Elder Law Guys: Why 'observation status' can be a tricky issue for Medicare recipients who end up in the ER

JULIAN GRAY AND FRANK PETRICH

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Generally, when a Medicare patient enters a hospital, it's often through the emergency department, with the patient in some degree of distress.

Then, a physician has to determine whether or not to discharge the patient from the emergency department, admit that individual as an inpatient or to put them in "observation status" without being formally admitted to the hospital.

It should be noted that with over 64 million Medicare enrollees and 36 million of them being in what one would call traditional Medicare i.e., not a Medicare Advantage program, that this can be a significant issue for some of the reasons below. Thus, it's also important to know what Medicare Plan you have.

It's not just semantics as to the patient's status as there can be serious financial implications for the patient who is considered under the observation status rubric.

Observation status can be fairly intense for the patient, both mentally and physically, involving having physical and mental assessments made, including diagnostic tests, short-term treatments, feedings, drug administration, etc. as bases to determine whether the patient can be

discharged, continue to be placed in observation status or needs to be treated more intensively as an inpatient.

This decision can often be initially difficult for the emergency department physician particularly when the physician may be aware of lack of care giving services for the patient who may have some degree of medical need for follow-up if there is to be a fairly quick discharge from the facility.

Observation services are classified as outpatient services, not covered by Medicare Part B. Thus, a patient will normally have to pay out of pocket for co-payments (a fixed amount 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 their insurance policy).

These are all costs that the patient might not have to pay if they were admitted and classified as an inpatient.

The other major adverse financial consequence for our Medicare clients is Medicare's requirement for a three-day inpatient stay for eligibility for nursing facility coverage, a requirement that has generally been waived until Oct. 13 because of COVID-19. A skilled nursing facility is where many discharged patients may go for a temporary stay. It's important to note that when the three-day requirement was instituted, the average inpatient length of stay of a Medicare beneficiary was more than 13 days. It's significantly less today even though the three-day requirement for skilled nursing coverage hasn't changed (but for the temporary waiver).

In 2015, Pennsylvania enacted the "Hospital Observation Status Consumer Notification Act" that requires a hospital, for patients receiving more than 23 consecutive hours of onsite hospital services including a hospital bed and meals in an area not in the emergency department and where that patient has not been formally admitted to the hospital, to provide notice to that patient, both in writing and orally of their observation (outpatient) status.

Also, in 2015, then-President Barack Obama signed into law the "Notice of Observation Treatment and Implication for Care Eligibility Act" ("Notice Act") which requires a hospital to tell a patient that they are in "Observation Status if they have been receiving services in a hospital for more than 24 hours. Then, if the patient is receiving such services after 36 hours, the patient must be informed orally and in writing (similar to the PA law) of her/his "Observation Status.'"

The written notice is to explain that the patient is not an inpatient, "the reasons for such status," and what this may mean both for cost-sharing of hospital charges and for "subsequent eligibility for coverage" in a skilled nursing facility. The patient or person acting on the patient's behalf, or, if they refuse, a staff member of the hospital, must sign the written notice.

Fast forward to March of this year.

A recent federal court decision, as part of a class action lawsuit brought against the Secretary of Health and Human Services, found that certain Medicare beneficiaries (those who were initially admitted as inpatient but then had their status switched to observation status) now have the right to appeal that decision to Medicare. A member of that class, under Medicare Part A (inpatient coverage), to appeal must:

— Have been hospitalized since January 1, 2009, and

— Have been a Medicare beneficiary with traditional Medicare (not Medicare Advantage), during that hospitalization, and

— Have been admitted as an inpatient and then had that status changed to observation status during the hospitalization, and

— Have received a Medicare Outpatient Observation Notice from the hospital or a Medicare Summary Notice, stating that the patient either will or did receive observations services not covered by Medicare Part A, and

— Have either Medicare Part A only (no Part B) or had both Medicare Part A and Part B and have been hospitalized for at least three consecutive days, but for fewer than three days as an inpatient and was or still could be admitted to a skilled nursing facility within 30 days of discharge from the hospital.

The federal government is in the process of implementing the court's decision. Many thanks to the Connecticut based Center for Medicare Advocacy (www.Center for Medicare Advocacy.org) for staying on top of this issue.

Julian Gray and Frank Petrich are certified elder law attorneys who practice in the Pittsburgh area at Gray Elder Law. Send questions to elderlawguys@grayelderlaw.com or visit grayelderlaw.com.

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