



Medicare Utilization Review Version

KEY CONCEPTS OUTLINE

Module 8: Medicare Inpatient Notices

I. Important Message from Medicare (“IM”)

A. General Rule

1. Medicare beneficiaries have a right to an expedited review of their discharge when the hospital and their physician determine inpatient care is no longer necessary. <See *Medicare Claims Processing Manual*, Chapter 30 § 200.2>
2. Hospitals are responsible for notifying beneficiaries of their right to an expedited determination through a standard form (the Important Message from Medicare). <*Medicare Claims Processing Manual*, Chapter 30 § 200.2, 200.3.3>

B. Scope of Requirement

1. All hospitals must comply, including PPS and non-PPS hospitals (e.g., CAHs). <See *Medicare Claims Processing Manual*, Chapter 30 § 200.1; 42 C.F.R. 405.1205(a)(1)>
2. The IM must be delivered to all beneficiaries covered by Medicare, including Medicare as a primary or secondary payer and beneficiaries with a Medicare Advantage plan. <See *Medicare Claims Processing Manual*, Chapter 30 § 200.2, 42 C.F.R. 422.620>
 - a. The IM is delivered even if the beneficiary agrees with the hospital discharge. <See *Medicare Claims Processing Manual*, Chapter 30 § 200.3.3>
3. The IM is not delivered if the beneficiary is not entitled to an expedited determination, and hospitals should not provide an IM “just in case” or routinely to all beneficiaries. Situations in which the beneficiary is not entitled to an expedited determination include:
 - a. The beneficiary is not in a Medicare covered inpatient hospital stay.
 - b. The beneficiary transfers to another hospital at an inpatient level of care;

- c. The beneficiary exhausts their benefits, including lifetime reserve days, prior to or while in the hospital;
- d. The beneficiary ends care on their own initiative (e.g., elects hospice);
- e. The hospital changes the beneficiary's status under procedures for condition code 44;
- f. The physician does not concur with the discharge. <See *Medicare Claims Processing Manual*, Chapter 30 §§ 200.2 and 200.2.1>

C. The Required Form

- 1. The IM is the required form for providing beneficiaries notice of their discharge appeal rights and is available in English, Spanish, and large print versions. Handout 10 is the current IM.
 - a. The latest IM form has an expiration date 12/31/2025 and can be downloaded from the Beneficiary Notice Initiative (BNI) page. <cms.gov website, "Beneficiary Notice Initiative (BNI)" page, "FFS & MA IM" page>

Link: Beneficiary Notice Initiative under Medicare-Related Sites – General

The IM must be provided within two specific timeframes related to:

- The date of admission ("First IM"); and
- The date of discharge ("Follow-up Copy").

D. Timing of the IM Notice

- 1. First IM Notice
 - a. The First IM is delivered at or near admission, but in all cases:
 - i. No more than seven calendar days before admission, as part of pre-admission protocols; and
 - ii. No later than two calendar days after admission. <See *Medicare Claims Processing Manual*, Chapter 30 § 200.3.4.1>
- 2. Follow-up IM Notice

- a. The follow-up IM must be delivered within two calendar days of discharge and at least four hours before discharge. <See *Medicare Claims Processing Manual*, Chapter 30 § 200.3.4.2>
 - i. The IM can be delivered once the discharge is planned. A discharge order is not required before giving the IM. <See *Medicare Claims Processing Manual*, Chapter 30 § 200.3.4.1
 - ii. The follow-up IM applies when the beneficiary is physically discharged from the hospital or discharged to a lower level of care in the same hospital such as swing bed or custodial care. <See *Medicare Claims Processing Manual*, Chapter 30 § 200.2>
 - iii. The same notice may function as the First IM and the follow-up IM if it meets both specified timeframes. <See *Medicare Claims Processing Manual*, Chapter 30 § 200.3.4.2>

Example: Patient is admitted on Monday. The IM is provided on Wednesday. Patient is discharged on Friday. No additional notice is required because the IM on Wednesday occurred within two calendar days of discharge.

- b. The follow-up IM can be provided in two ways:
 - i. Deliver a new copy of the IM and have the beneficiary sign and date the form again; or
 - ii. Deliver a copy of the signed First IM and have the beneficiary initial and date in the “Additional Information” section. <See *Medicare Claims Processing Manual*, Chapter 30 § 200.3.4.2, 200.3.8>

E. Delivery of the IM Notice

1. The IM is a standardized two-page form and may not be altered except as allowed. Allowed alterations include:
 - a. Adding a hospital logo, provided it does not shift text to the second page;
 - b. Filling in the beneficiary’s name and hospital issued number, which may not be the patient’s Social Security Number, HICN, or Medicare Beneficiary Identifier (MBI);
 - c. Filling in the contact information for the QIO for the state;

- d. Adding information in the “Additional Information” section relevant to the beneficiary’s situation or delivery of the form. <See *Medicare Claims Processing Manual*, Chapter 30 § 200.3.1, 200.3.2>
2. The hospital may provide the IM through electronic delivery (i.e., viewed on an electronic screen), including a digitally captured signature, but the beneficiary must have the option of requesting paper delivery and must be provided a paper copy of the completed, signed IM. <See *Medicare Claims Processing Manual*, Chapter § 200.3.3>
3. Beneficiary Comprehension
 - a. If the beneficiary cannot read the contents of the IM or comprehend the oral explanation, the hospital must use translators, interpreters, or assistive technology to ensure comprehension of the notice. <See *Medicare Claims Processing Manual*, Chapter § 200.3.6>
4. Provision to a Beneficiary’s Representative
 - a. The IM may be delivered to a beneficiary’s appointed representative, authorized representative, or a person representing the patient if there is no appointed or authorized representative. <See *Medicare Claims Processing Manual*, Chapter 30 § 200.3.7>
 - i. An appointed representative is an individual designated by the beneficiary to act on their behalf via an “Appointment of Representative” form (CMS-1696). For more information, see *Medicare Claims Processing Manual*, Chapter 29 § 270. <See *Medicare Claims Processing Manual*, Chapter 30 § 200.3.7>
 - ii. An authorized representative is an individual who may make health care decisions on a beneficiary’s behalf under State or other applicable law (e.g., a legal guardian or someone named in a durable power of attorney). <See *Medicare Claims Processing Manual*, Chapter 30 § 200.3.7>
 - b. If the beneficiary is incapacitated and has no appointed or authorized representative, a person the hospital has determined could reasonably represent the beneficiary may receive the IM on their behalf. <See *Medicare Claims Processing Manual*, Chapter 30 § 200.3.7>
 - i. The person acting on the beneficiary’s behalf should act in their best interests, in manner protective of their interests and have no relevant conflict of interest. <See *Medicare Claims Processing Manual*, Chapter 30 § 200.3.7>

- ii. When notice is provided to a person acting on the beneficiary's behalf, the hospital should document the name of the staff person initiating contact, the name of the person contacted and the date, time and method of contact (e.g., in person, telephone). <See *Medicare Claims Processing Manual*, Chapter 30 § 200.3.7>

c. Delivery to off-site representatives

- i. If the beneficiary's representative or the person acting on their behalf is not physically present, the hospital may deliver the IM by telephone. The date of the telephone call is considered the date of receipt. <See *Medicare Claims Processing Manual*, Chapter 30 § 200.3.7>
- ii. When the hospital provides an IM by telephone they should:
 - a) Verbally convey all contents of the IM;
 - b) Document in the "Additional Information" section that the information was verbally communicated to the representative, along with the name of the staff person, the name of the representative, the date and time of the telephone contact and the telephone number called; and
 - c) Provide the representative with a copy of the IM by:
 - 1) Mailing a copy to the representative the same day as the telephone contact by certified, return receipt or other method with signed verification of receipt;
 - 2) Emailing or faxing a copy via HIPAA compliant secure fax or email if the representative agrees. <See *Medicare Claims Processing Manual*, Chapter 30 § 200.3.7>

5. Beneficiary or Representative Signature

- a. The beneficiary or their representative must sign and date the IM confirming their receipt and understanding. <See *Medicare Claims Processing Manual*, Chapter 30 § 200.3.3>
- b. If the beneficiary refuses to sign the form, the hospital should annotate the form indicating the date of refusal of the notice, which is considered the date of receipt of the notice. <See *Medicare Claims Processing Manual*, Chapter 30 § 200.3.5>

Case Study 1

Facts: A Medicare patient is admitted to the hospital as an inpatient on Sunday evening. The First IM was given to the patient on Monday morning. The hospital staff explained to the patient their discharge appeal rights and the patient indicated they understood the information and signed the IM form. On Tuesday, the physician discusses with the patient her plans to discharge the patient the following afternoon. Is the hospital required to provide a follow-up IM?

II. Beneficiary Request for Expedited Review

- A. A beneficiary who disagrees with their discharge from the hospital may request an expedited review by contacting the QIO at the contact information provided in the IM. <See *Medicare Claims Processing Manual*, Chapter 30 § 200.4.1.1>
 1. A beneficiary's request is considered timely if it is made before midnight on the day of discharge and the beneficiary has not left the hospital. <See *Medicare Claims Processing Manual*, Chapter 30 § 200.4.1.1>
 - a. For a timely request, and the QIO agrees with the hospital, the patient's liability begins at noon on the day after the QIO notifies the beneficiary of their decision. <See *Medicare Claims Processing Manual*, Chapter 30 § 200.4.2>
 - b. For a timely request, and the QIO agrees with the beneficiary, the hospital should issue a new follow-up IM when a new discharge date is determined. <See *Medicare Claims Processing Manual*, Chapter 30 § 200.4.2>
 2. The QIO must make its determination and notify the beneficiary and hospital no later than one calendar day after it receives all requested information. <See *Medicare Claims Processing Manual*, Chapter 30 § 200.5.6>
 - a. The QIO must also notify the beneficiary of their right to an expedited reconsideration by the QIO and provide them with information regarding how to request a reconsideration. <See *Medicare Claims Processing Manual*, Chapter 30 § 200.5.6>
 - b. If the QIO does not receive requested information from the hospital, the QIO may make their decision based on the information available or delay a decision until the information is provided, but the hospital will be financially liable for services during the delay. <See *Medicare Claims Processing Manual*, Chapter 30 § 200.5.6>

3. A beneficiary may make an untimely request for an expedited review while still in the hospital or up to 30 days after discharge. <See *Medicare Claims Processing Manual*, Chapter 30 § 200.4.3>
 - a. For an untimely request, and the patient remains in the hospital, the QIO is required to notify the beneficiary and hospital of their determination within 2 calendar days and the patient is not protected from liability while the QIO makes their determination. <See *Medicare Claims Processing Manual*, Chapter 30 § 200.4.3>

Note: the beneficiary is still protected by the Limitations on Liability statute and the hospital must provide notice in the form of a Hospital Issued Notice of Non-coverage (HINN), discussed below, to hold the patient financially liable.
 - b. For an untimely request, and the patient has been discharged from the hospital, the QIO is required to notify the beneficiary and the hospital of their determination within 30 calendar days. <See *Medicare Claims Processing Manual*, Chapter 30 § 200.4.3>

III. Hospital Responsibilities when Beneficiary Requests Expedited Review

A. Detailed Notice of Discharge (DND)

1. When a beneficiary makes a request for an expedited review, the hospital must deliver a DND no later than noon of the day following notification of the request by the QIO. <See *Medicare Claims Processing Manual*, Chapter 30 §§ 200.4.4, 200.4.5>
2. The DND is the required form for providing beneficiaries information about their discharge following an appeal and is available in English, Spanish and large print versions. Handout 11 is the current DND.
 - a. The latest DND form has an expiration date 12/31/2025 and can be downloaded from the Beneficiary Notice Initiative (BNI) page. <cms.gov website, “Beneficiary Notice Initiative (BNI)” page, “FFS & MA IM” page>

Link: Beneficiary Notice Initiative under Medicare-Related Sites – General

3. Completion of the DND

- a. The DND is a standardized one-page form and may not be altered except as allowed. <See *Medicare Claims Processing Manual*, Chapter 30 § 200.4.5>

- b. On the DND, the hospital must complete the form with:
 - i. The facts specific to the beneficiary's discharge and determination that coverage should end;
 - ii. A specific and detailed explanation of why services are either no longer reasonable and necessary or no longer covered; and
 - iii. A description of and citation to Medicare coverage rules, instructions, or other policies relied on for the review. <See *Medicare Claims Processing Manual*, Chapter 30 § 200.4.5>
- c. The DND does not have a signature line for the beneficiary to sign, but if the beneficiary refuses to accept the DND, the hospital should annotate the notice accordingly. <See *Medicare Claims Processing Manual*, Chapter 30 § 200.4.5>

B. Documents Supplied to the QIO

- 1. The hospital must forward to the QIO the IM and DND provided to the beneficiary no later than noon of the day following notification of the request by the QIO. <See *Medicare Claims Processing Manual*, Chapter 30 § 200.4.4>
- 2. The hospital must provide the QIO with all requested information by phone, in writing, or electronically. If information is provided by phone, the hospital must keep a written record of the information provided in the beneficiary's medical record. <See *Medicare Claims Processing Manual*, Chapter 30 § 200.4.4>

C. Documents Supplied to the Patient

- 1. At the beneficiary's request, the hospital must provide access to or a copy of the information sent to the QIO, including written records of information provided by telephone. <See *Medicare Claims Processing Manual*, Chapter 30 § 200.4.4>
 - a. The hospital must provide the requested information by close of the first business day following the request and may charge a reasonable copying/delivery fee. <See *Medicare Claims Processing Manual*, Chapter 30 § 200.4.4>

Case Study 2

Facts: On Friday morning, hospital staff discuss with a patient the physician's plan to discharge the patient home that afternoon. The patient informs the hospital staff that her daughter, who is coming to care for her after her discharge, is not going to arrive until Monday morning. The patient explains to the hospital that she does not want to leave the hospital until her daughter arrives even though she understands that the hospital has determined her care is no longer medically necessary and her physician is planning to discharge her.

The patient elects to appeal her discharge to the QIO. The QIO notifies the hospital of the patient's appeal on Friday afternoon. How long does the hospital have to provide the Detailed Notice of Discharge?

IV. Inpatient Hospital Issued Notice of Non-Coverage (HINN)

A. General Rule

1. A properly prepared and delivered HINN using CMS model language satisfies the LOL notice requirement for inpatient services that are not considered reasonable and necessary or are custodial. <See *Medicare Claims Processing Manual*, Chapter 30 §§ 40.3.1, 200, and 240>
 - a. A Pre-Admission/Admission HINN may, but is not required, to be used for services that are never covered by Medicare. <See *Medicare Claims Processing Manual*, Chapter 30 § 200.2>

B. The HINN Forms

1. The HINN forms provided by CMS are considered model forms that may be modified; however, unapproved modification of a model notice may cause the notice to be defective. <See *Medicare Claims Processing Manual*, Chapter 30 § 40.3.1>
 - a. Handout 12 is the model forms for the two most common HINNs used for inpatient hospital non-covered services:
 - i. The Pre-Admission/Admission Hospital Issued Notice of Non-Coverage
 - ii. The HINN 12 – Non-covered Continued Stay

Link: Beneficiary Notice Initiative under Medicare-Related Sites – General

C. Timing of Delivery

1. Hospitals provide a HINN to beneficiaries prior to admission or at any point during an inpatient stay if they determine the care the beneficiary is or will receive is not covered because it is not medically necessary, not delivered in the most appropriate setting, or is custodial in nature. <CMS.gov, “FFS HINNs” website; see *Medicare Claims Processing Manual*, Chapter 30 §§ 200 and 240>
2. Pre-Admission HINN
 - a. If the Pre-Admission HINN is provided prior to the beneficiary’s admission to the hospital, the beneficiary will be responsible for all charges during the non-covered stay. <See *Medicare Claims Processing Manual*, Chapter 30 § 240.2>
3. Admission HINN
 - a. If the Admission HINN is provided upon admission, liability depends on when the patient is provided the HINN. <See *Medicare Claims Processing Manual*, Chapter 30 § 240.2>
 - i. If the HINN is provided before 3pm, the beneficiary will be responsible for all charges incurred after provision of the notice.
 - ii. If the HINN is provided after 3pm, the beneficiary will be responsible for all charges beginning on the day following the date of the notice.
4. Continued Stay HINN
 - a. A HINN 12 may be delivered at the direction of the QIO following a beneficiary appeal or if the beneficiary’s continued stay is no longer necessary, but the beneficiary is not appealing their discharge.

D. Requirements for Delivery

1. Hospitals should follow all requirements for in-person delivery, beneficiary representatives, beneficiary comprehension, signature, and date (including refusal to sign), and delivery and retention for the Important Message (IM) from Medicare, in *Medicare Claims Processing Manual*, Chapter 30 § 200.3.1. <See *Medicare Claims Processing Manual*, Chapter 30 § 240.1>

CMS has not published detailed manual instructions for HINN 12. CMS has included “Instructions for Completion of the HINN 12” in the same zip file as the HINN forms on the BNI HINN page of the CMS website.

Case Study 3

Facts: A Medicare beneficiary, with a BMI of 32, is admitted for gastric bypass surgery to assist with weight loss and control of his Type II diabetes. The NCD for bariatric surgery states it is covered for beneficiaries that have a BMI of ≥ 35 , have at least one obesity related co-morbidity and have been unsuccessful with medical treatment for their obesity. Is the hospital required to provide the patient with a notice? If so, which notice?

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CASE STUDIES

Case Study 1

Facts: A Medicare patient is admitted to the hospital as an inpatient on Sunday evening. The First IM was given to the patient on Monday morning. The hospital staff explained to the patient their discharge appeal rights and the patient indicated they understood the information and signed the IM form. On Tuesday, the physician discusses with the patient her plans to discharge the patient the following afternoon. Is the hospital required to provide a follow-up IM?

Analysis: No, the same notice may function as the First IM and the follow-up IM as long as it falls within the required time frame, i.e., within 2 days of admission and at least 4 hours prior to discharge.

Refer to *Medicare Claims Processing Manual*, Chapter 30 § 200.3.4.2.

Case Study 2

Facts: On Friday morning, hospital staff discuss with a patient the physician's plan to discharge the patient home that afternoon. The patient informs the hospital staff that her daughter, who is coming to care for her after her discharge, is not going to arrive until Monday morning. The patient explains to the hospital that she does not want to leave the hospital until her daughter arrives even though she understands that the hospital has determined her care is no longer medically necessary and her physician is planning to discharge her.

The patient elects to appeal her discharge to the QIO. The QIO notifies the hospital of the patient's appeal on Friday afternoon. How long does the hospital have to provide the Detailed Notice of Discharge?

Analysis: The hospital should provide the DND as soon as possible but not later than noon on Saturday. Note the QIO should complete their review by Sunday and the patient would become liable on Monday.

Refer to *Medicare Claims Processing Manual*, Chapter 30 §§ 200.4.4 and 200.4.5.

Case Study 3

Facts: A Medicare beneficiary, with a BMI of 32, is admitted for gastric bypass surgery to assist with weight loss and control of his Type II diabetes. The NCD for bariatric surgery states it is covered for beneficiaries that have a BMI of ≥ 35 , have at least one obesity related co-morbidity and have been unsuccessful with medical treatment for their obesity. Is the hospital required to provide the patient with a notice? If so, which notice?

Analysis: Yes, the hospital should provide a Preadmission/Admission HINN to the patient informing him that his procedure is not covered by Medicare. If the hospital fails to inform the patient that his procedure is not covered by Medicare, the hospital, rather than the patient will be liable for the procedure. The IM notice is not required in this case because the stay is not covered by Medicare.

Refer to *Medicare Claims Processing Manual*, Chapter 30 §§ 240.2 and 200.2.

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Excerpt from Medicare Claims Processing Manual, Chapter 30

150.15 - Supplier's Right to Recover Resaleable Items for Which Refund Has Been Made

(Rev. 1587, Issued: 09-05-08, Effective: 03-03-08, Implementation: 03-01-09)

If the contractor denies Part B payment for an item of medical equipment or supplies on the basis of §1862(a)(1), §1834(a)(17)(B), §1834(j)(1), or §1834(a)(15) of the Act, and the beneficiary is relieved of liability for payment for that item under §1834(a)(18) of the Act, the effect of the denial, subject to State law, cancels the contract for the sale or rental of the item and, if the item is resaleable or re-rentable, permits the supplier to repossess that item for resale or re-rental. In the case of consumable items or any other items which are not fit for resale or re-rental and which cannot be made fit for resale or re-rental, suppliers are strongly discouraged from recovering these items since such actions reasonably could be viewed as purely punitive in nature. If a supplier makes proper refund under §1834(a)(18) of the Act, Medicare rules do not prohibit the supplier from recovering from the beneficiary items which are resaleable or re-rentable.

Alternatively, when the contract of sale or rental is cancelled on the basis described above, whether or not the supplier physically repossesses the resaleable or re-rentable item, the supplier may enter into a new sale or rental transaction with the beneficiary with respect to that item as long as the beneficiary has been informed of their liability. If the circumstances which preclude payment for the item have been removed, e.g., the supplier has now obtained a supplier number, the supplier may submit to the contractor a new Part B claim based on the resale or re-rental of the item to the beneficiary. If Part B payment is still precluded, the supplier can establish the beneficiary's liability for payment for the denied resold or re-rented item by giving the beneficiary an ABN notifying the beneficiary of the likelihood that Medicare will not pay for the item and obtaining the beneficiary's signed agreement to pay for the item. The resale or re-rental of the item to the beneficiary does not change the fact that the beneficiary is relieved of liability in connection with the original transaction.

Under the capped-rental method, if the contractor determines that the supplier is obligated to make a refund, the supplier must repay Medicare those rental payments that the supplier has received for the item. However, the Medicare beneficiary must return the item to the supplier.

200 - Expedited *Determinations of Inpatient Hospital Discharges*

(Rev. 11210; Issued: 01-21-2022; Effective: 04-21-2022; Implementation: 04-21-2022)

Medicare beneficiaries who are hospital inpatients have a statutory right to appeal to a BFCC-QIO for an expedited review when a hospital, with physician concurrence, determines that inpatient care is no longer necessary.

200.1 - Statutory Authority

(Rev. 11210; Issued: 01-21-2022; Effective: 04-21-2022; Implementation: 04-21-2022)

- *Sections 1866(a)(1)(M),*
- *1869(c)(3)(C)(iii)(III), and*
- *1154(e) of the Act.*

This process was implemented through a final rule with comment period, CMS-1655-F (81 FR 56761, 57037 through 57052, August 22, 2016), effective October 1, 2016. The resulting regulations are located at 42 CFR Part 405.1205 and 405.1206).

There is a parallel process for beneficiaries enrolled in Medicare health plans. (See 42 CFR 422.620 - 422.622 and §100.1 in the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance.) Please see the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance for Medicare Advantage instructions.

200.2 - Scope

(Rev. 11210; Issued: 01-21-2022; Effective: 04-21-2022; Implementation: 04-21-2022)

The expedited determination process is available to beneficiaries in Original Medicare who are being discharged from a Medicare covered inpatient hospital stay. All beneficiaries receiving covered inpatient hospital care must receive an Important Message from Medicare (IM). This includes, but is not limited to, beneficiaries in the following circumstances:

- *Beneficiaries for whom Medicare is either the primary or secondary payer.*
- *Beneficiaries with brief inpatient hospital stays.*
- *Beneficiaries physically discharged from the hospital or discharged to a lower level of care (such as a Swing Bed) in the same hospital.*

NOTE:

For purposes of these instructions, the term “beneficiary” means either beneficiary or representative, when a representative is acting for a beneficiary.

Hospitals Affected by these Instructions. *These instructions apply to hospitals as well as Critical Access Hospitals (CAHs) per section 1861(e) and section 1861(mm) of the Social Security Act. CAHs, as well as psychiatric hospitals, are included in the scope of these instructions.*

200.2.1 - Exceptions

(Rev. 11210; Issued: 01-21-2022; Effective: 04-21-2022; Implementation: 04-21-2022)

The following situations are not eligible for an expedited determination. Hospitals should not deliver an IM in these instances.

- *When a beneficiary transfers to another hospital at the same level of care (e.g., a beneficiary transfers from one hospital to another while remaining a hospital inpatient).*
- *When beneficiaries exhaust their benefits (e.g., a beneficiary reaches the number of lifetime reserve days of the Medicare inpatient hospital benefit.)*
- *When beneficiaries end care on their own initiative (e.g., a beneficiary elects the hospice benefit).*
- *Condition Code 44 (CC44) (See Section 50.3 of Chapter 1 of the Medicare Claims Processing Manual)*
- *Physician does not concur with discharge. (See Section 220 of this chapter.)*

NOTE:

The IM should only be given when an inpatient admission is pending or has occurred. It should not be given 'just in case', such as a hospital delivering to all Medicare patients being treated in a hospital emergency room.

200.3 - Important Message from Medicare (IM)

(Rev. 11210; Issued: 01-21-2022; Effective: 04-21-2022; Implementation: 04-21-2022)

The IM is subject to the Paperwork Reduction Act (PRA) process and approval by the Office of Management and Budget (OMB). The IM may only be modified as per the accompanying instructions, as well as per guidance in this section. Unapproved modifications cannot be made to the OMB-approved, standardized IM. The notice and accompanying instructions may be found online at [Hospital Discharge Appeal Notices](#).

200.3.1 - Alterations to the IM

(Rev. 11210; Issued: 01-21-2022; Effective: 04-21-2022; Implementation: 04-21-2022)

- *The IM must remain two pages. The notice can be two sides of one page or one side of two separate pages, but **must not** be condensed to one page.*

- Hospitals may include their business logo and contact information on the top of the IM. Text may not be shifted from page 1 to page 2 to accommodate large logos, address headers, etc.
- Hospitals may include information in the optional “Additional Information” section relevant to the beneficiary’s situation.

NOTE:

Including information normally included in the Detailed Notice of Discharge (DND) in the “Additional Information” section does not satisfy a hospital’s responsibility to deliver the DND, if otherwise required. See §200.4.5 ‘The Detailed Notice of Discharge (DND)’.

200.3.2 - Completing the IM

(Rev. 11210; Issued: 01-21-2022; Effective: 04-21-2022; Implementation: 04-21-2022)

Hospitals must use the OMB-approved IM (CMS-10065). Hospitals must add the following information in the corresponding blanks of the IM:

1. Patient name
2. Patient number
3. BFCC-QIO contact information

NOTE:

The Patient number may be a unique medical record or other provider-issued identification number. It may not be the Social Security Number, HICN or any other Medicare number issued to the beneficiary such as the MBI (Medicare Beneficiary Identifier).

200.3.3 - Hospital Delivery of the IM

(Rev. 11210; Issued: 01-21-2022; Effective: 04-21-2022; Implementation: 04-21-2022)

Hospitals must deliver the IM to all beneficiaries eligible for the expedited determination process per §200.2. An IM must be delivered even if the beneficiary agrees with the discharge.

- The hospital must ensure that the beneficiary or representative signs and dates the IM to demonstrate that the beneficiary or representative received the notice and understands its contents. See 200.3.7 ‘Ensuring Beneficiary Comprehension’.
- Use of assistive devices may be used to obtain a signature.

- *Electronic issuance of the IM is permitted.*

If a hospital elects to issue an IM viewed on an electronic screen before signing, the beneficiary must be given the option of requesting paper issuance over electronic issuance if that is what the beneficiary prefers. Regardless of whether a paper or electronic version is issued and regardless of whether the signature is digitally captured or manually penned, the beneficiary must be given a paper copy of the IM, as specified in 200.3.9, and the required beneficiary specific information must be inserted, at the time of notice delivery.

200.3.4- Required Delivery Timeframes

(Rev. 11210; Issued: 01-21-2022; Effective: 04-21-2022; Implementation: 04-21-2022)

200.3.4.1- First IM

(Rev. 11210; Issued: 01-21-2022; Effective: 04-21-2022; Implementation: 04-21-2022)

Hospitals must deliver the first copy of the IM at or near admission, but no later than 2 calendar days following the date of the beneficiary's admission to the hospital.

Hospitals may deliver the first copy of the notice if the beneficiary is seen during a preadmission visit, but not more than 7 calendar days in advance of admission.

A hospital must deliver the IM to all inpatients, including those in the hospital for a short stay.

- *Once the discharge date is planned, a hospital does not need discharge orders in advance of delivering the IM.*

Timing of First IM Delivery

Pre-Admission	<i>Up to 7 days before admission</i>
At Admission	<i>At admission</i>
After Admission	<i>Up to 2 days following admission</i>

200.3.4.2 - Follow-Up Copy of the IM

(Rev. 11210; Issued: 01-21-2022; Effective: 04-21-2022; Implementation: 04-21-2022)

Hospitals must deliver the follow up copy of the IM within 2 days of discharge. It may be given as late as four hours prior to discharge.

However, if delivery of the first IM is within 2 calendar days of the date of discharge, no follow-up notice is required. For example, if a beneficiary is admitted on Monday, the IM is delivered on Wednesday and the beneficiary is discharged on Friday, no follow-up notice is required.

- *A hospital may deliver a new copy of the IM (not a copy of the signed IM) during the required timeframes; however, the hospital must obtain the beneficiary's or representative's signature and date on the notice again at that time, or*
- *A hospital may deliver a copy of the signed, first IM with the date of delivery of the follow up copy indicated on the IM.*

Timing of Follow-Up IM Delivery

<i>No sooner than:</i>	<i>Two days before discharge</i>
<i>No later than:</i>	<i>Four hours prior to discharge</i>

Notes:

- *If two or fewer days have passed since delivery of the first IM, no follow-up IM is required.*
- *The follow-up IM may be copy of signed first IM and does not need to be re-signed.*

200.3.5 - Refusal to Sign the IM

(Rev. 11210; Issued: 01-21-2022; Effective: 04-21-2022; Implementation: 04-21-2022)

If the beneficiary refuses to sign the IM the provider should annotate the notice to that effect, and indicate the date of refusal on the notice. The date of refusal is considered to be the date of notice receipt. Beneficiaries who refuse to sign the IM remain entitled to an expedited determination.

200.3.6 - Ensuring Beneficiary Comprehension

(Rev. 11210; Issued: 01-21-2022; Effective: 04-21-2022; Implementation: 04-21-2022)

The OMB-approved standardized IM is available in English and Spanish. If the individual receiving the notice is unable to read its written contents and/or comprehend the required oral explanation, hospitals and CAHs must employ their usual procedures to ensure notice comprehension. Usual procedures may include, but are not limited to, the use of translators, interpreters, and assistive technologies. Hospitals and CAHs are reminded that recipients of Federal financial assistance have an independent obligation to provide language assistance services to individuals with limited English proficiency (LEP) consistent with section 1557 of the Affordable Care Act and Title VI of the Civil Rights Act of 1964. In addition, recipients of Federal financial assistance have an independent obligation to provide auxiliary aids and services to individuals with disabilities free of charge, consistent with section 1557 of the Affordable Care Act and section 504 of the Rehabilitation Act of 1973.

200.3.7 - IM Delivery to Representatives

(Rev. 11210; Issued: 01-21-2022; Effective: 04-21-2022; Implementation:04-21-2022)

The IM may be delivered to a beneficiary's appointed or authorized representative.

Types of Representative

<i>Appointed Representative</i>	<i>Authorized Representative</i>
<i>Appointed representatives are individuals designated by beneficiaries to act on their behalf. A beneficiary may designate an appointed representative via the "Appointment of Representative" form, the <u>CMS-1696</u>. See <u>Chapter 29 of the Medicare Claims Processing Manual, section 270.1</u>, for more information on appointed representatives.</i>	<i>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).</i>

Notes:

- However, if a beneficiary is temporarily incapacitated and there is no representative, a person (typically, a family member or close friend) whom the hospital 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 IM. 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.*
- In instances where the notice is delivered to a representative who has not been named in a legally binding document, the hospital must annotate the IM with the name of the staff person initiating the contact, the name of the person contacted, and the date, time, and method (in person or telephone) of the contact.*

Delivery to off-site representatives

If the IM must be delivered to a representative who is not physically present, the hospital is not required to personally deliver the IM or have the IM delivered via courier to the representative. The hospital must complete the IM as required and may instead telephone the representative and then mail the IM. The date and time of the telephone call is considered the receipt date of the IM.

The hospital must complete all of the following actions.

- 1. Verbally convey all contents of the IM;*

2. *Note the date and time this information is communicated verbally;*
3. *Annotate the “Additional Information” section to reflect that IM was communicated verbally to the representative; and*
4. *Annotate the “Additional Information” section with the name of the staff person initiating the contact, the name of the representative contacted by phone, the date and time of the telephone contact, and the telephone number called.*
5. *Mail a copy of the annotated IM to the representative the day telephone contact is made.*

A hard copy of the IM must be sent to the representative by certified mail, return receipt requested, or any other delivery method that can provide signed verification of delivery (e.g., FedEx, UPS). The burden is on the hospital to demonstrate that timely contact was attempted with the representative and that the notice was delivered.

If the hospital and the representative both agree, the hospital may send the notice by fax or e-mail; however, the hospital or CAH’s fax and e-mail systems must meet the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy and security requirements.

200.3.8- Notice Retention for the IM

(Rev. 11210; Issued: 01-21-2022; Effective: 04-21-2022; Implementation: 04-21-2022)

The hospital or CAH must retain the signed IM in the beneficiary’s medical record. The beneficiary receives a paper copy of the IM that includes all of the required information described in this section. Electronic notice retention is permitted.

Hospitals must also document delivery of the follow-up copy of the IM in the patient records, when applicable. For example, hospitals may use the “Additional Information” section of the IM to document delivery of the follow-up copy by adding a line for the beneficiary’s or representative’s initials and date.

200.4 - Expedited Determination Process

(Rev. 11210; Issued: 01-21-2022; Effective: 04-21-2022; Implementation: 04-21-2022)

200.4.1 - Expedited Determination Process

(Rev. 11210; Issued: 01-21-2022; Effective: 04-21-2022; Implementation: 04-21-2022)

200.4.1.1 - Timeframe for Requesting an Expedited Determination
 (Rev. 11210; Issued: 01-21-2022; Effective: 04-21-2022; Implementation: 04-21-2022)

A beneficiary who receives an IM and disagrees with the discharge may request an expedited determination by the appropriate BFCC-QIO for the state where the services were provided. The beneficiary must contact the BFCC-QIO by midnight of the day of discharge, before leaving the hospital. The beneficiary may contact the BFCC-QIO by telephone or in writing.

200.4.1.2 - Provide Information to BFCC-QIO
 (Rev. 11210; Issued: 01-21-2022; Effective: 04-21-2022; Implementation: 04-21-2022)

The beneficiary must be available to answer questions or supply information requested by the BFCC-QIO. The beneficiary may, but is not required to, supply additional information to the BFCC-QIO that he or she believes is pertinent to the case.

200.4.2 - Beneficiary Liability During BFCC-QIO Review
 (Rev. 11210; Issued: 01-21-2022; Effective: 04-21-2022; Implementation: 04-21-2022)

When the beneficiary makes a timely request for a BFCC-QIO expedited determination per §200.4.1.1, the beneficiary is not financially responsible for inpatient hospital services (except applicable coinsurance and deductibles) furnished before noon of the calendar day after the date the beneficiary receives notification of the expedited determination from the BFCC-QIO. Please see §200.5.6 for QIO notification requirements.

When Liability Begins

<i>BFCC-QIO determination</i>	<i>Liability begins</i>
<i>Unfavorable to the beneficiary</i>	<i>Noon of the day <u>after</u> the BFCC-QIO notifies the beneficiary of the decision.</i>
<i>Favorable to the beneficiary</i>	<i>Once the hospital again determines that the beneficiary no longer requires inpatient care, determines a new last date of coverage and notifies the beneficiary with a follow-up copy of the IM.</i>

200.4.3 - Untimely Requests for Review*(Rev. 11210; Issued: 01-21-2022; Effective: 04-21-2022; Implementation: 04-21-2022)**Untimely request timeframes*

<i>Beneficiary location</i>	<i>BFCC-QIO determination</i>
<i>Beneficiary in hospital</i> <i>[may request expedited review anytime while in hospital]</i>	<i>BFCC-QIO will make its determination and notify the beneficiary, the hospital, and the physician of its determination within 2 calendar days after it receives all requested information.</i>
<i>Beneficiary left hospital</i> <i>[may request expedited review within 30 days of discharge]</i>	<i>BFCC-QIO will make its determination and notify the beneficiary, the hospital, and the physician of its determination within 30 calendar days after it receives all requested information.</i>

The coverage protections discussed in §200.4.2 do not apply to a beneficiary who makes an untimely request to the BFCC-QIO.

200.4.4 - Hospital Responsibilities*(Rev. 11210; Issued: 01-21-2022; Effective: 04-21-2022; Implementation: 04-21-2022)*

When a hospital is notified by a BFCC-QIO of a beneficiary request for an expedited determination, the provider must perform all of the following actions.

- 1. Deliver the beneficiary a DNC (see §200.4.5) as soon as possible, but no later than noon of the day after BFCC-QIO notification;*
- 2. Supply the BFCC-QIO with copies of the IM and DNC as soon as possible, but no later than noon of the day after BFCC-QIO notification;*
- 3. Supply all information, including medical records, requested by the BFCC-QIO. The BFCC-QIO may allow this required information to be supplied via phone, writing, or electronically. If supplied via phone, the provider must keep a written record of the information it provides within the patient record; and*
- 4. Furnish the beneficiary, at their request, with access to or copies of any documentation it provides to the BFCC-QIO. The hospital may charge the beneficiary a reasonable amount to cover the costs of duplicating and delivering the documentation. This documentation must be provided to the beneficiary by close of business of the first day after the material is requested.*

200.4.5 - The Detailed Notice of Discharge (DND)

(Rev. 11210; Issued: 01-21-2022; Effective: 04-21-2022; Implementation: 04-21-2022)

The Detailed Notice of Discharge (DND) is subject to the Paperwork Reduction Act (PRA) process and approval by the Office of Management and Budget (OMB). The DND may only be modified as per the accompanying instructions, as well as per guidance in this section. Unapproved modifications cannot be made to the OMB-approved, standardized DND. The notice and accompanying instructions may be found online at <https://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices>

Hospitals are responsible for the delivery of the DND to beneficiaries who request an expedited determination by the BFCC-QIO.

The DND must contain all the following information:

- 1. The facts specific to the beneficiary's discharge and provider's determination that coverage should end.*
- 2. A specific and detailed explanation of why services are either no longer reasonable or necessary or no longer covered.*
- 3. A description of, and citations to, the Medicare coverage rule, instruction, or other policies applicable to the review.*

The delivery must occur in person by noon of the day after the BFCC-QIO notifies the provider that the beneficiary has requested an expedited determination.

The DND does not require a signature but should be annotated in the event of a beneficiary's refusal to accept the notice upon delivery.

200.5 – BFCC-QIO Responsibilities

(Rev. 11210; Issued: 01-21-2022; Effective: 04-21-2022; Implementation: 04-21-2022)

200.5.1 - Receive Beneficiary Requests for Expedited Review

(Rev. 11210; Issued: 01-21-2022; Effective: 04-21-2022; Implementation: 04-21-2022)

BFCC-QIOs must be available to receive beneficiary requests for review 24 hours a day, 7 days a week.

200.5.2 - Notify Hospitals and Allow Explanation of Why Covered Services Should End

(Rev. 11210; Issued: 01-21-2022; Effective: 04-21-2022; Implementation: 04-21-2022)

When the BFCC-QIO receives a request from a beneficiary, the BFCC-QIO must immediately notify the provider of services that a request for an expedited determination

was made. If the request is received after normal working hours, the BFCC-QIO should notify the provider as soon as possible on the morning after the request was made.

200.5.3 - *Validate Delivery of the IM*

(Rev. 11210; Issued: 01-21-2022; Effective: 04-21-2022; Implementation: 04-21-2022)

The BFCC-QIO should determine that IM delivery was valid if all of the following criteria are met:

- *The notice used is the OMB approved IM published by CMS.*
- *The notice was delivered timely per 200.3.4.*
- *The notice was signed and dated by the beneficiary.*

If the BFCC-QIO determines that the hospital did not deliver a valid notice, the BFCC-QIO will provide education to the hospital on valid notice requirements.

200.5.4 - *Solicit the Views of the Beneficiary*

(Rev. 11210; Issued: 01-21-2022; Effective: 04-21-2022; Implementation: 04-21-2022)

The BFCC-QIO must solicit views of the beneficiary who requested the expedited determination.

200.5.5 - *Solicit the Views of the Hospital*

(Rev. 11210; Issued: 01-21-2022; Effective: 04-21-2022; Implementation: 04-21-2022)

The BFCC-QIO must afford the provider an opportunity to explain why the discharge is appropriate.

200.5.6 - *Make Determination and Notify Required Parties*

(Rev. 11210; Issued: 01-21-2022; Effective: 04-21-2022; Implementation: 04-21-2022)

No later than one calendar day after it receives all requested information, the BFCC-QIO must make its determination on whether the discharge is appropriate based on medical necessity or other Medicare coverage policies.

The BFCC-QIO must perform the following actions.

1. *Notify the beneficiary, the beneficiary's physician, and the provider of services of its determination. This notification must include the rationale for the determination and an explanation of Medicare payment consequences and beneficiary liability.*
2. *Inform the beneficiary of the right to an expedited reconsideration by the BFCC-QIO and how to request a timely expedited reconsideration.*

3. *Make its initial notification via telephone and follow up with a written determination letter.*

NOTE:

If the BFCC-QIO does not receive supporting information from the hospital, it may make its determination based on the evidence at hand, or defer a decision until it receives the necessary information. If this delay results in continued services for the beneficiary, the provider may be held financially liable for these services as determined by the BFCC-QIO.

200.6 - Effect of a BFCC-QIO Expedited Determination

(Rev. 11210; Issued: 01-21-2022; Effective: 04-21-2022; Implementation: 04-21-2022)

The BFCC-QIO determination is binding unless the beneficiary pursues an expedited reconsideration per section 300 of this chapter.

200.6.1 - Right to Pursue an Expedited Reconsideration

(Rev. 11210; Issued: 01-21-2022; Effective: 04-21-2022; Implementation: 04-21-2022)

If dissatisfied with the expedited determination, the beneficiary may request an expedited reconsideration according to the procedures described in section 300 of this chapter.

200.6.2 - Effect of a BFCC-QIO Determination on Continuation of Care

(Rev. 11210; Issued: 01-21-2022; Effective: 04-21-2022; Implementation: 04-21-2022)

A beneficiary may choose to remain in the hospital beyond the last day of coverage, but may be liable for services after that day. The hospital should issue a Hospital-Issued Notice of Non-coverage (HINN 12) to inform the beneficiary of potential liability. Please see (<https://www.cms.gov/Medicare/Medicare-General-Information/BNI/HINNs>) for HINN delivery instructions.

200.6.3 - Right to Pursue the Standard Claims Appeal Process

(Rev. 11210; Issued: 01-21-2022; Effective: 04-21-2022; Implementation: 04-21-2022)

If the beneficiary is no longer an inpatient in the hospital and is dissatisfied with this determination, the determination is subject to the general claims appeal process (See Chapter 29 of this manual.).

220 - Hospital Requested Expedited Review

(Rev. 1257; Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

When a hospital determines that a beneficiary no longer needs inpatient care, but is unable to obtain the agreement of the physician, the hospital may request a QIO review.

Excerpt from Medicare Claims Processing Manual, Chapter 30

240 - Preadmission/Admission Hospital Issued Notice of Noncoverage (HINN)

(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

Regulations found at 42 CFR Part 476.71 require QIOs to review the medical necessity of hospital discharges **and admissions**, in addition to other requirements specified in that section of the regulation. Therefore, a beneficiary has a right to request an expedited review by the QIO when a hospital (acting directly or through its utilization review committee) has determined at the time of preadmission or admission, that the beneficiary is facing a non-covered hospital stay because the services are not considered to be reasonable and necessary in this case, the services could be safely provided in another setting, or the care is considered custodial in nature.

The utilization review committee or the hospital may issue a preadmission/admission HINN. QIOs may also issue such notices after having been contacted by a hospital regarding care believed to be medically unnecessary, inappropriate, or custodial. The hospital need not obtain the attending physician's concurrence, or the QIO's, prior to issuing the preadmission/admission HINN. This also applies to direct admissions to swing beds (i.e., the beneficiary is admitted to the swing bed when the hospital determines that the beneficiary does not need hospital-level care, but instead needs only skilled nursing (SNF) or custodial nursing (NF) level services).

240.1 - Delivery of the Preadmission/Admission HINN

(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

When delivering the Preadmission/Admission HINN, hospitals must follow the notice delivery requirements in Section 200.3.1 regarding:

- In-Person Delivery,
- Notice Delivery to Representatives,
- Ensuring Beneficiary Comprehension.
- Beneficiary Signature and Date.
- Refusal to Sign.
- Notice Delivery and Retention.

240.2 - Notice Delivery Timeframes and Liability

(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

Preadmission: In preadmission situations, the beneficiary is liable, if admitted, for customary charges for all services furnished during the stay, except for those services for which he or she is eligible to receive payment under Part B.

Admission: If the admission notice is issued at 3 p.m. or earlier on the day of admission, the beneficiary is liable for customary charges for all services furnished after receipt of the notice, except for those services for which the beneficiary is eligible to receive payment under Part B.

If the admission notice is issued after 3 p.m. on the day of admission, the beneficiary is liable for customary charges for all services furnished on the day following the day of receipt of the notice, except for those services for which the beneficiary is eligible to receive payment under Part B.

240.3 - Timeframes for Submitting a Request for a QIO Review

(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

Preadmission: In preadmission situations, a beneficiary who chooses to exercise the right to a QIO review should request immediately, but no later than 3 calendar days after receipt of the notice, or if admitted, at any point during the stay, an immediate review of the facts related to the admission.

Admission: In admission situations, a beneficiary who chooses to exercise the right to a QIO review should request immediately, or at any point in the stay, an immediate review of the facts related to the admission.

240.4 - Results of the QIO Review

(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

If the QIO disagrees with the hospital's determination and says the stay is reasonable and necessary, the beneficiary will be refunded any amount collected except applicable coinsurance and deductibles, and convenience items or services not covered by Medicare.

If the QIO agrees with the hospital determination and says the stay is not reasonable and necessary, the beneficiary will be responsible for all services on the date specified by the QIO.

240.5 - Effect of the QIO Review

(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

The QIO will send the beneficiary a formal determination of the medical necessity and appropriateness of the hospitalization determination is binding on the beneficiary, the physician, and hospital except in the following circumstances:

Right to pursue a reconsideration. If the beneficiary is still an inpatient in the hospital and is dissatisfied with the determination, he or she may request a reconsideration according to the procedures described in §405.1204 (See Section 300 of this chapter.)

Right to pursue the general claims appeal process. If the beneficiary is no longer an inpatient in the hospital, the determination is subject to the general claims appeal process (See Chapter 29 of this manual.)

Instructions for Completion of the HINN 12

A. General Instructions. As with comparable notices, legal or letter-size paper may be used for reproduction of this notice. All information should remain on the same page as it appears in this instruction. If possible, hospitals should use the exact font given in the notice, Times New Roman, 12-point, otherwise another comparable font at least 12-point in size, 18-point for the title should be used. A visually high-contrast combination of dark ink on a pale background must also be used. Do not use font effects, such as bolding, italicizing, or highlighting, other than those appearing in this instruction.

Entries for all blanks on the notices can be hand-written, but handwriting must be legible. The handwriting should be no smaller than approximately font size 10. If typing entries into the notice, font size 12 is recommended, but size 10 is also permissible.

B. HINN-12 Specific Instructions. The model notice itself appears at the end of these instructions. Other general guidance for the reproduction of this specific notice include the following:

- The notice is produced as a one-page document.
- The following text should be removed before reproducing the notice: “Insert Hospital Letterhead And/Or Contact Information”; “Insert Reason Medicare Is Not Expected To Pay”; and “Insert Estimated Total or Average Daily Cost”.
- The following detailed instructions for completing the notice are in two parts: the header section on the first page and the remainder of the first page.

1. Header Section (Page 1 from Top to “*Insert Hospital Letterhead...*”)

Retain the HINN 12 title. Remove the instruction about inserting the letterhead. Insert hospital letterhead, logo and/or basic contact information: hospital name, address and telephone number. If the letterhead or logo does not provide the basic contact information, it must be added here.

2. Instructions for Completing the notice (Remainder of Page after Header)

A. “Name of Patient or Representative”

Write legibly or pre-print the name of the patient or representative affected by this notice.

B. “Identification Number”

Write legibly or pre-print the identification number of the affected Medicare beneficiary [**Note:** Health Insurance Card (HIC) numbers must not be placed on the notice].

C. Purpose of Notice and “Reason Medicare is not Expected to Pay”

The purpose of the notice is to inform the beneficiary that the hospital believes that his/her continued hospital stay will not be covered by Medicare. Hospitals must specify, in plain language the reason for noncoverage of the stay, including a brief description of and citations to the appropriate Medicare coverage policies or guidelines.

D. “...we believe that beginning on _____ ”

Fill in the date upon which the beneficiary will become responsible for payment.

E. “Insert Estimated Total or Average Daily Cost”

Insert the estimated cost of the beneficiary’s stay beginning from the date of noncoverage. This estimate can be an average daily cost.

F. Physician Referral

Advise the beneficiary to speak with his/her physician about his/her health care needs, including continuing his/her current stay.

H. “Signature of Beneficiary or Representative” and “Date”

The notice must be signed and dated by the beneficiary or representative.

The beneficiary or representative must receive a copy of the signed and dated notice.

Version 04/29/2014
Check for Updates

Version 04/29/2024
Check for Updates