

PRINTABLE ARTICLE-STYLE GUIDE

The Hospital Discharge & Medicare Quick Guide

A plain-English printable guide for families trying to understand discharge, rehab, home care, long-term care, plan decisions, and confusing bills.

Written from a healthcare-worker perspective by Andrew Ciccarelli, RN, BSN. Educational only. Verify with official sources, plan documents, agency notices, SHIP, or a qualified professional.

1. Plan What is being recommended?	2. Payer Who is expected to pay?	3. Paper What document explains it?	4. Deadline What changes soon?	5. Next call Who can verify it?
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DIRECT ANSWER

Before discharge, slow the process down enough to identify the plan, the payer, the documents, and the next person to call. You do not need to understand every Medicare rule. You need to know what is being recommended, what is actually ordered, what is still pending, and what paper explains the answer.

Why this matters

Hospital discharge moves quickly. Families often hear words like rehab, home health, observation, authorization, Medicare, Medicaid, or private pay before anyone has clearly explained how they connect. A safe plan is not just “where is the patient going?” It is also “who accepted the patient, what services are ordered, what might be denied or delayed, and what should we do if the plan falls apart?”

What to ask

- **Plan:** “Where is the patient expected to go after discharge?”
- **Payer:** “Which coverage path is being used: Original Medicare, Medicare Advantage, Medicaid, employer insurance, supplemental coverage, or private pay?”
- **Deadline:** “Is there a notice, appeal, discharge, authorization, or payment deadline we need to act on today?”
- **Services:** “What home health, rehab, equipment, medication, or follow-up is actually ordered?”
- **Pending items:** “Is anything still waiting on authorization, delivery, acceptance, or review?”

What to keep

- **Discharge papers:** instructions, medication list, follow-up appointments, and service referrals.
- **Names:** case manager, social worker, physician, therapy contact, plan representative, agency, facility, supplier, and billing office.
- **Proof:** notices, orders, denial letters, authorization updates, itemized bills, MSN, EOB, and call reference numbers.

Short script

“I am trying to make sure the discharge plan is safe and that we understand the payment path. Can you tell me what is ordered, what is still pending, what document explains it, and who we call if something does not happen?”

Source note: Built from Medicare.gov, Medicaid.gov, CMS discharge/appeal resources, SHIP resources, and the official source map at the end of this guide.

HOSPITAL STATUS

Is the patient inpatient or observation?

A plain-English page for families trying to ask the right next question.

DIRECT ANSWER

Ask for the patient's official hospital status and the date and time that status began. Do not assume a patient is inpatient just because they stayed overnight, had a hospital room, received tests, or was very sick.

Why this matters

Hospital status can affect billing and may affect some post-acute care questions. Observation is generally treated as outpatient hospital care, even when the patient sleeps in the hospital. Inpatient status usually depends on an inpatient admission order. The practical issue is simple: if a later decision depends on hospital status, you need the official answer in writing, not a guess.

What to ask

- **Current status:** "Is the patient inpatient, outpatient, or observation right now?"
- **Notice:** "Was a Medicare Outpatient Observation Notice or other status notice given?"
- **Verification:** "Can utilization review, case management, or billing confirm this in writing?"
- **Start time:** "If inpatient, what date and time did the inpatient admission begin?"
- **Impact:** "Could this status affect skilled nursing facility, rehab, or billing questions?"

What to keep

- **Status notice:** MOON or any other written status notice.
- **Discharge packet:** final summary, orders, follow-up instructions, and facility or agency referrals.
- **Admission details:** inpatient order timing if available.
- **Plan messages:** authorization updates, denials, or coverage-ending notices.

Short script

"I am not trying to argue. I am trying to understand the official hospital status because it may affect billing or the next care setting. Can someone print or send the notice or documentation that explains the status?"

Source note: Built from CMS and Medicare.gov materials on inpatient versus outpatient/observation status, Medicare Outpatient Observation Notice materials, Medicare.gov skilled nursing facility materials, and SHIP resources.

REHAB OR SNF

What should I ask before rehab or SNF transfer?

A plain-English page for families trying to ask the right next question.

DIRECT ANSWER

Before agreeing to rehab or skilled nursing facility transfer, ask what skilled need is documented, whether the facility is approved or in-network for the payer, whether authorization is approved or pending, and what happens if coverage ends sooner than expected.

Why this matters

Rehab is not one single thing. A patient may be considered for a skilled nursing facility, inpatient rehab, outpatient therapy, home health, or private support at home. The medical recommendation and the payment decision are connected, but they are not the same. A therapist may recommend rehab while the plan, facility, or Medicare rules still require documentation, timing, participation, network status, authorization, or review.

What to ask

- **Setting:** “Is this skilled nursing facility care, inpatient rehab, outpatient therapy, home health, or custodial support?”
- **Facility:** “Has the receiving facility accepted the patient?”
- **Authorization:** “Is authorization approved, pending, denied, or likely to need renewal?”
- **Skilled need:** “What skilled nursing or therapy need is documented today?”
- **Payer fit:** “Is the facility participating, approved, or in-network for this coverage?”
- **Backup plan:** “What happens if authorization is delayed, denied, or ends before the patient is safe?”

What to keep

- **Therapy notes:** PT, OT, speech, nursing, wound care, mobility, oxygen, or safety documentation.
- **Coverage papers:** authorization notice, denial notice, coverage-ending notice, or appeal instructions.
- **Facility information:** facility name, contact, acceptance status, and network/participation status.

Short script

“I am trying to verify the rehab plan before transfer. What skilled need supports this setting, has the facility accepted the patient, is payer approval complete, and what is the appeal or backup plan if the answer changes?”

Source note: Built from Medicare.gov skilled nursing facility materials, Medicare.gov care comparison resources, Medicare Advantage coverage and appeal materials, CMS appeal resources, and SHIP resources.

HOME HEALTH

What does home health actually include?

A plain-English page for families trying to ask the right next question.

DIRECT ANSWER

Home health usually means specific skilled services ordered for the home. It does not automatically mean round-the-clock help, daily custodial care, transportation, meal help, or a private aide whenever the family needs one.

Why this matters

Families often hear “home health” and picture broad home support. In practice, home health may be intermittent skilled nursing, therapy, or other ordered services under specific rules. A discharge plan may still assume family members can handle the hours between visits. If the patient cannot safely be home without more help, that needs to be said clearly before discharge.

What to ask

- **Order:** “What exact home health services are ordered?”
- **Agency:** “Which agency accepted the referral, and when is the first visit?”
- **Frequency:** “How often will visits happen, and how long do they usually last?”
- **Between visits:** “Who helps with bathing, meals, toileting, supervision, transportation, or medications between visits?”
- **Unsafe at home:** “Who do we call if the patient is not safe after discharge?”

What to keep

- **Agency details:** name, phone number, start date, and accepted services.
- **Orders:** home health order, therapy order, nursing order, wound care order, medication list, and equipment order.
- **Safety concerns:** falls, confusion, oxygen needs, mobility limits, wound care, medication risks, or lack of caregiver support.

Short script

“When you say home health, what services are actually ordered, when will the first visit happen, and what support is expected between visits? If family cannot safely provide that help, what should we do before discharge?”

Source note: Built from Medicare.gov home health materials, Medicare.gov durable medical equipment materials, Medicare.gov long-term care materials, Medicaid.gov long-term services and supports materials, and SHIP resources.

EQUIPMENT AND MEDICATION

What equipment and medications need to be ready?

A plain-English page for families trying to ask the right next question.

DIRECT ANSWER

Before discharge, confirm that essential equipment, supplies, and medications are ordered, approved if needed, assigned to a supplier or pharmacy, and available when the patient actually gets home.

Why this matters

A discharge can look fine on paper but fail at home because oxygen, a walker, wound supplies, a hospital bed, a commode, a medication, or a follow-up instruction was delayed. Equipment and medication problems are easier to fix before the patient leaves than after the family is already home and trying to solve them alone.

What to ask

- **Equipment:** “What equipment or supplies are needed before the patient is safe at home?”
- **Order:** “Is the prescription, diagnosis, face-to-face note, therapy note, or medical-necessity documentation complete?”
- **Medication bridge:** “Will the patient have enough medication until follow-up?”
- **Supplier:** “Which supplier is providing the item, and is the supplier participating or in-network?”
- **Timing:** “When and where will the equipment arrive?”
- **Backup:** “What should we do if an item is denied, delayed, or substituted?”

What to keep

- **Orders:** prescriptions, equipment orders, diagnosis notes, and delivery instructions.
- **Plan notices:** authorization approval, denial, or pending status.
- **Supplier/pharmacy contacts:** name, phone number, delivery window, and reference number.

Short script

“I want to confirm the patient can safely function at home. What equipment, supplies, and medications are required before discharge, who is providing them, and what is the backup plan if something is delayed?”

Source note: Built from Medicare.gov durable medical equipment materials, Medicare.gov home health materials, Medicare.gov plan and prescription resources, CMS appeal resources, and Medicare Advantage plan decision materials.

MEDICARE VS MEDICAID

When does Medicare stop and Medicaid or long-term care become the question?

A plain-English page for families trying to ask the right next question.

DIRECT ANSWER

Medicare is usually the medical insurance starting point. Medicaid may become relevant when the issue is long-term services and supports, income or asset eligibility, nursing home care, home and community-based support, or help for people with limited resources.

Why this matters

Medicare and Medicaid are often discussed together, but they do different jobs. Medicare does not automatically pay for ongoing custodial long-term care. Medicaid rules can vary by state and may involve eligibility, level-of-care rules, estate recovery, spousal protections, and specific application steps. If someone is about to agree to private pay for ongoing care, slow down and ask which program is actually being discussed.

What to ask

- **Care type:** “Is this short-term skilled care, long-term custodial care, assisted living, nursing home care, or home/community support?”
- **State agency:** “Which state Medicaid office or aging resource should we contact?”
- **Advice:** “Should we speak with SHIP, an elder-law attorney, or a qualified Medicaid planning professional before major financial decisions?”
- **Program:** “Is the answer coming from Medicare, Medicare Advantage, Medicaid, another payer, or private pay?”
- **Eligibility:** “What documents are needed to evaluate eligibility?”

What to keep

- **Care description:** the level of care being recommended and why.
- **Notices and applications:** denial, coverage-ending notice, Medicaid request, application checklist, or document request.
- **Program names:** Medicare, Medicare Advantage, Medicaid, state waiver, facility private pay, or other payer.

Short script

“I need to understand whether this is a Medicare medical-care question, a Medicaid long-term support question, or a private-pay question. What program applies, what document explains the answer, and who can help us verify the state-specific rules?”

Source note: Built from Medicare.gov long-term care materials, Medicaid.gov eligibility materials, Medicaid.gov long-term services and supports materials, Medicaid.gov estate recovery and spousal impoverishment materials, CMS Medicare-Medicaid coordination resources, and SHIP resources.

PLAN DECISION

What if a Medicare Advantage plan says no or authorization is pending?

A plain-English page for families trying to ask the right next question.

DIRECT ANSWER

Ask whether the decision is approved, denied, pending, ending, out-of-network, or missing information. Then ask for the written notice, the reason, the deadline, and the appeal or expedited-review path.

Why this matters

Medicare Advantage is still Medicare, but plans can use networks, prior authorization, plan rules, medical-necessity review, and appeal steps. A neutral, specific question usually works better than arguing. The goal is to identify the exact decision and what can be done next.

What to ask

- **Status:** “Is this approved, denied, pending, ending, or missing information?”
- **Network:** “Is the hospital, rehab facility, home health agency, supplier, or clinician in-network?”
- **Deadline:** “What is the appeal deadline, and is expedited review available if the patient may be unsafe?”
- **Reason:** “What is the reason listed for the decision?”
- **Alternative:** “If this option is not approved, what approved or in-network alternative is being offered?”

What to keep

- **Written notice:** denial, noncoverage, coverage-ending notice, or authorization update.
- **Call log:** representative name, date, reference number, fax/upload instructions, and deadline.
- **Clinical support:** therapy note, physician order, nursing note, wound note, oxygen/mobility note, or unsafe-discharge concern.

Short script

“I am trying to understand the plan decision. Is this approved, denied, pending, or ending? What written notice explains the reason, what is the deadline, and what appeal or expedited-review option applies?”

Source note: Built from Medicare.gov Medicare Advantage materials, Medicare.gov appeals materials, CMS managed-care appeal resources, plan decision resources, and SHIP resources.

MEDICAL BILLS

How do I check a medical bill before paying?

A plain-English page for families trying to ask the right next question.

DIRECT ANSWER

Do not pay a confusing bill until you match it to the processed claim story. Compare the provider bill with the Medicare Summary Notice, Explanation of Benefits, denial notice, adjustment, and any financial-assistance option.

Why this matters

A bill is a request for payment. An MSN or EOB explains how a claim was processed. Those documents should tell a coherent story: who provided the service, what date it happened, how the payer processed it, what was adjusted or denied, and what the patient may owe. If the documents do not match, ask questions before paying.

What to ask

- **Match:** “Does this bill match the date, provider, service, and account on the MSN or EOB?”
- **Reason:** “Why is this amount patient responsibility?”
- **Processing:** “Was there a denial, noncovered service, network issue, coding issue, authorization issue, deductible, copay, or coinsurance?”
- **Hold:** “Can you place the account on hold while this is reviewed?”
- **Assistance:** “Can this account be screened for financial assistance or charity care?”

What to keep

- **Bill:** provider bill and itemized bill if requested.
- **Claim document:** MSN for Original Medicare or EOB for a private insurer or Medicare Advantage plan.
- **Review notes:** billing office name, plan representative, reference number, correction request, appeal, or financial-assistance application.

Short script

“I am not refusing to pay. I am trying to match this bill to the processed claim before payment. Can you explain why this amount is patient responsibility and whether the account can be reviewed or placed on hold?”

Source note: Built from Medicare.gov Medicare Summary Notice materials, Medicare.gov appeals materials, Medicare.gov cost materials, HealthCare.gov glossary definitions, and the official source map.

PAPER TRAIL

What documents should I keep?

A plain-English page for families trying to ask the right next question.

DIRECT ANSWER

Keep the documents that prove what was ordered, what was decided, what was denied or approved, what deadline applies, and who said what. A simple folder can prevent weeks of confusion later.

Why this matters

Families often lose the paper trail because the discharge felt urgent. Later, a bill arrives, home health never starts, a facility says authorization ended, or a plan says a deadline passed. The person who has the documents and call notes is in a much better position to ask for review, correction, appeal, or explanation.

What to ask

- **Before leaving:** “Can we have copies of the discharge summary, orders, medication list, and follow-up plan?”
- **For coverage:** “Can we have the authorization, denial, noncoverage, or coverage-ending notice?”
- **For bills:** “Can we have the itemized bill, MSN, EOB, and account notes?”
- **For calls:** “Can you give me a reference number or document ID for this conversation?”

What to keep

- **Discharge:** discharge packet, medication list, orders, follow-up appointments, and safety instructions.
- **Coverage:** status notice, authorization, denial, appeal notice, noncoverage notice, and plan letters.
- **Care:** facility acceptance, home health agency information, equipment supplier details, and therapy/nursing notes if available.
- **Bills:** itemized bills, MSN, EOB, payment plans, financial-assistance applications, and correction requests.
- **Call log:** date, time, name, department, phone number, reference number, and next step.

Short script

“I am keeping a folder so we do not miss anything. Can you tell me which document explains this decision, whether there is a deadline, and who we should call if the document does not match what we were told?”

Source note: Built from Medicare.gov appeals and Medicare Summary Notice materials, CMS beneficiary notice resources, Medicaid.gov eligibility and LTSS resources, SHIP resources, and the official source map.

CALLS AND SCRIPTS

Who should I call, and what should I say?

A plain-English page for families trying to ask the right next question.

DIRECT ANSWER

When you are overwhelmed, use one short question at a time. Ask for the rule, the document, the deadline, and the next person responsible. Write down the answer before moving to the next call.

Why this matters

Families often call the wrong place with a broad question and get bounced around. A better call starts with the exact problem: hospital status, rehab transfer, home health start date, equipment delivery, plan authorization, Medicaid application, or a bill that does not match the processed claim.

What to ask

- **Hospital/case management:** "What is the discharge plan, what is ordered, and what is still pending?"
- **Facility or agency:** "Have you accepted the patient, and what services are actually scheduled?"
- **Billing office:** "Can this bill be reviewed against the processed claim and financial-assistance options?"
- **Plan or Medicare question:** "What decision was made, what document explains it, and what is the appeal deadline?"
- **Supplier/pharmacy:** "When will the item or medication be ready, and what happens if it is delayed?"
- **SHIP/state agency:** "Can you help me understand the Medicare or Medicaid question before we make a decision?"

What to keep

- **Call log:** who you called, who answered, department, date, time, reference number, and exact next step.
- **Deadlines:** appeal deadline, discharge review deadline, authorization deadline, payment due date, and document request date.
- **Proof:** notices, emails, portal screenshots, fax confirmations, mailings, and uploaded documents.

Short script

"I need help with one specific question: [status / rehab / home health / equipment / authorization / Medicaid / bill]. What rule applies, what document explains the answer, what deadline matters, and who is responsible for the next step?"

Source note: Built from Medicare.gov appeals materials, CMS beneficiary notice resources, SHIP locator resources, Medicaid.gov resources, Medicare.gov MSN materials, and the official source map.

OPTIONAL TRUST LAYER

Endnotes and Source Map

Official sources used to keep the short guide grounded without turning it into a textbook.

1. Medicare.gov — Skilled nursing facility care: <https://www.medicare.gov/coverage/skilled-nursing-facility-care>
2. Medicare.gov — Inpatient or outpatient hospital status: <https://www.medicare.gov/basics/your-medicare-rights/your-protections/your-rights-in-the-hospital>
3. CMS — Medicare Outpatient Observation Notice: <https://www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative/moon>
4. Medicare.gov — Home health services: <https://www.medicare.gov/coverage/home-health-services>
5. Medicare.gov — Durable medical equipment: <https://www.medicare.gov/coverage/durable-medical-equipment-dme-coverage>
6. Medicare.gov — Long-term care: <https://www.medicare.gov/coverage/long-term-care>
7. Medicare.gov — Medicare Advantage Plans: <https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options>
8. Medicare.gov — Original Medicare: <https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/your-coverage-options/compare-original-medicare-medicare-advantage>
9. Medicare.gov — Medigap: <https://www.medicare.gov/health-drug-plans/medigap/basics/how-medigap-works>
10. Medicare.gov — Appeals: <https://www.medicare.gov/claims-appeals/how-do-i-file-an-appeal>
11. Medicare.gov — Medicare Summary Notices: <https://www.medicare.gov/basics/forms-publications-mailings/mailings/claims-and-appeals/medicare-summary-notice>
12. Medicare.gov — Medicare costs: <https://www.medicare.gov/basics/costs/medicare-costs>
13. Medicaid.gov — Eligibility: <https://www.medicaid.gov/medicaid/eligibility/index.html>
14. Medicaid.gov — Long-term services and supports: <https://www.medicaid.gov/medicaid/long-term-services-supports/index.html>
15. Medicaid.gov — Estate recovery: <https://www.medicaid.gov/medicaid/eligibility/estate-recovery/index.html>
16. Medicaid.gov — Spousal impoverishment: <https://www.medicaid.gov/medicaid/eligibility/spousal-impoverishment/index.html>
17. CMS — Coordination between Medicare and Medicaid: <https://www.cms.gov/medicare/coordination-benefits-recovery/medicare-medicoid-coordination>
18. Medicare.gov — Medicare Savings Programs: <https://www.medicare.gov/basics/costs/help/medicare-savings-programs>
19. Medicare.gov — SHIP help: <https://www.shiphelp.org/>
20. HealthCare.gov — Health insurance glossary: <https://www.healthcare.gov/glossary/>