Submitter : Ms. Jennifer Woolsey **Date:** 04/12/2006

Organization : BSAHS

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

I think that providing a notice to all patients prior to discharge is not only unreasonable, but unfeasible to expect that we produce basically from my understanding notice of noncoverage prior to discharge to all Medicare patients.

Submitter :

Date: 04/12/2006

Organization :

Category : **Nurse**

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-4105-P-22-Attach-1.DOC

April 12, 2006

RE: File code CMS-4105-P

To Whom It May Concern:

Collection of Information Requirements

As the Director of a Case Management Department, I have experience in issuing HINN letters and I assure you that your estimate of the time it will take to issue these notices you are proposing is totally inaccurate. A nurse/representative cannot just walk into a patient room and hand the patient/family a letter telling them they are being discharged or they will be responsible for payment. There are always questions, concerns and often times anger and hostility directed toward the "messenger." The nurse/representative delivering the letter will make more than one visit as there are always additional questions/concerns that are thought of after the initial meeting (after the rest of the family is made aware of the "hospital throwing mom/dad out.") It currently takes a minimum of 2-3 hours to prepare the letter, meet with the patient/family initially and at least one additional meeting. The proposed two-step process will take at least an additional 1-2 hours. With the distribution of the initial notification, there will be many questions as this is something they have never received before. They will want to know specifically what this notification means and will probably think they have to, or should challenge the discharge as many elderly patients think they should stay in the hospital until they are ready to go home. They do not want to go to an SNF/nursing home for further convalescence because they get more attention at the hospital, already "know" all the nurses/caregivers, and their perception of a SNF/nursing home is for "old and confused" people.

Regulatory Impact

The hospital staff currently delivering the HINN letters are the case managers. Most case managers in hospitals have a caseload of 20-25 patients. By requiring them to deliver both a generic notice and then a detailed notice when the patient is dissatisfied will place an unnecessary additional burden and will result in additional costs to the hospital for over-time and/or additional case manager positions. The retention of RN case managers is already abomniable, by adding this additional burden you will be contributing to the continuing loss of RNs in the workplace.

Patients are currently made aware of their appeal rights with the Important Message From Medicare received at admission and those who refuse to be discharged either already know their rights or are made aware of them immediately. The new process you propose actually encourages patients to question the ethics of their physicians and healthcare providers when there is no basis for it. There is no need for this change in a process that is currently effective and working. There is no need for an increase in the costs to hospitals for a change that has no additional benefits to anyone.

Unlike HHAs, SNFs or CORFs, there are frequent times that a patient's discharge from an acute care facility is not definitely known the day before. Many times the discharge is pending diagnostic test results or clinical improvements that cannot be predicted. The discharge plans are in place and the patient/family know the discharge plan prior to the day of discharge, but the exact date may be unknown. This makes the delivery of the generic letter the day before discharge an impossibility for many patients. Unless CMS wants to increase the reimbursement for DRGs, this again increases the financial burden for hospitals.

Since there is no measurable benefit to this proposed change, I appeal to your sense of fairness to leave the process the way it is.

Sincerely,

A Weary and Concerned Case Management Director

Submitter : **Mrs. Jodi Bunde** **Date: 04/12/2006**

Organization : **Lakes Regional Healthcare**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

I am a UR Coordinator at our facility and have some concerns regarding this proposed ruling. What will be the process for those patients that have only a one day stay? They will not get the Notice one day prior to their discharge. Also what about those patients who are anticipated to leave on a certain day and have a set back on the proposed day of discharge and stay a few more days. Can the Notice be amended or recinded as with the SNF Notices? I did not see anything to address this in the information I read. As far as the cost to the facilty, I believe that this is unfairly low. We provide UR coverage during the weekdays only so we will have to educate all of our nursing supervisors and floor nurses the ins and outs of issuing the Notices and getting a valid signature etc. I do not feel that these expenses have been calculated into the grand cost, and should be considered before inplementing the rule. Thank you for letting me comment.

Submitter : Ms. katie orman **Date:** 04/12/2006

Organization : auburn memorial hospital

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

Regulatory Impact re: CMS-4105-P..RE: notifying Medicare patients of right to appeal one day prior to discharge. This is unrealistic as frequently it is not known if the patient would be d/c the next day..much of that depends on how the patient does over night etc. By requiring the one day, this will extend patients LOS at times, or cause duplicate notice to be issued when d/c are delayed due to medical status. Patient's do not need "extra" time to think over their d/c..I have found they are very well versed in stating they are not ready to go ho9me!

Submitter : **Mrs. Vicki Quaid** **Date: 04/12/2006**

Organization : **Holy Spirit Hospital**

Category : **Nurse**

Issue Areas/Comments

GENERAL

GENERAL

What has become of the paper reduction act? Now we are going to add additional paperwork to a patient's chart to notify them of discharge? As a discharge planner in an acute facility I am already documenting the discharge plan when indicated. I also do perdiem home health nursing and am familiar with notification of patients from home health. I don't feel that a discharge notification is necessary in a hospital setting.

Submitter : **Ms. Delphine Yurick** **Date: 04/12/2006**

Organization : **Mille Lacs Health System (hospital)**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

We are a small rural hospital which strives daily to provide patients with quality nursing and medical care. In your effort to inform patients of their rights and reduce paperwork, you are burdening the health system and patients with increased paperwork needlessly. Patients already receive Medicare information on admission. We are a critical access hospital in which our patients stay less than 4 days most 2-3 days. Do you think that patients/family forget in that amount of time what their rights are? Do you understand how much confusion and frustration Patient/family experience when every day they are confronted with paperwork from Medicare that they have to sign and explain over and over there rights that they already understand. If a patient has an exception to being discharged and need further recourse, we are happy to provide them with the information. However, to blanket the entire Medicare-MA population, with needless paperwork so that you feel their rights are being covered is an excessive and overburdensome requirement. I am the professional that is responsible for this task. I also am an R.N. I do patient care coordination, discharge planning, utilization review, concurrent review for physicians, swing beds, Quality Net Exchange for mandatory reporting and diabetic teaching for clinic and hospital. We have 3-6 admissions a day and probably that many discharges between 10 physicians. Do you know what your asking when you now want patients to receive virtually the same information we just gave them within 1 day of discharge. How many phone calls will that involve if I happen to miss the physician on rounds, or the physician is waiting on tests results to determine discharge that day, or the physician is off that day and you can't reach them or its a one day stay. Does this include observation patients because we have several of those as well. Do you want us to delay discharge if they have to have 24 hours notice? It creates even more burden if I am gone a day, or take a vacation. We don't have extra staff around to do this. This involves lots of extra steps. It is not just your two steps. Itis all the steps we have to take to get a physician to commit to a day of discharge. This form which you describe as simple, is very difficult for patients to understand why they have to put their signature on yet another piece of paper. Home Care, Hospice, swing beds, nursing home, those care venues are weeks, mostly months of care service. It is reasonable to give them reminders of their rights before discharge. Hospital stays are short term measures for the majority of patients. Why would you add so much extra burden for a few days. I strongly urge you to reconsider this proposal. In my view, we inform patients of their rights on admission, if they have issues, they get a HINN letter, with how they can appeal. To my knowledge no other insurer requires this much detail. I'm all for patient rights but this is paperwork compliance which I don't believe serves the patients interests. The time taken away from patients to do this 'required' work is lost when the majority of patients don't need it. Thank You for the opportunity to express my concern.

Submitter : **Date: 04/14/2006**

Organization :

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

After discussion with our case managment team and other who this rule directly impacts, we feel the goverment is underestimaitng the man hours and time this would take. We have procees in place to issue HEIN letter which allows more control by the hospital over this process.

Submitter : Ms. Mary Gruenwald **Date:** 04/14/2006

Organization : Georgetown Memorial Hospital

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

April 10, 2006
Docket ID Number CMS-4105-P

Proposed Rule: Notification Procedures for Hospital Discharges

COMMENT:

IN RESPONSE TO THE PROPOSED RULE, GEORGETOWN HOSPITAL SYSTEM WOULD LIKE TO SUBMIT THAT THIS WOULD CREAT A HARDSHIP FOR HOSPITAL PROCESSES AND PERSONEL. STAFF ARE NOT EMPOWERED TO OBTAIN AN ORDER PRE-DISCHARGE TO ALERT THE PATEINT 24 HOURS IN ADVANCE OF DISCHARGE. THIS IS DEPENDENT SOLELY UPON THE WILLINGNESS AND AVAILABILITY OF THE ATTENDING PHYSICIAN TO AGREE TO WRITE 24 HOURS PRIOR TO DC. GENERATING A MESSAGE TO THE PATIENT WOULD HAVE TO BE ELECTRONICALLY FLAGGED AND DELIVERED AT THAT TIME.MOST PATIENTS ARE AWARE THAT AN ACUTE CARE STAY IS TEMPORARY AND INVOLVES THE STABILITY/RESOLUTION OF THEIR ACUTE CARE NEEDS. DISCHARGE PLANNING WOULD ADDRESS FURTHER CONCERNS RELATED TO POST ACUTE CARE NEEDS.THERE IS A PROCESS CURRENTLY FOR ADRESSING PATIENTS WHO DISAGREE WITH THE DISCHARGE AND CMS HAS DESIGNED THE HINN TO ADDRESS THIS.

Mary Gruenwald, RN,BS,CCM
Director of Case Management
Georgetown Memorial Hospital
Georgetown,S.C. 29442

Submitter : **Dr. Daniel Duvall** **Date: 04/17/2006**

Organization : **Riverbend GBA (Fiscal Intermediary)**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P-92-Attach-1.DOC

17 April 2006
Re: CMS-4105-P Proposed Rule: Hospital Discharges, Notification Procedures
Comment:

An acute inpatient stay is not comparable to a SNF in that the entire reason for the stay (both clinically and statutorily) is based on the physician determination that the services cannot be safely provided in an outpatient environment. Therefore, if the treating physician believes inpatient care is no longer necessary, the patient's objection is irrelevant since medical necessity will not exist and the stay will no longer be covered. The disagreement between the physician and a review organization is much more important than the disagreement between the patient and the attending physician.

Beneficiary protection could therefore be insured through the requirement that a beneficiary notice would be required in two instances: in the instance where beneficiary coverage ends for non-medical reasons, such as benefits exhausted (simple notification) and in the instance where the hospital determines that an inpatient stay is no longer required AND the treating physician does NOT agree (i.e. documents in the chart that he does not concur with the decision.)

Given that the average length of stay for most conditions is on the order of 3 to 5 days in acute care facilities, and given that very few admissions result in either forced discharge or the creation of patient liability, in the majority of admissions there is no benefit from the additional personalized notice and there is a sizeable administrative burden associated with prediction of discharge and the creation and distribution of the personalized short form. This is further magnified by the large number of acute care admissions relative to the number of SNF (or CORF or hospice) admissions.

In acute care facilities the decision to discharge is frequently made on the morning of discharge, not 24 hours ahead. To avoid instituting a rule that has the potential to impede patient turnaround, an implementation similar to the following would be helpful:

1. With respect to hospital inpatient stays, in the instance where benefits are exhausted or the termination of coverage arises for non-medical reasons, the short notice is required 24 hours prior to the end of coverage.
2. In the instance where the termination of coverage is based on a medical necessity determination performed by a review entity, the short notice is required if the treating physician does not concur and so documents in the orders. The beneficiary must then be allowed 24 hours between notification and discharge. The long notice must be provided if the beneficiary decides during that time to pursue an expedited appeal.
3. In any instance in which the treating physician orders discharge on his own and the patient expresses disagreement, or when the treating physician orders discharge at the recommendation or direction of a review entity but does not register an objection in the orders, only the short notification is required and the notice is effective when delivered (24 hours are not required).
4. Since the Important Message from Medicare is, in most instances, issued only several days prior to discharge, the general information included in the short discharge notice should be included in the Important Message for hospital inpatients.

Daniel J. Duvall, MD, Fiscal Intermediary Medical Director, Riverbend, 423-763-3038

Submitter : Mrs. Lori Pinzon **Date:** 04/17/2006

Organization : Advocate Good Shepherd Hospital

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

This proposed rule will add unnecessary increased costs to healthcare and confusion for beneficiaries. Patients that request a discharge would be required to stay an additional day to meet this rule. Patients are often told they can be discharged based on test results or their ability to tolerate a diet, etc. In these cases, notices would have to be given for possible discharges which could create greater confusion. Patients would then be concerned they would be responsible for bills when discharge dates are delayed for medical reasons. Discharges are often delayed due to a lack of space at extended care or rehab facilities. This again could cause distress and confusion for our medicare beneficiaries. Multiple letters would need to be given to patients that had delays in their discharge for medical reasons or delays due to unavailable beds or services. Our hospital will not discharge a patient until the patient and family accept discharge arrangements, post-discharge services are available, and they are medically stable. We monitor all readmissions. The law already allows the patient to appeal any discharge decision they don't agree with. A cost of $7000 per provider includes the cost of distributing notices; it doesn't include the cost of medically unnecessary discharge delays that will occur if this ruling becomes effective.

Submitter : Ms. Jill Benson **Date:** 04/18/2006

Organization : Spine Hospital of South Texas

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

In reviewing the proposal for all Medicare patients to receive discharge notice the day before discharge I can see all sorts of potential for problems. Nurses and physicians do a good job explaining to patients about discharge and trying from the point of admission to discuss discharge with the patient so the patient is prepared. But now to have to be able to predict precisely when all Medicare patients will go home and make sure they get information the day before. Patients cannot all be put in the same basket and treated the same which is something that Medicare does not seem to understand. You give us GMLOS for post acute care transfers and now want us to predict the exact day of discharge so we can make sure these patients have information in case they don't think we as healthcare professionals are doing our job. The majority of patients do not feel like they are ready to go home and when given the option would rather stay. This new process will only increase the number of days patients stay in the hospital requiring them to pay the difference, decrease the number of nurses and healthcare professionals to take care of other patients (and there is already a severe shortage) and over burden the entire system all because Medicare wants to keep the patient informed. Medicare needs to understand that healthcare professionals are caring, intelligent, highly skilled individuals who have been trained to take care of the sick. Please let us do our job.

Submitter : **Ms. Jane Goldstein** **Date: 04/18/2006**

Organization : **Main Line Health**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

CMS-4105-P2
"PROVISIONS OF THE PROPOSED RULE"

CMS has acknowledged that there are "relatively rare situations where beneficiaries wish to dispute the discharge." If that is the case, what is it about the proposed rule that would be "helpful to patients?"

I believe that the rule will be a burden to many patients for the following reasons:

1. Patients often don't understand the EOB that comes to their homes, fearing that it is a bill. That document arrives after the patient is out of the acute setting, in his or her own environment, and presumably, feeling recovered. If handed a notice of "termination" of benefits while still in the hospital, many patients are likely to become anxious and upset, believing that the notice puts them at risk for payment of a hospital bill, especially because CMS requires a patient signature.

2. Who will explain the notice to patients who are vision or hearing impaired, or suffering from dementia or other mental deficit? If it is the hospitals' responsibility to do so, your estimate of 5 minutes delivery time is seriously flawed.

3. Many patients will question other hospital workers about the notice. Those workers may not understand the nature of the notice and give conflicting information to the patient.

4. Delivery of the notice will introduce concern where none need exist.

5. For many patients, the notice may give them the impression that they may ask for an extension of stay without any understanding of medical necessity. This puts patients and caregivers in an adversarial position, damages the therapeutic relationship and may result in an extended length of stay that is not covered, causing real financial liability on the patients' part.

I believe the rule will be a burden to hospitals for the following reasons:

1. As CMS notes, hospital discharge dates are volatile.
2. In many cases, the hospital UM/CM staff would not be required to visit a Medicare or Medicaid patient on the day before discharge, so the notice delivery would be extra. In that case, the 5 minute estimate is grossly underestimated. It can take 5 minutes to get to an elevator. The patient may not be in the room on the first try, they might be asleep, or in the bathroom.
3. It would take much longer to deliver the notice to patients who needed an interpreter, or who asked that the notice be discussed with their family members.
4. CMS indicates that the notice is to be signed. That implies that the hospital keep the notice on file. Filing and archiving these records is an additional burden that CMS did not acknowledge.
5. Many utilization management departments are minimally staffed on the weekends, and those staff are fully occupied with admission reviews for medical necessity.

At a time when CMS is asking hospitals to use their resources to be ever more vigilant about managing patients to medical necessity, it seems unrealistic to add administrative burdens that have no clear benefit to beneficiaries.

Submitter : Miss. Eve Duhart **Date:** 04/19/2006

Organization : Christus Spohn Memorial Hospital - Corpus Christi

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

I do not agree with the proposed plan to require day before discharge notification. As a nurse case manager, I have found that from one day to the next, many of our government funded patients have multiple comorbid conditions that increase thier chances of acute changes in medical status. Are we are now to be penalized because of changes that are sometimes out of our control?

Submitter : **Ms. Barb Dalenberg** **Date: 04/19/2006**

Organization : **Carle Foundation Hospital**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

I think it is great to give patients 24 hr notice of discharge. But our LOS is around 4 days so this would have to be given upon admission with no information. The expectation to give the patients document and explain them, this will be very time consuming for the Case Management staff because patients will not understand all of this. We will then most likely have to repeat to family members which in most instances will be after deparmtment hours. This will take the Case Managers away from their daily duties which is getting the best/safeest discharge for our patients.

Submitter : **Date: 04/19/2006**

Organization :

Category : **Other Practitioner**

Issue Areas/Comments

GENERAL

GENERAL

"PROVISIONS OF THE PRPOSED RULE"
If hospitals are required to give a HINN to all Medicare patients the day prior to discharge, the patient will have extra days they can stay, even if they don't appeal. This is due to CMS regulations, which require hospitals to allow a 3 day period before patient liability begins, starting from the time the letter is issued.

What will prevent patients from saying "I'm going to stay until the day before my liability begins"? By giving this letter we are offerring an option to every patient to remain in the hospital past the time the physician believes they will be ready for discharge.

Submitter : Mrs. FERRELL YOLANDA **Date:** 04/19/2006

Organization : MCCUNE-BROOKS HOSPITAL

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

CMS 4105:IT WILL BE HARD TO PROPERLY IMPOSE AND WILL BE A WASTE OF TIME AND RESOURCES TO GET A ONE DAY NOTICE OF DISCHARGE FOR ACUTE CARE PATIENTS.I HAVE BEEN AN RN FOR 32 YEARS AND WITH MY EXPERIENCE I KNOW HOW UNPRIDECTABLE PATIENTS ARE ESPECIALLY IN ACUTE CARE SETTING. THEY COULD BE AS SICK AND UNSTABLE THE DAY BEFORE AND THE FOLLOWING DAY THEY COULD RECOVER REMARKABLY WELL THAT DRS MIGHT BE READY TO DISCHARGE THEM.WITH THE NEW CMS 4105 RULE PTS CANNOT BE DICHARGE AND WOULD HAVE TO WAIT ANOTHER DAY. WE ARE A CRITICAL ACCESS HOSPITAL AND TRY TO WATCH 96 ALOS CLOSELY. AS SOON AS THE PATIENT IS STABLE WE COULD DISCHARGE THE PT. WITH THE NEW PROPOSAL, WE WILL BE DELAYING DISCHARGES JUST TO COMPLY WITH THE I DAY NOTICE PRIOR TO DISCHARGE.IN HEALTHCARE WE ARE SO OVERWHELMED WITH PAPER WORKS. IT WOULD BE A BIG BREAK FOR US TO CUT DOWN ON PAPERWORKS NOT ADD ANOTHER ONE.THANK YOU VERY MUCH FOR GIVING US THE APPORTUNITY TO COMMENT ON THIS ISSUE.

Submitter : **Ms. Lana Daniel** **Date: 04/20/2006**

Organization : **Baptist St. Anthony's Health System**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

I believe this change will be an additional burden to hospitals and their staff with little or no benefit to Medicare beneficiaries. The expectation that staff will know a day in advance of a discharge in order to notify the patient is often not realistic. Therefore, one additional day in the hospital may be required for nothing more than providing the standard denial letter according to the timeframe established by the rules. Also, notifying every Medicare beneficiary one day prior to discharge has the potential to prompt some people to appeal a discharge that they would not otherwise, and for no medical reason. This has the potential to back up discharges and drive the cost of healthcare up. The current method of issuing a HINN only when a patient disagrees with the discharge is effective and appropriate. Please consider leaving the requirements as they are.

Submitter : **Mrs. Catherine Wazny** **Date: 04/20/2006**

Organization : **Bay Regional Medical Center**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Burdensome doesn't come close to describing the impact of having to present a NONC letter to every Medicare patient. An acute hospital admission in no way follows the time frames allowed in an SNF or CORF where this is now apparently taking place. In those settings the Level of the Acuity is not changing on a daily basis as it is in the acute setting. The attending decides on the patients readiness for discharge in all situations. In those cases that involve peer review for level of care decision making and the attending does not conur with the Physician Reviewer the patient may be given a NONC letter, and at that time their financial liability and their rights to appeal are explained to the patient. I've been involved in the Utilization process since 1979 and can see no value to the patient or the institution to establish this process. Presently, when a NONC of letter is presented to the patient the time averages about 90 minutes for completion. In those cases the level of anxiety is greatly increased due to their fear of having to pay out of pocket. Again, please reconsider any changes to the present process.

Submitter : Ms. Mary Gruenwald **Date:** 04/20/2006

Organization : Georgetown Memorial Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

Proposed Rule: Notification Procedures for Hospital Discharges

COMMENT:

IN RESPONSE TO THE PROPOSED RULE, GEORGETOWN HOSPITAL SYSTEM WOULD LIKE TO SUBMIT THAT THIS WOULD CREAT A HARDSHIP FOR HOSPITAL PROCESSES AND PERSONNEL. STAFF ARE NOT EMPOWERED TO OBTAIN AN ORDER PRE-DISCHARGE TO ALERT THE PATIENT 24 HOURS IN ADVANCE OF DISCHARGE. THIS IS SOLELY DEPENDENT UPON THE WILLINGNESS AND AVAILABILITY OF THE ATTENDING PHYSICIAN TO AGREE TO WRITE 24 HOURS PRIOR TO DC. GENERATING A MESSAGE TO THE PATIENT WOULD HAVE TO BE ELECTRONICALLY FLAGGED AND DELIVERED AT THAT TIME. MOST PATIENTS ARE AWARE THAT AN ACUTE CARE STAY IS TEMPORARY AND INVOLVES THE STABILITY/RESOLUTION OF THEIR ACUTE CARE NEEDS. DISCHARGE PLANNING WOULD ADDRESS FURTHER CONCERNS RELATED TO POST ACUTE CARE NEEDS.THERE IS A PROCESS CURRENTLY FOR ADVISING PATIENTS WHO DISAGREE WITH THE DISCHARGE AND CMS HAS DESIGNED THE HINN TO ADDRESS THIS.

Submitter : **Mrs. Chris Ferguison** **Date: 04/20/2006**

Organization : **St Alphonsus Regional Medical Center**

Category : **Nurse**

Issue Areas/Comments

GENERAL

GENERAL

Attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter : Mr. Brian Van Dine **Date:** 04/24/2006

Organization : Advocate Good Samaritan Hospital

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

Generally speaking, I like the idea of giving patients advanced warning of their anticipated discharge as from a psychological perspective this will help to create momentum in the direction of discharge. Many patients and their families complain about not receiving advanced notice of discharge, creating hardship for families who are trying to coordinate the logistics around discharge. But, here too, is the problem. Physicians often have difficulty anticipating discharge as it is contingent upon pending trends of lab results which the physician must monitor on a day-to-day basis. Furthermore, patients with complicated medical conditions often don't follow a trend but seem to swing back and forth from almost medically stable to new complications on a daily basis making predicting discharge difficult. I am also concerned upon which staff the burden of giving notice will fall; discharge planners are the likely candidates and yet the discharge planner doesn't control medical stability. In many organizations physicians don't feel the need to communicate plans with discharge planners beyond writing orders for the nebulous "discharge planning." Furthermore, discharge planners do not usually have the authority to correct this situation. Therefore, I see the potential for discharge planners to be placed between a rock and a hard place being made responsible to give patients notice without necessarily having knowledge of when the physician is planning discharge. Lastly, whereas it can be helpful to communicate to a patient the actual limits of financial coverage, wording should be carefully crafted to not send patients into an unnecessary panick causing them to believe that their hospital stay isn't covered.

Submitter : **Ms. D. Susan Rich** **Date: 04/24/2006**

Organization : **Bothwell Regional Health Center**

Category : **Nurse**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P-222-Attach-1.DOC

Bothwell Regional Health Center
A Lifetime of Caring

601 East 14th Street • P.O. Box 1706 • Sedalia, Missouri 65302-1706 • 816-826-8833
Address Correction Requested

Attachment #22

Centers for Medicare & Medicaid Services
File Code: CMS – 4105 - P
Issue Identifier: **"PROVISIONS OF THE PROPOSED RULE"**

To Whom It May Concern:

I have experienced the "NODMAR" process while working in Hawaii. We issued NODMAR's at the time of discharge for the HMSA Medicare plan. The process was cumbersome at best and created many dilemmas that in general were a nightmare for all involved (including the insurance company). What may seem a simple idea on paper when applied to real life in a hospital setting becomes an involved tedious process requiring energy from many different disciplines, none of which impacts or increases the quality of care patient's receive. In fact, due to constant changes, expectations and certainly no reduction in paperwork, patient care tends to suffer. I believe it is in the best interest for patients to receive appropriate care in a timely fashion and be discharged/transferred to a lower level of care as soon as they are medically stable. I will list below rational for NOT adding this additional burden on hospitals and caregivers.

- Acute inpatient stays cannot be compared to Home Health or Skilled services. Due to the age and comorbidities of Medicare patients, physicians may not know the exact day their patients will be ready for discharge. They may anticipate a patient will be ready for discharge within 24 hours and an unexpected change in condition may occur delaying the discharge or they may improve at a faster rate. In the former possibility, the discharge day filled in the NODMAR is incorrect and another letter would need to be issued. The estimated letter preparation time of 5 minutes (which in no way relates to the reality I experienced) could turn into considerable time and more than likely has confused the patient/family on when to expect discharge. Not to mention increase anxiety levels and lower confidence levels. This scenario could continue at length and would it be necessary to wait another 24 hours to comply with the rule? Patient's that improve sooner than expected would be required to remain in the hospital increasing their risk of hospital-acquired illnesses and increasing length of stay.
- The 5-minute preparation time per letter in no way reflects actual procedure and processes involved in this endeavor. Policies and procedures must be written in order to have a standardized process. Education to physicians and staff involved in delivering NODMAR's to patients or tracking down families if the patients cannot sign for themselves must be accounted for. A tracking mechanism must be developed by the hospital as well as CMS to assure the process works. The letters must be reviewed to make sure they are filled out appropriately. If they are not filled out appropriately, must the patient then receive a corrected copy by certified mail? And tracked and logged?
- Deciding the most appropriate caregiver to address the NODMAR opens a floodgate of additional problems. If it's a department that is not in house 24/7, discharges will be delayed. Delays increase the opportunity for hospital acquired infections or errors that affect outcomes and patient safety. Bedside nurses are already burdened with paper work and documentation requirements, taking them away from the bedside. Another layer of beurocracy added the day prior to discharge with no direct benefit to patient care will be of low priority and pushed to the back burner.

- A domino effect could occur caused by patients forced to stay in the hospital waiting on a NODMAR letter. Patients needing an acute bed could be forced to wait in the Emergency Department or in the hall due to bed shortages. With all the emphasis on "throughput", NODMAR letters are another obstacle to efficiency

These are just some of the very real possibilities that should be considered before straining the health care system any further. If the information in the NODMAR is considered imperative for patients to receive, give it to them when they enter the hospital and include it into a process that is already in place or modify the current notice to include information you think is missing. I have given hundreds of NODMAR letters and I can't remember one time the patient used or benefited from receiving a NODMAR letter.

Sincerely,

Susan Rich, RN
Director of CQI/Resource Management
Bariatric Program Coordinator

Submitter : **Date: 04/24/2006**

Organization :

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

CMS-4105-P2 should not be needed, since Medicare beneficiaries are already informed at time of admission about their rights if they think they are being asked to leave the hospital too soon. By imposing additional notification procedures, CMS would likely increase the costs of care and the lengths of stay, and would be placing an additional unnecessary requirement on the hospital. If such a requirement were to be imposed, it should be imposed upon the attending physician, rather than the hospital, as the attending physician is responsible for giving the discharge order. Also, there are occasions when discharge cannot reasonably be anticipated a day in advance. A patient can exhibit rapid improvement and be stable for discharge, but the notification requirement would prohibit that patient from receiving a discharge at the earliest time discharge was felt clinically appropriate. Please reconsider the necessity and application of this proposed rule.

Submitter : Mr. Lee Tinsley RN,CLNC **Date:** 04/24/2006

Organization : Lake Chelan Community Hospital

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

The proposed rule would add siginificant time amd administrative burden on hospitals. The patient already recives this information in the Important Message from Medicare given to them on admission. There is also a system using HINN letters to give the patient and hospital the oppertunity for a QIO review when a discharge is disputed. The prior day notice requirement is not workable as patients sometimes improve more rapidly than expected or turn out to not be as sick as suspected on admission

Submitter : Ms. Sally Hammond **Date:** 04/24/2006

Organization : Northwest Medical Center

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

Hospital length of stay (LOS)and cost will increase. Cost to Medicare will increase as LOS increases on an annual basis, not to mention the impact it will have on the Transfer DRG program that is supposed to save Medicare millions annually. This will potentially be a patient dis-satisfier. Often physicians decide to discharge a patient when body functions return, ie bowel sounds. Letters would have to be given daily until such body function returns. Or the patient would have to be kept an additional day to meet the 24 hour requirement. Operationalizing this process, monitoring compliance, and the impact on the state QIO receiving unnecessary review requests will be a nightmare. The Important Message from Medicare, given upon admission, has been sufficient in the past and should continue to be sufficient w/o adding this resource intensive measure. This is ridiculous and will only increase cost and LOS.

Submitter : Mrs. Lavonda Allen **Date:** 04/25/2006

Organization : White River Medical Center

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

All Medicare beneficiaries currently have the right to an expedited review and an additional three days of inpatient care if the patient disputes the discharge decision.

The requirement to provide beneficiaries with a one-day notice of discharge has the potential to delay discharge resulting in additional LOS for the hospital, which is medically unnecessary. This potential increase will outweigh the potential for early discharge we might currently have.

The requirement for a one-day notice has the potential to require additional staff, which will not have a positive affect on the patient s quality of care and therefore be an unnecessary expense for the hospital.

Submitter : **Dr. Joseph Schwartz** **Date: 04/25/2006**

Organization : **Dr. Joseph Schwartz**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Attn: CMS

At a time when all of us ought to be concerned over the rising cost of health care, we witness still another example of an attempt to decrease the cost for one segment of the medical care industry, not by attempting to improve efficiency or decrease nonessential administrative overhead, but by attempting to shift more of the cost of medical care to the already overburdened backs of the hospitals.

The proposed rule on notification procedures for hospital discharges is an ill-conceived idea. It will not reduce but rather will prolong the duration of Medicare inpatient stays and will simultaneously expand the administrative burden of hospitals while contributing nothing at all to the quality of the care our Medicare patients receive. The estimated cost to hospitals for this cumbersome plan exceeds $31,000,000 and this does not include the cost of copying and mailing the entire medical record to the QIO via overnight mail whenever a QIO review is requested by the beneficiary.

As a practicing physician, I promise you that the requirement to notify the patient of the intended discharge by the close of business on the preceding day is not only impractical but requires almost as much intuition as medical expertise. Time and time again, we physicians will be confronted by the Medicare patient who recovers from an illness more rapidly than expected and ought to be discharged, yet spends an extra day in the hospital because the required notification was not delivered by the close of the preceding business day.

I thus feel compelled to ask you to abandon this proposal and to place your future efforts into projects that will improve the quality and efficiency of medical care system wide, rather than continuing to follow a robbing Peter to pay Paul strategy which only increases administrative complexity, undermines efficiency, increases overall cost, and ultimately harms all of us.

Sincerely yours,
Joseph R Schwartz MD

Submitter : Dr. JOHN RINKE **Date:** 04/25/2006

Organization : COMMUNITY MEMORIAL HOSPITAS

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHMENT

CMS-4105-P-282-Attach-1.DOC

25April06

Attn: CMS

At a time when all of us ought to be concerned over the rising cost of health care, we witness still another example of an attempt to decrease the cost for one segment of the medical care industry, not by attempting to improve efficiency or decrease nonessential administrative overhead, but by attempting to shift more of the cost of medical care to the already overburdened backs of the hospitals.

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Sincerely yours,

John Rinke, MD

Submitter : **Dr. Richard Shimp** **Date: 04/25/2006**

Organization : **Infinity Health Care**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Attn: CMS

At a time when all of us ought to be concerned over the rising cost of health care, we witness still another example of an attempt to decrease the cost for one segment of the medical care industry, not by attempting to improve efficiency or decrease nonessential administrative overhead, but by attempting to shift more of the cost of medical care to the already overburdened backs of the hospitals.

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As a practicing physician, I promise you that the requirement to notify the patient of the intended discharge by the close of business on the preceding day is not only impractical but requires almost as much intuition as medical expertise. Time and time again, we physicians will be confronted by the Medicare patient who recovers from an illness more rapidly than expected and ought to be discharged, yet spends an extra day in the hospital because the required notification was not delivered by the close of the preceding business day.

I thus feel compelled to ask you to abandon this proposal and to place your future efforts into projects that will improve the quality and efficiency of medical care system wide, rather than continuing to follow a robbing Peter to pay Paul strategy which only increases administrative complexity, undermines efficiency, increases overall cost, and ultimately harms all of us.

Sincerely yours,

Richard J. Shimp, MD

Submitter : **Valerie Rinkle** **Date: 04/25/2006**

Organization : **Asante Health System**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

Please see the attachment

CMS-4105-P-302-Attach-1.DOC

Provisions of the Proposed Rule

Acute care hospitals are distinctly different entities from HHAs, SNFs, CORFs and hospices whose length of stay is significantly longer than acute care hospitals. Requiring the notice one day before the anticipated day of discharge will be a significant administrative burden for hospitals with no apparent benefit to beneficiaries. We strongly disagree that this "will not be overly burdensome for providers."

Once again, CMS is tying the fate of hospital reimbursement and compliance to physicians when the physicians have no accountability to work with hospitals on this requirement. We respectfully request that if CMS adds a discharge notice requirement and continues to require physician concurrence with the date of discharge and the discharge notice, that CMS consider some means to require physicians to provide hospitals with anticipated discharge dates and that physicians not be paid the professional fee for discharge (CPTs 99238 or 99239) without a modifier indicating that they have informed the hospital of the anticipated discharge date in time for the hospital to meet the notice requirement.

How are hospitals supposed to document that the physician concurred with the discharge date of the notice? Will CMS expect the physician's written discharge order to match the date on the notice? This level of detail will significantly increase the administrative burden to hospitals. What are CMS' expectation regarding this issue?

There are some patient stays that are 24 hours or less and required by CMS to be an inpatient. See the OPPS inpatient only list. Furthermore, a significant number of hospital discharges are 3 days or less. Also, many discharges are determined on the day of discharge by physicians performing morning daily rounds on their patients.

If hospitals must give a one day notice with physician consent, this will likely increase the length of stay due to the logistics of obtaining the discharge date from the physician order, or anticipating the discharge date and getting the concurrence of the physician, producing the notice and explaining it to the patient, and documenting the signature or notating that the notice was given. Therefore, providers are greatly concerned that this requirement will likely increase the cost of hospital stays to Medicare by at least one day on many short-stay cases. In the short term, this will significantly increase cost to hospital providers and not to Medicare because the DRG payment is prospectively determined. In the long run, however, this will also increase costs to the Medicare as hospitals will report one additional day length of stay in many cases. To avoid this unintended, costly consequence, will CMS consider the following:

- Allowing hospitals to provide the notice on the day of admission for cases anticipated to stay 3 days or less.
- Allowing hospitals to work with physician medical directors to establish expected lengths of stay by condition such that medical staff approved policies are equivalent to the admitting physician's concurrence with a discharge date.
- Limiting the notice to elective admissions only and not acute illnesses or trauma.

- Waiving the notice requirement if the physician discharge order is timed and dated for the same day as discharge is ordered.

What is the beneficiary benefit? Has CMS had complaints from beneficiaries who believe they were inappropriately discharged from the hospital without an opportunity to request a QIO review? Also, patients are not always aware of what their status is – a patient may be an inpatient may be next to another patient who is an observation outpatient – this notice requirement sets up a differential practice between the two types of patients.

Patients have a lot of paperwork to sign and review with each admission, adding more paperwork will not improve patient safety, patient satisfaction or quality of care. In fact, we submit that providing such a notice could potentially be detrimental to the patient, particularly on short length of stay cases. Patients can be quite ill and improve dramatically in a short period of time. Knowing this, the physician may anticipate discharge the next day and the notice would be given – the patient sees a written notice that the hospital stay will not be covered on the day after the discharge date and that s/he would be financially liable – that patient may still feel quite ill at the time the notice is given and this notice would be very emotionally threatening to the patient. This could then become medically threatening in the case of angina or hypertension, for example. In addition, it could cause significant enmity between the treating physician and the patient and the hospital. We do not see how this requirement adds to patient safety, patient satisfaction or quality of care – in fact, it can be a bureaucratic impediment to these important CMS and hospital goals.

We believe that patient rights are sufficiently protected with the "Important Message from Medicare" that is currently required and given upon admission. An alternative to giving written notice to each inpatient, would be adding more protections from financial liability of non-covered days of care. As an alternative, hospitals could be prohibited from billing beneficiaries for non-covered hospital days of care without providing an individualized notice and obtaining QIO review. This would protect beneficiaries from inappropriate financial liability without burdening all hospitals with an administrative requirement for a discharge notice on all patients.

Submitter : **Ms. jackie harms** **Date: 04/26/2006**

Organization : **Medical Center of SE Oklahoma**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

I feel that this proposed ruling would increase length of stay, and cost to health care providers. It would also increase patient's risk of developing infections due to increased length of stay. Hospitals now have diffuculty meeting all of the regulations, we have to beg insurance company's for addtional time for extrememly sick patient's, why place a extra burden on hospitals to discharge medicare patient's that meet discharge critera. We get denied days from medicaid because they feel that the patient can be cared for at home but you will be placing a burdon on hospital's to discharge Medicare Patients. This does not seem to be using good judgement.
Thank you

Submitter : **Ms. Linda Chapman** **Date: 04/27/2006**

Organization : **Pella Regional Health Center**

Category : **Critical Access Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P-322-Attach-1.DOC

CMS-4105-P-322-Attach-2.DOC

Attachment #32

Linda Chapman, Case Manager
Pella Regional Health Center
404 Jefferson Ave.
Pella, Iowa 50219

April 25, 2006

To whom it may concern:

Pella Regional Health Center is a small rural 25-bed Critical Access Hospital with a very active and supportive case management department. We are concerned that the proposed ruling, *Notification of Hospital Discharge CMS 4105-P,* would lead to increased length of stay for our Medicare patients. It is one of our primary responsibilities as case managers to screen patients daily for severity of illness, intensity of service and appropriateness for discharge. This leads us to question the use of current existing review criteria such as McMillan and Roberts (which Medicare uses), when this process could be subject to appeal.

Federal criteria for a Critical Access Hospital includes an average length of stay of less than 96 hours; if exceeded we could risk losing our critical access certification. The notification and appeal process could also extend a patient's length of stay unnecessarily.

Patients may potentially be at risk for increased exposure to nosocomial infections, hence again increasing length of stay.

There could be an increase in cost to the Medicare program as Critical Access Hospitals are reimbursed at 101 percent of cost. With concern for Medicare funding in the future, it would appear this could present increased financial responsibility to an overburdened health care system.

Respectfully,

Linda Chapman RN, CPUR
Case Manager

Janet Naset-Payne B.S. RN
Director of Inpatient Services

Submitter : Ms. Stefani Daniels **Date:** 04/27/2006

Organization : Ms. Stefani Daniels

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

Consistency is good. And the desire to know, in advance, that a patient is going to be discharged the next day is very good. However, hospitals don't discharge patients - physicians do. So unless there is some consequence for the physician who refuses to 'cooperate' in the discharge planning process and continues to practice 'just-in-time' discharge, it will be the hospital and its staff which will suffer. The doctor is going to get paid no matter when he decides to write the discharge order, but the hospital won't. And if the hospital doesn't get paid, the staff and the community suffer. As a front line hospital worker, its time that the regulations and reimbursement mechanisms lined up equally for the hospital and the physician. Until there is a level playing field, I and my nurse colleagues will continue to bear the clinical and financial burden of poor medical practice decisions.

Submitter : Mr. Mark Rossato **Date:** 04/28/2006

Organization : Dickinson County Healthcare System

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

Dickinson County Healthcarte system does not support this proposed rule change as we feel it would cause an unnessesary increase in a patient's Medicare days and would also cause an increase in a patient's length of stay in hospitals because of paperwork issues. This rule would be a logistical nightmare with the doctors rounding at different times through out the day and lack of documentation of definitive discharge date. It would be very difficult to stay in compliance with over 2000 medicare discharges/year. We would be required to track every Medicare patient for potential discharge and make sure they recieve a letter the day prior to discharge. This would be an issue for one and two day IP stays, as well as with last minute decisions to discharge and weekend admissions and discharges.

Submitter : Ms. Wendy Dwyer **Date:** 04/28/2006

Organization : St Peter's Hospital

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

I THINK A TWO STEP PROCESS FOR NOTIFICATION OF DISCHARGE IS AN UNDO BURDON UPON HOSPITAL STAFF GIVEN THE SPEED WITH WHICH PATIENTS ARE ADMITTED AND DISCHARGED THESE DAYS. MIGHT HAVE BEEN ACCEPTABLE 30 YEARS AGO WHEN PEOPLE STAYED INPATIENT FOR A WEEK FOR MOST EVERYTHING, BUT NOT NOW. THE FOCUS NEEDS TO BE ON PATIENT CARE NOT FORMS. ONE STEP FOR DISCHARGE NOTICE IS MORE THAN ENOUGH. THANKS.

Submitter : Mrs. Cindy Kreter **Date:** 04/28/2006

Organization : Medina Memorial Healthcare System

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

The propsed two- step notice process would be difficult to comply with. Our current LOS is an average of 4 days. Nursing finds it difficult to comply with the 24 hour notice now as physicians make their discharge decisions on the same day of discharge. With such a short LOS it would be hard for the patient to understand the process as they will still be acute when they recieve the letter. One day notice gives the patient time to appeal the dischage if that is their desire. Usually the patient is feeling better at that time and can understand that it would be resonable for them to be going home on the next day.

Submitter : Mrs. Renee Johnson **Date:** 05/01/2006

Organization : Reid Hospital & Health Care Services

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-4105-P-372-Attach-1.DOC

Provisions of the Proposed Rule
CMS-4105-P
April 28, 2006

The Center for Medicare and Medicaid Services propose a rule that would require hospitals to give **all** Medicare beneficiaries a standardized notice of non-covered services **the day before** discharge. This is a 2 step notice process when discharging patients from the hospital level of care that is similar to the notice requirements regarding service terminations applicable to home health agencies, skilled nursing facilities, comprehensive outpatient rehab facilities and hospices. This was suggested for hospitals in January 2001 and rejected in 2003 due to significant administrative burden. This is true today as well. I have reviewed home care and hospice process and have found the following problems.

A. Excessive Burden on Staffing

a. **Not enough staff**-I have 3.4 fte's to perform Utilization Management functions on all payers. This is very lean for my 253-bed hospital. As we are 75% Medicare and Medicaid, this will decrease the amount of review time my staff has on these charts due to giving the letters daily. The weekend will be especially difficult as I only have one reviewer.
b. **Short stays** (what about the patient's who come in one day and leave the next?)
c. **Education of the Pts and Families**-in my opinion, this will take longer than 5 minutes to give the letter. A large majority of our patients don't understand the HINN letters and we have to track down younger family members to educate them on the notification letters. This new process will add to that burden.
d. **Physician Practice Change**-we will have to educate and train physicians to write an 'anticipate discharge on _____' or that we can give the letter. They don't do what we ask now. The resistance to a new RULE will be high. The burden on the staff to try to anticipate the discharge will be tenfold.
e. **Billing Procedure Changes**-the billing process will become even more complex with this new rule. A process will need to be developed between the billing office and the UM staff for a flawless billing process. More hours will be required to facilitate a bill that is correct.

B. Patient and Family Perception of the Hospital

f. **Discharged too early**-it has been my experience when giving HINN letters that the patients and families believe it is the hospital who is stopping their insurance coverage and therefore making

them leave the hospital. This new rule will only add to this perception.

C. Conflict of Interest

g. **Conflict of interest between the patient and the** conditions of participation require us to evaluate and monitor Medicare patients for criteria. When we don't find any, we are required to inform them of their financial responsibility to the hospital. Ethically, this is wrong. We are telling them that they now have to pay for services out of pocket, that they were receiving when their insurance was paying, if they want to stay in the hospital. How can the hospitals NOT come off looking bad?

D. Hospital Burden

g. **Staff Education**-Our Medicare population is around 75%. This is a large population to manage the education of patient, family, nurses, case management and physicians. All staff would need education to make this process flawless. The staff/physician/patient will need to realize this as a federal compliance issue not something the hospital/case management has made up.

h. **Physician dissatisfaction with Medicare recipients**- will be increased with more rules about how they care for the patient at discharge. The physician will need to concur with discharge before the letter is given. In my opinion this is redundant as the physician indeed agrees when he writes a discharge order or why would he write it in the first place.

i. **Appeals** will be before noon or the hospital assumes liability for that day and until at least noon of the day after the QIO 's decision.

j. **"The burden on hospitals would be substantially less than earlier proposed."-** I believe they have overlooked the knowledge and understanding of the patients about health care reimbursement and rights. Working with beneficiaries as we do on a daily basis the information the beneficiaries have and the expectations are not always aligned. Putting the burden on the hospitals for the education with every hospital discharge is tremendous and costly.

k. **Proposed 405.1205** under the description for the notice # 5 states "any other information required by CMS" is very opened ended and should not be left for interpretation by CMS at a later date.

l. **Transitions rather than discharges**-While this is being done to promote uniformity in all settings I believe this is not in the hospitals best interest as the focus for discharge is different than in other settings. Our discharges are usually transitioned to another level of care due to the criteria we enforce. The detailed notice includes 4 very lengthy explanations why services are no longer reasonable and necessary. Explaining to the patients and families that the care

they are receiving can be performed in a less acute setting is difficult. Now, we have to have this conversation with all Medicare patients. This, too, will add to the amount of time that we spend giving the letters.

m. **Underestimated the time and cost requirements for delivering a notice**-They propose it will only take 5 minutes to deliver this notice. I understood the proposal to be given for the beneficiary to understand their rights. I am not sure there is anything you can explain in 5 minutes. They also estimate12.5 million notices annually at the cost of $31.2 million. The cost to each provider they estimate would be $5,200. I find this extremely low. This does not include the appeal process. CMS estimates 60 to 90 minutes. We give occasionally HINN letters that take 2-3 hours depending on the situation. Insurance denials take more than an hour. Hospitals across the nation give very few HINN letters due to the time and cost involvement.

Submitted by
Renee Johnson
Reid Hospital
Richmond, IN

Submitter : Ms. Trudy Mick **Date:** 05/01/2006

Organization : SSFHS

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

The proposal to require 2 day notice of discharge date is not appropriate for acute care settings due to the inability to make that judgment accurately with the changing stability of that patient population. It would not be of value to the patients or to Medicare Healthworks.

Submitter : **Ms. Sally Maruska** **Date: 05/01/2006**

Organization : **North Country Regional Hosptial**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

To burden hospitals with the amount of paperwork that would be entailed to do this seems unbelievable. At our hospital I am the person who currently gives denials to patients when they are required. I find that it takes a lot of time to explain the process to patients, etc., because it is in fact somewhat confusing. I think that implementing this process would make patient's feel more negatively about the care they are receiving. There could be a lot of feelings of resentment due to this as patient's may feel the government is imposing even more on their health care.

Submitter : **Ms. Susan Evans** **Date: 05/01/2006**

Organization : **Sarasota Memorial Hospital**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P-402-Attach-1.DOC

April 21, 2006

Re: File Code CMS-4105-P

In response to the proposed rule above, please consider the following:

1) We believe that "The Important Message From Medicare" standard notice given to all Medicare beneficiaries upon admission and the process for delivering Hospital Issued Notices of Non-Coverage (HINN) when beneficiaries disagree with a physician's order for discharge, sufficiently provide beneficiaries with a clear understanding of their rights to appeal.

2) We also believe that since one of the standard components of any patient's plan of hospital care is an understanding of the appropriate level of care following hospital discharge (including written discharge instructions), that requiring a written statement of the reason for discharge would be redundant and unnecessary.

3) The background on this proposed rule says "We believe that the . . . process . . . is helpful to beneficiaries." Considering the administrative burden (see #4 below) this would put on hospitals, we would like to see the data to support this proposal. Have you conducted surveys with beneficiaries or is this based on actual cases of inappropriate discharges where beneficiaries were unaware of their appeal rights. If it is the latter, how many were there?

4) This proposed rule would require the following at our facility:

   - Consider expanding case management staffing to handle preparation, delivery, reconciliation of needed vs. missing signatures as well as identifying and tracking situations where a notice was delivered and signed by the beneficiary but the discharge date changed resulting in another notice needing to be delivered.
   - Accommodate manual forms with additional space and staffing for physical storage and retrieval.
   - Add resources to redesign processes, educate staff, and coordinate implementation.
   - In situations where a physician discharges a patient unexpectedly, and the patient's discharge is pending only the delivery of this notice, beds may not be utilized efficiently; therefore unnecessarily increasing lengths of stay.

Thank you for your consideration,

Susan Evans, Regulatory Compliance Specialist
Sarasota Memorial Healthcare System

Colleen Ryan, Integrated Case Management Clinical Supervisor
Sarasota Memorial Healthcare System

Sarasota Memorial Healthcare System
1700 S. Tamiami Trail
Sarasota FL 34239
(941) 917-9000

Submitter : **Dr. billa m Fisher** **Date: 05/02/2006**

Organization : **Dr. billa m Fisher**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I have been submitting to you claims with procedure code 90935(in hospital dialysis)with diagnostic code 585.6(end stage renal disease)the payment was denied because of the code, and I was told by the medicare office that 585.6 isn't the code for 90935 or 90937 or 90945 and to put another code 586.586 diagnostic code was denied.
Till this date I didn't recieve an answer forthe problems. The number of your denials are increasing every day as every day I see patients in the hospital that go on Dialysis. My Medicare # is 00467
Thank you Billa Fisher MD, 9178213919

Submitter : Mrs. Kathy Hunter **Date:** 05/02/2006

Organization : Samaritan Medical Center

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

Requiring hospitals to issue another discharge notice, in addition to that information currently required at the time of discharge, would pose an administrative burden on the Case Management staff at our facility, taking time away from effecting safe timely discharges to carry out a bureaucratic procedure. It may add increased stress for beneficiaries and their families at a time when heightened anxiety already exists. There is a potential of escalating length of stay and increasing bed and resource utilization longer than medically necessary. I believe our patient population would be better served by concentrating on improving the interdisciplinary communication process to involve beneficiaries and their families in the plan of care with the natural progression to discharge awareness being the end result.

Submitter : **Dr. Jonathan Harding** **Date: 05/02/2006**

Organization : **Tufts Health Plan**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

While I understand the desire to empower beneficiaries to appeal the few discharges that may be considered premature, the impact of this rule will cost Medicare billions of dollars. The impact is not the trivial increased cost of delivering notices. The impact is on delayed discharges of many many admissions. Physicians do not know the date of the discharge 24 hours in advance in most cases. If we know the patient is ready to go today, we don't wait a day to discharge, we send the patient home today. Discharge is contingent on a patient reaching a certain physiologic milestone - passing gas, lowered temperature, lower pulse, higher hemoglobin. We cannot accurately predict 24 hrs. in advance that the patient will achieve that milestone. Once a patient achieves that milestone, they can be discharged that day.

Requiring the patient stay an additional 24 hrs. beyond that point, to consider their notice of intent to discharge, will increase average length of stay for inpatient care by 1 extra day in most cases. Have you considered the costs of THAT in your analysis? I have not seen that mentioned.

Submitter : **Ms. Marla Brady** **Date: 05/02/2006**

Organization : **Harrison Medical Center**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

May 1, 2006

Department of Health and Human Services
Centers for Medicare & Medicaid Services
RE: Proposed Rule related to Notification Procedures for Hospital Discharges
File code CMS-4105-P
To whom it may concern:

Harrison Medical Center is providing comment on this proposed rule. We oppose adoption of this rule based on the following concerns:
" Discharge from the hospital is based on conclusion of medically necessary acute care services. Sometimes, this is not known the day prior to discharge. Would it be a violation to discharge the patient without giving the notice the day before? Would we be required to keep the patient another day and thus fail to discharge as physician ordered?
" The payer is not always known, even at time of discharge for short length of stays. How would this be addressed?
" Short lengths of stays negatively impact the day before discharge determination and thus may lengthen the length of stay unnecessarily.
" The amount of time and dollars estimated by CMS for providers to implement this rule in our opinion are greatly underestimated. Trained hospital staff must be on site and available seven days per week to deliver the specific document and to assist in the appeal process as requested by the beneficiary. Again, added lengths of stay may result in waiting for QIO intervention with appeals (is the QIO going to be available on weekends and Holidays for appeal review?) These are added costs to hospitals with no additional payment by CMS. We believe actual costs to hospitals to be greater than 10 fold the estimate provided by CMS

We believe this proposed rule places undue hardship on hospitals and should not be adopted. Thank you.

SEE ATTACHMENT DOCUMENT

CMS-4105-P-442-Attach-1.DOC

May 1, 2006

Department of Health and Human Services
Centers for Medicare & Medicaid Services
RE: Proposed Rule related to Notification Procedures for Hospital Discharges
File code CMS-4105-P
To whom it may concern:

Harrison Medical Center is providing comment on this proposed rule. **We oppose adoption of this rule based on the following concerns:**

- Discharge from the hospital is based on conclusion of medically necessary acute care services. Sometimes, this is not known the day prior to discharge. Would it be a violation to discharge the patient without giving the notice the day before? Would we be required to keep the patient another day and thus fail to discharge as physician ordered?
- The payer is not always known, even at time of discharge for short length of stays. How would this be addressed?
- Short lengths of stays negatively impact the day before discharge determination and thus may lengthen the length of stay unnecessarily.
- The amount of time and dollars estimated by CMS for providers to implement this rule in our opinion are greatly underestimated. Trained hospital staff must be on site and available seven days per week to deliver the specific document and to assist in the appeal process as requested by the beneficiary. Again, added lengths of stay may result in waiting for QIO intervention with appeals (is the QIO going to be available on weekends and Holidays for appeal review?) These are added costs to hospitals with no additional payment by CMS. We believe actual costs to hospitals to be greater than 10 fold the estimate provided by CMS

We believe this proposed rule places undue hardship on hospitals and should not be adopted. Thank you.

Marla Brady, RN, MSN
Administrator Service Excellence and CMO Operations
360.792.6888 FAX 360.792.6515
mbrady@harrisonmedical.org

Submitter : Dr. George Weir **Date:** 05/02/2006

Organization : Schneck Medical Center

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

The proposal of predischarge notification is well intended. It obviously is unworkable. The paperwork adds another needless expense to an already underfunded system. There is no way that HHS could possibly respond in a timely manner. Hospitals would face unnecessary increased length of stay and therefore increased expense. HHS employees, in some remote location, could not possibly evaluate readiness for discharge in an accurate or consistent manner. The return would not be justified by the expense if you were actually paying for all of the paper work involved. You should not attempt to saddle the hospitals with this burdensome administrative nightmare.

Submitter : Ms. Judith Gangle **Date:** 05/03/2006

Organization : Sitka Community Hospital

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

I find this rule very cumbersome because it is usually impossible to give a letter of discharge the day before. Our facility is a 14 bed rural access hospital with swing bed capacity. Our physicians often tend to decide on discharge the morning of. Often patients are admitted and discharged on the same day. This is partly due to Medivac to a larger hospital (we are located on an island), or to tourists returning to a cruise ship doctor's care. How can the length of stay for an Inpaitent visit be determined before hand? Are we going to keep everyone a day extra so that we can be sure to meet the rule and give everyone a night to sleep on it? I find this an impossible task. Also, the 5 minute estimate of the time it takes to explain yet another Medicare form to an elderly population who does not understand is unrealistic.

Submitter : Dr. Terry Lee **Date:** 05/04/2006

Organization : University Medical Group

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

A regulation requiring 24 hour notice of intent to discharge will create additional unnecessary costs in caring for patients. It is an unnecessary step and will contribute to longer length of stay.
While I agree that the patient benefits from advance notice when being discharged from the hospital.... it rarely occurs that the hospital discharge comes as a surprise to the patient. I frequently cannot accurately predict the rate of patient improvement, however, the when rapid improvement is noted and the patient wants to go home, I believe many physicians will choose to "wait the prescribed 24 hours" and prolong the patient's hospital stay before disharging.
I truly believe when assessing the risks vs the benefits of implementing this rule, will bring an excess of cost relative the small benefit that may occur as a result of requiring a written notice of intent to discharge (with attendant appeals process). Please do not implement such a change without planning to spend a lot more money on hospital medical care.

Submitter : Mrs. HELGA CRAWFORD **Date:** 05/04/2006

Organization : PARADISE VALLEY HOSPITAL

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

THIS WOULD BE AN IMPOSSIBLE RULE TO FOLLOW. IN SOME CASES, MEDICAL CONDITIONS CAN CHANGE VERY QUICKLY. IF THIS RULE SHOULD PASS, IT WOULD CERTAINLY UNNECESSARILY EXTEND THE LENGTH OF STAY AND WASTE ACUTE HOSPITAL DAYS FOR THE BENEFICIARY AND UTILIZATION FOR THE HOSPITALS.

Submitter : **Sheryl Tiemeyer** **Date: 05/04/2006**

Organization : **Schneck Medical Center**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

Please see attached comments to 4105-P.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter : Dr. Lori Richardson **Date:** 05/04/2006

Organization : Harris Methodist Hospital Fort Worth

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

As the Medical Director for Utilization Management of a 700 licensed bed facility with a >40% MCR population, I am very concerned about giving EVERY patient one of these letters. These letters are time-consuming to produce and explain and result in, at best, a very confused patient/family or, at worst, a very ANGRY patient/family. While I'm sure that someone hopes these letters give patients and their families an understanding of their length of stay, it gives the patients the impression they are being kicked out or that they don't matter just the use of the bed in the hospital does. I have practiced in an environment where the commercial Healthplans did this for all their members and it was a nightmare for the providers and the patients alike. Please do not do this to the MCR beneficiaries! Thanks for taking comments. Lori Richardson, M.D.

Submitter : **Ms. Deborah Adams** **Date: 05/04/2006**

Organization : **Phoenix Baptist Hospital**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

Providing a HINN or NODMAR letter will not improve service or care for the medicare beneficiary. It will take the case managers/social workers away from providing useful services to the beneficiary. Since the patient is sicker and stays in a shorter time at an acute care facility, the case managers and social workers have limited time available in which to provide quality discharge planning and utilization.

Submitter : Mrs. Charlotte Brooks **Date:** 05/05/2006

Organization : Carilion Health System

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

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Please direct your questions or comments to 1 800 743-3951.

Submitter : **Mrs. Charlotte Brooks** **Date: 05/05/2006**

Organization : **Carilion Health System**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment. This is my second attempt today to send comments.

CMS-4105-P-532-Attach-1.DOC

CARILION
Health System

Attachment #53

Date: 5/5/06

To: CMS

From: Carilion Medical Center
Patty Steinbach, RN, BSN
Manager, Case Management/Utilization Management
Carilion Medical Center

Re: Proposed rule /CMS-4105-P Comments

This letter comes to CMS in response to the proposed rule: CMS-4105: Notification Procedures for Hospital Discharges.

My response and rationale focus on the following areas:

- Administrative burden is both resource/time and cost prohibitive.
- Staff resource use causes undue burden and increased cost to hospitals.
- Physician participation in ruling required for **any compliance** achievement
- Patient capacity to receive the notice/ability to understand the notice
- Carilion Medical Center Statistics/Costs to process CMS 4105-P
- Recommendations for alternate ways to meet this need.

"BACKGROUND"

This proposal was suggested in 2001 and it was determined that the administrative burden on Hospitals was such that it was not feasible to implement such a plan. This new proposal does not decrease the administrative, nor the employee resource burden. Why re-propose such a plan. Patients do not need to have the same information given to them in medico-legal terminology more than once per visit.

"PROVISIONS OF THE PROPOSED RULE"

Administrative and Staff Resource Burden

This proposed rule sets forth new requirements for hospital discharge notices under both original Medicare and the Medicare Advantage program. The rule would require hospitals to comply with a two-step notice process when discharging patients from the hospital level of care similar to the process used in HHA, SNF and CORF. It would require a generic notice of discharge (physician concurring) and Medicare appeal rights to be delivered one day before discharge. If the patient disagrees with the physician's decision to discharge, they may request an expedited appeal. This results in the hospital being required to provide a second notice to the beneficiary with detailed explanation why services are either not longer reasonable and necessary or are otherwise no longer covered; a description of any applicable Medicare coverage rule,

instruction, or other Medicare policy, including citations to the applicable Medicare policy rules or information about how the beneficiary may obtain a copy of the Medicare policy; facts specific to the beneficiary and relevant to the coverage determination that are sufficient to advise the beneficiary of the applicability of the coverage rule or policy to the beneficiary's case; and any other information required by CMS. All of this information is to be inserted on the detailed notice and should be individualized and written in plain language to facilitate beneficiary understanding.

To be more concise, CMS is requiring the hospital to in effect, document what the Physician's rationale is for discharging the patient which in itself will take significant amounts of time and effort just to obtain the Physician's opinion, and then be well enough versed or perhaps develop Medicare templates to be able to insert into the "individualized" letters to explain Medicare's rules and how we use them to determine medical necessity for continued stay.

Perhaps each beneficiary upon enrollment in Medicare should be provided with a copy of the Interqual criteria on medical necessity for admission to acute care for their review and reference. We will need to be available to explain all of this in "terms" the beneficiary can understand. After the "detailed notice", is presented do we follow with a HINN since the patient likely does not meet criteria for acute inpatient stay or he/she would not be discharged? This generates another notice to deliver and explain appeal rights. Then copy the chart again and send it off to the QIO for review. ...another few days of no liability to the patient and increased resource consumption for the hospital. At this point the patient will be so confused and frustrated with the attempts at ensuring their benefit rights are known to them it will take a Medicare expert to try to explain things.

I have several concerns with this proposed ruling. HHA do not provide the Important Message about Medicare booklet at admission that describes the appeal rights of the beneficiary as the Acute Care Hospitals do. So, we are already providing this information at an appropriate level at admission.

In the acute care setting, unlike HHA, Hospice and CORF/SNF settings the patient's conditions change rapidly. The estimated discharge date is not reliable and therefore it would be next to impossible to ensure delivery of a discharge notice the day before discharge. The notice would have to be delivered with the "Important Message from Medicare" brochure on admissions anticipated to be 1-2 day stays.

Hospitals would have to increase their UM staff to work much later in the day in order to catch the late rounding physicians in case they document plans to discharge the next day, and hopefully notify the UM department in order to deliver the notice. This process, contrary to the statistical data provided by CMS, will result in a significant burden to the hospitals, both in administrative resource use as well as UM and skilled RN Case Manager staff time. Hospitals would have to increase their staff to meet this regulation. In order to identify potential discharges for the next day, hospitals would have to be reviewing the patient medical records at least daily (or more frequently to

catch late rounding physicians) for physician progress notes that indicate a potential discharge and then facilitate the discharge notice or alert other staff to prepare and deliver the notice. The staff delivering such notice would have to be well versed in the Medicare policies, rules and denial and appeal processes. This process would also require a second staff member be present for the delivery and witness of the patient's signature (or refusal to sign) for documentation purposes. The alternative would be to provide concurrent coding on all inpatient units to provide a preliminary DRG and its' expected length of stay. The hospital could then drive an expected discharge report off this data and attempt to deliver DC notices in accordance with this. Unfortunately, frequently the preliminary DRG is incorrect and/or the patients condition changes and thus the DRG changes and the expected LOS is no longer valid.

Physician Participation

In order to do this, massive Physician education and compliance would be required. Physician participation in documenting in advance the plan to discharge and ensuring the appropriate staff were alerted to this in order to facilitate delivery of the notice to discharge would be needed. Currently, Physicians round at various times of the day, evening and night and occasionally write progress notes to indicate a potential discharge the "next day" or "in a few days" and routinely write this daily. Many physicians have remarked to me that they do not write specific plans to discharge "the next day" because they are concerned with insurance denials if they do.

Until the Physicians are directly impacted to comply with this, hospitals will continue to struggle to meet CMS demands. Until CMS requires physicians to comply with their regulations, compliance efforts will fall short. Even in cases where we "thought" we had a probable discharge for the next day, the likelihood of the plan changing the next day is significant and results in waste of resources of staff to print and complete the letter, deliver the letter, explain the letter and appeal rights, document that the letter was given and explanations provided. Then the patient does not discharge for various reasons and the letter is removed (?) or voided and the cycle starts again when the physician "thinks" he/she may discharge "tomorrow". To try to deliver these discharge notices the day before discharge is next to impossible in the acute care setting. Unlike rehabilitative settings where the plan of care and progress of the patient are more consistent and predictable, acute care setting is fast paced, unpredictable and expected discharge dates, for the majority of patients are unreliable. The only realistic way to accurately provide a beneficiary with a notice to discharge would be for the physician to be responsible for the delivery of the notice to discharge during his/her discussion with the patient about the discharge plan.

Another issue regarding physician interaction is this...if a physician had discharged a patient one would assume that in 99% of the cases the patient no longer meets criteria for acute care stay and is ready to discharge. If the patient disagrees with the discharge and we send in an expedited appeal what happens? Does the QIO call the attending physician to tell them that they think that the patient should not be discharged? Does the QIO then tell the physician how the patient should be treated? Does the hospital

now get additional reimbursement as well? If the physician feels the patient is ready to discharge and the patient requests an expedited review is he/she now obligated to cancel the discharge and write some sort of orders to appease the patient and/or the QIO? If the patient truly feels that they should not be discharged for medially necessary reasons related to the diagnosis they are being treated for and not medical convenience or family convenience wouldn't they have discussed this with their physician and the discharge would not have been written? It seems redundant to have a patient be aware that they are to be discharged and then give them a notice that their coverage will end at the time of discharge. This information should have been provided to the patient before they are ever admitted to the hospital; perhaps at the time of enrollment in their insurance plan.

Patient Capacity

Another concern is that of patient capacity. If the patient lacks capacity to receive the discharge notice and there is no available responsible party what is the course of action. If it is the same process that is used for HINN's then we are keeping a patient in acute care, increasing our LOS, likely at a loss financially, while we try to reach family. Will we be required to go so far as to try to send certified letters to documented responsible parties and await receipt, signed or unsigned, before being able to discharge the patient? This will increase our length of stay and resource consumption in a case that may have already exceeded resource allocation by CMS.

In our organization, licensed RN case managers are unit based and also perform the utilization review function. This process will require additional administrative work by licensed staff, diverting highly skilled staff from assessing and developing plans to progress the patient through to discharge. The hospitals would likely have to re-design their staffing in order to increase FTE's to print out discharge notices for delivery whenever notified of a "potential" discharge. This staff would not be administrative staff, they would have to be trained and well versed in UM and Medicare rules and regulations in order to provide detailed explanations to the patients and families. Explanations that may be best directed to CMS themselves.

Hospitals would also have to increase their staffing in order to cover all weekend and holiday discharges that may not be currently covered by staff with the UM expertise required.

"OVERVIEW OF THE CHANGES"

Carilion Medical Center Statistics/Costs to process CMS 4105-P

CMS proposes a $2.50/discharge notice cost when done by a health care worker and a time burden of 5minutes per discharge to deliver the notice of discharge and appeal rights letter to each Medicare beneficiary. CMS proposes the cost of the detailed notice at $45 and time burden of 90 minutes.

Per CMS calculations, this equates to $3,847.50 and 1261 hours/year for the first discharge notice and 454 hrs/yr and $13,635.00 for the detailed notices for Carilion Medical Center.

When I put time and dollars to our total Medicare discharges, I get a very different picture.

Statistical breakdown of the proposed time and cost projected by CMS for Carilion Medical Center based on 2005 data of total Medicare discharges (original Medicare, replacements plans, advantage plans) at 15,139 discharges:

• Review report with anticipated MC discharges/5min (write report program to alert to expected discharge date from admission preliminary DRG and it's expected LOS)	1261 hrs/yr
• Hire additional coders to ensure concurrent coding on all units to capture the potential DRG/expected LOS data entry and drive the DC report (currently have 4 coders/8 floors; require 7 additional:	14,560 hrs/yr
• Five min to type/print DC notice (make copy for signature and placement on chart)	1261 hrs/yr
• Five minutes to deliver notice of DC two staff/5min (require two staff to deliver and witness signature)	2523 hrs/yr
• Presentation and explanation of legal document at 10min	2523 hrs/yr
• Put signed DC document on medical record 3min (punch holes in paper, find chart, place on chart)	757 hrs/yr
• 2% (303) disagree and require detailed letter: 90 min/each	454 hrs/yr
• Confer with physician to provide "details" for letter: 10 min	51 hrs/yr
• Present (2 staff) and explain, witness signature on Detailed discharge notice: 15min	76hrs/yr
• Receive call from QIO/prepare documents to mail/fax To QIO for expedited review: 30 min	152 hrs/yr
• Receive QIO determination; present to patient, Physician, document QIO determination with Copy to chart: 10 min	51 hrs/yr

Time in hours to perform CMS proposed two step discharge notice for Carilion Medical Center: **23,669 hrs/yr.**

This equates to **4.4 full time employee hours in CM/UM and 7 FTE employees in Coding.**

Currently CMC does not have the opportunity to add this new function into our already maximized job roles and responsibilities. Therefore, this would require the addition of at least 7 FTE full time employees to perform concurrent coding on 13 inpatient units (total salary of $254,363.20) to enable the facility to project the expected discharge date from preliminary DRG data entry. The Case Management/Utilization management

department would require 4 full time equivalent employees with a salary of $33,000/each ($148,500.00)at a Utilization Management Analyst rate, versus $55,057/each ($247,758.40) for unit based case managers to deliver notices to patients that have already received the same information in their admission packet.

Carilion Medical Center versus	**CMS projected time/dollars/yr for 4105-p:**
$402,863.20	$17,482.50
23,669 hrs/yr.	1715 hrs/yr

We would project a significant higher cost both in dollars and resources to maintain compliance with CMS proposed rule 4105 of:
$385,380.70
21,954 hrs annually

I do not believe CMS has considered the actual day to day tasks and administrative functions and costs that would be required to be able to accurately determine the discharge date one day in advance, nor the amount of repetitive work and likely re-work in attempting to get the notices to the beneficiary in the correct time-frame.

RECOMMENTATIONS FOR MEDICARE/MEDICARE REPLACEMENTS

Provide information at admission in the required booklet:
Include the pertinent information about cessation of benefits at the time of discharge and the appeal rights at admission to the hospital, in the "Important Message from Medicare" Booklet already required (It seems that most people are aware that coverage ends when the physician has discharged them..? No other payer provides a notice at discharge) These patients receive so much information during their stay that another "notice" just adds more confusion for them. Not only is the language difficult, but times of illness and stress are not good environments for learning.

Include this information in the Medicare and You Booklet for new beneficiaries and yearly updates.
Medicare beneficiaries are provided with information on their plan via paper documentation, computer access to the Medicare web page; CMS telephone number and many other avenues. Beneficiaries should be responsible to familiarize themselves with the content and specifics of their plan. The hospital should not be responsible to provide beneficiaries with education on their insurance benefits every time they are admitted to the hospital. The provider should be responsible to provide/disclose information on their plan to the consumer.

Include this information on the back of the beneficiary's medicare card
Or perhaps provide a "second" card together with their benefit card with pertinent information needed for reference with any provider contact.

Physician role options

Propose that the delivery and obtaining the patient signature on the form be delegated to the physician providing care for the patient. If the patient disagrees with the discharge, the physician can refer to the hospital UM department.

Physician required to notify the UM department the day before planned discharge; during business hours to schedule delivery of the notice.