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Complete Healthcare Compliance Manual 2024
Revenue Cycle: Hospital Discharge Appeal Notices

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What Are Hospital Discharge Appeal Notices?

Hospital discharge appeal notices serve to address initiation and termination of events. Two notices will be discussed in this chapter. The Centers for Medicare & Medicaid Services (CMS) requires that each hospitalized patient receive the Important Message from Medicare, which informs hospitalized beneficiaries of their hospital discharge appeal rights.[2] The Detailed Notice of Discharge (DND) explains the reasons for discharge and is given to a beneficiary who requests an appeal.

Each organization needs to have an effective process for notifying patients of their rights. The challenge in doing so is meeting the required deadlines, especially when lengths of stay are relatively short, and ensuring that patients understands their rights. Failure to notify patients of their hospital discharge appeals could result in extended stays and patient dissatisfaction and identify faulty processes in the organization.

For decades, The Joint Commission has encouraged early planning and alerts to patients and their families about what lies beyond a hospital stay. Early planning places special importance on this information if the patient is expected to be transferred to another care facility. The Center for Medicare Advocacy asserts "good discharge planning for patients, their families, and their healthcare providers, paves the way to successful transitions from one care setting to another. Good discharge notices and good discharge planning should go hand in hand."[3]

Today, the push for discharge planning to start at the time of admission is also emerging from the C-suite and revenue cycle. Why? With many payers paying on a case rate similar to a diagnosis related group (DRG), an extra day on the tail of the stay continues to consume resources for which the organization will not be paid. Additionally, every day that a patient unnecessarily occupies an inpatient bed is a day when an emergency department patient with an admission order cannot. The *costs* of holding the patient in the emergency department are multiple, including the safety of the patient, the impact on the patient's health outcome, and the staffing required to care for the patient as an inpatient in a holding bed. This article's focus is hospital discharge appeal notices. These notices place yet another focus on discharge planning.

The hospital discharge appeal notice is just one of nine categories of notices generated from the Beneficiary Notices Initiative (BNI).[4] The CMS website provides descriptions for the other eight notice categories (see Table 1 at the end of this article).[5] The BNI obtains its authority to mandate the use of these forms from section 1879 of the Social Security Act, which "[r]equires a provider to notify a beneficiary in advance when s/he believes that items or services will likely be denied either as not reasonable and necessary or as constituting custodial care. If such notice…is not given, providers may not shift financial liability to beneficiaries for these items or services if Medicare denies the claim." [6]

From a revenue cycle perspective, this authority is what drives a number of the denials for medical necessity. The use of the Advance Beneficiary Notice of Noncoverage (ABN), for example, is mandatory when the services are not reasonable and necessary, such as for certain medical equipment and/or supplies, custodial care, hospice

care for a patient who is not terminally ill, and certain other services. (See the "Revenue Cycle: Advance Beneficiary Notice of Noncoverage" article in this chapter for more information.)

BNI notices are triggered by three main events:

1. Initiations:
    - Beginning of new patient encounter,
    - Start of plan of care, and
    - Beginning of treatment.
2. Reductions:
    - Decrease in a component of care.
3. Terminations:
    - Discontinuation of services or items.

Hospital discharge appeal notices serve to address initiation and termination events. Again, from a revenue cycle perspective, the process triggered by an appeal notice may result in an extended stay or possibly the conversion of a portion of the stay to self-pay (the responsibility of the patient), a situation that many revenue cycle leaders wish to avoid.

Risk Area Governance

Hospital discharge appeal notices are defined by the BNI. This initiative is overseen by CMS, specifically Medicare. Both Medicare beneficiaries and providers have certain rights and protections related to financial liability and appeals under the Fee-for-Service (FFS) Medicare and the Medicare Advantage (MA) programs. These rights are defined in the notices prescribed by BNI. These financial liability and appeal rights and protections are communicated to beneficiaries through notices given by providers.

Financial Liability Protections and Regulations

Applicable laws related to financial liability protections can be found in Title 18 (XVIII) of the Social Security Act:

- Limitation on liability: § 1879 (a)–(g); 42 C.F.R. §§ 411.400–408 (all 411 Subpart K)
- Refund requirements: §§ 1834(a)(18) and (j)(4),1842(l), and 1879(h)
- Statutory exclusions from Medicare benefits: § 1862(a)
- Expedited determination process: § 1869(b)(1)(F)
- Quality improvement organization (QIO) review of termination of services or discharge and reconsideration: Social Security Act §§ 1154, and 1155

Regulations related to expedited determinations and reconsideration are found at:

- Nonhospital process: 42 C.F.R. §§ 405.1200, 405.1202
- Hospital process: 42 C.F.R. §§ 405.1206, 405.1208

- Reconsideration process: 42 C.F.R. § 405.1204

The hospital discharge appeal notice category includes two notices:

- Important Message from Medicare (IM, Form CMS-10065)
- Detailed Notice of Discharge (DND, Form CMS-10066)[7]

Important Message from Medicare

Hospitals are required to deliver the Important Message from Medicare (IM) (formerly CMS-R-193 and now CMS-10065) to *all* Medicare hospital inpatients to inform them of their hospital discharge appeal rights. The hospital must use the standardized notice, as specified by CMS. This notice explains a patient's rights as a hospital patient, including the patient's discharge appeal rights. It is to be given at or near admission, but no longer than two calendar days following the beneficiary's admission to the hospital. See 42 C.F.R. § 405.1205 (traditional Medicare) and 42 C.F.R. § 422.620 (Medicare Advantage). [8][9]

Content of the IM Notice

2. The notice must include the following information:
    i. The beneficiary's rights as a hospital inpatient including the right to benefits for inpatient services and for post-hospital services in accordance with 1866(a)(1)(M) of the Act.
    ii. The beneficiary's right to request an expedited determination of the discharge decision including a description of the process under § 405.1206, and the availability of other appeals processes if the beneficiary fails to meet the deadline for an expedited determination.
    iii. The circumstances under which a beneficiary will or will not be liable for charges for continued stay in the hospital in accordance with 1866(a)(1)(M) of the Act.
    iv. A beneficiary's right to receive additional detailed information in accordance with § 405.1206(e).
    v. Any other information required by CMS.[10]

These rights are protected by the delivery timeline of the IM notice.

One of the revenue cycle challenges for healthcare facilities with the revised IM is its content for a Medicare Advantage patient. Unlike original Medicare, the IM need only include the name and telephone number for the local QIO. However, for MA, the healthcare organization must enter the appropriate toll-free number for the individual MA plan and the plan's name. The task of maintaining a current list of plan names and toll-free numbers for expedited appeal purposes will be daunting. The question remains whether the Member Services telephone number often appearing on an individual's MA plan ID card will be considered sufficient.

"The revised IM process is based on a rule that grew out of a lawsuit filed against Medicare. The lawsuit, *Weichardt v. Leavitt*, defines the intent of the settlement for notification of patients' rights. However, when the overhaul of the IM was in process, there were also some changes to the Social Security Act § 1879 that address the notification of Limitations of Liability (LOL). This concurrent revision created some confusion and resulted in the process of each becoming more difficult to understand."[11] The BNI categories helped to eliminate the confusion. Having a distinct IM sets the stage for providing guidance to patients about their rights.

More information follows about the second notice on this category, the Detailed Notice of Discharge.