

Observation Stays Deny Medicare Beneficiaries Access to Critical Skill Nursing Care, Cost Thousands

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The Society for Post-Acute and Long-Term Care Medicine

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The Coalition of Geriatric Nursing Organizations

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Lutheran Services in America

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n4a

National Association of Area Agencies on Aging

NAELA

National Academy of Elder Law Attorneys, Inc.

NAHCA

National Association of Health Care Assistants

NASL

National Association for the Support of Long Term Care

NASOP

National Association for State Long-Term Care Ombudsman Programs

NCAL

National Center for Assisted Living

NCHC

National Coalition on Health Care

National Committee to Preserve Social Security & Medicare

The National Consumer Voice for Quality Long-Term Care

SHM

Society of Hospital Medicine

Special Needs Alliance

The Issue

Medicare requires beneficiaries to be hospitalized for medically-necessary inpatient hospital care for at least three consecutive days before covering post-hospital care in a skilled nursing care center. Yet, patients often remain under observation status in the hospital for several days. These days are considered outpatient, and therefore, do not count toward Medicare's three-day inpatient stay requirement.

The Effort

The Observation Stays Coalition, consisting of 28 national organizations, has launched an effort to collect stories that put a face on this critical issue that leaves millions at risk of getting stuck with high medical bills – or foregoing needed care – because of their observation status in the hospital.

The Coalition continues to support bipartisan legislation that would count observation stays towards the three-day stay requirement. Senators Sherrod Brown (D-OH), Susan Collins (R-ME), Bill Nelson (D-FL), and Shelley Moore Capito (R-WV) along with Representatives Joe Courtney (D-CT) and Joe Heck (R-NV) have introduced the Improving Access to Medicare Coverage Act of 2015 (S. 843/H.R. 1571) to count all hospital days spent in observation towards the three-day stay requirement.

The Stories

The following real patient stories highlight how Americans in need of skilled nursing care have been forced to pay out-of-pocket costs because of Medicare's current observation status policy.

CONNECTICUT

After a car accident left him with a neck fracture, Angelo Verdini, a 90-year-old North Haven resident, was shocked to receive a \$7,700 bill for the weeks he spent in a rehabilitation center. The Connecticut man was rushed to an emergency room after the accident where he was subjected to a battery of tests. He spent five days in the hospital room and felt like an admitted patient. Verdini told NBC 4 New York, "I couldn't tell the difference, and I don't know if anyone else who has experienced it could tell the difference." But there was a huge difference. He later discovered that he was "under observation" and not admitted. As a result, Medicare did not cover post-hospital care. After several appeals, Angelo Verdini fears he will have to fight Medicare until his death. Read more about Angelo Verdini's story on NBC 4 New York's website at www.nbcnewyork.com/investigations.

DISTRICT OF COLUMBIA

On November 22, Mary, a resident of the Lisner-Louise-Dickson-Hurt (LLDH) Home in Washington, D.C., was sent to the hospital after a fall that left her unable to walk. From the emergency room, Mary was transferred to the general medicine floor where she was unknowingly kept under observation status and not admitted as an inpatient. During that time, she learned her degenerative joint disease in her back and legs had become worse. The physical therapist at the hospital recommended Mary return to the skilled nursing center for intensive rehabilitation, but because Mary was not admitted as an inpatient to the hospital, the center could not access her Medicare Part A benefit. On November 25, after four days in the hospital under observation status, Mary returned to the skilled nursing center where she was required to apply for Medicaid in order to pay for her stay.

FLORIDA

An 80-year-old female patient was admitted to the Opis Highland Lake Center in Lakeland, Florida, from a local hospital on November 21 for rehabilitation services. After being admitted, the Center discovered that she was kept at the hospital at least three nights under observation and was never admitted as an inpatient. As a result, Medicare would not cover her \$4,500 bill for post-hospital treatment. In this instance, the family was able to privately cover the charges.

ILLINOIS

Susan was admitted to Burgess Square Healthcare and Rehab Centre in Westmont, Illinois, on January 26, 2016 following a hospitalization for illnesses, including cerebral infarction, vertigo, spinal stenosis and weakness. Prior to this hospitalization, the 75-year-old had several emergency room visits due to falls at home where she lived with her elderly husband. Unfortunately, this time was different. She was unable to return home directly from the hospital as a result of her injuries. After being admitted to the center for physical and occupational therapy so she could safely return home, she was shocked to learn that she missed having a three-day qualifying stay by several hours. Since Susan did not have her qualifying stay for Medicare Part A coverage, she and her husband were left with thousands of dollars in out-of-pocket medical expenses.

MINNESOTA

When Gladys fell at her Butterfield, Minnesota, home and suffered several compression fractures, she was rushed to the hospital. There she spent four days under observation status before being admitted to a skilled nursing center for treatment and rehabilitation. The intense pain Gladys was experiencing made it impossible for her frail husband – already on a very limited income – to manage her care at home. If she had met the three-day stay requirement, her post-acute care would have been covered by Medicare. Instead, the couple was stuck with a bill of \$10,551. “We could have observed her at home,” said a family member. The family thought she was receiving care and not just being observed.

NEW YORK

A man who lived alone was rushed to the hospital when he suddenly could not stand or walk. Instead of being admitted, the hospital kept him under observation. As a result of not being classified as an inpatient for at least three days, the man and his family were shocked to discover later Medicare would not pay for his needed rehabilitation at a skilled nursing center. Instead, he was forced to pay thousands of dollars for critical post-acute care. To learn more about this story, contact Toby Edelman at the Center for Medicare Advocacy at TEdelman@medicareadvocacy.org.

OHIO

Beachwood

A 66-year-old male patient was at Ahuja Hospital in Cleveland, Ohio, following a bicycle accident that left him with a broken hip. He spent hours in the emergency room and was later transferred to another unit of the hospital. His orthopedic surgeon determined that he would need to have rehabilitation for his hip. After two nights in the hospital under observation status, he was told he would be discharged. Not understanding the impact of the three-day stay requirement, his rehab stay at Montefiore of four weeks was not covered by Medicare. The patient was devastated to learn later that Medicare would not cover his over \$10,000 post-hospital bill. He was required to pay it on his own.

An elderly man was rushed to the hospital for severe injuries after falling in his home. The hospital kept him under observation for five days. As a result of not being classified as an inpatient for at least three days, Medicare denied him coverage for his needed post-hospital care. The man could not afford to pay for his rehabilitation on his own and opted to return home where he lived alone. Prior to his hospital stay, he was independent and only needed to use a cane. After he was discharged from the hospital, his health declined. He is now at high risk for returning to the hospital.

An elderly woman who was living independently in an assisted living community fractured her elbow and was sent to the hospital in Beachwood, Ohio. At the hospital, she experienced extreme pain and needed help with activities of daily living, including getting in and out of bed and using the bathroom. For three days, she was kept under observation and not classified as an inpatient. As a result, Medicare did not cover her needed post-rehabilitation treatment and 24-hour care at a skilled nursing center. She could not afford to pay on her own and returned home.

Coldwater

After spending seven days at the hospital, a female patient was referred to the Briarwood Village Community in Coldwater for rehabilitation. A few hours prior to the transfer, the case manager at Briarwood learned that the patient did not have the three-day stay requirement for Medicare to cover her post-hospital care. Although she had surgery at the hospital, she was kept under observation for her entire seven-day stay. The patient was immediately notified about the circumstances and the impact it had on her Medicare Part A benefits. She was distraught. She was not able to afford the over \$7,000 in out of pocket expenses, so she had no choice but to return home.

OHIO continued

Garfield Heights

A fractured ankle resulting from a fall sent a 94-year-old woman living alone to the hospital where she had surgery. The physical therapist recommended a skilled nursing stay for around-the-clock care and rehabilitation treatment instead of returning to her apartment alone. Her family agreed but was shocked to learn that she had been kept under observation the entire time and did not have the three-day stay requirement for Medicare to cover her post-acute costs. Unfortunately, the patient was unable to pay privately for her time in rehab and had no choice but to return home.

Piketon

Thomas was hospitalized with a fractured fibula and other chronic conditions prior to being admitted for skilled therapy services at Pleasant Hill Manor in Piketon, Ohio. For more than ten days, Thomas was kept under observation. When he later found out, he was stunned. As a result, Medicare would not cover his post-hospital expenses since he did not have the three-day stay requirement as an inpatient. He could not afford to pay more than \$21,000 in out-of-pocket expenses to cover his around-the-clock skilled nursing care and therapy.

OKLAHOMA

When Mrs. Scott's husband lost function of his arms as a result of spinal stenosis, he was rushed to the hospital in Tahlequah, Oklahoma. He spent five days in the hospital under observation before starting his long road to recovery with several weeks at a skilled nursing rehabilitation center. Mrs. Scott was shocked when she received her husband's medical bill for over \$23,000. He was charged for all of his rehabilitation treatment and care at the center because her husband did not have at least three days as an inpatient at the hospital. Mrs. Scott has spent many hours and days trying to resolve a bureaucratic injustice that she is still pursuing to this day.

PENNSYLVANIA

In December 2009, Winnie, a beloved grandmother, fell and was rushed to the hospital. After a brief stay in the emergency room, she was moved to a room where care and services continued for several days. Days into her stay, it was determined that she would need physical therapy prior to returning to her assisted living home. The family was shocked and confused to learn later that Winnie was never formally admitted to the hospital. Instead, her stay was classified as an observation stay. There were two options: pay out-of-pocket for therapy in the nursing center of her choice or send her to a rehabilitation hospital nearby, where she could be formally admitted and stay for three more days to meet the Medicare qualifying stay requirement. She went to the rehabilitation hospital to generate the qualifying stay. After her third day there, she moved to the nursing center of her choice with Medicare coverage kicking-in to complete her rehab.

OREGON

Diana went to the emergency room for urgent medical care at Meridian Park Hospital in Tualatin Oregon. After three days at the hospital under observation, she was discharged to a skilled nursing center for rehabilitation. She was stunned and confused when she received a bill for \$107,757 for her post-hospital rehabilitation at a skilled nursing center. Medicare had refused to cover her expenses since she was never admitted as an inpatient. She is appealing her classification status.