Are You In or Are You Out?

Are you in or are you out?" is a question all Medicare beneficiaries and their families should be asking if they unfortunately find themselves in the Emergency Room. The answer could place a tremendous financial burden on beneficiaries and create a significant barrier to obtaining subsequent skilled or rehabilitative care a patient might require post discharge.

A new trend is appearing across the country as an unintended consequence, or in response to the government's attempt to curb health care costs, by penalizing hospitals with high readmission rates and denying Medicare payments to hospitals for inappropriate hospitalizations. Increasingly, hospitals are attempting to avoid these penalties or reimbursement denials by classifying some patients as being admitted under outpatient "Observation Status," instead of being admitted as an inpatient even if the patient stays overnight for several days.

The Centers for Medicare and Medicaid Services (CMS) defines observation classification for services as "short-term treatment, assessment and/or re-assessment furnished while a decision is being made regarding whether a patient will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Such observation services are not supposed to last more than 24 to 48 hours." CMS estimates an increase in observation status from three percent of all Medicare hospitalizations in 2006 to almost eight percent in 2010.

As a consequence of the classification of a hospital stay as outpatient "observation," Medicare Part A (Hospital Insurance) does not pay for the hospital stay; Medicare Part B (Medical Insurance) is billed. Instead of paying a one-time deductible for all administered hospital services under Part A, an outpatient would pay co-pays for each individual outpatient hospital service -- Including being charged co-pays for x-rays services, IVs, EKGs, lab work, and for the cost of prescription medications used while in the hospital.

And, should a patient require a skilled nursing facility (SNF) stay or rehabilitation facility after leaving the hospital, the patient will find that Medicare will not cover any of the SNF charges having never satisfied the Medicare prerequisite of a patient having at least three consecutive days of an inpatient admission (not counting the day of discharge). Without Medicare coverage, some patients will need to choose to return home verses several weeks at a sub-acute setting.

At an acute care hospital, the care a patient classified under observation receives is often indistinguishable from the care received by admitted inpatients. While patients usually stay in observation status for no longer than 48 hours, anecdotal evidence is showing that many older people are experiencing much longer stays because there are times when a patient does not meet criteria for inpatient care but still hasn't improved enough or stabilized to be discharged home. The Center for Medicare Advocacy has heard increasingly about beneficiaries whose entire stay in a hospital**,** including as long as 14 days, are classified by the hospital as "outpatient observation". And in some instances, the beneficiary's physician ordered their admission, but the hospital retroactively reverses the decision.

This was the case with Hillary C., who recently spent five days at the hospital after a fall. After 24 hours in the Emergency Department, this 81-year old woman was transferred to a hospital room. The doctors and nurses examined her daily and gave her medications and oxygen to help her breathe. When she was discharged in early June, the family was shocked to find Medicare would not pay for any follow–up sub-acute rehab care, because she did not have the pre-requisite three days of inpatient hospital care. She was never told that she was not actually admitted to the hospital and had remained on observation status her entire hospitalization. It was the sub-acute nursing facility that told the family their mother would need to pay privately there.

Because Hillary did not have the requisite three day inpatient hospital stay, the sub-acute rehabilitation facility sought payments of over $10,000 for services which would have typically been covered by Medicare had she been an inpatient during her five day hospitalization. When contacted for consultation and future care planning, a Geriatric Care Manager suggested that Hillary and her family appeal the observation status in the hospital with Medicare, as well as the denial of Medicare coverage for the subsequent sub-acute stay.

Recently, CMS has asked for public comments on potential policy changes related to observation status and rule changes to hospital outpatient prospective payment system regarding its impact on both hospitals and beneficiaries. In addition, federal legislation has been introduced, H.R. 1543 / S. 818, the Improving Access to Medicare Coverage Act of 2011, which seeks to count all time in the hospital towards meeting the prerequisite for a three-day admission in an acute hospital so that post discharge SNF and rehabilitative care would be covered by Medicare plans. And on the legal front, the Center for Medicare Advocacy and the Senior Citizens Law Center have filed a class action lawsuit, Bagnall v. Sebelius (No. 3:11-CV-01703, D. Conn) on behalf of seven Medicare beneficiaries who have been adversely affected by the observation designation.

Physicians, social workers, and geriatricians need to alert their Medicare clients about the issue to ensure that their patients know the status of their admission and can answer whether they are in or out and the reimbursement consequence. And, if necessary, contact a Geriatric Care Manager or other trained professional to answer questions, help in an appeal if necessary, and to advocate on behalf of the patient working with hospital staff to define discharge and follow up options based on insurance coverage, resources available, and the health and safety of the patient.