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New Definition

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It's Not the 'Notice', It's the 'Message' that Matters:

Addressing Patients' Rights to be Informed of Discharge and Rights to Appeal

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Introduction

On July 1, 2007 a revision of the practice of notifying Medicare Beneficiaries of their discharge rights became effective. Hospitals are required to use a two step process to assure that Medicare Beneficiaries can exercise their rights: Fist, hospitals must deliver a notice of discharge rights, including the right to appeal a discharge, in the form of a revised version of the Important Message to Medicare Beneficiaries. The requirement to give a copy of an Important Message (the IM) has been in place for close to two decades. Second: If a patient or his or her representative chooses to appeal a discharge, the review process begins, including the issuance of a 'detailed notice; must be prepared.

Neither of these two steps are new processes. This iteration of the Medicare Beneficiaries rights is based on a lawsuit titled ***WEICHARDT v. LEAVITT No. C 03-05490 VRW (N.D.Cal.), filed December 5, 2003*** with a settlement signed in October of 2005. In April of 2006 a proposed rule was published with an open comment period. The final rule was published on November 27, 2006. The versions of the required forms and the directions on how the rule must be implemented were published in the ***Medicare Claims Processing Manual Chapter 30 – Financial Liability Protections***. *http://www.cms.hhs.gov/transmittals/downloads/R1257CP.pdf*

Overlapping Regulations

In 1988 the Federal Regulations for Discharge Planning were incorporated into the Social Security Act (SSA) and the rules are now found in the SSA § 1861(ee). The purpose of those rules is "to ensure a timely and smooth transition to the most appropriate type of and setting for post-hospital or rehabilitative care." *http://www.ssa.gov/OP_Home/ssact/title18/1861.htm* The standards within this section of the SSA involve identifying a patient who is at risk of adverse health consequences without adequate discharge planning, conduct an evaluation of the patient's post-acute needs, developing a plan and assuring that plan is implemented.

Notification of Discharge Rights:

The rule that is in currently on the minds of hospital administrators, including case management departments, is the requirement that assures that patients are informed of their appeal rights, and rights to be informed of any real or potential financial liability. Both Medicare beneficiaries and providers have certain rights and protections related to financial liability under the Fee-for-Service (FFS) Medicare and the Medicare Advantage (MA) Programs. The

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term used by Medicare to group all notices affecting patients who are receiving services from any provider (home health, skilled nursing facilities, etc) is called the "Beneficiary Notice Initiative (BNI) *http://www.cms.hhs.gov/BNI/01_overview.asp#TopOfPage*

These financial liability and appeal rights and protections are communicated to beneficiaries through notices given by providers. In the case of hospitals, the notice is called the 'Notification of Discharge Rights'. This is given to the patient as an "Important Message", abbreviated as the 'IM'. The IM has generally three parts:

1. a statement of the patient's rights to medically necessary care and services that may be needed after discharge;
2. a statement of the patient's 'discharge rights';
3. instructions on how to appeal to the QIO for a review of discharge and a general statement about whether or not the patient would have to pay for hospital services, other than a co-pay or deductible.

Part 2 is especially important for case managers who facilitate the function of discharge planning. To quote from the form titled "The Important Message from Medicare (OMB #0938-0692) (CMS-R-193):

"Planning For Your Discharge: During your hospital stay, the hospital staff will be working with you to prepare for your safe discharge and arrange for services you may need after you leave the hospital. When you no longer need inpatient hospital care, your doctor or the hospital staff will inform you of your planned discharge date."

One way to assess the impact of this rule is to look more closely at how the Medicare Beneficiary will be involved. ***Rather than looking at the rule as a way to deliver a 'notice', it should be viewed as a way to give a 'message' to patients.***

The Notification of Discharge *and* Appeal Rights is a two-step process:

Step 1: The revised IM that contains more specific information to the Medicare Beneficiary or his or her representative is delivered within two days of admission to acute inpatient level of care. The new requirement in this rule is that patient must sign the IM at admission and that a copy of the signed IM, or a new IM, be given to the patient no sooner than 2 days before discharge. The copy of the IM can be delivered on the day of discharge, but only for unanticipated situations, and with time for the patient to consider his or her rights.

Step 2: If the patient appeals his/her discharge, the patient, or representative, will be instructed to call the Quality Improvement Organization (QIO) to start the appeal process who in turn will notify the hospital. Then the hospital will be required to prepare and deliver a 'detailed notice' outlining the facts related to the decision that the patient no longer meets 'medical necessity' for hospital level of care. The issue of 'financial liability' comes into play when the patient appeals a discharge and a review is put into action.

The financial liability risks can be encountered by either the patient or the hospital. Briefly, if the QIO concurs that the patient's hospital stay is no longer medically necessary, the patient begins to be financially liable on the next day. If the QIO concurs with the patient that the discharge is not medically appropriate, the patient can stay in the hospital without financial liability. If the hospital does not submit information to the QIO in a timely manner so that an adequate review can be conducted, the hospital may assume financial liability until the QIO can complete the review.

The hospital assuming financial liability is more related to a longer length of stay, since under the Medicare prospective payment system (PPS) the hospital is paid the same amount regardless of the length of stay. The big picture, however, is that while waiting for a review by the QIO patient flow may be affected. Patients can't be discharged until the review is completed by the QIO. Delay in discharge for one patient often creates a delay in admission for another.

The intention of delivering a 'message' rather than a notice to patients and families is to avoid an 'appeal'. **Using the 'notice' as an opportunity to give the patient the 'message' that discharge planning will be provided, that the patient won't be discharged until it is safe, and that the hospital and physician care about what happens to the patient after discharge, is a strategy that may help avoid an appeal by a dissatisfied, displeased, frustrated or frightened patient or representative.**

What can a hospital do?

Step 1: Start 'Discharge Planning' on admission:

- This revised rule can provide an opportunity to prepare the patient that he/she will be involved in the discharge process and will be discharged when hospital care is no longer needed.
- The message should acknowledge that the patient may still be 'sick' or 'ill' or that their disease is still there, but that, the hospital is not the best place for them at that point in time.
- Hospitals are places where medical conditions are stabilized, a diagnosis is determined or verified, and a plan for continuing care is done. Other places, like home with family support or with home health services, a short term rehabilitation facility, or a hospice are better equipped to take care of patients after hospital level of care is no longer medically necessary.
- Give patients that message on admission, and as often as is needed. Patients admitted through the emergency department are usually not ready to hear that message, but as soon as they are, that 'message' should be delivered.

Step 2. Work to deliver the message in the most patient centric way:

- Interview the patient and family about his/her 'prior level' of care.
  - How was he/she managing before being admitted to the hospital "How have you been managing at home?"

- "Does your family know you're here?" "Who is going to help you after discharge?"
- Were services in place prior to admission?
- If the patient had Home Health services or came from a skilled nursing facility, get specific details and contact that agency or facility immediately for some base-line information.
- Ask if the patient was recently in a hospital. Get details: where, when, how many days, and why.
- Ask if the patient had a recent visit to an ED. Get details: why, what happened, and what was the follow-up plan? Ask who the patient's primary care physician is and make contact with him or her.

Step 3: Give the patient an estimate about how long he or she will be in the hospital.

- The estimate should be based on clinical status of the patient that are verified with the patient's attending physician.
- Predict or estimate Patient's LOS:
  - Assess the patient's functional status and potential capacity to return to the prior level of care. What will it take to support functional deficits?
  - Use the PPS/DRG estimated length of stay based on the patient's admitting diagnosis
  - Determine which comorbities may affect a length of stay.
- Tell patient and family a possible range of time the patient will be in the hospital.
  - Time this message when the patient is stable and receptive. Giving a length of time while the patient is still in an ICU or medicated may be perceived by the patient and family as an attempt to 'kick mama out of the hospital.'
  - Ask the patient: "Do you have an idea of how long you'll be in the hospital?"
  - Use CareGraphs™ to track progression to readiness for discharge.

Step 3: Complete a discharge plan and verify that it is 'workable, reasonable, acceptable' and meets the needs of the patient.

This rule 'overlaps' other long standing regulations that guide hospitals in the discharge planning process. If a hospital has been successful in following these existing rules, modifying practices that exist should not be an overwhelming task.

Changes in HINNs and NODMAR

Because there will necessarily be changes in the way patients are notified of their appeal rights, some of the Hospital Issued Notices of Non-coverage (HINN) and the Notification of Medicare Discharge Appeal Rights (NODMAR) were also changed.

The NODMAR, a tool used by Medicare Managed Care organizations is eliminated. The IM and the Detailed Notice forms will be consistently used regardless of payer source. Medicare Managed Care organizations can delegate the function to hospitals. Hospitals should review the contracts to assure that there is language dealing with this delegated function.

The HINN structure will be simplified. The somewhat generic HINN can be used for situations in which the question of medical necessity needs to be clarified.

- Situations in which a patient does not appeal is the Pre-admission/Admission HINN. This can be used for advanced beneficiary notice as well as a notice that, during their admission.
- There is also another form that can be used by hospital—the Hospital Requested Review HRR form. This is used when a hospital utilization review committee believes that the patient is no longer hospital level of care and the patient's attending physician may or may not concur with that opinion. A hospital can use the HRR and request an independent review by the QIO.
- Another type of HINN is referred to as HINN 11 (the 11th version of the HINN process). This HINN is used when a patient is at hospital level of care, but may require services that are not paid for by Medicare.

Case managers play an increasingly significant role in the movement of a patient through the health care system, as well they should. Advocating for the patient has never been more important, in particular the advocacy of what it takes to transition the patient to the next level of care when it is appropriate.

Review Chapter 30 of the Conditions of Participation for discharge planning and for utilization review so that there can be a better chance of compliance to overlapping rules that apply to how a patient is admitted, assessed, planned for, and discharged. For audits, consults, training, coaching, and other assistance for physicians, social workers, and nurses providing the discharge planning function of case management, contact The Center for Case Management. CareGraph™ is a registered trademark of CCM.