Self-Help Packet for Hospital Discharge

Introduction

The Center for Medicare Advocacy produced this packet to help you understand Medicare coverage and how to file an appeal if appropriate.

Medicare is the national health insurance program to which many people with disabilities and older people are entitled under the Social Security Act. All too often, Medicare claims are erroneously denied. It is your right as a Medicare beneficiary to appeal an unfair denial; we urge you to do so.

For additional assistance, contact your State Health Insurance Assistance Program (SHIP). You can find your state program's information at https://www.shiptacenter.org/.

Hospital Discharge Checklist

- **Step One:** Review the "Quick Screen for Inpatient Hospital Care" included in this packet to determine whether the hospital care you need is covered by Medicare.
- **Step Two:** Review the document entitled, "Hospital Discharge Rights."
- **Step Three:** Ask for a copy of your discharge plan. Review the plan.
- **Step Four:** If you disagree with the plan either because you need to stay in the hospital for more care, or because the hospital is sending you to a skilled nursing facility too far away from your community, or because you need to go to a skilled nursing facility and the hospital is sending you home, ask for a Hospital Issued Notice of Non-Coverage.
- **Step Five:** Once you receive the Hospital Issued Notice of Non-Coverage, immediately call the BFCC-QIO, the entity that reviews Medicare decisions. Its telephone number will be on the Hospital Issued Notice of Non-Coverage. Explain to the BFCC-QIO why the decision to end Medicare coverage and your discharge plan is inappropriate.
- **Step Six:** If the BFCC-QIO agrees with the hospital, ask it to reconsider its decision. After you receive the initial decision, **you have until noon of the following day** to request the Reconsideration. **NOTE**: If you do this, and are not successful, you may become financially responsible for your hospital stay if you remain in the hospital.
- **Step Seven:** If you are not successful with the Reconsideration, appeal to the Administrative Law Judge.

Medicare Coverage for inpatient Hospital Care: A Quick Screen to Aid in Identifying Coverable Cases

Medicare claims for inpatient hospital care are suitable for Medicare coverage, and appeal if they have been denied, if they meet the following test:

The patient's condition must have been such that the care he required could only have been provided in a hospital, **or**, after a 3 day hospital stay, he required a skilled nursing facility (SNF) level of care, and no SNF bed was actually available. (Note: A SNF level of care means that the patient required skilled services – from a physical therapist or a registered nurse, for example – on a daily basis.)

ADDITIONAL ADVOCACY TIPS:

1. The opinion of the patient's attending physician is the most important element in your case. If the physician believes it is medically necessary for the patient to receive care in the hospital, or that he needs at least a skilled nursing facility level of care but no skilled nursing facility bed is actually available, you probably have a winning case.
2. Ask the attending physician to put his or her favorable opinion in writing, explaining with as much detail as possible why the coverage standard described above is met in the patient's case.
3. Usually a Medicare denial doesn't mean that the patient must leave the hospital, but rather that any further stay will be at his own expense.
4. The patient is entitled to "expedited" review, which may allow additional time in the hospital before charges accrue, if the review is requested immediately. The Medicare denial notice given by the hospital will tell you how to immediately appeal by calling the Beneficiary and Family Centered Card Quality Improvement Organization (BFCC-QIO). BFCC-QIOs are divided into five service areas:
    - Area 1 – CT, ME, MA, NH, NJ, NY, PA, PR, RI, VT, VI – Livanta, 866-815-5440 or www.BFCCQIOAREA1.com
    - Area 2 – D.C., DE, FL, GA, MD, NC, SC, VA, WV – KEPRO, 844-455-8708 or www.keproqio.com
    - Area 3 – AL, AR, CO, KY, LA, MS, MT, ND, NM, OK, SD, TN, TX, UT, WY – KEPRO, 844-430-9504 or www.keproqio.com
    - Area 4 – IA, IL, IN, KS, MI, MN, MO, NE, OH, WI – KEPRO, 855-408-8557 or www.keproqio.com
    - Area 5 – AK, AZ, CA, HI, ID, NV, OR, WA – Livanta, 877-588-1123 or www.BFCCQIOAREA5.com

Hospital Discharge Rights

Hospitalized Medicare beneficiaries have a right to discharge planning and an expedited (fast) review of a planned discharge. However, to stop an inappropriate discharge, these rights must be exercised as soon as the patient is given notice of the discharge date. These rights do not apply to beneficiaries admitted to outpatient Observation Status.

Typical Scenarios:

Generally, inappropriate discharges happen for one of two reasons:

1. **Scenario One:** You are hospitalized. Your doctor wants you to go to a skilled nursing facility (nursing home) for Medicare covered follow up care. However, the discharge planner cannot find a facility near your home that can take you. So she intends to either send you far away, meaning that your family will have a hard time visiting you, or send you home.
2. **Scenario Two:** You are hospitalized due to a new problem or worsening of an old problem. You have not yet been properly diagnosed or the problem has not yet adequately resolved. The hospital discharge planner still intends to send you to a skilled nursing facility or home.

Action Steps:

- **Step One: Ask for a Written Copy of the Discharge Plan**

Hospitals are required to create a discharge plan to ensure that patients do not suffer adverse health consequences upon discharge. The discharge plan should include pre-discharge counseling and education for you and your caregivers. It should also include a list of the available Medicare covered skilled nursing facilities and home health aide agencies within your community.

- **Step Two: Object to the Discharge Plan**

If the discharge plan is unsatisfactory, either because you will be discharged from the hospital too soon, or to a skilled nursing facility that is too far away from your community, or because you will be sent home when you should be sent to a skilled nursing facility, object to the discharge plan. Ask the hospital for a **Hospital-Issued Notice of Non-coverage** (HINN). This document will include the telephone number for the Beneficiary Family –Centered Care Quality Improvement Organization (BFCC-QIO). As soon as you get the notice, call the telephone number and explain that you object to the discharge plan and why you object. You will not become financially responsible for your care at the hospital until noon of the calendar day after your receive the BFCC-QIO's response to your appeal.

- **Step Three: Ask for a Reconsideration**

If the BFCC-QIO tells you that it agrees with the hospital regarding your discharge, you have until noon of the following day to ask the BFCC-QIO to reconsider its decision. It will have 72 hours to do this, unless you ask for an extension (not to exceed 14 days). If the BFCC-QIO continues to agree with the hospital, you will most likely become financially responsible for your continued stay at the hospital.

- **Step Four: Request an Administrative Law Judge Hearing**

The BFCC-QIO will send you a written copy of its Reconsideration with information about how to request an Administrative Law Judge (ALJ) hearing. You have 60 days to request the hearing. Unfortunately, ALJ hearings and decisions are not expedited. This means that you may have to wait a long time (several months) before your hearing is held. Further, while the ALJ is supposed to issue a decision within 90 days of receipt of the request for hearing, it often takes longer. **To get a hearing and decision as quickly as possible, write "BENEFICIARY APPELLANT," in bold on the request and on the envelope. If the ALJ issues a decision in your favor, you**

will not be financially responsible for the previously denied hospital care. On the other hand, if the judge issues an unfavorable decision, you will remain financially responsible for the continued care unless you successfully appeal to the next step, the Medicare Appeals Council. The ALJ's decision will tell you how to file an appeal with the Medicare Appeals Council.

- For more details, see our Advocacy Tips: Medicare Administrative Law Judge (ALJ) Hearing Process

Glossary of Terms

BENEFICIARY

An individual enrolled in the Medicare program.

BFCC-QIO (Beneficiary Family Centered Care Quality Improvement Organization)

A contractor paid by the federal government to monitor the care given to Medicare patients. It reviews complaints about the quality of care given by hospitals (inpatient and outpatient), skilled nursing facilities, and home health agencies. It also reviews discharge appeals. In Connecticut the BFCC-QIO is Livanta. The telephone number is 1-866-815-5440.

CLAIMANT

An individual requesting reimbursement from Medicare for expenses incurred for medical care (or the individual requesting payment on behalf of a Medicare enrollee).

CO-INSURANCE

The amount a beneficiary must pay as his or her share of the cost of a given service. For example, a beneficiary must pay part of the cost of days 21 through 100 in a skilled nursing facility. There is also a co-insurance (20% of the reasonable charge) which must be paid for Part A or B services.

CMS (Centers for Medicare and Medicaid Services)

The federal agency which administers the Medicare program: part of the Unites States Department of Health and Human Services.

DEDUCTIBLE

The amount which a beneficiary must pay before Medicare (or other insurance program) will begin to cover the bill. Each calendar year a deductible must be paid before Medicare will cover hospital care under Part A, or physician visits and other services under Medicare Part B.

HEALTH INSURANCE CLAIM NUMBER

The Social Security number under which you receive benefits. This number is the number on your health insurance (Medicare) card.

INPATIENT

An individual admitted to a hospital, skilled nursing facility, or other health care institution for treatment

MEDICARE ADVANTAGE

Medicare offered by private, for-profit insurance companies subsidized by the federal government. Coverage is required to be equivalent to traditional Medicare, but choice is generally limited.

MEDICARE CLAIM DETERMINATION

The written notice of denial of Medicare coverage issued by the intermediary.

MEDICARE CONTRACTOR

An agent of the federal government, often an insurance company, which makes Part A Medicare claim

determinations for skilled nursing facility and home health coverage, and issues payments to providers.

MEDIGAP

Private insurance which covers the “gaps” in Medicare (such as deductibles and co-insurance amounts). Significantly, these policies generally do not pay when Medicare refuses coverage.

OBSERVATION STATUS

The practice by hospitals of classifying beneficiaries’ stays, regardless of length or services rendered, as “Outpatient” rather than “Inpatient.” This designation has serious billing and coverage ramifications for beneficiaries.

QIO (QUALITY IMPROVEMENT ORGANIZATION)

A contractor paid by the federal government to monitor the care given to Medicare patients. It reviews complaints about the quality of care given by hospitals (inpatient and outpatient), skilled nursing facilities, and home health agencies.

RECONSIDERATION

Review of a “Redetermination” by an Independent Contractor.

REDETERMINATION

An examination of a claim by the fiscal intermediary (FI), carrier, or Medicare Administrative Contractor (MAC) personnel who are different from the personnel who made the initial claim determination.

SHIP

State Health Insurance Assistance Program. These programs are funded to help beneficiaries with insurance choices, enrollment and appeals. See https://www.shiptacenter.org/..

SKILLED CARE

Care which requires the skill of technical or professional personnel in order to ensure its safety and effectiveness, and is furnished directly by, or under the supervision of, such personnel. (Nurses and physical or occupational therapists are examples of professional personnel.)

SKILLED NURSING FACILITY (SNF)

A skilled nursing facility, or “SNF,” is a nursing home which delivers a relatively substantial degree of skilled nursing and rehabilitative care, and personal care. In order to receive Medicare coverage for nursing home care, a patient must receive daily skilled care in a Medicare-certified skilled nursing facility.

SPELL OF ILLNESS (BENEFIT PERIOD)

The name of the benefit period for Medicare Part A. The “spell of illness” begins on the first day a patient receives Medicare-covered inpatient hospital care and ends when the patient has spent 60 consecutive days outside the institution, or remains in the institution but does not receive Medicare-coverable care for 60 consecutive days.

Federal Regulations

- **Discharge Planning:** https://www.law.cornell.edu/cfr/text/42/482.43
- **Expedited Determination Procedures:** https://www.law.cornell.edu/cfr/text/42/405.1206