DISCHARGED FROM HOSPITAL TOO SOON?
NEW RULES OFFER BETTER PROTECTION FOR MEDICARE PATIENTS

Medicare patients who are hospitalized sometimes find themselves being told to leave the hospital too soon, before they can safely be cared for at home or at a nursing home. The protections provided for hospital patients in this situation have recently been improved, due to a lawsuit brought by the Center for Medicare Advocacy, Inc.

Background

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 got no written notice of the appeal process for challenging the discharge decision, and was told that if they stayed on they would be personally liable for the high cost of hospital care. Several community groups that serve seniors joined the individuals as plaintiffs in the case. The plaintiffs asked that defendant Department of Health and Human Services (DHHS) require that beneficiaries be given timely written notice of the reasons for their discharge and of the procedures for appealing a discharge decision.

Ultimately the Weichardt lawsuit was settled, with the DHHS’ Centers for Medicare & Medicaid Services (CMS) agreeing to propose new regulations requiring notice of discharge rights that met agreed-upon standards under the Medicare statute and due process.

The proposed regulations were published on April 5, 2006, at 71 Fed. Reg. 17052. They 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.

The New Hospital Discharge Procedures

Final regulations setting out the new Medicare hospital discharge notice and appeal procedures were published on November 27, 2006, at 71 Fed. Reg. 68709, with an effective date of July 1, 2007. The portion of these regulations applicable to hospitals under original Medicare are codified at 42 C.F.R. § 405.1205 et seq., and the portion applicable to hospitals under Medicare Advantage (managed care) are codified at 42 C.F.R. § 422.620 et seq. They contain several changes from the proposed regulations

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1 Both hospitals and managed care organizations are reimbursed by Medicare on fixed payment methodologies that make unusually long stays by Medicare beneficiaries unprofitable.
that dilute the protections for patients, but the new procedures remain an improvement over the situations experienced by plaintiffs prior to the Weichardt case.

The final regulations provide that hospitalized beneficiaries will receive the Important Message from Medicare (IM) both on admission and again at discharge. The IM is a form notice mandated by the Medicare statute, to be given to patients on admission to advise them of their rights. 42 U.S.C. § 1395cc(a)(1)(M). The hospital can give the IM up to two days after admission, and up to two days before discharge, so that for patients staying less than five days, the IM could be given only one time. In a disappointing dilution of the protections in the proposed regulation, CMS now allows the second IM to be given on the day of discharge, though it should be given at least 4 hours prior to the time of discharge.

Under the new regulations, the IM will contain explicit information about the processes for requesting appeals of discharge decisions, the right to remain in the hospital without charge if an expedited decision is requested, and the right to receive a detailed notice of the reasons for discharge. 42 C.F.R. § 405.1205, for hospitals; 42 C.F.R. § 422.620, for Medicare Advantage (MA) plans. The IM must be given to a patient “at or near admission,” defined as within 2 days of admission.

Under the prior regulations, many hospital patients reported that they were not aware of having been given the IM on admission. Even if it was given, critics noted that patients were not likely to read a notice included in the many papers routinely accompanying a hospital admission, particularly at a time when acute medical conditions focus the patient’s attention elsewhere. The new regulations require the patient (or representative) to sign and date the IM, which should increase the ability to monitor hospital compliance with the obligation to deliver the IM.

When a hospital or MA plan decides that a Medicare patient should be discharged, the new regulations require it to give the patient (or representative) another copy of the IM. No patient signature or date is required on this second copy, an omission that is unfortunate given the greater need for notice at this point in time than at admission. The follow-up notification must be given “as far in advance as possible, but no more than 2 calendar days prior to discharge.” Since this provision would allow crucial information about appeal rights to be given on the actual day of discharge, its usefulness in enabling patients to exercise the right to remain in the hospital during an expedited appeal is compromised.

For the patient who does follow the procedure spelled out in the IM for an expedited appeal, the expedited appeal process can be very useful. See 42 C.F.R. §405.1206; 42 C.F.R. § 422.622. The patient has the right to immediate review of the discharge decision by an independent review agency, called a Quality Improvement Organization (QIO). The patient may remain in the hospital at least until noon of the day after the QIO expedited review decision without charge for the stay pending appeal. If the QIO finds that the discharge decision was wrong, the patient can continue to receive covered care in the hospital until another discharge decision is made and a new notice is given.

To obtain expedited review, the patient or his representative must contact the QIO by phone or in writing before the end of the day of requested discharge. The hospital or MA plan is then contacted by the QIO and required to prepare and deliver to the patient a detailed notice by noon of the day following contact by the QIO. This detailed notice must advise the patient of the specific facts of his condition, as well as the legal rules, upon which the hospital or MA plan determined that further services would not be covered by Medicare.
The patient may, but is not required to, submit evidence to the QIO in support of his need for continued inpatient hospital services. (The best evidence would be a statement by his attending physician, which would have to be obtained very quickly due to the very short time frame for decision). Most helpfully, the regulations state that the hospital or MA bears the burden of proving that inpatient hospital services no longer met Medicare coverage requirements.

These new rules, along with some guidelines for beneficiaries, will be discussed in further detail in our next Alert. The Center for Medicare Advocacy is interested in hearing about patients’ experiences after these new hospital discharge notice procedures go into effect on July 1, 2007.

Patients or their representatives who encounter problems, or those wishing for more information are asked to contact Sally Hart (shart@vanosteens.com) at (520) 322-0126.