August 31, 2012

Just How Long Is an “Observation Stay”?  

(We welcome Matt Hartman back to Illinois Health Care Association, replacing Mark Westenberger as Director of Member Services. Matt helped research and collaborate on this article.)

Hospitals are increasingly keeping nursing home residents under “observation status” rather than formally admitting them on an inpatient basis. Whereas the “23-hour observation” was the primary form of observation in the past, more and more hospitals seem to be keeping residents under observation for two, three or four days – and even one report of seven days. Because of this trend, nursing home residents who return from the hospital are not eligible for Medicare because they lack the three-day qualifying stay in the hospital.

Unfortunately, there are no clear requirements, definitions or guidelines on ‘observation status’ in either federal law or regulations. Instead, there are only references in a number of Centers for Medicare and Medicaid Services (CMS) manuals, which define observation status 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. Observation status is commonly assigned to patients who present to the emergency department and who then require a significant period of treatment or monitoring before a decision is made concerning their admission or discharge.

Observation services are covered only when provided by the order of a physician or another individual authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient tests. In the majority of cases, the decision whether to discharge a patient from the hospital following resolution of the reason for the observation care or to admit the patient as an inpatient can be made in less than 48 hours, usually in less than 24 hours. In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours.”

As described above, the manuals state most beneficiaries may not remain in observation status for more than 24 to 48 hours. However, based on a number of conversations with CMS, there is, in fact, NO limit on observation days, leading to denial of Medicare Part A benefits for nursing home residents. CMS is very aware this is becoming an increasingly controversial topic, with more and more observation stays exceeding 48 hours.

There are a few courses of action a provider or Medicare beneficiary can take.

Because of many instances of problems with the issue, CMS has requested written public comments and concerns. You can electronically submit detailed comments about your experiences by visiting http://www.regulations.gov, following the instructions under the tab “How to submit a comment” on the right side of the screen and using the file code CMS-1589-P. You can also submit comments in writing to:
NOTE: Comments must be filed no later than 5:00 p.m., this coming Tuesday, September 4, 2012.

Providers or families losing their nursing home Medicare benefits from not having a qualifying stay can also directly file a complaint by phone with CMS customer relations by calling (312) 886-5354 or emailing rochifm@cms.hhs.gov.

You can additionally contact the Illinois Quality Improvement Organization, Telligen, anonymously at 800-647-8089 to help mediate the issue with the local hospital.

LTC Facilities Do NOT Need to Register for the Centralized Repository Vault (CRV)

A letter was sent to many different providers in the state signed by the directors of five state human services agencies (DHS, IDPH, HFS, DOA, DCFS) informing providers that, if they have contracts or receive grants from the state, they must register a series of documents online at the Centralized Repository Vault (CRV).

There has been some confusion as to whether the Medicaid Provider Agreement with HFS or the nursing home license with IDPH constitutes a “contract.” The answer is NO. The only providers required to register are those that receive an outright grant under contract from a state agency. Fee for service reimbursement NOT constitute a grant.

We reiterate: If you received or viewed a letter (dated June 27, 2012) saying you should register for the Centralized Repository Vault, the letter does NOT apply to any licensed or certified long term care facility (i.e., SNF, ICF, SC, ALF, ICF/DD, SNF/Ped), unless you are separately receiving a service grant from one of the five Illinois state human service agencies. DHS states the CRV applies mostly to CILAs and home- and community-based service providers.

Medicaid Payment Update

The associations received the following confirmation on payment schedules from the Department of Healthcare and Family Services as of August 29, 2012.

- Nursing Facilities (NFs): 5/12 services paid into group 2. 5/12 services vouchered into group 5.
- Expedited Nursing Facilities (ENFs): 5/12 services paid.
- Institutions for Mental Disease (IMDs): 5/12 services paid into group 2. 5/12 services vouchered. 6/12 services vouchered into group 2.
- Expedited Institutions for Mental Disease (EIMDs): 5/12 services paid.
- Facilities for the Developmentally Disabled (DDs): 2/12 services paid into group 4. 2/12, 3/12, 4/12 and 5/12 services vouchered. 6/12 services vouchered into group 3.
- Supportive Living Facilities (SLFs): 3/12 services paid. Part of 4/12 services paid. 4/12 to 5/12 services vouchered. Part of 6/12 services vouchered.
- Expedited Supportive Living Facilities (ESLFs): 5/12 services paid.

Question of the Week
Q: The Spousal Impoverishment eligibility levels were recently rolled back by the Illinois legislature to 2010-2011 levels, effective July 1, 2012. Are facilities required to post the new levels?

A: Federal regulation 483.10(b)(7)(ii), found under surveyor guidelines F156, requires that “the facility must furnish a written description of legal rights which includes a description of the requirements and procedures for establishing eligibility for Medicaid including…a couple’s non-exempt resources…” Posting is not required or prohibited. The most common practice is to include a notice in the Admission Packet for each new resident. A sample copy of a model notice with the new July 1 rates was included with the August 10, 2012 This Week and linked here.