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10 NYCRR 405.9

Section 405.9. Admission/discharge

(a) *General.*

(1) The governing body shall establish and implement written admission and discharge policies to protect the health and safety of the patients and shall not assign or delegate the functions of admission and discharge to any referral agency and shall not permit the splitting or sharing of fees between a referring agency and the hospital.

(b) *Admission.*

(1) Each patient shall be advised of their rights pursuant to section 405.7 of this Part and, as appropriate, the criteria for Medicaid eligibility.

(2) No person shall be denied admission to the hospital because of race, creed, national origin, sex, disability within the capacity of the hospital to provide treatment, sexual orientation or source of payment.

(3) Except in emergencies, patients shall be admitted only upon referral and under the care of a licensed and currently registered practitioner who is granted admitting privileges by the governing body. The patient's condition and provisional diagnosis shall be established on admission by the patient's admitting practitioner and shall be noted in the patient's medical record.

(4) Except in emergencies, a hospital shall admit as patients only those persons who require the type of medical services authorized by the hospital's operating certificate.

(5) Except as provided in section 405.2(f)(4) of this Part, the hospital shall have a licensed and currently registered physician, or a registered physician's assistant under the general supervision of a physician, or a nurse practitioner in collaberation with a physician, available on the premises at all times who shall be responsible for receiving patients for care in accordance with policies established by the hospital and for the appropriate disposition of requests to admit patients.

(6) Insofar as it is practicable, the admitting practitioner shall request of each person being admitted, information concerning signs or symptoms of recent exposure to communicable diseases as defined in Part 2 of this Title. Whenever there are positive findings of exposure to such communicable disease, the patient shall be isolated and managed in accordance with the hospital's infection control policies and the provisions of Part 2 of this Title.

(7) Pediatrics.

(i) The hospital shall admit pediatric patients consistent with its ability to provide qualified staff, space and size appropriate equipment necessary for the unique needs of pediatric patients. The hospital shall establish a separate pediatric unit if the hospital regularly has 16 or more pediatric patients at one time or if pediatric patients cannot be adequately and safely cared for in other than separately certified pediatric beds. If a hospital cannot meet these requirements the hospital must develop criteria and policies and procedures for transfer of pediatric patients.

(ii) Hospitals maintaining certified pediatric beds shall assure that admission to those beds is limited to patients who have not yet reached their 21st birthday except in instances when there are no other available beds within the hospital. In such instances, the hospital shall afford priority admission to the pediatric bed to patients 20 years of age or younger.

(iii) Children under the age of 14 shall not be admitted to a room with patients 21 years of age or over except with the knowledge and agreement of the child's attending practitioner and parent or guardian and the concurrence of the other patients occupying the room and their attending practitioners.

(iv) In the event a separate pediatric unit is not available, arrangements for the

admission of all children shall be made consistent with written policies and procedures to ensure the safety of each patient.

(v) The hospital shall develop policies and procedures enabling parents/guardians to stay with pediatric patients. To the extent possible given the patient's health and safety, the hospital shall allow at least one parent/guardian to remain with the patient at all times.

(8) The hospital shall require that a member of the medical staff who has privileges to admit patients shall assume the principal obligation and responsibility for managing the patient's medical care. Postgraduate trainees and supervising physicians shall consult with and be directed by the attending practitioner with regard to therapeutic decisions and changes in patient status. Direct patient care may be provided by postgraduate trainees and medical students, within their permitted scope of responsibility and privileges with supervision as required in section 405.4 of this Part with the concurrence of the attending practitioner. Occurrence of urgent or emergent situations may preclude the attending or admitting practitioner from direct participation in decisionmaking regarding patient care. In such circumstances, the supervising physician shall concur in the decision, and the attending practitioner shall be notified as soon as possible. Responsibility for such decisions made in the absence of consultation with the responsible attending practitioner resides with the involved postgraduate trainees and supervising physicians.

(9) The hospital shall provide for the assignment, management, and disposition of patients who are not admitted as private patients of members of the medical staff. The hospital shall develop and implement policies and procedures which provide for the continuity of care of such patients and shall include a procedure by which each patient is assigned to a member of the medical staff, who shall be the personal practitioner to the patient and assume professional responsibility for his/her care in the hospital and for a proper plan of care after discharge.

(10) No hospital shall be required to admit any patient for the purpose of performing an induced termination of pregnancy, nor shall any hospital be liable for its failure or refusal to participate in any such act, provided that the hospital shall inform the patient of its decision not to participate in such an act or acts. The hospital in such event shall inform the patient of appropriate resources for services or information.

(11) A complete and permanent record shall be maintained of all patients admitted, including but not limited to the date and time of admission, name and address, date of

birth, the next of kin or sponsor, veteran status (insofar as these are obtainable), the admitting diagnosis, condition, the name of the referring practitioner, the hospital attending practitioner or service, and as to discharge, the date and time, condition and principal diagnosis.

(i) If a patient is identified as a veteran, the hospital shall notify such veteran of the possible availability of services at a hospital operated by the Veteran's Administration. For the purposes of this paragraph, a *veteran* shall be defined as a person who served in the United States Military, who received a discharge other than a dishonorable discharge and who is eligible for benefits provided by the Veteran's Administration.

(ii) If a patient eligible for transfer to a hospital operated by the Veteran's Administration requests such transfer, hospital staff shall make such arrangements. Transfer shall be effected in accordance with paragraph (f)(7) of this section.

(12) Every patient shall have a complete history and physical examination performed by an appropriately credentialed practitioner within 30 days before or 24 hours after admission. If recorded in the patient's medical record by an individual other than the attending practitioner, the history and physical examination shall be reviewed and countersigned by the attending practitioner. When the history and physical is completed within the 30 days prior to admission, an examination, to update any changes in the patient's health status, must be completed and documented in the patient's medical record within 24 hours after admission.

(i) Such examination shall include a screening uterine cytology smear on women 21 years of age and over, unless such test is medically contraindicated or has been performed within the previous three years, and palpation of breast, unless medically contraindicated, for all women over 21 years of age. These examinations shall be recorded in the medical record.

(ii) Insofar as it is possible to identify patients who may be susceptible to sickle cell anemia, all such presumptively susceptible patients, including infants over six months of age, shall be examined for the presence of sickle cell hemoglobin unless such test has been previously performed and the results recorded in the patient's medical record or otherwise satisfactorily recorded, such as on an identification card.

(13) No patient 18 years of age or older shall be detained in a hospital against his will, nor shall a minor be detained against the will of his parent or legal guardian, except as authorized by law. This provision shall not be construed to preclude or prohibit attempts to persuade a patient to remain in the hospital in his/her own interest, nor the temporary detention of a mentally disturbed patient for the protection of himself/herself or others, pending prompt legal determination of his/her rights. In no event shall a patient be detained solely for nonpayment of his/her hospital bill or practitioner's statement for medical services.

(14) The hospital shall adopt and make public the following admission notices to be provided to all patients receiving inpatient hospital care. Medicare patients shall be given the notice set forth in subparagraph (i) and all other inpatients shall be given the notice set forth in subparagraph (ii) of this paragraph.

(i) Hospital Admission Notice for Medicare Patients

You have the following rights under the New York State law:

Before you are discharged, you must receive a written Discharge Plan. You or your representative have the right to be involved in your discharge planning.

Your written Discharge Plan must describe the arrangements for any future health care that you may need after discharge. You may not be discharged until the services required in your written Discharge Plan are secured or determined to be reasonably available.

If you do not agree with the Discharge Plan or believe the services are not reasonably available, you may call the New York State Health Department to investigate your complaint and the safety of your discharge. The hospital must provide you with the Health Department' s telephone number if you ask for it.

For important information about your rights as a Medicare patient, see the “IMPORTANT MESSAGE FROM MEDICARE,“ which you must receive when admitted to a hospital.

(ii) Hospital Admission Notice

An Important Message Regarding Your Rights as a Hospital Inpatient

Your Rights While a Hospital Patient

You have the right to receive all of the hospital care that you need for the treatment of your illness or injury. Your discharge date is determined only by YOUR health care needs, not by your DRG category or your insurance.

You have the right to be fully informed about decisions affecting your care and your insurance coverage. ASK QUESTIONS. You have the right to designate a representative to act on your behalf.

You have the right to know about your medical condition. Talk to your doctor about your condition and your health care needs. If you have questions or concerns about hospital services, your discharge date or your discharge plan, consult your doctor or a hospital representative (such as the nurse, social worker, or discharge planner).

Before you are discharged you must receive a written DISCHARGE NOTICE and a written DISCHARGE PLAN. You and/or your representative have the right to be involved in your discharge planning.

You have the right to appeal the *written* discharge plan or notice you receive from the hospital.

IF YOU THINK YOU ARE BEING ASKED TO LEAVE THE HOSPITAL TOO SOON

Be sure you have received the written notice of discharge that the hospital must give you. You need this discharge notice in order to appeal.

This notice will say *who to call and how to appeal.* To avoid extra charges you must call to appeal by 12 noon of the day after you receive the notice. If you miss this time you may still appeal. However, you may have to pay for your continued stay in the hospital, if you lose your appeal.

DISCHARGE PLANS

In addition to the right to appeal, you have the right to:

Receive a written discharge plan that describes the arrangements for any future health care you may need after discharge. You may not be discharged until the services required in your written discharge plan are secured or determined by the hospital to be reasonably available. You also have the right to appeal this discharge plan.

PATIENTS' RIGHTS

A general statement of your additional rights as a patient must be provided to you at this time.

FOR ASSISTANCE/HELP

The Independent Professional Review Agent (IPRA) for your area and your insurance coverage is:

(Hospitals are permitted to use a checklist to indicate the IPRA that the patient should contact.)

(15) In conjunction with the requirements for complete history and physical examination as established in this section, hospitals approved by the Office of Alcoholism and Substance Abuse Services (OASAS) or the Division of Alcoholism and Alcohol Abuse, a predecessor agency, shall provide a health intervention services (HIS) program to screen all admitted patients for signs of alcoholism or alcohol abuse that may relate to the condition requiring hospital admission. Specifically, such hospitals shall:

(i) maintain a dedicated staff that are adequate in number and trained, including continuing education and inservice training, to perform all the activities required of the HIS program;

(ii) identify patients who exhibit signs of alcoholism or alcohol abuse through a comprehensive screening protocol; and

(iii) offer patients intervention and referral services consistent with their assessed needs.

(16) The hospital shall ask each patient for the name of his or her primary care provider, if known, on admission and shall document such information in the patient's medical record.

(c) *Treatment of sexual offense survivors and maintenance of sexual offense evidence.*

(1) Treatment of survivors. Hospital shall:

(i) maintain current protocols regarding the care of patients reporting sexual assault;

(ii) provide a patients who are suspected or confirmed victims of sexual offenses appropriate assessment, emergency treatment and referrals to meet the health care needs of such individuals, to provide emotional support to them and to minimize further trauma;

(iii) advise patients of the availability of services provided by a local rape crisis or victim assistance organization and, unless the patient declines such services, contact such organization with information concerning the age and sex of the victim, language spoken by the victim if other than English, and any other information that may impact the assignment of a victim advocate, such as mental retardation, etc., so that a representative may offer the patient the services that the organization provides;

(iv) as provided by the department and consistent with current standards of professional practice, provide to patients written and verbal information necessary to make an informed choice in regard to treatment options, including pregnancy prophylaxis;

(v) provide to patients, upon request, prophylaxis against pregnancy, sexually transmitted diseases, hepatitis B and HIV, as medically indicated;

(vi) discuss with patients the option of reporting the sexual offense to the police, and upon consent of the patient, report the offense to the local law enforcement agency; and

(vii) reasonably assure patients an appropriate and safe discharge.

(2) Maintenance of sexual offense evidence. The hospital shall provide for the maintenance of evidence of sexual offenses. The hospital shall establish and implement written policies and procedures that are consistent with the requirements of this section and that shall apply to all service units of the hospital which treat victims of sexual offenses, including but not limited to medicine, surgery, emergency, pediatric and outpatient services.

(i) The sexual offenses subject to the provisions of this subdivision shall be sexual misconduct, rape, sodomy, sexual abuse and aggravated sexual abuse as defined in article 130 of the Penal Law.

(ii) The sexual offense evidence shall include, as appropriate to the injuries sustained in each case, slides, cotton swabs, clothing or portion thereof, hair combings, fingernail scrapings, photographs, and other items specified by the local police agency and forensic laboratory in each particular case.

(iii) The hospital shall preserve items of sexual offense evidence and ensure that clothes and samples or swabs are dried, stored in paper bags and labeled, and

shall mark and log each item of evidence with a code number corresponding to the patient's medical record number.

(iv) *Privileged sexual offense evidence* shall mean evidence collected or obtained from the patient during the hospital examination and treatment of injuries sustained as a result of a sexual offense.

(v) *Sexual offense evidence that is not privileged* shall mean evidence which is obtained from victims of suspected child abuse or maltreatment, and that derived from other alleged crimes, attendant to or committed simultaneously with the sexual offense, which are required to be reported to a police agency, such as bullet or gunshot wounds, powder burns, burn injuries, which may also be required to be reported to the state fire administrator, or other injuries arising from or caused by the discharge of a gun or firearm, or wounds which may result in death and which are inflicted by a knife, ice pick or other sharp or pointed instrument in accordance with sections 265.25 and 265.26 of the Penal Law. Nothing in this paragraph shall prevent the reporting of diseases or medical conditions required by law to be reported to health authorities.

(vi) Upon admission of a patient who is an alleged sexual offense survivor, the hospital shall seek patient consent, or consent of the person authorized to act on the patient's behalf, for collection and storage of the sexual offense evidence and shall explain the specific rights of the patient and obligations of the hospital as outlined in this paragraph. The hospital shall store the sexual offense evidence in a locked, separate and secure area for not less than 30 days unless:

(*a*) the patient or person authorized to act on the patient's behalf signs a statement directing the hospital not to collect and keep privileged evidence; or

(*b*) such evidence is privileged and the patient or person authorized to act on the patient's behalf signs a statement directing the hospital to surrender the evidence to the police before the 30-day period has expired; or

(*c*) the evidence is not privileged and the police request its surrender before 30-day period has expired.

(vii) If none of the above acts have occurred within 30 days from commencement of treatment, the evidence shall be discarded and the patient's possessions shall be returned upon the patient's request.

(viii) The hospital shall designate a staff member to coordinate the required actions and to contact the local police agency and forensic laboratory to determine their specific needs and requirements for the maintenance of sexual offense evidence.

(d) *Child abuse and maltreatment.* The hospital shall provide for the identification, assessment, reporting and management of cases of suspected child abuse and maltreatment. The hospital shall establish and implement written policies and procedures which are consistent with the requirements of this section and which shall apply to all service units of the hospital which treat victims of child abuse and maltreatment, including but not limited to medicine, surgery, emergency, pediatrics and outpatient services.

(1) The hospital shall provide orientation and continuing education to the nursing, medical and social work personnel of, at least, the hospital's emergency, pediatric and outpatient services in the recognition of indicators of domestic violence and suspected child abuse and maltreatment and in the individual's responsibilities in dealing with such case.

(2) A staff member shall be designated to coordinate the **required** reporting to the New York State Central Register of Child Abuse and Maltreatment and the **hospital's** actions taken with respect to such cases in accordance with procedures set forth in article 6, title 6 of the State Social Services Law.

(e) *Domestic violence.* The **hospital** shall provide for the identification, assessment, treatment and appropriate referral of cases of suspected or confirmed domestic violence victims. The **hospital** shall establish and implement written policies and procedures consistent with the **requirements** of this section which shall apply to all service units of the **hospital**.

(f) ***Discharge.***

(1) The **hospital** shall ensure that each patient has a **discharge plan** which meets the patient's post-**hospital** care needs. No patient who **requires** continuing health care services in accordance with such patient **discharge plan** may be **discharged** until such services are secured or determined by the **hospital** to be reasonably available to the patient.

(2) The **hospital** shall have a **discharge planning** coordinator responsible for the coordination of the **hospital discharge planning** program. The **discharge planning** coordinator shall be an individual with appropriate training and experience as

determined by the **hospital** to coordinate the **hospital discharge planning** program.

(3) The **hospital** shall ensure:

(i) that **discharge planning** staff have available current information regarding home care programs, institutional health care providers, and other support services within the **hospital's** primary service area, including their range of services, admission and **discharge** policies and payment criteria;

(ii) the utilization of written criteria as part of a screening system for the early identification of those patients who may **require** post-**hospital** care **planning** and services. Such criteria shall reflect the **hospital's** experience with patients **requiring** post-**hospital** care and shall be reviewed and updated annually;

(iii) that upon the admission of each patient, information is obtained as **required** to assist in identifying those patients who may **require** post-**hospital** care **planning**;

(iv) that each patient is screened as soon as possible following admission in accordance with the written criteria described in subparagraph (ii) of this paragraph and that this screening is coordinated with the utilization review process;

(v) that each patient identified through the screening system as potentially in need of post-**hospital** care is assessed by those health professionals whose services are appropriate to the needs of the patient to determine the patient's post-**hospital** care needs. Such assessment shall include an evaluation of the extent to which the patient or patient's personal support system can provide or arrange to provide for identified care needs while the patient continues to reside in his/her personal residence;

(vi) that for each patient determined to need assistance with post-**hospital** care, the health professionals whose services are medically necessary, together with the patient and the patient's family/representative shall develop an individualized comprehensive **discharge plan** consistent with medical **discharge** orders and identified patient needs;

(vii) that each patient determined to need assistance with post-**hospital** care and the patient's family/representative receive verbal and written information regarding the range of services in the patient's community which have the capability of

assisting the patient and the patient's family/representative in implementing the patient' s individualized **discharge plan** which is appropriate to the patient's level of care needs;

(viii) that the patient and the patient's family/representative shall have the opportunity to participate in decisions regarding the selection of post-**hospital** care consistent with and subject to any limitations of Federal and State laws. **Planning** for post-**hospital** care shall not be limited to placement in residential health care facilities for persons assessed to need that level of care, but shall include consideration of noninpatient services such as home care, long-term home health care, hospice, day care and respite care;

(ix) that when residential health care facility placement is indicated, the patient and the patient's family/representative shall be afforded the opportunity, consistent with and subject to any limitations of Federal and State laws, to participate in the selection of the residential health care facilities to which applications for admission are made.

(x) that contact with appropriate providers of health care and services is made as soon as possible, but no later than the day of assignment of alternate level of care status and that each patient's record contains a record of all such contacts including date of contact and provider response as well as a copy of any standard assessment form, including but not limited to any **hospital**/community patient review instrument as contained in section 400.13 of this Title and any home health assessment, completed by the **hospital** for purposes of post-**hospital** care;

(xi) that relevant **discharge planning** information is available for the utilization review committee; and

(xii) the development and implementation of written criteria for use in the **hospital** emergency service indicating the circumstances in which **discharge planning** services shall be provided for a person who is in need of post emergency care and services but not in need of inpatient **hospital** care.

(4) The **hospital** shall establish and implement written policies and procedures governing the admissions and **discharge** process which ensure compliance with State and Federal antidiscrimination laws which apply to the operator. Such laws include, but need not be limited to, the applicable provisions of this Part; Public Health Law, section 2801-a(9); the New York State Civil Rights Law, sections 40 and 40-c; article

15 (Human Rights Law) of the State Executive Law, sections 291, 292 and 296; and title 42 of the United States Code, sections 1981, 2000a, 2000a-2, 2000d, 3602, 3604 and 3607. Copies of the cited State and Federal statutes are available from West Publishing Company, P.O. Box 64526, St. Paul, MN 55164-0526, the publisher of *McKinney's Consolidated Laws of New York* annotated and the United States Code annotated. Copies of such statutes are also available for public inspection and copying at the Records Access Office, New York State Department of Health, Corning Tower Building, Governor Nelson A. Rockefeller Empire State Plaza, Albany, NY 12237.

(5) **Discharge** planners shall inform each patient and his/her family of the admission policies of the residential health care facilities to which they are referred.

(6) The **requirements** of this subdivision relating to a patient's family/representative participating in the **discharge planning** process and in receiving an explanation of the reason for a patient's transfer or **discharge** shall not apply in the following circumstances:

(i) when a competent adult patient objects to such participation by, or to an explanation regarding transfer or **discharge** being given to, any family/representative. Any such objections shall be noted in the patient's medical record; or

(ii) when the **hospital** has made a reasonable effort to contact a patient's family/representative in order to provide an opportunity to participate in the **discharge planning** process or to explain the reason for transfer or **discharge**, and the **hospital** is unable to locate a responsible family member/representative, or, if located, such individual refuses to participate. The reasons a patient's family/representative did not participate in the **discharge planning** process or did not receive an explanation of the reason for a patient's transfer or **discharge** shall be noted in the patient's medical record. A reasonable effort shall include, but not be limited to, attempts to contact a patient's family/representative by telephone, telegram and/or mail.

(7) The **hospital** shall ensure that no person presented for medical care shall be removed, transferred or **discharged** from a **hospital** based upon source of payment. Each removal, transfer or **discharge** shall be carried out after a written order made by a physician that, in his/her judgment, such removal, transfer or **discharge** will not create a medical hazard to the person or that such removal, transfer or **discharge** is considered to be in the person's best interest despite the potential hazard of

movement. Such a removal, transfer or **discharge** shall be made only after explaining the need for removal, transfer or **discharge** to the patient and to the patient's family/representative and prior notification to the medical facility expected to receive the patient.

(i) The **hospital** shall maintain a record of all removals, **discharges** and transfers from the **hospital**, including the date and time of the **hospital** reception or admission, name, sex, age, address, presumptive diagnosis, treatment provided, clinical condition, reason for removal, transfer or **discharge** and destination. A copy of such information shall accompany any person transferred or **discharged** to a health care facility or a certified or licensed home care services agency and, where applicable become a part of the person's medical record.

(ii) Patients **discharged** from the **hospital** by their attending practitioner shall not be permitted to remain in the **hospital** without the consent of the chief executive officer of the **hospital** except in accordance with provisions of subdivision (g) of this section.

(iii) In the absence of a written order of an attending practitioner **discharging** a patient, with respect to a patient who insists upon **discharging** himself from the **hospital**, the **hospital** shall obtain, where practicable, a written release from the patient absolving the **hospital** and the patient's attending practitioner of liability and damages resulting from such **discharge**.

(8) Unless otherwise provided by law, the **hospital** shall ensure that a minor shall be **discharged** only in the custody of his parent, a member of his immediate family or his legal guardian or custodian, unless such parent or guardian shall otherwise direct.

(9) A dead body, including a stillborn infant or fetus estimated by an attending physician to have completed 20 weeks of gestation, shall be delivered only to a licensed funeral director or undertaker or his/her agent. If, at the time of death, the patient was diagnosed as having a specific communicable or infectious disease, including but not limited to those diseases designated in Part 2 of this Title, a written report of such disease shall accompany the body when it is released to the funeral director or his/her agent.

(10) The **hospital** shall develop and implement written policies and procedures pertaining to the review and communication of laboratory and diagnostic test/service results ordered for a patient while admitted or receiving emergency services to the

patient. If the patient lacks medical decision-making capacity, the communication shall be to the patient's medical decision-maker. The results shall also be provided to the patient's primary care provider, if known. Such policies and procedures shall be reviewed and updated as necessary and at a minimum shall include:

(i) a **requirement** that all laboratory and other diagnostic tests/service results be reviewed upon completion by a physician, physician assistant or nurse practitioner familiar with the patient's presenting condition;

(ii) a **requirement** that all laboratory and other diagnostic test services results be forwarded to the patient's primary provider, if known, after review by a physician, physician assistant or nurse practitioner;

(iii) provisions to include in the **discharge plan** information regarding the patient's completed and pending laboratory and other diagnostic test/service results, medications, diagnoses, and follow-up care and to review such information with the patient or, if the patient is not legally capable of making decisions, the patient's parent, legal guardian or health care agent, or surrogate, as appropriate, subject to all applicable confidentiality laws and regulations;

(iv) a **requirement** that patients may not be **discharged** from the **hospital** or the emergency room until any tests that could reasonably be expected to yield “critical value“ results - results that suggest a life-threatening or otherwise significant condition such that it **requires** immediate medical attention - are reviewed by a physician, physician assistant (PA) and/or nurse practitioner (NP);

(v) a **requirement** that before a patient is **discharged**, any critical laboratory test results are communicated to the patient or, if the patient is not legally capable of making decisions, the patient's parent, legal guardian or health care agent, or surrogate, as appropriate, subject to all applicable confidentiality laws and regulations;

(vi) a **requirement** that all information be presented to the patient or if the patient is not legally capable of making decisions, the patient's parent, legal guardian or health care agent, or surrogate, as appropriate, subject to all applicable confidentiality laws and regulations, in a manner that reasonably assures that the patient, their parents or other medical decision makers understand the health information provided in order to make appropriate health decisions.

(g) ***Hospital*** *inpatient* ***discharge*** *review program.*

(1) A **hospital** inpatient **discharge** review program applicable to all patients other than beneficiaries of title XVIII of the Federal Social Security Act (Medicare) shall be established in accordance with this subdivision. No **hospital** inpatient subject to the provisions of this subdivision may be **discharged** on the basis that inpatient **hospital** service in a general **hospital** is no longer medically necessary and that an appropriate **discharge plan** has been established unless a written notice of such determinations and a copy of the **discharge plan** have been provided to the patient or the appointed personal representative of the patient. The patient or the appointed personal representative of the patient shall have the opportunity to sign the notice and a copy of the **discharge plan** and receive a copy of both signed documents. Every **hospital** shall use the common notice set forth in paragraph (9) of this subdivision. The patient, or the appointed personal representative of the patient may request a review of such determinations by the appropriate independent professional review agent or review agent in accordance with paragraph (4) of this subdivision. Notwithstanding that the patient **discharge** review process provided in accordance with Federal law and regulation shall apply to beneficiaries of title XVIII of the Federal Social Security Act (Medicare), a written copy of the **discharge plan**, and **discharge** notice shall be provided to the beneficiary or the appointed personal representative of the beneficiary. The beneficiary or the appointed personal representative of the beneficiary shall have the opportunity to sign the documents and receive a copy of the signed documents.

(2)

(i) For patients eligible for payments by state governmental agencies for **hospital** inpatient services as the patient's primary payor an *independent professional review agent* shall mean the commissioner or his designee. In conducting **hospital** inpatient **discharge** reviews in accordance with this paragraph, the commissioner may utilize the services of department personnel or other authorized representatives, including a review agent approved in accordance with subparagraph (ii) of this paragraph.

(ii) For patients who are not beneficiaries of title XVIII of the Federal Social Security Act (Medicare) nor eligible for payments by state governmental agencies as the patient's primary payor, an *independent professional review agent* shall mean a third-party payor of **hospital** services or other corporation approved by the commissioner in writing for purposes of conducting **hospital** inpatient

discharge reviews in accordance with this subdivision. For a third-party payor of **hospital** services or other corporation to be approved as an independent professional review agent in accordance with this subparagraph, such third-party payor or other corporation must meet the following approval criteria:

(*a*) the review agent shall employ or otherwise secure the services of adequate medical personnel qualified to determine the necessity of continued inpatient **hospital** services and the appropriateness of **hospital discharge plans**;

(*b*) the review agent shall demonstrate the ability to render review decisions in a timely manner as provided in this subdivision;

(*c*) the review agent shall agree to provide ready access by the commissioner to all data, records and information it collects and maintains concerning its review activities under this subdivision;

(*d*) the review agent shall agree to provide to the commissioner such data, information and reports as the commissioner determines necessary to evaluate the review process provided pursuant to this subdivision;

(*e*) the review agent shall provide assurances that review personnel shall not have a conflict of interest in conducting a **discharge** review for a patient based on **hospital** or professional affiliation; and

(*f*) the review agent meets such other performance and efficiency criteria regarding the conduct of reviews pursuant to this subdivision established by the commissioner. The commissioner may withdraw approval of an independent professional review agent where such review agent fails to continue to meet approval criteria established pursuant to this subparagraph.

(iii) Each **hospital** shall enter into contracts with one or more independent professional review agents approved by the commissioner in accordance with subparagraph (ii) of this paragraph for purposes of conducting **hospital** inpatient **discharge** reviews in accordance with this subdivision for patients, including uncompensated care patients, who are not beneficiaries of title XVIII of the Federal Social Security Act (Medicare) nor eligible for payments by State governmental agencies as the patient's primary payor; provided, however, a payor of **hospital** service authorized under article 43 of the State Insurance Law or certified as health maintenance organizations under article 44 of the Public Health Law, may designate the review agent for their subscribers or

beneficiaries or enrolled members and shall reimburse such designated review agent for costs of the **discharge** review program.

(3)

(i) If a **hospital** and the attending physician agree that inpatient **hospital** service in a **hospital** is no longer medically necessary for a patient, other than a beneficiary of title XVIII of the Federal Social Security Act (Medicare), and an appropriate **discharge plan** has been established for such patient, at that time the **hospital** shall provide the patient or the appointed personal representative of the patient with a written **discharge** notice and a copy of the **discharge plan**, meeting the **requirements** of paragraph (1) of this subdivision.

(ii) If a **hospital** has determined that inpatient **hospital** service in a **hospital** is no longer medically necessary for a patient, other than a beneficiary of title XVIII of the Federal Social Security Act (Medicare), and an appropriate **discharge plan** has been established for such patient but the attending physician has not agreed with the **hospital's** determinations, the **hospital** may request by telephone a review of the validity of the **hospital's** determinations by the appropriate independent professional review agent. Such review agent shall conduct a review of the **hospital's** determinations and prior to the conclusion of the review shall provide an opportunity to the treating physician and an appropriate representative of the **hospital** to confer and provide information which may include the patient's clinical records if requested by the review agent. Such review agent shall notify the **hospital** of the results of its review not later than one working day after the date the review agent has received the request, the records **required** to conduct such review, and the date of such conferring and receipt of any additional information requested. The **hospital** shall provide notice to the attending physician of the results of the review. If the review agent concurs with the **hospital's** determinations, the **hospital** shall provide the patient or his appointed personal representative with a written notice of such determinations and notice that the patient shall be financially responsible for continued stay, and with a copy of the proposed **discharge plan**. The patient or the appointed personal representative of the patient shall have the opportunity to sign the notice and a copy of the proposed **discharge plan** and receive a copy of both signed documents. Every **hospital** shall use the notice set forth in paragraph (l0) of this subdivision which shall indicate the determinations made, shall state the reasons therefor and that the patient's attending physician has disagreed, and shall state that
the patient or the appointed personal representative of the patient may request a review of

such determinations by the appropriate review agent.

(4) A patient in a **hospital**, or the appointed personal representative of the patient, who receives a written notice in accordance with subparagraph (3)(i) or (3)(ii) of this subdivision, may request a review by the appropriate review agent of the determinations set forth in such notice related to medical necessity of continued inpatient **hospital** service, the appropriateness of the **discharge plan** and the availability of **required** continuing health care services.

(i) If a patient while still **hospitalized** or while no longer an inpatient, or the appointed personal representative of such patient, requests a review by the appropriate review agent, the **hospital** shall promptly provide to the review agent the records **required** to review the determinations. Such request for a patient no longer an inpatient shall take place no later than 30 days after receipt of a notice provided in accordance with paragraph (3) of this subdivision or seven days after receipt of a complete bill for all inpatient services rendered, whichever is later. The review agent shall conduct a review of such determinations, and shall provide the treating physician and an appropriate representative of the **hospital** with an opportunity to confer and provide information prior to the conclusion of the review. The review agent shall provide written notice to the patient, or the appointed personal representative of the patient, and the **hospital** of the results of the review within three working days of receipt of the requests for review and the records **required** to review the determinations. The **hospital** shall provide notice to the attending physician of the results of the review.

(ii) If a patient while still an inpatient in the **hospital**, or the appointed personal representative of the patient, requests a review by the appropriate review agent not later than noon of the first working day after the date the patient, or the appointed personal representative of the patient, receives the written notice, the **hospital** shall provide to the appropriate review agent the records **required** to review the determinations by the close of business of such working day. The appropriate review agent shall conduct a review of such determinations and provide written notice to the patient, or the appointed personal representative of the patient, and the **hospital** of the results of the review not later than one full working day after the date the review agent has received the request for review and such records. The **hospital** shall provide notice to the attending physician of the results of the review.

(5) If the appropriate review agent, upon any review conducted pursuant to subparagraph (3)(ii) or pursuant to paragraph (4) of this subdivision does not

concur in the determinations, continued stay in a **hospital** shall be deemed necessary and appropriate for the patient for purposes of payment for such continued stay.

(6) If a patient eligible for payment for inpatient **hospital** services under the casebased payment per **discharge** system or the appointed personal representative of the patient, requests a review by the appropriate review agent in accordance with subparagraph (4)(ii) of this subdivision, the **hospital** may not demand or request any payment for additional inpatient **hospital** services provided to such patient subsequent to the proposed time of **discharge** and prior to noon of the day after the date the patient or the appointed personal representative of the patient receives notice of the results of the review by the review agent except deductibles, copayments, or other charges that would be authorized for a patient for whom inpatient **hospital** services in a **hospital** continue to be necessary and appropriate.

(7) In any review conducted pursuant to subparagraph (3)(ii) or pursuant to paragraph (4) of this subdivision, the review agent shall solicit the views of the patient involved, or the appointed personal representative of the patient, and the attending physician.

(8) Each patient, or the appointed personal representative of the patient, provided a notice by a **hospital** in accordance with paragraph (3) of this subdivision shall be provided at such time by the **hospital** with a notice of such patient's right to request a **discharge** review in accordance with this subdivision. The patient or the appointed personal representative of the patient shall have the opportunity to sign this form and receive a copy of the signed form.

(9) Notice that inpatient **hospital** service is no longer medically necessary. For purposes of subparagraph (3)(i) of this subdivision, the **hospital** shall utilize the following notices:

(i) The following form shall be used for patients covered under the case payment system:

DISCHARGE NOTICE

DATE:/_____/_____

READ THIS LETTER CAREFULLY—IT CONCERNS YOUR PRIVATE INSURANCE

BENEFITS OR MEDICAID BENEFITS OR IF YOU ARE UNINSURED

PATIENT NAME:_____ PRIMARY PAYOR

AT **DISCHARGE**:_____

ATT. PHYS.:_____MR NO.:_____

ADM DATE:_____ / _____/_____

Dear Patient:

Your doctor and the **hospital** have determined that you no longer **require** care in the **hospital** and will be ready for **discharge** on:

_____
_____

Day of Week _____/ Date/_____

IF YOU AGREE with this decision, you will be **discharged**. Be sure you have already received your written **discharge plan** which describes the arrangements for any future health care you may need.

IF YOU DO NOT AGREE and think you are not medically ready for **discharge** or feel that your **discharge plan** will not meet your health care needs, you or your representative may request a review. Contact the review agent indicated on the reverse side of this letter if you would like a review of the **discharge** decision.

IF YOU WOULD LIKE A REVIEW, you should immediately, but not later than noon of

(Day and Date)

call the telephone number checked off on the reverse side of this page.

IF YOU CANNOT REQUEST THE REVIEW YOURSELF, and you do not have a family member or friend to help you, you may ask the **hospital** representative at extension

, who will request the review for you.

IF YOU REQUEST A REVIEW, the following will happen:

1. The review agent will ask you or your representative why you or your representative think you need to stay in the **hospital** and also will ask your name, admission date and telephone number where you or your

representative can be reached.

2. After speaking with you or your representative and your doctor and after reviewing your medical record, the review agent will make a decision which will be given to you in writing.

3. While this review is being conducted, you will not have to pay for any additional **hospital** days until you have received the review agent's decision.

IF THE REVIEW AGENT AGREES WITH THE **DISCHARGE** DECISION, you will be financially responsible for your continued stay after noon of the day after you or your representative has been notified of the review agent's decision.

IF THE REVIEW AGENT AGREES THAT YOU STILL NEED TO BE IN THE **HOSPITAL**: for Medicaid patients, Medicaid benefits will continue to cover your stay; for private health insurance patients, coverage for your continued stay is limited to the scope of your private health insurance policy.

NOTE: If you miss the noon deadline mentioned on the first page of this notice, you may still request a review. However, if the review agent disagrees with you, you will be financially responsible for the days of care beginning with the proposed **discharge** date.

If you would like a review of your **hospital** stay after you have been **discharged**, you may request a review by the review agent within 30 days of the receipt of this notice or seven days after receipt of a complete bill from the **hospital**, whichever is later, by writing to the review agent.

I have received this notice on behalf of myself as the patient or as the representative of the patient:

Signature _____ / Date/_____

Time

_____

Relationship

(ii) The following form shall be used for patients covered under a per diem reimbursement system:

DISCHARGE NOTICE

DATE /_____/_____

READ THIS LETTER CAREFULLY—IT CONCERNS YOUR PRIVATE INSURANCE

BENEFITS OR MEDICAID BENEFITS OR IF YOU ARE UNINSURED

PATIENT NAME:_____ PRIMARY PAYOR

AT **DISCHARGE**:_____

ATT. PHYS.:_____MR NO.:_____

ADM DATE:_____ / _____/_____

Dear Patient:

Your doctor and the **hospital** have determined that you no longer **require** care in the **hospital** and will be ready for **discharge** on:

_____

_____

Day of Week / Date/

IF YOU AGREE with this decision, you will be **discharged**. Be sure you have already received your written **discharge plan** which describes the arrangements for any health care you may need when you leave the **hospital**.

IF YOU DO NOT AGREE and think you are not medically ready for **discharge** or feel that your **discharge plan** will not meet your health care needs, you or your representative may request a review of the **discharge** decision by contacting your review agent indicated on the reverse side of this page.

IMPORTANT NOTICE ABOUT THE PAYMENT FOR YOUR CARE

· If your **hospital** care is covered by private health insurance, you may be charged directly while you remain in the **hospital** while the **discharge** review is being conducted. Whether you have to pay during this period will depend on your private health insurance benefits and if the review agent agrees with you that you need to stay in the **hospital**.

· If your **hospital** care is covered under the Medicaid program, Medicaid will pay for the days you remain in the **hospital** while the **discharge** review is being conducted.

IF YOU WOULD LIKE A REVIEW, you should immediately, but not later than noon of

(Day and Date)

call the telephone number checked off on the reverse side of this page.

IF YOU CANNOT REQUEST THE REVIEW YOURSELF, and you do not have a family member or friend to help you, you may ask the **hospital** representative at extension

, who will request the review for you.

IF YOU REQUEST A REVIEW, the following will happen:

1. The review agent will ask you or your representative why you or your representative think you need to stay in the **hospital** and also will ask your name, admission date and telephone number where you or your representative can be reached.

2. After speaking with you or your representative and your doctor and after reviewing your medical record, the review agent will make a decision which will be given to you in writing.

IF THE REVIEW AGENT AGREES WITH THE **DISCHARGE** DECISION, you will be financially responsible for your continued stay after noon of the day you or your representative has been notified of the review agent's decision.

IF THE REVIEW AGENT AGREES THAT YOU STILL NEED TO BE IN THE **HOSPITAL**: for Medicaid patients, Medicaid benefits will continue to cover your stay; for private health insurance patients, coverage for your continued stay is limited to the scope of your private health insurance policy.

NOTE: If you miss the noon deadline mentioned on the first page of this notice, you may still request a review. However, if the review agent disagrees with you, you will be financially responsible for the days of care beginning with the proposed **discharge** date.

If you would like a review of your **hospital** stay after you have been **discharged**, you may request a review by the review agent within 30 days of the receipt of this notice or seven days after receipt of a complete bill from the **hospital**, whichever is later, by writing to the review agent.

I have received this notice on behalf of myself as the patient or as the representative of the patient:

_____ _____

_____

Signature / Date/

Time

_____
Relationship

(10) Notice that inpatient **hospital** services is no longer medically necessary. For purposes of subparagraph (3)(ii) of this subdivision, a **hospital** shall utilize the following notice:

HOSPITAL LETTERHEAD

DATE /_____/_____

CONTINUED STAY DISCHARGE NOTICE

(ATTENDING PHYSICIAN AGREES/REVIEW AGENT AGREES)

READ THIS LETTER CAREFULLY—IT CONCERNS YOUR INSURANCE

BENEFITS OR MEDICAID BENEFITS

PATIENT NAME: _____ PRIMARY PAYOR: _____

ADDRESS: _____

ATT. PHYS.:_____ MR NO.: _____ ADM. DATE: _____/_____/_____

Dear Patient:

After careful review of your medical record and consideration of your own views regarding medical condition, the (name of review agent) (the review agent approved by the Department of Health) has agreed with the **hospital** that you no longer **require** care in the **hospital** because you are ready for **discharge**.

IF YOU AGREE with this decision, you should discuss with your doctor the arrangements for any further health care you may need. This means if you have health insurance benefits or Medicaid benefits, these benefits will no longer pay for any additional **hospital** days as of:

_____
_____
Day of Week / Date/
_____

IF YOU DO NOT AGREE THAT YOU ARE READY FOR **DISCHARGE**, IMMEDIATELY

AFTER RECEIPT OF THIS NOTICE YOU OR YOUR REPRESENTATIVE MAY CALL THE (name of review agent) AT (phone no.) TO REQUEST AN IMMEDIATE REREVIEW OF YOUR MEDICAL RECORD.

_____

If you cannot request the reconsideration yourself and you do not have a representative to help you, you may notify the **hospital** representative at extension_____ to request the reconsideration to you. In either case, the individual review agent approved by the Department of Health will request your name, admission date, and telephone number where you or your representative can be reached. If the individual review agent approved by the Department of Health did not ask your views before, it must do so now.

IF YOU REQUEST A REVIEW, the following will happen:

(1) You or your representative will be informed in writing of the results of the review.

(2) IF THE REVIEW AGENT AGREES WITH THE **HOSPITAL's** DECISION that you are ready for **discharge** or that your condition could be **safely** treated in another setting and you have health insurance benefits or Medicaid benefits, your health insurance benefits or Medicaid benefits will PAY FOR YOUR STAY ONLY UNTIL NOON OF THE NEXT DAY AFTER YOU OR YOUR REPRESENTATIVE HAVE BEEN NOTIFIED.

(3) If the review agent determines that you still need to be in the **hospital**, for purposes of payments under health insurance or Medicaid benefits, your continued stay will be considered necessary and appropriate.

IN EITHER CASE (2 OR 3), YOU WILL NOT HAVE TO PAY FOR ANY ADDITIONAL **HOSPITAL** DAYS UNTIL YOU HAVE BEEN NOTIFIED OF THE REVIEW AGENT DETERMINATION.

NOTE: If you miss the noon deadline mentioned on the reverse side of this notice, you may still request a review during your **hospital** stay. However, if the review agent rules against you, you will be financially responsible starting on the date you receive the notice. Of course, if the review agent determination is in your favor, you are not liable for payment for the extra days.

If you would like a review of your **hospital** stay after you have been **discharged**, you may request an individual review agent review within 30 days of receipt of this notice or seven

days after receipt of a complete bill from the **hospital**, whichever is later, by writing to the review agent.

(REVIEW AGENT NAME/ADDRESS)

_____

_____

_____ _____

_____

(**Hospital** Representative Signature) (Date)

(Time)

If your **hospital** stay is not covered under the per case payment system, you may still request a **discharge** review. However, you will continue to be charged for **hospital** services during the review process.

IF YOU HAVE ANY DIFFICULTY UNDERSTANDING THIS NOTICE OR IF YOU NEED MORE INFORMATION, YOU MAY CALL THE REVIEW AGENT DIRECTLY

_____

AT:(Telephone No.)

I have received this notice on behalf of myself as the patient or as a representative of the patient to whom it is addressed:

_____ _____

_____

Signature / Date/

Time

_____

Relationship

cc: Attending Physician

Hospital Billing Office

(11) The provisions of this subdivision shall apply to **hospital** inpatients admitted on and after January 1, 1988.

Credits

Sec. filed July 25, 1977; repealed, new filed Aug. 11, 1988; amds. filed: Dec. 9, 1988; Aug. 25, 1989; Aug. 28, 1989; March 5, 1992; Dec. 16, 1992; Feb. 25, 1993; April 2, 1996; Dec. 28, 2006 eff. Jan. 17, 2007. Amended (c); amds. filed May 13, 2010 eff. June 2, 2010;

amd. filed Dec. 17, 2013 eff. Dec. 31, 2013.

Current with amendments included in the New York State Register, Volume XXXVI, Issue 43, dated October 29, 2014.

10 NYCRR 405.9, 10 NY ADC 405.9

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