Aging in Place Advocate's

Hospital Discharge Guide

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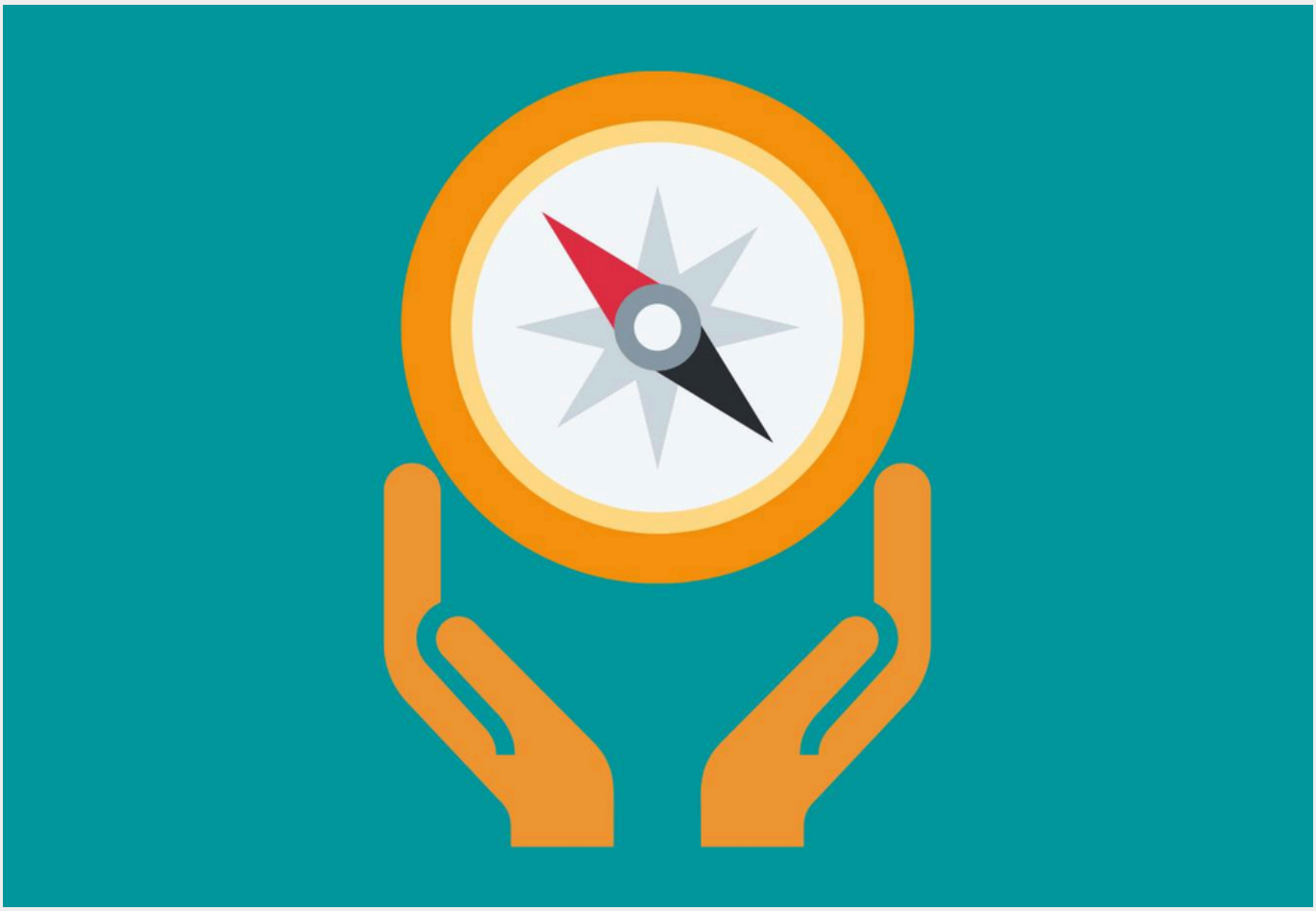
i. Introduction

Do you help care for a senior loved one who, after a period of hospitalization, has been told they are being discharged back home or to a skilled nursing facility? Were they aging in place independently before suffering an injury or getting sick? Many seniors won't object to a discharge order because they want to get out of the hospital as quickly as possible, which is completely understandable. However, **premature discharge–being released from the hospital too soon–can be problematic.**

Aging in place requires the ability to safely carry out all the many activities of daily living. After a senior is sick enough to be admitted to the hospital, getting sent home while they still need inpatient care can cause serious setbacks like falls, missed medications, malnutrition and readmission to the hospital. Getting sent to a skilled nursing facility too soon can mean underlying health problems may not be properly diagnosed and treated. **These outcomes create a higher risk that a senior's baseline functioning will be left at such a low point that they cannot return to independent living.**

If your senior loved one is being pressured to accept discharge before it's safe for them to leave the hospital, **this information will help you deal with the hospital in your efforts to raise objections to an unsafe premature discharge.**

Your senior loved one's ability to successfully age in place is important for their long-term quality of life. **You may be able to delay, challenge, or obtain independent review of an unsafe discharge decision.**



01 Understanding What “Premature Discharge” Really Means

"Discharge" is the term used by healthcare professionals when discussing the patient leaving the hospital, either to their own residence or with caregivers.

The moment hospital staff first bring up discharge can be the most critical.

Hospitals must base discharge decisions on whether inpatient-level care remains medically necessary and whether an appropriate discharge plan has been developed. However, discharge planning often occurs under operational pressures such as bed availability and insurance coverage limitations, which can accelerate the discharge process.

Once discharge planning begins, reversing it is a challenge.

Early, informed objections by the patient advocate may prevent an unsafe, premature discharge.

Rejecting Assumptions and Reframing the Conversation

Patient advocates should reject the assumption that discharge equals readiness.

Hospitals often present discharge as a routine, medically inevitable step. Advocates should instead view discharge as a medical decision that must meet safety standards.

Discharge should only occur when:

- The patient's condition has been evaluated sufficiently to determine that inpatient-level care is no longer medically necessary,
- Outstanding tests or issues can be safely managed in an outpatient or post-acute care setting,
- The patient has recovered enough to receive care outside the hospital, and
- An appropriate post-hospital plan has been arranged.

If any of these conditions are missing, discharge may be premature and unsafe, regardless of how it is framed by hospital staff.

Discharge is appropriate only when the patient's condition has stabilized and no longer requires inpatient-level care.

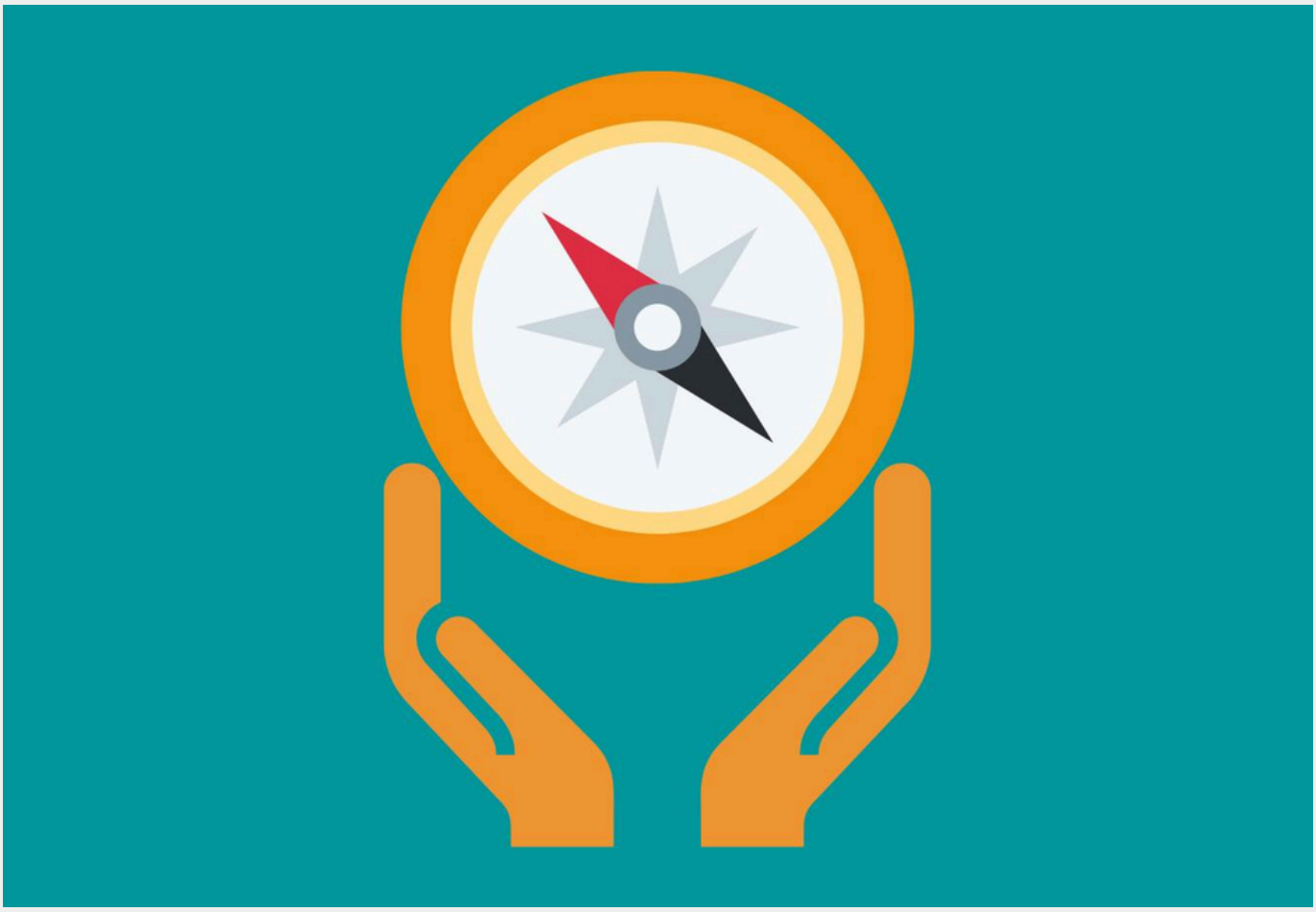
For seniors, this includes not only vital signs and lab values but also:

- Cognitive status,
- Mobility and fall risk,
- Ability to eat, drink, and take medications safely,
- Respiratory stability,
- Infection status, and
- Ability to participate in rehabilitation if discharge is to a skilled nursing facility.

Premature discharge occurs when:

- Symptoms persist but are minimized or undocumented,
- Diagnostic testing is deferred to "outpatient follow-up,"
- Decline is attributed to "baseline" (normal old age) without verification,
- The patient cannot safely function in the proposed setting,
- Discharge happens before functional assessment is complete,
- Care coordination is not adequate, or
- The facilities being considered for transfer are unprepared for complex needs.

A senior who was independent prior to admission may not be safe at home, or even in a skilled nursing facility, at the time discharge is proposed.



02 Establishing Advocate Authority to Raise Objections

Health Insurance Portability and Accountability Act (**HIPAA**) Access Rights for Family Advocates

HIPAA Is Commonly Misunderstood—and Misused

HIPAA is often cited incorrectly as a reason to withhold information from family members. In reality, HIPAA permits disclosure to family and caregivers involved in the patient's care when such disclosure is in the patient's best interest.

Facilities that reflexively say "HIPAA won't allow that" are often prioritizing administrative convenience over patient safety.

Health care providers may share relevant medical information with family members or others involved in the patient's care if:

- the patient agrees,
- the patient does not object and disclosure is relevant to care, or
- the patient lacks decision-making capacity and the provider determines disclosure is in the patient's best interest.

If, on the other hand, the patient is competent and objects, the facility must generally honor that objection unless another legal authority (such as a Medical Power of Attorney) is in place.

Medical Power of Attorney (MPOA)

A Medical Power of Attorney (also called a health care agent, proxy, or durable power of attorney for health care) provides formal authority to:

- Access medical records,
- Participate in care decisions,
- Participate in discharge planning and raise discharge safety concerns.

When a MPOA Exists, Advocates Can:

- Provide a copy immediately,
- Request confirmation that it is uploaded to the chart,
- Ask staff to document the agent's authority.

Possible Steps When No Paperwork Exists

When no MPOA, advance directive, or guardianship exists, advocates can still consider the following steps:

- Seek verbal consent from the patient if possible,
- Ask for a capacity assessment of the patient to clarify their decision-making limitations,
- Invoke HIPAA best-interest disclosure requirement explicitly,
- Request inclusion in all discharge planning discussions, and/or
- Submit written requests and objections to create a paper trail.

These steps can establish practical authority grounded in patient safety, which may be sufficient to slow down the discharge process.

SAMPLE TEMPLATE: Request for Medical Record Access (Amend as Needed)

Purpose: To assert HIPAA rights and obtain records necessary to evaluate discharge safety.

Re: Patient: [Name, DOB]

I am acting as the patient's representative and primary advocate for purposes of care coordination and discharge planning.

Pursuant to HIPAA and applicable patient-rights laws, I am requesting access to the portions of the patient's medical record relevant to care coordination and discharge planning, including physician notes, nursing notes, care plans, medication records, test results, therapy notes, and discharge planning documentation.

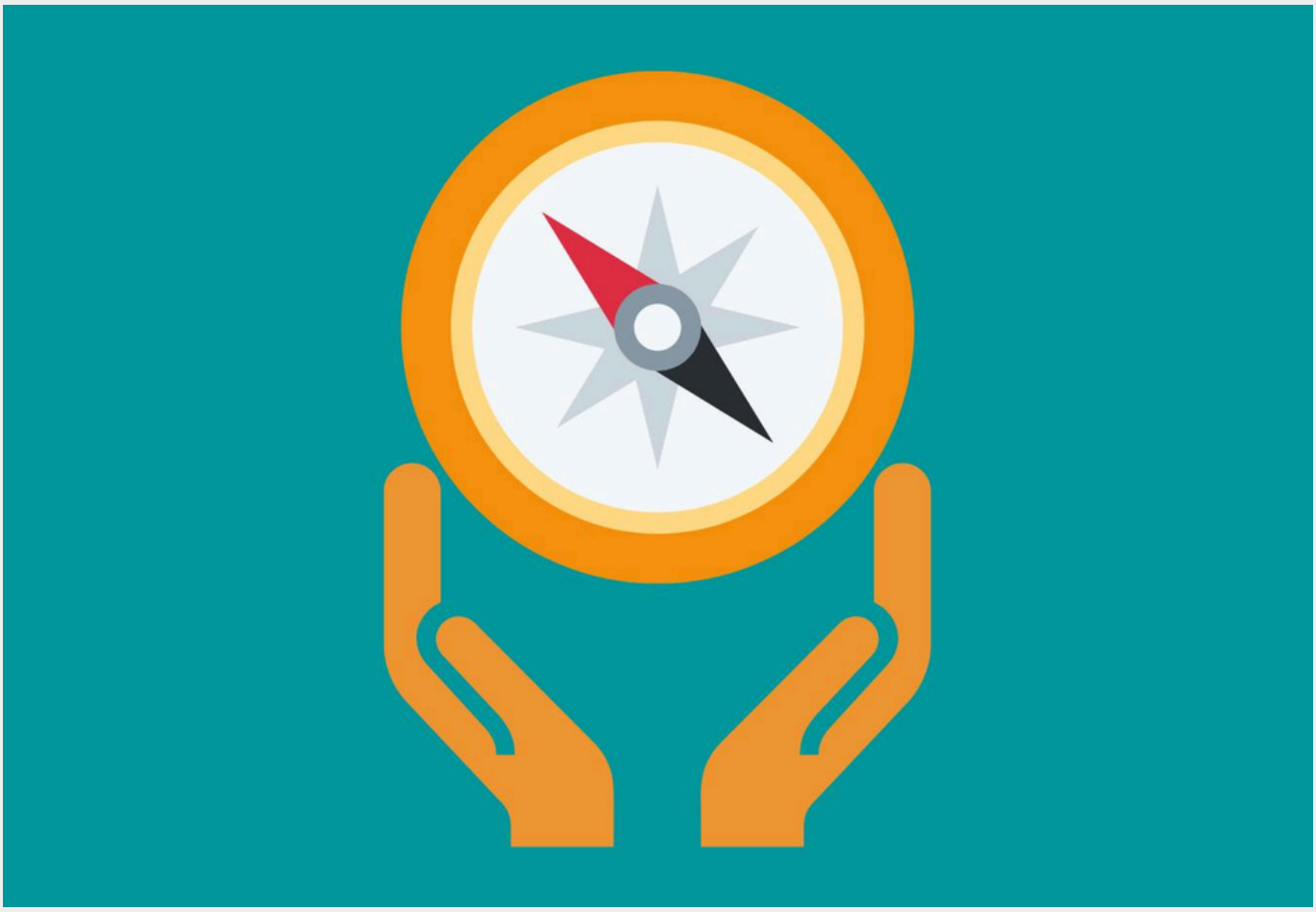
This request is made to ensure patient safety and continuity of care and is authorized under HIPAA provisions permitting disclosure to individuals involved in the patient's care and acting in the patient's best interest.

Please advise when and how these records will be made available.

Sincerely,

[Advocate Name]

NOTE: Even when disclosure is permitted, providers generally limit the information shared to what is reasonably necessary for the person's involvement in the patient's care.



03 Shifting the Focus from Fast Discharge to Documenting Discharge Risks

One important tool available to an advocate is naming the discharge as unsafe early and clearly.

Research and advocacy experience show that once safety objections are formally raised, hospitals are more likely to slow the discharge process and reassess.

SAMPLE SCRIPT: Unsafe Discharge (Amend as Needed)

Purpose: This language reframes discharge as a risk management issue, not a preference dispute or power struggle.

> *"We are concerned that discharge at this time would be unsafe and could result in serious harm."*

SAMPLE SCRIPT: Making a Record of the Advocate's Safety Concerns (Amend as Needed)

Purpose: Documentation in the chart of your safety concerns.

> *"Please document that I am the patient's representative and that I have raised safety concerns regarding discharge."*

Silence Equals Consent When No Objections are Raised

How Facilities Interpret Silence

In hospital and skilled nursing facility discharge planning, lack of explicit objection is routinely documented as consent. Common chart entries include:

- “Family agreeable to discharge.”
- “No barriers to discharge.”
- “Patient cleared for discharge.”

These statements may appear even when families were confused, overwhelmed, or not directly asked. Discharge planning meetings often occur quickly, informally, or without all decision-makers present.

If no one states a clear objection, the process continues uninterrupted.

When the patient cannot clearly object, the advocate's silence can substitute for consent, regardless of the patient's actual medical condition.

A clear statement of non-agreement forces the care team to pause, reassess, and document concerns.

SAMPLE SCRIPT: Formal Objection to Discharge (Amend as Needed)

This sentence can be used calmly and repeated as necessary:

> *"We do not agree that discharge is safe at this time."*

Advocates can immediately follow this statement with:

> *"Please document that the family objects to discharge due to safety concerns."*

This language:

- Frames discharge as a patient-safety issue, not a preference,
- Can trigger documentation obligations,
- Alerts staff to regulatory and liability concerns.

Request Clarification

Advocates can request specific explanations, such as:

- What criteria define “medical stability” for this patient,
- What unresolved symptoms remain,
- How will functional or cognitive risks be managed after discharge.

Advocates can also request formal functional evaluations by:

- physical therapy,
- occupational therapy, or
- geriatric consultation to document mobility, fall risk, and ability to perform activities of daily living.

Further, hospitalized older adults are at high risk for delirium (sudden confusion) which can significantly impair judgment, mobility, and safety after discharge.

Advocates can request:

- delirium screening or geriatric evaluation,

if confusion or behavioral changes occur. These assessments often influence discharge planning decisions.

Hospitals participating in Medicare must evaluate discharge needs, involve the patient or representative in planning, and document the basis for the discharge decision.

Hospitals must also evaluate the availability of appropriate post-hospital services and, when home health or post-acute care is needed, provide the patient with a list of Medicare-participating providers.

Require Documentation of Unresolved Discharge Risks

Why Documentation is an Important Tool

In discharge disputes, **what is documented outweighs what is said**. Hospitals and skilled nursing facilities defend discharge decisions almost entirely through the written medical record. If symptoms, functional decline, or safety risks are not charted, they are often treated as if they never existed.

Advocates can insist that:

- Symptoms,
- Functional limitations, and
- Cognitive changes be clearly charted before discharge proceeds.

Once risks are documented, discharge can become significantly riskier for the facility.

SAMPLE SCRIPT: Request a note be put into the chart (Amend as Needed)

> *"Please note in the chart that the family has raised safety concerns and does not agree with discharge at this time."*

Hospitals and skilled nursing facilities are highly sensitive to:

- Documented safety objections,
- Explicit non-consent,
- Requests for interdisciplinary review.

Read Bedside Nursing Notes

Nursing notes provide important day-to-day observations about functional status and symptom changes. These observations help clarify whether the discharge plan reflects the patient's actual clinical condition.

Bedside nurses document:

- Functional ability across shifts,
- Confusion and agitation,
- Respiratory effort,
- Missed medications,
- Assistance required for basic tasks.

These notes often contradict discharge narratives, making them important in disputes and appeals.

Advocates can routinely request to review nursing notes and compare them to physician and discharge documentation.

SAMPLE SCRIPT: Requesting Symptom Documentation (Amend as Needed)

> *"I am concerned that this symptom has not been documented. Please chart that the patient experienced [specific symptom] at [time], required [level of assistance], and that this represents a change from the patient's baseline functioning."*

SAMPLE SCRIPT: When Staff Minimize Symptoms (Amend as Needed)

"Even if you believe this is expected or temporary, it needs to be documented. Accurate charting is essential for safe discharge planning."

SAMPLE SCRIPT: Escalating When Documentation Is Refused (Amend as Needed)

Purpose: This request alone often results in immediate charting.

"Please note in the chart that I requested documentation of this symptom and that it was declined."

SAMPLE SCRIPT: Speaking With Charge Nurses and Nurse Managers (Amend as Needed)

Purpose: To bring safety concerns to the attention of clinical supervision and management.

"I'm concerned about the safety of discharge based on what we're seeing day-to-day. The patient is still experiencing [specific symptoms or functional issues], and I don't see that reflected in the discharge plan. I'm requesting a reassessment and that these concerns be documented."

If initial concerns are minimized:

"I understand discharge planning pressures, but these are patient safety issues. I'm asking that a nurse manager review this and that our objections be entered into the record."

SAMPLE SCRIPTS: Redirecting a Case Manager Who Pushes Discharge (Amend as Needed)

Purpose: To reframe the discussion around medical readiness and safety.

> *"We're not refusing discharge. We're stating that discharge is not medically or functionally safe at this time. What clinical criteria are being used to determine readiness?"*

If the case manager cites "medical stability":

> *"Medical stability alone doesn't address functional decline, cognition, or safety at home. How have those been evaluated and documented?"*

If pressure continues:

> *"Please document that we've raised safety concerns and requested further clinical assessment before discharge."*

This request can pause discharge momentum.

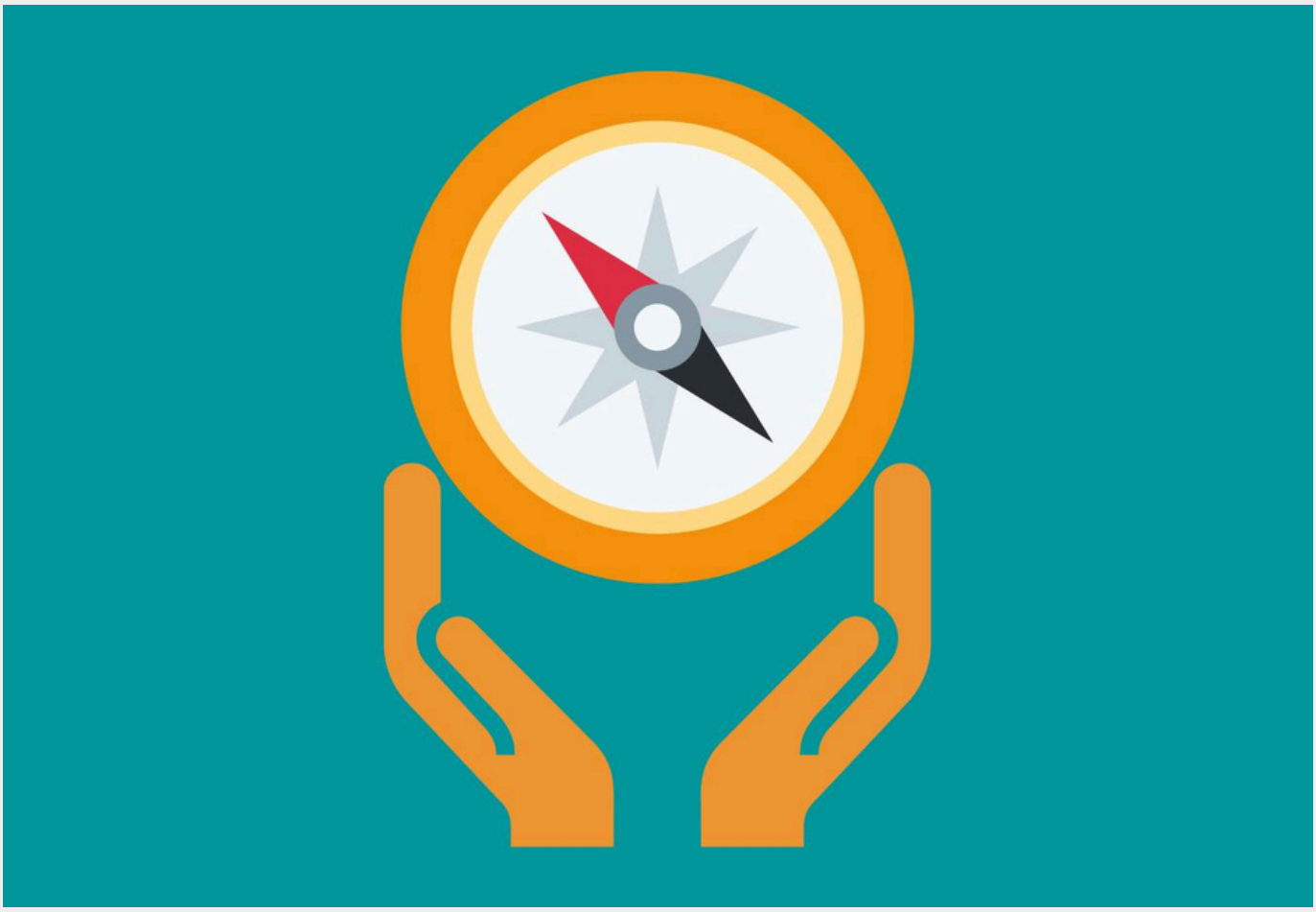
Hospitals are Risk-Averse institutions.

When:

- Nursing leadership is engaged,
- Documentation gaps are highlighted,
- Safety objections are formally recorded,

the institution becomes accountable for downstream harm.

These steps can slow the discharge process and may lead the care team to reassess the patient's condition, perform additional evaluations, or modify the discharge plan.



04 Requesting a Care Conference to Highlight Documented Risks

If Discharge is Still Unsafe, the Advocate can Request a Care Conference in Writing

Advocates can request a care conference when discharge safety is disputed and not adequately addressed. Waiting until the discharge order is written narrows options and accelerates discharge timelines.

Why a written request matters:

- It creates a paper trail.
- It triggers institutional obligations.
- It elevates the issue beyond bedside conversations.

Who Must Attend

Families often believe “the doctor” controls discharge.
In reality, discharge authority is distributed.

Required Care Conference Participants:

Attending Physician (or Responsible Physician of Record):

- Holds ultimate clinical authority for discharge and must answer for medical criteria used.

Primary Bedside Nurse or Charge Nurse:

- Provides day-to-day functional and seen-over-time observations.

Case Manager or Discharge Planner:

- Explains the proposed discharge plan and timing.

Patient and/or Authorized Advocate:

- Raises safety objections and documents dissent.

Optional but Helpful:

Nurse manager, social worker, or risk management when safety disputes persist.

While care conferences are not legally required in every case, they are widely used in hospitals and skilled nursing facilities to coordinate discharge planning and address safety concerns.

How to Make Physician Participation More Likely (Without Confrontation):

Physicians may decline to attend care conferences, delegating attendance to case management staff. Advocates can tie physician participation to unresolved clinical questions:

- Frame the request as clinical clarification, not disagreement.
- Cite unresolved symptoms, functional decline, or cognitive instability.
- Request documentation if doctor participation is declined.

Refusing to address safety questions creates institutional risk.

SAMPLE TEMPLATE: Care Conference Request (Amend as Needed)

Email
Subject

Dear [Hospital/Facility Administrator, Case Manager, or Unit Manager],

I am formally requesting an immediate care conference regarding the proposed discharge of [Patient Name], who remains under your care.

There are unresolved clinical and safety concerns, including [briefly list key issues: functional decline, cognitive changes, unresolved symptoms], that directly affect discharge readiness. These concerns have not been adequately addressed or documented.

To ensure patient safety and informed decision making, this conference must include:

- The attending or responsible physician of record,
- Nursing leadership familiar with the patient's day-to-day status,
- Case management,
- The patient and/or authorized advocate.

Please confirm the date and time of this conference as soon as possible. If physician participation is declined, please document the reason in the medical record.

This request is made to ensure compliance with accepted discharge planning standards and patient safety obligations.

Sincerely,

[Your Name]
[Relationship to Patient]
[Contact Information]

SAMPLE SCRIPT: Care Conference Questions

Safety-Based Discharge Challenges (Amend as Needed)

Purpose: These questions are intended to expose unsupported discharge claims and force clinical specificity.

Medical Readiness

- *"What specific medical criteria are being used to declare this patient ready for discharge?"*
- *"How does today's status compare to the patient's baseline function and cognition?"*

Functional Safety

- *"What objective assessment shows the patient can safely transfer, ambulate, and perform basic activities?"*
- *"What nursing documentation supports that conclusion?"*

Cognitive and Neurologic Risk

- *"How has delirium or cognitive fluctuation been assessed over time?"*
- *"What safeguards are in place if cognition worsens after discharge?"*

Discharge Plan Integrity

- *"What risks remain if the patient deteriorates within 24 to 72 hours?"*
- *"Who assumes responsibility if those risks materialize?"*

Documentation Accountability

- *"Will today's unresolved concerns be documented in the medical record?"*

Silence, deflection, or vague answers should be specifically noted.

What an Advocate Can Do When the Conference Confirms Unsafe Discharge

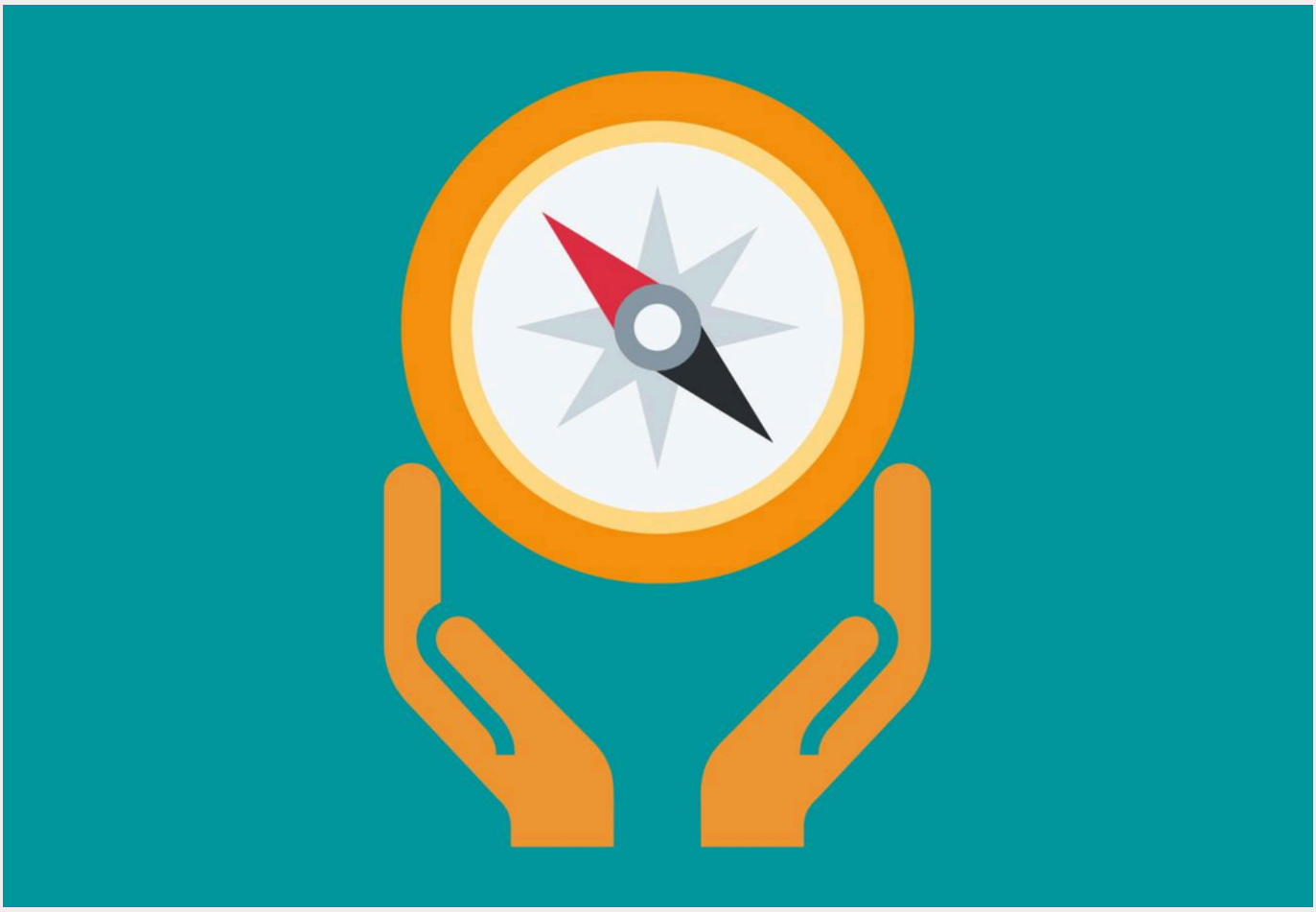
If the care conference reveals:

- Missing assessments,
- Contradictory documentation,
- Unresolved safety risks,

Advocates can immediately:

- Request postponement of discharge pending reassessment,
- Demand documentation of objections,
- Prepare for appeals or external escalation.

Requesting a care conference can halt discharge momentum, because it requires interdisciplinary agreement and documentation.



05 Formal Objections: Policy Violation Grievances and Medicare Appeals

Using Hospital Policies Against Unsafe Discharge

Hospitals often frame discharge decisions as purely medical judgments. In reality, those decisions are constrained by the hospital's own written policies and by federally mandated Medicare participation requirements. These internal rules are not optional; they are enforceable conditions of operation.

For patient advocates, hospital policies can provide three advantages:

- They shift the discussion from opinion to compliance.
- They create internal accountability and risk exposure.
- They trigger responses from departments medical facilities prefer to keep out of discharge disputes, such as compliance, quality, and risk management.

Understanding and invoking these policies can be more effective than arguing clinical details alone.

Patient Rights Policies: Advocates Can Demand These Documents

Every hospital and skilled nursing facility participating in Medicare is required to maintain written Patient Rights and Responsibilities policies. These policies typically cover:

- The right to participate in care and discharge planning,
- The right to be informed of risks and alternatives,
- The right to voice grievances without retaliation,
- The right to safe, appropriate discharge planning.

Why Patient Rights Matter in Discharge Disputes

Unsafe discharge frequently violates multiple patient rights simultaneously, including:

- The right to informed decision-making,
- The right to refuse unsafe plans,
- The right to adequate planning for post-hospital care.

When advocates specifically cite patient rights, they:

- Elevate the issue beyond bedside disagreement,
- Create an obligation to respond,
- Force documentation of compliance or non-compliance.

How Advocates Can Use Patient Rights Policies:

- Request a copy of the medical facility's Patient Rights policy,
- Identify sections related to participation, safety, and grievances,
- Reference those sections verbatim in objections and written communications.

Medical facilities are far less dismissive when advocates speak in the institution's own policy language.

What "Medicare Conditions of Participation" Are

Conditions of Participation (CoPs) are federal requirements hospitals must meet to receive Medicare reimbursement. They govern:

- Patient rights,
- Nursing services,
- Discharge planning, and
- Quality and safety systems.

Failure to comply can place Medicare funding and accreditation at risk.

Medicare Discharge Planning Requirements

Under Medicare Conditions of Participation, hospitals must:

- Identify patients at risk for adverse outcomes after discharge,
- Develop discharge plans based on the patient's individual needs,
- Involve the patient and/or advocate in planning, and
- Ensure that discharge is safe and appropriate, not merely efficient.

For seniors, this explicitly includes attention to:

- Functional limitations,
- Cognitive impairment,
- Ability to effectively manage multiple daily medications, and
- Availability of caregivers and services.

Discharging a patient into conditions likely to cause harm often violate these requirements.

Advocates do not need to cite regulatory code sections to use Medicare Conditions of Participation effectively.

EXAMPLE SCRIPT: Invoke Medicare Conditions of Participation-based Concerns (Amend as Needed)

- *"The hospital has an obligation to ensure discharge planning is safe and individualized."*
- *"Conditions of Participation require meaningful patient involvement in discharge decisions."*

These statements signal regulatory awareness and can trigger internal escalation.

Unsafe Discharge Violates Medicare Conditions of Participation

Unsafe discharge commonly reflects:

- Failure to assess functional status,
- Ignoring cognitive instability,
- Lack of realistic post-discharge support, and
- Rushed timelines driven by bed availability.

Medical facilities must identify patients who are likely to suffer adverse health consequences after discharge if adequate planning is not performed.

Discharge disputes framed as regulatory compliance issues are treated far more seriously than those framed as family disagreement alone.

Medical facilities are highly sensitive to internal complaints because they can:

- Escalate to compliance departments,
- Be discoverable in litigation,
- Be reviewed during accreditation surveys, and
- Lead to external complaints or audits.

Even when no external agency is contacted, unsafe discharge complaints are dangerous for medical facilities because they often involve:

- Predictable harm,
- Foreseeable readmission or injury,
- Documentation gaps, and
- Witnessed objections by family advocates.

If harm occurs after discharge, internal complaints become evidence that the hospital was on notice.

This gives leverage to advocates because when advocates state that:

- Patient rights are being violated,
- Conditions of Participation may not be met,
- A formal complaint is being considered,

medical facilities often slow discharge, request reassessment, or convene additional reviews to mitigate risk.

EXAMPLE SCRIPT: Framing Policy-Based Objections (Amend as Needed)

Effective framing avoids threats and focuses on compliance:

- *"We are concerned this discharge plan does not align with patient rights policies."*
- *"We believe additional assessment is required to meet discharge planning obligations."*
- *"Please document how this plan complies with Conditions of Participation."*

This language signals seriousness without inviting conflict.

Policy-based objections can work better than medical argument alone because medical judgments can be debated. Policies cannot.

Medical facilities may disagree about:

- Symptom severity,
- Recovery timelines,
- Prognosis.

They are far less willing to dismiss:

- Documented policy conflicts,
- Rights-based objections,
- Compliance concerns.

Filing Internal Grievances Before Discharge Occurs

Most families assume grievances are something you file after harm occurs. In reality, internal grievances filed before discharge can immediately slow or halt an unsafe discharge because they trigger institutional obligations, documentation requirements, and risk review. Hospitals and skilled nursing facilities must maintain a formal grievance process and provide a written response describing the steps taken to investigate the grievance, the results, and the date of completion.

Hospitals and skilled nursing facilities are far less concerned about verbal objections than they are about written grievances, which must be logged, tracked, and answered under federal participation requirements.

Complaint vs. Grievance: A Critical Difference

A complaint is:

- Informal,
- Often verbal,
- Frequently undocumented,
- Easy to acknowledge, then ignore or "resolve" without action.

A grievance is:

- A formal expression of dissatisfaction,
- Made in writing,
- About care, safety, or rights,
- Required to receive a documented response.

Under Medicare rules, grievances must be:

- Logged,
- Reviewed, and
- Responded to within a reasonable timeframe, generally not exceeding 7 days unless additional investigation is required.

Once something is labeled a grievance, the institution's risk profile increases significantly.

Why This Distinction Is So Important in Discharge Disputes

Unsafe discharge objections framed as grievances:

- Cannot be dismissed as "family disagreement,"
- Must be routed beyond bedside staff,
- Create discoverable records if harm occurs later.

This is why advocates should explicitly use the word "grievance."

How Internal Grievances May Slow Discharge

Internal grievances can slow an unsafe discharge because they:

- Trigger compliance review,
- Create documentation obligations,
- Alert risk management, and
- Increase institutional liability if harm occurs.

Hospitals and skilled nursing facilities know that proceeding with discharge after a documented grievance may later be characterized as willful disregard of known risk. As a result, a documented internal grievance may:

- Delay discharge,
- Order reassessments,
- Convene care conferences,
- Modify discharge plans.

What an Effective Pre-Discharge Grievance Includes

An effective grievance:

- Uses the word *grievance* explicitly,
- Identifies unresolved safety risks,
- References patient rights or discharge planning obligations,
- Requests review *before* discharge occurs,
- Is calm, factual, and non-accusatory.

EXAMPLE TEMPLATE: Grievance Letter/Email (Amend as Needed)

Internal Grievance Letter — Hospital Version

Email
Subject: Formal Grievance Regarding Unsafe Discharge Plan

Dear Patient Relations / Grievance Coordinator,

This letter constitutes a formal grievance regarding the proposed discharge of [Patient Name], who is currently hospitalized at your facility.

There are unresolved safety and clinical concerns that make discharge unsafe at this time, including [briefly list key issues: functional decline, cognitive changes, unresolved symptoms, lack of safe post-discharge support]. These concerns have been raised but remain inadequately addressed or documented.

We are requesting that this grievance be reviewed prior to any discharge, as required under patient rights and discharge planning obligations. Please confirm that this grievance has been logged and advise what steps will be taken to evaluate these safety concerns before discharge proceeds.

We are not refusing discharge; we are objecting to a discharge that is not medically or functionally safe.

Sincerely,

[Your Name]
[Relationship to Patient]
[Contact Information]

EXAMPLE TEMPLATE: Grievance Letter/Email (Amend as Needed)

Internal Grievance Letter — Skilled Nursing Facility (SNF) Version

Email
Subject

Dear Administrator / Grievance Official,

This letter serves as a formal grievance regarding the planned discharge of [Resident Name] from your skilled nursing facility.

At this time, discharge presents significant safety risks, including [list concerns: inability to ambulate safely, unresolved medical issues, cognitive impairment, lack of adequate caregiver support]. These issues place the resident at risk for harm if discharge proceeds as planned.

We request that this grievance be reviewed and addressed before any discharge occurs, consistent with resident rights and discharge planning requirements. Please confirm receipt of this grievance and provide information regarding the review process and timeline.

This grievance is submitted to protect the resident's safety and to ensure compliance with applicable standards of care.

Sincerely,

[Your Name]
[Relationship to Resident]
[Contact Information]

Options After the Grievance Is Filed

Advocates can immediately:

- Ask for written confirmation the grievance was logged,
- Note the date and time of submission,
- Request that discharge be paused pending review,
- Prepare for escalation if discharge proceeds regardless.

If discharge continues despite a pending grievance, ***the grievance itself becomes evidence*** in support of appeals and external enforcement.

FORMAL APPEALS AND EXTERNAL ENFORCEMENT

Important Note: Some hospital patients are classified as being on "observation status" rather than formally "admitted" as inpatients. Patients in observation status are considered outpatients under Medicare rules and generally do not have access to the hospital fast-appeal process. Patients placed in observation status must receive a written Medicare Outpatient Observation Notice (MOON) explaining that they are not admitted as inpatients and may not have hospital discharge appeal rights.

The Medicare Fast Appeal for Patients Admitted to Medical Facilities

When a hospital or skilled nursing facility insists that discharge or termination of Medicare-covered care is imminent, and other measures to stop a premature discharge have failed, the Medicare Fast Appeal becomes an extremely important tool. Properly used it can halt discharge, preserve Medicare coverage, and force an independent medical review, even when the facility insists that "nothing further can be done."

Written Notice that Medicare-Covered Services are Ending Triggers Medicare Fast Appeal Rights

Fast appeal rights are triggered when a Medicare beneficiary receives a formal written notice stating that Medicare-covered services are ending, including:

- From a Hospital: *Important Message from Medicare (IM)* or follow-up discharge notice;
- From a Skilled Nursing Facility, Home Health, or Hospice: *Notice of Medicare Non-Coverage.*

These notices are legally required and must:

- Be provided before coverage ends,
- Explain appeal rights,
- Identify the Quality Improvement Organization (QIO) that handles appeals.

Hospitals must provide the Important Message from Medicare within two days of admission and again shortly before discharge.

If no notice has been given, advocates can immediately object and demand it in writing.

Verbal Statements Do NOT Replace Appeal Rights

Facilities often say:

- "Medicare is done paying,"
- "Therapy says there's no more progress,"
- "The patient is being discharged tomorrow."

None of these statements end appeal rights.
Only proper written notice does.

Timing Is Everything: Filing Correctly and On Time

The Critical Deadline

For hospitals, a fast appeal must be filed by the end of the calendar day of planned discharge (no later than 11:59pm). Otherwise, Medicare coverage ends at that time if you have not filed the appeal.

For skilled nursing facilities, a fast appeal must typically be requested by noon of the calendar day before Medicare-covered services are scheduled to end.

Missing these deadlines can forfeit important protections, including continued Medicare coverage during review.

Who Files the Appeal

An appeal may be filed by:

- The patient,
- A family member or lay advocate acting on the patient's behalf,
- A legally authorized representative (if available).

Formal Power of Attorney is not required to file a fast appeal.

How to File

Fast appeals are filed by contacting the QIO listed on the notice:

- Usually by phone,
- Sometimes by fax or online.

Advocates should document the date, time, and name of the QIO.
IMPORTANT NOTE: LAWS CAN CHANGE WITHOUT NOTICE-ALWAYS REVIEW THE FORMAL NOTICE PROVIDED BY THE MEDICAL FACILITY TO CONFIRM FILING DEADLINES.

Detailed Notice of Discharge (DND)

When a hospital fast appeal is filed, the hospital must provide a **Detailed Notice of Discharge** explaining the medical reasons for ending inpatient services and citing the clinical evidence used. This document is reviewed by the Quality Improvement Organization (QIO) and is a key piece of evidence in the appeal.

Note that skilled nursing facilities have much stronger legal discharge protections under federal law.

Federal law permits nursing home discharge only if:

- The resident's welfare requires transfer,
- The resident's health has improved sufficiently,
- The resident's safety is endangered,
- Other residents' safety is endangered,
- The facility cannot meet the resident's needs,
- The resident fails to pay after reasonable notice, or
- The facility is closing.

Federal regulations also require skilled nursing facilities to prepare and document a safe and orderly discharge plan designed to meet the resident's ongoing care needs. Additionally, the written notice must identify the location to which the resident will be transferred or discharged.

In most situations, ***skilled nursing facilities must provide at least 30 days written notice before discharge***. The written discharge notice must include the reason for transfer or discharge, the effective date, the resident's appeal rights, and contact information for the state long-term care ombudsman. Shorter notice is permitted in limited situations such as medical emergencies or when resident safety is at risk. Residents have the right to request a state administrative hearing to challenge the transfer or discharge.

What Protections Apply During the Medicare Fast Appeal

When the appeal is filed on time, the medical facility generally may not bill the patient for inpatient services until the QIO decision is issued, and discharge is typically delayed until the review is completed.

This alone often changes facility behavior.

Independent Medical Review

The QIO:

- Reviews medical records,
- Applies Medicare coverage standards,
- Is independent of the hospital or SNF.

Facilities often rely on the assumption that families will not challenge them. Appeals disrupt that assumption.

Retaliation Is Prohibited

Facilities may not legally retaliate against a patient for filing an appeal, including by:

- Withholding care,
- Accelerating discharge,
- Pressuring the family to withdraw the appeal.

Any such behavior should be documented immediately.

Example Script: Step-by-Step Medicare Fast Appeal (Amend as Needed)

Refer to the following language when calling the QIO or Medicare:

> "I am calling to file a Medicare fast appeal regarding the termination of Medicare-covered services for [Patient/Resident Name].
>
> We believe the care remains medically necessary and that discharge or termination would be unsafe.
>
> Please confirm that this appeal has been accepted, that coverage is protected during review, and advise what additional information you require."

After the call, immediately write down:

- Date and time,
- QIO representative's name,
- Any confirmation or case number provided.

Medicare Fast Appeal Suggested Filing Checklist

Before Filing:
□ Obtain and review the written Medicare termination notice
□ Confirm the filing deadline (found on the notice)
□ Identify the correct Quality Improvement Organization (QIO)

During Filing:
□ State clearly: "This is a Medicare fast appeal"
□ Identify the patient and facility
□ Object on safety and medical necessity grounds

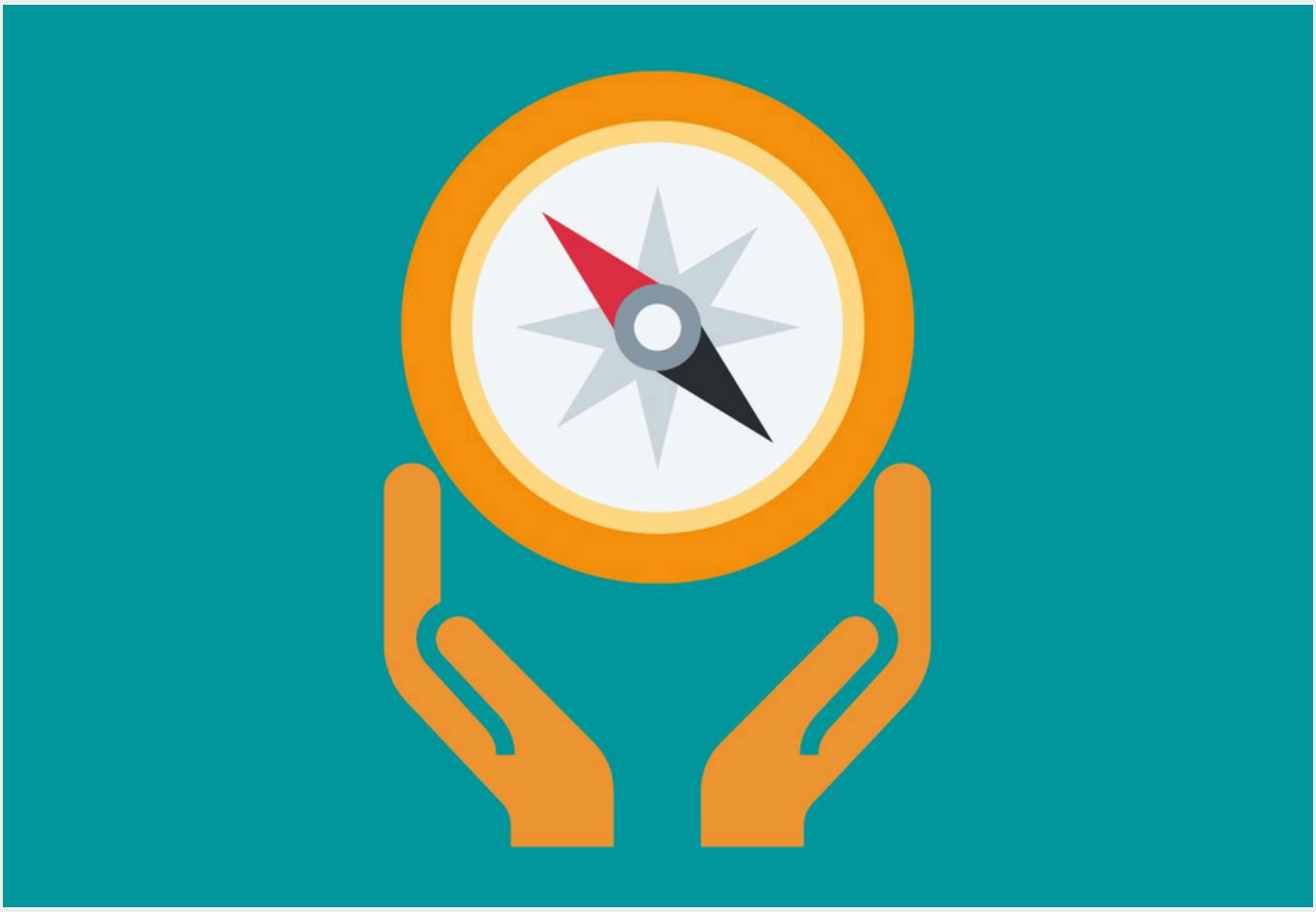
After Filing:
□ Document the call details
□ Notify the facility in writing that an appeal is pending
□ Monitor for retaliation or improper discharge pressure

Why Fast Appeals Can Work (Even When Families Are Told They Won't)

Facilities often discourage appeals because:

- They delay discharge,
- They trigger record scrutiny,
- They expose weak documentation or improper decision-making.

Even when an appeal is ultimately denied, the process itself can buy critical time to stabilize the patient and arrange for safer post-discharge care.



06 Resources

Resources

Advocates can also contact:

- State Department of Health
- Long-Term Care Ombudsman (assists residents of nursing homes and assisted living facilities but does not generally investigate hospital discharge decisions)
- Centers for Medicare & Medicaid Services Regional Office
- Joint Commission Complaint Line
- State Survey Agencies

Medicare beneficiaries may also file complaints directly with Medicare through 1-800-MEDICARE, which can refer the case to the appropriate oversight agency.

Sources Referenced in This Document

- Code of Federal Regulations
- Centers for Medicare & Medicaid Services Discharge Planning Rules
- Centers for Medicare & Medicaid Services Patient's Rights Rules
- U.S. Department of Health and Human Services
- Agency for Healthcare Research and Quality
- National Institute on Aging
- American Medical Association
- Uniform Health-Care Decisions Act
- Journal of the American Geriatrics Society
- National Institutes of Health
- Center for Medicare Advocacy
- California Advocates for Nursing Home Reform
- Boston University (health law, geriatrics, and patient safety scholarship)
- Nursa (clinical nursing and discharge practices)
- Brain Injury Association of America

ii. Disclaimer

This guide cannot address every conceivable legal or medical issue raised by the topics discussed.

The content presented in this guide is informational only and provides general guidance and understanding on the topics discussed. It's not a substitute for specific, individualized professional legal or medical advice and cannot be construed or relied upon as such.

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