



Elder Law: Red flags on the way to hospital

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A recent report by the U.S. Department of Health & Human Services Office of Inspector General highlights the significant issues involved for Medicare beneficiaries (patients) who may be subject to observation status and also hospitals and nursing homes.

Let's first start with a review of what observation status is. When a Medicare patient enters a hospital, usually through the emergency department, physicians often have to decide whether to admit them as inpatients or to "observe" them. This can often be a difficult initial decision, particularly when the physician is aware that the patient lives alone or with someone else unable or unwilling to care for them if there is to be a fairly quick discharge.

Observation status can involve feeding the patient, making assessments involving diagnostic tests and short-term treatments, including the use of drugs to determine whether the patient can be discharged or needs to be treated more intensively as an inpatient.

The Centers for Medicare & Medicaid Services, or CMS, policy is that these observation services should usually be needed for 24 hours or less and should rarely take longer than 48 hours. However, some individuals have been classified as observation status for as long as 13 days.

Since observation services are classified as "outpatient" services, a patient will normally have to pay out of pocket for co-payments (a fixed amount that one must pay each time one receives a medical service) or co-insurances (the percentage of the total Medicare allowable amount paid for a service that the patient is responsible for under her/his insurance policy). These are costs the patient might not be responsible for if he or she were admitted and classified as an inpatient.

In addition, and particularly notable in our elder law practice, is the requirement for a three-day inpatient stay for eligibility for Medicare's limited nursing facility coverage.

For 2013, Medicare will cover the first 20 days of skilled nursing care at no cost to the beneficiary; days 21 to 100 with a \$148 daily co-payment; and no coverage after the 100th day. At an average Pennsylvania daily nursing facility rate of \$276.40, one can see the importance of having met the three-day inpatient stay requirement for such coverage and not having been inappropriately classified as observation status.

The CMS study found that in 2012 there were 1.5 million observation stays, with these Medicare beneficiaries having spent one night or more in the hospital (78 percent beginning in an emergency department) along with 1.1 million short inpatient stays, often for the same reasons as observation stays.

Why are these classifications important?

Medicare usually won't pay a hospital for inpatients who should have been classified as observation status and thus many hospitals classified more patients as observation status. There is also the issue that if an observation status patient returns to the hospital within 30 days and is then admitted as an inpatient, the hospital doesn't get financially penalized for having a readmission of that patient because they weren't officially admitted in the first place. Catch-22, anyone?

In 2012, Medicare paid \$255 million for skilled nursing facility care for beneficiaries that should have not been covered because they did not meet the three-day inpatient stay requirement. Those represented only 4 percent of almost 618,000 individuals who were not eligible for subsequent nursing facility coverage because they were never classified as inpatients. Obviously, a lot of folks are affected by these determinations.

In the last few years, the Fed's program to revisit/audit paid Medicare claims has had a significant impact on hospitals' bottom lines. In fiscal 2012, what are called Recovery Audit Contractors (RACs in hospital parlance -- think medieval torture), collected almost \$2.3 billion in Medicare overpayments.

An American Hospital Association survey found that up to 80 percent of the denials in "complex" cases were for "medically unnecessary" care, with 65 percent of the total dollar value related to one- to two-day inpatient stays. Six out of 10 short-stay denials were because the care was provided as an inpatient rather than as an observation stay. It's again obvious that a physician, who is the only one who can admit the patient, is in a very difficult position as to how to classify a patient.

This August, CMS published final regulations, the intent of which was to reduce the frequency of extended observation care when it may not be appropriate.

However, if you have a Medicare beneficiary who spends a total of three days in the hospital environs, one of which is in observation status, he or she still would not generate sufficient inpatient days to qualify for Medicare payment for skilled nursing facility care. Great for the patient, eh?

The Center for Medicare Advocacy and the National Senior Citizens Law Center filed a federal lawsuit in 2011 on behalf of seven Medicare beneficiaries against Health & Human Services to end observation status. This past Thursday the judge dismissed the lawsuit. The plaintiffs are now considering their options.

How can this dilemma best be solved?

One reasonable way is by legislatively treating all of the time spent in the hospital (observation and inpatient) as part of the three-day rule. Remember the three-day rule was instituted when the average inpatient length of stay of a Medicare beneficiary was more than 13 days. Today, it's approximately 5.6 days, a 57 percent decrease while the three-day inpatient requirement hasn't changed.

Legislation was introduced in Congress in March that now has 98 co-sponsors and is in the subcommittee on health. Until this issue is resolved, this confusion will continue.

What to do if you feel you're caught in this twilight zone?

Ask the hospital, "Am I an observation patient or an inpatient?" Have your physician on your side.

If you are ultimately classified as observation status, appeal the decision from the Medicare Summary Notice you receive as to any Part B (outpatient) services. Have the skilled nursing facility, if you are discharged to such a facility absent having fulfilled the three-day inpatient stay requirement, do what is called "demand bill" Medicare Part A (inpatient) services for all of the dates at issue.

And, lobby your legislator to change the three-day requirement. Better yet, stay healthy.

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