Unsafe Discharges: Ethics, Risk Reduction, and Obligations, Part 2

By Sing Palat, MD, CMD

Part 1 of this story was published in the previous issue of Caring for the Ages (2016).

The Health Plan: Medical Necessity

Health plans are often considered contenders in the provision of health care but may be better characterized as colleagues. Wayne Saltsman, MD, PhD, CMD, senior medical director with Commonwealth Care Alliance, reveals that when coverage for a skilled nursing facility stay is completed, many patients are unfairly told, “The health plan will discharge you today”—when, in actuality, the health plan has simply questioned whether SNF care is medically necessary.

In the health insurance realm, medical necessity is understood to include health care services or supplies that are needed to diagnose or treat an illness, injury, condition, disease, or its symptoms, and meet accepted standards of medicine. The Centers for Medicare & Medicaid Services goes a bit farther to define necessity as proper and needed benefits for issues around a medical condition that meet the standards of good medical practice in your area and that are not mainly serving patient or provider convenience. Services not considered medically necessary include those that could have been furnished in a lower-cost setting and evaluation and management services that exceed necessity or reason. For instance, the health plan may ask whether services being provided in acute rehabilitation could be provided in a subacute rehabilitation setting, or whether a skilled service should be covered for 14 days when seven days are sufficient by local standards.

Variations in health plan decision-making criteria are described in each plan’s Evidence of Coverage, proprietary criteria, independent review organization, and local and national coverage determinations (LCD and NCD). NCDs come from a CMS-driven, evidence-based process that welcomes public commentary. LCD is used when there is no NCD or when further NCD clarification is warranted. LCDs have authority from Medicare to determine what makes a particular service reasonable or necessary within their jurisdiction. In addition, health plans routinely solicit advice from outside experts to help determine medical necessity, and these determinations model known society guidelines with regard to unique populations.

Objective, unbiased utilization reviews looking at clinical factors and coding in the medical record help health plans avoid arbitrary decisions around coverage. However, the reviewers are not necessarily up to speed on each member’s individual circumstances. If a discharge from a SNF appears unsafe, fostering communication with the health plan will account for factors that the reviewer may not be aware of.

Communication with insurance companies is generally considered an abhorrent chore for physicians, whether it takes the form of a peer review, request for prior authorization, or simple signing off on forms. Peer-to-peer conversations, which are typically offered by commercial and managed plans around denials, follow the standards of the National Committee for Quality Assurance. Prepare for such conversations by scheduling a mutually convenient time for a call and having a good understanding of the conversation’s goal.

While physicians view communication with insurance companies as a chore, health plan medical directors find value in conversations with colleagues in the field.

During the conversation, Dr. Saltsman advises, please don’t yell! You may be speaking to a health plan medical director who is willing to have a conversation that advocates for the patient. Express your concerns, whether it is safety at home, function, cognition, or social determinants of health. Present the clinical information, including the documentation and latest laboratory results or X-rays, and offer timely data (i.e., not from a year ago) and any peer-reviewed, published data to support your case. Understand that the support staff may be conveying different information on the health plan than you think, and many times a Prior Authorization is applicable.

Most health plans are asking on behalf of their members, What is the right care, in the right place, for the right cost? Health plans are not medical decision makers or primary drivers of clinical care, nor do health plans make arbitrary decisions about coverage. Health plan medical directors find value in conversations and updates with colleagues in the field. Furthermore, no health plan would compel a provider to discharge a patient, nor would they threaten not to pay for a member who leaves AMA.

Documentation, Documentation, Documentation

The specific facts and circumstances of each discharge AMA affect the future liability of a facility or physician. Laws and regulations vary from state to state, but in all cases documentation in the medical record is vital, whether using the AIMED approach, the ACE for capacity assessment, or a Release of Liability.

A Release of Liability for waiver of treatment is a legal document that outlines the resident’s desire to be discharged AMA, notifies the resident of risks, and releases from liability and provides indemnification (holds harmless) for the health care provider in its efforts to discharge the resident AMA. A recommendation from Neville M. Bilimoria, Esq., a partner at Duane Morris LLP, is that if your facility doesn’t have a robust liability waiver, request that the facility attorney draft one.

Releases are drafted to release not only the facility from liability, but the medical director and/or attending physician as well. The documents should include the fully documented informed consent. Some patients are, instead, willing to complete a questionnaire without release of liability, merely showing that they have been informed of risks. The questionnaire may ask if there are “any other problems not discussed with the provider” to avoid the plaintiff later arguing in court that there were other issues not addressed before discharge AMA.

To prevent a future malpractice lawsuit, does the physician need to follow up with a patient who discharged AMA? Legally, no. Collins v. ACA Health Services of Tennessee, Inc. (517 S.W. 3d 84 [2016]) held that a “physician’s duty to attend a patient continues as long as required unless the physician–patient relationship is ended by ... the dismissal of the physician by the patient.” In that case, a patient left the hospital psychiatric unit AMA and declined to sign a release. After jumping out a hospital window, she sued for injuries. It was held that once the patient terminated treatment and decided to leave AMA, her status as a patient of the hospital ceased, as did the hospital’s duty of care for the patient. In Kruse v. Fard, M.D. (835 S.E. 2d 163 [2019]), a release was signed when the patient left AMA after a procedure, but the plaintiff claimed that she thought the release was just a discharge form. The plaintiff argued that her physician should have been liable for his failure to provide follow-up care after discharge. The court held, again, that discharge AMA from the hospital after surgery ended the physician–patient relationship. The physician no longer had a duty to provide medical care to the patient, and the court dismissed the patient’s negligence claims.

Even without a legal obligation, physicians, NPs, and PAs may set up post-discharge appointments and arrange prescriptions after AMA discharges in efforts to fulfill an ethical obligation to beneficence. Competent, ethical care and documentation, documentation, documentation are always the best defense.

Dr. Palat is a geriatrician and medical director in Denver, CO. She serves as a board member of CMDA – The Colorado Society for Post-Acute and Long-Term Care Medicine and on the Society’s Transitions of Care Committee.

Wayne Saltsman, MD, PhD, CMD, is the editor of this column.