

Kathleen Martin is an attorney with O'Donnell, Weiss & Mattei, P.C., and a newspaper columnist for The Mercury, which gave permission for this article to be reprinted.

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## **Inpatient or not, how your hospital stay is classified is important to know**

The Center for Medicare Advocacy (the Center) ([www.medicareadvocacy.org](http://www.medicareadvocacy.org)) recently sent out an alert about a disturbing trend in the treatment of Medicare beneficiaries and hospital admissions. This trend has also been noted by elder law attorneys throughout the state. There have been an increasing number of reports of Medicare beneficiaries throughout the country whose entire hospital stay, as long as 14 days, has been classified as *observation* and not as a hospital admission. In other instances, the hospital admission is reclassified as observation or outpatient care.

Most beneficiaries, or families of beneficiaries, may not realize the consequences when a patient, who thinks that he or she is an inpatient, is classified as being under observation. Time spent in the emergency room does not “count” toward actual admission time in the hospital. However, a person who is in an actual hospital room may not be considered to be an inpatient, but may never realize the distinction that is being made.

This distinction can affect Medicare beneficiaries in several ways. One significant way is that a subsequent transfer to a nursing home for rehabilitation may not qualify for coverage by Medicare because the beneficiary did not spend three days (listed as three “midnights”) as a patient in the hospital. This is a hard and fast rule which must be complied with to qualify the beneficiary for *any* Medicare coverage of a short term nursing home stay. No less significant is that the failure to actually admit the beneficiary to the hospital may mean that Medicare A (the hospital benefit) will not cover the hospital stay. The cost of the hospital stay will be covered by Medicare Part B, which has deductibles and co-payments for which the beneficiary did not plan. Additionally, Medicare covers prescription drugs for inpatients, but not for outpatients.

It appears that leaving a beneficiary in observation status for more than 24 to 48 hours violates the regulations set up by the Centers for Medicare and Medicare Services (CMS). Moreover, there are specific regulations for reversing a physician’s order to admit a beneficiary to the hospital. The Center expects this situation to become worse in 2009, since the Recovery Audit Contractor (RAC) program is moving from demonstration status to a permanent, nationwide program. This program is intended to detect and correct improper payments in the Medicare program, a program which is headed for trouble due to the rising costs of Medicare coverage.

The Center is working on solutions to the aforementioned issues. Hospitals should be giving Medicare beneficiaries notice of non-coverage (Advance Beneficiary Notice or ABN). However, it has come to light that many beneficiaries are not receiving any notices.

What can a beneficiary do to protect him or herself? Beneficiaries should appeal any notices they do receive from hospitals or skilled nursing facilities. At the same time, the subsequent denial of Medicare coverage for nursing home care should be appealed also. If you do not receive a notice, a request should be filed with the Medicare Administrative Contractor (such information must be provided by the hospital upon request). If you are billed for prescription drugs during a hospital stay, follow your Part D plan’s process for submitting claims from an out-of-network pharmacy. And let the Center for Medicare Advocacy know of your issues.