Livanta Webinar
Medicare Inpatient Hospital Notices Compliance Training for the New Jersey Hospital Association

Date: Tuesday, December 4, 2018
Time: 1-2 p.m. Eastern Time
Presenter: Livanta LLC
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Topic
Medicare Inpatient Hospital Notice Compliance Training

Audience
The New Jersey Hospital Association (NJHA)

Hosted by: NJHA Vice President for Post-Acute Care Policy & Special Initiatives Theresa Edelstein

Date/Time
Date: December 4, 2018
Time: 1-2 p.m. Eastern Time
By: Livanta LLC (Livanta)

Purpose
The webinar was presented as an instructional module to educate and train the attendees on how to comply with the correct protocol for legally-required Medicare inpatient hospital notices.

History
Livanta is a Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) under contract with the Centers for Medicare & Medicaid Services (CMS). Livanta’s QIO program serves as one of the largest federal programs dedicated to improving health care quality at the community level. The program focuses on work with Medicare beneficiaries, caregivers, health care providers, and other stakeholders. It supports the development of healthy people in healthy communities, resulting in better care and lower costs. Livanta is the CMS designated BFCC-QIO for CMS Area 1 (Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont, Puerto Rico and the U.S. Virgin Islands) and Area 5 (Alaska, Arizona, California, Hawaii, Idaho, Nevada, Oregon, Washington, American Samoa, Guam, and the Northern Mariana Islands).

Medicare beneficiaries (or their family members/caregivers) who receive health care services in CMS Area 1 or Area 5 can contact their BFCC-QIO, Livanta, to do the following:

- Appeal a decision to discharge a beneficiary from the hospital when there is a concern that the discharge is happening too soon;
- Appeal a decision to end a course of skilled treatment, such as rehabilitation, skilled nursing home care, home health services, hospice care, or skilled therapy, when there is a concern that the beneficiary still needs skilled care; and
- File a complaint or concern about the quality of health care a beneficiary received in the past or is undergoing now.

In addition to the efforts described above, Livanta is charged with reviewing certain Medicare beneficiary medical records to verify that the coding was accurate, that the care provided was medically necessary, and that the care was delivered in the most appropriate setting.

Introductions/Greetings
Jennifer Bitterman, Director of Communications/Person and Family Engagement, Livanta
Steven Stein, MD, Medical Director, Livanta
Kim Storms, Quality Assurance Manager, Livanta
Gina Westphal, Communications Lead, Livanta

Ms. Bitterman welcomed the webinar attendees. She expressed appreciation to the NJHA and particularly to NJHA Vice President for Post-Acute Care Policy & Special Initiatives Theresa Edelstein for the opportunity to present this webinar to hospital stakeholders.

Agenda:
- Description of the Livanta Appeals Outlier Project
  - Methodology
Hospital Feedback
Beneficiary Notices Initiative (BNI) Notice Decision Tree
Hospital-Issued Notices and Best Practices
Important Message from Medicare (IM)
Hospital-Issued Notices of Noncoverage (HINNs)
Physician Reviewer’s Perspective
Additional QIO Services and Tools
Immediate Advocacy
Arrow App
Medicare Quality Helpline App
Questions and Answers

QIO Partners
Ms. Bitterman identified the two Quality Improvement Organizations serving the state of New Jersey

1. Beneficiary and Family Centered Care (BFCC-QIO): Livanta LLC

2. Quality Innovation Network (QIN-QIO): Quality Insights

Appeals Outlier Project
Ms. Bitterman provided an overview of the Appeals Outlier Project. She shared with those in attendance results from data analysis performed in 2017, when outliers were discovered among hospitals with patients eligible for QIO appeals services. The threshold ratio for an outlier was set at 1:101 appeals to discharges for Weichardt appeals. Eighteen hospitals were sampled, and 180 medical records were reviewed for notice compliance.

Methodology
Ms. Bitterman shared the following steps Livanta used to perform the data analysis:

1. Identified the facilities with less than 1% Weichardt appeals of Medicare discharges
2. Selected the last 10 discharges from those facilities
3. Performed the audit to see if proper notices were given and were in the medical record
4. Notified the providers in writing of the audit results
5. Provided individual education for providers with instances of undocumented or incorrect notices
6. Performed remeasurement after education

She provided the webinar attendees with the New Jersey case results from the Appeals Outlier Project, as follows:

<table>
<thead>
<tr>
<th></th>
<th>Round 1</th>
<th>Round 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appropriate Language and Liability</td>
<td>36</td>
<td>92</td>
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<td>49</td>
</tr>
<tr>
<td>Total</td>
<td>180</td>
<td>180</td>
</tr>
</tbody>
</table>

Hospital Feedback
Ms. Bitterman shared the feedback Livanta received from providers during the Appeals Outlier Project. She communicated that the following reasons were given for problems with notices:

- Staff turnover
- Version control
- Misunderstanding timelines
- System migration
- Department hand-offs

Beneficiary Notices Initiative (BNI) Notice Decision Tree
Ms. Bitterman displayed a Beneficiary Notices Initiative (BNI) Notice Decision Tree (Figure 1) and explained each step from the types of Medicare coverage being reduced through the actions and decisions required for each of those types, including:

- Pre/Reduction in Part A Coverage (QIO does appeal)
- Reduction in Part B Coverage (MAC or Plan does appeal)
Discharge from Part A Coverage (QIO does appeal)

Her discussion included physician review information, inpatient and non-inpatient appeals, Hospital-Issued Notice of Noncoverage 10 (HINN 10) and HINN 12, Important Message from Medicare (IM), Notification of Medicare Non-Coverage (NOMNC), Detailed Notice of Discharge (DND), Detailed Explanation of Non-Coverage (DENC), and QIO agreement or disagreement with discharge.

Ms. Bitterman then discussed Beneficiary Knowledge Standards, including the following information:

- The term is covered under Medicare Claims Processing Manual Chapter 30 – Financial Liability Protections Section 40.2
- Explains what patients and families can reasonably be expected to know
- Covers all written notices required for participation in Medicare

Ms. Bitterman provided the following information about Written Notice as Evidence of Knowledge:

- This term is covered under Medicare Claims Processing Manual Chapter 30 - Financial Liability Protections Section 40.2.2
• Explains the basis for written patient notifications
• Covers reasonable expectations for providers
• Provides protection for providers

Ms. Bitterman next addressed **Sources of Written Notice** with the audience and provided the following:

• This term is covered under Medicare Claims Processing Manual Chapter 30 - Financial Liability Protections Section 40.2.3
• Details all the different types of notices
• Explains the information and language that is required to terminate Medicare covered services
• Covers providers and Medicare contractors

Ms. Bitterman provided the following explanation of **Basic Delivery Requirements**:

• This term is covered under Medicare Claims Processing Manual Chapter 30 - Financial Liability Protections Section 40.3.4.1
• Must be hand-delivered
• Patient or family is permitted to refuse notice
• Best practice: verbally explain the rights and services offered in the notice and document
• Best practice: include the notices in discharge planning meetings

Ms. Bitterman also provided the following information about **Official Sources of Instruction** about notices:

• The topic is covered under Medicare Claims Processing Manual Chapter 30 - Financial Liability Protections Section
• More information can be found at [https://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html](https://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html)

**Hospital-Issued Notices and Best Practices**

**The Important Message (IM) from Medicare**

Ms. Bitterman provided the following requirements regarding the **Important Message from Medicare (IM)**

• Download the latest version of the IM from Medicare on the CMS website
• If a patient requests an appeal of his/her discharge, a detailed notice may be issued
• The font must be no less than 12 point

Ms. Bitterman provided the following requirements regarding the content and delivery of the IM:

**Header Content**

• Department of Health and Human Services, Centers for Medicare & Medicaid Services and the OMB number
• Patient Name
• Patient ID number
• Physician
• Hospital logo (optional)

**Body Content**

• Report any concerns you have about the quality of care you receive to the Quality Improvement Organization (QIO) listed here:
  • QIO Name: Livanta LLC
  • QIO Phone: 1-866-815-5440
  • TTY: 1-866-868-2289

• To speak with someone at the hospital about this notice, call ________________
• Patient or representative signature
• Date/Time
• Insert name and telephone number of QIO in bold
  • QIO Name: Livanta LLC
  • QIO Phone: 1-866-815-5440
  • TTY: 1-866-868-2289
• Name of the hospital
• Any additional information

**Delivery Requirements**

• Must be delivered within 2 days of admission
• Inpatient hospital only
• Must be delivered again at discharge determination
• For observation appeals, call 1-800-Medicare

Ms. Bitterman provided the following information regarding the **Detailed Notice of Discharge**:
• Required if patient or family files an appeal
• Must be delivered timely to patient and family
• Best practice: Go into detail
• Best practice: Use simple language

Ms. Bitterman provided the following content requirements for the **Detailed Notice of Discharge**:
• OMB control number
• Minimum of 12-point font or the equivalent
• Patient name
• Patient ID number
• Physician
• Date issued
• Where to insert logo

Ms. Bitterman provided the following additional information regarding the IM:

**Expedited Review (Timely)**
• Patient and family request for appeal must be timely
• QIO will notify all parties: provider, patient, and family
• 24-48-hour turnaround

**Patient Liability**
• Liability for further inpatient hospital services depends on the QIO decision
  • Unfavorable determination
  • Favorable determination

**Hospital-Issued Notices of Non-Coverage (HINNs)**

Ms. Bitterman provided the following explanation of the **HINN 1 (Preadmission/Admission HINN)**:
• A patient and family right
• Includes swing beds
• Preadmission versus Admission HINN
• Preadmission HINN

• Patient is liable
• QIO review
• Admission HINN
• Patient liability
• QIO review

Ms. Bitterman then gave the following information regarding **HINN 10 (Notice of Hospital Requested Review)**:
• Hospitals have the right to the QIO Review
• Required if Hospitalist and Attending Physician cannot agree on termination of services
• Facility must notify QIO and request review
• Facility must also notify the patient and patient’s family

Ms. Bitterman provided the following information regarding **HINN 11 (Noncovered Service(s) during a Covered Stay)**:
• For specific criteria only
• Only for services normally covered under Medicare
• Medicare determination required

Ms. Bitterman stated that the **HINN 12 (Noncovered Continued Stay)** should be used in association with the hospital discharge appeals notices to inform beneficiaries of their potential liability for a noncovered continued stay.

**Physician Reviewer’s Perspective**

At this point, Ms. Bitterman introduced Livanta’s Medical Director, Dr. Steven Stein. Dr. Stein provided the following example of a good review:

> “You were admitted to the hospital on xx/xx/xx, for care and treatment of asthma with COPD exacerbation overlap. You underwent several diagnostic tests to determine an appropriate treatment plan. It was determined that you had asthma with COPD exacerbation overlap. During your hospital course, you received intravenous (IV) antibiotics and fluids. Your medical condition was fully
assessed and treated. Your pain management, blood pressure, heart rate, respiratory rate, and temperature became stable. You no longer require constant 24-hour-a-day treatment and monitoring, including hospitalization and/or management by physicians or assessment by licensed professionals. Additionally, you no longer require medication at a hospital level of care. Your physician has now determined that you can safely be discharged home with home health services, if applicable."

To provide a basis for comparison, Dr. Stein then presented an example of a physician’s review that did not include any details of the assessment:

“No comments included in the notice.”

After Dr. Stein conveyed the importance of having a detailed description of patient care and services in the physician’s review, he concluded his remarks with a thank you to the hosts, NJHA and Ms. Edelstein.

Next, Dr. Stein introduced Ms. Gina Westphal, a member of Livanta’s Communication’s Team. Ms. Westphal provided information regarding the QIO’s additional services and tools.

**Additional QIO Services and Tools**

**Immediate Advocacy**

Ms. Westphal informed the group that she would be speaking about the **Immediate Advocacy Program**, which had blossomed due to the data that was collected during Livanta’s pilot program for Person and Family Engagement (PFE). Livanta learned that patients need help in resolution of their immediate concerns and challenges related to a pending discharge.

Ms. Westphal provided the following information about **Immediate Advocacy**:

**Outcomes**
- Reduces the 30-day hospital and acute inpatient readmissions
- Improves health literacy

**Process**
- An appeal is received.
- If the patient or his/her family need additional support with the discharge planning process, a Livanta advocate is assigned to the case. The advocate works with the patient and his/her family to aid in understanding and/or resolving concerns related to discharge.

She provided the following example of an Immediate Advocacy Case for illustration:

“A 71-year-old male, who lives alone and is a stroke patient, was being discharged to home. The patient called Livanta to appeal. The case was assigned to a Livanta advocate. Livanta was able to increase the patient’s understanding and was able to communicate with the provider. There was improved patient-centered care and outcomes.”

**Arrow App**

Ms. Westphal provided an introduction and explanation of “Arrow” — Livanta’s new user-friendly downloadable application (app) that provides a fast and convenient way for one to check his/her case status (appeals or QIO cases) online. There is no telephone or phone tree to navigate. The Arrow App simply requires inserting the case number and clicking the “search” feature.

**Medicare Quality Helpline App**

Ms. Westphal provided the following information regarding Livanta’s **Medicare Quality Helpline App**:

**Features**
- One-touch dialing
- GPS enabled
- Arrow case tracking
- Medicare Rights Reviewer
- Absolutely free App (message and data rates may apply)
Ms. Westphal invited the audience to provide feedback on the app by having them participate in a live practicum exercise. She asked the audience to open the App Store for iPhone or Google Play for Android on their smartphones and/or tablets. They were instructed to search for “Livanta.” After searching for “Livanta,” they were instructed to download and install the app. Following the installation of the app, they were asked to provide a rating and review.

After completing the exercise, Ms. Westphal expressed appreciation to the hosting organization, NJHA, and the audience. She then opened a questions and answers session to the audience by introducing Livanta’s Quality Assurance Manager Kim Storms, who provided the answers.

**Question and Answer (Q&A) Session**

**Note:** Questions and Answers given during the session have been edited for clarity and content.

**Q:** Is there a time limit in which the HINN 12 can be issued after the discharge appeal is upheld and the patient/family is aware of financial liability?

**A:** There is no time limit for HINN 12 currently. Under the Medicare rules, patients should be made aware of their potential liability in writing prior to the appeal decision. The implied deadline is before their liability begins.

**Q:** Is there a discharge appeal process for patients with other insurance such as Medicaid or commercial insurance, or for those without insurance?

**A:** Each payer type has its own rules and requirements related to utilization management appeals. This question is beyond the scope of this session, but I can have our managed care staff contact you.

**Q:** Does the IM notice also apply to an acute inpatient rehabilitation facility? How about an inpatient behavioral unit?

**A:** As long as the Medicare patient is in an acute level of care, he/she will receive the IM. If he/she is in a lower level of care, he/she will receive a Notice of Non-Coverage. Medicare beneficiaries and Medicare Advantage (MA) plan enrollees who are hospital inpatients have a statutory right to appeal to a Medicare Quality Improvement Organization.

**Q:** Attending physicians can change. Can the physician listed on a notice be the admitting physician?

**A:** Yes.

**Q:** Does the second notice require a patient signature?

**A:** The follow-up (second) IM associated with the patient’s discharge may be either a new blank IM or a copy of the IM that was signed after admission; whichever is most convenient. It is strongly recommended that hospitals obtain the signature or initials of the patient when delivery of the follow-up copy is necessary, although a signature isn’t required. Providers may utilize other forms of documentation, such as inclusion in a discharge form checklist.

**Q:** A HINN 1 question. A patient is admitted Sunday night. On Monday, a utilization review physician advisor reviews the case and decides that admission is not appropriate, but that observation is needed. The attending physician agrees to change the order to observation status. Does the facility have to issue a HINN 1 (Preadmission/Admission HINN)?

**A:** No, the HINN process is not applicable.

Hospitals and critical access hospitals (CAHs) are required to provide a Medicare Outpatient Observation Notice (MOON) to Medicare beneficiaries (including Medicare Advantage health plan enrollees) informing them that they are outpatients receiving observation services and are not inpatients of a hospital or critical access hospital (CAH).

Change of an inpatient admission to an outpatient...
admission by the utilization review committee would not require delivery of the copy of the signed IM and would not trigger the QIO appeal process.

Q: Can you elaborate on the timing of short stays? If a patient's length of stay is three days, is the provider required to issue an IM at discharge?

A: No. For example, if the patient presents on March 1st and is given the IM on March 1st and he/she is discharged on March 2nd or 3rd, he/she will not get a follow-up notice. If the IM is received on March 1st and he/she is discharged on March 4th, then he/she will require a follow-up IM.

There are known exceptions for not giving a discharge notice: the patient expires, the patient transferred to another acute care setting, if the patient is leaving against medical advice (AMA), and if the patient chose hospice.

Q: Who is allowed to fill out the Detailed Notice of Discharge (DND)?

A: There is no requirement currently. Case management personnel usually fill them out.

When a QIO notifies the hospital that a Medicare beneficiary has requested an expedited review, the hospital will deliver a DND to the patient or representative as soon as possible but not later than noon of the day after the QIO's notification.

When a Medicare Advantage (MA) plan enrollee requests an expedited review, the MA plan, directly or by delegation to the hospital, will deliver a DND to the MA plan enrollee or representative as soon as possible but not later than noon of the day after the QIO’s notification.

Q: I just want to confirm that upon discharge from my acute hospital to an acute rehabilitation facility that I MUST give an IM?

A: An IM is not required if the patient is going from an acute setting to another acute setting. A notice will be given at the receiving hospital.

Transfer from one inpatient hospital setting to another inpatient hospital setting will not require delivery of the follow-up copy of the signed notice at the time of transfer and will not trigger the discharge appeal process. This includes transfer from a short-term acute care hospital to a long-term acute care hospital, which is considered the same level of care. A patient may always refuse care and contact the QIO if they have a quality of care concern regarding the transfer. The receiving hospital must deliver the IM again after transfer, and the notice requirements would begin again.

Q: How should we document if the beneficiary refuses to sign or acknowledge the IM? On the form? In the patient’s medical record?

A: Ideally both, but it is required on the medical record. Delivery of a beneficiary notice is only valid when the notice is signed and dated by the beneficiary, indicating the notice was received and understood. If a beneficiary refuses to sign, the provider should annotate the notice to indicate the refusal, and the date of the refusal should be the date placed on the notice. The date that someone receives (or refuses to sign), is the date of receipt. Beneficiaries who refuse to sign the notice are still entitled to a determination by the QIO.

Q: Can you discuss the procedure for when a patient is unable to receive a notice and no representative is available?

A: Try to contact the best representative you have on file. If he/she came from a facility reach out to him/her and ask if he/she has a court appointed guardian. Try to make three different attempts at reaching someone and document each attempt.

A notice may also be delivered to an authorized representative. Generally, an authorized representative is an individual who, under State or other applicable law, may make health care decisions on a beneficiary’s behalf (e.g., the beneficiary’s legal guardian, or someone appointed in accordance with a properly executed durable medical power of attorney). Notification to a beneficiary who has been deemed legally incompetent is typically made to an authorized representative of the beneficiary.

However, if a beneficiary is temporarily incapacitated, a person (typically, a family member or close friend) whom the hospital or
CAH 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 notice. 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.

**Q:** If the patient signs an IM while under an observation order and the order is later changed to admission, do we need to get another IM signed?

**A:** If it’s within two days of admission or two days of discharge, another IM is not required. Hospital outpatients who are receiving Part B services, such as those in observation stays or in the emergency department, do not receive the IM, unless and until they subsequently require inpatient care.

**Q:** Best practice is Important Message from Medicare (IM) followed by a Detailed Notice of Discharge (DND) followed by a Hospital-Issued Notice of Noncoverage 12 (HINN 12)?

**A:** A DND is considered the best practice. The DND is required as follows:

When a QIO notifies the hospital that a Medicare beneficiary has requested an expedited review, the hospital will deliver a DND to the patient or representative as soon as possible but not later than noon of the day after the QIO’s notification.

When a Medicare Advantage (MA) plan enrollee requests an expedited review, the MA plan, directly or by delegation to the hospital, will deliver a DND to the MA plan enrollee or representative as soon as possible but not later than noon of the day after the QIO’s notification.

**Q:** It was mentioned to include the second IM notice in the discharge package at the time of discharge for signature. In the past, I believe that CMS frowned at handing out these notices on the day of discharge. Is this still true?

**A:** This is still true, but sometimes it cannot be avoided. Delivery of the follow-up copy of the IM notice as a part of the routine process on the day of discharge or every two days during the inpatient stay should be avoided. When the follow-up copy must be given on the day of discharge, patients should be given at least 4 hours to consider discharge appeal rights, without being pressured to leave.

**Q:** What is Livanta’s process when the family withdraws the appeal? I have received different instructions from Livanta.

**A:** If the appeal has gone to a physician for review, we will let the physician complete the review, send it back to Livanta, and issue the decision. If medical records are not yet received, we will notify the hospital that the family has withdrawn the appeal. Everyone is notified by phone about the withdrawal. Livanta may discontinue the review process when contacted and requested to do so by the patient/representative provided that the case has not gone to physician review and the patient has not incurred any financial liability.

**Q:** What is your advice for the patients who appeal their discharge with every admission? They are telling staff this is how they get an extra day upon arrival. Many times, the appeal is due to lack of communication but not with this scenario. Please advise.

**A:** Notify Livanta immediately, so we can try to provide a quick turnaround. Livanta does not consider or alter the statutory process based on how often a patient exercises the right to appeal. Each request for an appeal stands alone. The burden of proof remains with provider to submit medical documentation in support of the specific decision to discharge.

**Q:** Did I hear Livanta say that it’s okay to give IM for patients who are under observation? What I do not want to happen is for the facility to give both IM and MOON letter at the same time.

**A:** No, hospitals and critical access hospitals (CAHs) are required to provide a MOON to Medicare beneficiaries (including Medicare Advantage health plan enrollees) informing them that they are outpatients receiving observation
services and are not inpatients of a hospital or critical access hospital (CAH). Patients who remain under observation do not received the IM.

Q: Does everybody get an advocate when appealing the discharge, and how do we know if they have one?

A: If the patient can identify his/her concerns, we are there to assist. If we cannot be of assistance, then the patient will be assigned an advocate.

Q: Which letter should be used for the observation patient who signed the MOON letter but is refusing to leave after the discharge order is written?

A: A HINN 12 can be given, so the patient is aware of his/her liability. You should call 1-800-Medicare. This will be explored with the local Medicare Administrative Contractor. Hospitals and critical access hospitals (CAHs) are required to provide a MOON to Medicare beneficiaries (including Medicare Advantage health plan enrollees) informing them that they are outpatients receiving observation services and are not inpatients of a hospital or critical access hospital (CAH).

Hospital protocols for handling a patient who refuses to leave are dictated by the facility. Consider consulting your hospital administration.

Note: A HINN 12 is a liability notice to be used in association with the Hospital Discharge Appeal Notices to inform beneficiaries of their potential liability for non-covered hospital-level inpatient care.

Q: Does Code 44 (Inpatient Admission Changed to Outpatient) get a letter?

A: All Medicare beneficiaries must be notified in writing when their payor source changes. If your hospital has not developed a form to notify Medicare beneficiaries that they have been placed in observation status from full inpatient status, a HINN 12 may be used in conjunction with their notification as it informs the recipient of the liability amount.

When the provider employs Condition Code 44 to change of an inpatient admission to an outpatient admission through utilization review, the hospital should deliver the MOON to Medicare beneficiaries (including Medicare Advantage health plan enrollees) informing them that they are outpatients receiving observation services and are not inpatients of a hospital or critical access hospital (CAH). This would not trigger the appeal process.

HINN 12 is a liability notice to be used in association with the Hospital Discharge Appeal Notices to inform beneficiaries of their potential liability for non-covered hospital-level inpatient care.

Q: For the second (follow-up IM prior to discharge), can Livanta talk about how to handle cases when the patient has been deemed not competent and there is no family available?

A: If a patient had been deemed incompetent prior to this hospitalization and has no one willing or able to act as guardian, there should be a court-appointed representative of some sort. If a Medicare beneficiary presents to your hospital and is without representation and unable to represent him/herself, calling the sending facility and speaking with someone in an advocacy role (e.g., social services at the nursing home, case manager at the group home) would be considered notification. If a patient presents who is not able to make decisions and has no family, call the last phone number you have on file for this person from previous hospitalizations. Document all attempts to reach someone. CMS considers three attempts to be due diligence.

The IM and the follow-up copy of the IM may also be delivered to an authorized representative. Generally, an authorized representative is an individual who, under state or other applicable law, may make health care decisions on a beneficiary’s behalf (e.g., the beneficiary’s legal guardian, or someone appointed in accordance with a properly executed durable medical power of attorney). Notification to a beneficiary who has been deemed legally incompetent is typically made to an authorized representative of the beneficiary.
Consider consulting your administration for internal protocols/policies.

Q: Is the IM notice required if a patient is placed in observation sometime after admission?

A: The IM is required within 2 days of full inpatient admission and within 2 days of discharge.

Q: Is a signature required by CMS on the second IM?

A: Acknowledgement is required. Ideally this would be a full signature, but it could be an “X” or initials or documentation from the staff of refusal or inability to sign. All along with the date.

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.

Q: How should it be documented if an IM/MOON attempt is made, but the patient is not within his/her room due to reasons such as undergoing a test or laboratory work? Should this be documented on the form and scanned into the electronic medical record (EMR)?

A: Yes. You can document that the patient was off the floor and a copy was left at the bedside. Assuming, of course, that a copy was actually left at the bedside. Follow-up attempts should be made, and documented, to ensure an understanding of the IM.

Q: Is there an equivalent notice to the HINN 12 that can be provided to observation patients?

A: The HINN 12 is the only form in the HINN family which notifies patients of actual liability; other notices tell patients when liability begins, but not the actual amount. Ideally, observation patients would receive the MOON.

Q: Do we need to mail the initial and follow-up IM to patients’ relatives for those patients who may be confused?

A: If you are able to reach the representative by phone, delivery is considered made. Not voicemail, but a conversation. If you had to mail the first one and can reach the person by phone for the second, you need not mail the follow-up notice. If you are unable to reach the representative by phone at all, then both notices are to be mailed. Regardless of the competency of a beneficiary, if the hospital is unable to personally deliver a notice to a representative, then the hospital should telephone the representative to advise him or her of the beneficiary’s rights as a hospital patient, including the right to appeal a discharge decision.

Q: Would it be acceptable to give the second notice to the patient and have staff acknowledge in the medical record that it was given?

A: It is acceptable but should not be done routinely. Ideally, the notice itself would contain the initials/signatures/dates. The reason for the follow-up notice is that patients are given this information in a meaningful time-frame. Routinely documenting delivery of the notice in the medical record alone gives the impression that patients are not given the opportunity to appeal should they wish to.

The follow-up (second) IM that is associated with the patient’s discharge may be either a new blank IM or a copy of the IM that was signed after admission; whichever is most convenient. It is strongly recommended that hospitals obtain the signature or initials of the patient when delivery of the follow-up copy is necessary, although a signature isn’t required. Providers may utilize other forms of documentation, such as inclusion in a discharge form checklist.

Q: Is Livanta open on the weekend and holidays to handle appeals?

A: Yes. Livanta is open 365 days/year to handle appeals. If the caller is not able to reach a live
representative, voicemail messages are date and time-stamped. Calls are returned as soon as possible.

**Q:** But Code 44 is not observation; it is outpatient (OP)?

**A:** Observation status is a type of OP status. Outpatient Observation Status is paid by Medicare under Part B.

**Q:** Can we give an admission denial if the patient does not want to leave?

**A:** If the patient does not meet admission criteria, an admission denial should be issued. An admission denial is not based on a patient’s willingness to leave the facility.

**Closing Remarks**

Following the Q&A Session, Ms. Bitterman expressed Livanta’s appreciation for the opportunity to present the webinar. She shared that the Livanta Team is looking forward to building a productive and collaborative relationship with the NJHA to provide Medicare patients and providers with the information, education, and best practices in patient-centered care.

The webinar ended with the reiteration of Livanta’s QIO contact information.

For general questions, contact: communications@livanta.com

240-712-4313

For clinical or case inquiries, contact:

Livanta Medicare HelpLine:

Call anytime; staff is onsite 9-5 p.m. weekdays and 11-3 p.m. weekends and holidays

1-866-815-5440

www.livantaqio.com

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