



Discharge Planning for Better Health Care **Advocacy Tips for Assisting Medicare Patients in Nursing Facility Discharge**

Discharge Planning for NURSING FACILITY 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_BreathingLifeIntoDischargePlanning_06.22.04.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.

Discharge Planning in the Nursing Facility Setting

When nursing facility care needs arise, it is important to contact the local Medicare office or the Social Security office for a list of Medicare participating providers and suppliers, or check www.Medicare.gov/NHCompare.

Resident Assessment

- Facilities are to develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident’s medical, nursing, and mental and psycho-social needs that are identified in the comprehensive assessment (42 C.F.R. §483.20(b)).
- Facilities are to assess the resident’s discharge potential, an assessment of the facility’s expectation of discharging the resident from the facility within the next 3 months (42 C.F.R. §483.20(b)(xvi)).

Skilled Nursing Facility (SNF) Advance Beneficiary Notice (ABN)

- A SNF must provide notice when it believes Medicare will not pay for an item, service, or purchase. A SNF must also provide proper notice explaining appeal rights and the recommendations for non-coverage. CMS has developed a model notice, the SNFABN, which facilities may use (*Form no: CMS-10055; MCM, Pub. 100-04, Ch. 30, §70.3.1*).

Discharge planning

- A facility must provide *sufficient preparation and orientation* to residents to ensure safe and orderly transfer or discharge from the facility (*42 C.F.R. §483.12(a)(7)*).
- Resident records should contain a final resident discharge summary which addresses the resident's post-discharge needs (*42 C.F.R. §483.20(l)*).
- Facilities are to develop a post-discharge plan of care, developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment. This applies to discharges to a private residence, to another nursing facility, or to another type of residential facility such as board and care or nursing facilities (*42 C.F.R. §483.20(l)*).
- Post-discharge plan of care means the discharge planning process, which includes assessing continuing care needs and developing a plan designed to ensure the individual's needs will be met after discharge from the facility into the community (*42 C.F.R. §483.20(l)*).
- Factors to explore in accessing whether a facility has provided appropriate post-discharge planning include:
 - Does the discharge summary have information pertinent to continuing care for the resident?
 - Is there evidence of discharge planning in the records of discharged residents who had an anticipated discharge or those residents to be discharged shortly (*e.g.*, the next 7-14 days)?
 - Do discharge plans address necessary post-discharge care?
 - Has the facility aided the resident and his/her family in locating and coordinating post-discharge services?
 - What types of pre-discharge preparation and education has the facility provided the resident and his/her family?

(See, Long-Term Care and Resident Assessment Surveys. State Operations Manual Transmittal No. 8, May 1, 1999, Medicare and Medicaid: SNF Surveys, F283, F284; CMS Pub. 100-07, Appendix PP, Guidance to Surveyors for Long-Term Care Facilities).

Avoiding the Medical Improvement Trap

- Skilled nursing services include observation and assessment of a patient's medical condition. A frail or chronically ill person need not show deterioration or medical setback in order to justify skilled nursing observation and assessment, including the observation and assessment of acute psychological problems in addition to physical problems (42 C.F.R. §§409.31(b)(1)-(5); 409.32; 409.33).
- The Medicare program recognizes maintenance therapy as a legitimate aspect of skilled care services provided in a SNF; that coverage cannot be denied merely because a beneficiary has no restoration potential or has achieved insufficient progress toward Medical improvement has been achieved restoration (42 C.F.R. §409.32(c)).

Notice of admission

- The Nursing Home Reform Law does not require that a facility provide a beneficiary a notice of denial of admission.
- The Nursing Home Reform Law prohibits certain discriminatory admissions practices (e.g., waiving rights to Medicare, requiring written or oral assurance that the individual is not eligible for and will not apply for Medicare or Medicaid, requiring third-party guarantee of payment) and requires that facilities display prominently in the facility information about how to apply for and use Medicare benefits. (42 U.S.C. ' 1395i-3(c)(5)(A); 42 C.F.R. 483. 12(d)(1), (2)).

Prospective payment and access

- As a practical matter, with respect to admissions, some nursing facilities in response to Medicare's Prospective Payment System (PPS) for Nursing Facilities, (Resource Utilization Groups (RUG-III) criteria) are evaluating potential patients before formal hospital discharge and making admission decisions based on the beneficiary's likely RUG-III categorization. Patients in these circumstances do not get a notice of a denial of admission and in fact may not even know that they have been evaluated for purposes of a skilled nursing facility admission. Note: The PPS RUG-III system does not change Medicare skilled nursing facility (SNF) criteria for admission or services. In addition, the failure to be placed in a high RUGs category does not automatically mean that the beneficiary would be denied SNF coverage under Medicare. (See Pub. L. No. 105-33 (Aug. 5, 1997) §4432(a), amending §1888 of the

Social Security Act, by adding subsection (e), 42 U.S.C. §1395yy, effective on or after July 1, 1998. See also, 42 C.F.R. ' 413.330 et seq.).

Transfer of patient to non-skilled bed

- If the nursing facilities determines that a patient no longer qualifies for Medicare covered skilled nursing services and wishes to transfer the patient to a non-Medicare certified bed, it must give the beneficiary a transfer notice, explaining appeal rights and the steps to take to exercise the right of appeal (42 C.F.R. §483.12(a)).

Refusal of transfer

- A Medicare beneficiary has the right to refuse a transfer from a portion of the facility that is a skilled nursing facility to a portion that is not a skilled nursing facility (42 U.S.C. §1395i-3(c)(1)(A)(x); 42 C.F.R. §483.10(o)).

Bed-hold policies and readmission

- The Medicare law does not provide for holding beds as does Medicaid. Under Medicaid, however, when a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies the facility's bed-hold policies. The policies must be consistent with the provisions of the state Medicaid plan regarding bed-hold (42 U.S.C. §1396r(c)(2)(D)); (42 C.F.R. §483.12(b)). The Medicare law does not guarantee readmission rights for a Medicare beneficiary who is hospitalized. There is, however, a right of readmission under Medicaid law for Medicaid beneficiaries who's hospitalization or therapeutic leave exceeds the period paid by the state for bed-hold if the Medicaid beneficiary requires the facility's services. The right of readmission is an immediate right to the first available bed in a semi-private room (42 U.S.C. §1396r(c)(2)(D)).

Demand bills

- If a SNF decides that Medicare will no longer cover an item, service, or procedure and the facility wishes to bill the beneficiary, it must give the beneficiary written notice of non-coverage, including information about the right to request an appeal of the facility's non-coverage decision and the steps to take to exercise that right (42 U.S.C. §1395pp (waiver of liability provisions); 42 C.F.R. §411.100 et seq.; *Sarrassat v. Sullivan, Medicare and Medicaid Guide (CCH), ¶38,504 (N.D. Cal. 1989), HCFA Ruling 95-1 (Dec. 22, 1995); HCFA SNF Manual, Chapter 3, §357A (establishing when the beneficiary is on notice of non-coverage); §352.1 (determining beneficiary liability)).*
- If the beneficiary does not agree with the facility's non-coverage decision, he or she

may request that the SNF submit the bill to Medicare *even when* the facility believes that services will not be covered by Medicare. This submission is called a “demand bill” or a “no-payment bill.” Demand bills are required to be submitted at the request of the beneficiary. The facility cannot bill the beneficiary for the disputed charges until the Medicare fiscal intermediary issues a formal claim determination (*Medicare Intermediary Manual §3630; Sarrassat v. Sullivan, Medicare and Medicaid Guide (CCH), ¶38,504 (N.D. Cal. 1989)*).

October 2008