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Medicare Hospital Discharge Appeal

Winning Against a Stacked Deck

Winning Again

Medicare Hospital Discharge Appeal

By
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My mother experienced severe symptoms caused by her cancer treatment. Consequently, she was hospitalized. Two days later, she was still experiencing essentially the same symptoms. We asked for an evaluation by a specialist.

The next morning, the nurse took Mom's vital signs while announcing she would be discharged during the afternoon. I asked about the specialist. "There will be no specialist," she responded, "because no one is available to see her before the planned discharge." In other words, the doctor agreed Mom needed to see a specialist, but since seeing one would extend her hospital stay, our request was denied.

This is precisely the sort of situation where the Medicare regulations allow for an appeal, but winning an appeal is extremely unlikely.

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st a Stacked Deck

Medicare beneficiaries have a legal right to appeal a hospital discharge but the regulations are written such that it is almost impossible to win such an appeal. Understanding why is vital to successful advocacy.

Hospital Discharge Appeal Regulations

Any Medicare patient who disagrees with her doctor's decision to discharge her from a hospital can appeal the decision.[1] She simply needs to call the organization hired by the Centers for Medicare & Medicaid Services (CMS) to handle discharge appeals.[2] These Medicare contractors are called "Beneficiary and Family Centered Care–Quality Improvement Organizations" (BFCC-QIOs).[3]

To initiate a hospital discharge appeal, the Medicare patient or her representative must call the BFCC-QIO[4] "no later than the day of discharge."[5] Pursuant to Medicare regulations, the beneficiary, or his or her representative, must be available to discuss the case[6] and the beneficiary may, but is not required to, submit written evidence.[7]

My mother, like most beneficiaries exercising their right to appeal an inappropriate hospital discharge, did not have access to helpful written documentation, and even if she had, she had no way to send it to the BFCC-QIO, because of course, she was in a hospital bed. That said, when one reads the regulations, it does seem like Medicare beneficiaries should generally prevail in discharge appeals because the burden of producing evidence falls on the hospital, not on the beneficiary.[8]

However, here's reality. Medicare regulations create a legal right to appeal hospital discharges, but this right is only procedural, it is not substantive. This is because the actual appeal process is designed such that it almost invariably results in a decision upholding the hospital doctor's discharge order. To begin with, the hospital is not required to send the patient's entire hospital record for review. It only sends the documentation it deems necessary for establishing that discharge is appropriate. As instruction to hospitals, one BFCC-QIO specifically directs, "What is required is the medical documentation that supports your decision to issue the notice. *Please do not send the entire medical record."* (emphasis added)[9]

Based on this truncated medical record, the BFCC-QIO must issue its decision as to whether the hospital discharge is appropriate, "within one calendar day after it receives all requested pertinent information."[10] This leaves little time for the patient or her family to collect additional evidence to potentially contradict the doctor's decision. So in my mother's case, the hospital would send information about my mother's presenting symptoms and subsequent treatment. It would not send additional information because such evidence would obviously not support the hospital's decision to issue the discharge notice. As stated above, the regulations do allow the beneficiary a small window of time to send additional information, but my mother, like most Medicare beneficiaries trying to appeal an inappropriate discharge, was very sick and she is not a medical expert. To overrule the hospital's decision, the BFCC-QIO would need to have considered information contradicting the hospital's decision, such as a detailed

1 42 C.F.R. § 405.1206(a).
2 42 C.F.R. § 405.1206(b).
3 *See* Quality Improvement Organizations, CMS, *About BFCC-QIOs*, https://qioprogram.org/about/what-are-qios (last visited Sept. 19, 2018).
4 The telephone number for the BFCC-QIO will be provided by the hospital as part of the "Important Message from Medicare." CMS, Hospital Discharge Appeal Notices https://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html (last visited Sept. 19, 2018).
5 42 C.F.R. § 405.1206(b)(1).
6 42 C.F.R. § 405.1206(b)(2).
7 42 C.F.R. § 405.1206(b)(3).
8 42 C.F.R. § 405.1206(c). Burden of proof. When a beneficiary (or his or her representative, if applicable) requests an expedited determination by a BFCC-QIO, the burden of proof rests with the hospital to demonstrate that discharge is the correct decision, either on the basis of medical necessity, or based on other Medicare coverage policies. Consistent with paragraph (e)(2) of this section, the hospital should supply any and all information that a BFCC-QIO requires to sustain the hospital's discharge determination.
9 Livanta, *Medical Records*, https://bfccqioarea5.com (click on I Want to Find: Provider Resources, then click on Medical Records) (last visited Sept. 19, 2018).
10 42 C.F.R. § 405.1206(d)(6)(i).

medical analysis linking her symptoms to her cancer treatment — information my mother was not in a position to produce. Since most Medicare beneficiaries seeking to appeal an inappropriate hospital discharge are, like my mother, not in a position to send documentation supporting their continued need to stay in the hospital, generally speaking, the only medical records reviewed by the BFCC-QIO are those produced by the hospital which support the discharge order.

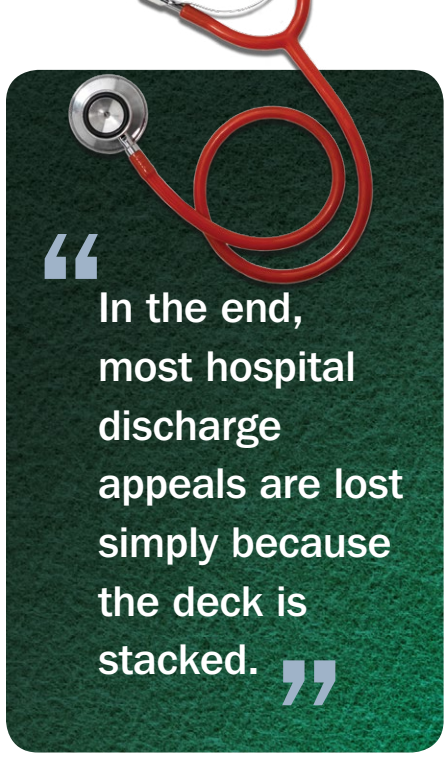
The House Always Wins

There was a time in the not so distant past when, if a person were hospitalized, her general practitioner (community physician) would have admitting privileges to the hospital and would act as her attending (treating) physician during the hospitalization. Those halcyon days of yore are gone. Today, when a person is admitted to a hospital, her attending physician is a hospitalist. A hospitalist is a doctor who works for the hospital.[11] My mother's treating physician during her hospitalization was a hospitalist. The hospitalist did not know my mother before the hospitalization or have a working knowledge of her cancer treatment and its possible side effects. With this lack of information, the hospitalist did not appreciate the medical ramifications of my mother's symptoms and thus ordered her hospital discharge.

Here's why Medicare beneficiaries rarely win hospital discharge appeals. They are very sick and in the hospital; they must have the gumption to disagree with the hospitalist about the planned discharge; and then they must call the BFCC-QIO.

They might have a chance of winning the appeal if the BFCC-QIO sent a doctor into the hospital to see the patient and review the record. Or, if the patient's community doctor was in the hospital, he or she could review the medical record and intervene on the beneficiary's behalf. But the BFCC-QIO will not send a doctor into the hospital, most community physicians do not have hospital privileges, and the BFCC-QIO will make its decision solely on the information sent by the hospital, information culled specifically to support the decision to discharge the patient.

In the end, most hospital discharge appeals are lost simply because the deck is stacked. The beneficiary and/or her representative are permitted to send written support to the BFCC-QIO to support the claim that the discharge is inappropriate, and they may even get the opportunity to discuss their case with the BFCC-QIO, but they are very unlikely to prevail because they lack the medical expertise necessary to convince the BFCC-QIO that they know more about the patient's medical needs than the licensed hospitalist who ordered the discharge.



In counseling beneficiaries or their families about appealing a hospital discharge, I always first explain that success requires that there must be a medical reason for the continued hospitalization.[12] As a general rule, for example, Medicare will not pay for a continued hospital stay just because there is no one in the patient's home to take care of the patient. However, if there is a medical reason for a continued stay, as there was in my mother's case, I encourage the family to appeal, but I explain that they must enlist the support of a physician to advocate on the patient's behalf. Often this means contacting the beneficiary's general practitioner and asking that doctor to contact the hospitalist and the BFCC-QIO and advocate on the beneficiary's behalf. For this method to succeed, that is to prevent the inappropriate discharge, the doctor-advocate must make an argument based on his or her medical expertise as to why the patient continues to need a hospital inpatient level of care.

Know When to Hold 'Em

To review, my mother was in the hospital, received some treatment, and was going to be discharged even though she continued to manifest the exact symptoms that led to the hospitalization. We asked to have her case reviewed by a specialist. The medical need for this specialist was not denied, but the hospital doctor intended to discharge my mother anyway because it might have been up to two days before the specialist performed rounds on my mother's hospital floor. At this point, I followed my own advice.

My mother's oncologist had privileges at the hospital. He came in to check on my mother. I explained the situation. He assessed my mother and agreed she needed to be seen by a specialist before she left the hospital. He left, promising to speak to the hospitalist.

Lunch was served, but not eaten. The hospitalist entered my mother's hospital room. She explained that she and the oncologist had a "long" discussion about my mother's care. She told us that she'd been convinced that my mother

11 Steve Pantilat, *What Is a Hospitalist?*, The Hospitalist (Feb. 2006), https://www.the-hospitalist.org/hospitalist/article/123072/what-hospitalist.

12 Medicare.gov, *What Part A covers*, https:// www.medicare.gov/what-medicare-covers/what-part-a-covers (last visited Sept. 19, 2018).

should see the specialist prior to the discharge. The order was placed. And then, as if by magic, the specialist did see my mother within the next hour.[13] My mother's medications were appropriately changed. Success!

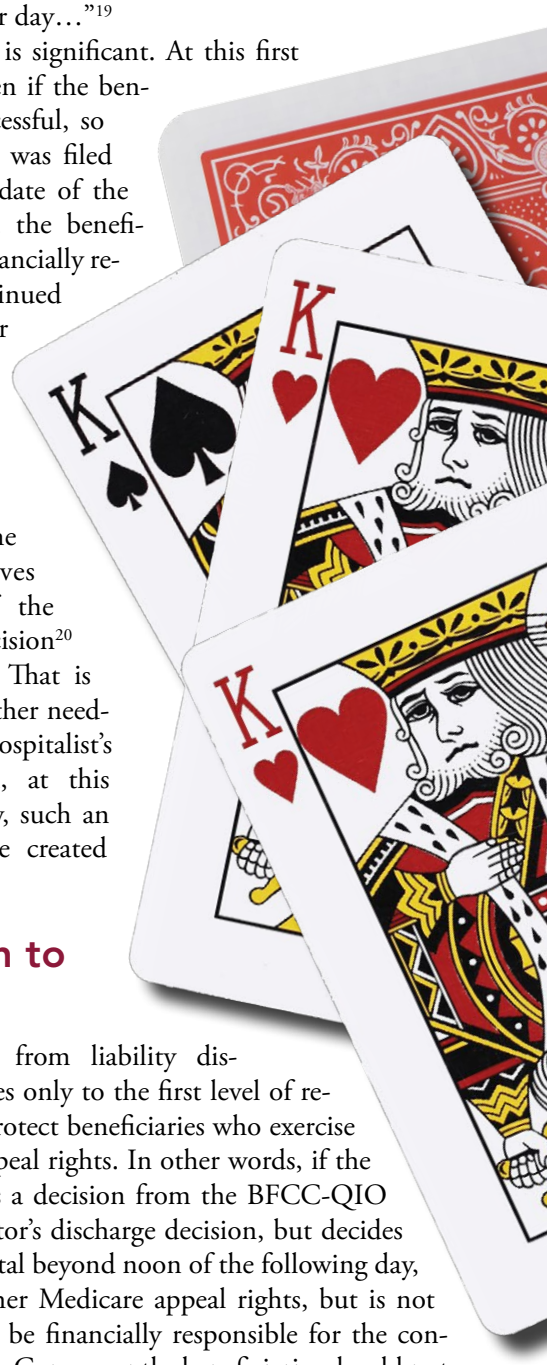
Note that in the end, my mother did not need to use Medicare's official discharge appeal process. This is because the doctor-to-doctor conversation achieved her desired goal of obtaining an evaluation by a specialist prior to her planned discharge. However, had this method not worked, we would have initiated the official appeal process by calling the BFCC-QIO. We would have then asked my mother's oncologist for assistance. We would have asked him to justify my mother's need to see the specialist in writing and then had him fax that justification to the BFCC-QIO. This is important, because as part of the record, the expert opinion of my mother's oncologist would have countered the medical expertise of the hospitalist.

The term used in Medicare regulations for the planned discharge appeal described above is an "expedited determination."[14] To avoid confusion, note that the regulations still refer to QIOs rather than BFCC-QIOs, even though BFCC-QIO's were created in 2014.[15]

When the BFCC-QIO receives a beneficiary's request for an expedited determination, it must immediately notify the hospital.[16]

After the hospital receives notice of the appeal, it is required to issue a "detailed notice" that includes the following information: a detailed explanation why services are either no longer reasonable and necessary or are otherwise no longer covered; a description of any applicable Medicare coverage rule, instruction, or other Medicare policy, including information about how the beneficiary may obtain a copy of the Medicare policy; facts specific to the beneficiary and relevant to the coverage determination that are sufficient to advise the beneficiary of the applicability of the coverage rule or policy to the beneficiary's case; and any other information required by CMS.[17] The hospital must also supply all information that the BFCC-QIO "needs to make its expedited determination."[18] After the BFCC-QIO receives the requested information, pursuant to Medicare regulations, it "must make a determination and notify the beneficiary, the hospital, and physician of its determination within one calendar day…"[19]

This next point is significant. At this first level of appeal, even if the beneficiary is not successful, so long as the appeal was filed no later than the date of the planned discharge, the beneficiary will not be financially responsible for continued hospital care (other than applicable coinsurance and deductible) "furnished before noon of the calendar day *after* the beneficiary…receives notification…" of the BFCC-QIO's decision[20] (emphasis added). That is to say, had my mother needed to appeal the hospitalist's discharge decision, at this first level of review, such an appeal would have created no financial risk.



Know When to Walk Away

The protection from liability discussed above applies only to the first level of review. It does not protect beneficiaries who exercise their remaining appeal rights. In other words, if the beneficiary receives a decision from the BFCC-QIO upholding the doctor's discharge decision, but decides to stay in the hospital beyond noon of the following day, exercises more of her Medicare appeal rights, but is not successful, she will be financially responsible for the continued hospital stay. Consequently, beneficiaries should not stay in the hospital simply to prove a point. They should

13 I think the oncologist used his status in the hospital to prevail upon the specialist, probably also stressing the urgency of the matter.

14 "Beneficiary's right to an expedited determination by the QIO. A beneficiary has a right to request an expedited determination by the QIO when a hospital (acting directly or through its utilization review committee), with physician concurrence, determines that inpatient care is no longer necessary." 42 C.F.R. § 405.1206(a).

15 Quality Improvement Organizations, *QIO Program: Beneficiary and Family Centered Care – Quality Improvement Organizations A Better Way to Serve Medicare Beneficiaries*, CMS (Aug. 2014), https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityImprovementOrgs/Downloads/Fact-Sheet-Beneficiary-and-Family-Centered-%E2%80%94-Quality-Improvement-Organizations-BFCC-QIOs.pdf.

16 42 C.F.R. § 405.1206(d)(1).

17 42 C.F.R. § 405.1206(e)(1).

18 42 C.F.R. § 405.1206(e)(2). Note that these records are available to the beneficiary upon request, but that the hospital may charge the beneficiary "a reasonable amount to cover the costs of duplicating the documentation and/or delivering it to the beneficiary. The hospital must accommodate such a request by no later than close of business of the first day after the material is requested." 42 C.F.R. § 405.1206(e)(3).

19 42 C.F.R. § 405.1206(d)(6)(i).

20 42 C.F.R. § 405.1206(f)(2).

only stay beyond the first level of appeal if it is medically necessary and they understand the potential financial risk.

As with the first level of review, if a beneficiary pursues additional appeals, she can and *should* submit evidence to be considered by the arbiter in support of her argument that continued care at the hospital is or was medically necessary.[21] As discussed earlier, failure to submit additional information will mean the record reviewed at each level will only be that which was submitted by the hospital. And remember, the hospital was only asked to submit documentation supporting its decision to discharge the patient. Consequently, success at any level in the appeals process is dependent on submitting documentation refuting the hospitalist's decision that the beneficiary no longer requires or required an inpatient hospital level of care.

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With the above point regarding potential financial liability understood, if the beneficiary receives an unfavorable decision from the BFCC-QIO and is still an inpatient in the hospital, she has a right to an expedited reconsideration.[22] Reconsideration decisions are issued by organizations contracted by CMS called Qualified Independent Contractors (QICs).[23] To exercise her right to an expedited reconsideration, the beneficiary must notify the QIC "in writing or by telephone, by no later than noon of the calendar day following initial notification…" of the BFCC-QIO's decision.[24] Once the QIC receives the request, "no later than 72 hours after receipt of the request for an expedited reconsideration, and any medical or other records needed for such reconsideration," the QIC must issue its decision.[25] The QIC's initial notification may be done by telephone, followed by a written notice including: the rationale for the reconsideration decision; an explanation of the Medicare payment consequences of the determination and the beneficiary's date of liability; and information about the beneficiary's right to appeal the QIC's reconsideration decision to an Administrative Law Judge (ALJ), including how to request an appeal and the time period for doing so.[26] ALJ decisions are not expedited. ALJs have a 90-day period to issue decisions. The period begins on the date the request for hearing is received.[27] Unfavorable ALJ decisions can be appealed to the Medicare Appeals Council (MAC).[28] An unfavorable MAC decision can be appealed to Federal district court.[29]

Know When to Count 'Em

To progress beyond the reconsideration level of review, the regulations require that there be a minimum amount in controversy. The minimum amount in controversy requirement for ALJ hearings for the calendar year 2018 is $160.[30] The minimum amount in controversy requirement for judicial review for the calendar year 2018 is $1,600.[31]

The Dealings Done

Sometimes Medicare beneficiaries are discharged from hospitals before their medical symptoms are adequately under control, creating the likelihood of further complications and rehospitalization. To prevent this from happening, they have a legal right to appeal. However, the Medicare expedited appeal regulations are written in such a way that success with such an appeal is unlikely. This is because the hospital has more medical knowledge than the average beneficiary and because the hospital controls what information will be reviewed. The best way to effectively increase the beneficiary's odds of staying in the hospital to get necessary medical care is to enlist the assistance of a physician. Such a physician can speak as an expert regarding the beneficiary's need for ongoing hospital care. In the case described above, I enlisted the assistance of my mother's oncologist. Using his medical expertise, the oncologist successfully advocated for my mother and my mother ultimately received the required inpatient hospital care. ■

21 42 C.F.R. §§ 405.966; 405.1018; 405.1036(e); and 405.1122.
22 42 C.F.R. § 405.1206(g)(1).
23 CMS, *Qualified Independent Contractors (QIC) Fact Sheet*, CMS.gov, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/QIC_Fact_Sheet.pdf (last visited Sept. 19, 2018).
24 42 C.F.R. § 405.1204(b)(1).
25 42 C.F.R. § 405.1204(b)(3).
26 42 C.F.R. § 405.1204(b)(4).
27 42 C.F.R. § 405.1016(a).
28 42 C.F.R. § 405.1112.
29 42 C.F.R. § 405.1136.
30 Federal Register, *Medicare Program; Medicare Appeals; Adjustment to the Amount in Controversy Threshold Amounts for Calendar Year 2018* (Sept. 29, 2017), https://www.federalregister.gov/documents/2017/09/29/2017-20883/medicare-program-medicare-appeals-adjustment-to-the-amount-in-controversy-threshold-amounts-for.
31 *Id.*