HOSPITAL-ISSUED NOTICE OF NONCOVERAGE

Citations and Authority for Hospital-Issued Notice of Noncoverage (HINNs)

The statutory authorities applicable to your review of a Hospital-Issued Notice of Noncoverage (HINN) are found at §1154(e), §1154(a), and §1879 of the Social Security Act (the Act). The regulatory authorities for issuing a HINN are found at 42 CFR 489.34, 42 CFR 411.404, and 42 CFR 412.42(c).

Statutory HINN Requirements and the QIO

Inpatient hospitals have been required to issue notices of noncoverage, specifically called hospital issued notices of noncoverage or "HINNs", to beneficiaries, if the hospital determines that the care the beneficiary was about to receive, or was receiving, was not covered because it was not medically necessary, or was not delivered in the most appropriate setting, or was custodial in nature.

§1879 of the Act requires notification prior to noncoverage if beneficiaries under original (FFS) Medicare are to incur financial liability. The specific process for inpatient hospitals described under 1154(e) has existed for some time, but has been codified in regulations for the first time effective July 1, 2005 (42 CFR 405.1206 and .1208).

Regulations found at 42 CFR 476.71 require QIOs to review the medical necessity of hospital discharges and admissions, in addition to other requirements specified in that section of the regulation. QIOs perform admission review when requested for all inpatient hospital stays.

BFCC-QIO Scope

The QIOs must conduct review of admissions and discharges as specified in 42 CFR 476.71(a)(6). Review of the medical record must indicate that inpatient hospital care was medically necessary, reasonable, and appropriate for the diagnosis and condition of the patient at any time during the stay. The patient must demonstrate signs and/or symptoms severe enough to warrant the need for medical care and must receive services of such intensity that they can be furnished safely and effectively only on an inpatient basis.

Section 1154(e) of the Act also requires QIOs to review all hospital notices of noncoverage upon a request from a Medicare beneficiary, his/her representative, or a hospital.

Types of Fee-For-Service (FFS) HINNs

HINN 1 – Preadmission/Admission HINN: the hospital may issue a preadmission/admission HINN when the hospital has determined at the time of preadmission or admission that a beneficiary's stay will be a non-covered stay.

HINN 10 – Hospital Requested Review (HRR): When a hospital determines that a beneficiary no longer requires an acute level of inpatient care, but the attending physician does not agree, the hospital may request a QIO review of the medical record—known as a hospital requested review (HRR). Hospitals must notify the beneficiary that the review has been requested. The QIO review of the hospital's

determination considers whether or not continued inpatient care is needed (42 CFR 405.1208(b)(1), effective July 1, 2005).

HINN 11 is used for non-covered items or services provided during an otherwise covered inpatient stay. The notice may be used to hold beneficiaries liable for certain non-covered services. The item or service at issue must be a diagnostic or therapeutic service excluded from Medicare coverage as medically unnecessary and the beneficiary must require continued inpatient hospital care.

HINN 12 is a liability notice to be used in association with the Hospital Discharge Appeal Notices to inform beneficiaries of their potential liability for a non-covered continued stay after the appeal is completed or the time frame for requesting an expedited review is past. The compliance with this notice does not fall under the review authority of the QIO.

For more information on Hospital Discharge Notices, go to the BNI website (www.cms.gov/BNI) and select "Hospital Discharge Appeals Notices" on the left side menu.

Provider Delivery of HINNs

Hospitals give HINNs to beneficiaries when issues of noncoverage arise for hospital-level inpatient care. The HINN may be given prior to admission, at admission, or at any point during the inpatient stay. It may be issued by hospital staff or utilization review committees based on Medicare instructions, including: coverage guidelines, notices, bulletins, or other written guides or directives from intermediaries or QIOs.

After the hospital issues a notice of noncoverage, the beneficiary or his/her representative is considered to have knowledge that services are not covered and is liable for customary charges. The hospital is not required to issue a HINN when it does not plan to bill the beneficiary or his/her representative.

General Content Requirements of HINNs

CMS provides model HINN language, giving providers some flexibility in the preparation of HINN notices. However, hospitals must ensure beneficiaries understand the notice. Therefore, the letters should be easy for beneficiaries to understand. In order to avoid questions of invalid notice, HINNs must contain specific information for both provider and the beneficiary's protection, including:

- Description of the care at issue;
- Dates care is determined to be non-covered/point at which beneficiary becomes liable/effective date;
- Reason(s) why care is non-covered (e.g., admission non-covered because the services could be performed safely and effectively on an outpatient basis);
- Who made the determination (e.g., the hospital, with the concurrence of the attending physician, or the hospital with QIO's concurrence);
- Justification for the assessment of noncoverage (e.g., citation to specific Medicare policy);
- Description of subsequent financial liability/cost (payment will be due for what type of services);
- Clarification that the notice is not an official Medicare determination;

- Description of the beneficiary's review rights;
- The procedures for requesting QIO review; and
- The effects the notice and a QIO review request have on the beneficiary's liability, including exactly when liability begins.

Inappropriate HINNs

An inappropriately issued HINN would be any case where the QIO determines:

- The hospital's finding is invalid (e.g., where the admission was covered and where continued acute care was medically necessary)
- The content of the notice is not in compliance;
- The patient was charged for services without a notice;
- The patient requires SNF care and there was no available SNF bed (i.e., can't be used when placement is not available)

Timing for Preadmission/Admission HINN Request & Review

When a beneficiary or his/her representative requests review of a preadmission or an admission HINN, the QIO will review any records pertaining to health care services furnished. This includes records pertaining to any inpatient hospital services provided or proposed to be provided to the Medicare beneficiary whether or not, in the hospital's view, the services are covered.

Immediate Review – If the beneficiary or his/her representative disagrees with the hospital preadmission notice, he/she may request your review, by telephone or in writing, within 3 calendar days of receipt of the HINN. If admitted, the beneficiary or his/her representative may request your review at any point during the stay. In either situation, the QIO will review the case within 2 working days following the beneficiary's or his/her representative's request, and issue either a denial notice or a notice explaining that the care would be, or is, covered.

Review after Discharge or When Beneficiary Was Not Admitted to Hospital – The beneficiary or his/her representative may request review within 30 calendar days after receipt of the notice. The QIO completes this review within the timeframe specified for any retrospective review – 30 calendar days. Once the QIO review is completed, either a denial notice or a notice explaining that the care would be, or is, covered is issued.

In all cases of appropriately requested reviews, QIOs will formally determine if the hospital notification was valid, if the hospital's findings were valid, and if beneficiaries will be liable should they remain in the hospital. If the right to reconsideration is exercised, final notification does not occur until the reconsideration is complete.

Beneficiary Payment Responsibility

HINNs do not address every aspect of beneficiary responsibility for payment. Beneficiaries remain liable for applicable deductible and coinsurance amounts, and for charges for convenience items or services never covered by Medicare, even in periods where covered care is also delivered. Hospitals are not required to issue HINNs when the beneficiary will not be billed/liable.

- Preadmission HINN -- The beneficiary or his/her representative is liable for customary charges for all services furnished if he/she enters the hospital after receipt of a preadmission HINN.

- Admission HINN -- Determine liability as follows:

  HINN Issued on the Day of Admission – The beneficiary or his/her representative is liable for customary charges for all services furnished after the admission HINN is received. However, to hold a beneficiary or his/her representative liable for charges on the day of admission, the hospital must issue the admission HINN no later than 3:00 p.m. on the day of admission. If the hospital does not meet these requirements, the beneficiary or his/her representative is protected from liability until the day following receipt of the admission HINN (e.g., a HINN issued for an admission after 3:00 p.m. or a late evening admission).

  HINN Issued After the Day of Admission – The beneficiary or his/her representative is liable for customary charges for all services furnished beginning the day following the date of receipt of the admission HINN.

Other HINN Uses

Exhaustion of Benefits – 42 CFR 412.42(e) gives hospitals the ability to charge beneficiaries for non-covered services when benefits either do not apply or are exhausted, but does not specify that notice is required. Hospitals are mindful of the general 1879 requirement to notify beneficiaries before they are held liable for non-covered care. As a consequence, many hospitals voluntarily use the HINN to notify beneficiaries when benefits are about to exhaust in addition to required uses of the notice.

References

- Fee for Service (FFS) HINN Forms, model letter template language and instructions for providers are found on the CMS Beneficiary Notices Initiative (BNI) website at: www.cms.gov/bni
- Instructions regarding hospital interactions with QIOs are in the CMS Internet-Only Manual (IOM); Publication 100-04 – Medicare Claims Processing Manual at: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912.html?DLPage=1&DLSort=0&DLSortDir=ascending

  Chapter 1-General Billing Requirements
  Section 60.4 Outpatient Billing With an ABN
  Chapter 30-Financial Liability Protections
  Section 40.3 Delivery Requirements
  Section 200 Important Message
  Section 220 Hospital Requested Review/HINN 10
  Section 240 Preadmission/Admission HINN
  Section 300 Expedited Reconsiderations

- Transmittal 594, Change Request 3903 (issued 2005) http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R594CP.pdf

- Related instructions for the Quality Improvement Organization (QIO) can be found in Tthe Medicare Quality Improvement Organization Manual, Publication 100-10, Chapter 7- Denials, Reconsiderations, & Appeals. http://cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019035.html?DLPage=2&DLSort=0&DLSortDir=ascending

For all other inpatient hospital services, including those paid on a reasonable cost basis, noncoverage notices are addressed under the general provisions of 42 CFR 411.404, related to 1879.

HINN FAQs

1. Does Livanta handle admission reviews?
   Yes. Livanta must conduct review of admissions and discharges as specified in 42 CFR 476.71(a)(6). Review of the medical record must indicate that inpatient hospital care was medically necessary, reasonable, and appropriate for the diagnosis and condition of the patient at any time during the stay. The patient must demonstrate signs and/or symptoms severe enough to warrant the need for medical care and must receive services of such intensity that they can be furnished safely and effectively only on an inpatient basis.

2. When is the Preadmission/Admission HINN issued?
   The Preadmission/Admission HINN is used if the hospital determines the care the beneficiary was about to receive, or was receiving, was not covered, because it was not medically necessary, or was not delivered in the most appropriate setting, or was custodial in nature. The hospital is not required to issue a HINN when it does not plan to bill the beneficiary or his/her representative.

3. How can I get more information on the status of a QIO HINN review?
   You may utilize Livanta's online case status tool, Arrow, by visiting www.BFCCQIOArea1.com/checkyourcase.html and entering the case number. If you need additional information on specific case outcomes, call 1-855-878-1720 for assistance.

4. What is the approved HINN format?
   While there is no standardized format for the HINN, they must conform to the content outlined in the Medicare Claims Processing Manual. For a sample with appropriate verbiage, you can refer to http://www.cms.gov/Medicare/Medicare-General-Information/BNI/HINNs.html.

5. Where can I find out more information on HINNs?
   Please refer to http://www.cms.gov/Medicare/Medicare-General-Information/BNI/HINNs.html for more information on HINNs.

6. Is the provider required to issue a Preadmission HINN to patients disputing their discharge from outpatient observation?
   No, while the provider may have deemed continued outpatient care is no longer necessary, the Preadmission HINN is for proposed inpatient services only.

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