PATIENT DISCHARGE, REVOCATION, AND TRANSFER

SCOPE:

All Ascension At Home, LLC colleagues. For purposes of this policy, all references to "colleague" or "colleagues" include temporary, part-time and full-time employees, independent contractors, clinicians, officers and directors.

PURPOSE:

The purpose of this Policy is to provide guidelines for Ascension At Home, LLC and its subsidiaries (the "Company") on the process for discharging a patient from the Company's services.

POLICY:

The Company will assess each patient's discharge planning and/or continuing care needs on an ongoing basis and will involve the physician, the patient and the caregiver in the process. Patients will be discharged when they meet the discharge criteria. The Company will provide appropriate discharge planning and notification in accordance with applicable law and regulations and this policy, with the understanding that state licensure statutes and regulations may stipulate additional requirements that shall be confirmed and updated by the Company as necessary.

PROCEDURE:

Planning For Patient Discharge

- Planning for discharge will begin after evaluation of the data and information gathered during the Initial and Comprehensive Assessments in accordance with the Company's Initial and Comprehensive Assessment Policy, Policy No. 503.

- Changes in a patient's needs during the provision of care will be identified and assessed on an ongoing basis through Interdisciplinary Group ("IDG") meetings, progress notes and comprehensive assessments.

- The data/information and patient/caregiver participation utilized in planning for discharge may be evidenced in the following:

    1. Initial Comprehensive Assessment form;

    2. Progress notes; and

    3. IDG documentation.

Patient Discharge

- The Company shall establish a discharge planning process that accounts for the prospect that a patient's condition might stabilize or change such that the patient cannot continue to be certified as terminally ill. The discharge planning process must include planning for any necessary family counseling, patient education, or other services before the patient is discharged because he or she is no longer terminally ill.

- The Company may discharge a patient if the patient meets one of the following criteria:

    1. The patient revokes the hospice benefit;

    2. The patient transfers to another hospice;

    3. The patient dies;

    4. The patient no longer resides within the Company's service area;

    5. The patient's condition improves such that he or she is no longer considered terminally ill.

- The Company shall discharge a patient if it determines that the patient is no longer terminally ill.

    1. If based on clinical documentation, the Company's IDG sees indications of improvement in a patient's condition such that hospice care may no longer be appropriate, the IDG shall take steps to confirm that the patient is no longer eligible for hospice (*i.e.*, is no longer terminally ill).

    2. The Company will communicate with the patient's physician and, as needed, obtain a written discharge order from the Medical Director. The Company will confirm the need for discharge and identify any remaining discharge planning needs.

- The Company may discharge a patient for cause, including behavior that is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the Company to operate effectively is seriously impaired.

    1. If the Company is considering discharging a patient for cause, it must first advise the patient that discharge is being considered and make a reasonable effort to resolve the problem.

2. The Company must document the problem and resolution efforts in the patient's medical records.

3. Prior to discharging a patient for cause, the Company will obtain a written physician's discharge order from the Medical Director.

Medicare Patients – Notice of Medicare Provider Non-Coverage Form

- For all discharges of Medicare patients, the Company will provide notice of discharge on the Company's Notice of Medicare Provider Non-Coverage form.

  1. In order for the Notice of Medicare Provider Non-Coverage to be valid, the patient (or the patient's representative) must understand the reason for the notice and must sign and date the notice. Accordingly, at the time of delivering the notice, the Company will ensure the patient (or patient's representative) understands that the purpose and contents of the notice is to notify the patient that: (a) the end of covered care is imminent; and (b) the patient or patient's representative may appeal the termination decision.

  2. The patient or patient's representative should sign and date the Notice of Medicare Provider Non-Coverage on the Company's form. One copy will be left with the patient and one copy will be included in the medical record.

  3. If the patient or the patient's representative refuses to sign the Notice of Medicare Provider Non-Coverage form, the Company representative should document on the form the refusal to sign.

- The Company will provide the Notice of Medicare Provider Non-Coverage at least two (2) days before the proposed end of covered services. If the time between the patient's scheduled services is less than two (2) days, the Notice of Medicare Provider Non-Coverage will be provided no later than the next to the last time services are provided. If services are anticipated to be fewer than two (2) days in duration, the Company will provide the Notice of Medicare Provider Non-Coverage at the time of admission.

- The Company must (a) explain to the patient's representative that the patient's services will no longer be covered by Medicare; and (b) describe the patient's appeal rights, including providing the name and telephone number of the state quality improvement organization ("QIO").

- In the event that the patient is not competent and Company representatives are unable to make direct phone contact with the patient's representative, the following steps must be taken:

  1. The Company will send a Notice of Medicare Provider Non-Coverage to the patient's representative by certified mail, return receipt requested.

2. The date of receipt is the date the representative (or someone at that address) signs (or refuses to sign) the notice. Patients or patient representatives who refuse to sign the notice are still entitled to appeal the Company's decision.

3. If notices are returned by the post office with no indication of a refusal date, the patient's liability for coverage of services will begin on the second working day after the date the Company mailed the notice.

- The Company will retain a copy of all Notice of Medicare Provider Non-Coverage forms given to patients in their records and will give completed copies to:

1. The patient (or patient's representative); and

2. The QIO, if requested.

A copy may also be given to the patient's physician, but this is not required.