Hospital Discharge Planning for Medicare Beneficiaries: Know your Rights

By Robert K. Schweitzer, CELA
December 2020

True story: A few weeks ago, I received a call from a woman to say that her mother, who is in her 90s, has underlying health conditions and is a fall risk, fell in her home while trying to get to the bathroom. Her mother was able to use her emergency pendant to contact 911 and was taken to the hospital for an examination. After spending a few days in the hospital recovering, the hospital decided to discharge her mother. The problem was the mother was not ready to go home without assistance. Her daughter lives out of state and no home health agency could implement services or staffing in the short time presented for discharge. Attempts to delay the discharge went unanswered and requests for discharge to a rehabilitation facility were denied without even checking with the mother's Medicare insurance provider. The mother was taken home in a taxi called for by the hospital. She remained there alone until her daughter could make airline reservations and arrive a day and half later. The daughter asked what her mother's legal rights were. The bad news is that after the fact of discharge, not much can be done. However, the mother, as a Medicare beneficiary had appeal rights while she was in the hospital but did not properly exercise those rights due to a lack of understanding. This article addresses a Medicare beneficiary's rights, and a hospital's obligations, regarding discharge planning.

What is Discharge Planning?

Simply put, discharge planning identifies a patient's expected health care needs after they leave the hospital. While only a physician can authorize a patient's discharge from the hospital, discharge planning can be completed by a social worker or case manager. Ideally, discharge planning includes the input of your family and their ability to care for you. It should also include whether caregiver training or support is needed and referrals to home health care agencies (as, and if, needed) and arranging for follow up appointments. Good discharge planning can decrease the chances of your readmittance to the hospital and aid in your recovery.

What are Hospitals Obligations in Planning for your Discharge?

A hospital has the following obligations:

- Ensure that patients have the right to access their own medical records upon oral or written request, in the form and format requested by the patient (including electronically, if readily

producible in that format) and within a reasonable time frame.

- Develop and implement an effective discharge planning process that:
    - Focuses on the patient's goals and treatment preferences; and
    - Includes the patient and his or her caregivers/support person(s) as active partners in the planning for post-discharge care.
- Include discharge planning evaluations that:
    - Allow for timely arrangement of post-hospital care prior to discharge;
    - Include evaluation of the likely need for, availability of, and patient access to non-health care services and community-based care providers; and
    - Provide patients and their caregivers with assistance selecting a post-acute care provider, including the sharing of home health agencies, skilled nursing facilities, in patient rehabilitation facilities or long term care hospital data on quality and resource use measures relevant to the patient's goals of care and treatment preferences.
        - The last point is of particular importance when dealing with discharge planning—the patient's treatment preferences are to be given consideration and thus each discharge plan should be individualized.

What if you Disagree with the Decision to be Discharged?

Every hospital that accepts Medicare must deliver to you written notice using the "Important Message from Medicare" ("IM") form. This notice explains your rights regarding discharge planning; including discharge appeal rights. It is to be given to you at, or near, the time of admission but no longer than two days following your hospital admission. A follow up copy of the notice is to be given as far as possible in advance of discharge but no more than two calendar days prior to discharge (some limited exceptions apply). This notice explains:

- Your right to get all medically necessary hospital services;
- Your right to be involved in any decisions that the hospital, your doctor, or anyone else makes about your hospital services and to know who will pay for them;
- Your right to get the services you need after you leave the hospital;
- Your right to appeal a discharge decision and the steps for appealing the decision;
- The circumstances under which you will or won't have to pay for charges for continuing to stay in the hospital; and
- Information on your right to get a detailed notice about why your covered services are ending.

If the hospital gives you the IM more than two days before your discharge day, it must give you a copy of your original, signed IM or provide you with a new one (that you must sign) before you are discharged.

You may have the right to ask for a fast appeal. Follow the directions on the IM to request a fast appeal if you think your Medicare-covered hospital services are ending too soon. You must ask for a fast appeal no later than the day you are scheduled to be discharged from the hospital. If you ask for your appeal within this time frame, you can stay in the hospital while you wait to get the decision. You will not have to pay for your stay (except for applicable coinsurance or deductibles).

If you miss the deadline for a fast appeal, you can still ask for a review your case, but different rules and time frames apply and you might be responsible for the cost of the hospital stay past the original day the hospital tries to discharge you. If you are in a Medicare Advantage Plan, you can ask your plan for an appeal, but different rules apply.

What if it is Decided that you are Being Discharged too Soon?

Medicare will continue to cover your hospital stay as long as medically necessary (except for applicable coinsurance or deductibles) if your plan previously authorized coverage of the inpatient admission, or the inpatient admission was for emergency or urgently needed care.

You may need to appeal the denial of coverage for your plan to pay if your plan never authorized the inpatient admission, or the inpatient admission was not for emergency or urgently needed care.

What if it is Decided that you are ready to be Discharged and you met the Deadline for Requesting a Fast Appeal?

You will not be responsible for paying the hospital charges (except for applicable coinsurance or deductibles) incurred through noon of the day after you make the decision. If you get any inpatient hospital services after noon of that day, you may have to pay for them.