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## Current Hospital Issues in the Medicare Program

Diane Walter  
3205 5<sup>th</sup> Avenue C  
South Milwaukee, WI 53172  
414-571-6114  
[dianewalter@att.net](mailto:dianewalter@att.net)

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CMS  
Department of Health and Human Services  
Attn: CMS-1589-P  
P.O. Box 8013  
Baltimore, MD 21244-1850

I am writing to you today to enter a public comment in regard to observation status and our family experience with it. This newer practice is costing beneficiaries thousands of dollars because SNF care is not covered when a patient is discharged from a regular hospital bed to continued care and rehabilitation when in an "obs" status. It can be financially and emotionally devastating to a family.

My 81 year old father was admitted a total of three times under observation status in a local hospital in northern Wisconsin:

1. 3/16/2010 to 3/18/2010; diagnosis: severe weakness and dehydration and a fractured clavicle after a fall. My parents were not given the information he was being admitted under the observation status until discharge to a SNF for rehab and strengthening. During this stay, he received PT, OT, some intravenous fluids, tests and x-rays, just as a regular hospital admitted patient would receive. He was discharged to the SNF and my Mom paid \$3500 to get him in the door with additional charges for medications and therapy co pays. He received PT/OT at least twice a day, sometimes three times a day. He stayed there from 3/18 until 3/30 and was released to go home. Total costs: about \$4873.00 (OOP).
2. 12/15/2010 to 12/17/2010; diagnosis: severe weakness, low pulse oximetry and re-injury to his shoulder after another fall; also unable to walk. He did not meet the Milliman criteria for inpatient admission and observation status was used again. This time, my parents were informed of the status, but there was no way he could walk at that point so had to stay. Rehydration, (intravenous), PT and OT therapies, oxygen therapy, labs and tests were run. Dad was discharged to a SNF on 12/17/2010 where he received more PT/OT. (OOP costs about \$4800) On 1/5/11, my father developed a delusional psychotic episode and became verbally

and physically combative. He was transferred to a hospital by local police and then to the only facility that would take him; the state mental hospital three hours south of their home. He was taken into custody under the Chapter 51.50, and transported via police escort to the mental hospital. They did a medication wash and in two days, Dad emerged exhausted, but his normal self. (Of note: all medical personnel were told not to give Dad narcotics over the past five years as he had several of these episodes in his history due to vascular dementia and the interaction with medications. He was given narcotics and anti-psychotic medication at the SNF and the first hospital to deal with pain issues.) He received excellent care at the mental hospital and the stigma of a place like that is no longer with our family. The driving distance was the only difficulty.

It took 45 days to find a facility that would accept him from a mental hospital. The group home was very nice and comfortable. He was admitted there 2/8/2011. It was so much safer than to take him home. The cost was \$4000 a month plus medications.

3. 5/27/11- 6/10/2011; diagnosis: Spinal fractures after another fall, confusion. The fractures, severe pain, unable to walk and a little confusion were still not considered a reason for regular admission. Observation status was fully explained to my Mom this time. We had no choice. He was not in good shape and had so much pain. Dad received all the regular care; IV, CT scans, x-rays, lab work, etc. etc. A procedure called kyphoplasty was recommended and completed on about 6/4. When he woke up he was unable to swallow and changed to an inpatient status. Many, many tests were run to find out why he couldn't swallow. He developed a terrible thrush infection. They really could not give a definitive answer. We were given the choice of tube feeding via a nasogastric tube or a tube that goes through the abdominal wall directly to the stomach to feed him or palliative end of life care. I asked for other options such as TPN but they said those were more invasive and short term. The agonizing decision to choose palliative care was made and all treatments were discontinued on about 6/7/2011. Dad transferred back to the group home under hospice care about 5 P.M. 6/10/2011 and passed mid-afternoon on 6/11/2011.

We want to try and help others avoid all of this pain, frustration, expense, demoralization and terrible emotional stress if at all possible. That is why we want to tell Dad's story. I have worked in a major Milwaukee hospital ICU for 33 years and have seen the evolution of our healthcare system and our health insurance policies. I have a few thoughts and/or suggestions in regard to changes in the use of observation status:

Hospitals should not fear the RAC and the RAC employees all must be RN's or above.

Only MD's should be making the status decisions for a beneficiary, NO ONE ELSE.

Milliman admission criteria should be used as a guideline only. A doctor's assessment should be used for the final decision.

We all need to pause and think about the very vulnerable senior citizens, especially those without the financial resources to pay out of pocket for their care. Someday, we will be senior citizens.

Beneficiaries need to be fully informed about what their admission status is and have a mechanism in place to make appeals. (Current appeal processes do exist, but are lengthy to comply with: I have submitted all the Medicare requested reports as part of my current employment for patients being discharged from my unit.)

Mental and physical diagnoses need equal consideration.

Every hour as a patient in a hospital, no matter what the status, needs to count toward after hospital care. A patient should not be allowed in the observation status for more than twenty-four hours.

Dementia screenings and medication profiles need closer scrutiny for all patients, especially our senior citizens.

Thank you for this opportunity to express an opinion.

Diane Walter  
Daughter of a proud American man and U.S. Army veteran