Patient Name: _____
Patient ID Number: _____
Physician: _____

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
OMB Approval No. 0938-0692

AN IMPORTANT MESSAGE FROM MEDICARE ABOUT YOUR RIGHTS

AS A HOSPITAL INPATIENT, YOU HAVE THE RIGHT TO:

- Receive Medicare covered services. This includes medically necessary hospital services and services you may need after you are discharged, if ordered by your doctor. You have a right to know about these services, who will pay for them, and where you can get them.
- Be involved in any decisions about your hospital stay, and know who will pay for it.
- Report any concerns you have about the quality of care you receive to the Quality Improvement Organization (QIO) listed here **Qualis Health at 1-877-290-4346**.

YOUR MEDICARE DISCHARGE RIGHTS

Planning For Your Discharge: During your hospital stay, the hospital staff will be working with you to prepare for your safe discharge and arrange for services you may need after you leave the hospital. When you no longer need inpatient hospital care, your doctor or the hospital staff will inform you of your planned discharge date.

If you think you are being discharged too soon:

- You can talk to the hospital staff, your doctor and your managed care plan (if you belong to one) about your concerns.
- You also have the right to an appeal, that is, a review of your case by a Quality Improvement Organization (QIO). The QIO is an outside reviewer hired by Medicare to look at your case to decide whether you are ready to leave the hospital.
    - **If you want to appeal, you must contact the QIO no later than your planned discharge date and before you leave the hospital.**
    - If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).
- If you do not appeal, but decide to stay in the hospital past your planned discharge date, you may have to pay for any services you receive after that date.
- **Step by step instructions for calling the QIO and filing an appeal are on page 2.**

To speak with someone at the hospital about this notice, call 208-262-2300.

Please sign and date here to show you received this notice and understand your rights.

_____ _____
Signature of Patient or Representative Date

STEPS TO APPEAL YOUR DISCHARGE

- **STEP 1**: You must contact the QIO no later than your planned discharge date and before you leave the hospital. If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).
    - Here is the contact information for the QIO:
      Qualis Health
      1-877-290-4346
    - You can file a request for an appeal any day of the week. **Once you speak to someone or leave a message, your appeal has begun.**
    - Ask the hospital if you need help contacting the QIO.
    - The name of this hospital is **NORTHWEST SPECIALTY HOSPITAL 130066.**
- **STEP 2**: You will receive a detailed notice from the hospital or your Medicare Advantage or other Medicare managed care plan (if you belong to one) that explains the reasons they think you are ready to be discharged.
- **STEP 3**: The QIO will ask for your opinion. You or your representative need to be available to speak with the QIO, if requested. You or your representative may give the QIO a written statement, but you are not required to do so.
- **STEP 4**: The QIO will review your medical records and other important information about your case.
- **STEP 5**: The QIO will notify you of its decision within 1 day after it receives all necessary information.
    - If the QIO finds that you are not ready to be discharged, Medicare will continue to cover your hospital services.
    - If the QIO finds you are ready to be discharged, Medicare will continue to cover your services until noon of the day after the QIO notifies you of its decision.

IF YOU MISS THE DEADLINE TO APPEAL, YOU HAVE OTHER APPEAL RIGHTS:

- You can still ask the QIO or your plan (if you belong to one) for a review of your case:
    - If you have Original Medicare: Call the QIO listed above.
    - If you belong to a Medicare Advantage Plan or other Medicare managed care plan: Call your plan.
- If you stay in the hospital, the hospital may charge you for any services you receive after your planned discharge date.

For more information, call 1-800-MEDICARE (1-800-633-4227), or TTY: 1-877-486-2048.

Additional Information:

I have had an opportunity to review this information, had my questions answered and understand my appeal rights. Initials_____ Date_____

EXCLUSIONS FROM MEDICARE BENEFITS

*Medicare does **not** pay for **all** health care costs for a beneficiary. Medicare **only** pays for **covered** benefits.*
Listed below, for your information, is a general summary of some exclusions from Medicare benefits.

SUMMARY OF EXCLUSIONS*

- Personal comfort items.
- Routine physicals and most tests for screening.
- Most shots (vaccinations).
- Routine eye care, eyeglasses and examinations.
- Hearing aids and hearing examinations.
- Cosmetic surgery.
- Most outpatient prescription drugs.
- Dental care and dentures (in most cases).
- Orthopedic shoes and foot supports (orthotics).
- Routine foot care and flat foot care.
- Health care received outside of the USA.
- Services by immediate relatives.
- Services required as a result of war.
- Services under a physician's private contract.
- Services paid for by a governmental entity that is not Medicare.
- Services for which the patient has no legal obligation to pay.
- Home health services furnished under a plan of care, if the agency does not submit the claim.
- Items and services excluded under the Assisted Suicide Funding Restriction Act of 1997.
- Items or services furnished in a competitive acquisition area by any entity that does not have a contract with the Department of Health and Human Services (except in a case of urgent need).
- Physicians' services performed by a physician assistant, midwife, psychologist, or nurse anesthetist, when furnished to an inpatient, unless they are furnished under arrangements by the hospital.
- Items and services furnished to an individual who is a resident of a skilled nursing facility or of a part of a facility that includes a skilled nursing facility, unless they are furnished under arrangements by the skilled nursing facility.
- Services of an assistant at surgery without prior approval from the peer review organization.
- Outpatient occupational and physical therapy services furnished incident to a physician's services.

** This is only a general summary of exclusions from Medicare Benefits. It is not a legal document. The official Medicare program provisions are contained in relevant laws, regulations, and rulings.*

BENEFICIARY NOTICE

NORTHWEST
SPECIALTY HOSPITAL

Description of Medicare Rules for Inpatients

You have been registered at our hospital as an **Inpatient.** This pamphlet briefly explains what it means to be an **Inpatient** and how Medicare rules are applied.

We encourage you to refer to information by Medicare, including your Medicare Handbook, or contact Medicare Northwest by telephone if you have any questions. You may reach the local Medicare office by calling 1-877-567-9234. The Medicare website may be found at www.cms.hhs.gov .

What is means to be an **Inpatient**

If you have been registered at our hospital as an **Inpatient**, this means your doctor has decided that treatment for your condition or illness is expected to take 24 hours or longer and is best performed on an inpatient basis.

Medicare has published a listing of the types of services that should be performed on an inpatient basis. Hospitals and physicians generally follow these recommendations when determining how you will be admitted to our facility.

It is important to understand if your treatment will be considered Outpatient or **Inpatient** as the amount of out-of-pocket expenses (the amount you pay) is different.

Diagnostic Test

Your physician may order certain laboratory, x-ray and other diagnostic tests while you Are an Inpatient at our hospital. Medicare will cover these diagnostic tests if they are Medically necessary, according to Medicare guidelines. Diagnostic tests are included as part of your Inpatient visit.

Skilled Nursing Home Care

If you are discharged to a skilled nursing home, Medicare will only cover that care if you have been a hospital Inpatient for at least three consecutive days and required skilled care in a hospital.

What You Pay:

Hospital Stays- **Inpatient Hospital Services**

- ⇒ You pay an annual **2011 deductible** of $1132.00 for covered services for a hospital stay of 1-60 days.
- ⇒ $283.00 a day for the 61st day to the 90th day.
- ⇒ $566.00 a day for 91st day to the 150th day.
- ⇒ You will also be responsible for any non-covered services upon notification from the hospital.

Skilled Nursing Facility .

- ⇒ You pay $141.50 per day for days 21-100. (Except non-covered services)

Laboratory

- ⇒ Included in your **inpatient** visit. **Exceptions: Pre-operative lab work performed three days before your scheduled surgery date is billed by LabCorp. LabCorp will bill Medicare for you. You will be receiving a separate bill from them.**

X-ray

- ⇒ X-ray procedure included in your **inpatient** visit. Interpretation or reading of the x-ray is outsourced to another provider. **The outsourced provider shall bill Medicare for you. You will be receiving a separate bill from the Radiologist. Exceptions: X-rays procedures performed three days before your scheduled Surgery will be billed separately.**

MRI

- ⇒ MRI procedure included in your **inpatient** visit. The Interpretation or reading of the MRI is included in your bill. **Exceptions: MRI procedures performed three Days before your scheduled surgery will be billed separately.**

. Prescription (Self Administered Drugs)

- ⇒ Included in your **inpatient** visit.

Supplemental Insurance

- ⇒ As a courtesy, we will bill your supplemental insurance on an "assignment" basis. This means we will ask the insurance company to pay us directly. Any amounts not covered by your supplemental insurance will be your financial responsibility. In some cases, your supplemental may be considered an out of network claim. This means the insurance check will be mailed to you. You will be financially responsible I paying your co-payment and any amount not covered by your supplemental insurance.

#2005-05-012

NORTHWEST
SPECIALTY HOSPITAL

Description of Medicare Rules for Outpatients

You have been registered at our hospital as an **Outpatient.** This pamphlet briefly explains what it means to be an **Outpatient** and how Medicare rules are applied.

We encourage you to refer to information by Medicare, including your Medicare Handbook, or contact Medicare Northwest by telephone if you have any questions. You may reach the local Medicare office by calling 1-877-567-9234. The Medicare website may be found at www.cms.hhs.gov .

What is means to be an **Outpatient**

If you have been registered at our hospital as an outpatient, this means your doctor has decided that treatment for your condition or illness can be done on an outpatient basis.

The following Hospital visits or services are considered **Outpatient:**

- ⇒ Outpatient Surgery that is expected to include recovery within 24 hours or less, with minimal follow up care.
- ⇒ Observation of medical condition to determine if an exact diagnosis and treatment. (e.g. nausau, post operative bleeding,). This is usually under 24 hours. If observation time exceeds 48 hours, you must either be discharged or your status changed to an inpatient if further acute care is needed.

Outpatient Diagnostic Tests

Your physician may order certain laboratory, x-ray and other diagnostic tests while you are an **Outpatient** at our hospital. Medicare will pay for these diagnostic tests if they are medically necessary, according to Medicare guidelines. If the reason for the diagnostic tests does not support medical necessity in Medicare's opinion, Medicare will not pay for the test. You will be informed of this prior to the procedure being performed and will be asked to sign an "Advance Beneficiary Notice" indicating you will be financially responsible for the test.

Description of Medicare Rules for Outpatients

Self-Administered Drugs

Similar to when you go to your pharmacist to fill a prescription, an oral pill(s)/medications (e.g., ampicillin or Tylenol) or injections you give yourself will not be covered by Medicare and you will be financially responsible.

Conversion from and **Outpatient** to and Inpatient

If your condition needs a longer stay, your physician may change you from an Outpatient to and Inpatient. We will tell you if you are being admitted as an Inpatient. This information is important because Medicare pays for an Outpatient different than an Inpatient, and any amounts you may owe would change as well.

Nursing Home /Transitional Care

If you are discharged to a nursing/transitional care facility, Medicare will only cover skilled care if you have been a hospital inpatient for at least three consecutive days and required skilled care in the hospital.

What You Pay:

Hospital Stays- **Inpatient Hospital Services** **(If your outpatient status changes to Inpatient).**

- ⇒ You pay an annual **2011 deductible** of $1132.00 for covered services for a hospital stay of 1-60 days.
- ⇒ $283.00 a day for the 61st day. to 90th day.
- ⇒ $566.00 a day for 91st day to 150th day.
- ⇒ You will also be responsible for any non-covered services upon notification from the hospital.

Skilled Nursing Facility

- ⇒ You pay $141.50 per day for days 21-100. (Except non-covered services)

Outpatient Hospital Services including Observation Care

- ⇒ You pay $162.00 annually Part B Deductible
- ⇒ You also pay a coinsurance amount as calculated by Medicare, for each major service provided, not to exceed $1132.00.
- ⇒ You will also be responsible for any non-covered services upon notification from the hospital.

Description of Medicare Rules for Outpatients

Outpatient Laboratory

- ⇒ Necessary laboratory services are covered with no co-payment or deductible.. **Exceptions: Pre- operative lab work performed prior to three days before your scheduled surgery date is billed by LabCorp. LabCorp will bill Medicare for you. You will be receiving a separate bill from them.**
- ⇒ You pay for non-covered services upon notification from the hospital.
- ⇒ You pay for most "screening" or "routine" services.
- ⇒ Medicare deductible and coinsurance do not apply to most laboratory procedures.

X-ray

- ⇒ X-ray procedure is included in your outpatient visit. Interpretation or reading of the x-ray is outsourced to another provider. **The outsourced provider shall bill Medicare for you. You will be receiving a separate bill from the Radiologist.**
- ⇒ You pay a $162.00 annually Part B Deductible.
- ⇒ You also pay a coinsurance amount as calculated by Medicare, for each major service provided, not to exceed $1132. 00
- ⇒ You will also be responsible for any non-covered services upon notification from the hospital.

MRI

- ⇒ MRI procedure can be included if you have other outpatient service. The Interpretation or reading of the MRI is included in your bill.

Prescription (Self Administered Drugs)

- ⇒ You are responsible for full payment.

Supplemental Insurance

As a courtesy, we will bill your supplemental insurance on an "assignment" basis. This means we will ask the insurance company to pay us directly. Any amounts not covered by your supplemental insurance will be your financial responsibility. In some cases, your supplemental may be considered an out of network claim. This means that the insurance check will be mailed directly to you. You will be financially responsible in paying your co-payment and any amount not covered by your supplemental insurance.

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