NRLN
NATIONAL RETIREE LEGISLATIVE NETWORK

601 Pennsylvania Avenue, N.W.
Suite 900, South Building
Washington, D.C. 20004-2601
Tel: 202-220-3172 Toll-Free: 1-866-360-7197
Email: contact@nrln.org Website: www.nrln.org

August 5, 2014

The Honorable Lloyd Doggett
U.S. House of Representatives
201 Cannon House Office Building
Washington, DC 20515-4335

Dear Representative Doggett:

I am writing to you on behalf of the more than 2 million retirees and future retirees represented by the National Retiree Legislative Network (NRLN) to question why you introduced H.R. 5232, the Notice of Observation Treatment and Implication for Care Eligibility Act, when there are two other House bills on this issue that would be more beneficial to Medicare participants?

Your bill would only require hospitals to provide certain notifications to individuals classified by such hospitals under observation status rather than admitted as inpatients of such hospitals. The NRLN supports passage of H.R. 3531, the Creating Access to Rehabilitation for Every Senior (CARES) Act, a bipartisan bill with 29 cosponsors that has been pending in the House Ways and Means Committee since it was introduced on November 19, 2013 by Rep. James Renacci (OH-16).

H.R. 3531 would eliminate the three-day "inpatient" hospital stay requirement for Medicare beneficiaries who are in need of skilled nursing facility (SNF) services, thus not requiring a patient to be hospitalized prior to receiving SNF services to be paid by Medicare. This would save Medicare the hospital costs.

The NRLN also finds acceptable H.R. 1179, the Improving Access to Medicare Coverage Act, which has been pending in the Ways and Means Committee and Energy and Commerce Committee since it was introduced on March 14, 2013 by Rep. Joe Courtney (CT-2). This bill, which has 158 bipartisan cosponsors, would count being in a hospital for "observation" toward satisfying the three-day "inpatient" requirement for Medicare to cover the costs of SNF services. However, it does not eliminate the hospitalization requirement as H.R. 3531 does. This bill has a companion bill (S. 569) pending in the Senate Finance Committee with 26 cosponsors.

Congressman Doggett, why is it that you are a cosponsor of H.R. 1179 yet introduced H.R. 5232 as a competing bill that would not serve Medicare participants as nearly as well as H.R. 3531 or H.R. 1179?

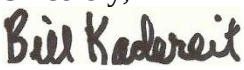
(More)

As a fellow Texan (4th Congressional District), I like to think that all members of the Texas Congressional Delegation are working in the best interest of their constituents. Your introduction of H.R. 5232 which only requires a hospital to notify individuals whether they are classified for "observation" or "inpatient" when there are bills pending that are more beneficial is a disservice to your constituents, Texans and all Americans.

Since you are a member of the Ways and Means Committee where H.R. 3531 and H.R. 1137 are pending, I urge you to press Chairman Dave Camp to call up H.R. 3531 and get it passed by the Committee and voted on in the House soon after the August recess. On July 15, 2014, I faxed letters to Chairman Camp and Rep. Sander Levin, Ranking Member, urging them to work for the passage of H.R. 3531.

It is time for your Ways and Means Committee to do its part to put an end to the three-day hospitalization as an "inpatient" to qualify for SNF services. Too many seniors like the attached testimonials collected by the NRLN are suffering financial hardships as a result of the ridiculous three-day "inpatient" bureaucratic regulation.

Sincerely,



Bill Kadereit, President
National Retiree Legislative Network
Email: president@nrln.org
Phone: 972-722-5928

Attachment

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Testimonials Attest to Negative Impact of 3-Day Impatient Rule

Medicare covers Skilled Nursing Facility (SNF) services only if the beneficiary has an "inpatient" hospital stay of at least three days. As the testimonials below attest and other stories the NRLN has heard indicate, many Medicare beneficiaries are often unaware that doctors or hospitals have admitted them for "observation" rather than "inpatient" until they are required to pay for SNF services.

From: Linda Debold, RN MSN, Fort Lauderdale, FL

The impact of the 3-day stay rule is causing an increase in the cost per case of hospital days. Why is it that the HMO's (MCR) do not abide by the same rule? As an acute care case manager, I can tell you that patients are ready to go to SNF by criteria for clinical indicators but the 3-day rule keeps them in the hospital. Physicians for the most part do not fully understand the impact for their patients.
Government has changed the MCR admission ruling to the 2 MN stay to indicate an "inpatient"
status but we still need to wait for the 3-day stay rule to transfer to the SNF.

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From: Teresa Davidson, Indianapolis, IN, daughter of Margaret Dorsett

My mother, Margaret Dorsett, was hospitalized in 2013 for severe back and leg pain. She was in the hospital for three days and was diagnosed with spinal stenosis and a pinched nerve. At her age (at the time 87), the doctors wanted to take a moderate approach in treating her. So, physical therapy was ordered. She had two days of it in the hospital with her discharge on the 3rd day. Her doctor wanted her to go to rehab for more intense therapy; however when trying to set this up, case management reported that Medicare wouldn't pay for it as they considered her an "inpatient" for 2 days; i.e. the first day of hospitalization the doctor admitted her for "observation" and this did not count as an "inpatient" day.

Of course, we did not know this and was not aware until Medicare wouldn't approve her for therapy. My mother's doctor did not want her to go home, but she did not quality for more days in the hospital either. So, we opted to get her physical therapy at a rehabilitation place and self-pay to get her the treatment she needed. Mom was there about a week. At the time we were unaware that we could have provided her own medication which would have saved us quite a bit of money; but the rehab place didn't tell us upfront so that ended up being a big bill too.

The rehab facility did get her "Physical Therapy" approved for payment with Medicare; however, not her meds or room and board. I think we ended up paying around $2,400.00 for room and board and another $1,100.00 for medication. If she had been approved for the Physical Therapy from the hospital with a three-day admission as an "inpatient", Medicare would have paid for it all. The exclusion of the first day (observation) was what caused the problem. I think this is ridiculous as she was in the hospital three days.

I do hope you all can have some leverage in changing this for seniors on Medicare. It sure would have helped my mother as $3,500.00 is a lot of money for her and took a chunk out of her savings.

Thank you for letting us share her story. My mother has dementia and could not write to you herself.

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From: Gary Butler, Pinehurst, NC

This situation happened to my 90s something mother a few years ago, exactly when I cannot recall, maybe 2010. Her name was Thelma Butler and lived in Rochester, NY. At that time I lived, as I do now, in North Carolina. As my Mom's only living child I hurried to Rochester when she was admitted to Rochester General Hospital, to the emergency room, via ambulance. The hospital "admitted" her. Not to a room, but to an area in the emergency room quarters area. We're speaking of a 90 year old women, sick, confused, not knowing what to do.

When I finally arrived, two days later, she was still in the emergency room area. I requested they place her in a hospital room, remove Mom from the emergency area, and provide the care she required. They did, at that point, but only because of my request. She had a few days stay after that. She was then released to return to her home.

Then came the "knockout punch" a bill for $8,000, as she was not really admitted as an “inpatient”, as we both thought. She was just there for “observation”. I am not speaking of a women who had huge savings, or large monthly income. Her savings at that point were maybe $38,000, monthly income about $1,100 from Social Security and a New York State pension, so in order to live, pay her bills, she was depleting her savings to the tune of about $5,000 per year.

Anyway, as I have a years old good friend who is a lawyer, I called him. He put me in contact with a lawyer friend of his who specializes in these matters. Both of those lawyers provided their work, pro bono, of which I, and Mom are most grateful.

The key evidence in the case was that my mother’s primary physician had authorized her to be admitted as an “inpatient”, that paperwork was submitted. The good news is Mom won the case and the $8,000 invoice went away.

That situation should not happen to any of us.

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From: Randall Cook, Rochester, NY

Earlier this year (2014) I ran into this situation with my mom at Unity Hospital in Rochester, NY. She was listed as “observation”, which was new to me and I kept inquiring as to exactly what that meant. Finally I was told about the 3-day stay requirement when they were suggesting rehab at a skilled nursing facility (SNF). I pushed with the doctors and due to some other circumstances with my mom. They finally admitted her and we got the 3-day stay (barely) before transferring to a SNF. (She subsequently became worse, requiring a longer more permanent SNF stay and passed away shortly afterwards). It was very frustrating dealing with the hospital regarding the “observation” status. Fortunately, we eventually won that one, probably because I told them she essentially didn’t have any money for the rehab.

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From: Richard Czerniejewski, Toledo, OH, son of Olga Czerniejewski

My mother who is 88 years old fell out of bed. She called 911 because she could not get up off the floor due to injuries from the fall. She injured her shoulder, her leg and bruised her head and side. She was transported to the hospital and admitted for 6 days. X-rays were taken because she complained of pain in her leg and shoulder. She stayed for 3 days and was told that she probably would go to rehab and it would have to be out of pocket cost because she was admitted for “observation”. She complained of pain and stayed 3 more days for (observation). She could not get out of bed and had numerous tests.

I questioned the hospital about the “observation” status and asked, at what point is a patient admitted and they would not give me an answer.. They claimed that a review board determines if you are admitted as and “inpatient”. She was not allowed out of bed and then transported to rehab, by ambulance. She stayed there 3 weeks for rehab. At a cost of $3,000.00 plus for room and therapy. She was in pain and not allowed out of bed with strict warnings that a nurse was to be present to help her use restroom.

The 3 day “observation” rule needs to be re-evaluated and explained as to its context so patients are fully aware of what it means and its ramifications. It appears that Medicare is skirting its responsibilities and obligations with less than proper procedures. How can you be in hospital for 6 days and not be admitted as an “inpatient”, with bed restrictions.

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From: Barbara Zeuske, West Linn, OR

My sister-in-law, Doreen Zeuske, lives in Salem, Oregon. Last year, 2013, she had an extensive foot surgery on her left foot requiring three-day hospitalization and eight weeks of rehab in a skilled nursing facility (SNF). She was classified as “inpatient” and her hospitalization AND rehab were covered.

This year, it was determined that she required another surgery on the same foot as the first one was unsuccessful. She assumed that all would proceed as it had last year.

She was again in the hospital for three days. AFTER her surgery, the hospital staff advised her that she had been admitted as "observation" and that she would have to pay for the 10 weeks of SNF rehab that was required. She, of course, was in shock and could not understand how someone could be admitted to the hospital, have a 4-5 hour surgery and be required to remain there for three days --- and be classified as "observation." She was sent from the hospital to the Avamere Rehab Center in Keizer, Oregon. **She had to PREPAY the facility $19,051.90 plus all medication costs.**

We are all stunned to learn of this ridiculous situation. She has appealed this to the staff members of the hospital and the rehab center but to no avail.

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From: David Peiffer, Lucas, TX

I am submitting the details of this situation on behalf of my 80 year old aunt. In my opinion this is an example of the scenario you are trying to resolve with Medicare.

My aunt is on a fixed income and is living alone in a HUD multi-apartment facility. Approximately three years ago she fell and injured her knee. The EMT ambulance delivered her to the Meadville Medical Center, Meadville, PA. She was in that facility for 7 days while they performed tests, took X-rays etc. and put a semi-rigid device on her leg. At the end of that time she was still not able to take care of herself so the doctor said that she needed go to a local Nursing Home for care and therapy until she was able to take care of herself. She spent 7 days in that facility before returning to her residence. At the end of that stay, the Rest Home gave her a bill for $1800. They said they would not submit the bill to Medicare because the hospital had classified her as being in the hospital under "observation" and that Medicare would refuse to pay the Nursing Home bill. Fearing that trying to deal with Medicare would take a lot of time and require administrative skills she does not have, in addition to causing damage to her credit rating, she paid the bill and suffered the economic hardship that it caused her.

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From: Melissa McNeil, Suamico, WI

I was not impacted but my 88 year old Step Mom was. She was taken by emergency to the hospital kept 3 days in intensive care unit and then transferred over to the SNF for rehab which I thought was too early but they did it anyway. She paid over 10,000 dollars out of her own pocket because they refused to admit her as an "inpatient" even after we requested it for medical necessity reasons. We live in the Green Bay, Wisconsin area. The hospital was Bellin Hospital, and the SNF was Kindred Care Nursing Rehab Center. They would not take her unless she wrote a check for 30 days of care regardless of how long she was expected to stay. She stayed 3 weeks. /////