Costly Medical Surprises for Seniors

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In 2009 1.1 Million seniors received unpleasant and costly surprises from Medicare, the hospital where they were initially treated and the Skilled Nursing facility that they were sent to for recovery and continuing treatment. These seniors thought they were "admitted" to a hospital for treatment for the three days Medicare requires in order to have the doctor order continuing medical rehabbing at a Skilled Nursing Facility which would be covered by Medicare and many Medicare Supplements. The key is are you being "admitted" to the hospital for treatment or are you being "observed" or "observation". Observation at a hospital is paid for by Medicare but does not qualify as "being admitted". Thus when the senior is transferred to the Skilled Nursing Facility for continuing treatment and recovery, it is not covered by Medicare.

If the senior is "admitted" to the hospital for three days treatment, order written by doctor for continued treatment in a Skilled Nursing Facility (meeting Medicare regulations and requirements) Medicare and Medicare Supplements can cover up to 100 days of treatment. The wording and lack of communications and lack of understanding can cost seniors thousands of dollars. The lack of communications or lack of understandable communications is unacceptable. According to Medicare you have to appeal before you leave the hospital. This appears to be a "Catch-22" where by the time you realize what happened to you it is too late. Many of our seniors and their families can not afford these "surprises". I think if we closely scrutinize the chain of people involved, we will see that there are many people not helping and not directing people with questions to the source that can fully inform them. People are routed through the system and out the door.

The hospital is paid by Medicare. Seniors and/or families think that the Skilled Nursing Facility will be a covered item but it does not qualify because the senior was not "admitted" By the time you find out it may be upon receipt of the Medicare Summary Notice reflecting Amounts Charged, Medicare Approved, Medicare Payments to Providers and the surprise comes under the column "You May Be Billed".

Shouldn't we be able to tell people this is covered and this in not covered? Shouldn't people and families have the opportunity to choose whether they incur an expense that is not covered? Is it ethical treatment of seniors and families if institutions, professionals and administrators do not fully communicate or knowingly communicate in language/jargon that is not understood by their audience?