Medicare Hospital Manual

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

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HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
312 – 350 (Cont.)	3-15 - 3-18 (4 pp.)	3-15 – 3-16.3 (5 pp.)
399 Exhibits	3-18.1 (1 p.)	3-17 (1 p.)
Exhibit 5-8	3-25 – 3-26 (2 pp.)	3-25 – 3-39 (15 pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE: January 22, 2003*
IMPLEMENTATION DATE: August 1, 2003

Subject: Admission Notice To Beneficiaries--*Important Message From Medicare (IM)*

Section 312, Notice to Beneficiaries, is revised to include new instructions for the use of the new English and Spanish forms CMS-R-193, the *Important Message From Medicare*. Hospitals are required to issue the *Important Message From Medicare* to all Medicare beneficiaries that are admitted as inpatients to the hospital at or about the time of their admission or at some point during the course of the hospital stay.

Section 312.1, PRO Monitoring of Hospital Admission Notice to Beneficiaries, is being deleted since the PROs (now, QIOs) no longer perform this function.

Section 399, Exhibits, is revised to include two new Exhibits 5 and 6, English and Spanish (respectively), forms CMS-R-193, the *Important Message From Medicare*, and to delete existing Exhibits 5 through 8, that were replaced by the new forms. These revised CMS-R-193 forms were approved by OMB on January 22, 2003 and are standard forms that may not be modified. Hospitals may begin to use the new forms immediately on a voluntary basis and are required to use only the new forms on and after August 1, 2003.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

312. ADMISSION NOTICE TO BENEFICIARIES

A. Medicare Beneficiary Right to Written Admission Notice. Section 1866(a)(1)(M) of the Act (amended by §9305 of the Omnibus Budget Reconciliation Act of 1986) requires all hospitals (including hospitals paid under the prospective payment system--PPS, and those waived or exempt from PPS) to provide all Medicare beneficiaries (or their representatives) a written statement which explains:

- The beneficiary's right to benefits for inpatient hospital services and post-hospital services;
- The circumstances under which the beneficiary will or will not be liable for charges for continued stay in the hospital;
- The beneficiary's right to appeal denials of benefits for continued inpatient hospital services, including the practical steps to initiate such appeals; and
- The beneficiary's liability for payment for services if such a denial of benefits is upheld upon appeal.

B. The *Important Message From Medicare*

The *Important Message From Medicare--(*Exhibits 5 (English) and 6 (Spanish)) is the notice that you must provide Medicare beneficiaries. Section 1866(a)(1)(M) requires that this admission notice be issued at or about the time of admission. However, because issuing the notice to beneficiaries (or their representative) at or about the time of admission is not always possible, the regulations at 42 CFR §489.27 allow the *IM* to be issued at some point during the course of the inpatient's hospital stay as long as it is not issued in conjunction with the beneficiary's notice of noncoverage (Hospital Manual Section 414). Hospitals must ensure that Medicare beneficiaries, whose primary language is Spanish, receive the Spanish-version of the *IM (Exhibit 6)*.

Although the liability for continued inpatient hospital care is different for beneficiaries that are admitted to hospitals paid under the prospective payment system (PPS) versus those admitted to non-prospective payment system (non-PPS) hospitals, the IM forms under Exhibits 5 and 6 are appropriate for both hospital types including acute care hospitals in waivered States, specialty hospitals, and hospital units exempt from PPS (e.g., rehabilitation and psychiatric units).

NOTE: You are now required to issue the *IM* to patients who are transferred (or admitted) to swing beds (for skilled care or less than skilled care). A swing bed is not considered a part of the hospital unit exempt from PPS. Previously, the *IM* was designed to explain immediate review rights to the beneficiary (or his/her representative) in accordance with the provisions of the Omnibus Budget Reconciliation Acts of 1986 and 1987--provisions which do not apply to continued stay notices of noncoverage involving transfers/admissions to swing beds. However, this revised IM gives general appeals information, including the name of the Quality Improvement Organization.

C. CMS-R-193 Form Instructions

Approved Notice Language.--The Adobe Acrobat PDF file version of this notice, form CMS-R-193, published by CMS on its Web site at http://www.cms.hhs.gov/medicare/bni/ is the official, replicable version of this notice.

1. Completion of the Notice.--There is no information that is required to be completed on this notice. Users (hospitals) may elect to add their identifying information, e.g., logo, name, address, telephone number, to the header, i.e., to the top of the notice above the title "IMPORTANT MESSAGE FROM MEDICARE". No other modification may be made to this notice.

2. Delivery of Notice.--Hospitals participating in the Medicare program are required to deliver this notice, the "IMPORTANT MESSAGE FROM MEDICARE," to all Medicare beneficiaries (including those enrolled in a Medicare managed care health plan) at or about the time of a Medicare beneficiary's admission or during the course of his or her hospital stay.

3. OMB Notice.--According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0692. The time required to complete this information collection is estimated to average 1 minute per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850.

315. MEDICARE PARTICIPATING PHYSICIANS/SUPPLIERS DIRECTORY (MEDPARD)

Section 9332(e) of OBRA 1986 requires you to make available to your patients the Participating Physician Directory that carriers publish for the area you service. Also, if your personnel, in the inpatient, outpatient, or emergency areas, refer a patient to a nonparticipating physician for further medical care on an outpatient basis, they must inform the patient that the physician is a nonparticipating physician who may, or may not, accept assignment. They must identify at least one qualified participating physician listed in the Directory who provides the type of service needed.

Carriers will furnish you copies of the Directory and updated copies each year.

350. OUTPATIENT REGISTRATION PROCEDURES

A. Patient Identification.--Upon registration of a Medicare beneficiary, or as soon thereafter as practical, ask the patient for his/her health insurance card to obtain the HICN. (See §304.) If the patient is unable to provide it, contact the SSO for assistance.

B. Determining Who To Bill.--The procedures for determining whether another payer exists are the same for outpatient situations as for inpatient. Therefore, follow the admission questionnaire procedures found in §301.2 for developing other coverage. If you identify another insurer primary to Medicare, follow §§259, 262, 263, 264, or 289, as appropriate.

C. Source of Admission.--Your registration process must distinguish whether the referral source for this registration/admission is from:

- Your hospital;
- An encounter in another hospital (see subsection F for definition of encounter); or
- Any other source.

Determine the appropriate source of admission by asking the patient who referred him/her to your hospital and whether the referral took place as a result of an encounter in your hospital, another hospital, or elsewhere.

The NUBC decided to use the inpatient coding structure for outpatient source of admission coding on the bill. This requires you to make further distinction as provided by the following coding structure.

1. Physician Referral.--The patient was referred to this facility for outpatient or referenced diagnostic services by his or her personal physician or the patient independently requested outpatient services (self-referral).

2. Clinic Referral.--The patient was referred to this facility for outpatient or referenced diagnostic services by this facility's clinic or other outpatient department physician.

3. HMO Referral.--The patient was referred to this facility for outpatient or referenced diagnostic services by an HMO physician.

4. Transfer From a Hospital.--The patient was referred to this facility for outpatient or referenced diagnostic services by a physician of another acute care facility.

5. Transfer From a SNF.--The patient was referred to this facility for outpatient or referenced diagnostic services by a physician of the SNF where he or she is an inpatient.

6. Transfer From Another Health Care Facility.--The patient was referred to this facility for outpatient or referenced diagnostic services by a physician of another health care facility where he or she is an inpatient.

7. Emergency Room.--The patient was referred to this facility for outpatient or referenced diagnostic services by this facility's emergency room physician.

8. Court/Law Enforcement.--The patient was referred to this facility for outpatient or referenced diagnostic services upon the direction of a court of law, or upon the request of a law enforcement agency representative.

Determine the proper source of admission code based on the patient's response and/or any other information you may have available from your pre-registration records or scheduling data. Enter the proper source of admission code in item 18 of Form HCFA-1450, also know as the UB-92.

If the patient was referred for services by a physician at:

- o Your hospital, enter codes 2 or 7;
- o Another hospital, enter code 4; or
- o Some other source, enter codes 1, 3, 5, 6, or 8, as appropriate.

If you are sure the admission source is not from your hospital or another hospital but cannot determine which of the codes apply, enter code 1 on Medicare bills. However, incorrect reporting where services were referred by staff at your hospital or another hospital (codes 2, 4, or 7 are applicable) is considered program abuse and subject to applicable sanctions.

D. Type of Bill.--To bill properly, assign a type of bill based on whether:

- o Services are for referred diagnostic tests ordered by a source other than a clinic, emergency room, or other outpatient department physician at your facility. For example, if the patient is seen by a physician in his office and is referred to your facility for a diagnostic test the bill type will be a 14X; or
- o Services are related to consultation or therapy managed by professional staff in your emergency room, clinic or other outpatient area as a result of an encounter in your hospital. This may include diagnostic tests. For example, if the patient is seen by a physician at your clinic for consultation and diagnostic testing, the bill type will be a 13X.

E. Definition of Diagnostic Services.--A service is "diagnostic" if it is an examination or procedure to which the patient is subjected, or which is performed on materials derived from a hospital outpatient, to obtain information to aid in the assessment of a medical condition or the identification of a disease. (See §230.3A.) Among these examinations and tests are diagnostic laboratory services such as hematology and chemistry, diagnostic X-rays, isotope studies, EKGs, pulmonary function tests, psychological tests and other tests given to determine the nature and severity of an ailment or injury.

F. Definition of Encounter.--The term "encounter" means a direct personal contact in the hospital between a patient and a physician, or other person who is authorized by State law and, if applicable, by hospital staff by-laws to order or furnish services for diagnosis or treatment of the patient. Direct personal contact does not include telephone contacts between a patient and physician. Nor is the compensation arrangement between the physician and the hospital relevant to whether an encounter has occurred. Patients will be treated as hospital outpatients for purposes of billing for certain diagnostic services that were ordered during or as a result of an encounter that occurred while they were in an outpatient status at the hospital. If a Medicare outpatient is referred to another provider or supplier for further diagnostic testing or other diagnostic services as a result of an encounter that occurs in your hospital, you are responsible for arranging with the other entity for the furnishing of services. You are not required to verify that all ordered services are furnished but only to assure that when it is necessary to refer a patient to an outside entity, the referral is made to a provider or supplier with which you have an arrangement. This requirement is necessary to assure that billing for services that are furnished is processed through your hospital.

When a patient has follow-up visits with a physician in the hospital following an initial encounter, each subsequent visit to the physician will be treated as a separate encounter.

399. EXHIBITS

Exhibit 1. Certificate of Social Insurance Award

Exhibit 2. Temporary Notice of Medicare Eligibility

Exhibit 4. Notice to Beneficiary of PRO Review of Need for Continued Hospitalization

Exhibit 5. Important Message from Medicare (CMS-R-193)

Exhibit 6. Spanish Important Message from Medicare (CMS-R-193)

Exhibit 5
Important Message from Medicare (CMS-R-193)

IMPORTANT MESSAGE FROM MEDICARE

YOUR RIGHTS AS A HOSPITAL PATIENT

- You have the right to receive necessary hospital services covered by Medicare, or covered by your Medicare Health Plan ("your Plan") if you are a Plan enrollee.
- You have the right to know about any decisions that the hospital, your doctor, your Plan, or anyone else makes about your hospital stay and who will pay for it.
- Your doctor, your Plan, or the hospital should arrange for services you will need after you leave the hospital. Medicare or your Plan may cover some care in your home (home health care) and other kinds of care, if ordered by your doctor or by your Plan. You have a right to know about these services, who will pay for them, and where you can get them. If you have any questions, talk to your doctor or Plan, or talk to other hospital personnel.

YOUR HOSPITAL DISCHARGE & MEDICARE APPEAL RIGHTS

Date of Discharge: When your doctor or Plan determines that you can be discharged from the hospital, you will be advised of your planned date of discharge. You may appeal if you think that you are being asked to leave the hospital too soon. If you stay in the hospital after your planned date of discharge, it is likely that your charges for additional days in the hospital will not be covered by Medicare or your Plan.

Your Right to an Immediate Appeal without Financial Risk: When you are advised of your planned date of discharge, if you think you are being asked to leave the hospital too soon, you have the right to appeal to your Quality Improvement Organization (also known as a QIO). The QIO is authorized by Medicare to provide a second opinion about your readiness to leave. You may call Medicare toll-free, 24 hours a day, at 1-800-MEDICARE (1-800-633-4227), or TTY/TTD: 1-877-486-2048, for more information on asking your QIO for a second opinion. If you appeal to the QIO by noon of the day after you receive a noncoverage notice, you are not responsible for paying for the days you stay in the hospital during the QIO review, even if the QIO disagrees with you.
The QIO will decide within one day after it receives the necessary information.

Other Appeal Rights: If you miss the deadline for filing an immediate appeal, you may still request a review by the QIO (or by your Plan, if you are a Plan enrollee) before you leave the hospital. However, you will have to pay for the costs of your additional days in the hospital if the QIO (or your Plan) denies your appeal. You may file for this review at the address or telephone number of the QIO (or of your Plan).

OMB Approval No. 0938-0692. Form No. CMS-R-193 (January 2003)

Exhibit 6
Spanish Important Message from Medicare (CMS-R-193)

MENSAJE IMPORTANTE DE MEDICARE

SUS DERECHOS COMO PACIENTE EN UN HOSPITAL

- Usted tiene derecho a recibir los servicios de hospital necesarios cubiertos por Medicare o por su Plan de Seguro de Medicare ("su Plan"), si está inscrito en un Plan.
- Usted tiene derecho a estar al tanto de cualquier decisión que el hospital, su médico, su Plan, o cualquier otra persona tome sobre su estadía en el hospital y quién pagará por la misma.
- Su médico, su Plan, o el hospital debería hacer los arreglos de los servicios que necesitará después de salir del hospital. Medicare o su Plan podría cubrir algunos de los cuidados en el hogar (cuidado de salud en el hogar) y otros tipos de cuidado si lo ordena su médico o su Plan. Usted tiene derecho a saber sobre estos servicios, quién va a pagar por ellos y dónde puede recibirlos. Si tiene alguna pregunta, hable con su médico o su Plan, o hable con otro personal del hospital.

INFORMACIÓN SOBRE SU SALIDA DEL HOSPITAL Y DERECHOS DE APELACIÓN

Fecha de Alta: Cuando su médico o Plan determine que puede ser dado de alta del hospital, le informarán la fecha planificada para su alta. Usted podría apelar si considera que le están pidiendo que salga del hospital antes de tiempo. Si permanece en el hospital después de la fecha para la cual está programada su alta, es problable que Medicare o su Plan no cubran los días adicionales que permanezca en el hospital.

Su Derecho a una Apelación Inmediata sin Riesgos Financieros: Cuando le informen la fecha para la cual está planificada su alta del hospital, si usted considera que le están dando de alta del hospital antes de tiempo, tiene derecho a apelar a su *Organización Para el Mejoramiento de la Calidad* (conocida como QIO, por sus siglas en inglés). La QIO cuenta con la autorización de Medicare para proveerle una segunda opinión sobre si usted está preparado o no para salir del hospital. Puede llamar gratis, 24 horas al día al 1-800-MEDICARE (1-800-633-4227) o TTY/TTD: 1-877-486-2048 para obtener más información sobre como pedir una segunda opinión a la QIO.
Si usted apela a la QIO antes del mediodía del día después de que reciba el aviso de no cobertura, usted no será responsable por los costos por los días que se quedó en el hospital mientras la QIO hace la revisión, aún si la QIO no está de acuerdo con usted. La QIO tomará una decisión en un día, después de que reciba la información necesaria.

Otros Derechos de Apelación: Si usted no cumple con la fecha límite para solicitar una apelación inmediata, aún podría solicitar una revisión de la QIO (o por su Plan, si está inscrito en un Plan) antes de salir del hospital. Sin embargo, tendrá que pagar el costo por los días adicionales en el hospital, si la QIO (o su Plan) deniega su apelación. Podría solicitar esta revisión a la dirección o número de teléfono de la QIO o su Plan.

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