Lawyers Journal

The improvement standard and observation status: Two barriers to Medicare coverage

By Alice Bers

March 2012

According to the statute, Medicare provides coverage for care that is "reasonable and necessary."[1] The real-world application of this standard, however, can become complicated. This article highlights two areas where Medicare's purpose has been thwarted by policies that inappropriately deny coverage to beneficiaries. One of the policies -- dubbed the "improvement standard " by advocates -- has been deeply ingrained in the medical system for decades, whereas the other -- "observation status" in hospitals -- has come to the fore more recently.

IMPROVEMENT STANDARD

Many people who work with elders or people with disabilities have had the experience of a skilled nursing facility or home health agency informing them that a person's Medicare coverage will be terminating because the patient has "plateaued" or is "chronic and stable," "maintenance only" or simply not improving. It can happen, for example, to a patient in a physical therapy setting who is re-learning to walk, or to a patient in a home health care setting who requires ongoing wound care.

These coverage terminations are often devastating to the patient and his or her family, who have been relying on services to slow the course of a disease or maintain functioning. Some people cannot even access coverage in the first place because an agency will not accept a patient who is "chronic" or not able to improve. Many of those affected have degenerative conditions, such as multiple sclerosis, Alzheimer's disease, Parkinson's disease or ALS.[2]

Yet the improvement standard at the root of these coverage denials is not supported by law.[3] To receive coverage, patients in a nursing home or receiving home health care must require skilled services of some kind, but they are not required to improve to receive coverage. The Medicare regulations explicitly state:

> The restoration potential of a patient is not the deciding factor in determining whether skilled services are needed. Even if full recovery or medical improvement is not possible, a patient may need skilled services to prevent further deterioration or preserve current capabilities.[4]

Further, the regulations regarding skilled services specifically recognize that there are cases in which *maintenance* therapy must be provided by skilled personnel.[5] Medicare recently clarified its home health regulations to emphasize that skilled care can include services to maintain a person's condition, and that no informal rules, including those that require restoration potential, should be used to deny care.[6] But despite these directives, denials for patients who "plateau" or are "chronic" remain commonplace.

The improvement standard imposes a rule of thumb that operates as an illegal condition for coverage. Many patients do not appeal coverage terminations because, based on what medical personnel have told them about the improvement standard, they think they cannot succeed. And it is often the practice of Medicare contractors that conduct coverage determinations and lower-level administrative appeals to apply the improvement standard and deny coverage.

While beneficiaries who appeal up to the administrative law judge (ALJ) level have a better chance of success, such lengthy appeals are difficult to pursue, especially without representation, and beneficiaries generally must incur liability for the cost of services provided while their appeal is pending. Providers continue to apply the improvement standard because that is how they have been trained and how they see Medicare handling submitted claims.

There has been some litigation on the improvement standard resulting in decisions favorable to beneficiaries. *Fox v. Bowen*[7] prohibited the use of arbitrary rules of thumb and mandated that each patient's unique medical condition be assessed to determine whether skilled physical therapy services are required. More recently, courts in Pennsylvania and Vermont held that Medicare had inappropriately applied an improvement or stability standard to individual beneficiaries.[8] The Department of Health and Human Services did not appeal these decisions, so they are not binding outside the states in which they were brought.

However, in January 2011, the Center for Medicare Advocacy and Vermont Legal Aid filed a national class action lawsuit against the secretary of Health and Human Services to end the improvement standard nationwide. *Jimmo et al. v. Sebelius*[9] was filed in the District of Vermont on behalf of several individual plaintiffs and organizational plaintiffs, including the National Multiple Sclerosis Society, the Alzheimer's Association and Paralyzed Veterans of America.

The plaintiffs challenge the secretary's continued use of the improvement standard as a policy that results in the illegal termination, reduction or denial of coverage for thousands of Medicare beneficiaries. In October 2011, the court largely denied the government's motion to dismiss.[10] The motion for class certification is pending. As the case proceeds, the goal is to eliminate this unlawful rule of thumb and ensure that each Medicare beneficiary receives coverage based on his or her unique condition and individual needs as required by law.

OBSERVATION STATUS

Another more recent barrier to Medicare coverage in hospitals and skilled nursing facilities is use of observation status during hospitalization. For Medicare to cover a stay in a skilled nursing facility, the beneficiary is required, among other things, to have been hospitalized for at least three consecutive days as an inpatient prior to admission to the facility.[11]

An increasing number of Medicare beneficiaries have been finding that although they thought they had been a hospital inpatient for at least three days, they were formally classified as being on observation status or receiving "observation services," which are not covered by Part A (which generally covers inpatient services), but by Part B (which generally covers outpatient claims).

These beneficiaries often come to the hospital after a fall or some other acute event. They are often moved from the emergency room to a regular hospital floor where they are treated just as any other inpatient would be. They are staying overnight in a hospital bed, wearing a wristband, served hospital food, given medication, tested, monitored, etc. They are too sick to go home and must remain hospitalized for several days. Patients often become deconditioned, meaning they have lost some functional ability, and, when they are well enough to leave the hospital, they need rehabilitation services in a skilled nursing facility.

However, upon discharge to the facility, they learn that Medicare will not provide coverage because they did not have a qualifying three-day *inpatient* stay. Beneficiaries must choose between paying out of pocket for the nursing facility (which in Massachusetts can cost around $10,000 per month) or forgoing the skilled care they need. For those who are eligible, Medicaid may cover their nursing facility stay, thereby shifting the cost of care to the state.

The terms "observation status" or "observation services" are nowhere to be found in the Medicare statute or regulations. "Observation services" appears only in sub-regulatory Medicare policy manuals, where it is circularly defined as:

> a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment, before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital.[12]

Yet the "well-defined" set of services is not found in Medicare policy. What hospitals tend to use to decide whether a patient is classified as an inpatient or outpatient are commercial criteria, such as the "InterQual" criteria published by McKesson Corp. These criteria are proprietary and not available to the general public. The criteria assess the severity of the patient's illness and intensity of services, but result in a paperwork decision that does not involve an in-person examination by a doctor or an individualized determination that takes the patient's unique situation into account.

Even if a doctor initially orders that a beneficiary be admitted as an inpatient, Medicare has authorized hospital utilization review committees to retroactively change a patient's status to observation status in certain circumstances. Medicare policy states that observation care is generally not supposed to last for more than 24 hours, occasionally up to 48 hours, but only in "rare and exceptional cases" should it last beyond 48 hours.[13] However, the incidence and length of observation status stays is increasing,[14] and advocates have seen examples of beneficiaries being on observation status for as long as 14 days.[15]

Compounding the problem is that Medicare does not require patients who are initially placed in observation status to receive notice. Only if the hospital retroactively changes a patient's status from inpatient to outpatient does Medicare policy require a notice, but in actual practice, it seems that few beneficiaries are given such notice, and those notices that are provided contain no language about appeal rights.

Indeed, it is not clear that patients have any appeal rights with regard to observation status. While they will eventually receive a Medicare Summary Notice in the mail listing the hospital services as outpatient claims, beneficiaries attempting to appeal those claims will often find themselves in

a morass of communications from Medicare. They may be told that only *denied* services can be appealed, whereas these services were *covered* by Part B, and thus there is no basis for appeal, or that only a doctor can decide whether a patient is an inpatient or outpatient.

Beneficiaries who manage to appeal up to an ALJ may find their claim dismissed for lack of jurisdiction. Beneficiaries who go to a nursing facility after their hospital stay may receive a notice that their stay cannot be covered for lack of a qualifying three-day hospital stay, but use of such notices is discretionary for the facility. On top of this confusing process, beneficiaries and their families are often still dealing with the serious condition that brought them to the hospital in the first place.[16]

Why are hospitals placing more patients on observation status? The reason heard most often is Medicare's Recovery Audit Contractor (RAC) program, which was put into place to address fraud, waste and abuse. The program began as a three-year demonstration and was made permanent by the Tax Relief and Health Care Act of 2006.

The RAC reviews hospitalizations of Medicare beneficiaries, and if it finds what it believes to be improper payments to hospitals under Part A, it recoups the payment from the hospital, which cannot re-bill under Part B. It has apparently become a safer bet for hospitals to bill claims for some patients as Part B outpatient services rather than Part A inpatient services. Advocates have heard from many doctors and other hospital personnel that they are frustrated with observation status as well; they have seen how it can harm their patients.

Advocates and legislators are working to address the observation status problem. Legislation that would require time spent in observation status to count toward the three-day stay requirement has been introduced in both the House of Representatives and the Senate.[17] A congressional briefing sponsored by the Center for Medicare Advocacy, AARP, the Alzheimer's Association and the American Medical Association, among others, was held in October 2011.

In November 2011, the Center for Medicare Advocacy and the National Senior Citizens Law Center filed a national class action lawsuit against the Secretary of Health and Human Services that seeks to end Medicare's practice of depriving beneficiaries of Part A, inpatient coverage of their hospital stays by allowing (and, in fact, implicitly encouraging) them to be placed on observation status. *Bagnall et al. v. Sebelius*,[18] filed in the District of Connecticut, also addresses beneficiaries' lack of notice and appeal rights. The government has filed a motion to dismiss, which will probably be decided in the next few months.

Dealing with Medicare denials caused by either the improvement standard or observation status can be very difficult. While there are no quick fixes at the moment, beneficiaries are advised to seek help from advocates. They can attempt to appeal denials, ideally with the support of a treating physician. The website of the Center for Medicare Advocacy contains self-help packets for appeals.[19]

[1]42 U.S.C. § 1395y(a)(1)(A) (2011).

[2]While this article discusses the improvement standard in the traditional Medicare program, the problem also arises for beneficiaries enrolled in the Medicare Advantage program who receive their coverage through private companies.

[3]The only provision in the Medicare statute that requires improvement is specifically for improving the functioning of a "malformed body member." 42 U.S.C. § 1395y(a)(1)(A) (2011). The intent of this provision was to distinguish between cosmetic and functional services so that coverage is allowed only for functional purposes. *See Jimmo, et al vs. Sebelius: Center for Medicare Advocacy Files Class Action to Block Illegal Medicare Denials for Patients with Chronic Conditions*, CENTER NEWS (Ctr. for Medicare Advocacy, Willimantic, Conn.), Winter/Spring 2011, at 2.

[4]42 C.F.R. § 409.32(c) (2010).

[5]42 C.F.R. § 409.33(c)(5) (2010).

[6]42 C.F.R. § 409.44(c)(2)(iii) (2010).

[7]656 F. Supp. 1236 (D. Conn. 1987).

[8]*Papciak v. Sebelius*, 742 F. Supp.2d 765 (W.D. Pa. 2010) (holding Medicare Appeals Council erred in failing to address whether plaintiff required skilled care to maintain her level of functioning); Anderson v. Sebelius, No. 5:09-cv-16, 2010 WL 4273238 (D. Vt. Oct. 25, 2010) (holding ALJ impermissibly applied a retrospective "stability standard" in concluding that skilled care was not required).

[9]*Jimmo et al. v. Sebelius*, No. 5:11-cv-17 2011 WL 5104355 (D. Vt. Oct. 25, 2011).

[10]*Id.*, at *1.

[11]42 C.F.R. § 409.30(a)(1) (2010). Some Medicare Advantage plans do not require a three-day stay as a prerequisite to skilled nursing facility coverage.

[12]Medicare Benefit Policy Manual, CMS Pub. No. 100-02, Ch. 6, §20.6.A, *available* at www.cms.gov/manuals/Downloads/bp102c06.pdf; same language appears in Medicare Claims Processing Manual, CMS Pub. No. 100-04, Ch. 4, §290.1 *available* at www.cms.gov/manuals/downloads/clm104c04.pdf.

[13]Medicare Benefit Policy Manual § 20.6.A.

[14]In a September 2010 presentation, the Medicare Payment Advisory Commission (MedPAC), which advises Congress on Medicare matters, stated that from 2006 to 2008, the number of observation claims increased by 22.4 percent, the average period of observation status increased from 26 to 28 hours, and the claims for periods of 48 hours or longer increased by 70.3 percent, which accounted for 8 percent of all claims in 2006 and 12 percent of all claims in 2008. Zach Gaumer & Dan Zabinski, MedPAC, *Recent Growth in Hospital Observation Care (Sept. 13, 2010)* available at www.medpac.gov/transcripts/observation%20sept%202010.pdf.

[15]*See When is a Hospital Stay Not a Hospital Stay? When the Patient is on 'Observation Status,'* CENTER NEWS (Ctr. for Medicare Advocacy, Willimantic, Conn.), Summer/Fall 2010, at 1. Hospitalizations of the individual plaintiffs in Bagnall et al. v. Sebelius, No. 3:11-CV-1703 (D. Conn. filed Nov. 3, 2011) ranged from three to seven days.

[16]For a good description of one family's observation status experience, see: Tamar Lasky, *Caregiver Perspective: "Observation Days" in a Kafkaesque Hospital Setting*, 1 INT'L J. OF USER-DRIVEN HEALTHCARE 66 (2011).

[17]Improving Access to Medicare Coverage Act of 2011, H.R. 1543, 112th Cong. (2011) (introduced by Rep. Joe Courtney, D-CT, now 13 co-sponsors); S. 818, 112th Cong. (2011) (introduced by Sen. John Kerry, D-MA, now four cosponsors).

[18]No. 3:11-CV-1703 (D. Conn. filed Nov. 3, 2011).

[19]Medicare Coverage and Appeals, CENTER FOR MEDICARE ADVOCACY, INC., www.medicareadvocacy.org/medicare-info/medicare-coverage-appeals/#SelfHelp (last visited Feb. 11, 2012).

Alice Bers practices elder law at Benjamin & Bers in East Longmeadow and is a consulting attorney for the Center for Medicare Advocacy, a national nonprofit education and advocacy organization. Before entering private practice and joining the center, Bers represented Medicare beneficiaries at Western Massachusetts Legal Services (now Community Legal Aid).