LONG TERM CARE COMMUNITY COALITION

Advancing Quality, Dignity & Justice

Frequently Asked Question:

What can you do when a resident receives a notice of involuntary discharge?

Two Illustrative Examples

1) Mr. Caruthers has lived in the nursing home for three years and is on Medicaid. He was just given a notice that in 30 days he will be discharged to a homeless shelter because he no longer needs nursing home services.

2) Ms. Stewart is in the nursing home for short-term rehab. She received a notice that her physical therapy will no longer be covered because she has reached a "plateau" and is no longer improving.

- - See the back page for what happened to Mr. Caruthers & Ms. Stewart - -

Relevant Nursing Home Standards

I. Transfer and discharge—Facility Requirements [42 CFR 483.15(c)(1)(i)]

Nursing homes are prohibited from discharging or transferring residents against their will except under very limited circumstance, such as when the welfare of the resident, or other residents, is at serious risk, the resident no longer needs nursing home care, the resident fails to pay (or have paid under Medicare or Medicaid) for his or her care or the facility closes. For more details on the specific facility requirements, see our free *CONSUMER FACT SHEET: TRANSFER & DISCHARGE RIGHTS*, available in the Learning Center at www.nursinghome411.org.

II. Timing of the Notice [42 CFR 483.15(c)(4) and 42 CFR 405.1202(b)(1)]

In most cases, if the resident's stay in the facility has exceeded 30 days the resident must be given at least 30 days' notice of discharge. A short-term resident under Medicare may be given only two days' notice of non-coverage but may continue to reside in the facility during appeal if able to pay for the services.

III. Appeals Process [42 CFR 483.204, 42 CFR 431.200-250, and 42 CFR 405.1202(b)]

Each state must provide an appeals system subject to certain guidelines. In New York State, involuntary discharge notices are appealed to the Department of Health by calling (888)201-4563. One has 60 days to file the appeal, but must file within 15 days of receiving the notice in order to remain in the facility during the appeals process.

Appeals of notices of Medicare non-coverage are made to the regional Quality Improvement Organization (QIO). The QIO for NY State is Livanta, at (866)815-5440. To obtain an expedited

appeal one must file by noon of the day following reception of the notice. After that one may request a standard appeal, which will take longer to resolve. This is important, because if one loses the appeal one must pay in full for all services received since the Medicare termination date.

Important Considerations on Making an Appeal

Prepare carefully & as soon as possible. It is essential to prepare very carefully before appealing either a discharge notice or notice of Medicare non-coverage. If you simply file the appeal, without adding information to support your case, you will almost certainly lose. Consult an attorney if possible. If not, call the nearest office of the Long-Term Care Ombudsman Program for guidance. To win a Medicare non-coverage appeal you will usually require supporting evidence from a physician confirming that Medicare services are still necessary. If you cannot provide this evidence, the prospect of having to pay for services received after termination may make the appeal unfeasible. The deadline for filing an expedited appeal is so short that most people cannot meet it, especially if they need time to consult their physician.

For Medicare (short-term rehab) Discharges. Discharges of short-term residents are subject to the same federal regulations as long-term residents. A notice of Medicare non-coverage is technically not a discharge notice. However, to remain in the facility after coverage lapses one will need another source of payment.

What Happened With Our Two Illustrative Examples?

1) Upon receiving a discharge notice Mr. Caruthers dialed the number for the Long-Term Care Ombudsman Program, which the notice is required to list. They referred him to an agency that was able to provide a *pro bono* attorney. The attorney carefully examined the medical record and discharge plan. She found that Mr. Caruthers requires dialysis, making shelter placement medically unsafe. She also uncovered income sources for Mr. Caruthers (Social Security and a pension), making the resident eligible for subsidized housing. The Administrative Law Judge (ALJ) who heard the appeal directed the nursing home to pursue a non-shelter discharge plan and initiate a housing application.

2) Ms. Stewart was able to provide a statement from her physician attesting that she still needed skilled therapy services to keep her from losing the progress that she made. According to an important legal decision, *Jimmo v. Sebelius,* it is not necessary to continue to show actual improvement in order to qualify for Medicare payment of skilled therapy services, but only that skilled therapy is needed to keep a person from relapse or decline.

Resources for More Information

WWW.NURSINGHOME411.ORG. LTCCC's website includes materials on the relevant standards for nursing home care, including our fact sheets and other resources.
WWW.MEDICAREADVOCACY.ORG. The Center for Medicare Advocacy has information and resources on consumer rights, particularly for Medicare beneficiaries.
WWW.THECONSUMERVOICE.ORG. The Consumer Voice has many resources for residents, families and LTC ombudsmen on discharge and transfer and other resident rights issues.