Letterhead

_____
Date of Notice

_____ _____
Name of Patient or Representative Admission Date

_____ _____
Address Health Insurance Claim (HIC) Number

_____ _____
City, State, Zip Code Attending Physician's Name

YOUR IMMEDIATE ATTENTION IS REQUIRED

Dear _____:

This notice is to inform you that we have reviewed the medical services you have received for **(specify services or condition)** from **(date of admission)** through **(date of last day reviewed)**. Your attending physician has been advised and has concurred that beginning **(specify date of first noncovered acute care day)**, you no longer need an acute level of care. You will begin to receive the type of hospital services which are furnished in a skilled nursing facility (SNF) beginning **(specify date of first SNF swing- bed day)**. This is known as SNF swing-bed services. Medicare will pay for your SNF swing-bed services (if you have not used up all your SNF benefit days in the benefit period). However, this notice is not an official Medicare determination. The **(name of QIO)** is the quality improvement organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of **(name of State)** and to make that determination.

- If you disagree with our conclusion and want an immediate review:
  - Request immediately, or at any point in the stay, an immediate review of the facts in your case. You may make this request through us or directly to the QIO at the address listed below.
- If you do not request an immediate review:
  - You may still request QIO review within 30 days after you receive this notice. Request this QIO review at the address listed below.
- QIO Review Results:
  - The QIO will send you a formal determination of the medical necessity and appropriateness of your hospitalization, and will inform you of your reconsideration rights.
  - IF THE QIO DISAGREES WITH THE HOSPITAL (i.e., it determines that your care is covered by Medicare), you will continue to receive acute care services covered under Medicare. You will continue to be responsible for payment of any applicable amounts for deductible, coinsurance, and convenience services or items normally not covered by Medicare.

- IF THE QIO AGREES WITH THE HOSPITAL: you will continue to receive SNF swing bed services paid under Medicare. You will continue to be responsible for payment of any applicable amounts for deductible, coinsurance, or convenience services or items normally not covered by Medicare.

- QIO Address:

  Name: _____

  Address: _____

  Telephone Number: _____

Sincerely,

_____

Chairperson of Utilization Review Committee, Medical Staff, etc

ACKNOWLEDGMENT OF RECEIPT OF NOTICE

This is to acknowledge that I received this notice of noncoverage of services from the **(name of hospital**) at **(time)** on **(date).** I understand that my signature below does not indicate that I agree with the notice, only that I have received a copy of the notice.

_____ _____ _____

(Signature of beneficiary or person acting on behalf of beneficiary) (Time) (Date)

cc: QIO

Attending Physician

Letter 5 - Model HINN- Continued Stay (QIO Concurs)

Hospital Letterhead

_____
Date of Notice

_____ _____
Name of Patient or Representative Admission Date

_____ _____
Address Health Insurance Claim (HIC) Number

_____ _____
City, State, Zip Code Attending Physician's Name

YOUR IMMEDIATE ATTENTION IS REQUIRED

Dear _____:

We have reviewed the medical services you have received **for (specify services or condition)** from **(date of admission)** through **(date of last day reviewed)** and has determined that further hospitalization is not necessary. This determination is based upon our understanding and interpretation of available Medicare coverage policies/guidelines.

The **(name of QIO)** is the quality improvement organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of **(name of State)**. The **(name of the QIO)** has concurred with our decision that beginning **(specify date of first noncovered day)** further **(specify)** services to be furnished (or) condition to be treated **(specify)** is/are medically unnecessary **(or)** could be safely furnished in another setting. You will also receive a notice from **(name of QIO)** confirming the review decision.

We have advised your attending physician of the denial of further inpatient hospital care. You should discuss other arrangements with your attending physician for any further health care you may require.

If you decide to stay in the hospital, you will be responsible for payment for all services provided to you by this hospital, except for those services for which you are eligible to receive payment under Part B, beginning **(specify date)**.[1/]

For specialty hospital and PPS-exempt units, insert the date specified by the QIO. The beneficiary's (or representative's) liability begins on the day following the date of receipt of the notice.

- If you disagree with this decision:
  - You may request by telephone or in writing an expedited reconsideration of the QIO's determination. An expedited reconsideration will be performed if you make your request while in the hospital. You should make this request immediately through us or to the QIO at the address listed below.

[1/] Insert: The date following the day of receipt of the hospital notice. For PPS hospitals and short term/acute care hospitals in waivered States, insert the date of the third day following the date of receipt of the notice.

Letter 5 (Cont.)

- If you do not request an expedited reconsideration:
  - You may still request a reconsideration. Instructions on how to request this reconsideration will be given to you in a notice sent by **(name of QIO).**
- QIO Reconsideration Results:
  - The QIO will send to you a formal reconsideration determination of the medical necessity and appropriateness of your hospitalization and will inform you of your appeal rights.
  - IF THE QIO OVERTURNS ITS DECISION (i.e., it determines that your care is covered by Medicare), you will be refunded any amount collected except for any applicable amounts for deductible, coinsurance, and convenience services or items normally not covered by Medicare.
  - IF THE QIO UPHOLDS ITS DECISION (i.e., it reaffirms that your care is not covered by Medicare), you are responsible for payment beginning **(specify date)**.
- QIO Address:

  Name: _____

  Address: _____

  Telephone Number: _____

Sincerely,

_____

Chairperson of Utilization Review

Committee, Medical Staff, etc

ACKNOWLEDGMENT OF RECEIPT OF NOTICE

This is to acknowledge that I received this notice of noncoverage of services from the **(name of hospital**) at **(time)** on **(date)**. I understand that my signature below does not indicate that I agree with the notice, only that I have received a copy of the notice.

_____ _____ _____

(Signature of beneficiary or person acting on behalf of beneficiary) (Time) (Date)

cc: QIO
Attending Physician

Letter 6 - Model HINN- Continued Stay - (QIO Concurs, Change from Acute to NF Level of Care)

Hospital Letterhead

_____

Date of Notice

_____ _____

Name of Patient or Representative Admission Date

_____ _____

Address Health Insurance Claim (HIC) Number

_____ _____

City, State, Zip Code Attending Physician's Name

YOUR IMMEDIATE ATTENTION IS REQUIRED

Dear _____:

We have reviewed the medical services you have received for **(specify services or condition)** from **(date of admission)** through **(date of last day reviewed)** and has determined that further hospitalization paid under Medicare is not necessary. This determination is based upon our understanding and interpretation of available Medicare coverage policies and guidelines.

The **(name of QIO)** is the quality improvement organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of **(Name of State)**. The **(name of QIO)** has concurred with our decision that beginning **(specify date of noncovered acute care day)** further **(specify services to be furnished or condition to be treated) (specify is/are)** medically unnecessary or could be safely furnished in another setting. You will also receive a notice from **(name of QIO)** confirming the review decision.

We have advised your attending physician of the denial of further acute hospital care. Upon receipt of this notice, the items and services which you receive will no longer be covered under Medicare. The care that you need now is not hospital or skilled nursing care and Medicare does not pay for it.

You are financially liable for all costs of the care you receive, except for those services for which you are eligible under Part B, beginning on **(specify date)**.[1]/ You should discuss other arrangements with your attending physician for any further health care you may require.

- If you disagree with this decision and want an expedited reconsideration:
- You may request by telephone or in writing an expedited reconsideration of the QIO's determination. An expedited reconsideration will be performed if you make your request while in the hospital. You should make this request immediately through us or to the QIO at the address listed below.

Letter 6 (Cont.)

- If you do not request an expedited reconsideration:
  - You may still request a reconsideration. Instructions on how to request this reconsideration will be given to you in a notice sent by **(name of QIO**).
- QIO Reconsideration Results:
  - The QIO will send to you a formal reconsideration determination of the medical necessity and appropriateness of your hospitalization and will inform you of your appeal rights.
  - IF THE QIO OVERTURNS ITS DECISION (i.e., it determines that you require acute care), you will be refunded any amount collected except for any applicable amounts for deductible, coinsurance, and convenience services or items normally not covered by Medicare.
  - IF THE QIO UPHOLDS ITS DECISION (i.e., it reaffirms that your care is not covered by Medicare), you are responsible for payment beginning **(specify date).** If you leave the hospital on **(specify date)**[1], you will not be liable for costs of care except for payment of any applicable deductible, coinsurance, and convenience services or items normally not covered by Medicare.

- QIO Address:
  Name:_____
  Address:_____
  Telephone: _____

Sincerely,

_____
Chairperson of Utilization Review
Committee, Medical Staff, etc

ACKNOWLEDGMENT OF RECEIPT OF NOTICE

This is to acknowledge that I received this notice of noncoverage of services from the **(name of hospital)** at **(time)** on **(date)**. I understand that my signature below does not indicate that I agree with the notice, only that I have received a copy of the notice.

_____ _____ _____
(Signature of beneficiary or person acting on behalf of beneficiary) (Time) (Date)

cc: QIO
Attending Physician

_____

[1]/ Insert: The date following the day of receipt of the hospital notice. For PPS hospitals and short term/acute care hospitals in waivered States, insert the date of the third day following the date of receipt of the notice.

Letter 7 - Model HINN - Continued Stay (QIO Concurs, Change from Acute to SNF Level of Care)

Hospital Letterhead

_____

Date of Notice

_____ _____

Name of Patient or Representative Admission Date

_____ _____

Address Health Insurance Claim (HIC) Number

_____ _____

City, State, Zip Code Attending Physician's Name

YOUR IMMEDIATE ATTENTION IS REQUIRED

Dear _____:

This notice is to inform you that we have reviewed the medical services you have received for **(specify services or condition)** from **(date of admission)** through **(date of last day reviewed)** and has determined that acute care services are not necessary. This determination is based upon our understanding and interpretation of available Medicare coverage policies and guidelines.

The **(name of QIO)** is the quality improvement organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of **(Name of State)**. The **(name of QIO)** has concurred with our decision that beginning **(specify date of first noncovered acute care day)** you no longer require an acute level of care. You will begin to receive the type of hospital services which are rendered in a skilled nursing facility (SNF) beginning **(specify date of first SNF swing-bed day)**. This is known as SNF swing-bed services. The Medicare program will pay for your SNF swing-bed services (if you have not used up all your SNF benefit days (100) in the benefit period).

- If you disagree with this decision and want an expedited reconsideration:
  - You may request by telephone or in writing an expedited reconsideration of the QIO's determination. An expedited reconsideration will be performed if you make your request while in the hospital. You should make this request immediately through us or to the QIO at the address listed below.
- If you do not request an expedited reconsideration:
  - You may still request a reconsideration. Instructions on how to request this reconsideration will be given to you in a notice sent by **(name of QIO).**

Letter 7 (Cont.)

- QIO Reconsideration Results:
  - The QIO will send to you a formal reconsideration determination of the medical necessity and appropriateness of your hospitalization and will inform you of your appeal rights.
  - IF THE QIO OVERTURNS ITS DECISION (i.e., it determines that your care is covered by Medicare), you will be refunded any amount collected except for any applicable amounts for deductible, coinsurance, and convenience services or items normally not covered by Medicare.
  - IF THE QIO UPHOLDS ITS DECISION (i.e., it reaffirms that you do not require acute care), you will continue to receive SNF swing-bed services paid under Medicare. You will be responsible for payment of any applicable deductible, coinsurance, and convenience services or items normally not covered by Medicare.
- QIO Address:

  Name: _____

  Address: _____

  Telephone Number: _____

Sincerely,

_____

Chairperson of Utilization Review

Committee, Medical Staff, etc

ACKNOWLEDGMENT OF RECEIPT OF NOTICE

This is to acknowledge that I received this notice of noncoverage of services from the **(name of hospital)** at **(time)** on **(date)**. I understand that my signature below does not indicate that I agree with the notice, only that I have received a copy of the notice.

_____ _____ _____

(Signature of beneficiary or person acting on behalf of beneficiary) (Time) (Date)

cc: QIO
Attending Physician

Letter 9 - Model HINN - Direct Preadmission/Admission to NF Swing Bed

Hospital Letterhead

_____
Date of Notice

_____ _____
Name of Patient or Representative Admission Date

_____ _____
Address Health Insurance Claim (HIC) Number

_____ _____
City, State, Zip Code Attending Physician's Name

YOUR IMMEDIATE ATTENTION IS REQUIRED

Dear _____:

The purpose of this notice is to inform you that we find that your admission for **(specify service or condition)** is not covered under Medicare because the services to be performed **(specify are not considered skilled care or constitute custodial care)**. This determination was based upon our understanding and interpretation of available Medicare coverage policies and guidelines. You should discuss other arrangements with your attending physician for any further health care you may require. If you decide to **(be admitted to/remain in)** the hospital, you will be financially responsible for [1]/.

This notice, however, is not an official Medicare determination. The **(name of QIO)** is the quality improvement organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of **(name of State)** and to make that determination.

- If you disagree with our conclusion and want an immediate review **(Select as appropriate)**

_____

[1]/ For preadmission notices, insert: "all customary charges for services furnished during the stay, except for those services for which you are eligible to receive payment under Part B."

For admission notices issued not later than 3:00 P.M. on the date of admission (i.e., before 3:00 P.M.), insert: "customary charges for all services furnished after receipt of the hospital notice, except for those services for which you are eligible to receive payment under Part B." (If these requirements are not met, insert the liability phrase below.)

For admission notices issued after 3:00 P.M. on the day of admission, insert: "customary charges for all services furnished on the days following the day of receipt of this notice, except for those services for which you are eligible to receive payment under Part B."

Letter 9 (Cont.)

Preadmission:

- Request immediately, but no later than 3 calendar days after receipt of this notice, or, if admitted, at any point in the stay, an immediate review of the facts in your case. You may make this request through us or directly to the QIO by telephone or in writing to the address listed below.

Admission:

- Request immediately, or at any point during your stay, an immediate review of the facts in your case. You may make this request through us or directly to the QIO by telephone or in writing to the address listed below.

- If you do not wish an immediate review:
  - You may still request a review within 30 calendar days from the date of receipt of this notice by telephoning or writing to the address specified below.
- Results of the QIO Review:
  - The QIO will send you a formal determination of the medical necessity and appropriateness of your hospitalization, and will inform you of your reconsideration and appeal rights.
  - IF THE QIO DISAGREES WITH THE HOSPITAL (i.e., the QIO determines that your care is covered), you will be refunded any amount collected except for any applicable amounts for deductible, coinsurance, and convenience services or items normally not covered by Medicare.
  - IF THE QIO AGREES WITH THE HOSPITAL, you are responsible for payment for all services beginning on **(specify date).**[1]/ If you leave the hospital on **(specify date)**[1]/, you will not be liable for costs for care, except for payment of any applicable deductible, coinsurance, and convenience services or items normally not covered by Medicare.

- QIO Address:

  Name: _____

  Address: _____

  Telephone Number: _____

[1]/ See footnote 1 on preceding page.

Sincerely,

_____

Chairperson of Utilization Review

Committee, Medical Staff, etc

ACKNOWLEDGMENT OF RECEIPT OF NOTICE

This is to acknowledge that I received this notice of noncoverage of services from the **(name of hospital)** at **(time)** on **(date)**. I understand that my signature below does not indicate that I agree with the notice, only that I have received a copy of the notice.

_____ _____ _____

(Signature of beneficiary or person acting on behalf of beneficiary) (Time) (Date)

cc: QIO
Attending Physician

Letter 10 - Model Hospital Notice to Beneficiary of QIO Review of Need for Continued Hospitalization

Hospital Letterhead

_____

Date of Notice

_____ _____

Name of Patient or Representative Admission Date

_____ _____

Address Health Insurance Claim (HIC) Number

_____ _____

City, State, Zip Code Attending Physician's Name

YOUR IMMEDIATE ATTENTION IS REQUIRED

Dear _____:

We have has determined that you no longer require an acute (hospital inpatient) level of care. Because your doctor disagreed with this decision we are asking the quality improvement organization **(Name of QIO)** to review your case.

(Name of QIO) will contact you to solicit your views about your case and the care you need.

You do not need to take any action until you hear from the quality improvement organization.

Sincerely,

_____

Chairperson of Utilization Review

Committee, Medical Staff, etc