



# Medicare Advocacy Project

Protecting your medicare rights.

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Committee on Ways and Means

## **Re: Current Hospital Issues in the Medicare Program**

The Medicare Advocacy Project (MAP) of Greater Boston Legal Services represents Massachusetts Medicare beneficiaries to insure that they receive the Medicare and Medicare-related health insurance coverage to which they are entitled. On behalf of our clients, most of whom have low incomes, we appreciate the opportunity to submit comments to your committee on current hospital issues in the Medicare program, specifically regarding the ongoing problem of observation status.

Many Massachusetts Medicare beneficiaries have sought our assistance due to the adverse impact they have experienced from having their time spent in hospitals classified as receiving observation, rather than inpatient, services. We are well aware of the increasing utilization of observation and of its adverse impact on Medicare beneficiaries. From the standpoint of our clients, attention to this problem has been long awaited and is long overdue. Classification as an outpatient precludes meeting the three day hospital admission prerequisite for Medicare skilled nursing facility coverage and costs many beneficiaries the full costs of skilled nursing facility care which can be thousands of dollars.

Unfortunately, because of the lack of due process rights afforded these hospitalized beneficiaries, who do not receive written notice about their categorization and have no appeal route for challenging this status, we have so far not been successful in obtaining for these beneficiaries the Medicare coverage to which they would otherwise be entitled. We have tried to appeal the Part B coverage awarded for their hospital services, saying the services should have been covered by Part A, but most of the contractors refuse to consider such an appeal.

Detailed below are examples of some of the Massachusetts Medicare beneficiaries the Medicare Advocacy Project is attempting to assist in challenging their hospitalization characterization as outpatient observation rather than as inpatient. Each of these beneficiaries was in a hospital room for at least three consecutive nights and received care that appeared to merit inpatient

hospitalization followed by inpatient skilled care.

Harold E, age 91, was admitted to Beth Israel Deaconess (BID) Medical Center on March 28, 2013, for open repair of recurrent left inguinal hernia. Prior to entering the hospital, he had been working part-time. Mr. E's medical history included prostate cancer, complicated by radiation proctitis. According to the hospital discharge summary, following surgery, he was admitted to the Acute Care service for pain management. A Foley catheter had been inserted during surgery, Mr. E had difficulty urinating after it was discontinued, and a Foley was reinserted after an unsuccessful trial of Lomax. On March 31, 2013, he experienced hematuria, most likely secondary to Foley placement. There was also concern about a possible blood clot obstruction. An April 1, 2013, Case Management Continued Stay review stated that per rounds that morning, it had been projected that he would likely be medically cleared to discharge on April 2 and no longer require acute care hospitalization and also stated, without any notification to Mr. E, that he was currently in observation level of care. However, April 1, 2013, Patient Notes report increasingly red urine and discharge plans were placed on hold. On April 2, 2013, Case Management Continued Stay review stated that Mr. E had been medically cleared that day to be discharged from the acute care setting. The Foley catheter was still in place at discharge. Throughout his hospitalization he received physical therapy services and he was discharged home on April 2, 2013, with a referral for Visiting Nurse Association skilled nursing and physical therapy services. Throughout the hospitalization, as well as on discharge, Mr. E had difficulty ambulating and was considered to be at risk for falling. His mental status was impaired and he underestimated or forgot his limitations. On April 4, 2013, Mr. E returned to BID Medical Center due to nausea and vomiting. His Foley catheter was still in place. His previous BID Medical Center hospital course was characterized in the record as complicated by urinary retention, with traumatic Foley placement resulting in hematuria with clots. Admission to medicine was recommended, fluid was administered through his veins and medication to treat his nausea was provided. An admission chest x-ray revealed fluid retention in the left lower lung. The fluid was drained through a tube on April 6, 2013, but re-accumulated and the possibility of pneumonia could not be ruled out. Blood was noted in the Foley on April 8, 2013; and Mr. E experienced difficulty voiding. In fact, the April 8, 2013, Progress Notes expresses a need for close monitoring to see if clots form or hematuria worsen and transfusion and/or a urology consult are needed. In total, Mr. E's diagnoses for this hospitalization included viral gastritis, pleural effusion, urinary retention and pneumonia, a hospital stay that was complicated by a loculated pleural effusion necessitating treatment with a chest tube and bloody urine. Mr. E was also seen by physical therapy during this hospitalization. On April 10, 2013, Foley catheter still in place, he was discharged from the hospital and admitted to a skilled nursing and rehabilitation facility where he remained until June 6, 2013, and received daily skilled care. However, because both his admissions were billed as observation, he was denied Medicare coverage for his \$266/day April 10 to June 6, 2013, nursing home stay, totaling \$17,556.

Ann G, age 83, who lives alone, fell inside her home and bumped her head on Friday morning, February 8, 2013, and was taken by ambulance to the BID Hospital/Milton Emergency Room (ER). She arrived at the ER at approximately 11:00 a.m. Hospital personnel ordered a CT scan, which came back clean, followed by a pelvic x-ray, which revealed fractures in two places. They then brought her to a room on the second floor and as far as she knew she had been admitted to the hospital. Not until just prior to her discharge did she learn that although she had been "admitted," the admission was for observation/outpatient, rather than inpatient, status. She was neither informed about nor aware of the distinction nor its ramifications. It is possible,

given that the assessment of Ms. G's admission status was done by a physician consulting from a remote site, (Executive Health Resources in Pennsylvania.) the fact that the CT scan was read first and came back showing no apparent head, neck or spine injury led the physician, on seeing only that image, to make his "outpatient/observation" determination, unaware that subsequent images revealed two pelvic fractures. While the record indicates that the pelvic fractures might have been old injuries, in fact Ms. G has never previously had a fractured pelvis, and any injuries showing on the x-ray were new injuries in need of immediate attention. Ms. G was not only told, however, that surgery for her fractured pelvis was not an option, but also that her pain medication options were Percocet, Ultram, and Tylenol, all in pill form. This was despite the fact that the orthopedic surgeon called in for consultation while Ms. G was in the ER, had ordered IV pain medication (Tramadol) to be administered, as needed. Ms. G would have accepted this medication if it had been offered and would have requested it had she had known it had been ordered. Although she did report being comfortable when lying perfectly still, straight, and flat; she consistently described her pain level as 8 or 9 on a scale of 1-10 with even the slightest movement of her lower body; and she never reported her pain level as 4, as the record incorrectly indicates. Ms. G's medical history includes asthma, a lobectomy and radiation due to lung cancer in 2007 with a resulting diagnosis of bronchiectasis, a paralyzed vocal cord which was treated surgically in May 2012 in a (failed) attempt to restore her ability to speak, a tracheostomy in 2012, and diabetes. Because of the fractured pelvis, physical and/or occupational therapists visited Ms. G at least twice during her hospitalization. The services they provided, which included monitoring, supervising and actively facilitating getting her out of bed safely, walking her a few steps, and then safely returning her to bed, are outside the realm of care provided under observation. In addition, Ms. G has diabetes which she treats with glipizide in pill form on a daily basis to control her blood sugar. While in the hospital, her diabetes control regimen was changed, however, to include multiple daily insulin injections. This was not a medical treatment she was trained to provide on her own at home and was also outside the realm of care provided under observation. Ms. G remained in the same hospital bed during her entire 5-day (Friday to Tuesday) stay. The first time a social worker mentioned her status being observation versus inpatient was on Monday afternoon, February 11, when orally informing her that "Because you're observation and not inpatient, Medicare will not cover the room and board charge" at the selected rehabilitation facility. In the context of and prior to the provision of her actual medical care she was never so informed. Neither did she ever receive anything in writing. After arriving at the BID Hospital/Milton ER on Friday, February 8, 2013, subsequent to falling at home, she clearly required more intervention than mere observation and was not ready to be transported to a rehabilitation facility until Tuesday, February 12th, the fifth day after she was brought to the ER. She remained at the rehabilitation facility until February 28, 2013, where she received daily skilled care. However, because her admission was billed as observation, she was denied Medicare coverage for her \$418/day February 12-28, 2013, nursing home stay, totaling \$7,106.

Sylvia G, age 87, who lives alone, entered North Shore Medical Center on 10/29/12 via the emergency room after falling at home due to dizziness that she reported to the examining physicians in the Emergency Department. An X-ray was taken and she was found to have a fracture of her Left shoulder as a result of this fall. The emergency department physician noted in his report that there was a need for further work-up and treatment in the hospital; that the reason for her dizziness should be evaluated. He also wrote that her condition was new, serious, that she should be admitted to the hospital, and he wrote in her record that "she is a full admission" and she remained hospitalized until 11/01/2012. During her stay she was given IV fluids, a Foley

catheter was inserted, and one of her medications, Amlodipine, was discontinued because it was thought that it lowered her blood pressure too much and may have contributed to her dizziness. Ms. G's diagnoses included hypertension, hypercholesterolemia, mild pulmonary hypertension, and a mitral valve leak. Her past medical history included torticollis of her neck for which she receives Botox injections every four months to prevent her neck from twisting to the right; a left ankle fracture in June 1992 with ORIF; two incidences of breast cancer in her left breast which resulted in a November, 2005, mastectomy; spinal arthritis and sciatica pain; a hysterectomy; and complaints to her primary care physician of feeling "off balance" during windy weather. During her hospitalization, she was unable to get in and out of bed or ambulate independently. She received PT and OT evaluations while in the hospital and notes in the record state that she was only able to walk a distance of 10 feet and would "continue to benefit from skilled PT services to determine the most appropriate assistive device and increase functional mobility and safety". The occupational therapist recommended short term rehabilitation to address maximal independence with self-care and mobility. In accordance with these recommendations, Ms. G went from the hospital to a skilled nursing and rehabilitation facility where she required and received daily skilled care and where she remained until December 12, 2012. However, because her hospitalization had been characterized as outpatient observation, rather than inpatient, her stay was not covered by Medicare and she was required to pay \$355/day, or \$10,650.

James B, age 87, who lives alone, slipped at home and entered Beverly Hospital on November 26, 2013, via the emergency room. He has one paralyzed arm and fell on and injured the other arm and shoulder. His past medical history includes hypertension, hyperlipidemia, gout, macular degeneration, prostate issue, heard of hearing and balance disorder. The medical records reflect that he was experiencing significant discomfort and although x-rays did not show any obvious dislocation, a fracture could not be excluded. He was admitted to the hospital with a diagnosis of an acute shoulder injury with possible fracture and intractable pain. He remained in the hospital for three days where he received IV morphine and was evaluated for physical therapy and was then discharged to a skilled nursing and rehabilitation facility where he remained until January 28, 2014, and received daily skilled therapy. The admitting physician wrote that he would be admitted to observation and is expected to stay less than two midnights in the hospital. He, in fact remained in the hospital more than two midnights, and was not discharged until November 29, 2013. However, because his admission had been classified as observation he was denied Medicare coverage for his \$365/day November 29, 2013 to January 28, 2014, nursing home stay, totaling \$21,900.

Richard S, age 78, arrived at the Newton Wellesley Hospital emergency room on May 6, 2013. He had fallen twice the previous night, was having visual hallucinations, was dizzy and, according to his spouse, was disoriented. He complained of diarrhea and urinary incontinence and was too unsteady to ambulate. His past medical history included coronary artery disease, hyperlipidemia and hypertension. He was "admitted" to the hospital where he remained until May 9, 2013. While there, a CT scan and IV therapy for hydration were performed and he was seen in consultation with neurology who was concerned about normal pressure hydrocephalus and recommended a large volume spinal tap to evaluate for gait disturbance. Because the spinal tap did not improve Mr. S's walking normal pressure hydrocephalus seemed less likely and that his symptoms were more related to Lewy body dementia with some Parkinsonism features. He was also evaluated for and received physical and occupational therapy services. The neurologist and therapists recommended transfer to a rehabilitation facility for further assessment and therapy services and on May 9, 2013, Mr. S transferred to a skilled nursing facility. He

remained at this facility, where he required and received daily skilled care, until May 23, 2013, where, because his admission had been categorized as outpatient observation, he was required to pay \$266/day, or \$5,852.

Ruth D, age 90, who lives at home with her elderly husband, entered North Shore Medical Center on April 15, 2012, after falling at home and hitting her head. She was in pain; was unable to ambulate, despite her use of a walker; and an x-ray done in the emergency room revealed a fractured shoulder. Her past medical history included diabetes, myocardial infarction, breast cancer, chronic acquired lymphedema, hyperlipidemia, hypertension, stasis dermatitis, A Fib on Coumadin, diabetic retinopathy, cellulitis, osteoarthritis, GI hemorrhage, pneumonia, diastolic CHF, cystitis, hypoglycemia, edema, and dehydration. The hospital plan was for admission to the medical service due to her need of rehab given her need to use a walker, admission was ordered on 4/15/2012, therapy services were ordered and provided, and she remained as a hospital inpatient until 4/19/2012. Following her hospitalization she went to a skilled nursing and rehabilitation facility where she remained until July 10, 2012, and received daily skilled therapy. Based on her fractured shoulder and need for a walker, the potential for an adverse event happening and her need for 24 hour access to a physician in case of a possible head fracture, inpatient hospitalization from April 15-19, 2012, was appropriate. However, because her admission was billed as observation, she was denied Medicare coverage for her \$395/day April 19 to July 11, 2012, nursing home stay, totaling \$32,390.

On behalf of the above described Medicare beneficiaries, as well as the multitude of other beneficiaries adversely impacted by the increasing practice of hospitals to admit Medicare beneficiaries to outpatient observation, rather than inpatient, status we therefore ask that congress ideally eliminate the three day prior inpatient prerequisite for obtaining Medicare skilled nursing facility coverage but, if not, pass H.R. 1179 and S. 569 which would allow days spent as "observation outpatients" to count towards this three-day prior hospitalization prerequisite. We also appreciate your consideration of this important issue and thank you again for providing us with an opportunity to submit comments.

Very truly yours,

Diane F. Paulson  
Senior Attorney