On August 12, 2011, my mother, Frances E. O'Keefe, fell at the retirement community in Hingham, MA. where she lived independently. She was taken by ambulance to the South Shore Hospital Emergency Room. She was badly bruised, but x-rays showed nothing was broken so she was discharged that same day and returned to her apartment in the retirement community.

Unfortunately, over the next few weeks her conditioned deteriorated to the point where she could not walk and was in excruciating pain. On September 4, 2011 she was transported back to the South Shore Hospital Emergency Room (ER) via ambulance. I was present in the ER when she was examined by a physical therapist and physician. The physical therapist rated her pain level as a 10 on a 1 to 10 scale and indicated it was unsafe for her to be discharged. The physician was concerned that she her condition had deteriorated since the fall and that she was experiencing a tingling sensation in her feet. The physician order an MRI and strong pain medications, including intravenous (IV) morphine. (IV morphine cannot be administered at a nursing home or rehab facility.) The physician told me she would be admitted to the hospital under the care of the "hospitalist" physician. She was admitted to the hospital and transferred out of the ER to a patient floor within a few hours after entering the ER.

Later that same evening they attempted to complete the MRI but my mother was still in such pain and so anxious, she could not tolerate the procedure. The following day, after the medications had reduced her pain, and she was given an anti-anxiety medication, the MRI was completed. The Hospitalist physician ordered a neurological consult which was completed on September 7, 2011. The MRI did not show any fractures or breaks, and the neurologist determined that my mother could be discharged to a skilled nursing facility to receive physical and occupational therapy. The Hospitalist physician determined it was medical necessary for my mother to be transported to the facility via ambulance.

My mother received the therapy and continued pain management medications she required including Percocet, an oral narcotic medication. Unfortunately during the time she was at the rehab center, she developed dementia and was unable to return to her independent living situation. She died a few months later on February 8, 2012. I was appointed executor to her estate by the Plymouth County Probate Court.

My mother's hospital stay in September for 4 days and 3 nights was paid under Medicare Part B. The physical and occupational therapy she received at the rehab facility was paid for by Medicare; however the room and board charges, which amounted to over $28,000 were not paid. After extensive investigation I learned that the rehab room and board charges were not paid because Medicare had determined that my mother did not have a 3 day pre-qualifying hospital admission prior to going into the rehab facility. Despite the fact that the hospital records clearly indicate that my mother was admitted to the hospital for 3 days as an "inpatient", (see enclosed hospital admission record) the hospital billed Medicare as if she was an "outpatient" and the bill was paid under Medicare part B, instead of part A.

As executor to her estate, I initiated the 5-step Medicare appeals process. The appeals process is very time consuming and complicated. I had to consult with a few attorneys to completely understand what had to be done. Then I had some logistical problems which required me to get the Medicare

Ombudsman's Office involved to rectify. The situation actually involved two appeals. I would have to appeal the decision that my mother's September hospital stay that was paid under Medicare part B and get that changed so that was paid under Medicare part A, and I would have to appeal the Medicare refusal to pay for the rehab room and board charges which were denied because of the hospital stay being paid as if my mother was an "outpatient" under Medicare Part B instead of part A.

To further complicate matters two different companies were involved with the two different bills. NHIC Corp. had processed the hospital stay claim, while Novitas Solutions handled the rehab facility claim. Obviously, successfully appealing the refusal to pay the rehab bill was dependent on my successfully appealing the NHIC decision to pay the hospital bill under Medicare part B, instead of part A. There were more logistical problems as Novitas could not find my appeal despite the fact I sent everything Return Receipt Requested.

NHIC indicated they could not find my appeal as well, and indicated that, in fact, they did not handle such appeals despite the fact that the Medicare Summary Notice states that appeals should be sent to them. NHIC indicated that they send any such appeal to Mass Pro. Working with Pat P of the Medicare Ombudsman's Office, I got the address of Mass Pro and was asked to send my appeal to them. I sent the appeal Return Receipt Requested, but it was returned as the address was old and incorrect. I obtained the new address and resent the appeal to their correct address (Return Receipt Requested), however, when I followed up with Mass Pro a few months later they stated they never received my appeal (I have the signed Return Receipt green card) and they did not handle such appeals anyway???

I tried to contact Pat Pierorazio at the Ombudsman's Office several times and left several messages but she has never returned my calls. At this point my right to appeal the Medicare decisions has, in a de facto sense, been completely blocked and I am only at step one of the five step process. The appeals bureaucracy is absurd.

The 3 day pre-qualifying hospital stay Medicare requirement is arbitrary and ridiculous. While the records indicate that my mother had a 3 day pre-qualifying "inpatient" hospital stay prior to entering the rehab facility, whether she had stayed 1 day or 5 days either as an "inpatient" or an "outpatient", my 89 year old mother could not walk when she left the hospital and had to be placed in a skilled nursing facility and Medicare should have paid for her room and board at that facility.

It is my understanding that there are some 62,000 cases similar to mine regarding this absurd regulation. Indeed, when I became eligible for Medicare none of the supplemental private Medicare insurers I looked at required the 3 day pre-qualifying hospital stay. It is time for congress to act and get rid of this ridiculous regulation and pay the backlogged 62,000 claims.

Thank you for your time and consideration.

Very truly yours,

Walter F. O'Keefe