CMS Provides ACMA with FAQ Document Addressing Case Managers’ Concerns Surrounding the IM Second Notice

The Centers for Medicare & Medicaid Services (CMS) provided ACMA with the following frequently asked questions (FAQ) document, containing responses to questions and concerns ACMA shared with the agency surrounding the Medicare Important Message (IM) second notice.

**Background**
In order to recommend changes to CMS regarding the structure of the IM system, the ACMA Public Policy Committee developed an online survey, and asked case management professionals nationwide to provide input and share their experiences. Following an overwhelming response to the survey, and passionate accounts and recommendations from attendees at the Medicare Important Message Forum during the 2010 NICM/ACMA National Conference, ACMA CEO L. Greg Cunningham met with a group of CMS administrators at agency headquarters in Baltimore.

At the conclusion of the meeting, CMS officials requested that ACMA produce a prioritized list of the most pressing issues and concerns surrounding the IM second notice.

The FAQ document provides guidance on a number of common questions related to the IM second notice. The document also clarifies specific Medicare requirements and addresses common misconceptions.

CMS is currently revising sections of the Medicare manual, and the agency plans to include some of the FAQs developed by ACMA in the revised edition, expected to be released sometime in 2011.

CMS officials have been receptive to the feedback and concerns shared by ACMA, and have been committed to working with our association to establish clarity of compliance for some of the concerns raised by the membership.

ACMA continues its efforts, both with CMS administrators and with legislators, to ensure that case management is able to provide input and affect change within legislation and regulatory issues.

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Important Message (IM): Frequently Asked Questions

1. Is the second notice required for a length of stay of 2 days or less?

   **CMS:** No. The follow-up copy of the IM is not required in this example unless the original IM was delivered more than two days prior to discharge (e.g. during a pre-admission visit).

2. If the second notice is given in good faith at day 3 or beyond and the patient stays an additional 1-4 days, must the notice be given again?

   **CMS:** If discharge occurs more than two days after delivery of the last follow-up copy, another copy must be delivered.

3. For patients who are admitted as observation, is a notice required?

   **CMS:** The Important Message from Medicare is only for patients admitted to the inpatient setting/level of care.

4. Condition Code 44 patients receive a notice upon admission and then their status is changed to observation. Would the next appropriate step be to issue an Advance Beneficiary Notice (ABN)?

   **CMS:** CMS recommends that hospitals follow up with these patients to ensure that they understand that the information regarding discharge appeal rights contained in the Important Message is inapplicable to their outpatient/observation stay. An Advance Beneficiary Notice of Noncoverage (ABN) should only be issued to original Medicare beneficiaries if the provider expects Medicare to deny the outpatient/observation stay as not reasonable and necessary.

5. Please clarify the Important Message process for the following scenario: A patient is admitted as observation, and then his or her status is changed to inpatient.

   **CMS:** Consistent with 42 CFR §405.1205(b)(1), delivery of the IM must occur within two calendar days of the patient being admitted to inpatient hospital status. The term “within
“two calendar days” of admission is not inclusive of the day of the admission and should not be misinterpreted as meaning 48 hours.

6. Can the patient’s financial responsibility be active throughout QIO determination if the hospital and/or attending physician has supported a decision to discharge?

**CMS:** No, as long as a beneficiary makes a timely request for QIO review, s/he cannot be held financially responsible for any of the inpatient stay while the QIO is conducting the review. Once the QIO issues its decision, a provider may begin holding a beneficiary liable for his/her stay.

7. Does the follow-up notice require a signature when issued? If not, how can one prove that the notice was issued?

**CMS:** The follow-up copy is usually a copy of the initial IM that the beneficiary signed; therefore, another signature is not required. However, if a blank or unsigned IM is being delivered as the follow-up copy, the beneficiary’s signature is required. CMS encourages hospitals to collect patient initials or a signature on the follow-up copy. Hospitals may document delivery by having the hospital staff initial the notice as part of a document checklist, in the patient's record.

8. If a situation requires the follow-up notice to be given the day of discharge, would the delivery still be considered in compliance with regulations?

**CMS:** As long as the hospital does not routinely deliver the follow-up copy on the day of discharge, and there are extenuating circumstances preventing delivery before the day of discharge, such as waiting for lab results, the hospital can validly deliver the follow-up IM on the day of discharge.

When the IM is delivered on the day of discharge, the hospital must allow the beneficiary to remain inpatient for at least 4 hours following IM delivery, so that s/he has time to consider, and if desired, submit a QIO review request. The beneficiary is not required to remain in the hospital 4 hours after notice delivery if s/he is in agreement with the discharge decision.

9. Are hospitals permitted to deliver the follow-up copy of the IM routinely on certain days of the week to all Medicare beneficiaries, such as every Monday, Wednesday and Friday?

**CMS:** Hospitals may not pre-schedule delivery of the IM or the follow-up IM to all inpatients on certain days (e.g., deliver IMs to all patients every Tuesday, Thursday, Saturday). This practice specifically violates § 200.3.2 (“. . . no more than 2 calendar
days before the planned date of discharge. Thus, when discharge seems likely . . . “) in the manual instructions. This practice may also be a violation of the Conditions of Participation (COPs) under § 482.13 because it is inconsistent with properly informing patients of their health status.

We also note that there are reasonable circumstances which will warrant the delivery of more than one follow-up IM. For example, if a follow-up notice is delivered in anticipation of discharge, but the patient is not discharged as expected and stays more than 2 days following delivery of the follow-up IM, another follow-up IM must be delivered prior to the next proposed discharge date.

10. What is the QIO role in the Medicare Important Message process, specifically in regards to patient appeal interaction and patient education?

CMS: The QIO serves as the independent review entity in the IM process. As such, the QIO generally has responsibility for:

1) Accepting and processing the patient’s request for review of the discharge decision;
2) Informing the hospital that a review has been requested;
3) Requesting medical records from the hospital
4) Soliciting patient input and, if asked, answering patient questions;
5) Evaluating the validity of the notices;
6) Reviewing the discharge decision; and
7) Providing the patient and the hospital with a copy of its decision in easily understandable language.

11. Could the patient’s copy of the initial IM be retained at bedside or in the patient’s room where it is uniformly and easily accessible so that follow-up IM delivery would be a review of this copy?

CMS: Hospitals wanting to implement this practice may do so with certain caveats:

- The copy of the initial IM retained at bedside or in the patient’s room cannot be the patient’s personal copy of the IM. When the patient is provided with his/her own copy of the initial IM for retention, the document belongs to the patient. The patient may want to reread the document, make notes on the document, or give it to a friend or family member to review or retain. A facility can make 2 copies of the IM after it is signed so that there is an IM for the patient record, an IM for retaining in the patient’s room, and an IM to give to the patient.

- HIPAA standards regarding protected health information apply to the copy posted or retained in the patient’s room.

- When the hospital uses the “posted” copy to issue as the follow up IM, the notice must be personally presented to the beneficiary by the appropriate hospital staff
person. There cannot be assumptions that because the notice was in close proximity to the patient, the beneficiary is aware of the notice contents.

- Delivery of the follow up notice must still be documented per CMS requirements.

12. Please provide clarification as to what to do when the patient has a surrogate decision maker who is not available to speak with the responsible health care professional for an extended period of time (one day or more) to obtain signature or consent of acknowledgement of form?

**CMS:** If the Important Message from Medicare (IM), Form CMS-193 cannot be delivered to the patient’s representative within the first two days after admission, annotate that in the patient’s record, preferably in the “Additional Information” part of the IM. Once the authorized representative is capable of receiving the notice, deliver it. This would inform surveyors as to why the notice is signed outside of the regulatory time requirements.

When direct phone contact cannot be made, send the notice to the representative by certified mail, return receipt requested, or other delivery method that requires signed verification of delivery. The date that someone at the representative’s address signs (or refuses to sign) the receipt is the date received. Place a copy of the notice in the beneficiary’s medical file, and document the attempted telephone contact to the members representative. The documentation should include: the name of the staff person initiating the contact, the name of the representative you attempted to contact, the date and time of the attempted call, and the telephone number called.

13. Please provide guidance on what the QIO response timelines are once they receive a request for an appeal?

**CMS:** QIO and hospital response timeline for a timely appeal (beneficiary submits request for QIO review before midnight on the day of the proposed discharge) is as follows:

- QIO receives request and immediately notifies the hospital of the review request
- Hospital must deliver a Detailed Notice of Discharge (CMS-10066) to the beneficiary and to the QIO by noon the day after QIO notification.
- Hospital must deliver any and all information needed to make and expedited determination to the QIO by noon the day after QIO notification.
- QIO must make its determination and notify the beneficiary, hospital, and physician within one calendar day of receipt of pertinent information.
Please note that per regulatory policy a “day” is a calendar day and NOT defined as a 24-hour time period.

14. Please provide clarification on what specifically could be documented in the medical record that could replace the initialed or signed copy of the second notice? Some QIOs are requiring a second document (dated/timed), and others are stating that one can just document in the medical record the delivery and acknowledgement by the patient with a date and time of notification.

**CMS:** Hospitals must document timely delivery of the follow-up copy of the IM in the patient records, when applicable. Hospitals are responsible for demonstrating compliance with this requirement. If hospitals have processes in place to document delivery of other information related to discharge that includes a beneficiary signature and date, hospitals may include the follow-up copy of the notice in those documents. If there are no other existing processes in place, hospitals may use the “Additional Information” section of the IM to document delivery of the follow-up copy, for example, by adding a line for the beneficiary’s or representative’s initials and date.

15. Could you provide guidance on how one should communicate with Condition Code 44 patients? They are given an IM on admission and then they are changed to observation. Varying guidance has been given by QIOs as to the next steps. Normally, one would issue an ABN to an observation patient.

**CMS:** There is no mandatory notice associated with this billing claim code. If a Medicare Fee for Service, observation patient is refusing or disputing discharge, an ABN should be issued in order to shift financial liability to the beneficiary for care that is not medically reasonable and necessary.

16. The following questions are typically asked by providers when confronted with the qualifying 3-day inpatient stay:

- Does the inpatient time spent while an appeal is in process count towards a qualifying 3-day inpatient stay?

  **CMS:** This depends on whether their stay during the appeal process was medically necessary or not.
Does the inpatient time spent while an appeal is being processed count towards a qualifying 3-day inpatient stay if the QIO agrees with the discharge decision?

**CMS:** Per CFR 42 §409.30 (a)(1), the 3 day qualifying stay must be medically necessary inpatient care.

Pub. 100-02, Chapter 8, § 20.1 of the CMS Internet Only Manual states: “When the facts that come to the intermediary’s attention during the course of its normal claims review process indicate that the hospitalization may not have been medically necessary, it will fully develop the case, checking with the attending physician and the hospital, as appropriate. The intermediary will rule the stay unnecessary only when hospitalization for 3 days represents a substantial departure from normal medical practice.”

The validity of the 3 day qualifying stay is subject to Financial Intermediary discretion on a case by case basis and cannot be generalized to answer this question definitively.

If the QIO agrees with the discharge decision, is the inpatient time spent while the appeal is being processed considered medically unnecessary; and therefore, does not count toward the qualifying 3-day inpatient stay?

**CMS:** See answer above.