 BY MONICA J. FRANKLIN AND GABRIELLE BLAKE

Two Crucial Words for Your Medicare Vocabulary: 'Observation' vs. 'Admission'

In general terms, Medicare is health insurance subsidized by the federal government. It is a great program, with excellent benefits at a low cost. As a legal advocate and as a family member, it is helpful to build your Medicare vocabulary as the benefits and rules change

"Classification of a Medicare beneficiary's hospitalization as an 'admission' is crucial to her pocketbook and health."

within the program, sometimes profoundly affecting the way care is delivered. A hot issue for Medicare beneficiaries is whether a doctor charts a Medicare beneficiary's hospitalization status as "observation" or "admission." Those magic words make the difference as to whether your client will incur additional costs for the hospitalization and whether your client will receive the Medicare benefit to pay for skilled care in a rehabilitation facility.

Imagine this hypothetical: Mr. Smith suffers a fall in the bath. He is 86, has suffered multiple past falls and has dementia. The ambulance races Mr. Smith to the local hospital. The emergency room doctor says that a bone is broken in his arm, and he will be moved to a hospital room for a few days.

Three days after Mr. Smith's admission, the family representative meets with the hospital's discharge planner, "Debbie." Debbie's job is to find a placement for Mr. Smith that will safely meet his needs. Mr. Smith's family representative has already made a plan knowing that Mr. Smith will need rehabilitation after three days in the hospital, especially considering his dependence upon a walker, now compromised by his broken arm, and of course his worsening dementia. The family has already picked out their top three choices of facilities offering skilled rehabilitation.

The family is aware that Mr. Smith must be in the hospital for three midnights and have a doctor's order for further skilled care before he may gain Medicare approval for payment of his rehabilitation. Fortunately, Mr. Smith has *original* Medicare and a medi-gap or Medicare supplemental insurance policy. This rehabilitation, which may include therapy (physical, occupational, speech) or other skilled care, is crucial to Mr. Smith achieving his optimal level of functioning.

Unfortunately, Debbie, the discharge planner, advises that Mr. Smith is *not* eligible for Medicare payment of skilled care in a rehabilitation facility because he was never "admitted" to the hospital. Instead his chart is marked that he was in the hospital for "observation." Mr. Smith's representative argues that there must be some mistake. He has been on the hospital floor for three midnights. Debbie responds that "according to his chart, Mr. Smith was on the hospital floor for observation. It is different from being admitted, and therefore Medicare will not pay for therapy and further treatment at a skilled nursing facility." Mr. Smith must return home and is only eligible to receive home health services which are provided three times a week.

This scenario has become more common in recent years as Medicare has become more stringent with hospitals over admission criteria, especially for shorter lengths of stay. The American College of Emergency Physicians explains:

> With short inpatient hospital stays

(less than the average LOS [length of stay]) Medicare is concerned about overpayment and appropriateness of the admission. As a result, Medicare and a state's Quality Improvement Organization (QIO) monitor hospital discharge data and specifically target short hospital stays.

If a hospital is found to have a high frequency of short inpatient hospital stays Medicare will investigate and if inappropriate admissions are found the sanctions can be severe. As a result, hospital health information management (HIM) and utilization management (UM) staff closely monitor the medical necessity of inpatient hospital admissions and short inpatient hospital stays. Their efforts can put pressure on emergency department physicians to make sure that each inpatient admission from the [emergency departments] is medically necessary and will pass fiscal intermediary or Medicare Area Contractor (MAC) scrutiny.

In some cases the use of observation status might be an alternative to an immediate inpatient admission.[1]

Why does 'observation' or 'admission' make a difference to your client?

First, if the client's hospitalization is classified as "observation," the client will incur more out-of-pocket costs for the hospitalization than if he had been "admitted." This is true because an "admission" is covered under Medicare Part A, which covers inpatient admissions; however, "observation" status is covered under Part B, which treats the hospitalization as an outpatient service.

Second, Medicare will only pay for skilled nursing care after a person has been "admitted" to the hospital for three midnights. If faced with a decision to pay out of pocket for skilled care (to the tune of thousands of dollars) or to forego treatment, many choose the latter option placing them at a higher risk for re-hospitalization. They are still eligible for home health, but home health care does not provide the intensity and frequency of therapy seen in skilled nursing facilities.

Skilled care is offered on a separate hospital floor or inside a nursing home, which has the added benefit of providing day-to-day nursing care while undergoing therapy. If a client does not receive the intensive skilled care provided in a rehabilitation facility, then he is at a greater risk of needing a higher level of care, such as assisted living or even nursing home care. For example, if a client does not receive necessary skilled care, he will be more prone to falls. Falls are one of the highest risk factors for causing a client to need long-term nursing home care.

The Center for Medicare Advocacy warns that the level of care can change without notice or can be retroactively reversed:

> 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 [skilled nursing facility] stay, having never satisfied the statutory three-day hospital stay requirement.[2]

Protecting our clients from this unfair practice requires a change in the law.[3]

On Nov. 3, 2011, the Center for Medicare Advocacy, and co-counsel National Senior Citizens Law Center, filed a nationwide class action to challenge this illegal policy and practice. *Bagnall v. Sebelius* (No. 3:11-cv-01703, D. Conn) states that the use of observation status violates the Medicare Act, the Freedom of Information Act, the Administrative Procedure Act, and the Due Process Clause of the Fifth Amendment to the Constitution. As of April 2013, two motions were pending — a motion for class certification and motion to dismiss. Oral argument was scheduled for May 2013.[4]

The CMS, "Final FY 2014 Hospital Inpatient Prospective Payment System," was issued Aug. 2, 2013.[5] According to the expert analysis of Medicare Advocacy attorneys, these regulations do not provide a true "fix" to the issue of patients being classified as "observation" versus "admission" status. *However, a change in the law would provide the appropriate solution to protect our clients.*

Legislation on the Horizon

H.R.1179 and S. 569 — Improving Access to Medicare Coverage Act of 2013[6] was introduced in the House and Senate on March 14, 2013. The proposed legislation amends title XVIII (Medicare) of the Social Security Act to deem an individual receiving outpatient observation services in a hospital to be an inpatient with respect to satisfying the three-day inpatient hospital requirement in order to entitle the individual to Medicare coverage of any post-hospital extended care services in a skilled nursing facility.

As an advocate for Medicare beneficiaries, please contact your congressional representative and ask him or her to support this legislation. Urge your clients and their families to do the same. MedicareAdvocacy.org provides talking points when a person calls a representative or senator.[7]

Empower your client's family to advocate for an 'admission.'

1. Families should know the differences in "admission" and "observation" status. Medicare provides a helpful pamphlet detailing the differences.[8]
2. When the client visits the emergency room, advise the family to give the doctor the full clinical picture. It may help to have the primary care physician consult with the ER doctor and/or fax recent records. If family is unable to be with the client, they should phone the ER department and request to give information to the doctor or nurse.
3. If treatment goes beyond the ER, families should ask what level of care determination has been made. Ask this question daily to make sure the status has not changed. If the family

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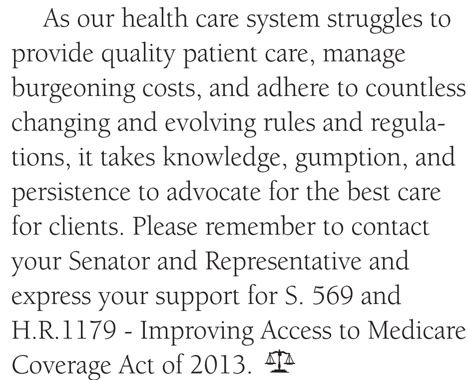
Senior Moments *continued from page 29*

does not agree with the level of care, advise them to try to have it changed by speaking with the doctor, utilization review nurse and case manager. Families should also ask the primary care doctor to consult with the hospital doctor.

4. Families should begin working with the discharge planner as early as possible. Many discharge planners do not work weekends, but one can still ask to leave a voicemail requesting a call as soon as she returns to the hospital. If ineligible for Medicare payment of skilled nursing care, make sure that the doctor has written an order for home health and the referral process is begun.

5. For more information on appeals, read the helpful Self Help Packet for Medicare "Observation Status" published by the Center for Medicare Advocacy Inc.[9]



As our health care system struggles to provide quality patient care, manage burgeoning costs, and adhere to countless changing and evolving rules and regulations, it takes knowledge, gumption, and persistence to advocate for the best care for clients. Please remember to contact your Senator and Representative and express your support for S. 569 and H.R.1179 - Improving Access to Medicare Coverage Act of 2013.

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Notes

1. http://www.acep.org/Clinical---Practice-Management/Utilization-Review-FAQ/.

2. http://www.medicareadvocacy.org/medicare-info/observation-status/#definition.

3. The information in this section is either quoted or paraphrased based on the information provided at www.medicareadocacy.org.

4. .http://www.medicareadvocacy.org/bagnall-v-sebelius-no-11-1703-d-conn-filed-november-3-2011. The decision is pending. Watch MedicareAdvocacy.org for updates.

5. To see the press release with links to fact sheets and other information, go to http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-Releases/2013-Press-Releases-Items/2013-08-02.html.

6. http://www.govtrack.us/congress/bills/113/hr1179/text.

7. http://org.salsalabs.com/o/777/p/dia/action/public/?action_KEY=8514/.

8. http://www.medicare.gov/Pubs/pdf/11435.pdf.

9. http://www.medicareadvocacy.org/self-help-packet-for-medicare-observation-status/.

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