



Discharge Planning for Better Health Care Advocacy Tips for Assisting Medicare Patients

Discharge Planning for HOSPITAL PATIENTS

Introduction

General guidelines and cautions

The following information for Medicare beneficiaries and their advocates is useful in challenging a discharge or reduction in services in hospital, skilled nursing, home health, and hospice care settings:

- Read carefully all documents that purport to explain Medicare rights. If unable to do so, have family members, friends, or other representatives read such document(s).
- Question treating physicians, nurses, social workers, home health care providers, and other care providers about necessary services as the beneficiary's condition improves, remains the same, or requires more services. If the beneficiary has opinions and concerns about care, voice them and participate fully in all care decisions.
- Become familiar with Medicare guidelines about eligibility for hospital and home and community based care, including nursing facility services and home health services available under the Medicare and Medicaid programs. It is also important to explore options for services that may be available through other state-based sources of coverage for home and community-based services (HCBS).
- Identify and become familiar with available health care services such as visiting nursing services, home health agencies, nursing homes, respite care, friendly visiting services, and religious and civic groups that provide services. An important source of information about services is the Elder Care Locator 1-800-677-1116. In addition, contact the Medicare program's information line B 1-800-MEDICARE (1-800-633-4227) (TTY: 1-877-486-2048 for the hearing impaired).
- Become familiar with discharge planning and its interplay with "transitions," an

activity that includes the preparing for and moving from one care setting to another. See, “Breathing Life Into Discharge Planning,” by Alfred J. Chiplin, Jr., http://www.medicareadvocacy.org/WAUpdate_BreathingLifeIntoDischargePlanning06.22.04.PDF

- Use physicians and suppliers who are Medicare-participating providers and, as such, have agreed to accept the Medicare reasonable charge amount, less the 20% beneficiary co-payment, as payment in full for Medicare-covered physician and supplier services (*See, 42 U.S.C §§1395u(b)(3);1395n; 42 C.F.R.§§ 410.152(amounts of payment); 424.55(b)(payment to suppliers); 414.48 (limiting charge for non-participating suppliers); see also, 400.402(definitions specific to Medicare, including payment on an assignment related basis).*
- Beware of using physicians who have opted out of Medicare and the impact of using such physicians and consequent impact on access to Medicare coverage for the services. See, 42 C.F.R. §§405.400 et seq.
- Pay attention to access to coverage concerns that may arise from recently instituted Medicare rules that exclude and limit payment for hospital-acquired conditions (HACs) and incidents that should never happen in hospitals (never events).
- Contact your local Medicare office or the Social Security office for a list of Medicare participating providers and suppliers in your area.

Hospital Discharge planning services include:

- Identifying, at an early stage of hospitalization, those patients who are likely to suffer adverse health consequences upon discharge in the absence of discharge planning services.
- On a timely basis, conducting a discharge planning evaluation for all patients identified by their physicians as needing discharge planning services as well as any patient requesting a discharge planning evaluation.
- Placing the discharge planning evaluation in the patient’s medical record for use in planning post-hospital services.
- Discussing with the patient (and representatives) the elements of the discharge plan evaluation.
- Arranging, when requested by a patient’s physician, for the development and the initial implementation of a discharge plan for the patient.

- Assuring that discharge planning evaluations and discharge plans are developed by, or under the supervision of, a registered professional nurse, social worker, or other appropriately qualified personnel (42 U.S.C. §1395x(ee); 42 C.F.R. §482.43. *Condition of participation: Discharge planning*).
- When a Quality Improvement (QIO) or hospital makes a determination whether an inpatient hospital stay is medically necessary, it must make an individualized assessment of the patient's need for skilled nursing facility care. If the patient requires skilled nursing facility care, the QIO or hospital must determine whether there is a bed available to the patient in a participating skilled nursing facility in the community or local geographic area (42 C.F.R. §§424.13(b)(1), 412.42(c)(1)).

Obtaining Necessary Assistance

- Medicare beneficiaries and their advocates who question the appropriateness of a proposed discharge from a Medicare hospital, whether the discharge is too soon or whether necessary post-hospital services have been arranged, should contact the local Quality Improvement Organization (QIO) and file a complaint. The beneficiary's hospital discharge notice should provide the name, address, and phone number of the QIO serving your hospital, along with instructions on how to file a complaint (*See 42 C.F.R. §§412.42-412.48*).
- If a beneficiary needs help in filing a complaint with the QIO, contact the Elder Care Locator for information about community-based Medicare assistance, including legal assistance providers funded under the Older Americans Act, the Legal Services Corporation, or private attorney services, or through your network of Health Insurance Counseling Program (HICAP)[sometimes called State Health Insurance Counseling Programs (SHIPs) or Insurance Counseling Assistance (ICAs)]. (*Use the eldercare locator number listed above for information about the location of HICAPs/SHIPs/ICAs in your area.*). Moreover, QIOs have an obligation to assist Medicare beneficiaries in completing and filing a written complaint.
- Before leaving the hospital, make sure that the hospital has discussed post-hospital care needs and that a post-hospital plan of care and services has been developed prior to discharge.
- Make sure that one's discharge plan identifies necessary services, including how those services will be provided, and requesting assistance in putting services in place.

Discharge from the Hospital Setting

- Effective July 1, 2007, Medicare participating hospitals must deliver valid, written notice, using the "Important Message from Medicare" (IM). This notice is to explain a patient's rights as a hospital patient including discharge appeal rights. It

is to be given at or near admission, but no longer than 2 calendar days following the beneficiary's admission to the hospital. 42 CFR 405.1205(Traditional Medicare) and 42 CFR §422.620 (Medicare Advantage).

- A follow-up copy of the signed IM is given again as far as possible in advance of discharge, but no more than 2 calendar days prior to discharge. 42 CFR §405.1205(c)(1); 42 CFR §422.620(c)(1). Follow-up notice is not required if the provision of the admission IM falls within 2 calendar days of discharge. 42 CFR 405.1205(c)(2)(Traditional Medicare) and 42 CFR 422.620(c)(2) (Medicare Advantage). The exception to the two-notice requirement is an individual who is in the hospital for just 3 days. One IM can be given on day 2, and suffice as both the initial and discharge IM.
- The patient becomes financially responsible for the services provided beyond the second day following the date of the notice. 42 C.F.R. §412.42(c)(3)(ii). See also 42 C.F.R. §§422.620, 489.27 (Beneficiary Notice of Discharge Rights – Medicare Advantage (MA) plans).
- For a hospital stay, a beneficiary must request expedited review, orally or in writing, by noon of the first working day after he or she receives written notice that the hospital has determined that the hospital stay is no longer necessary. 42 CFR §405.1206(d)(1); 42 CFR §422.622(d)(1).
- The beneficiary (or his or her authorized representative), when requested by the QIO, must be prepared to discuss the case with the QIO. 42 CFR §405.1206(d)(2); 42 CFR §422.622(d).
- On the date that the QIO receives the beneficiary's request, the QIO must notify the hospital that the beneficiary has filed a request for expedited review. 42 CFR §405.1206(e)(1); 42 CFR §422.622(e)(1).
- The hospital must supply any information, including medical records, that the QIO requires to conduct its review and must make it available, by phone or in writing, by the close of business of the first full working day after the day the beneficiary receives notice of the planned discharge. 42 CFR §405.1206(e)(2); 42 CFR §422.622(e)(2).
- When the beneficiary requests an expedited determination in accordance with §405.1206(d)(1), the QIO must make a determination and notify the beneficiary, the hospital, and physician of its determination by close of business of the first working day after it receives all requested pertinent information. 42 CFR §405.1206(e)(5); 42 CFR §422.622(e)(5).
- If the QIO sustains the decision to terminate services or discharge the beneficiary, the beneficiary may request expedited reconsideration, orally or in writing, by noon of the calendar day following initial notification. The reconsideration will be

conducted by the QIC, which must issue a decision within 72 hours of the request. If the QIC does not comply with the time frame, the beneficiary may escalate the case to the administrative law judge level. See 42 CFR 405.1204.

- Beneficiaries retain the right to utilize the standard appeals (42 U.S.C §1320c-3(a)(14); 42 C.F.R. 466.70 et seq.) process rather than the expedited process in all situations. A QIO may review an appeal from a beneficiary's request that is not timely filed, but the QIO does not have to adhere to the time frame for issuing a decision, and the limitation on liability does not apply.
- It is the hospital and not the health plan that provides the notice for beneficiaries in hospitals that are part of a Medicare Advantage (MA) Organization. 42 C.F.R. §422.620(c).
- A person in a Medicare Advantage Organization hospital who misses the PRO appeal deadlines can use the Medicare Advantage expedited appeals process. 42 C.F.R. §422.584.

What Information Must the “IM” Contain?

The IM must contain the following essential pieces of information:

- The name(s) of the patient's physician(s) and the patient's ID number.
- A statement of the right to file an appeal or raise questions with a QIO about quality of care, including hospital discharge.
- The name and telephone number of the QIO that serves the area in which the hospital in question is located.
- A space for the beneficiary or representative to sign and date the document.
- The steps necessary to appeal a hospital discharge decision or to file a complaint about the quality of care.

What Information Must the “Detailed Notice” Contain?

The Detailed Notice must contain the following essential pieces of information:

- The name(s) of the patient's physician(s) and the patient's ID number.
- The date the Notice was issued.
- The date the inpatient hospital services are to end.
- A statement that the *Detailed Notice* is not an official Medicare decision.
- Specific information about the patient's current medical condition.
- The hospital and/or Medicare plan telephone number for requesting copies of documents to be sent to the QIO.

When Must the “IM” be Distributed?

- The patient must receive the original IM within two days of admittance to the hospital. The hospital must obtain the signature of the beneficiary or of his or her representative and provide a copy to that person at that time. If the patient or representative refuses to sign the IM, then the hospital is required to make a note to that effect; for purposes of requesting an appeal, the date of the refusal to sign is considered the date of notification. A follow-up copy of the signed IM should again be given “as far in advance of the discharge as possible, but not more than 2 calendar days before discharge.” If discharge occurs within 2 days of the date the IM was given, no follow-up copy is required.
- A beneficiary may be considered discharged when Medicare decides it will no longer pay for the medical services or when the physician and hospital believe that medical services are no longer required. The Medicare Claims Manual provides that a patient may be considered to have been discharged when s/he is either physically required to leave the hospital (not merely transferred to another inpatient setting) or when s/he remains in the hospital but at a lower level of care.

Discharge Decision Concerns

- **Four Hour Notice Requirement**

Notification of the beneficiary’s discharge and appeal rights should not be hindered when the hospital cannot anticipate the date of discharge. According to CMS, if hospitals cannot anticipate the discharge date, the follow-up IM notice may be given on the day of discharge, at least four hours in advance of the actual discharge.

- **Problems With Four Hour/Same Day Notice**

Beyond requiring that the follow-up IM be given at a minimum of four hours in advance of discharge, CMS does not require the hospital to again obtain the patient’s signature when this follow-up IM is given. The hospital may simply distribute a copy of the signed and dated IM that was given at admission. However, hospitals are not precluded from obtaining a new IM and verifying signature from the beneficiary. By allowing this practice, CMS has made it possible for hospitals to eliminate the need for a follow-up copy of the IM during inpatient stays of up to 5 days. This lack of timely notice may hinder the ability of Medicare patients to be fully aware of and exercise their appeal rights.

Appeals of Hospital Discharge

When a hospital (with physician concurrence) determines that inpatient care is no longer necessary, the Medicare beneficiary has the right to request an expedited QIO

review. The CMS guidelines provide that the appeal for expedited review must be made before the beneficiary leaves the hospital.

Timely QIO Review

- In order for the review request to be considered “timely,” beneficiaries must submit their requests in writing or by telephone no later than midnight of the day of discharge and before they leave the hospital. The beneficiary, therefore, should not be discharged upon requesting the QIO review, so long as the request is made on the same day.
- The beneficiary or qualified representative should be contacted by the QIO to discuss the case with the QIO and provide any necessary information that may be required. The hospital is required to submit all pertinent information to the QIO. The patient or his or her representative also has the ability to obtain the same information from the hospital and/or QIO. In addition, the QIO should obtain medical records from the hospital, including speaking to the patient’s physician(s). A timely request will trigger the QIO to render a decision within 1 calendar day after receiving all of the necessary information.

Detailed Notice of Discharge

- The *Detailed Notice* of discharge must be delivered “as soon as possible” after the beneficiary has requested a QIO review, but no later than noon of the day after the QIO notifies the hospital of the beneficiary’s request for the review. Under the CMS guidelines, hospitals are only required to deliver the *Detailed Notice* after the beneficiary has contacted the QIO for expedited review or when the beneficiary requests more detailed information from the medical care provider prior to requesting a QIO review. The *Detailed Notice* is not an official Medicare decision. It is designed to give the patient further explanation about why the hospital and/or physician believe that the medical services are no longer necessary.

Financial Liability

- Beneficiaries are not financially liable for hospital costs incurred during a timely QIO review; they are responsible only for coinsurance and deductibles. Further, the burden of proof lies with the hospital to demonstrate that the discharge is the correct decision based on either medical necessity or other Medicare coverage policies. If the QIO decision is in agreement with the hospital (unfavorable to the patient), the beneficiary becomes liable for the medical expenses beginning at noon on the *day after* notification of the decision is given.

Additional background on the new IM

- The new notice, *An Important Message from Medicare about Your Rights* (IM), can be found on the CMS website at http://www.cms.hhs.gov/BNI/12_HospitalDischargeAppealNotices.asp#TopOfPage (site visited October 3, 2008). The requirements for the new notice are discussed in Guidelines which were released by the Centers for Medicare & Medicaid Services (CMS) on May 25, 2007. In the Guidance, CMS explains when and how Medicare patients must be given information about their discharge and appeal rights. See, <http://www.cms.hhs.gov/Transmittals/downloads/R1257CP.pdf>.
- Upon receipt of a hospital's discharge decision, beneficiaries may appeal the decision by requesting a timely review by the appropriate Quality Improvement Organization (QIO). When QIO review is requested, an additional notice called the *Detailed Notice of Discharge (Detailed Notice)* is to be given. CMS has issued a Question & Answer document elaborating on the use of IM and the *Detailed Notice*. See, <http://www.cms.hhs.gov/BNI/Downloads/CMS-4105-FINAL%20RULE%20Qs%20and%20As%2004%2003%2007.pdf>.
- Weichardt v. Thompson, Civil Action No. C 03 5490 (N.C. Cal. 2003), was filed in federal district court in San Francisco on behalf of three Medicare beneficiaries who were forced to leave their hospitals before they were medically ready. Each plaintiff (or a family representative) objected to being discharged, but received no written notice of the appeal process for challenging the discharge decision. Neither was told that if they stayed on in the hospital, they would be personally liable for the cost of care. The plaintiffs sought a requirement that Medicare beneficiaries are given timely written notice of the reasons for their discharge and of the procedures for appealing a discharge decision.
- As a result of settlement discussions, proposed regulations were published on April 5, 2006, at 71 Fed. Reg. 17052. See, <http://edocket.access.gpo.gov/2006/pdf/06-3280.pdf>. The proposed regulations required that a Generic Notice of Hospital Non-coverage be given to all Medicare hospital patients at least one day before a planned discharge. This generic notice would specify the date of discharge and explain the procedure for the patient to obtain an expedited review of the medical necessity for continued inpatient care. If the patient indicates that she wishes to appeal, the proposed regulations require that a detailed follow-up notice with specifics about the medical reasons for individual's discharge be given to her by noon of the next day.

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