HUTCHINSON
REGIONAL MEDICAL CENTER

August 16, 2023

Jodi Fowler-Legal Guardian for Sharon Fowler
334 East 8th Avenue
Hutchinson, KS 67501

RE: Sharon Fowler
RL: 14467

Dear Ms. Fowler,

As you may recall, you notified our organization on August 4, 2023 with the following concerns:

- You were unhappy with the quality of care your mother Sharon received while she was being treated at our facility from July 29, 2023 to August 3, 2023.
- You were also dissatisfied with the lack of communication you received regarding the discharge plans for your mother.

We responded to your concerns in a letter dated August 9, 2023 informing you we would review your concerns. The purpose of this letter is to inform you of the final outcome of our review into your concerns and actions that have been taken.

We are very sorry you were not completely satisfied with the care and discharge plan for your mother. We have spoken to each of the supervisors of the departments involved. We insure your that further education and the skill of thorough communication will be carried out to the staff involved.

Our ultimate goal is to provide the best quality of care to your family member and our community

This issue was completely resolved on August 16, 2023.

Should you have any further questions regarding this matter please feel free to contact me at 620-513-3866. Again, thank you for bringing this matter to our attention.

Sincerely,

Misty Harner
Patient Relations Manager
Hutchinson Regional Medical Center

August 22, 2023

HRMC
Attn: Misty Harner
Patient Relations Manager
1701 E. 23rd Ave
Hutchinson, KS 67502

Re: RL: 14467

Misty,

As you are aware, I contacted you on 8/4/2023 to voice concerns regarding the quality of care (including hygiene), violation of patient and caregiver rights, no notification of my mother's discharge as her guardian, the dignity of which she was discharged and lack of information provided to Diversicare before she arrived. She was admitted to HRMC on 7/29/23 and discharged 8/4/23.

I received your response indicating the actions taken were that the supervisors of each department were spoken to. Due to the passing of my mother on 8/9/23 (the date of your letter), I was unable to respond to your letter until 8/17/23. Per our phone conversation on 8/17/23, I'm writing this letter laying out in detail my concerns. I do not feel simply speaking to the supervisors is a satisfactory outcome.

I think it's important to remind you and others that should respond to these concerns, my mother was deemed incompetent to make her own decisions. A copy of this evaluation and DPOA paperwork was given to the hospital on 11/25/2022. I called the ER Dept on the evening of 7/29/23 as I was unable to be at the hospital but offered to email a copy of the court order appointing me as my mother's legal guardian. I was informed the DPOA was sufficient. I also informed the Hospitalist Alisha Storer of this information when she asked about advanced directives on 7/30/23.

- Per the CARE (Caregiver, Advise, Record and Enable) Act of 2018, caregivers are to be notified of a patient's discharge or transfer to another facility. This was passed into law in Kansas on 7/1/2018 by Governor Brownback.

I was not informed of my mother's discharge.

- Per KAR 28-51-111 Patient's Bill of Rights, patients and clients have the right to:
    - (a)(1) choose health care professionals and the right to communicate with those health care professionals.

Because I was not notified of my mother's discharge or change in the level of care, I was also not given the right to choose a different provider for a Skilled Nursing Unit. The Care Team Social Worker *assumed* I would choose Diversicare where she was a resident (not a patient).

- You found a note she was showered on 7/30/23 and not bed bathed again until the day of her discharge on 8/3/23. I would refer back to KAR 28-51-111(a)(12). This was neglectful of her hygiene and dignity.

In review of her medical records, it was not charted her behaviors and episodes of panic and anxiety. Diversicare was not aware of her screaming out, trying to get out of bed, sweating, pulling out her IV or other behavioral concerns. This is imperative information the Skilled Nursing Unit should have been made aware of in advance. This information would have guided Diversicare in choosing a room closer to the nurse's station.

It was also noted "no family by bedside" and not having patient history. However, a simple phone call does not require a lot of effort and would have been beneficial to her care. The only call I received from a Hospitalist was the day after her admission. Not once did a Hospitalist call me to acquire medical history.

I am a very strong advocate of patient and client's rights. This is about more than just my mother's care. My mother was lucky enough to have a daughter who is skilled and knowledgeable about what her and her caregiver's rights are. If this happened to my mother, how many other times has this occurred to others and how will you ensure it does not happen again.

HRMC claims ICARE as a core value (Integrity, Compassion, Accountability, Respect and Excellence). I would not agree these values were met. I respectfully request responses to these concerns be in written communication.

Respectfully,

Jodi Fowler, LBSW
334 E. 8th Ave
Hutchinson, KS 67501
620.931.5728

Cc:
Jason Probst
State Representative 102nd District
PO Box 3262
Hutchinson, KS 67504

Medicare
Medicare Contact Center Operations
PO Box 1270
Lawrence, KS 66044

AARP
6220 SW 29th St Suite 300,
Topeka, KS 66614

Office of Quality and Patient Safety
The Joint Commission
One Renaissance Boulevard
Oakbrook Terrace, Illinois 60181

Enclosures: Informational references

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- (a)(5): continuity of care.

Diversicare was not provided information regarding my mother requiring one-on-one care multiple times during her stay or information regarding her high anxiety and panic episodes requiring a prescription medication, Ativan. This information would have prepared Diversicare for services needed upon her arrival.

- (a)(6) to be advised in advance of any change in the plan of care before the change is made.

As I was not advised my mother was being discharged, I was also not informed her level of care was changing. She entered HRMC as a resident of Diversicare; she was discharged as a patient of a Skilled Nursing Unit.

- (a)(12) be free from verbal, physical and psychological abuse and to be treated with dignity.

My mother entered HRMC fully clothed. She was discharged in a hospital gown with only a bra, no panties and exited with a male driver. Her clothing and shoes were in a bag. She deserved to be clothed and appropriately dressed when discharged to preserve her dignity. She was also not bathed for several days; this is physical neglect.

- (b)(1) to request information about the diagnosis, prognosis and treatment, including alternatives to treatment and risks involved, in terms that the patient and the patient's family can readily understand in order to give informed consent.

Again, I was not notified of my mother's discharge to have this discussion. I was only contacted to give verbal permission for a CT and Angiogram the day before her discharge.

- Medicare requires the hospital to deliver the "Immediate Message from Medicare" (IM) within two days of admission and no more than 48 hours prior to discharge.
  - Per my conversation with you on 8/9/23, she was given this notice in the Emergency Room. As previously stated, my mother was found to be incompetent and should not have been expected to understand her rights. HRMC should have asked me to come to HRMC to sign it sometime in the following two days.
  - The IM was NOT provided within 48 hours prior to discharge. I should have been contacted for this to review and sign.
  - The IM provides important informatoin on what to do if the patient (or guardian in this case) wishes to appeal a patient's discharge. Again, because I was not notified of her discharge, my right to request an appeal was violated. Given her condition when she arrived at Diversicare, I would have appealed the discharge decision.
  - Because the right to request an appeal was not provided, none of the following requirements of an appeal process were met that could have resulted in a different discharge plan.
  - My mother was discharged with a referral for Skilled Nursing but was placed on hospice care within five to six hours and passed six days later. I believe the appeal would have resulted in a different discharge plan.
- When my mother arrived at Diversicare, her appearance was disheveled to say the least. Her hair was matted and appeared to have not been brushed or bathed during her time in HRMC.

- You found a note she was showered on 7/30/23 and not bed bathed again until the day of her discharge on 8/3/23. I would refer back to KAR 28-51-111(a)(12). This was neglectful of her hygiene and dignity.

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Kan. Admin. Regs. § 28-51-111

Section 28-51-111 - Patients' and clients' bill of rights

(a) Each governing body shall establish a bill of rights that shall be equally applicable to all patients and clients. The following provisions shall be included in the patients' and clients' bill of rights:

(1) The right to choose health care professionals and the right to communicate with those health care professionals;

(2) the right to participate in the planning of the patient's or client's plan of care and the right to appropriate instruction and education regarding the plan of care;

(3) the right to home health services, HCBS, and supportive care services that are provided without discrimination as to race, color, creed, sex, or national origin;

(4) the right to receive home health services, HCBS, or supportive care services only if the licensee has the ability to provide safe, professional care at the level of intensity needed;

(5) the right to reasonable continuity of care;

(6) the right to be advised in advance of any change in the plan of care before the change is made;

(7) the right to confidentiality of all clinical records and client records, communications, and personal information;

(8) the right to review all health records pertaining to the patient or client unless medically contraindicated in the clinical record or client record by the physician, nurse practitioner, clinical nurse specialist, or physician assistant;

(9) the right to be referred to another home health agency if the patient or client is denied home health services, HCBS, or supportive care services for any reason;

(10) the right to voice grievances and suggest changes in home health services, HCBS, and supportive care services or the staff providing the home health services, HCBS, and supportive care services, without fear of reprisal or discrimination;

(11) the right to be fully informed of home health agency policies and charges for home health services, HCBS, and supportive care services, including eligibility for, and the extent of payment from third-party reimbursement sources, before receiving care. Each patient and client shall be informed of the extent to which payment could be required from the patient or client;

(12) the right to be free from verbal, physical, and psychological abuse and to be treated with dignity;

(13) the right to have the patient's or client's property treated with respect;

(14) the right to be advised in writing of the availability of the department's toll-free complaint telephone number; and

(15) the right to be free from the use of restraints in the home setting.

(b) Each governing body shall establish a bill of rights that shall be applicable to all patients, in addition to the rights specified in subsection (a). The following provisions shall be included in the patients' bill of rights:

(1) The right to request information about the diagnosis, prognosis, and treatment, including alternatives to treatment and risks involved, in terms that the patient and the patient's family can readily understand in order to give informed consent;

(2) the right to refuse home health services or HCBS and the right to be informed of the possible health consequences of any refusal; and

(3) the right to be advised in advance of the home health services or HCBS that will be provided and the frequency of visits proposed to be provided.

Kan. Admin. Regs. § 28-51-111

Authorized by K.S.A. 65-5109; implementing K.S.A. 65-5104; effective, T-86-23, July 1, 1985; effective May 1, 1986; amended Feb. 28, 1994; amended by Kansas Register Volume 41, No. 18; effective 5/20/2022.

Governor Signs the CARE Act Providing Support for Kansas Caregivers

By Mary Tritsch , April 28, 2017 05:41 PM

Great news for our state's more than 345,000 caregivers and the people for whom they provide care. The Kansas Legislature has passed and Governor Brownback has signed the Kansas Lay Caregivers Act, otherwise known as the Caregiver, Advise, Record and Enable or CARE Act. The new law, which goes into effect on July 1, 2018, will support caregivers when the person they are caring for is hospitalized and then returns home and is in need of care.

AARP volunteers and staff have worked tirelessly to get the legislation passed so that when patients are admitted to a Kansas hospital, they have a right to designate a caregiver. The designated caregiver is then informed before the patient is discharged or transferred to another facility and is given instructions on how to care for the patient at home.

"The CARE Act will help improve post-discharge health outcomes, reduce costly hospital

readmissions, and enable older Kansans to stay in their homes longer," said AARP Kansas Director Maren Turner. "And, it will support our state's caregivers by making sure they know what to do to help their loved one get well after a hospital stay."

Kansas caregivers have big responsibilities. In a December 2016 survey conducted by AARP, 66 percent of Kansas caregivers reported helping their loved ones with complicated medical tasks, wound care, infusion therapy and complex medication management. This is in addition to the everyday tasks they perform for their loved ones like assisting them with bathing and dressing, meals and transportation. Of those surveyed, 95 percent indicated their support for requiring hospitals to instruct caregivers prior to their loved one being discharged.

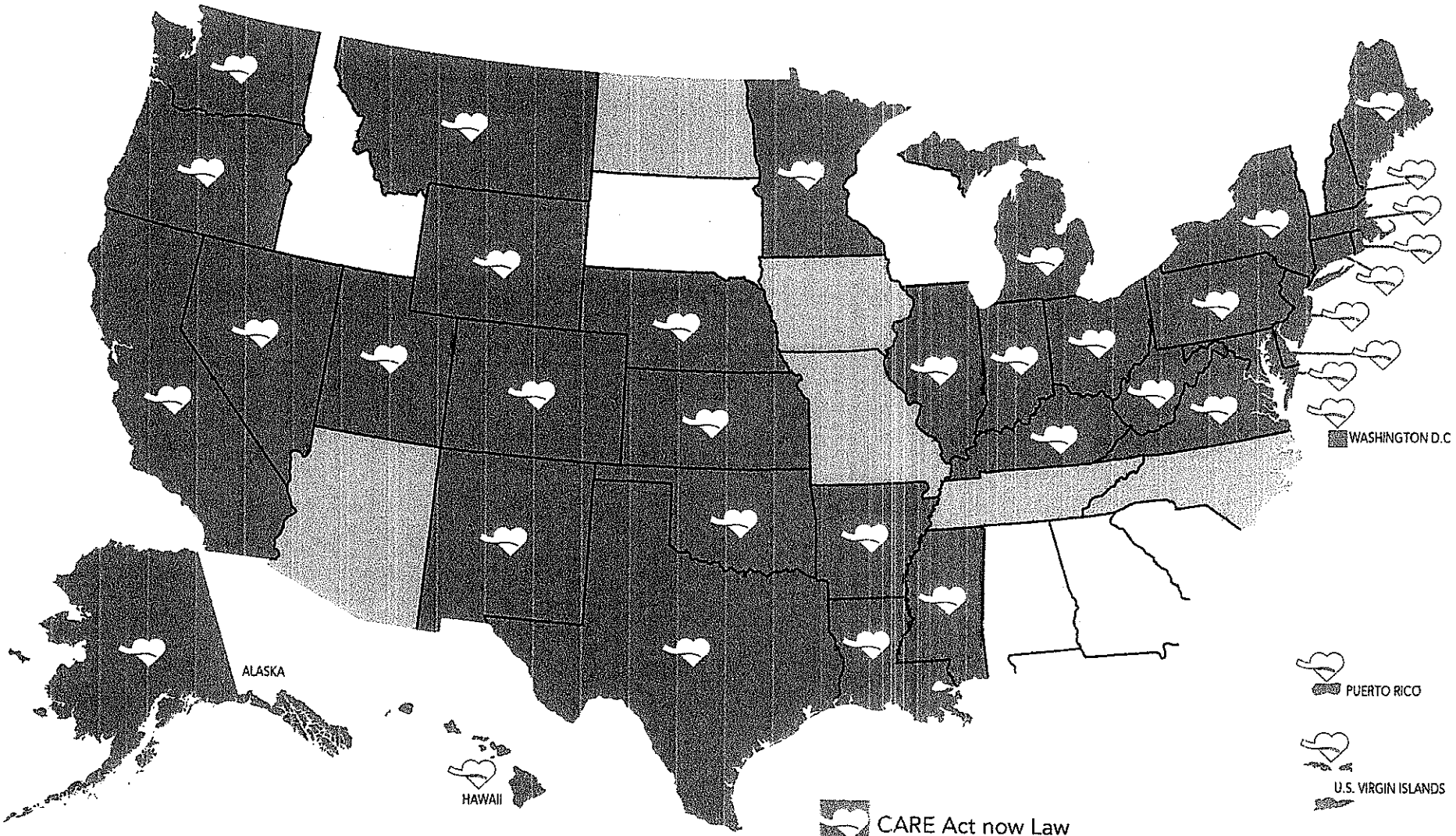
With passage of the CARE Act, Kansas becomes the 37 th state to support our state's caregivers who provide $3.8 billion dollars in unpaid care each year. As of this writing, 38 states have passed a version of the CARE Act.

Between now and the time the CARE Act goes into effect in 2018, AARP will be working to educate Kansans about the provisions of the new law. For more information, contact us at 866-448-3619 or ksaarp@aarp.org.

TOPICS caregiving caregivers CARE Act aarp kansas #iheartcaregivers

The Caregiver Advise, Record, Enable (CARE) Act

The CARE Act is a commonsense solution that supports family caregivers when their loved ones go into the hospital, and provides for instruction on the medical tasks they will need to perform when their loved one returns home.



CARE Act goes into effect:

Alaska, 1/1/17; Arkansas, 7/22/15; California, 1/1/16; Colorado, 5/8/15; Connecticut, 10/1/15; Delaware, 1/1/17; Hawaii, 7/1/17; Illinois, 1/27/2016; Indiana, 1/1/16; Kansas, 7/1/18;Kentucky, 6/29/17; Louisiana, 8/1/16; Maine, 10/15/15; Maryland, 10/1/16; Massachusetts, 11/8/17; Michigan, 7/12/16; Minnesota, 1/1/17; Mississippi, 7/1/15; Montana, 10/1/17; Nebraska, 3/30/16; Nevada, 10/1/15; New Hampshire, 1/1/16; New Jersey, 5/12/15; New Mexico, 6/17/15; New York, 4/23/16; Ohio, 3/21/2017; Oklahoma, 11/5/14; Oregon, 1/1/16; Pennsylvania, 4/20/17; Puerto Rico, 12/31/15; Rhode Island, 3/14/17; Texas, 5/26/17; Utah, 2/10/16; Virgin Islands, 3/30/16; Virginia, 7/1/15; Washington D.C., 7/6/16; Washington, 6/9/1 6; West Virginia, 6/8/15; Wyoming, 7/1/16

**Updated on 6/10/2017

I ♥ Caregivers AARP Real Possibilities

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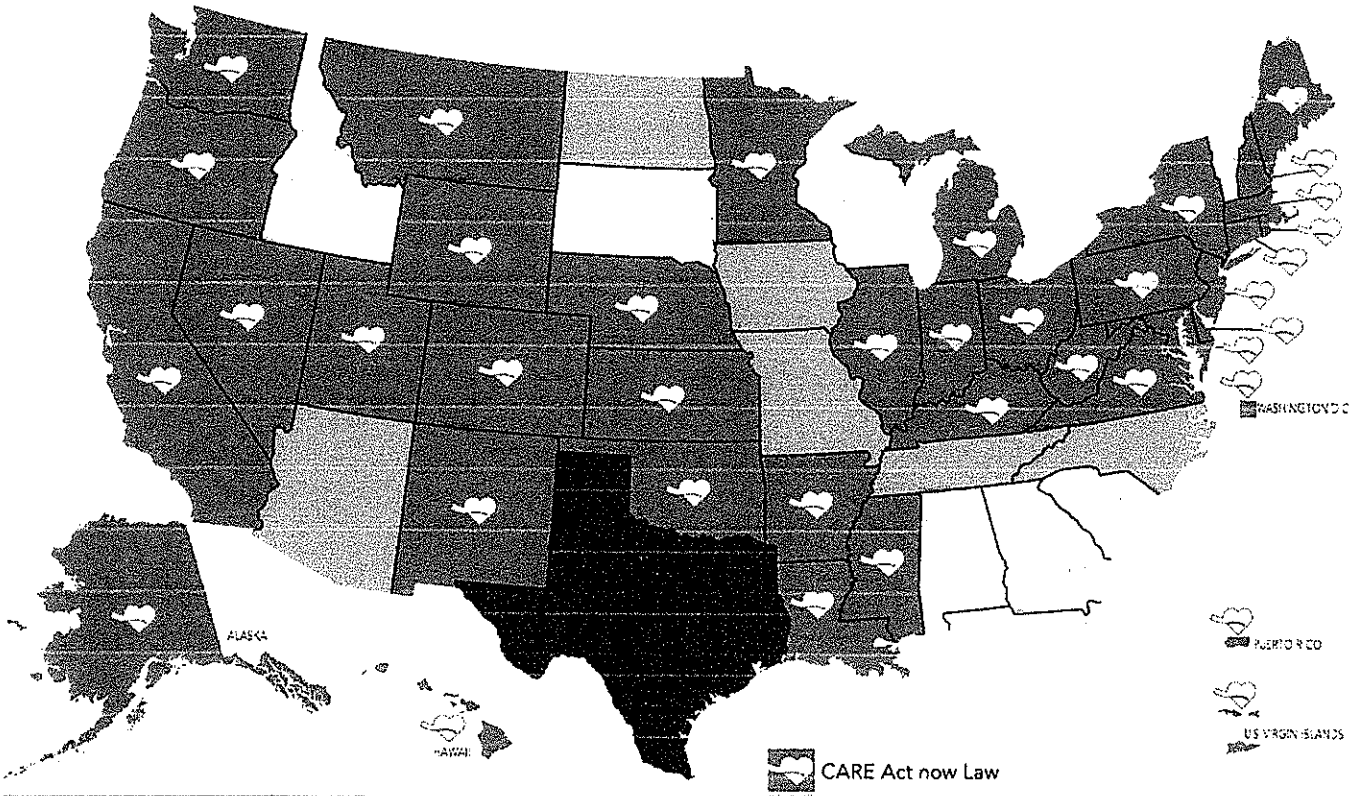

CARE Act goes into effect:
Oklahoma, 11/5/14; Colorado, 5/8/15; New Jersey, 5/12/15; West Virginia, 6/8/15; New Mexico, 6/17/15; Mississippi, 7/1/15; Virginia, 7/1/15; Arkansas, 7/22/15; Connecticut, 10/1/15; Nevada, 10/1/15; Maine, 10/15/15; Puerto Rico, 12/31/15; California, 1/1/16; Indiana, 1/1/16; New Hampshire, 1/1/16; Oregon, 1/1/16; Illinois, 1/27/2016; Utah, 2/10/16; Nebraska, 3/30/16; Virgin Islands, 3/30/16; New York, 4/23/16; Washington, 6/9/16; Wyoming, 7/1/16, Washington D.C., 7/6/16; Michigan, 7/12/16; Louisiana, Maryland, 10/1/16; Alaska, 1/1/17; Delaware, 1/1/17; Minnesota, 1/1/17; Rhode Island, 3/1[illegible] 3/20; Pennsylvania, 4/20/17; Kentucky, 6/29/17; Hawaii, 7/1/17; Montana, 10/1/17; Kansas, Massachusetts, TBD;

**Updated on 5/20/2017

I ❤ Caregivers AARP Real Possibilities

Written by [illegible]

About seven in ten older adults need [illegible] at some point. In many cases, it is a family member who provides that care to help them remain in their homes as long as possible and stay out of nursing homes and other institutions. The [illegible] is designed to assist family caregivers, by helping to ensure a smooth transition when the people they care for are moving between home and hospital.

Family caregivers provide a wide range of caregiving services, from simple

caregivers in the US perform these medical services for the people they love. More...
It is important for family caregivers to know when the people they love are leaving the hospital and what types of care they will need when they return home.

In states that have implemented the CARE Act, hospitals must include the names of family caregivers in patients' medical records. Hospitals also must alert family caregivers when their loved ones are about to [illegible]. And, hospitals must provide family caregivers with information on how to perform needed medical services after their loved ones return home from the hospital.

The CARE Act is law in 36 states, as well as the District of Columbia, Puerto Rico, and the US Virgin Islands. States that have passed the CARE Act are: Alaska, Arkansas, California, Colorado, Connecticut , Delaware, Hawaii, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, Ohio, Oklahoma, Oregon, Pennslyvania, Rhode Island, Texas, Utah, Virginia, Washington, West Virginia, Wyoming.

Here's more from Just Care:

- [illegible]
- [illegible]
- [illegible]
- [illegible]
- [illegible]

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JAMA Forum

Supporting Family Caregivers, One State at a Time: The CARE Act

Diana Mason, PhD, RN

Article Information

December 13, 2017

Question: With the US Congress apparently unable to advance federal policies, except for a tax reform bill, how do we move forward the policies needed for improving health and health care, while reducing costs?

Image description not available.

Image: Rawpixel Ltd/Thinkstock

Answer: One state at a time and with a committed constituency.

In May 2016, I wrote a *JAMA* Forum **blog post** about a 2012 survey of family caregivers conducted by Susan Reinhard, PhD, RN, director of the AARP Public Policy Institute, Carol Levine, MA, who directs the United Hospital Fund's Families and Health Care Project, and Sarah Samis, MPA, now chief of staff at

Caregivers Providing Complex Chronic Care, confirmed that almost half of family

caregivers provide complex medical-nursing tasks, such as changing wound dressings and administering multiple medications by various routes, often with little, if any, guidance. Consequently, they are uncertain, fearful of causing harm and are isolated in providing the care their loved ones need.

A champion of the 43.5 million US adult family caregivers, AARP outlined the elements for a policy that could ensure that hospitals are not discharging patients without preparing family caregivers. **The CARE (Caregiver Advise, Record, Enable) Act** requires hospitals to do 3 things: ask patients if they have a family caregiver, contact that person if the patient is to be discharged or transferred, and teach the family caregiver how to provide the care the patient will need after discharge.

Recognizing that passing such a federal policy could take years, AARP developed a strategy for moving this policy forward, one state at a time. In 2014, Oklahoma was the first state to pass the CARE Act. On a recent webinar for the Institute for Healthcare Improvement, AARP Vice President for State Advocacy and Strategy Integration Elaine Ryan reported that in less than 4 years, 39 states, territories, and the District of Columbia have enacted the CARE Act through legislation or regulation and it is under consideration in the remaining states. This state-by-state approach has meant that some variations have been enacted, but the 3 key elements are in every version.

To identify challenges and best practices in its implementation, AARP has been conducting a national scan of hospitals in states that have passed the CARE Act. (Disclosure: I am a consultant to AARP and have conducted some site visits.) In 2017, there were 18 visits in 7 states, including at community and teaching hos-

Visits include talking with those who have led CARE Act implementation and those engaged in providing care it requires. The scan will continue through 2019.

Culture Change

Invariably, hospital leaders and clinicians say they've "always done what the act requires," but in further probing, they acknowledge the act is formalizing procedures that had been sporadic, at best—such as changing the electronic record so it captures necessary information and gearing postdischarge teaching toward a family member's preferred ways of learning.

Most hospitals find that the act is contributing to a culture change in which family caregivers are recognized as partners for the patient's recovery and improved outcomes. This has been helped along by the movement for patient- and family-centered care, but other federal policies enacted under the Obama administration have focused attention on reducing hospital readmissions and improving patient and family satisfaction.

It will be impossible to sort out what can be attributed to the CARE Act versus these other forces, but the act has given hospitals impetus to rethink how they engage with patients and families. For example, most hospitals have formed or are forming patient and family advisory councils; in one instance, a council helped to shape a workable policy for open visiting hours about which the staff had been leery. Other hospitals are including family caregivers in daily team rounds and creating or enhancing existing processes for family caregivers to call for help after discharge. At least one hospital credited these changes with helping them to reduce readmissions significantly.

patient doesn't end at the discharge. In one health system that is also an ac-

countable care organization, the procedures the act requires have been extended to the outpatient practices of physicians affiliated with its hospitals, even though the law doesn't require this. Other hospitals expressed an interest in moving in this direction.

Political Lessons

This one-state-at-a-time approach to policy change isn't easy but may be more successful than a federal approach. As the largest consumer advocacy organization in the world, AARP has a powerful membership that is active through its state offices. Members know their state policy makers and can identify legislative and regulatory champions, many of whom have had personal experiences of family caregiving. This is not a partisan issue.

Carol Levine, an author of the *Home Alone* report and a leading advocate of family caregivers, often asks: "Why are we assuming that family members can provide complex care to their loved ones?" The question speaks to the need for conversations on family caregiving that can lead to a culture change, not just within hospitals but also within our health care system overall, our communities, and our nation.

***About the author*:** Diana J. Mason, PhD, RN, Senior Policy Service Professor and Co-Director of the Center for Health Policy and Media Engagement, George Washington University School of Nursing; and Professor Emerita at Hunter College, City University of New York. She is former president of the American Academy of Nursing. (Image: Ted Grudzinski/AMA)

See More

CHILD DEVELOPMENT | NURSING | PEDIATRICS

Kan. Admin. Regs. § 28-51-111

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- Make sure that one's discharge plan identifies necessary services, including how those services will be provided, and requesting assistance in putting services in place.

Hospital Discharge Planning Services

- Identifying, at an early stage of hospitalization, those patients who are likely to suffer adverse health consequences upon discharge in the absence of discharge planning services.
- Conducting, on a timely basis, a discharge planning evaluation for all patients identified by their physicians as needing discharge planning services as well as any patient requesting a discharge planning evaluation.
- Placing the discharge planning evaluation in the patient's medical record for use in planning post-hospital services.
- Discussing with the patient (and representatives) the elements of the discharge plan evaluation.
- Arranging, when requested by a patient's physician, for the development and the initial implementation of a discharge plan for the patient.
- Assuring that discharge planning evaluations and discharge plans are developed by, or under the supervision of, a registered professional nurse, social worker, or other appropriately qualified personnel. (42 U.S.C. §1395x(ee); 42 C.F.R. §482.43. Condition of participation: Discharge planning).
- When a Quality Improvement (QIO) or hospital makes a determination whether an inpatient hospital stay is medically necessary, it must make an individualized assessment of the patient's need for skilled nursing facility care. If the patient requires skilled nursing facility care, the QIO or hospital must determine whether there is a bed available to the patient in a participating skilled nursing facility in the community or local geographic area (42 C.F.R. §§424.13(b)(1), 412.42(c)(1)).

Discharge from the Hospital Setting

Effective July 1, 2007, Medicare participating hospitals must deliver valid, written notice, using the "Important Message from Medicare" (IM) (https://www.medicareadvocacy.org/medicare-info/discharge-planning/#important%20notice#important%20notice) (site visited May 15, 2015). This notice is to explain a patient's rights as a hospital patient including discharge appeal rights. It is to be given at or near admission, but no longer than 2 calendar days following the beneficiary's admission to the hospital. See 42 CFR 405.1205 (Traditional Medicare) and 42 CFR §422.620 (Medicare Advantage).

The "Important Message from Medicare", Form CMS-R-193, and the "Detailed Notice of Discharge", Form CMS-10066, updated as of July 20, 2010 are posted on the Centers for Medicare & Medicaid Services (CMS) website: http://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html (http://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html). (Site visited May 18, 2015.) The latest version of the "Important Message from Medicare" requires hospitals to note the time of delivery. Note, after April 1, 2011, the notice of discharge forms with approval dates of 05/07 will not be valid.

- A follow-up copy of the signed IM is given again (https://www.medicareadvocacy.org/medicare-info/discharge-planning/#detailed%20notice#detailed%20notice) (site visited May 18, 2015) as far as possible in advance of discharge, but no more than 2 calendar days prior to discharge. 42 CFR §405.1205(c)(1); 42 CFR §422.620(c)(1). Follow-up notice is not required if the provision of the admission IM falls within 2 calendar days of discharge. 42 CFR 405.1205(c)(2)(Traditional Medicare) and 42 CFR §422.620(c)(2) (Medicare Advantage). The exception to the two-notice requirement is an individual who is in the hospital for just 3 days. One IM can be given on day 2, and suffice as both the initial and discharge IM.

- As provided in 42 C.F.R. §412.42(c)(4), if the beneficiary remains in the hospital after the appropriate notification, and the hospital, the physician who concurred in the hospital determination on which the notice was based, or the Quality Improvement Organization (QIO) subsequently finds that the beneficiary requires an acute level of inpatient hospital care, the hospital may not charge the beneficiary for continued care until the hospital once

again determines that the beneficiary no longer requires inpatient care, secures concurrence, and notifies the beneficiary in accordance with 42 C.F.R. §412.42(c)(1)-(3). See also 42 C.F.R. §§422.620, 489.27 (Beneficiary Notice of Discharge Rights – Medicare Advantage (MA) plans).

- The phrase, "inpatient hospital care" … "includes cases where a beneficiary needs a SNF level of care, but, under Medicare criteria, a SNF- level bed is not available. This also means that a hospital may find that a patient awaiting SNF placement no longer requires inpatient hospital care because either a SNF-level bed has become available or the patient no longer requires SNF-level care." 42 C.F.R. §412.42(c)(1); 42 C.F.R. §622(c)(1).
- If a beneficiary files a request for an expedited determination by the QIO in accordance with paragraph §1206(b)(1), the beneficiary is not financially responsible for inpatient hospital services (other than applicable coinsurance and deductible) furnished before noon of the calendar day after the date the beneficiary (or his or her representative) receives notification (either orally or in writing) of the expedited determination by the QIO. 42 C.F.R. §405.1206(f)(2) and 42 C.F.R. §422.622(f)(2).
- For a hospital stay, a beneficiary must request expedited review, in writing or by telephone, no later than the day of discharge. 42 CFR §405.1206(b)(1); 42 CFR §422.622(b)(1).
- The beneficiary (or his or her authorized representative), when requested by the QIO, must be prepared to discuss the case with the QIO. 42 CFR §405.1206(b)(2); 42 CFR §422.622(b).
- On the date that the QIO receives the beneficiary's request, the QIO must notify the hospital that the beneficiary has filed a request for expedited review. 42 CFR §405.1206(e)(1)); 42 CFR §422.622(e)(1).
- The hospital must supply any information, including medical records, that the QIO requires to conduct its review and must make it available, by phone or in writing, by the close of business of the first full working day after the day the beneficiary receives notice of the planned discharge. 42 CFR §405.1206(e)(2); 42 CFR §422.622(e)(2).
- The burden of proof of the appropriateness of discharge, either on the basis of medical necessity or on Medicare coverage policies lies with the hospital having submitted information to the QIO that justifies discharge. 42 C.F.R. §405.1206(c), 42 C.F.R. §422.622(c).
- When the beneficiary requests an expedited determination in accordance with §405.1206(b)(1), the QIO must make a determination and notify the beneficiary, the hospital, and physician of its determination by close of business of the first working day after it receives all requested pertinent information. 42 CFR §405.1206(e)(5); 42 CFR§422.622(e)(5).
- If the QIO sustains the decision to terminate services or discharge the beneficiary, the beneficiary may request expedited reconsideration, orally or in writing, by noon of the calendar day following initial notification. The reconsideration will be conducted by the QIC, which must issue a decision within 72 hours of the request. If the QIC does not comply with the time frame, the beneficiary may escalate the case to the administrative law judge level. See 42 CFR 405.1204.
- Beneficiaries retain the right to utilize the standard appeals (42 U.S.C §1320c-3(a)(14); 42 C.F.R. 466.70 et seq.) process rather than the expedited process in all situations. A QIO may review an appeal from a beneficiary's request that is not timely filed, but the QIO does not have to adhere to the time frame for issuing a decision and the limitation on liability does not apply.
- It is the hospital and not the health plan that provides the notice for beneficiaries in hospitals that are part of a Medicare Advantage (MA) Organization. 42 C.F.R. §422.620(c).
- A person in a Medicare Advantage Organization hospital who misses the PRO appeal deadlines can use the Medicare Advantage expedited appeals process. 42 C.F.R. §422.584.

Discharge Decision Concerns

- **Four Hour Notice Requirement**

Notification of the beneficiary's discharge and appeal rights should not be hindered when the hospital cannot anticipate the date of discharge. According to CMS, if hospitals cannot anticipate the discharge date, the follow-up IM notice may be given on the day of discharge, at least four hours in advance of the actual discharge.

- **Problems With Four Hour/Same Day Notice**

Beyond requiring that the follow-up IM be given at a minimum of four hours in advance of discharge, CMS does not require the hospital to again obtain the patient's signature when this follow-up IM is given. The hospital may simply distribute a copy of the signed and dated IM that was given at admission. However, hospitals are not precluded from obtaining a new IM and verifying signature from the beneficiary. By allowing this practice, CMS has made it possible for hospitals to eliminate the need for a follow-up copy of the IM during inpatient stays of up to 5 days. This lack of timely notice may hinder the ability of Medicare patients to be fully aware of and exercise their appeal rights.

Appeal of Hospital Discharge

When a hospital (with physician concurrence) determines that inpatient care is no longer necessary, the Medicare beneficiary has the right to request an expedited QIO review. The CMS guidelines provide that the appeal for expedited review must be made before the beneficiary leaves the hospital.

- **Timely QIO Review**

In order for the review request to be considered "timely," beneficiaries must submit their requests in writing or by telephone no later than midnight of the day of discharge and before they leave the hospital. The beneficiary, therefore, should not be discharged upon requesting the QIO review, so long as the request is made on the same day.

The beneficiary or qualified representative should be contacted by the QIO to discuss the case with the QIO and provide any necessary information that may be required. The hospital is required to submit all pertinent information to the QIO. The patient or his or her representative also has the ability to obtain the same information from the hospital and/or QIO. In addition, the QIO should obtain medical records from the hospital, including speaking to the patient's physician(s). A timely request will trigger the QIO to render a decision within 1 calendar day after receiving all of the necessary information.

- **Detailed Notice of Discharge**

The Detailed Notice of Discharge must be delivered "as soon as possible" after the beneficiary has requested a QIO review, but no later than noon of the day after the QIO notifies the hospital of the beneficiary's request for the review. Under the CMS guidelines, hospitals are only required to deliver the Detailed Notice after the beneficiary has contacted the QIO for expedited review or when the beneficiary requests more detailed information from the medical care provider prior to requesting a QIO review. The Detailed Notice is not an official Medicare decision. It is designed to give the patient further explanation about why the hospital and/or physician believe that the medical services are no longer necessary.

- **Financial Liability**

Beneficiaries are not financially liable for hospital costs incurred during a timely QIO review; they are responsible only for coinsurance and deductibles. Further, the burden of proof lies with the hospital to demonstrate that the discharge is the correct decision based on either medical necessity or other Medicare coverage policies. If the QIO decision is in agreement with the hospital (unfavorable to the patient), the beneficiary becomes liable for the medical expenses beginning at noon on the day after notification of the decision is given.

Information on the Required Notices

What Information Must the Important Message from Medicare ("IM") Contain?

- The name(s) of the patient's physician(s) and the patient's ID number.
- A statement of the right to file an appeal or raise questions with a QIO about quality of care, including hospital

discharge.

- The name and telephone number of the QIO that serves the area in which the hospital in question is located.
- A space for the beneficiary or representative to sign and date the document.
- The steps necessary to appeal a hospital discharge decision or to file a complaint about the quality of care.

What Information Must the Detailed Notice Contain?

- The name(s) of the patient's physician(s) and the patient's ID number.
- The date the Notice was issued.
- The date the inpatient hospital services are to end.
- A statement that the Detailed Notice is not an official Medicare decision.
- Specific information about the patient's current medical condition.
- The hospital and/or Medicare plan telephone number for requesting copies of documents to be sent to the QIO.

When must the "IM" be Distributed?

The patient must receive the original IM within two days of admittance to the hospital. The hospital must obtain the signature of the beneficiary or of his or her representative and provide a copy to that person at that time. If the patient or representative refuses to sign the IM, then the hospital is required to make a note to that effect; for purposes of requesting an appeal, the date of the refusal to sign is considered the date of notification. A follow-up copy of the signed IM should again be given "as far in advance of the discharge as possible, but not more than 2 calendar days before discharge." If discharge occurs within 2 days of the date the IM was given, no follow-up copy is required.

A beneficiary may be considered discharged when Medicare decides it will no longer pay for the medical services or when the physician and hospital believe that medical services are no longer required. The Medicare Claims Manual provides that a patient may be considered to have been discharged when s/he is either physically required to leave the hospital (not merely transferred to another inpatient setting) or when s/he remains in the hospital but at a lower level of care.

Additional Background on the New IM

The notice, "An Important Message from Medicare about Your Rights" (IM), can be found on the CMS website at http://www.cms.gov/BNI/12_HospitalDischargeAppealNotices.asp (http://www.cms.hhs.gov/BNI/12_HospitalDischargeAppealNotices.asp#TopOfPage) (site visited May 15, 2015). The requirements for the new notice are discussed in Guidelines which were released by the Centers for Medicare & Medicaid Services (CMS) on May 25, 2007. In the Guidance, CMS explains when and how Medicare patients must be given information about their discharge and appeal rights. See, http://www.cms.gov/Transmittals/downloads/R1257CP.pdf (http://www.cms.hhs.gov/Transmittals/downloads/R1257CP.pdf) (site visited May 15, 2015).

Upon receipt of a hospital's discharge decision, beneficiaries may appeal the decision by requesting a timely review by the appropriate Quality Improvement Organization (QIO). When QIO review is requested, an additional notice called the Detailed Notice of Discharge (Detailed Notice) is to be given. CMS has issued a Question & Answer document elaborating on the use of IM and the Detailed Notice. See, http://www.cms.gov/BNI/12_HospitalDischargeAppealNotices.asp (http://www.cms.gov/BNI/12_HospitalDischargeAppealNotices.asp). (Site visited May 15, 2015.)

Weichardt v. Thompson, Civil Action No. C 03 5490 VRW (N.D. Cal.), filed December 5, 2003, was filed in federal district court in San Francisco on behalf of three Medicare beneficiaries who were forced to leave their hospitals before they were medically ready. Each plaintiff (or a family representative) objected to being discharged, but received no written notice of the appeal process for challenging the discharge decision. Neither was told that if they stayed on

in the hospital, they would be personally liable for the cost of care. The plaintiffs sought a requirement that Medicare beneficiaries are given timely written notice of the reasons for their discharge and of the procedures for appealing a discharge decision.

As a result of settlement discussions, proposed regulations were published on April 5, 2006, at 71 Fed. Reg. 17052. See, http://edocket.access.gpo.gov/2006/pdf/06-3280.pdf (http://edocket.access.gpo.gov/2006/pdf/06-3280.pdf) (site visited May 15, 2015). The proposed regulations required that a Generic Notice of Hospital Non-coverage be given to all Medicare hospital patients at least one day before a planned discharge. This generic notice would specify the date of discharge and explain the procedure for the patient to obtain an expedited review of the medical necessity for continued inpatient care. If the patient indicates that she wishes to appeal, the proposed regulations require that a detailed follow-up notice with specifics about the medical reasons for individual's discharge be given to her by noon of the next day.

Problems with Observations Services (patients in hospitals but not "admitted")

Medicare beneficiaries throughout the country are experiencing the phenomenon of being in a bed in a Medicare-participating hospital for multiple days, sometimes over 14 days, only to find out that their stay has been classified by the hospital as outpatient observation. In some instances, the beneficiaries' physicians order their admission, but the hospital retroactively reverses the decision. As a consequence of the classification of a hospital stay as outpatient observation (or of the reclassification of a hospital stay from inpatient care, covered by Medicare Part A, to outpatient care, covered by Medicare Part B), beneficiaries are charged for various services they received in the acute care hospital, including their prescription medications. They are also charged for their entire subsequent SNF stay, having never satisfied the statutory three-day inpatient hospital stay requirement, as the entire hospital stay is considered outpatient observation. The observation status issue has been challenged in ***Bagnall v. Sebelius*** (No. 3:11-cv-01703, D. Conn), filed on November 3, 2011. Litigation is ongoing. For updates, see https://www.medicareadvocacy.org/bagnall-v-sebelius-no-11-1703-d-conn-filed-november-3-2011/ (https://www.medicareadvocacy.org/bagnall-v-sebelius-no-11-1703-d-conn-filed-november-3-2011/) (site visited May 27, 2015).

The Medicare statute and regulations authorize payment for skilled nursing facility (SNF) care for a beneficiary who, among other requirements, was a hospital inpatient for at least three days before the admission to the SNF. In the past, the Center's primary focus was how time in observation status and in the emergency room was not counted by the Medicare program when that time was followed by a beneficiary's formal admission to the hospital as an inpatient. Litigation challenging CMS's method of calculating hospital time was unsuccessful. ***Estate of Landers v. Leavitt***, 545 F.3d 98 (2d Cir. 2008).

Neither the Medicare statute nor the Medicare regulations define observation services. The only definition appears in various CMS manuals, where observation services are defined as: a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital; and in most cases, according to the Manuals, a beneficiary may not remain in observation status for more than 24 or 48 hours. See Medicare Benefit Policy Manual, CMS Pub. 100-02, Chapter 6, §20.6; the same language is in Medicare Claims Processing Manual, CMS Pub. 100-04, Chapter 4, §290.1.

Even if a physician orders that a beneficiary be admitted to a hospital as an inpatient, since 2004 CMS has authorized hospital utilization review (UR) committees to change a patient's status from inpatient to outpatient. Such a retroactive change may be made, however, only if (1) the change is made while the patient is in the hospital; (2) the hospital has not submitted a claim to Medicare for the inpatient admission; (3) a physician concurs with the UR committee's decision; and (4) the physician's concurrence is documented in the patient's medical record. See Medicare Claims Processing Manual, CMS Pub. No. 100-04, Chapter 1, §50.3, originally issued as CMS, "Use of Condition Code 44, 'Inpatient Admission Changed to Outpatient.'" Transmittal 299, Change Request 3444 (Sep. 10, 2004).