Delivering the Important Message from Medicare and Detailed Notice of Discharge

Version 1, Effective 3-15-22

IMPORTANT MESSAGE FROM MEDICARE PROCESS

BACKGROUND: The Important Message from Medicare (IM) informs Medicare beneficiaries who are hospital inpatients of their right to appeal to a BFCC-QIO for an expedited review of their discharge when a hospital, with physician concurrence, determines that inpatient care is no longer necessary.

REQUIREMENT: Hospitals must deliver the 1st IM within 2 calendar days of admission, must obtain the signature of the beneficiary or representative and provide a paper copy at that time. Hospitals must also document delivery of a follow-up copy of the signed notice as far in advance of discharge as possible, but not more than 2 calendar days before discharge. **NOTE:** The IM should only be given when an inpatient admission is pending or has occurred. It should not be given 'just in case', such as a hospital delivering to all Medicare patients in the emergency room.

APPLICABLE PATIENTS: All beneficiaries who are being discharged from a Medicare covered inpatient hospital stay must receive the IM. This includes, but is not limited to, beneficiaries in the following circumstances:

- Original Medicare beneficiaries
- Medicare Advantage Plan enrollees
- Beneficiaries for whom Medicare is either the primary or secondary payer.
- Beneficiaries with brief inpatient stays.
- Beneficiaries physically discharged from the hospital or discharged to a lower level of care (such as a Swing Bed) in the same hospital.

EXCEPTIONS: The following situations are not eligible for an expedited review determination. As such, hospitals should not deliver the IM in these instances:

- *When a beneficiary transfers to another hospital at the same level of care (e.g., a beneficiary transfers from one hospital to another while remaining a hospital inpatient).*
- *When beneficiaries exhaust their benefits (e.g., a beneficiary reaches the number of lifetime reserve days of the Medicare inpatient hospital benefit.)*
- *When beneficiaries end care on their own initiative (e.g., a beneficiary elects the hospice benefit).*
- *Condition Code 44 (when internal review subsequently determines that an inpatient admission should be changed to outpatient status)*
- *Physician does not concur with discharge.*

1st Delivery of the IM Requirements

- Timing:
  - ⇒ Pre-admission: Up to 7 days before admission
  - ⇒ At admission: At admission
  - ⇒ After admission: Up to 2 days following admission
- The beneficiary or representative must sign and date the IM (electronic form is permitted). *Note—if a hospital issues an electronic IM, the beneficiary must be given the option of requesting a paper issuance if that is preferred.*
- Beneficiary or representative must be given a paper copy of the signed IM (regardless if electronic or paper form was signed)
- A copy of the 1st signed IM must be stored in the medical record.

FOLLOW-UP Delivery of the IM Requirements:

- Timing: Deliver no sooner than 2 days before discharge and no later than 4 hours prior to discharge.
- If 2 or fewer days have passed since the delivery of the 1st IM, no follow-up IM is required. For example, if the patient is admitted on Monday, receives the 1st IM on Wed, and is discharged on Friday, no follow-up IM is required.
- IM Form Options:
  - ⇒ A copy of the 1st signed IM may be delivered. Staff should notate the date of the delivery in the "Additional Information" section of the IM (it does not have to be re-signed by the beneficiary or representative), or
  - ⇒ A new copy of the IM may be delivered but it must be signed and dated by the beneficiary or representative.
- Hospitals must document the delivery of the follow-up copy of the IM in the patient records.

REFUSAL TO SIGN THE IM: If the beneficiary refuses to sign the IM the provider should annotate the IM notice to that effect, and indicate the date of refusal on the notice. The date of refusal is considered to be the date of notice receipt. Beneficiaries who refuse to sign the IM remain entitled to an expedited determination.

DELIVERY TO REPRESENTATIVES

Type of Representative:

- **Appointed Representative:** Individuals designated by beneficiaries to act on their behalf. A beneficiary may designate an appointed representative via the "Appoint of Representative" form, the CMS 1696.
- **Authorized Representative:** An individual who, under State or other applicable law, may make health care decisions on a beneficiary's behalf (e.g., the legal guardian or someone appointed in accordance with a properly executed durable medical power of attorney).
- **No representative:** If a beneficiary is temporarily incapacitated and there is no representative, a person (typically, a family member or close friend) whom the hospital has determined could reasonably represent the beneficiary, but who has not been named in any legally binding document, may be a representative for the purpose of receiving the IM. Such a representative should act in the beneficiary's best interests and in a manner that is protective of the beneficiary and the beneficiary's rights. Therefore, a representative should have no relevant conflict of interest with the beneficiary. *The hospital must annotate the IM with the name of the staff person initiating the contact, the name of the person contacted, and the date, time, and method (in person or telephone) of the contact.*

Delivery to off-site representatives

- If the IM must be delivered to a representative who is not physically present, the hospital is not required to personally deliver the IM or have the IM delivered via courier to the representative. The hospital must complete the IM as required and may instead telephone the representative and then mail the IM. The date and time of the telephone call is considered the receipt date of the IM.
- The hospital must complete all of the following actions.
  1. Verbally convey all contents of the IM;
  2. Note the date and time this information is communicated verbally;
  3. Annotate the "Additional Information" section to reflect that IM was communicated verbally to the representative; and
  4. Annotate the "Additional Information" section with the name of the staff person initiating the contact, the name of the representative contacted by phone, the date and time of the telephone contact, and the telephone number called.
  5. Mail a copy of the annotated IM to the representative the day telephone contact is made by certified mail, return receipt requested, or any other delivery method that can provide signed verification of delivery (e.g., FedEx, UPS). The burden is on the hospital to demonstrate that timely contact was attempted with the representative and that the notice was delivered.
- If the hospital and the representative both agree, the hospital may send the notice by fax or e-mail; however, the hospital's fax and e-mail systems must meet the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy and security requirements.

COMPLETING THE IM: Hospitals must use the OMB-approved IM (CMS-10065) and must add the following information in the corresponding blanks of the IM:

1. Patient name
2. Patient number (e.g. medical record number; not the SS#, HICN or Medicare number)
3. BFCC-QIO contact information

ALTERATIONS TO THE IM:

- The IM must remain two pages. The notice can be two sides of one page or one side of two separate pages, but **must not** be condensed to one page.
- Hospitals may include their business logo and contact information on the top of the IM. Text may not be shifted from page 1 to page 2 to accommodate large logos, address headers, etc.
- Hospitals may include information in the optional "Additional Information" section relevant to the beneficiary's situation.
- The notice and accompanying instructions may be found online at https://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.

DETAILED NOTICE OF DISCHARGE PROCESS

TIMEFRAME FOR REQUESTING AN EXPEDITED DETERMINATION: A beneficiary who receives an IM and disagrees with the discharge may request an expedited determination by contacting the BFCC-QIO by telephone or in writing by midnight of the day of discharge, before leaving the hospital.

When the BFCC-QIO receives a request from a beneficiary, the BFCC-QIO must immediately notify the provider of services that a request for an expedited determination was made. If the request is received after normal working hours, the BFCC-QIO should notify the provider as soon as possible on the morning after the request was made.

The beneficiary must be available to answer questions or supply information requested by the BFCC-QIO. The beneficiary may, but is not required to, supply additional information to the BFCC-QIO that he or she believes is pertinent to the case.

HOSPITAL RESPONSIBILITIES: When a hospital is notified by a BFCC-QIO of a beneficiary request for an expedited determination, the provider must perform all of the following actions.

1. Deliver the beneficiary a Detailed Notice of Discharge (DND) as soon as possible, but no later than noon of the day after BFCC-QIO notification;
2. Supply the BFCC-QIO with copies of the IM and DNC as soon as possible, but no later than noon of the day after BFCC-QIO notification;
3. Supply all information, including medical records, requested by the BFCC-QIO. The BFCC-QIO may allow this required information to be supplied via phone, writing, or electronically. If supplied via phone, the provider must keep a written record of the information it provides within the patient record; and
4. Furnish the beneficiary, at their request, with access to or copies of any documentation it provides to the BFCC-QIO. The hospital may charge the beneficiary a reasonable amount to cover the costs of duplicating and delivering the documentation. This documentation must be provided to the beneficiary by close of business of the first day after the material is requested.

DETAILED NOTICE OF DISCHARGE: The DND may only be modified as directed by CMS. The notice and accompanying instructions may be found online at https://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.

Hospitals are responsible for the delivery of the DND to beneficiaries who request an expedited determination by the BFCC-QIO. The DND must contain all the following information:

1. The facts specific to the beneficiary's discharge and provider's determination that coverage should end.
2. A specific and detailed explanation of why services are either no longer reasonable or necessary or no longer covered.
3. A description of, and citations to, the Medicare coverage rule, instruction, or other policies applicable to the review.

The delivery must occur in person by noon of the day after the BFCC-QIO notifies the provider that the beneficiary has requested an expedited determination. The DND does not require a signature but should be annotated in the event of a beneficiary's refusal to accept the notice upon delivery.

EXPEDITED REVIEW DETERMINATION: No later than one calendar day after it receives all requested information, the BFCC-QIO must make its determination on whether the discharge is appropriate based on medical necessity or other Medicare coverage policies. The BFCC-QIO must perform the following actions.

1. Notify the beneficiary, the beneficiary's physician, and the provider of services of its determination. This notification must include the rationale for the determination and an explanation of Medicare payment consequences and beneficiary liability.
2. Inform the beneficiary of the right to an expedited reconsideration by the BFCC-QIO and how to request a timely expedited reconsideration.
3. Make its initial notification via telephone and follow up with a written determination letter.

NOTE: If the BFCC-QIO does not receive supporting information from the hospital, it may make its determination based on the evidence at hand, or defer a decision until it receives the necessary information. If this delay results in continued services for the beneficiary, the provider may be held financially liable for these services as determined by the BFCC-QIO.

References:

- IM and DND Forms and Instructions: FFS & MA IM | CMS
- Change Request 12546, dated January 21, 2022: r11210cp.pdf-0 (cms.gov)
- MLN Matters 12546: MM12546 - Expedited Review Process for Hospital Inpatients in Original Medicare (cms.gov)