Important Message from Medicare

HINNS

Medical Necessity

April 23, 2014
Overview

- Sections 1154 and 1866(a)(1)(M)
- Beneficiary right to quality improvement organization (QIO) review of discharge decisions
- Hospitals continue to be responsible for notifying beneficiaries of this right
Hospitals Affected by Rule

- Any facility providing care at the inpatient hospital level
  - Short term or long term
  - Acute or nonacute
  - Paid through a prospective payment system or other reimbursement basis
  - Limited to specialty care or providing a broader spectrum of services
- Includes critical access hospitals
Beneficiaries Covered by Rule

- All hospital inpatients who are Medicare beneficiaries
  - Beneficiaries in Original Medicare
  - Enrollees in Medicare Advantage and other Medicare health plans under MA regulations
  - Dual eligible
  - Beneficiaries with Medicare as a secondary payer
IM: Delivery Requirements for the Initial Copy

- Delivered w/in 2 calendar days of admission or at preadmission, but not more than 7 calendar days before admission
- Using Standardized Notice (CMS-R-193)
- Ensure beneficiary comprehension
- Signed and dated by beneficiary
- Beneficiary gets a copy
- Hospital retains a copy
IM: Delivery Requirements for the Follow-up Copy

- Deliver as far in advance as possible before discharge, but no more than 2 calendar days before the day of discharge.
- Deliver on the day of discharge only when unavoidable:
  - Allow at least 4 hours for patient to consider rights.
- Cannot routinely deliver on discharge date.
- May give new IM and obtain signature again.
- Hospitals must document delivery and demonstrate compliance.
Notice Delivery to Representatives

- Hospitals should have processes for identifying who may act for the beneficiary in accordance with state or other applicable law.
- Delivery should be in person.
- Delivery may be by phone (not by voicemail) with a notice mailed or faxed that same day.
**Notice Delivery to Representatives**

- If a representative agrees, notice may be emailed following phone call
- Electronic transmissions must meet HIPAA requirements
- If unable to reach by phone, the notice may be sent by certified mail
  - The date of signature or refusal is the date of notification
Requesting QIO Review

- Beneficiary must submit a request to the QIO **no later than the day of discharge**
- Beneficiary should not be discharged if s/he requests review
- Request may be in writing or by phone
- Beneficiary should be available to discuss the case with the QIO
- Beneficiary may submit written evidence to the QIO
Timely Requests:
Liability during the QIO Review

Beneficiary is responsible only for coinsurance and deductibles for inpatient hospital services furnished before noon of the day after QIO notifies the beneficiary of its decision.
Timely Requests:

Liability after the QIO Review

- **QIO agrees with hospital:**
  Liability for continued services begins at noon of the day after the QIO notifies the beneficiary

- **QIO agrees with the beneficiary:**
  No beneficiary liability for continued care (other than coinsurance and deductibles)
Untimely Requests: Liability during the QIO Review

Beneficiaries who do not request a review and remain in the hospital past the discharge date:

- May request QIO review at any time
- May be charged for any services provided after discharge date
- Will be refunded any funds collected, if the QIO finds for the patient

Beneficiaries on Original Medicare who miss the deadline and leave the hospital continue to have the right to request a QIO review w/in 30 calendar days of the discharge date. MA Plan enrollees who request an untimely appeal will be referred back to their MA Plan.
Hospital Responsibilities during Review

As soon as possible, but no later than noon of the day after the QIO notifies a hospital of the review request, the hospital must:

- Deliver the Detailed Notice of Discharge using the standardized notice
- Provide all information the QIO needs by telephone or in writing at the QIO’s discretion

continued →
Hospital Responsibilities during Review

- Provide a copy of information to beneficiary, if requested
- Burden of proof is on the hospital
- Failure to give needed information may result in a decision based on evidence at hand or a delay in making the decision
QIO Responsibilities

- Notify the hospital of the beneficiary’s request for a review
- Receive and examine records
- Determine if notice delivery was valid
- Solicit the views of the hospital
- Issue a decision within the applicable time frame
QIO Timeframes

- **Timely requests** – One calendar day after all information is received
- **Untimely request (in hospital)** – Two calendar days after all information is received
- **Untimely request (not in hospital)** – Thirty calendar days after all information is received
Exclusions:

- Inpatient to inpatient transfers – follow up IM not given
- Preadmission/admission for services that are not reasonable and necessary – IM not issued unless there is a subsequent inpatient admission
- Swing beds are excluded from IM
- Change of status from inpatient to outpatient
- End of Part A days – never deliver the IM for services that Medicare never covers or the end of Part A days
- If the hospital inpatient elects hospice coverage do not issue follow up IM if the election occurs before discharge from acute care
Reconsideration Review

- Medicare patients and MA plan enrollees have a right to a reconsideration review.

- Conducted by QIO – new physician reviewer
Differences for Medicare Health Plans

- Plan may delegate delivery of the Detailed Notice of Discharge
- Reviews of untimely requests are done by the plan
- Hospitals and plans both have responsibilities when providing information to the QIO
- Hospital requested QIO reviews should occur only in consultation with the plan
HINNs

- HINNS for continued stay no longer used
- Continue using:
  - Preadmission/admission HINN
  - New inpatient hospital stay ABN
  - HINN11
- HINN 10 replaced by Notice of Hospital Requested Review (HRR)
OVERVIEW OF HINNS
Hospital Issued Notices of Noncoverage (HINNs)

Hospitals provide HINNs to beneficiaries prior to admission, at admission or at any point during an inpatient stay if the hospital determines the care being received or about to be received is not covered, because it is:

- Not medically necessary,
- Not delivered in the most appropriate setting or
- Is custodial in nature
Types of HINNs:

HINN 10: Notice of Hospital Requested Review (HRR)

Should be issued by hospitals to beneficiaries in Original Medicare whenever a hospital requests QIO review of a discharge decision without physician occurrence.
Types of HINNs: HINN 11

Used for noncovered items or services provided during an otherwise covered stay (e.g., a cosmetic surgery tacked on the end of a medically indicated procedure)

NOTE: The time at which the medically indicated procedure is completed and the nonmedically indicated procedure begins starts the timing of the noncovered services.
Types of HINNs:

HINN 12

Should be used in association with the Hospital Discharge Appeal notices to inform beneficiaries of their potential liability for a noncovered continued stay.

- Do not give the HINN 12 until after appeal is completed.
Types of HINNs:

Preadmission/Admission HINN

Used prior to an entirely noncovered stay
Preadmission/Admission HINN: Appeal Process

- Beneficiary can request review \textit{within 3 calendar days} of receipt of the HINN or any time during stay
- Mountain-Pacific should perform review \textit{within 2 work days}
- If beneficiary is not admitted to hospital, the beneficiary can request a review \textit{within 30 calendar days} after receipt of notice
Preadmission/Admission HINN: Beneficiary Liability

Preadmission HINN
- Beneficiary liable for all services when entering hospital

Admission HINN
- Issued on day of admission before 3 PM, beneficiary liable for all services after HINN received
- Issued on day of admission after 3 PM, beneficiary liable the day following receipt of HINN
- Issued after day of admission, beneficiary liable the day following receipt of HINN
TWO MIDNIGHT PROVISION

Mountain-Pacific Quality Health
Two Midnight Provision Provider Questions

Provider Question #1:
The new CMS rule regarding the two-midnights states the physician has to certify that an inpatient admission was appropriate. If facilities have mid-level providers writing admission orders for patients that come through the ER does the physician still have to countersign or authenticate the admission by dictating a note that the inpatient stay is appropriate?
CMS Response

Response #1:

• If the mid-level providers do not have admitting privileges, but are described in the January 30 guidance [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/IP-Certification-and-Order-01-30-14.pdf](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/IP-Certification-and-Order-01-30-14.pdf) at section B.2.a. (e.g. residents, non-physician practitioners), any initial admission order completed by these providers would require countersignature by a physician with admitting privileges.

• If the mid-level providers have admitting privileges, no specific countersignature of the admission order is required. However, only physicians described in A.3 of the guidance would have authority to complete the certification requirement. If the admitting mid-level provider is not an MD, DO, dentist, or doctor of podiatric medicine, then a physician would be required to complete the certification requirement. It is not necessary that the certifying physician countersign each individual elements for the certification to be valid if it is clear from the medical record that all requirements are met.
In addition, we remind contractors that in the absence of an order for inpatient admission: “. . . in order for the documentation to provide acceptable evidence to support the hospital inpatient admission, thus satisfying the requirement for the physician order, there can be no uncertainty regarding the intent, decision, and recommendation by the physician (or other practitioner who can order inpatient services) to admit the beneficiary as an inpatient, and no reasonable possibility that the care could have been adequately provided in an outpatient setting.” In such cases, the contractor has the discretion to infer the order for admission.
Two Midnight Provision Provider Questions

Provider Question #2:
Please clarify the Critical Access Hospital statement, “For inpatient CAH services, the physician must certify that the beneficiary may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the CAH.” This does not agree with the CAH CoP which states: C-0212 §485.620(b) Standard: Length of Stay
• The CAH provides acute inpatient care for a period that does not exceed, on an annual average basis, 96 hours per patient.

• Transferring every patient that has exceeded their 96 hours doesn’t make sense when the hospital staff are capable of caring for the patients in their community. Who pays for the transport if the patient doesn’t meet medical necessity to be transported?
CMS Response Question #2

- The statement is referring the statutory requirement for certification of inpatient CAH services. This statutory requirement is found at section 1814(a)(8) of the Social Security Act (see the regulations at 42 CFR 424.15) and is a separate requirement from that of the CAH CoPs. Because the certification requirement is based on an expectation at the time of admission, we have said that if the physician, in good faith, certifies that he/she expects the individual to be discharged/transferred within 96 hours after admission but then something unforeseen occurs and the individual ends up staying longer, that is ok as long as that individual’s stay does not cause the CAH to exceed the CoP requirement that it maintain an annual average length of stay of 96 hours per patient. Therefore, it is possible that an individual may be an inpatient of a CAH for more than 96 hours. There aren’t any special transport rules associated with this certification requirement.
Provider Question #3:
Can a physician “override” an outside contracted utilization review service (EHR) who determines IP criteria is not being met. In this case the physician ordered IP admission then the EHR came back with determination for OBS. The physician did not agree but the patient was made OBS and did not get her 3 day stay. What documentation, if any, must the physician make if disagreeing with the EHR review determination?
CMS Response Provider Question #3

- CMS notes that the hospital Conditions of Participation require hospitals to have a utilization review (UR) plan. One of the functions of the UR committee is to review medical necessity of admissions and continued stays as an inpatient. In cases in which the UR committee believes that an inpatient admission was not medically necessary, there are guidelines and procedures that the UR committee should follow, one of which is to consult with the practitioner(s) responsible for the care before making the determination.
CMS Response to Question #3 - continued

• More details may be found in the MedLearn article SE0622. This article also describes use of condition code 44 which details the circumstances under which a hospital to change a patient’s status from inpatient to outpatient before discharge. The 2-midnight rule did not change the UR committee or condition 44 requirements (see section entitled “Use of Condition Code 44”).

COMMONLY ASKED QUESTIONS

Mountain-Pacific Quality Health
QUESTION
Who can submit a request for an appeal review? For example, if a patient has mental health issues and the POA doesn’t agree with discharge, could another family member request an appeal of the hospital discharge?

ANSWER
Although the regulations state that anyone who has the beneficiary's best interests at heart can request an appeal, the final decision to appeal rests with the beneficiary. If there is an active POA, the decision rests with the POA.
QUESTION
Can the provider request an appeal if the beneficiary isn’t competent to understand or make decisions and there isn’t a beneficiary representative?

ANSWER
Yes, the provider may request an appeal for an incompetent beneficiary without appropriate representation.
Question
What happens when the patient no longer needs acute care and requires skilled care but no skilled bed is available?

Answer
CMS allows hospitals to continue to bill Medicare for days awaiting placement in a skilled facility.

References:
Hospital Inpatient Admission Order and Certification (1/30/2014 - Page 2 second paragraph under A. Physician certification, 1. Content. C.)

Medicare Claims Processing Manual – Chapter 3- Inpatient Hospital Billing - 40.2.2. C – Inpatient Care No Longer Required
Useful Websites

Centers for Medicare & Medicaid Services – Beneficiary Notices Initiative (BNI)
www.cms.gov/bni

PEPPER Resources
www.pepperresources.org

Critical Access Hospital Center
http://www.cms.gov/Center/Provider-Type/Critical-Access-Hospitals-Center.html
Questions?

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