Discharge CHECKLIST

PATIENT NAME _____

№	TO DO	✓
1	Start discharge discussion with family 30-45 days in advance of DC	
2	Send Referral to both Home Health and Palliative Intakes	
3	Get PCP Contact Info from (HH or Palliative) provide to family if needed	
4	Complete NOMNC and review plan after discharge (Palliative vs Home Health)	
5	Complete DME Form and email to Haven/BV Providers with DC Summary	
6	Provide resources for purchasing DME (Amazon or ASAP)	
7	Schedule NP visit for DME (Hospital Bed and Oxygen)	
8	A day or more prior to discharge, email Haven/BV orders for DME pick up	
9	SNF Patients: Update Care Plan and Medication list as needed before DC	
10	Schedule PCP appointment after hospice discharge	
11	Order 30 day supply of Medication prior to discharge	
12	Day after discharge: Complete Discharge Summary	

Hospice Discharge - Equipment Pick up Protocol

Patient Name: _____ **Discharge Date:** _____

Hospice equipment is the property of the Hospice's contracted vendor. Equipment provided to patients on hospice must be returned at discharge. We understand some patients will need equipment after discharge. Hospice will permit essential equipment to remain in home for 60 days after discharge pending equipment will be approved by insurance. All other equipment will be returned at discharge. Any equipment denied by insurance must be returned immediately.

If equipment is not returned either initially or within 60 days, patient/family will be responsible for any rental or lost equipment fees. Hospice is not responsible for lost equipment.

DME to transfer to insurance/leave in home		**Needed to Qualify**
Hospital Bed, Mattress & Cover & Rails	☐	Bedbound, unable to reposition independently, reqired positioning asstance for optimal breathing
Oxygen Concentrator, Tanks & Supplies	☐	document O2 saturation of 88% on room air
Hand Held Nebulizer	☐	For pulmonary patients only: shortness of breath, wheezing

No other equipment may be left in the home. Can purchase from Amazon or rent from ASAP Pharmacy.

Care after Hospice (Pall, Home Health, PCP): _____

If going back to PCP, date of PCP appointment: _____

Signature below acknowledges the above policy and that all equipment will be return to hospice.

Pt/DPOA Name _____

Pt/DPOA Signature _____ Date: _____

Hospice Rep Name: _____ Date: _____

Haven Health
2855 Temple Avenue, Suite B, Signal Hill, CA 90755
Phone 562-426-7500 Fax 562-424-9588

Notice of Medicare Non-Coverage

Patient name: **Patient number:**

The Effective Date Coverage of Your Current **Hospice Services** Services Will End:

- Your Medicare provider and/or health plan have determined that Medicare probably will not pay for your current hospice services after the effective date indicated above.
- You may have to pay for any services you receive after the above date.

Your Right to Appeal This Decision

- You have the right to an immediate, independent medical review (appeal) of the decision to end Medicare coverage of these services. Your services will continue during the appeal.
- If you choose to appeal, the independent reviewer will ask for your opinion. The reviewer also will look at your medical records and/or other relevant information. You do not have to prepare anything in writing, but you have the right to do so if you wish.
- If you choose to appeal, you and the independent reviewer will each receive a copy of the detailed explanation about why your coverage for services should not continue. You will receive this detailed notice only after you request an appeal.
- If you choose to appeal, and the independent reviewer agrees services should no longer be covered after the effective date indicated above;
  - Neither Medicare nor your plan will pay for these services after that date.
- If you stop services no later than the effective date indicated above, you will avoid financial liability.

How to Ask For an Immediate Appeal

- You must make your request to your Quality Improvement Organization (also known as a QIO). A QIO is the independent reviewer authorized by Medicare to review the decision to end these services.
- Your request for an immediate appeal should be made as soon as possible, but no later than noon of the day before the effective date indicated above.
- The QIO will notify you of its decision as soon as possible, generally no later than two days after the effective date of this notice if you are in Original Medicare. If you are in a Medicare health plan, the QIO generally will notify you of its decision by the effective date of this notice.
- Call your QIO at: Livanta 877-588-1123 TTY:855-887-6668 to appeal, or if you have questions.

See page 2 of this notice for more information.

If You Miss The Deadline to Request An Immediate Appeal, You May Have Other Appeal Rights:

- If you have Original Medicare: Call the QIO listed on page 1.
- If you belong to a Medicare health plan: Call your plan at the number given below.

Plan contact information _____

_____

Additional Information (Optional):

Please sign below to indicate you received and understood this notice.

I have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision by contacting my QIO.

_____ _____

Signature of Patient or Representative Date

Optional Form to Document Alternate Delivery

Please fax completed (signed) Notice of Medicare Non-Coverage (NOMNC) to: _____

CONFIRMATION OF NOTICE BY TELEPHONE

(Notification by telephone is done only in situations where the notice must be delivered to an enrollee in an institutional setting, who is unable to make decisions for him/herself. See Medicare Managed Care Manual, Chapter 13, Section 60.1.3 for reference.)

Name of person contacted: _____

Date of contact: _____ Time: Telephone Number called: ____ ☐AM ☐PM

_____ _____

Signature of Health Plan/SNF/HHA/CORF/Medical Group Representative Date

CONFIRMATION OF FOLLOW-UP NOTICE BY MAIL

(Notification by mail must also be done if telephone notification was made. This is done only in situations where the notice must be delivered to an enrollee in an institutional setting, who is unable to make decisions for him/herself. See Medicare Managed Care Manual, Chapter 13, Section 60.1.3 for reference.)

Mailing address: _____

_____

Date sent: _____ Via: ☐ US Mail ☐ Certified Mail ☐ FedEx ☐ Priority Mail

Tracking # (if applicable): _____

CONFIRMATION OF REFUSAL TO SIGN

I confirm that the Notice of Medicare Non-Coverage was hand-delivered to the member or the member's authorized representative; however, the member or the member's authorized representative refused to sign the acknowledgment of receipt.

Name of person receiving notice:

Date of delivery: Time: ☐AM ☐PM

_____ _____

Signature of Person Delivering Notice Date

_____ _____

Signature of Witness to Delivery of Notice Date

Guidance Checklist When Issuing NOMNC to Other Than Member (See Medicare Managed Care Manual, Chapter 13, Section 60.1.3)	Responsible Party		Initial Completed	Date	Time
	SNF	MG/IPA			
Call patient's representative the day notice is issued. (Date of conversation is the date of the receipt of the NONMC). ID self and give organization, contact name and number, purpose of call (right to file an appeal) and describe the appeal right being discussed (e.g. QIO vs expedited).					
Inform representative that skilled services will no longer be covered beginning on: (date) _____ and financial responsibility starts on (date) _____					
Advise representative of appeal rights. (You must read directly from the letter)					
Advise representative that an appeal must be phoned to HSAG by 12:00 pm the following day of receipt of the NOMNC or phone call.					
Provide the representative with the QIO name (HSAG) and phone number listed in the appeal section of the letter. Provide address, fax or other method of communication needed by representative for QIO to receive appeal in a timely fashion.					
Inform representative how to get a detailed notice describing why the enrollee's services are not being covered					
Provide at least one phone number of an advocacy organization or 1-800-MEDICARE					
Confirm the telephone contact by written notice mailed same day.					
If direct phone contact cannot be made, including leaving voice mail, mail the notice to the representative, certified mail, return receipt requested. (If the Medical Group is sending the certified mail, the Facility must notify the Medical Group immediately that certified mail is required.) (If the Facility sent the certified mail, and HSAG is processing an appeal, the certified returned receipt must be submitted to HSAG. If not submitted, the appeal may be decided in favor of the member solely due to lack of the receipt which is the evidence of timely notification.)					
Document that representative verbalizes understanding of the information provided.					