

Medicare Minute Teaching Materials – July 2015 Hospital Transitions

1) What is hospital discharge planning?

Discharge planning helps ensure that you and your caregivers have the information, resources, and care you need as you transition from the hospital to your home or other living arrangement. Social workers, nurses, physicians, and other hospital staff are typically involved in the discharge planning process. The goal of the process is to give you and your caregivers the information and resources you need to transition from the hospital to the next care setting with ease. Adequate discharge planning should find the most appropriate care setting for you and help you to avoid future hospital readmissions for the same condition or injury. Note that Medicare has discharge planning requirements for other health care settings as well (e.g., Skilled Nursing Facilities, Home Health Agencies, etc.).

2) What are Medicare's requirements for hospital discharge planning?

Medicare requires hospitals to screen all inpatients and refer those who could be at risk for complications for a discharge planning evaluation. The evaluation judges whether you can be safely discharged from the hospital without advance planning and preparation. If the evaluation affirms the need for discharge planning, the hospital must provide you with an in-depth discharge plan. The discharge plan should reflect an evaluation of the most appropriate next-care setting for your health needs, your insurance options, additional community resources available, and any input from you and your caregivers.

Medicare's discharge planning requirements apply to all hospital inpatients with Medicare, whether they receive coverage through Original Medicare or a Medicare Advantage Plan. Keep in mind that while Medicare recommends that hospitals provide thorough discharge plans to all Medicare inpatients, it only **requires** discharge plans for inpatients considered at risk after their evaluation or for patients whose doctors request a discharge plan. Similarly, while Medicare encourages hospitals to provide abbreviated discharge plans to certain groups of hospital outpatients, Medicare does not require hospitals to provide discharge planning to outpatients. It's important to note that state law may require hospitals to provide additional discharge planning rights to patients.

3) When should screening for discharge planning begin?

Medicare requires hospitals to screen you during the early stage of your inpatient stay to determine whether you could be at risk for adverse health outcomes without comprehensive discharge planning. The initial screening serves to identify your health risks and thus require a thorough evaluation of your post-hospital needs. Medicare does not specify exactly when the early stage occurs, but recommends that hospitals begin screening when a patient is first admitted into the hospital as an inpatient or shortly thereafter. Medicare does specify that even if an inpatient hospital stay is less than 48 hours, the hospital must still screen you for a discharge plan and provide you with a completed plan, if needed, prior to discharge.

4) If a patient qualifies, what is included in a hospital discharge plan?

The ultimate goal of a discharge plan is to optimize your ability to return safely to the setting from which you came before your hospitalization (whether it be home, a nursing home, or an assisted living facility), and to provide education and resources to achieve this goal. The discharge plan is the action plan that you, your physicians, family members, and others follow to work toward your recovery.

The discharge plan must be developed with input from you and your caregivers, and should address:

- Your need for follow-up care, including additional medical care, supports, and medications.
- The most appropriate care setting for you after hospital discharge.
- If you are returning home, whether you can care for yourself reasonably well.
 - If not, the availability and capacity of caregivers or community-based supports to provide adequate assistance.
- Your access to coverage for follow-up care, including Medicare and Medicaid.

5) What initial steps must the hospital take to implement my discharge plan?

Discharge planning obligations do not end when the hospital develops a discharge plan for you. Hospitals must take initial steps to put your discharge plan in place. For example, before you leave the hospital, staff must educate you, your family, and/or your caregivers about your care needs. Hospital staff should also provide clear written instructions and a list of all the medications you need for post-hospital care. As appropriate, the hospital must arrange transfers to skilled nursing facilities or referrals to home health and hospice agencies that accept your Medicare coverage. Finally, the hospital must put you in touch with community services that help with financial assistance, transportation, meal preparation, and other needs.

6) How do I appeal a hospital discharge if I think I'm being asked to leave too soon?

If you believe you are being discharged from a hospital too soon (with or without a discharge plan), you have the right to immediate review by the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO), often called the Quality Improvement Organization or QIO for short. There are two regional QIOs that process inpatient hospital discharge appeals for the entire nation: KEPRO, which can be accessed at <https://www.keproqio.com>, and Livanta, which can be accessed at <http://bfccqioareal.com>.

To appeal, first look at the **Important Message from Medicare** (sometimes called the Important Message) the hospital provided you before your discharge. If you don't get this notice, ask for it. The Important Message notice lists the QIO's contact information and explains your appeal rights. To begin the appeal, call the QIO listed on your notice by midnight of the day of your discharge.

The QIO will ask you for information relating to your case. If additional information is needed, including your medical records, the QIO can contact the hospital directly. A decision about your appeal should be made within 24 hours. Note that the hospital is not allowed to force you to leave before the QIO reaches a decision. If the QIO decides that you're being discharged too soon, Medicare continues to cover your hospital stay for as long as medically necessary (though you may still be responsible for applicable coinsurance and/or deductibles).

If the QIO decides that you're ready to be discharged, you won't be responsible for paying the hospital charges (except for your coinsurances and/or deductibles) through noon of the day after the QIO gives you its decision. If you receive any inpatient hospital services after noon of that day, you may have to pay for them. Remember, if you are in the hospital as an outpatient, you do not have the right to appeal a discharge. For help with a hospital discharge appeal or understanding or the hospital discharge process, contact your SHIP (see last page for contact information).

7) What are the types of post-hospital care I could potentially receive that I should discuss with my hospital physician, social worker, and/or discharge planner?

Medicare covers post-hospital care one of two ways: 1) in a skilled nursing facility (SNF) or a nursing home, or 2) in your home with help from a home health agency or outpatient therapy provider. Medicare also covers hospice services received in a facility or at home. Medicare does not cover long-term care services provided by a nursing home. However, Medicare does provide coverage for short-term inpatient SNF services, home health services, outpatient therapy services, and hospice services. The questions below give specific information about when and how Medicare covers each of these services.

8) How does Medicare cover outpatient therapy services?

Many beneficiaries only require post-hospital care on an outpatient basis to regain strength, mobility, speech, and other functions after a hospitalization. Outpatient therapy services are covered by Medicare Part B when they are deemed medically necessary. Coverage rules are applicable regardless of whether a condition is temporary or chronic and whether the therapy is needed to improve or maintain the ability to function.

Medicare covers outpatient physical, occupational, and speech pathology services if:

- You need therapy and your doctor considers it a safe and effective treatment for you. This means that you need the technical skills that a trained therapist can provide or oversee.
- Your doctor or therapist sets up the plan of treatment before care begins and regularly reviews the plan of treatment to see if changes are needed.

Outpatient therapy services can be administered by a participating hospital, rehabilitation agency, Comprehensive Outpatient Rehabilitation Facility (CORF), public health agency, or therapist in private practice. You can also receive physical, speech, and occupational therapies as part of your home health or skilled nursing facility benefits. It is important to know that Original Medicare caps the amount of outpatient therapy that it covers. In 2015, Medicare covers up to \$1,940 for physical and speech therapy combined, and another \$1,940 for occupational therapy. Therapy caps apply to outpatient therapy received at:

- Therapists' or physicians' offices;
- Outpatient rehabilitation facilities; and
- Skilled nursing facilities (SNFs) for outpatients or residents who do not have Medicare-covered stays

Understand that even if you need care that exceeds the therapy caps, you can still get Medicare coverage if your provider confirms you need the care. If you are approaching the limit and your doctor or therapist feels you need more therapy, your doctor or therapist can tell Medicare that it's medically necessary for you to continue. With proper documentation from the provider, Medicare may cover additional therapy. If Medicare denies the claim, you can appeal through the Original Medicare appeal process. If you have a Medicare Advantage Plan, you may have a copayment for each instance of outpatient therapy you receive. Contact your plan to discuss your coverage options.

9) When does Medicare cover Skilled Nursing Facility Care (SNF) after a hospital discharge?

A SNF facility provides post-hospital extended care services on a short-term basis. Under Original Medicare, you qualify for SNF coverage if you use a Medicare-certified SNF and meet the following requirements:

- You were formally admitted as an inpatient to a hospital for at least three consecutive days.
- If you entered the SNF within 30 days of leaving the hospital.

- Your doctor certifies your need for skilled nursing care seven days per week or skilled therapy services at least five days per week, or you need a combination of skilled therapy and nursing services every day of the week.
- You need care that can only be provided in a SNF.

Note that if you visit the emergency room and remain in the hospital under observation, or if you only receive emergency room services, this time does not count toward meeting the three-day hospital requirement for SNF coverage. If you have met the Medicare-approved requirements, Original Medicare pays the full cost of the first 20 days of a covered SNF stay. In addition, it covers part of the cost of another 80 days of care in a Medicare-certified skilled nursing facility each benefit period as long as it is medically necessary. A benefit period begins the day you start receiving inpatient care and ends when you have been out of the hospital or skilled nursing facility for 60 days in a row. If you need more than 100 days of skilled nursing facility care, you may need to pay for this additional care out of pocket. If you have a Medicare Advantage Plan, you may have different costs for a covered SNF stay. Contact your plan to determine which facilities are in network and to further discuss your coverage options.

10) When does Medicare cover home health services?

Medicare's home health benefit covers a wide range of services including skilled nursing and therapy care and home health aide services. As long as you meet Medicare's coverage criteria, Medicare should pay for home care whether or not your condition is temporary or chronic. If you have Original Medicare, you do not have to pay for home health care services if you meet the four criteria below. However, Medicare Advantage Plans may have costs associated with home health care. Original Medicare helps pay for home care **if all of the following are true:**

1. You must be considered homebound. The homebound determination is based on a doctor's evaluation and knowledge of your condition over an extended period of time, not on a daily or weekly basis. Medicare considers you homebound if your doctor believes that your health or illness could get worse if you leave your home or you need the help of another person or medical equipment, such as crutches, a walker, or a wheelchair.
2. You need skilled nursing care or skilled speech, physical, or occupational therapy. This includes skilled nursing services on an intermittent basis. Intermittent means that you need care as little as once every 60 days to as much as once per day for three weeks. Skilled nursing services must be provided by a registered nurse (RN) or licensed practical nurse (LPN) and include:
 - Intravenous injections;
 - Tube feeding;
 - Catheter changes;
 - Changing sterile dressings on a wound;
 - Training beneficiaries and their caregivers to perform required tasks;
 - Observation and assessment of an individual's condition if they may have complications or their health may get worse; and
 - Management and evaluation of the plan of care.
3. Your doctor must sign a home health certification stating that you qualify for Medicare home care because you meet the two criteria previously discussed, meaning that you are homebound and need intermittent skilled care.

4. The certification must also say that a plan of care has been developed and that a doctor regularly reviews the plan. As part of the certification, doctors must also confirm that they (or certain other providers, such as nurse practitioners) have had a face-to-face meeting with you within 90 days before you start to receive home health care or within 30 days after you started receiving home health care. Your doctor must specifically state that the face-to-face meeting confirmed that you are homebound and qualify for intermittent skilled care.
5. Finally, to have Medicare cover home health care, you must receive care from a Medicare-certified home health agency. If you have Original Medicare, you must find a Medicare-certified agency that can provide care for your specific condition or need. You can do so by visiting Medicare's Home Health Compare website at <https://www.medicare.gov/homehealthcompare/>. If you have a Medicare Advantage Plan, you must find in-network health agencies. Contact your plan to further discuss your coverage options.

11) When does Medicare cover hospice care?

Hospice care is palliative care intended to make you physically and emotionally comfortable if you are terminally ill, have less than six months to live, and have elected to forgo treatments meant to cure your terminal illness. You do not need to be homebound (see question 10) to qualify for the Medicare hospice benefit. The hospice benefit is always covered under Original Medicare. If you have a Medicare Advantage Plan, your hospice care is still paid for by Original Medicare. You retain your Medicare Advantage Plan coverage for non-palliative care services (for example, if you break a hip while in hospice, your Medicare Advantage Plan pays for that treatment). Medicare pays for hospice care if you meet all of the following criteria:

- The hospice medical director and your doctor certify that you have a terminal illness and that your life expectancy is six months or less.
- You sign a statement electing to have Medicare pay for palliative care such as pain management, rather than for care to try to cure your condition.
- Your terminal condition is documented in Medicare's medical record.
- You receive care from a Medicare-certified hospice agency. Call 1-800-Medicare for assistance locating a Medicare-certified hospice agency.

The hospice benefit includes two 90-day hospice benefit periods followed by an unlimited number of 60-day benefit periods. You must have a face-to-face meeting with a hospice doctor or nurse practitioner if you reach your third benefit period. The third benefit period begins on day 180 of hospice coverage. After that, you must continue to have face-to-face meetings with a hospice doctor or nurse practitioner before the start of each new 60-day benefit period. The meeting must take place no earlier than 30 days before the new benefit period to confirm that you still qualify for hospice care.

Case Study

Shayna is 77 years old and receives her health coverage through Original Medicare. She recently had a stroke and was admitted to the hospital as an inpatient. She was just told that she will be discharged from the hospital tomorrow, but she and her family feel strongly that she is not ready to return home. Shayna received a notice about her health care rights as a Medicare hospital inpatient, but her doctor never discussed her need for continued care after being discharged from the hospital. As a result of the stroke, Shayna is having trouble with her motor skills and feels very weak. Her family would like her to receive therapy, but they aren't sure if she is eligible for these types of services under Medicare.

What should Shayna do?

- Shayna's family should contact their local Quality Improvement Organization (QIO) located on the Important Message from Medicare notice by midnight of the day of her discharge.
- Shayna did not receive information about her need for continued care. For additional support, Shayna's family should contact the State Health Insurance Assistance Program (SHIP) to learn more about Shayna's discharge rights. The SHIP counselor can explain the discharge planning process and can remind Shayna's family that the appropriate QIO contact information for her region is on the Important Message, if they would like to file a complaint. If they cannot find their copy of the Important Message, the SHIP can provide the QIO contact information based upon Shayna's region of the country.
 - If Shayna's family does not know how to find the SHIP, they can go to www.shiptacenter.org or call 877-839-2675 for assistance.
- The SHIP counselor should explain Medicare's coverage of skilled nursing care, home care, and therapy services so that Shayna's family is aware of how she can qualify for these services.

Local SHIP Contact Information

SHIP toll-free:

SHIP email:

SHIP website:

To find a state SHIP: Call 877-839-2675 or visit www.shiptacenter.org.

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