Policy:	MA.6024
Title:	**Notification of Inpatient Facility Discharge Appeal Rights**
Department:	Medical Management
Section:	Utilization Management
CEO Approval:	*/s/ Michael Hunn 12/20/2024*
Effective Date:	08/01/2005
Revised Date:	12/01/2024
Applicable to:	☐ Medi-Cal ☒ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy outlines the procedure for an inpatient facility to deliver written notification of a Member's inpatient facility rights and discharge Appeals rights.

II. POLICY

A. CalOptima Health or a delegated Health Network shall perform the authorization process in accordance with CalOptima Health Policies GG.1508: Authorization and Processing of Referrals and GG.1539: Authorization for Out-of-Network and Out-of-Area Services.

B. An inpatient facility shall deliver the Important Message from Medicare (IM) Notice to a Member receiving inpatient hospital Covered Services upon admission and before termination of such Covered Services as set forth in this Policy.

C. An inpatient facility and CalOptima Health, with the admitting physician's concurrence, shall determine when inpatient care is no longer Medically Necessary and discharge the Member from the inpatient facility. A discharge is a formal release of a Member from the inpatient facility that includes physical removal from the facility or transfer to a lower level of care.

D. A Member shall have the right to Appeal an inpatient facility discharge and request an immediate review in accordance with CalOptima Health Policy MA.9004: Expedited Pre-Service Integrated Appeal, and MA.9007: Appeal Process for Member Discharge from Inpatient Facility.

III. PROCEDURE

A. An inpatient facility shall distribute an IM Notice to inform the Member of the Member's inpatient facility rights and discharge Appeals rights. The inpatient facility shall include the following information on the IM Notice:

1. Member's full name;

2. Identification number, other than a social security number, to identify the Member;

3. Name of the Member's admitting physician;

4. Name and telephone number of the Quality Improvement Organization (QIO) that the Member can contact to Appeal a discharge;

5. Name and telephone number of a contact person at the inpatient facility for the Member to contact with questions regarding the IM Notice; and

6. Name of the inpatient facility, including the Medicare Provider identification number.

B. Delivery of the initial IM Notice

1. An inpatient facility shall deliver an initial IM Notice:

   a. At or near the Member's admission date, but no later than two (2) calendar days following the date the Member was admitted into the inpatient facility; or

   b. During a preadmission visit, but not earlier than seven (7) calendar days prior to the date of the Member's admission.

2. An inpatient facility shall deliver the initial IM Notice to the Member in-person. If the Member is incapable or incompetent, the IM Notice shall be delivered in-person to the Member's Authorized Representative.

3. If the inpatient facility is unable to deliver the initial IM Notice in-person to a Member's Authorized Representative, the inpatient facility shall contact the Member's Authorized Representative by telephone to inform him or her of the Member's inpatient facility rights and discharge Appeal right. If both the inpatient facility and the Member's Authorized Representative consent, the inpatient facility may send the IM Notice to the Member's Authorized Representative through electronic mail or facsimile in accordance with the Health Insurance Portability and Accountability Act (HIPAA) and CalOptima Health Policy HH.3014: Use of Electronic Mail with Personal Health Information (PHI).

4. The inpatient facility shall obtain a signature and date on the initial IM Notice from the Member or the Member's Authorized Representative. Prior to obtaining a signature and date, the inpatient facility shall make every effort to ensure that the Member or the Member's Authorized Representative comprehends the contents of the IM Notice and provide an opportunity for the Member or Member's Authorized Representative to ask questions.

5. The initial IM Notice shall not be delivered to a Member or the Member's Authorized Representative during an emergency and shall be delivered once the Member is medically stable.

6. If the Member or the Member's Authorized Representative refuses to sign and date the initial IM Notice, the inpatient facility shall document and date the refusal. The date of refusal shall be considered the date of receipt of the initial IM Notice.

C. Delivery of the follow-up copy of the signed IM Notice

1. An inpatient facility shall deliver a follow-up copy of the signed IM Notice before the Member's planned discharge date, but not more than two (2) calendar days before the discharge date.

2. If an inpatient facility delivers the follow-up copy of the signed IM Notice to the Member on the day of discharge, the inpatient facility shall allow the Member, if needed, at least four (4) hours to consider his or her inpatient facility rights and discharge Appeals rights. An inpatient facility shall not routinely deliver the follow-up copy of the signed IM Notice on the day of discharge.

3. The inpatient facility shall document the delivery of the follow-up copy of the signed IM Notice.

4. An inpatient facility shall not deliver a follow-up copy of the signed IM Notice if:

   a. A Member is being transferred from one inpatient facility to another inpatient facility with the same level of care; or

   b. The Member's planned discharge date is within two (2) calendar days after the Member's admission date.

IV. ATTACHMENT(S)

A. Important Message from Medicare (IM) Notice

V. REFERENCE(S)

E. CalOptima Health Policy GG.1508: Authorization and Processing of Referrals
F. CalOptima Health Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services
G. CalOptima Health Policy HH.3014: Use of Electronic Mail with Personal Health Information (PHI)
H. CalOptima Health Policy MA.9004: Expedited Pre-Service Integrated Appeal
I. CalOptima Health Policy MA.9007: Appeal Process for Member Discharge from Inpatient Facility
J. Medicare Claims Processing Manual, Chapter 30: Financial Liability Protections, Section 200.3 *et seq*.
K. Title 42, Code of Federal Regulations, § 422.620

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	08/01/2005	MA.6024	Notification of Inpatient Facility Discharge Appeal Rights	OneCare
Revised	09/01/2008	MA.6024	Notification of Inpatient Facility Discharge Appeal Rights	OneCare
Revised	02/01/2016	MA.6024	Notification of Inpatient Facility Discharge Appeal Rights	OneCare OneCare Connect
Revised	03/01/2017	MA.6024	Notification of Inpatient Facility Discharge Appeal Rights	OneCare OneCare Connect
Revised	10/01/2017	MA.6024	Notification of Inpatient Facility Discharge Appeal Rights	OneCare OneCare Connect

Action	Date	Policy	Policy Title	Program(s)
Reviewed	11/01/2018	MA.6024	Notification of Inpatient Facility Discharge Appeal Rights	OneCare OneCare Connect
Reviewed	08/01/2019	MA.6024	Notification of Inpatient Facility Discharge Appeal Rights	OneCare OneCare Connect
Reviewed	07/01/2021	MA.6024	Notification of Inpatient Facility Discharge Appeal Rights	OneCare OneCare Connect
Reviewed	12/31/2022	MA.6024	Notification of Inpatient Facility Discharge Appeal Rights	OneCare
Reviewed	12/31/2023	MA.6024	Notification of Inpatient Facility Discharge Appeal Rights	OneCare
Revised	12/01/2024	MA.6024	Notification of Inpatient Facility Discharge Appeal Rights	OneCare

IX. GLOSSARY

Term	Definition
Appeal	As defined at 42 CFR §422.561 and §423.560, the procedures that deal with the review of adverse initial determinations made by the plan on health care services or benefits under Part C or D the enrollee believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the enrollee) or on any amounts the enrollee must pay for a service or drug as defined in 42 CFR §422.566(b) and §423.566(b). These appeal procedures include a plan reconsideration or redetermination (also referred to as a level 1 appeal), a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (Council), and judicial review.
Authorized Representative/Legal Representative	An individual who is the legal representative or otherwise legally able to act on behalf of an enrollee, as the law of the State in which the beneficiary resides may allow, in order to execute an enrollment or disenrollment request; e.g., court appointed legal guardians, persons having durable power of attorney for health care decisions, or individuals authorized to make health care decisions under state surrogate consent laws, provided they have the authority to act for the beneficiary in this capacity (see §40.2.1). Form CMS-1696 may not be used to appoint an Authorized Representative for the purposes of enrollment and disenrollment. This form is solely for use in the claims adjudication or claim Appeals process and does not provide broad legal authority to make another individual's healthcare decisions.
Covered Services	Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract.
Health Network	For purposes of this policy, a Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy, and security of health information as amended.
Important Message From Medicare (IM) Notice	A notice given by the hospital to a patient receiving Medicare health care benefits, within two (2) days of being admitted to the hospital, but not sooner than seven days prior to admission, and when the patient is going to be discharged, that explains the patient's rights and tells them how to ask for an expedited review of the discharge decision by the Quality Improvement Organization (QIO).
Medically Necessary or Medical Necessity	Reasonable and necessary medical services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services includes Medi-Cal Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.

Term	Definition
Member	A beneficiary enrolled in the CalOptima Health OneCare program.
Protected Health Information (PHI)	Has the meaning 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima Health or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Quality Improvement Organization (QIO)	An organization comprised of practicing doctors and other health care experts under contract to the federal government to monitor and improve the care given to Medicare Members. A QIO reviews Complaints raised by Members about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Medicare managed care plans, and ambulatory surgical centers. A QIO also reviews continued stay denials for Members receiving care in acute inpatient hospital facilities as well as coverage terminations in Skilled Nursing Facilities, Home Health Agencies, and Comprehensive Outpatient Rehabilitation Facilities