



## **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](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.
- 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.
- 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.
- Conducting a discharge planning evaluation, made on a timely basis, 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.

- When a Quality Improvement Organization (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.

### **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 PRO serving your hospital, along with instructions on how to file a complaint.
- 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**

- 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.

- 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. Follow-up notice is not required if the provision of the admission IM falls within 2 calendar days of discharge. 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.
- 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.
- The beneficiary (or his or her authorized representative), when requested by the QIO, must be prepared to discuss the case with the QIO.
- 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.
- 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.
- 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.
- 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.
- Beneficiaries retain the right to utilize the standard appeals 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.
- A person in a Medicare Advantage Organization hospital who misses the PRO appeal deadlines can use the Medicare Advantage expedited appeals process.

## **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.

## **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.

*October 2008*