

MEDICARE HOSPITAL OUTPATIENT AND **OBSERVATION STATUS TOOLKIT**

Infographic

Frequently Asked Questions

Fact Sheet

Summary and Stories

Sample Hospital-Patient Notice

Webinar: Outpatient/Observation Status

Selected Beneficiary and Advocate Q&A

Self-Help Packet

Supported by
The John A. Hartford Foundation

August 2017



The Center for Medicare Advocacy is partnering with the John A. Hartford Foundation to help people caught in the web of “outpatient” Observation Status. **HAVE YOU DEALT WITH OBSERVATION STATUS?** Share your story at MedicareAdvocacy.org/ObservationStory

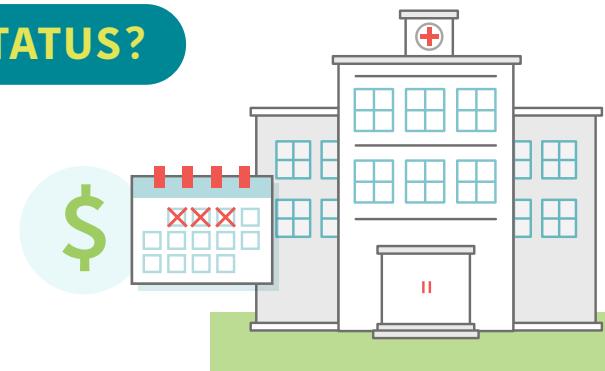
SHARE YOUR STORY!



WHAT IS “OUTPATIENT” OBSERVATION STATUS?

A hospital billing classification that can make **Medicare patients pay for the cost of their:**

- Hospital stay
- Hospital prescriptions
- Nursing home care
 - Patients must be classified as **inpatients for 3 days** in the hospital in order for Medicare to pay for subsequent nursing home care.



AskAboutObservation



OBSERVATION STATUS...

-  May be called “outpatient,” but it has **NOTHING TO DO with where a patient receives care or the kind of care received.**
-  **IS A BILLING CODE.** Hospitals use it to protect from overzealous auditors and Medicare readmission penalties.
-  May just seem like semantics, but **for Medicare beneficiaries, IT CAN RUIN LIVES.**
-  Saddles patients with increased out-of-pocket expenses. Patients who don't have Medicare Part B are responsible for the **FULL COST of the hospitalization.**

WHY DOES OBSERVATION STATUS MATTER?

Observation Status can be devastating. It can result in thousands of dollars in hospital bills, and thousands more in nursing home bills after a hospital stay.



In 2012 an average hospital stay in the U.S. cost **\$10,400**, and the median monthly cost for a nursing home in the U.S. was almost **\$8,000**.

AskAboutObservation



-  The use of “outpatient” Observation Status isn’t just wrong, **it can be DANGEROUS.**
-  Many patients **CAN’T AFFORD** their care if Medicare won’t pay.
-  If post-hospital care in a nursing home won’t be covered by Medicare, **many people GO WITHOUT that care altogether**, rather than face the enormous bills.
-  The problem is growing: the number of patients cared for under Observation Status **DOUBLED** from 2006 to 2014.

HOW TO FIGHT OBSERVATION STATUS

Observation Status is very hard to fight.

But here's what individuals can do:

ASK

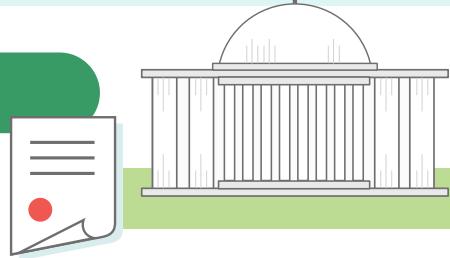
-  **Take action at the BEGINNING of a hospital stay** to try to stop Observation before it starts.
-  Ask the hospital doctor to “**admit the individual as an INPATIENT**” based on needed care, tests and treatments.
-  Ask the patient’s regular physician to **CONTACT THE HOSPITAL DOCTOR** to support this request.

ACT

-  **FILE AN APPEAL** with Medicare, if the patient’s nursing home coverage is denied.
-  **FILE A COMPLAINT** with the patient’s state health department, if he/she did not get notice about “outpatient” Observation Status.

SPREAD THE WORD

-  **CONTACT** The Medicare Agency (CMS), your Senators and Congressional Representatives.
-  **WRITE** to your local paper, **SHARE** this graphic on **social media** and **SUBMIT** your Observation story at MedicareAdvocacy.org/ObservationStory



AskAboutObservation



HOSPITAL “OUTPATIENT” OBSERVATION STATUS

Frequently Asked Questions

Introduction

Patients may find themselves in the hospital, receiving medical services, tests, and treatment, sometimes for many days, but learn they are considered *outpatients*, in Observation Status, *not* admitted *inpatients*. This is understandably confusing for patients and families – and difficult for hospital physicians and personnel.

This information is provided to help you understand and respond to an “outpatient” Observation Status.

Q: What is Observation Status?

A: Observation Status is a designation used by hospitals to bill Medicare. Unfortunately, it can hurt hospital patients who rely on Medicare for their health care coverage.

People who receive care in hospitals, even overnight and for several days, may learn they have not actually been admitted as inpatients. Instead, the hospital has classified them as Observation Status, which is an “outpatient” category. This designation can happen even for people who are extremely sick and spend many days in the hospital. For example, we have heard from people with recent hip and pelvic fractures who were designated as Observation Status.

The “outpatient” classification is often a surprise to patients; many do not realize their status until the patient is getting ready to leave the hospital. Hospital patients are often not told or given a written notice when they are designated as outpatients on Observation Status, although the NOTICE Act, discussed below, now requires hospitals to inform patients, both orally and in writing, when they are in observation status.

Q: Why Does Observation Status Matter?

A: When hospital patients are classified as outpatients on Observation Status, they may be charged for services that Medicare would have paid if they were formally and officially admitted as inpatients. For example, patients may be charged for their medications. (Thus, people may want to bring their medications from home if they have to go to the hospital. Note, however; many hospitals require that patients only take medicine provided by the hospital’s pharmacy.)

Most significantly, patients will not be able to obtain any Medicare coverage if they need nursing home care after their hospital stay. Medicare only covers nursing home care for patients who have a 3-day inpatient hospital stay – Observation Status doesn’t count towards the 3-day stay.

Outpatient Observation Status is paid by Medicare Part B, while inpatient hospital admissions are paid by Part A. Thus, Medicare beneficiaries who are enrolled in Part A, but not Part B, will be responsible for their entire hospital bill if they are classified as Observation Status.

Even if Medicare patients who have both Medicare Parts A and B, may be responsible for 20% of their hospital bill, which is covered under Part B, if they are considered outpatients..

Q: How Do Patients Know They Are Outpatients, or in Observation Status?

A: Since March 2017, federal law has required acute care hospitals to provide oral and written notification to patients who are classified as outpatients or Observation Status patients for more than 24 hours. Notice of non-inpatient status must be provided within 36 hours. CMS requires hospitals to use a standardized notice that it drafted, known as the Medicare Outpatient Observation Notice (MOON). After a space for the patient's name and Medicare number, the MOON includes a blank space for the hospital to write in the clinical reason the patient is not admitted as an inpatient.

At the end of the form, on the second side, the hospital, *if it chooses*, may add more information. CMS's instructions indicate that Additional Information may include, but is not limited to, Accountable Care Organization (ACO) information, notation that a beneficiary refused to sign the notice, hospital waivers of the beneficiary's responsibility for the cost of self-administered drugs, Part A cost sharing responsibilities if the beneficiary is subsequently admitted as an inpatient, physician name, specific information for contacting hospital staff, or additional information that may be required under applicable state law.¹

The rest of the standardized notice describes hospital charges, coverage and payment for post-hospital care, and medication costs as well as what to do if the patient is a Medicare Advantage plan enrollee or Qualified Medicare Beneficiary through the state Medicaid program.

Q: Are There Problems with the “MOON” Notice?

A: While it is helpful that hospitals are now required to inform patients when they are considered outpatients in Observation Status, there are still problems.

- 1. First, not all outpatients** will receive notice of their non-inpatient status. The Medicare agency has decided that only hospital patients who are classified as receiving “observation services” will receive the MOON. Patients who are just classified as outpatients, even for many days, are not required to get the notice.
- 2. Second,** the Medicare agency decided that, while observation patients will get notice of their hospital status, they do not have appeal rights – that is, they cannot challenge their

¹ The MOON and instructions for its use are at <https://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html?redirect=/bni>.

observation status and ask the Medicare program to decide if they should be admitted as inpatients.

Q: What Can Patients Do If They Are in Outpatient Observation Status?

A: 1. If the patient is still in the hospital:

- Seek the doctor's help to "admit the patient as an inpatient."
- Remind the hospital of Medicare's "two-midnight rule." If the doctor expects the patient to require hospital care for at least two midnights, the hospital should be able to admit the patient as an inpatient.
- Consider other post-hospital sources of care – inpatient rehabilitation hospital (also known as inpatient rehabilitation facility), home health, outpatient therapy – that do not require a three-day inpatient stay.

Reminder: If the patient needs nursing home care after the hospital stay, it is particularly important that the patient is admitted as an inpatient. (Medicare only covers nursing home care after a 3-day inpatient hospital stay.)

2. If the patient is no longer in the hospital:

- Unfortunately, seeking inpatient coverage from Medicare after an observation stay is very difficult. Medicare currently has no official method to appeal observation status, but as of August 2017 the Center is pursuing a nationwide class action lawsuit to establish a way to appeal. See our website for more detailed instructions on options for addressing observation status: <http://www.medicareadvocacy.org/self-help-packet-for-medicare-observation-status/>
- If the patient has gone to a skilled nursing facility (SNF) and is receiving a Medicare-covered level of care (generally, five days per week of therapy or seven days per week of skilled nursing care, or a combination of the two equaling seven days per week), ask the SNF to give the resident the Notice of Exclusion from Medicare Benefits – Skilled Nursing Facility (NEMB-SNF), <https://www.cms.gov/Medicare/Medicare-General-Information/BNI/Downloads/CMS20014.pdf>. This form is used for so-called technical denials of SNF coverage. Check Option 1 to have the Medicare agency make a coverage decision.

For more information visit the Center for Medicare Advocacy's Website, MedicareAdvocacy.org

Observation Stays Fact Sheet

SUPPORTED BY

AADNS

American Association of Directors of Nursing Services

AAHAM

American Association of Healthcare Administrative Management

AANAC

American Association of Nurse Assessment Coordination

AARP

ACMA

American Case Management Association

Aging Life Care Association

AHCA

American Health Care Association

AJAS

Association of Jewish Aging Services

Alliance for Retired Americans

American College of Emergency Physicians

American Medical Association

AMDA

The Society for Post-Acute and Long-Term Care Medicine

APTA

American Physical Therapy Association

Center for Medicare Advocacy

The Coalition of Geriatric Nursing Organizations

Emergency Nurses Association

The Hartford Institute for Geriatric Nursing

The Jewish Federations of North America

Justice in Aging

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LSA

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National Association of Area Agencies on Aging

NAEA

National Academy of Elder Law Attorneys, Inc.

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National Association of Health Care Assistants

NASL

National Association for the Support of Long Term Care

NASOP

National Association for State Long-Term Care Ombudsman Programs

NCAL

National Center for Assisted Living

NCHC

National Coalition on Health Care

National Committee to Preserve Social Security & Medicare

The National Consumer Voice for Quality Long-Term Care

SHM

Society of Hospital Medicine

Special Needs Alliance

Medicare beneficiaries are being denied access to Medicare's skilled nursing facility (SNF) benefit because of the way hospital stays are classified.

Under Medicare law, patients must have an *inpatient* stay in a short-term acute care hospital spanning at least three days (not counting the day of discharge) in order for Medicare to pay for a subsequent stay in a SNF. However, under current Medicare rules, acute care hospitals are increasingly holding patients under "observation," an *outpatient* designation, rather than admitting them as inpatients. Outpatients may stay for many days and nights in hospital beds and receive medical and nursing care, diagnostic tests, treatments, medications, and food, identical to that of inpatients. As a result, although the care received by patients in observation status is the same medically necessary care received by inpatients, outpatients who need follow-up care do not qualify for Medicare coverage in a SNF. Hospital stays classified as observation, regardless of their length and the type or number of services provided, are considered outpatient. These outpatient hospital stays, even if they span several days, do not qualify patients for Medicare-covered care in a SNF; only inpatient time counts.

Hospitals' use of observation status and the amount of time patients spend in observation status are both increasing.

An early study¹ found a 34% increase in the ratio of observation stays to inpatient admissions between 2007 and 2009, leading the researchers to conclude that outpatient observation status was increasingly becoming a substitute for inpatient status. The same study also documented increases in long-stay outpatient status, including an 88% increase in observation stays exceeding 72 hours. A 2013 report by the Office of Inspector General (OIG) found that in 2012, beneficiaries had 617,702 hospital stays that lasted at least three days, but that did not include three *inpatient* days. The pattern continued. In December 2016, the Inspector General reported that 748,337 long hospital stays were called outpatient, including 633,148 outpatient stays of three or more days, in FY 2014. Between FYS 2013 and 2014, outpatient stays increased by 8.1%, despite implementation of the two-midnight rule (see reverse side of document) that was expected to decrease outpatient stays.

Support for counting time spent in observation status toward the three-day prior inpatient stay continues to grow:

- The Inspector General's 2013 report was supportive of counting observation days towards the three-day inpatient stay requirement.
- In September 2013, the Congressionally-created Long Term Care Commission recommended that the Centers for Medicare & Medicaid Services (CMS) count time spent in observation status toward meeting the three-day stay requirement.
- In 2015, the Medicare Payment Advisory Commission (MedPAC) explored various policy options for counting time spent in observation toward meeting the SNF 3-day requirement. The Commission unanimously recommended that CMS revise the SNF 3-day rule to allow for up to two outpatient observation days to count toward meeting the requirement, recognizing that beneficiaries are needlessly facing barriers to accessing needed post-acute care.²

The *Improving Access to Medicare Coverage Act of 2017* counts the time Medicare beneficiaries spend in observation toward the three-day stay requirement, so that Medicare patients who spend three days in a hospital, regardless of inpatient/observation designation, are able to access post-acute care in a SNF when they need it.

Legislation re-introduced this Congress with bipartisan support would create a full and permanent solution. **The *Improving Access to Medicare Coverage Act of 2017 (S. 568/H.R. 1421)***, sponsored by Representatives Joe Courtney (D-CT) and Glenn 'GT' Thompson (R-PA) and Senators Sherrod Brown (D-OH), Susan Collins (R-ME), Bill Nelson (D-FL), and Shelley Moore Capito (R-WV) would help Medicare beneficiaries who are hospitalized in observation by requiring that time spent in observation be counted towards meeting the three-day prior inpatient stay.

¹ Zhanlian Feng, Brad Wright and Vincent Mor, Sharp Rise in Medicare Enrollees Being Held In Hospitals For Observation Raises Concerns About Causes And Consequences, *Health Affairs*, 31, no.6 (2012):1251-1259

² Medicare Payment Advisory Commission (MedPAC), June 2015 Report to Congress.

Recent efforts to address the problem of observation status have fallen far short of a comprehensive fix.

The NOTICE Act, while a step in the right direction, does not go far enough to ensure patients have access to needed post-acute care services.

Enacted into law in August 2015, the NOTICE Act requires hospitals to inform patients who are receiving outpatient observation services for more than 24 hours that they are outpatients, not inpatients. Hospitals and critical access hospitals had to begin using the Medicare Outpatient Observation Notice (MOON) no later than March 8, 2017. While receiving written and oral notice informs patients of their status, the law – although a positive step forward – does not give patients hearing rights or count the time in the hospital for purposes of SNF coverage.

The OIG recently found that a new rule intended to slow the growth in long outpatient stays – the so-called “two-midnight rule” – does not eliminate, and in fact has exacerbated, the barriers beneficiaries face in accessing needed post-acute care services.

How the 2-Midnight Rule Works

In October 2013, CMS adopted the “two-midnight rule”, which establishes time-based criteria for physicians to use when deciding to admit a patient as an inpatient or keep them under outpatient observation. The rule states that for patients expected to require hospital services for at least two midnights, inpatient admission will be presumed appropriate for payment. Likewise, for patients expected *not* to require hospital services for at least two midnights, outpatient observation is presumed appropriate. The rule was intended to give admitting physicians additional assurance that their decision to admit would not be questioned by auditors, thereby reducing the incidence of long outpatient stays. CMS intended the two-midnight rule to decrease the number of long outpatient stays and decrease the number of short inpatient admissions.

What the OIG Found

In a December 2016 report³, the OIG found that since the implementation of the two-midnight rule, total outpatient stays have increased and total inpatient stays have decreased – the opposite of CMS’ expectations – exacerbating an already challenging problem. It is now clear that while CMS intended to fix the problem through implementation of the two-midnight rule, it has inadvertently worsened the situation for thousands of beneficiaries who are unable to access needed post-acute care. The report recommends that CMS analyze the potential impacts of counting time spent in as an outpatient toward meeting the SNF three-day requirement so that beneficiaries receiving similar hospital care have similar access to post-acute care services.

While the rule and its revision reflect CMS’ concerns about long outpatient stays, hospitals are unlikely to change their practices when CMS provides no meaningful guidance on when an inpatient stay of fewer than two midnights is appropriate. Physician decisions about patient status continue to be reviewed by hospitals under the same standards as before: short inpatient decisions are prioritized for review by Quality Improvement Organizations (QIOs); and the specter of audits by Recovery Auditors (still known as RACs) remains. The mission of the RACs is to identify and correct Medicare and Medicaid improper payments. A RAC’s determination that a patient has been incorrectly classified as an inpatient requires the hospital to return most of the Medicare reimbursement for the patient’s stay, despite the fact that the services were medically necessary and coverable by Medicare.

Recently-imposed penalties for readmitting a hospital patient within 30 days increase hospitals’ motivation to classify patients as outpatients, rather than inpatients.

³Department of Health and Human Services Office of Inspector General (OIG), December 2016 Report OEI-02-15-00020.

Observation Stays Deny Medicare Beneficiaries Access to Critical Skill Nursing Care, Cost Thousands

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Special Needs Alliance

The Issue

Medicare requires beneficiaries to be hospitalized for medically-necessary inpatient hospital care for at least three consecutive days before covering post-hospital care in a skilled nursing care center. Yet, patients often remain under observation status in the hospital for several days. These days are considered outpatient, and therefore, do not count toward Medicare's three-day inpatient stay requirement.

The Effort

The Observation Stays Coalition, consisting of 28 national organizations, has launched an effort to collect stories that put a face on this critical issue that leaves millions at risk of getting stuck with high medical bills – or foregoing needed care – because of their observation status in the hospital.

The Coalition continues to support bipartisan legislation that would count observation stays towards the three-day stay requirement. Senators Sherrod Brown (D-OH), Susan Collins (R-ME), Bill Nelson (D-FL), and Shelley Moore Capito (R-WV) along with Representatives Joe Courtney (D-CT) and Joe Heck (R-NV) have introduced the Improving Access to Medicare Coverage Act of 2015 (S. 843/H.R. 1571) to count all hospital days spent in observation towards the three-day stay requirement.

The Stories

The following real patient stories highlight how Americans in need of skilled nursing care have been forced to pay out-of-pocket costs because of Medicare's current observation status policy.

CONNECTICUT

After a car accident left him with a neck fracture, Angelo Verdini, a 90-year-old North Haven resident, was shocked to receive a \$7,700 bill for the weeks he spent in a rehabilitation center. The Connecticut man was rushed to an emergency room after the accident where he was subjected to a battery of tests. He spent five days in the hospital room and felt like an admitted patient. Verdini told NBC 4 New York, "I couldn't tell the difference, and I don't know if anyone else who has experienced it could tell the difference." But there was a huge difference. He later discovered that he was "under observation" and not admitted. As a result, Medicare did not cover post-hospital care. After several appeals, Angelo Verdini fears he will have to fight Medicare until his death. Read more about Angelo Verdini's story on NBC 4 New York's website at www.nbcnewyork.com/investigations.

DISTRICT OF COLUMBIA

On November 22, Mary, a resident of the Lisner-Louise-Dickson-Hurt (LLDH) Home in Washington, D.C., was sent to the hospital after a fall that left her unable to walk. From the emergency room, Mary was transferred to the general medicine floor where she was unknowingly kept under observation status and not admitted as an inpatient. During that time, she learned her degenerative joint disease in her back and legs had become worse. The physical therapist at the hospital recommended Mary return to the skilled nursing center for intensive rehabilitation, but because Mary was not admitted as an inpatient to the hospital, the center could not access her Medicare Part A benefit. On November 25, after four days in the hospital under observation status, Mary returned to the skilled nursing center where she was required to apply for Medicaid in order to pay for her stay.

FLORIDA

An 80-year-old female patient was admitted to the Opis Highland Lake Center in Lakeland, Florida, from a local hospital on November 21 for rehabilitation services. After being admitted, the Center discovered that she was kept at the hospital at least three nights under observation and was never admitted as an inpatient. As a result, Medicare would not cover her \$4,500 bill for post-hospital treatment. In this instance, the family was able to privately cover the charges.

ILLINOIS

Susan was admitted to Burgess Square Healthcare and Rehab Centre in Westmont, Illinois, on January 26, 2016 following a hospitalization for illnesses, including cerebral infarction, vertigo, spinal stenosis and weakness. Prior to this hospitalization, the 75-year-old had several emergency room visits due to falls at home where she lived with her elderly husband. Unfortunately, this time was different. She was unable to return home directly from the hospital as a result of her injuries. After being admitted to the center for physical and occupational therapy so she could safely return home, she was shocked to learn that she missed having a three-day qualifying stay by several hours. Since Susan did not have her qualifying stay for Medicare Part A coverage, she and her husband were left with thousands of dollars in out-of-pocket medical expenses.

MINNESOTA

When Gladys fell at her Butterfield, Minnesota, home and suffered several compression fractures, she was rushed to the hospital. There she spent four days under observation status before being admitted to a skilled nursing center for treatment and rehabilitation. The intense pain Gladys was experiencing made it impossible for her frail husband – already on a very limited income – to manage her care at home. If she had met the three-day stay requirement, her post-acute care would have been covered by Medicare. Instead, the couple was stuck with a bill of \$10,551. “We could have observed her at home,” said a family member. The family thought she was receiving care and not just being observed.

NEW YORK

A man who lived alone was rushed to the hospital when he suddenly could not stand or walk. Instead of being admitted, the hospital kept him under observation. As a result of not being classified as an inpatient for at least three days, the man and his family were shocked to discover later Medicare would not pay for his needed rehabilitation at a skilled nursing center. Instead, he was forced to pay thousands of dollars for critical post-acute care. To learn more about this story, contact Toby Edelman at the Center for Medicare Advocacy at TEdelman@medicareadvocacy.org.

OHIO

Beachwood

A 66-year-old male patient was at Ahuja Hospital in Cleveland, Ohio, following a bicycle accident that left him with a broken hip. He spent hours in the emergency room and was later transferred to another unit of the hospital. His orthopedic surgeon determined that he would need to have rehabilitation for his hip. After two nights in the hospital under observation status, he was told he would be discharged. Not understanding the impact of the three-day stay requirement, his rehab stay at Montefiore of four weeks was not covered by Medicare. The patient was devastated to learn later that Medicare would not cover his over \$10,000 post-hospital bill. He was required to pay it on his own.

An elderly man was rushed to the hospital for severe injuries after falling in his home. The hospital kept him under observation for five days. As a result of not being classified as an inpatient for at least three days, Medicare denied him coverage for his needed post-hospital care. The man could not afford to pay for his rehabilitation on his own and opted to return home where he lived alone. Prior to his hospital stay, he was independent and only needed to use a cane. After he was discharged from the hospital, his health declined. He is now at high risk for returning to the hospital.

An elderly woman who was living independently in an assisted living community fractured her elbow and was sent to the hospital in Beachwood, Ohio. At the hospital, she experienced extreme pain and needed help with activities of daily living, including getting in and out of bed and using the bathroom. For three days, she was kept under observation and not classified as an inpatient. As a result, Medicare did not cover her needed post-rehabilitation treatment and 24-hour care at a skilled nursing center. She could not afford to pay own her own and returned home.

Coldwater

After spending seven days at the hospital, a female patient was referred to the Briarwood Village Community in Coldwater for rehabilitation. A few hours prior to the transfer, the case manager at Briarwood learned that the patient did not have the three-day stay requirement for Medicare to cover her post-hospital care. Although she had surgery at the hospital, she was kept under observation for her entire seven-day stay. The patient was immediately notified about the circumstances and the impact it had on her Medicare Part A benefits. She was distraught. She was not able to afford the over \$7,000 in out of pocket expenses, so she had no choice but to return home.

OHIO continued

Garfield Heights

A fractured ankle resulting from a fall sent a 94-year-old woman living alone to the hospital where she had surgery. The physical therapist recommended a skilled nursing stay for around-the-clock care and rehabilitation treatment instead of returning to her apartment alone. Her family agreed but was shocked to learn that she had been kept under observation the entire time and did not have the three-day stay requirement for Medicare to cover her post-acute costs. Unfortunately, the patient was unable to pay privately for her time in rehab and had no choice but to return home.

Piketon

Thomas was hospitalized with a fractured fibula and other chronic conditions prior to being admitted for skilled therapy services at Pleasant Hill Manor in Piketon, Ohio. For more than ten days, Thomas was kept under observation. When he later found out, he was stunned. As a result, Medicare would not cover his post-hospital expenses since he did not have the three-day stay requirement as an inpatient. He could not afford to pay more than \$21,000 in out-of-pocket expenses to cover his around-the-clock skilled nursing care and therapy.

OKLAHOMA

When Mrs. Scott's husband lost function of his arms as a result of spinal stenosis, he was rushed to the hospital in Tahlequah, Oklahoma. He spent five days in the hospital under observation before starting his long road to recovery with several weeks at a skilled nursing rehabilitation center. Mrs. Scott was shocked when she received her husband's medical bill for over \$23,000. He was charged for all of his rehabilitation treatment and care at the center because her husband did not have at least three days as an inpatient at the hospital. Mrs. Scott has spent many hours and days trying to resolve a bureaucratic injustice that she is still pursuing to this day.

PENNSYLVANIA

In December 2009, Winnie, a beloved grandmother, fell and was rushed to the hospital. After a brief stay in the emergency room, she was moved to a room where care and services continued for several days. Days into her stay, it was determined that she would need physical therapy prior to returning to her assisted living home. The family was shocked and confused to learn later that Winnie was never formally admitted to the hospital. Instead, her stay was classified as an observation stay. There were two options: pay out-of-pocket for therapy in the nursing center of her choice or send her to a rehabilitation hospital nearby, where she could be formally admitted and stay for three more days to meet the Medicare qualifying stay requirement. She went to the rehabilitation hospital to generate the qualifying stay. After her third day there, she moved to the nursing center of her choice with Medicare coverage kicking-in to complete her rehab.

OREGON

Diana went to the emergency room for urgent medical care at Meridian Park Hospital in Tualatin Oregon. After three days at the hospital under observation, she was discharged to a skilled nursing center for rehabilitation. She was stunned and confused when she received a bill for \$107,757 for her post-hospital rehabilitation at a skilled nursing center. Medicare had refused to cover her expenses since she was never admitted as an inpatient. She is appealing her classification status.

MOON NOTICE

Medicare Outpatient Observation Notice

Patient name:

Patient number:

You're a hospital outpatient receiving observation services. You are not an inpatient because:

Being an outpatient may affect what you pay in a hospital:

- When you're a hospital outpatient, your observation stay is covered under Medicare Part B.
- For Part B services, you generally pay:
 - A copayment for each outpatient hospital service you get. Part B copayments may vary by type of service.
 - 20% of the Medicare-approved amount for most doctor services, after the Part B deductible.

Observation services may affect coverage and payment of your care after you leave the hospital:

- If you need skilled nursing facility (SNF) care after you leave the hospital, Medicare Part A will only cover SNF care if you've had a 3-day minimum, medically necessary, inpatient hospital stay for a related illness or injury. An inpatient hospital stay begins the day the hospital admits you as an inpatient based on a doctor's order and doesn't include the day you're discharged.

- If you have Medicaid, a Medicare Advantage plan or other health plan, Medicaid or the plan may have different rules for SNF coverage after you leave the hospital. Check with Medicaid or your plan.

NOTE: Medicare Part A generally doesn't cover outpatient hospital services, like an observation stay. However, Part A will generally cover medically necessary inpatient services if the hospital admits you as an inpatient based on a doctor's order. In most cases, you'll pay a one-time deductible for all of your inpatient hospital services for the first 60 days you're in a hospital.

If you have any questions about your observation services, ask the hospital staff member giving you this notice or the doctor providing your hospital care. You can also ask to speak with someone from the hospital's utilization or discharge planning department.

You can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Form CMS 10611-MOON

Expiration 12/31/2019 OMB approval 0938-1308

(Hospitals may include contact information or logo here)

Your costs for medications:

Generally, prescription and over-the-counter drugs, including "self-administered drugs," you get in a hospital outpatient setting (like an emergency department) aren't covered by Part B. "Self- administered drugs" are drugs you'd normally take on your own. For safety reasons, many hospitals don't allow you to take medications brought from home. If you have a Medicare prescription drug plan (Part D), your plan may help you pay for these drugs. You'll likely need to pay out-of-pocket for these drugs and submit a claim to your drug plan for a refund. Contact your drug plan for more information.

If you're enrolled in a Medicare Advantage plan (like an HMO or PPO) or other Medicare health plan (Part C), your costs and coverage may be different. Check with your plan to find out about coverage for outpatient observation services.

If you're a Qualified Medicare Beneficiary through your state Medicaid program, you can't be billed for Part A or Part B deductibles, coinsurance, and copayments.

Additional Information (Optional):

Please sign below to show you received and understand this notice.

Signature of Patient or Representative

Date / Time

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CENTER FOR MEDICARE ADVOCACY

OBSERVATION STATUS WEBINAR

Updated, Spring 2017

Supported by The John A. Hartford Foundation

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ABOUT THE CENTER FOR MEDICARE ADVOCACY

Founded in 1986, the Center for Medicare Advocacy is a non-profit, non-partisan law organization that works to advance access to comprehensive Medicare and quality health care for older people and people with disabilities.

Headquartered in CT and Washington, DC with additional attorneys in MA, NJ, and CA.

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CONTENTS / AGENDA

- What is Observation Status?
 - Overview
 - Further details
- Why it Matters
- Notice Requirements
- Advocacy
 - Individual
 - Systemic Change

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OBSERVATION STATUS

- Beneficiary is in a hospital bed, receiving medical and nursing care, tests, treatments, drugs, food, supplies...
- But, is said to be outpatient in “observation status,” not an admitted inpatient
- Entire stay may be considered “outpatient”
 - Covered by Medicare Part B
 - Part A covers inpatient hospitalizations

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OBSERVATION STATUS

- Hospital patients are frequently classified as outpatients, although they may stay many days in the hospital receiving necessary care

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OBSERVATION STATUS

- While hospital “outpatients” who are not admitted as inpatients are often considered in “Observation Status”
- About half the time, they are just called outpatients.
- HHS Inspector General: Long outpatient stays increased 2012-2014.
 - IG, *Vulnerabilities Remain Under Medicare’s 2-Midnight Hospital Policy*, OEI-02-15-00020 (Dec. 2016),
<https://oig.hhs.gov/oei/reports/oei-02-15-00020.pdf>

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OBSERVATION STATUS

- Observation status is a Medicare billing issue.
 - Will the hospital bill Medicare Part A or Medicare Part B for the patient?
- Observation status is not about medical necessity or appropriateness of care.

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OBSERVATION STATUS

- The hospital care is usually indistinguishable from that provided to individuals admitted as inpatients.
 - Inpatients and “outpatients” often intermingled in the hospital/room.
- Physicians can order whatever care, tests, medications, etc. the patient needs.

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OBSERVATION STATUS



“When I use a word,’ Humpty Dumpty said in rather a scornful tone, ‘it means just what I choose it to mean--neither more nor less.’”

— Lewis Carroll

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OBSERVATION STATUS SHOULD ONLY BE FOR SHORT TIME

- Medicare Manual says observation status should be limited to 24, or, at most, 48 hours
 - While a decision is made either to admit or discharge the patient.
 - Jan. 2017, language added to Manual to reflect 2-midnight rule.

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2-MIDNIGHT RULE

- In 2013, federal regulations (for the first time) created time-based factor for determining whether a hospital patient is an inpatient or an outpatient.
 - Physician should generally admit a patient as an inpatient if the physician expects the patient to be hospitalized for 2 midnights or more, 42 C.F.R. §412.3(d)(1). Otherwise, outpatient.

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2-MIDNIGHT RULE

- If physician believes observation status patient will continue to need hospital care the next day (or later in the stay), physician can admit the patient to inpatient status.
 - But inpatient order is prospective only.
- Physician may order inpatient stay for less than 2 midnights, §412.3(d)(3), on case-by-case basis, but same factors as for 2 midnights.
- Physicians, particularly in emergency departments where patients usually enter the hospital, cannot accurately predict length of stay.

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2-MIDNIGHT OBSERVATION RULE VS. 3-DAY SNF RULE

- 2-Midnight rule did NOT change Medicare requirement that patient be hospitalized for at least 3 days as an inpatient (not counting day of discharge) to qualify for Medicare coverage of care in a SNF.

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CONDITION CODE 44

- Even if physician orders inpatient admission, hospital can reverse the decision to outpatient – retroactive to the day the patient was hospitalized.
 - Condition Code 44, Transmittal 299 (Sep. 2004), now at Medicare Claims Processing Manual, CMS Pub. No. 100-04, Ch. 1, §50.3, <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf> (scroll down to §50.3 at pp. 146-154)
- Patient must be notified of change in status.

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WHY IT MATTERS

- To qualify for Medicare Part A coverage for skilled nursing facility (SNF) care in traditional Medicare, patient must have at least 3 consecutive days as a hospital inpatient
 - Not counting day of discharge (i.e., 3 Midnights).
- Coverage for other post-hospital settings (e.g., Inpatient rehabilitation hospitals, home health, outpatient therapy) are not limited by hospital inpatient/outpatient status.

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WHY IT MATTERS

- Other Consequences
 - For Hospital – Patient responsible for:
 - Part B co-payments (Medigap policy may cover)
 - Prescription drugs (Can appeal to individual's Part D plan for some coverage as out-of-network pharmacy)
 - Entire hospital bill, if patient does not have Part B.)
 - For SNF – Patient responsible for entire bundled care
 - Medigap policy and TRICARE will not pay if Medicare doesn't pay
 - Individual therapies may be covered under Part B.)

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NOTICE ACT

- Beginning August 6, 2016, federal Notice of Observation Treatment and Implications for Care Eligibility (NOTICE) Act requires hospitals to inform patients, orally and in writing, that they are in observation status, not inpatients, and the consequences of that status.

Pub. L. 114-42, U.S.C. §1395cc(a)(1)(Y).

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NOTICE ACT: PROBLEMS IN IMPLEMENTATION

- Regulations explicitly say patients have NO RIGHT to challenge their outpatient status, 42 C.F.R. §405.926(u).
- Regulations say notice is given only to patients in observation status, not to other “outpatients” who have not been admitted as inpatients.
 - Federal interpretation is contrary to NOTICE Act and its legislative history; Congress intended anyone not formally admitted as an inpatient would get oral and written notice of status.

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NOTICE REGULATIONS

- Require hospital to use federal notice, called Medicare Outpatient Observation Notice (MOON)
 - <https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/RA-Listing-Items/CMS-10611.html>.
Click on the download for CMS-10611.
 -

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MOON

- Hospitals are required to give observation patients MOON (within 36 hours, if patient is in observation status for 24 hours or more) and to explain MOON orally.
- After public comment and review by Office of Management and Budget, CMS required hospitals to begin using MOON (and giving oral explanation) March 8, 2017.

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MOON INSTRUCTIONS

- MOON may be given to appointed representative, authorized (by law) representative, or “a person (typically a family member or friend)” identified by the hospital.
 - CMS, “Medicare Outpatient Observation Notice (MOON) Instructions,” Transmittal 3695, Change Request 9935 (Jan. 20, 2017), <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3695CP.pdf>.

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MOON FAQs

- MOON must explain “clinical rationale” for observation status.
- Hospital may use “pre-populated check boxes” to explain rationale.
<https://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html?redirect=/bni> (click on MOON FAQs)

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WHAT CAN PATIENTS IN OBSERVATION STATUS DO?

- If still in the hospital, try to get status changed to inpatient
 - No official way to do this
 - Work with hospital physician
 - Work with personal primary care physician (to intervene with hospital physician by, for example, explaining medical history)

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WHAT CAN PATIENTS IN OBSERVATION STATUS DO?

- If in the hospital, and need post-hospital care, consider other sources for this, which do not require prior 3-day inpatient hospital stay.
 - Inpatient rehabilitation hospital (also called inpatient rehabilitation facility [IRH/IRF])
 - Home Health
 - Outpatient therapy

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WHAT CAN PATIENTS IN OBSERVATION STATUS DO?

▪ If in a SNF

- Appeal.
- Ask SNF to give you “Notice of Exclusion from Medicare Benefits – Skilled Nursing Facility” form, <https://www.cms.gov/Medicare/Medicare-General-Information/BNI/Downloads/CMS20014.pdf>, to appeal to Medicare
- Medicare agency says patients do not have any appeal rights, but it has this form, so try anyway.

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ADDITIONAL EFFORTS TO DEAL WITH OBSERVATION

▪ Legislation

- Improving Access to Medicare Coverage Act of 2017, H.R.1421, S.568 (identical bipartisan bills introduced March 8, 2017) counts all time in hospital for purposes of 3 midnight requirement
- Broad coalition of supporting national organizations

▪ Litigation

- *Barrows* (National federal court case, District of CT)
 - Trying to get notice and opportunity to appeal to Medicare to challenge observation status.

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GET INVOLVED

- Tell the Center for Medicare Advocacy your observation status story,
<http://www.medicareadvocacy.org/submit-your-observation-status-story/>
- Sign the Center's petition (joint effort with the National Committee to Preserve Social Security and Medicare)
<https://secure.everyaction.com/MvrJkyUqNUiZSeOYjMqFFA2>

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GET INVOLVED

Contact your U.S. Representative and Senators

- Ask them to review *Improving Access to Medicare Coverage Act of 2017* (H.R.1421 and S.568)
- Ask them to consider eliminating Observation Status and/or Medicare 3-Day inpatient hospital requirement for SNF coverage
- Ask them to write U.S. HHS Secretary Price and CMS Administrator Verma to express their concerns re Observation Status and requesting change

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CENTER FOR MEDICARE ADVOCACY

Resources

- www.MedicareAdvocacy.org
- <http://www.medicareadvocacy.org/?s=observation&op.x=0&op.y=0>

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QUESTIONS? STORIES?

**Contact the
Center for Medicare Advocacy:
Observation@MedicareAdvocacy.org
(860)456-7790**

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Questions/Comments from the Observation Status Webinar – April 2017

Q: Thank you for conducting today's webinar. It was both timely and informative. I do have one question regarding the 2 midnight rule. It seems to me that it is still only a guideline and not a requirement. Do I have the right conclusion on this?

A: No, actually the 2-midnight rule is a regulation. 42 C.F.R. §412.3(d)(1). A shorter inpatient admission, on a case-by-case basis, was authorized later (2015) and now appears at 42 C.F.R. §412.3(d)(3). Thus, if the facts of a particular case warrant it, a stay of less than 2 midnights **can** be an inpatient admission.

Q: What happens if someone is listed as outpatient and they wanted to leave? Would that be considered to be Against Medical Advice (AMA)? Has anyone left and died by not being admitted and has there been any lawsuits?

A: The hospital may consider the patient's leaving AMA. We are not aware of anyone having left and died and resulting litigation. We have heard that hospitals and physicians are concerned that patients are leaving the hospital when they hear the financial consequences.

Q: Are there 'Rules' regulating WHEN the Hospital can reverse the Dr.'s decision of an Admittance, and make them Outpatient for the entire stay??

A: Condition Code 44 says the decision must occur while the patient is still in the hospital. Here's a MedLearn article on Condition Code 44 (2012), <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0622.pdf>.

After a patient leaves the hospital, however, the hospital can decide to withdraw its inpatient claim to Medicare and submit the claim for outpatient care instead. This is the rebilling option (which CMS put in place at the same time as the 2-midnight rule). 42 C.F.R. §414.5. But in this situation, the patient does **not** lose inpatient status for purposes of having the SNF stay covered. CMS confirms this point in the preamble to the final regulations, 78 Fed. Reg. 50495, 50921 (Aug. 19, 2013), <https://www.gpo.gov/fdsys/pkg/FR-2013-08-19/pdf/2013-18956.pdf>

Q: Can a person request the change over to inpatient hospital stay from the outpatient status and the doctor would comply?

A: A person can ask the hospital for an explanation of why the patient is an outpatient (the hospital is supposed to give an oral explanation of the Medicare Outpatient Observation Notice [MOON]). The patient can certainly also ask the physician if it would be appropriate to be an inpatient. The physician's decision and order for inpatient status is not the final word, however. The hospital's utilization review committee can ask the physician to reverse the inpatient order under Condition Code 44. And CMS treats the inpatient order only as a piece of evidence about the patient's status, not as the final word. 42 CFR §412.3(d)(1)(i) says: “

(i) The expectation of the physician should be based on such complex medical factors as patient history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event. The factors that lead to a particular clinical expectation must be documented in the medical record in order to be granted consideration.”

The preamble to the final rules discusses physician orders and their significance. 78 Fed. Reg. 50495, 50938 (Aug. 19, 2013), <https://www.gpo.gov/fdsys/pkg/FR-2013-08-19/pdf/2013-18956.pdf>. for example, at p. 50944, “Satisfying the requirements regarding the physician order and certification alone does not guarantee Medicare payment. Rather, in order for payment to be provided under Medicare Part A, the care must also be “reasonable and necessary,” as specified under section 1862(a)(1) of the Act.”

Q: Could the person (typically a family member or friend) identified by the hospital as a potential recipient of the MOON refuse the notice?

A: If the person refuses the notice, the hospital staff person will record the refusal. MOON Instructions, Medicare Claims Processing Manual, Chapter 30, section 400.3.5, <https://www.cms.gov/Medicare/Medicare-General-Information/BNI/Downloads/CR9935-MOON-Instructions.pdf>

“400.3.5- Refusal to Sign the MOON (Rev.3695, Issued: 01-20-17, Effective: 02-21-17, Implementation: 02-21-17)
If the beneficiary refuses to sign the MOON, and there is no representative to sign on behalf of the beneficiary, the notice must be signed by the staff member of the hospital or CAH who presented the written notification. The staff member’s signature must include the name and title of the staff member, a certification that the notification was presented, and the date and time the notification was presented. The staff member annotates the “Additional Information” section of the MOON to include the staff member’s signature and certification of delivery. The date and time of refusal is considered to be the date of notice receipt.”

Q: How long does a facility have to change the observation status from inpatient to observation. Can this flip back and forth?

A: The hospital must make the switch from inpatient to observation while the patient is still in the hospital and give notice to the patient, under Condition Code 44. The hospital can change the patient’s status, for purposes of its claim to Medicare, under the rebilling option.

The status can flip back and forth and sometimes does. Hospitals may consult with Executive Health Resources, a private company with physicians across the country consulting with hospitals on their patients’ status, <http://www.ehrdocs.com/>. We’ve seen instances where the EHR doctor one day makes one recommendation to the hospital about a patient’s status and the next day, a different EHR doctor makes a different recommendation.

Q: Since a patient cannot challenge outpatient status, they can leave the hospital, even if against medical advice
- And Medicare would cover the outpatient status?

A: It seems that Medicare would cover the outpatient status, unless there is a rule that says a hospital can’t bill Medicare if a patient leaves against medical advice. The patient would be billed the Part B copayments, presumably.

Q: I worked with a man who experienced his hospital status become retroactive to observation by a utilization review team soon before his discharge from a hospital to a SNF. Can you discuss advocacy efforts for CMS to review that particular rule and maybe change it?

A: This would certainly be fair and equitable. Currently we don't have any advocacy efforts directed towards the particular hospital practice of retroactively changing a patient's status from inpatient to outpatient. But advocacy efforts include: (1) supporting the legislation to count all time in the hospital, for purposes of the three-day inpatient requirements (H.R. 1421/ S.568, the Improving Access to Medicare Coverage Act of 2017); (2) drafting a legal memorandum arguing that CMS has authority under existing law to count all time in the hospital; (3) filing litigation, *Barrows*, to get notice and Due Process rights for patients who are called outpatients; (4) getting as much media coverage as possible; (5) collecting stories from beneficiaries and their families, <http://www.medicareadvocacy.org/submit-your-observation-status-story>; and (6) supporting a petition (joint effort with the National Committee to Preserve Social Security and Medicare)

<https://secure.everyaction.com/MvrJkyUqNUiZSeOYjMqFFA2>

Q: If in observation and then go to in-patient rehab, will 3 days there (rehab) count as in-patient admission?

A: If, by "inpatient rehab" you mean an inpatient rehabilitation hospital (also known as inpatient rehabilitation facility), because that care is considered by Medicare to be hospital inpatient care, then the time in the IRH/IRF would count as inpatient hospital time, if the patient then went to a SNF.

Q: If the notice is not given, is the consequence that liability for the cost of the care is shifted to the provider or is the notice essentially meaningless?

A: The NOTICE Act does not include any explicit consequence to the hospital of failing to give notice (and that answer is also true for the state laws we've read as well). But it's worth filing a complaint with the state department of health. A daughter we spoke to had her complaint substantiated (although she could not remember what the complaint was about, nor did the letter from the state say what complaint it was substantiating) and was then called by the hospital, which told her to come pick up a check for her mother's nursing home care. The hospital essentially picked up the SNF's charges.

Q: Why was observation status implemented by Medicare in the first place?

A: Observation status was initially created by hospitals when the prospective payment system (diagnosis-related groups, DRGs) went into effect decades ago. Hospitals wanted to get an additional source of payment – outpatient observation, followed by an inpatient (DRG-based) payment. The Federal Government put a stop to that practice by saying that the outpatient days were bundled into the inpatient stay and paid only by the DRG.

We really began hearing about extensive use of observation status (and other outpatient status) when the Recovery Auditor Contractor program (RAC, now just Recovery Auditors) began doing reviews. If the RAC decided that a hospital should have billed a patient as outpatient, not inpatient, the hospital had to give virtually ALL of the Medicare reimbursement back to Medicare – even though the care was medically necessary and appropriate. Hospitals didn't like the hassle of the RAC reviews, which looked at large numbers of records and went back years (and cost a lot of money. A Johns Hopkins University representative testified at a Congressional hearing in 2014 that the hospital spent \$2 million just getting ready for the RAC program to go into effect). So hospitals thought it would be better to get the lower Part B payments than risk RAC review and the possibility of nothing.

Some hospitals are still appealing these inpatient/outpatient claims. As many as about half the 700,000-800,000 appeals awaiting review by Administrative Law Judge hearings are hospitals appealing inpatient denials.

Q: If this policy is obviously so financially hurtful to Medicare beneficiaries, why isn't it being corrected?

A: Observation status saves Medicare money. Medicare is generally paying hospitals less (outpatient is usually cheaper than inpatient) and it's not paying for SNF care for lots of people.

The legislation to fix the problem has been introduced in Congress, now for the fourth time. It hasn't passed (even though there is an ad hoc coalition of 32 national organizations supporting the legislation and there is NO opposition) because (1) Bills need "scores" from the Congressional Budget Office (CBO) (A score is supposed to identify the cost of legislation; Congress requires bills to be paid for [i.e., take the money from someplace else] unless it decides to pass a bill without a score) and there is no score for this legislation; (2) Bills generally need some legislative "vehicle" to attach to. We don't have too many free-standing bills passed. Generally, legislation that needs to get enacted gets lots of other bills and ideas attached. The observation status bill could get attached to some other legislation if it had a low CBO score.

Q: I'm under the impression that part of the rationale for reduction in inpatient status has to do with key performance indicators for hospital quality of care relative to "readmission." Is this true?

A: The readmission penalty is another, more recent, incentive for hospitals to call patients outpatients. The readmission penalty applies only if a patient is an inpatient and then readmitted as an inpatient within 30 days (for certain medical issues, at this point). If either stay in the hospital is observation/outpatient, then the readmission penalty does not apply. But it seems the main rationale for observation status is RAC audits. Hospitals talk about "fraud" for calling patients inpatients. "Fraud" is not related to readmission penalties.

Q: Is there any kind of penalty if the patient dies?

A: There's no regulatory penalty.

Q: So if the services are pulled apart, ie: hospital bed, doctors, tests, meds, is it safe to say that the Part B coverage would only pay for the doctors' fees?

A: If a patient is in observation/outpatient, whatever tests, services, therapies, etc. the hospital bills is Part B, except that it also bills patients for medications and patients need to pay for the medications out-of-pocket. Patients can request that their Part D plans pay for the medications as an out-of-network pharmacy. Here's a *CMA Alert* about contacting the Part D plan, <http://www.medicareadvocacy.org/submitting-claims-to-part-d-for-prescription-drugs-administered-in-the-hospital-during-an-observation-status-stay/>

Q: So is the 2 midnight rule really only a guideline? Does the patient have any recourse with the hospital if they do not get a MOON?

A: The 2-midnight rule is a regulation, not just a guideline, but CMS also allows, on a case-by-case basis, 1-midnight inpatient stays. The 2-midnight rule is enforced by CMS through reviews on inpatient stays, reviews by Quality Improvement Organizations and reviews by Recovery Auditors.

The NOTICE Act does not give patients any specific recourse if the hospital doesn't give the moon. As discussed above, filing a complaint with the state health department might be an appropriate response and might get a result.

Q: What is the difference in the payment between an outpatient and an observation outpatient?

A: We believe that observation means that the hospital billed Medicare for observation hours (or what it may call observation services). If the hospital doesn't bill Medicare for observation hours, the patient may simply be an outpatient. The Inspector General's first report on observation indicated that about half the patients are specifically observation and half are outpatients. Here's a *CMA Alert* on the report, with a link to the IG's report. <http://www.medicareadvocacy.org/observation-status-oig-provides-an-analysis-and-cms-issues-final-regulations/>



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OBSERVATION STATUS SELF-HELP PACKET

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MEDICARE OBSERVATION STATUS SELF-HELP PACKET

1. Introduction
2. How to Use This Packet
3. Observation Status Self-Help
4. Federal Regulations Requirements for Medicare Coverage for Skilled Nursing Facility Care
5. Pertinent Federal Regulations for Medicare Appeals

INTRODUCTION

Dear Medicare Patient:

The Center for Medicare Advocacy has produced this Self-Help Packet to help you understand Observation Status and options for beneficiaries who are placed on Observation Status.

Medicare is the national health insurance program to which many disabled individuals and most older people are entitled under the Social Security Act. All too often, Medicare claims are erroneously denied. It is your right to appeal an unfair denial; we urge you to do so.

However, the situation for Observation Status appeals is unique. Medicare currently has no official method to appeal Observation Status. This may be illegal. As of August 2017, the Center is pursuing a class action lawsuit on behalf of Medicare beneficiaries to establish a way to appeal Observation Status. Sign up for the Center's Alerts and follow us on social media for important updates to the case. In the meantime, if you are placed on Observation Status, use this Packet to understand and review your options.

If you have any questions, contact the Center for Medicare Advocacy at (860) 456-7790.

HOW TO USE THIS PACKET

We've organized this packet so that it provides you with the information needed to understand observation status and to attempt to rectify the problems created by it.

1. Read the document entitled, **Observation Status Self-Help** included in this packet.
2. If you decide to file an appeal, follow each of the steps in the following Self-Help document.
3. Review the enclosed regulations to assist you with the appeal.
4. If you have questions, contact the Center for Medicare Advocacy at (860) 456-7790.

OBSERVATION STATUS SELF-HELP

Typical Experience

You are a Medicare beneficiary hospitalized for three or more days. At the hospital, you signed paperwork, slept in a hospital bed, underwent many tests, and saw various physician specialists. At some point during the hospitalization, you were told that you were not admitted as an inpatient but were, instead, an outpatient receiving “observation services.” (“Observation services” is the term Medicare uses for “observation status.”) You should have received the *Medicare Outpatient Observation Notice* (MOON) discussed below and it should have been explained to you. The MOON informs you that Medicare will not pay for care in a skilled nursing facility (nursing home) if you need that type of care after you are discharged from the hospital.

Introduction

Observation status is not new. However, its use by hospitals to avoid losing money, financial penalties, and accusations of Medicare fraud is growing. Observation status seriously affects Medicare beneficiaries’ access to care and finances. Attempts have been made to remedy the problem legislatively. For instance, bills have been introduced in Congress to eliminate the problem. In addition, the Center for Medicare Advocacy (Center) filed a nationwide class action lawsuit, now known as *Alexander v. Price* (formerly *Barrows v. Burwell* and *Bagnall v. Sebelius*), that is currently pending and seeks to establish a right for Medicare patients to appeal placement on observation status. While we wait for action on the legislation and the lawsuit, individual beneficiaries continue to be negatively affected by observation status.

This Packet includes information about observation status and outlines steps you might take if you are considered a hospital outpatient in observation status. For more information about observation status, visit the Center’s webpage at: www.medicareadvocacy.org. The process of challenging observation status is complicated and confusing. If you have questions, call the Center for Medicare Advocacy at (860) 456-7790.

1. Inpatient Admission

Medicare Part A pays for hospital inpatient care. In traditional Medicare, there is an initial deductible and, if you are hospitalized for more than 60 days, there are daily copayments. While you are hospitalized as an inpatient, Medicare Part B pays for the care provided by physicians, usually covering 80% of the Medicare-approved cost. Medigap policies or other supplemental insurance usually pays for the hospital deductible, copayments, and Part B cost-sharing.

Medicare Part A will pay for hospital care only if a physician orders inpatient care. To assist physicians with determining whether a patient/beneficiary should be admitted to the hospital as an inpatient, the Centers for Medicare & Medicaid Services (CMS), the federal agency that administers Medicare, published the following guidance in its policy manuals:

The physician or other practitioner responsible for a patient's care at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient. Physicians should use the expectation of the patient to require hospital care that spans at least two midnights period as a benchmark, i.e., they should order admission for patients who are expected to require a hospital stay that crosses two midnights and the medical record supports that reasonable expectation. However, the decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors, including the patient's medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the hospital's by-laws and admissions policies, and the relative appropriateness of treatment in each setting.¹

This language reflects new regulations that created a “two-midnight rule” - the direction to physicians to order inpatient admission for patients whom they expect will be hospitalized for at least two midnights.² Note that the two-midnight rule did not change the requirement that patients be hospitalized as an inpatient for three days, not including the day of discharge, in order for Medicare to cover post-hospital skilled nursing facility care.

If a hospital participates in the Medicare program, all of its physician inpatient admission orders must be reviewed by the hospital’s Utilization Review Committee (URC). The URC has the power to overturn any admitting physician’s admission order and to reassign patients to observation status, with the physician’s consent.

2. Observation Status

Observation status is defined by CMS in its policy manuals 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 in order to make a decision concerning their admission or discharge. Observation services are covered only when provided by the order of a physician or other 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**

¹ Medicare Benefit Policy Manual, Publ. 100-2, Ch. 1, § 10, which can be found at:

<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html>.

² 42 C.F.R. §412.3(d)(1).

reasonable and necessary outpatient observation services span more than 48 hours.³

However, despite this language, there are actually no services that are specifically observation services. CMS in fact tells physicians that they can order whatever care and services their patients need, whether they are inpatients or outpatients. In the Center for Medicare Advocacy's view, observation status is actually a Medicare billing issue (the question is whether a hospital will bill Medicare Part A or Medicare Part B for a patient's care), not a question of medical necessity or appropriateness of care.

When a Medicare patient is placed on observation status, despite the fact that the patient may be physically in the hospital for many days, for Medicare billing purposes the stay is considered outpatient care. The hospital bills Medicare Part B for each service provided (such as lab tests, intravenous medications, MRIs, EKGs).

If you are put on observation status, you will be responsible for the hospital Part B copayments and for the cost of any self-administered (prescription or over-the-counter) medications you receive while hospitalized.⁴ On the other hand, you will not be responsible for the Part A inpatient deductible. If you do not have Part B, the hospital services will not be covered.

3. The Heart of the Problem

When Medicare beneficiaries are put on observation status, Medicare Part B generally covers most of their care. The Part B cost-sharing is usually paid for by a Medigap policy or some other form of supplemental health insurance. However, if the beneficiary has opted out of Medicare Part B entirely, the hospitalization under observation could be very expensive because *nothing* will be covered by Medicare.

As a general rule, most beneficiaries are not burdened with the financial cost of the hospital stay, except for medications, but by the care they receive after the hospitalization in a nursing home.

Medicare Part A will pay for care in a skilled nursing facility (nursing home) only if the care follows a Medicare Part A covered three day *inpatient* stay in a hospital. For purposes of measuring days, the Medicare program uses calendar days, not 24-hour periods. For example, if a person is admitted to the hospital at 11:50 p.m., Medicare will count that day as the first day of admission, even though the person was "admitted" for only ten minutes. Also, the day of discharge is not counted toward the three-day period. The shorthand way of describing the three-day qualifying hospital stay requirement is "three midnights."

³ Medicare Benefits Policy Manual, Pub. 100-02, Chapter 6, § 20.6, <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html>.

⁴ The Office of the Inspector General (OIG) of the Department of Health and Human Services has stated that hospitals can discount or waive charges for an outpatient's self-administered drugs. Patients who are charged for such drugs should point the hospital to this statement. <https://oig.hhs.gov/compliance/alerts/guidance/policy-10302015.pdf> Also, patients who have a Part D plan may request that the plan pay for the drugs as an out-of-network pharmacy provider. See Center, "Submitting Claims to Part D for Prescription Drugs Administered in the Hospital During an Observation Status Stay" (CMA Alert, May 1, 2014), <http://www.medicareadvocacy.org/submitting-claims-to-part-d-for-prescription-drugs-administered-in-the-hospital-during-an-observation-status-stay/>

Any “midnight” on observation status does not count towards the three day qualifying hospital stay. **Thus, if the patient requires care in a nursing home after a hospital stay on observation status, even if that stay was for three or more days, Medicare will not pay for it.** Of course nursing home care is very expensive.

What You Can Do

Step One: Find Out Your Admission Status

Understandably, patients think that if they are kept in the hospital and spend the night in a hospital room, they are inpatients. Now that hospitals are increasingly using observation status, however, you cannot make this assumption. **So when you are hospitalized, find out whether you have been admitted as an inpatient or on observation status.**

Since March 8, 2017, hospitals have been required to give patients the Medicare Outpatient Observation Notice (MOON) within 36 hours if the patients are in observation status for 24 hours.⁵ Hospitals must also orally explain observation status and its financial consequences for patients. The MOON cannot be appealed to Medicare.

Step Two: Try to Get Your Status Changed

If you find out that you are on observation status and are concerned about Part B cost-sharing, the cost of self-administered medications, and/or Medicare payment for care in a skilled nursing facility after you leave the hospital, *try to get the status changed while you are at the hospital*. This will be difficult to do. Your best chance of success is having your community physician (regular doctor) talk to your treating physician at the hospital. Ask your community doctor to intervene on your behalf. He or she knows your medical history and speaks the same medical jargon as the hospital physician. Your community doctor might be able to convince the hospital physician that your status at the hospital should be changed from observation to inpatient.

You can try to use Medicare’s “two-midnight rule” to show the doctor or hospital that inpatient admission is appropriate.⁶ The two-midnight rule is supposed to be a way for doctors and hospitals to decide whether a patient should be admitted as an inpatient or not. Medicare states that if the doctor reasonably expects that a patient requires hospital care that will cross two midnights, she can admit the patient as an inpatient and Medicare should pay the claim under Part A.⁷ The documentation in the medical record should support the expectation of the physician. Remember that any inpatient stay is only counted from the time of the inpatient order. Time already spent in observation is not counted toward the inpatient stay even if inpatient admission is eventually ordered. So it’s important to address this question early in the

⁵ CMS-10611, available at <https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-10611.html>. The Notice of Observation Treatment and Implications for Care Eligibility (NOTICE) Act requires hospitals to inform patients, orally and in writing, that they are in observation status, not inpatients, and the consequences of that status. Pub. L. 114-42, U.S.C. §1395cc(a)(1)(Y).

⁶ A summary of the two-midnight rule put out by Medicare can be found at: <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-07-01-2.html>

⁷ Even patients who are expected to require less than two midnights of hospital care can be admitted as inpatients on a case-by-case basis.

hospitalization. Also remember that there is no prohibition against changing a patient's status from observation to inpatient if, for example, his medical condition worsens.

Step Three: Prepare For Discharge

In the event that you are not successful with changing your hospital observation status, but need follow up medical care, you have some decisions to make. If you can safely return home, ask your hospital or community physician to order home health care. As long as you are "homebound," (leaving home requires considerable effort ("taxing" effort, in the language of Medicare) and occurs infrequently) and you require skilled care (skilled nursing or physical or speech therapy), Medicare should pay for this care. Have this care set up for you by the hospital before you leave. You can find out more about home health care on the Center's website at www.medicareadvocacy.org.

If you need more medical care and therapy than you can get at home, ask your physician about going to an inpatient rehabilitation hospital (IRH, also known as an inpatient rehabilitation facility, IRF). This type of hospital does not require a three-day inpatient hospital stay. Unfortunately, not every community has an IRH and the more rigorous therapy provided by an IRH may be more intense than you can handle. But if you can participate in the level of therapy that an IRH offers, you will not need to worry about observation status and, a bonus, you may get better more quickly (and go home) than if you go to a SNF.

Step Four: Understand that Medicare Will Not Pay for Nursing Home Care After a Hospitalization on Observation Status

If you cannot safely return home, you can't go to an IRH, and the hospital physician has ordered care for you in a nursing home, check to see if the nursing home participates in the Medicare program, as most do. However, since you were not admitted to the hospital as an inpatient, Medicare will most likely not pay for this necessary care without a significant effort on your part. Even with significant effort it is very difficult to get Medicare coverage in these circumstances.

There is currently no official way to appeal observation status.⁸ Medicare claims that "only the doctor" at the hospital can decide whether you should have been admitted as an inpatient or placed on observation status and that a beneficiary cannot appeal this issue to Medicare. However, we outline some steps below that you can try. Once in a while, people succeed, though it's important to understand that is very rare.

You might be able to appeal the denial of coverage for your nursing home care as long as you spent at least three midnights in the hospital (not in the emergency room). Unfortunately, this appeal process can take a year or longer to resolve and, if you can manage to get a case into the appeal system, winning the case is difficult. Also, filing an appeal does not prevent the nursing home from requiring you to pay for your care pending the outcome of the appeal. Remember that an appeal is worth trying only if you receive the level of care that Medicare covers in the

⁸ As noted in the Introduction, this may be illegal and the Center is currently pursuing a class action case to establish a method of appeal.

skilled nursing facility – five days a week of therapy or seven days a week of skilled nursing or a combination of therapy and nursing equaling seven days a week. If you are not in a Part A stay, the nursing home can bill Medicare Part B for your therapy services.

Patients who receive five days of therapy per week in the nursing home have a better chance of winning their appeals than patients who are relying on claims of skilled nursing care, since most care is provided by unlicensed aides.

Step Five: *Start the Nursing Home Appeal*

If you decide to get care in a nursing home and it will be provided on a daily basis (five days a week of therapy or seven days a week of skilled nursing), let the nursing home know that you are going to appeal the denial of Medicare coverage. Medicare will only pay for a nursing home stay if it includes daily skilled care. Skilled care is care that is so *inherently complex* that it must be done by a skilled professional. The skilled nursing and/or therapy can be to improve or maintain your condition. Medicare will not pay for care in a nursing home when it is only custodial. Examples of custodial care include the administration of oral medications or assisting a patient with bathing or toileting. For more information about Medicare coverage of skilled nursing facility care, and how to appeal a denial visit our website at www.medicareadvocacy.org.

To start the appeal, ask the nursing home to submit a “demand bill” to Medicare for your entire stay. You can make this request after you leave the nursing home. However, note that nursing homes must bill Medicare within one year of the time the care began, so do not wait too long to make this request. In response to the nursing home’s demand bill, CMS will issue a denial of payment from which you can appeal. You can also ask the nursing home to give you a Notice of Exclusion from Medicare Benefits – Skilled Nursing Facility (NEMB-SNF),⁹ which is a form for so-called “technical denials” of coverage.

A technical denial means that you need the care the nursing home provides but that you do not qualify for Medicare coverage for technical reasons, such as not having a three-day inpatient hospital stay (the first box) or having used all 100 days in a benefit period. Check Option 1 so that the nursing home will submit the claim to Medicare for a decision about coverage.

Step Six: *Request a Redetermination for the Nursing Home Denial*

You will receive a Medicare Summary Notice (MSN) in the mail which will reflect the nursing home’s bill to Medicare. The MSN will indicate that Medicare has denied payment for your care in the nursing home because you did not have a *three day qualifying hospital stay*. Read the last page of the MSN. It will tell you that you have 120 days to appeal the denial of coverage. Follow the instructions on how to and file an appeal. Circle the denial of payment for your nursing home care. Write that you are appealing because you did receive three days of hospital inpatient care. If you have a copy of your hospital discharge summary reflecting that you were hospitalized for three days, send a copy of it with your MSN requesting an appeal.

⁹ CMS Form 20014, <https://www.cms.gov/Medicare/Medicare-General-Information/BNI/Downloads/CMS20014.pdf>.

If you have submitted the NEMB-SNF, you will receive a response that will tell you how to appeal the decision.

Step Seven: *Gather Hospital Records*

Write to the hospital and ask for a copy of your medical record. Ask that it send you the following documents: emergency room records; admission records; physician orders; consultation reports; lab reports; diagnostic imaging; medical records; nursing narratives; discharge summary; and social service documentation. The hospital may charge you for copying and sending the documents, although charges for records in support of Medicare claims are not allowed in some states, including Connecticut and Massachusetts. When you get the records, give a copy of them to your community physician. Ask your physician to review the records and to write a statement explaining that the care you received while hospitalized was inpatient hospital care.

Check the records carefully for any inpatient orders. If you *were* actually admitted as an inpatient for a period of time that crossed three midnights, that is the strongest type of appeal you can make. Without such an order, it will be exceedingly difficult to win your appeal. You can try to argue that the care you received was inpatient hospital care, but Medicare's position is that without an inpatient *order*, there can be no inpatient coverage under Part A.

Step Eight: *Gather Nursing Home Records*

Write to the nursing home and ask for a copy of your medical record. Ask for the following documents: MDS forms; physician orders; physician progress notes; medication records; therapy records (physical, occupational, and speech), nursing narrative notes; and physician certifications. As with the hospital medical records, the nursing home may charge you for copying and sending these documents. Also write to the nursing home physician and ask that he or she write a letter for you explaining that while you were a patient at the nursing home, you required and received a skilled nursing facility level of care.

Step Nine: *Request a Reconsideration for the Nursing Home Denial*

You should receive a "Redetermination" decision in the mail for your nursing home care. It will be "unfavorable." You will have 180 days to appeal. Follow the directions on the form for requesting a "Reconsideration." On the nursing home appeal request, write that you are appealing because you were hospitalized and received an inpatient level of care for three consecutive days prior to receiving care at the skilled nursing facility. If you have letters from physicians in support of your case, send copies with your request.

Step Ten: *Request an ALJ Hearing*

You should receive a "Reconsideration" decision in the mail for your nursing home care. Again this will be a denial. You will have 60 days to appeal. Follow the directions on the form for requesting an administrative law judge (ALJ) hearing. ALJ appeals are often successful.

Step Eleven: *Respond to the Notice of Hearing*

You will receive a written notice of hearing in the mail. Respond to the notice as directed. **Note:** Unrepresented beneficiaries have a right to **hearing by video teleconference**, which is generally a more effective method for making a case than a telephone hearing. Make sure that the notice states that a video teleconference is scheduled. If it does not, contact the ALJ and request that the hearing be rescheduled as a video teleconference. In addition, ask the judge to send you a copy of the **exhibit list** and **hearing file**.

Step Twelve: *Prepare for the Hearing*

When you receive the hearing file, make sure that it includes all the medical records that you have obtained from the hospital and the skilled nursing facility. If it does not, send the missing records to the ALJ. Be sure and send a copy of the letters of support you received from your physicians. Contact the nursing home and ask if a therapist or nurse will testify at the hearing on your behalf.

Step Thirteen: *Argue your Case*

Attend the hearing. Make sure the judge has the additional records that you sent in. If you can, have someone from the nursing home testify that the care you received while there was skilled care and that it was performed on a daily basis. Explain to the judge that your care at the skilled nursing facility was not covered by Medicare because the hospital erroneously billed your inpatient hospital level of care to Medicare Part B rather than Part A. Ask the judge to find that your hospital care was an inpatient level of care and that you've met the three day qualifying hospital stay requirement for skilled nursing facility care. Then ask the judge to find that your skilled nursing facility care was medically reasonable and necessary and coverable by Medicare Part A.

Step Fourteen: *If You Lose the Appeal*

You will receive the Administrative Law Judge's decision in the mail. If it is favorable, send a copy to the nursing home and ask that it reimburse you if you previously paid for any care or ask that it stop any collection efforts started against you. If it is unfavorable, follow the directions on the hearing decision for filing a Medicare Appeals Council request.

Conclusion

Trying to fix placement on observation status is very difficult and, in the rare cases where people succeed, it generally takes a long time. Should you have questions during the process, you can call the Center for Medicare Advocacy at (860) 456-7790. You can also report your difficulties with observation status to your Senators and Representative in Congress, as it's important that they understand the hardships people are facing. Finally, please continue to monitor our website www.medicareadvocacy.org for updates on proposed changes to the law and on our lawsuit.

**Federal Regulations
Medicare Coverage of
Skilled Nursing Facility Care
42 CFR 409.30 – 409.36**

All the links below can be found at:

<https://www.law.cornell.edu/cfr/text/42/part-409/subpart-D>

- [§ 409.30 Basic requirements.](#)
- [§ 409.31 Level of care requirement.](#)
- [§ 409.32 Criteria for skilled services and the need for skilled services.](#)
- [§ 409.33 Examples of skilled nursing and rehabilitation services.](#)
- [§ 409.34 Criteria for “daily basis.”](#)
- [§ 409.35 Criteria for “practical matter.”](#)
- [§ 409.36 Effect of discharge from posthospital SNF care.](#)

**Pertinent Federal Regulations
for Medicare Appeals
42 CFR §§ 405.900 – 405.1140**

All the links below can be found at:

<https://www.law.cornell.edu/cfr/text/42/part-405/subpart-I>

- [§ 405.900 Basis and scope.](#)
- [§ 405.902 Definitions.](#)
- [§ 405.904 Medicare initial determinations, redeterminations and appeals: General description.](#)
- [§ 405.906 Parties to the initial determinations, redeterminations, reconsiderations, hearings, and reviews.](#)
- [§ 405.908 Medicaid State agencies.](#)
- [§ 405.910 Appointed representatives.](#)
- [§ 405.912 Assignment of appeal rights.](#)

Initial Determinations (§§ 405.920 - 405.928)

- [§ 405.920 Initial determinations.](#)
- [§ 405.921 Notice of initial determination.](#)
- [§ 405.922 Time frame for processing initial determinations.](#)
- [§ 405.924 Actions that are initial determinations.](#)
- [§ 405.925 Decisions of utilization review committees.](#)
- [§ 405.926 Actions that are not initial determinations.](#)
- [§ 405.927 Initial determinations subject to the reopenings process.](#)
- [§ 405.928 Effect of the initial determination.](#)

Redeterminations (§§ 405.940 - 405.958)

- [§ 405.940 Right to a redetermination.](#)
- [§ 405.942 Time frame for filing a request for a redetermination.](#)
- [§ 405.944 Place and method of filing a request for a redetermination.](#)
- [§ 405.946 Evidence to be submitted with the redetermination request.](#)
- [§ 405.947 Notice to the beneficiary of applicable plan's request for a redetermination.](#)
- [§ 405.948 Conduct of a redetermination.](#)
- [§ 405.950 Time frame for making a redetermination.](#)
- [§ 405.952 Withdrawal or dismissal of a request for a redetermination.](#)
- [§ 405.954 Redetermination.](#)
- [§ 405.956 Notice of a redetermination.](#)
- [§ 405.958 Effect of a redetermination.](#)

Reconsideration (§§ 405.960 - 405.978)

- [§ 405.960 Right to a reconsideration.](#)
- [§ 405.962 Timeframe for filing a request for a reconsideration.](#)
- [§ 405.964 Place and method of filing a request for a reconsideration.](#)
- [§ 405.966 Evidence to be submitted with the reconsideration request.](#)
- [§ 405.968 Conduct of a reconsideration.](#)
- [§ 405.970 Timeframe for making a reconsideration following a contractor redetermination.](#)
- [§ 405.972 Withdrawal or dismissal of a request for reconsideration or review of a contractor's dismissal of a request for redetermination.](#)
- [§ 405.974 Reconsideration and review of a contractor's dismissal of a request for redetermination.](#)
- [§ 405.976 Notice of a reconsideration.](#)
- [§ 405.978 Effect of a reconsideration.](#)

Reopenings (§§ 405.980 - 405.986)

- [§ 405.980 Reopening of initial determinations, redeterminations, reconsiderations, decisions, and reviews.](#)
- [§ 405.982 Notice of a revised determination or decision.](#)
- [§ 405.984 Effect of a revised determination or decision.](#)
- [§ 405.986 Good cause for reopening.](#)

Expedited Access to Judicial Review (§ 405.990)

- [§ 405.990 Expedited access to judicial review.](#)

ALJ Hearings (§§ 405.1000 - 405.1058)

- [§ 405.1000 Hearing before an ALJ and decision by an ALJ or attorney adjudicator: General rule.](#)
- [§ 405.1002 Right to an ALJ hearing.](#)
- [§ 405.1004 Right to a review of QIC notice of dismissal.](#)
- [§ 405.1006 Amount in controversy required for an ALJ hearing and judicial review.](#)
- [§ 405.1008 Parties to the proceedings on a request for an ALJ hearing.](#)
- [§ 405.1010 When CMS or its contractors may participate in the proceedings on a request for an ALJ hearing.](#)
- [§ 405.1012 When CMS or its contractors may be a party to a hearing.](#)
- [§ 405.1014 Request for an ALJ hearing or a review of a QIC dismissal.](#)
- [§ 405.1016 Time frames for deciding an appeal of a QIC reconsideration or escalated request for a QIC reconsideration.](#)
- [§ 405.1018 Submitting evidence.](#)
- [§ 405.1020 Time and place for a hearing before an ALJ.](#)
- [§ 405.1022 Notice of a hearing before an ALJ.](#)
- [§ 405.1024 Objections to the issues.](#)
- [§ 405.1026 Disqualification of the ALJ or attorney adjudicator.](#)
- [§ 405.1028 Review of evidence submitted by parties.](#)
- [§ 405.1030 ALJ hearing procedures.](#)

- [§ 405.1032 Issues before an ALJ or attorney adjudicator.](#)
- [§ 405.1034 Requesting information from the QIC.](#)
- [§ 405.1036 Description of an ALJ hearing process.](#)
- [§ 405.1037 Discovery.](#)
- [§ 405.1038 Deciding a case without a hearing before an ALJ.](#)
- [§ 405.1040 Prehearing and posthearing conferences.](#)
- [§ 405.1042 The administrative record.](#)
- [§ 405.1044 Consolidated proceedings.](#)
- [§ 405.1046 Notice of an ALJ or attorney adjudicator decision.](#)
- [§ 405.1048 The effect of an ALJ's or attorney adjudicator's decision.](#)
- [§ 405.1050 Removal of a hearing request from an OMHA to the Council.](#)
- [§ 405.1052 Dismissal of a request for a hearing before an ALJ or request for review of a QIC dismissal.](#)
- [§ 405.1054 Effect of dismissal of a request for a hearing or request for review of QIC dismissal.](#)
- [§ 405.1056 Remands of requests for hearing and requests for review.](#)
- [§ 405.1058 Effect of a remand.](#)

Applicability of Medicare Coverage Policies (§§ 405.1060 - 405.1063)

- [§ 405.1060 Applicability of national coverage determinations \(NCDs\).](#)
- [§ 405.1062 Applicability of local coverage determinations and other policies not binding on the ALJ or attorney adjudicator and Council.](#)
- [§ 405.1063 Applicability of laws, regulations, CMS Rulings, and precedential decisions.](#)

Medicare Appeals Council Review (§§ 405.1100 - 405.1140)

- [§ 405.1100 Medicare Appeals Council review: General.](#)
- [§ 405.1102 Request for Council review when ALJ or attorney adjudicator issues decision or dismissal.](#)
- [§ 405.1106 Where a request for review or escalation may be filed.](#)
- [§ 405.1108 Council actions when request for review or escalation is filed.](#)
- [§ 405.1110 Council reviews on its own motion.](#)
- [§ 405.1112 Content of request for review.](#)
- [§ 405.1114 Dismissal of request for review.](#)
- [§ 405.1116 Effect of dismissal of request for Council review or request for hearing.](#)
- [§ 405.1118 Obtaining evidence from the Council.](#)
- [§ 405.1120 Filing briefs with the Council.](#)
- [§ 405.1122 What evidence may be submitted to the Council.](#)
- [§ 405.1124 Oral argument.](#)
- [§ 405.1126 Case remanded by the Council.](#)
- [§ 405.1128 Action of the Council.](#)
- [§ 405.1130 Effect of the Council's decision.](#)
- [§ 405.1132 Request for escalation to Federal court.](#)
- [§ 405.1134 Extension of time to file action in Federal district court.](#)
- [§ 405.1136 Judicial review.](#)
- [§ 405.1138 Case remanded by a Federal district court.](#)

- § 405.1140 Council review of ALJ decision in a case remanded by a Federal district court.