	Regulatory Compliance Policy	**No.** **COMP-RCC 4.25**
	Title: **HOSPITAL COVERAGE NOTICES FOR MEDICARE INPATIENTS (INCLUDING IMPORTANT MESSAGE FROM MEDICARE)**	**Page:** **1 of 19**
		Effective Date: **04-30-20**
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		Corporate Review Dated: **04-14-20**

I. SCOPE:

This policy applies to (1) Tenet Healthcare Corporation and its wholly-owned subsidiaries and affiliates (each, an "Affiliate"); (2) any other entity or organization in which Tenet Healthcare Corporation or an Affiliate owns a direct or indirect equity interest greater than 50%; and (3) any hospitals or entity in which an Affiliate either manages or controls the day-to-day operations of the facility provide inpatient care to Medicare beneficiaries (each, a "Tenet Hospital")[1] (collectively, "Tenet").

II. PURPOSE:

The purpose of this policy is to describe the circumstances in which Tenet Hospitals must issue the following notices to Medicare beneficiaries (Medicare fee-for-service or Medicare Advantage (MA) or other Medicare health plans subject to the MA regulations) regarding inpatient coverage issues: Medicare Outpatient Observation Notice (MOON), Important Message from Medicare (IMFM), Hospital-Issued Notice of Non-coverage (HINN), Hospital Request for Review (HRR) - by Quality Improvement Organization (QIO), and Detailed Notice of Discharge. The purpose of these beneficiary notices is to enable the beneficiary or representative to better participate in decisions affecting his or her care and financial liability. To the extent that the Centers for Medicare and Medicaid Services has issued a blanket waiver of any of the requirements of this policy during times of national emergency (e.g. COVID-19 pandemic), the requirements of this policy are waived during the effective period of the waiver.

III. DEFINITIONS:

A. For the purposes of this policy, "**Physician**" means a physician or other licensed independent practitioner who has been granted admitting privileges by the Tenet Hospital's medical staff and is legally accountable for establishing a patient's diagnosis.

B. "**Physician Order**" means an order from the Physician admitting the patient to the Tenet Hospital or the Physician responsible for the patient's general medical management during the admission. The order may be electronic, in writing, or be a telephone/verbal order as allowed by the Tenet Hospital's medical staff bylaws.

C. "**Case Management**" means a collaborative process of assessment, planning, facilitation, care coordination and advocacy for options and services to meet an

[1] This policy is Medicare-specific. It is not applicable to Medicaid recipients unless they are also Medicare beneficiaries

individual's health needs through communication and available resources to promote quality, cost- effective outcomes.

D. "**Inpatient**" means any person who has been admitted to a Tenet Hospital for bed occupancy for purposes of receiving hospital services.

E. "**Outpatient**" means a person who has not been admitted by the Tenet Hospital as an Inpatient but is registered on the Tenet Hospital records as an Outpatient and receives services from the Tenet Hospital. The duration of services and time of day are not determinative of Outpatient Status. Observation Services are considered an Outpatient level of care.

F. "**Patient Status**" means Inpatient or Outpatient.

G. "**Observation Services**" or "**Observation**" means assessment, short-term treatment, reassessment, and stabilization before decision to admit to Inpatient or discharge.

H. "**InterQual® or other Tenet approved clinical screening criteria**" mean clinical decision support guidelines licensed for use by hospitals and managed care companies to evaluate the appropriateness of medical interventions and level of care based on clinical criteria and standards

I. "**Secondary Physician Review**" means a clinical review performed by a physician on the Utilization Management Committee other than the ordering physician Tenet approved clinical screening criteria guidelines suggest a different Patient Status or Level of Care than that ordered.

J. "**Hospital Case Manager**" means, for the purpose of this policy, a Tenet Hospital representative appropriately educated in the accurate application Tenet approved clinical screening criteria. The Hospital Case Manager may be a Tenet Hospital employee or a contractor.

K. "**Federal health care program**" means any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government, including, but not limited to, Medicare, Medicaid/Medi-Cal, managed Medicare/Medicaid/Medi-Cal, TriCare/VA/CHAMPUS, SCHIP, Federal Employees Health Benefit Plan, Indian Health Services, Health Services for Peace Corp Volunteers, Railroad Retirement Benefits, Black Lung Program, Services Provided to Federal Prisoners, and Pre- Existing Condition Insurance Plans (PCIPs).

IV. POLICY:

A. Medicare Outpatient Observation Notice (MOON)

The Medicare Outpatient Observation Notice (MOON) is a standardized notice provided to all Medicare beneficiaries when they are an outpatient receiving observation services for more than 24 hours.

1. The MOON must be provided between the 24th hour and the 36th hour after observation services are initiated, or as soon as there is indication the patient will be in observation status for at least 24 hours;

2. An oral explanation of the notice must be provided at the time the notice is delivered

3. A signature must be obtained from the Medicare beneficiary or from the individual qualified to act on their behalf, to acknowledge receipt of the notice and understanding of the information

4. If the beneficiary or individual qualified to act on their behalf refuses to sign the notice, the hospital staff member providing the notice and a witness must sign the document

5. Hospital must deliver a hard copy of the MOON to beneficiaries and enrollees. Hospitals must retain the original signed MOON and may store the MOON electronically if electronic medical records are maintained

6. If a hospital elects to issue an MOON that is viewed on an electronic screen before signing, the beneficiary must be given the option of requesting paper rather than electronic issuance if that is what the beneficiary prefers. Regardless of whether a paper or electronic version is issued, and whether the signature is digitally captured or manually penned, the beneficiary must be given a paper copy of the signed MOON

7. In cases where the beneficiary has a representative who is not physically present, hospitals are permitted to give the MOON by telephone as long as a hard copy is delivered to the representative

B. Important Message from Medicare (IMFM)

The IMFM is a standardized written notice of beneficiary appeal rights regarding coverage decisions made during a hospital stay.

1. The IMFM notice must be given to all beneficiaries in original Medicare fee-for-service program and to those in Medicare Advantage (MA) and other Medicare health plans subject to the MA regulations.

2. The Tenet Hospital must provide the IMFM to the beneficiary:

   a. Within two days of admission (this is known as the "admission/initial IMFM"); **and**

   b. Not more than two calendar days before the day of discharge. (This is known as the Follow-up Notice.) A Follow-up Notice is not required if delivery of the admission IMFM falls within two calendar days of discharge; if the beneficiary is being transferred from one inpatient hospital setting to another inpatient hospital setting; or when a beneficiary exhausts Part A hospital day.

3. If the beneficiary is considered by the Tenet Hospital to be incapable of receiving or understanding the IMFM or Follow-up Notice, the Tenet Hospital must provide the notices to a beneficiary representative.[2]

4. The Tenet Hospital must obtain the signature of the beneficiary (or his/her representative) on a copy of the IMFM and Follow-up Notice(s) and must retain the signed copies in the beneficiary's medical record.

C. Detailed Notice of Discharge (Detailed Notice)

When a Tenet Hospital is notified by the QIO that a Medicare fee-for-service or MA or other Medicare health plans subject to the MA regulations beneficiary has requested expedited review of a discharge determination, the Tenet Hospital must deliver a Detailed Notice (CMS-10066) to the beneficiary and QIO as soon as possible, but not later than noon of the day after receiving notice from the QIO. The Tenet Hospital must also provide the medical record and any information the QIO requires to make the expedited determination; this information must be provided in writing or by telephone, as requested by the QIO, and it must be provided no later than noon of the day after the information was requested.

D. Hospital Notices Regarding Coverage Determinations

[2] Tenet Hospitals must have in place, and adhere to, appropriate State-specific processes for identifying when a beneficiary requires the assistance of a representative and who may act in that capacity.

1. Tenet Hospitals must also issue certain additional notices regarding coverage determinations to Medicare beneficiaries in the Medicare fee-for-service program. The type of notice to be issued and the effect of the notice upon beneficiary financial liability depend on the timing of the determination and the basis upon which the lack of medical necessity or appropriateness of level of care has been determined.[3]

   a. HINN — generally a HINN must be issued to a Medicare fee- for-service beneficiary when the Tenet Hospital determines that the inpatient services the Medicare beneficiary is receiving (or about to receive) will not be covered by the Medicare program because based on national coverage policy[4] or Local Coverage Determination (LCD)[5] the services are (a) not medically necessary; (b) not being delivered in the most appropriate setting; or (c) are custodial in nature. The HINN informs the beneficiary (a) when the beneficiary's financial responsibility for services will begin, and (b) how to appeal this hospital utilization review determination. A HINN may be issued prior to admission, at admission, or at any point during an inpatient stay when the Tenet Hospital makes the utilization determination.

   b. HRR Notice — a Tenet Hospital must issue an HRR to a Medicare fee-for-service beneficiary whenever the Tenet Hospital requests QIO review of a discharge decision with which the beneficiary's attending physician does not concur.

V. PROCEDURES:

A. Issuance of Medicare Outpatient Observation Notice (MOON)

1. The Tenet Hospital must design a process to identify patients receiving outpatient observation services for 24 hours or more

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[3] This policy sets forth the minimum standards for Tenet Hospitals. To the extent that local QIO instructions require more or different procedures, those QIO instructions must also be followed. In the event that a Tenet Hospital identifies a conflict between this policy and local QIO instructions, the Tenet Hospital should notify its Regional Counsel immediately.

[4] National Coverage Determinations can be found at the Centers for Medicare and Medicaid Services (CMS) coverage Web site at: http://www.cms.gov/center/coverage.asp. Occasionally, national Medicare coverage policy is issued through service-specific regulations. This policy applies in either situation.

[5] LCDs are formulated by MACS and intermediaries, which should be contacted for further information.

2. This process must be completed twice daily to reduce the likelihood of failure to deliver a notice

3. The Tenet Hospital must designate individuals who must issue a MOON to all Medicare beneficiaries.

4. The MOON must be given at 24 hours and no later than 36 hours after the start of the outpatient observation services

5. The individual providing the notice must provide the beneficiary with a verbal explanation of the notice

6. The individual providing the notice must obtain a signature from the Medicare beneficiary or from the individual qualified to act on their behalf, to acknowledge receipt of the notice and understanding of the information

7. The beneficiary must be provided with the signed copy of the notice and the original placed on the medical record

8. If a hospital elects to issue a MOON that is viewed on an electronic screen before signing, the beneficiary must be given the option of requesting paper rather than electronic issuance if that is what the beneficiary prefers. Regardless of whether a paper or electronic version is issued, and whether the signature is digitally captured or manually penned, the beneficiary must be given a paper copy of the signed MOON

9. In cases where the beneficiary has a representative who is not physically present, hospitals are permitted to give the MOON by telephone as long as a hard copy is delivered to the representative.

10. Beneficiary Refusal to Sign

11. If the beneficiary refuses to sign the MOON, the Tenet Hospital must designate individuals who must note the refusal and date of refusal on the notice form,[6] sign and date the notation and have the refusal witnessed by a second Tenet Hospital employee. The witness must sign and date a copy of the notice with the notation regarding the refusal for the beneficiary's

[6] Under these circumstances, the date of refusal will be considered the date of the notice.

medical record. The original document is to be given to the beneficiary.

B. Issuance of Admission IMFMs and Follow-Up Notices

1. Admission IMFM

a. Patient Access/Registration must issue an admission IMFM to all beneficiaries enrolled in Medicare fee-for- service, MA plans, and other Medicare health plans subject to the MA regulations who are admitted as inpatients, including those admitted as inpatients after receiving outpatient observation services.[7]

b. The admission IMFM must be given to the beneficiary as soon as possible within two (2) calendar days of admission, or at preadmission, but not more than seven (7) calendar days before admission.

c. The Tenet Hospital must designate individuals who must review the admission IMFM with the beneficiary and have the beneficiary sign and date the admission/initial IMFM to confirm receipt. The beneficiary must be given the original IMFM notice, and the Tenet Hospital must retain the signed copy in the beneficiary's medical record.

2. Follow-Up Notice

a. The Tenet Hospital must designate individuals who issue the Follow-Up Notice to all beneficiaries enrolled in Medicare fee-for- service, MA plans, and other Medicare health plans subject to the MA regulations.[8]

b. The Follow-Up Notice must be given to the beneficiary as soon as possible before discharge, but no more than two (2) calendar days before the day of discharge.[9]

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[7] This function might be performed by the House Supervisor, Charge Nurses, Patient Access, Case Management staff, Nursing Supervisor and/or Director of Clinical Quality Improvement (DCQI) as assigned and designated by the Tenet Hospital.

[8] This function might be performed by the House Supervisor, Charge Nurses, Patient Access, Case Management staff, Nursing Supervisor and/or DCQI as assigned and designated by the Tenet Hospital.

[9] If the beneficiary's status changes after the issuance of a Follow-up Notice so that the discharge falls beyond the

c. The Follow-up Notice may be delivered on the day of discharge, but only when unavoidable; this must not become the Tenet Hospital's routine practice. Once a Follow-Up Notice has been given, the Tenet Hospital must allow at least four (4) hours before discharging the beneficiary to allow the beneficiary to consider his or her rights.

d. The Tenet Hospital must designate individuals who must review the Follow-Up Notice with and have the beneficiary sign and date a copy of the Follow-Up Notice to confirm receipt. The beneficiary must be given the Follow-Up Notice and the Tenet Hospital must retain the signed copy in the medical record. The original document is to be given to the beneficiary.

3. Beneficiary Refusal to Sign

If the beneficiary refuses to sign the IMFM or Follow-up Notice, the Tenet Hospital must designate individuals who must note the refusal and date of refusal on the notice form,[10] sign and date the notation and have the refusal witnessed by a second Tenet Hospital employee. The witness must sign and date a copy of the notice with the notation regarding the refusal for the beneficiary's medical record. The original document is to be given to the beneficiary.

4. Notice Delivery to Beneficiary Representatives

a. When Tenet Hospital's designated individuals believe that a beneficiary is unable to read or understand the IMFM or Follow-Up Notice, the Tenet Hospital must deliver the IMFM or Follow-Up Notice to the beneficiary's authorized representative and have the representative sign and date a copy of the notice.[11]

b. If the Tenet Hospital is unable to deliver the notice to the beneficiary's representative personally, the Tenet Hospital's designated individuals must telephone the beneficiary's

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two-day timeframe, the Tenet Hospital must deliver another copy of the Follow-up Notice within two calendar days of the new planned discharge date. It cannot be routinely given on pre-scheduled days i.e., Monday, Wednesday, Friday.

[10] Under these circumstances, the date of refusal will be considered the date of the notice.

[11] This function might be performed by the House Supervisor, Charge Nurses, Patient Access, Case Management staff, Nursing Supervisor and/or DCQI as assigned and designated by the Tenet Hospital.

representative to advise him or her of the beneficiary's rights, including the right to appeal discharge decisions as discussed in the IMFM and Follow-Up Notices. If the representative agrees during a telephone call, a notice may be e-mailed to the representative.[12] All telephone documentation must be signed, dated and witnessed by two Tenet employees.

c. If the representative is not available for in-person or live telephone delivery (voicemail messages are not sufficient), the Tenet Hospital's designated individuals must forward the IMFM or Follow-Up Notice the same day by certified mail or fax to the representative. All such electronic transmissions must meet Tenet's information privacy and security policies and standards.

5. Medical Record Documentation

a. The Tenet Hospital's designated individuals must place a copy of the IMFM and Follow-Up Notices signed and dated by the beneficiary or beneficiary's representative in the beneficiary's medical record. In the case of a beneficiary's refusal to sign, a copy of the notice noting the refusal and witnessed (signed and dated) by a second Tenet Hospital employee must be placed in the beneficiary's medical record. The original document is to be given to the beneficiary.

b. The Tenet Hospital's designated individuals must also document in the beneficiary's medical record all attempted contacts with beneficiary representatives, including telephone calls, messages, faxes, e-mails and certified mail.

6. Beneficiary Appeal Rights: Hospital Responsibilities

a. A beneficiary who disagrees with the Tenet Hospital determination that inpatient care is no longer necessary has the right to request an expedited review of that determination by the QIO.[13]

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[12] Under these circumstances, the date of the telephone notice, fax, or certified letter will be considered the date of the notice.

[13] For expedited review, the beneficiary must request QIO review in writing or by telephone no later than the day of discharge. The QIO is available to accept the beneficiary discharge appeals 24 hours a day, seven days a week.

b. If the beneficiary refuses discharge or requests the expedited QIO review process, the individual receiving this information must immediately contact the Case Management Department.

c. The beneficiary must not be discharged if he or she requests expedited QIO review in writing or by telephone until the QIO determination has been made.

d. If the beneficiary or beneficiary's representative refuses discharge and does not seek QIO review, follow Section IV.C.6.c.(2) below.

C. Issuance of HINNs and HRRs

1. The Hospital Case Manager (HCM)[14] or designee[15] must conduct a clinical review of Medicare inpatients and potential inpatients using Tenet approved clinical screening criteria including discharge screens.

2. If a Medicare beneficiary does not meet admission or continued stay using Tenet approved clinical screening criteria, the HCM must contact the attending physician to determine whether there is additional clinical information that is not documented in the medical record and to request that the attending physician document any additional pertinent information.

3. If the attending physician provides additional documentation, the HCM must re-evaluate the case.

4. If the beneficiary still fails to meet admission or continued stay Tenet approved clinical screening criteria, the HCM must refer the case to the Physician Advisor (PA) of the Utilization Management (UM) Committee for review. See Attachment A for process flows.

5. If the PA of the UM Committee concludes that a beneficiary does not meet medical necessity for admission or continued stay, the HCM must issue a HINN to notify the beneficiary that the stay does not meet

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After discharge, a beneficiary may request QIO review within 30 calendar days of the date of discharge, or at any time for good cause

[14] Case Manager or other individual identified by the Tenet Hospital as being primarily responsible for issuing HINNs, Detailed Notices, and Hospital Review Requests.

[15] This function might be performed by the House Supervisor, Charge Nurses, Patient Access, Case Management staff, Nursing Supervisor and/or DCQI as assigned and designated by the Tenet Hospital.

inpatient

6. criteria; that the services will not be covered by Medicare; and that the beneficiary will be financially responsible for services rendered from the date and time noted in the HINN.

7. Common situations requiring Medicare beneficiary notices are described below, along with applicable procedures.[16]

   a. Preadmission Determinations – When a beneficiary's attending physician has ordered an inpatient admission, but preadmission review indicates that the beneficiary does not meet criteria for inpatient admission, the individuals designated by the Tenet Hospital must issue a preadmission HINN.[17]

   b. Determinations after Admission, but on the Date of Admission – When it is determined after admission, but still on the date of admission, that a beneficiary who has been admitted as an inpatient never met medical necessity criteria for hospital services, and the attending physician does not discharge the beneficiary, the individuals designated by the Tenet Hospital must issue an Admission HINN notice on the date of admission.[18]

   c. Determinations after the Date of Admission[19]

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[16] There may also be circumstances when items or services are requested for an inpatient that are excluded from Medicare coverage by a Local Coverage Determination (LCD), National Coverage Determination or other national Medicare policy for a beneficiary who requires continued hospital care. Although Medicare will not reimburse Tenet Hospital for such items or services, hospital are permitted to bill beneficiaries for such items and services if the patient is notified through a HINN 11 AND all of the following criteria are satisfied: (1) continued inpatient stay is reasonable and necessary, (2) the item or service requested is not bundled into or integral to payment or treatment for the diagnoses supporting the covered inpatient stay and (3) the item or service requested is non-covered based on a national coverage policy or LCD. *See* 42 C.F.R. § 412.42(d). When these situations are identified, Regional Counsel must be contacted to confirm the applicability of HINN 11 and further instructions.

[17] A Preadmission HINN notice may be issued without physician concurrence; however, Tenet Hospitals may choose to have the case reviewed by the PA and a second physician member of the UM Committee.

[18] Admission HINNs issued before 3PM on the date of admission establish beneficiary financial liability for services furnished after receipt of the notice. Admission HINNs issued after 3PM on the date of admission establish beneficiary financial liability for services furnished on the days following the admission date.

[19] The type of notice to be issued and effect of notice on beneficiary financial liability regarding determinations after the date of admission depends on the nature and basis for the hospital determination.

(1) Beneficiary Never Met Inpatient Criteria –

(a) When a beneficiary is found after the date of admission never to have met Tenet approved clinical screening criteria for admission, but the attending physician does not discharge the beneficiary,[20] an Admission HINN is no longer appropriate, and the case must be referred to the UM Committee for review by the PA and a second physician member of the UM Committee.

(b) If the PA and a second physician member of the UM Committee agree that the beneficiary did not meet criteria for admission, but the beneficiary's attending physician does not concur, the Tenet Hospital must contact the QIO and issue a Notice of HRR to inform the beneficiary that the Tenet Hospital has requested QIO review of the discharge decision because the attending physician does not concur. *See* procedures for Tenet Hospital requests for QIO review in Section IV.C.7., below.

(2) Beneficiary Originally Met, but No Longer Meets Inpatient Criteria and Attending Physician Concurs – When a continued stay review indicates that the beneficiary no longer meets inpatient criteria, that discharge screens are met, and that the attending physician agrees with the determination (*i.e.*, writes a discharge order) a Follow-up Notice indicating the planned discharge date must be given to the beneficiary or beneficiary's representative. *See* Section IV.A.2 of this policy, above. The beneficiary must be allowed four hours prior to discharge to evaluate and exercise their rights to appeal.

(a) If the beneficiary or beneficiary's representative refuses discharge and requests expedited QIO review follow Section IV.B.2., above.

[20] When the attending physician concurs, a Follow-up Notice will be given to the beneficiary indicating the planned discharge date. *See* Section IV.B.2, above, regarding this process and procedures.

(b) If the beneficiary does not seek expedited QIO review, but still refuses to be discharged, the Tenet Hospital's designated individuals must prepare and issue a Continued Stay HINN (HINN-12) to the beneficiary;[21]

(c) The Tenet Hospital's designated individuals must have the beneficiary date and sign the HINN and must contact the appropriate individuals to work with the patient to make financial arrangements for satisfaction of the beneficiary's account for services subject to the HINN.[22]

(i) If the beneficiary is incapable of reading or understanding the HINN, the HCM must speak with the beneficiary's representative in person to obtain a signature, or if necessary, attempt to discuss the notice by telephone with the beneficiary's representative and simultaneously mail the notice to the beneficiary's representative by certified mail with return receipt requested. The HCM may also use email, consistent with Tenet's information privacy and security policies and standards, to request a telephone call from the representative, but leaving a voice mail message is not sufficient for this purpose even if consistent with Tenet's information privacy and security policies and standards.

(ii) When direct telephone contact with the beneficiary's representative cannot be made, the HCM must mail the notice by certified mail, with return receipt

[21] This HINN will establish the beneficiary's financial responsibility for the services subject to the beneficiary's right to appeal to the QIO after discharge.

[22] If the patient refuses to make financial arrangements the case shall be immediately referred to the Chief Financial Officer and Compliance Officer for resolution.

requested.[23]

(iii) If the beneficiary is unable to read or understand the notice and the beneficiary has no representative, the HCM attempting to deliver the notice must clearly document his or her search for a beneficiary representative on a copy of the HINN to be placed in the beneficiary's medical record.

(iv) If the beneficiary or representative refuses to sign the HINN, the HCM must document who refused to sign and the date of the refusal. The HCM must initial and date the annotation.

(v) A copy of the signed or otherwise annotated Continued Stay HINN-12 must be retained in the beneficiary's medical record. The original document must be given to the beneficiary or representative.

(vi) Within 24 hours of a signed or otherwise annotated Continued Stay HINN-12, the Tenet Hospital's designated individual must notify the Hospital's Director of Revenue Analysis (DRA). The DRA must immediately place the patient account on manual bill hold.

(vii) The HCM and DRA must notify the billing department that a HINN-12 has been issued by completing Section 1: HINN-12 Issued for Non-Covered Continued Stay of the form Medicare Non-Covered Continued Stay (see Attachment F). Following the instructions on the form, the manual bill hold is released once all steps have been

[23] In this situation, the date that the letter is signed for at the address of the representative is considered the date of receipt.

completed.

(3) Beneficiary Originally Met, but No Longer Meets Inpatient Criteria and Attending Physician Does Not Concur –

(a) When a continued stay review indicates the beneficiary no longer meets inpatient criteria **and** that discharge screens are met, but the attending physician does not agree with the determination and does not discharge the beneficiary, the case must be referred to the UM Committee for review.

(b) If the PA and a second physician member of the UM Committee agree that the beneficiary no longer meets criteria for inpatient care, but the beneficiary's physician still does not concur, the Tenet Hospital must contact the QIO and issue a Notice of HRR to notify the beneficiary that the Tenet Hospital has requested QIO review of the discharge decision because the attending physician does not concur. See procedures for Tenet Hospital requests for QIO review in Section IV.C.7., below.

8. Hospital Requests for QIO Review – HRR

a. When the beneficiary's attending physician disagrees with the determination of the UM Committee that a beneficiary no longer needs inpatient care, the individuals designated by the Tenet Hospital must request QIO review of the case.

b. In these circumstances, the HCM must contact the Director of Case Management for guidance and the Director of Case Management must initiate the QIO review process. See Attachment A for process flows.

c. Concurrently, the HCM must notify the beneficiary that the Tenet Hospital has requested a review using a model language for the notice of HRR. The Tenet Hospital's designated individuals must simultaneously distribute copies of the HRR to: the beneficiary; Case Management files; the beneficiary's medical record; the beneficiary's attending physician, and the QIO.

d. The transmission to the QIO must be labeled "Attention: Immediate Review" and must include a copy of the relevant medical records, a copy of the IMFM, any Follow-up Notice(s) and a copy of the HRR. The HCM must also assemble and supply any pertinent information that the QIO needs to conduct its review by telephone or in writing, by close of business on the first full day immediately following the date the Tenet Hospital submitted the HRR request for review.[24]

9. Detailed Notice of Discharge (Detailed Notice): Beneficiary QIO Appeals[25]

a. When the Tenet Hospital receives notice that a beneficiary has requested an expedited determination by the QIO, the Tenet Hospital's designated individuals must prepare a Detailed Notice (CMS 10066) to advise the beneficiary in full sentences using plain language regarding the planned discharge date, why the services are no longer reasonable and necessary (or are otherwise non- covered), applicable Medicare coverage policies and specific information about the beneficiary's current medical condition rendering the identified coverage policies applicable and supporting the decision to discharge on the indicated date.

b. The Tenet Hospital's designated individuals must deliver the Detailed Notice to the beneficiary and to the QIO as soon as

[24] After receiving the HRR, the QIO is required to notify the hospital that it has received the request for review and must notify the hospital if it has not received pertinent records. The QIO is to solicit comment regarding the case from the hospital, attending physician, and beneficiary. The medical record and comments are to be referred to a QIO physician reviewer who may also discuss the case with the attending physician. The QIO will determine whether the services (1) are reasonable and medically necessary, (2) meet professionally recognized standards of care, and (3) could be safely delivered in another setting and will notify the beneficiary, the hospital, and the attending physician of its decision by telephone (and subsequently in writing) within two (2) days of the hospital's request and receipt of any pertinent information submitted by the hospital. The written notice of the expedited initial determination will contain the following: The basis for the determination; a detailed rationale for the determination; a statement explaining the Medicare payment consequences of the expedited determination and the date of liability if any; and a statement informing the beneficiary of his or her appeal rights and the timeframe for requesting an appeal. The expedited QIO determination is binding on the beneficiary, attending physician and the Hospital, unless the beneficiary remains in the Hospital and requests a reconsideration by an independent review entity (IRE). When a beneficiary who is no longer an inpatient in the hospital is dissatisfied with a QIO determination, the determination is subject to the general claims appeal process outlined in Medicare Claims Processing Manual Chapter 29.

[25] *See* 42 C.F.R. §405.1206 (expedited determination procedures for inpatient care) and 42 C.F.R. §422.622 (immediate QIO review of Medicare Advantage discharge determinations).

possible, but not later than noon of the day after the Tenet Hospital received notice of the appeal from the QIO.

c. The Case Management staff must also compile any documentation and information required by the QIO for this determination, including the IMFM and the Detailed Notice, and forward that documentation to the QIO and/or respond to telephone inquiries from the QIO no later than noon of the day following the date the Tenet Hospital received notice of the appeal from the QIO.[26] The HCM must respond to all inquiries from the QIO regarding the appeal and discharge decision.[27]

d. If the beneficiary requests copies of the documentation and/or information provided to the QIO (or any portion of it), [28] the Tenet Hospital's designated individuals must provide the requested copies and information to the beneficiary by close of business on the day after the request is received by the Tenet Hospital.

e. Within 24 hours of the beneficiary's request for a QIO review, the HCM must notify the DRA of the pending QIO determination. The DRA will immediately place the patient account on manual bill hold.

f. When the QIO determination is received, the HCM and DRA will determine if there is continued stay patient liability:

(1) If the QIO determination upholds the discharge and the review was requested timely, patient liability begins no sooner than noon on the day after the patient received notice of the QIO determination (see Section IV.B.8.c., above).

(2) If the QIO determination upholds the discharge but the

[26] Failure to meet these deadlines may result in delay of the expedited determination and additional financial exposure to the hospital. The QIO must normally render its determination within one calendar day after it receives the requested information. When a timely appeal has been filed, the beneficiary does not become financially responsible (other than for applicable coinsurance and deductible amounts) for services furnished prior to noon on the day after the beneficiary received notice of the QIO determination orally or in writing.

[27] The QIO is required to provide an opportunity for the hospital to explain why the discharge is appropriate.

[28] The Detailed Notice also asks whether the beneficiary would like a copy of the documents that have or are being sent to the QIO in connection with the appeal.

review was not requested timely, patient liability begins on a date as determined by the QIO (see Section IV.C.7.d., above).

When there is patient liability, the HCM and DRA notify the billing department by completing Section 2: QIO Review for Continued Stay of the form Medicare Non-Covered Continued Stay (see Attachment F). Following the instructions on the form, the manual bill hold will be released once all steps have been completed.

If the QIO does not uphold the discharge, there is no patient liability for continued stay. In this instance, no notification to the billing department is required and the DRA may release the bill hold.

All inquiries, requests for records and any determinations for any HINN for Medicare Inpatients related to QIO appeals must be documented/maintained in the Case Management Documentation System/Log.

D. Compliance Monitoring

A pattern of failure to issue beneficiary notices in accordance with this policy must be reported as a compliance issue pursuant to Regulatory Compliance policy COMP-RCC 4.21 Internal Reporting of Potential Compliance Issues.

E. Responsible Person

The Director of Case Management shall be responsible for assuring that all personnel adhere to the requirements of this policy, that these procedures are implemented and followed at the Tenet Hospital, and that instances of noncompliance with this policy are reported to the assigned Compliance Officer.

F. Enforcement

All employees whose job responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Failure to comply with this policy will be subject to appropriate performance management pursuant to all applicable policies and procedures, up to and including termination. Such performance management may also include

modification of compensation, including any merit or discretionary compensation awards, as allowed by applicable law.

V. REFERENCES:

- Quality, Compliance, and Ethics Program Charter
- Regulatory Compliance policy COMP-RCC 4.18 Clinical Determination of Appropriate Patient Status
- Regulatory Compliance policy COMP-RCC 4.21 Internal Reporting of Potential Compliance Issues
- - 42 C.F.R. §§ 412.42(c), (d) and (g)
- - 42 C.F.R. § 482.30
- - 42 C.F.R. §§ 405.1205-405.1208
- Medicare Claims Processing Manual 100-04, Chapter 29
- Medicare Claims Processing Manual 100-04, Chapter 30
- CMS Beneficiary Notices Initiative (BNI) website

VI. ATTACHMENTS:

- Attachment A: Process Flows
- Attachment: Medicare Outpatient Observation Notice (MOON)
- Attachment: Important Message from Medicare
- Attachment: HINN 1 – Pre-Admission/Admission Form
- Attachment: HINN 10 – Hospital Requested Review Form
- Attachment: HINN 11 – Non-Covered Services for Continued Stay
- Attachment: HINN 12 – Medicare Non-Covered Continued Stay Form
- Attachment: Detailed Notice of Discharge