The Medicare Observation-Status Scam: When Is An Inpatient Not An Inpatient?
By Robert E. Rains

One evening this past winter, I passed out while riding in a car being driven by my son. It appeared to him that I was not breathing and had no pulse, so he called 911. An ambulance came and transported me to a local hospital. I received excellent care in the emergency room and, by 2 a.m., had recovered enough to be moved to a regular bed. The very nice ER doctor told me that the hospital had located a room for me on the "OBS" ward. "Obstetrics?" I asked, somewhat puzzled. "If that were true," she replied, "we'd both be millionaires. You're going to an observation room." So, still connected to a lot of fancy equipment and on an IV drip, I was wheeled to a room upstairs, where I was poked and prodded and given various meds through the morning hours. As far as I could tell, the observation room was a normal hospital room, with the single exception being that it had paper towels instead of a cloth towel. Another doctor showed up around 11 a.m. and told me that after I received some more IV medicine I would be released, which was just fine with me. Sometime thereafter, a social worker came in with a form on a tablet telling me that I had only been on observation status and, contrary to appearances, had not been an inpatient. She asked me to sign the form indicating that I had read and understood it. Just as we all check off those electronic boxes indicating that we have read, understood and agree to the terms and conditions of whatever it is we want to order online, I duly signed the form, having no real understanding of its implications.

Here is what I have since learned.

Medicare Parts A and B
For Medicare beneficiaries, the distinction between inpatient and outpatient hospital status can have severe financial consequences, especially when the beneficiary lacks good supplemental private insurance. Medicare Part A pays for inpatient hospital stays, not for supposed "observation" stays while in the hospital. Medicare Part B does not cover hospital stays at all, but does cover doctors' services for both inpatient and outpatient stays, subject to deductibles, coinsurance and copayments. Critically important, if the patient is sent to a skilled nursing facility (SNF) at the end of a hospital stay, Medicare will only cover the SNF if the patient had been in a "qualifying inpatient hospital stay" for at least three days (midnights) in a row prior to transfer.

To make matters even more complicated, a hospitalized patient's status may change during the course of hospitalization. According to the Centers for Medicare and Medicaid Services (CMS), if a patient comes to the hospital emergency room with chest pain and is held in observation status for one night, then formally admitted for a second night, Medicare Part A will only pay for the second night of hospitalization.

Also, while the decision to formally admit the patient is theoretically a medical decision for the doctor to make, the reality is that the doctor can be overruled, even retroactively, either internally by the hospital's Utilization Review Committee or externally. In an effort to save money, Congress developed the Recovery Audit Contractor (RAC) program in 2005, empowering contractors to audit inpatient hospital admissions for appropriateness retrospectively and to recover amounts that represent "overbilling." According to a 2013 article in The New England

Journal of Medicine by Drs. Christopher W. Baugh and Jeremiah D. Schuur, titled "Observation Care — High-Value Care or a Cost- Shifting Loophole?," the RAC program resulted in more than $2 billion recovered from hospitals in 2012 alone. In those situations, the hospital must refund its Part A payment to the government and is barred from seeking reimbursement from the patient under Part B, so there is a strong economic incentive for hospitals to classify Medicare patients as being on observation status.

Not surprisingly, observation status hospitalizations have increased dramatically in recent years. An article published in Health Affairs in June 2012 reported that during 2007-09, the ratio of observation stays to inpatient admissions increased 34 percent. And, the Medicare Payment Advisory Committee reported to Congress in March 2014 that from 2002 to 2012, the number of outpatient observation claims submitted to Medicare increased by 88 percent, with the average length of such stays increasing to 29 hours.

Examples

Eighty-three-year-old Miriam Nyman was hospitalized in 2009 for four nights with a broken neck. Upon release, she was transferred to a SNF. Because she was classified as having been on observation care in the hospital, hence not an inpatient, Part A did not cover her hospital stay, and she had no coverage for her skilled nursing care. Her out-of-pocket expenses exceeded $35,000.

In 2010, Sarah Mulcahy, age 96, was taken to the ER with severe pain and other symptoms. She was hospitalized for five days, receiving IV medications and undergoing multiple tests. She was transferred to an SNF where she stayed for more than three months. Because her hospital stay was deemed to be observation status, it was not covered by Part A, and she owed roughly $335 in coinsurance under Part B. But much more significantly, none of her SNF care was covered by Medicare, so she owed another $30,000.

These two cases illustrate yet another aspect of the situation. Medicare recipients, by definition, are the elderly (over 65) and disabled. For a person under 65 to be eligible for Medicare, he or she must have been found to be disabled by the Social Security Administration and then is usually subject to a 29-month waiting period after that finding. (The only exceptions to the 29-month waiting period are for those with Amyotrophic Lateral Sclerosis — commonly known as ALS or Lou Gehrig's Disease — or end-stage renal disease.) Thus, Medicare recipients, by definition, constitute exactly that part of our population that one would expect to be the most medically vulnerable and in need of inpatient services when hospitalized.

Challenges and Remedies

There have, of course, been challenges to CMS' policies regarding inpatient status, but thus far with less than satisfactory results for hospitalized Medicare recipients. In 2009, in the case of Landers v. Leavitt, 545 F.3d 98, the 2nd Circuit Court of Appeals rejected claims that the Medicare statute entitled plaintiffs to coverage for their SNF stays. Plaintiffs had pointed out that neither the statute nor any applicable regulation defines "inpatient." But the court deferred to the agency's interpretation of "inpatient" in the absence of such authority and further rejected an equal protection claim. One of the named plaintiffs in that case was 101 years old when she

entered the ER and was considered to be on observation status despite receiving IV morphine for pain. She died before the case was decided.

A follow-up case is now pending within the 2nd Circuit. In *Bagnall v. Sebelius*, 2013 WL 5346659, the federal district court for the District of Connecticut had dismissed claims by 14 plaintiffs that they had been improperly denied Medicare coverage because they had not been formally admitted to the hospital. Actually, two of the plaintiffs had been formally admitted, but their admissions were later revoked. Plaintiffs appealed to the 2nd Circuit, asserting that they should be entitled under the Medicare Act and the Due Process Clause to expedited notice of the decision to place them into "observation status" or an expedited opportunity to challenge that decision. In 2015, in *Barrows v. Burwell*, 777 F.3d 106, the 2nd Circuit reinstated the plaintiffs' due process claims. Most recently, in 2017, the district court on remand granted class certification, and the matter is ongoing. *Alexander v. Price*, 275 F. Supp. 3d 313 (D.Conn. 2017). In fiscal year 2014, CMS implemented a "2-midnight" policy in an effort to clarify the inpatient/outpatient dichotomy. The policy establishes that inpatient admission is generally appropriate if physicians expect the hospitalization to last at least two midnights. Otherwise, outpatient status is generally appropriate. Such a relatively bright-line test seemed to be a good idea. But it hasn't worked out that way. In December 2016, the Department of Health and Human Services' Office of Inspector General (OIG) issued a report titled "Vulnerabilities Remain Under Medicare's 2- Midnight Hospital Policy." Among the OIG's findings under the policy were:

• Hospitals continue to bill for a large number of long outpatient stays.
• An increased number of beneficiaries in outpatient stays pay more and have limited access to SNF services than they would as inpatients.

Since March 2017, federal law has required acute care hospitals to give oral and written notice to patients who are classified as being on observation status for more than 24 hours. Notice must be provided within 36 hours. CMS has created a standard form, the Medicare Outpatient Observation Notice (the "MOON" notice). But, while patients are supposed to be provided such notice, CMS has decided that they do not have appeal rights to challenge their status and ask the Medicare program to decide if they should be admitted as inpatients.

What Can the Individual Medicare Recipient Do?

The sad truth is that there is not much the individual Medicare recipient can do in these situations, and elderly and disabled people may not be at their best when hospitalized or in a nursing home. It helps to have an informed relative or friend who can act as an advocate. If the recipient is still in the hospital and is unclear what her status is, she needs to ask and find out. If she is on observation status, she should ask her doctor why and ask to be changed to inpatient status. But, as noted, even if the doctor agrees, that decision can be overruled.

If the patient is already in an SNF after a three-day or longer hospitalization and learns that Medicare will not cover the expense of nursing care, he can pay the bill and seek coverage through a Medicare appeal or leave the facility. If the patient decides to remain in the SNF, he can ask the facility to fill out a "Notice of Exclusions from Medicare Benefits Skilled Nursing Facility" form. The SNF will check off a box indicating "no qualifying 3-day inpatient hospital stay." The patient then checks another box asking the SNF to submit it to Medicare along with

documentation supporting the need for skilled nursing services. If, as is likely, Medicare does not pay, that decision should be appealable. For more information and assistance, one may contact the Center for Medicare Advocacy's observation care website: www.medicareadvocacy.org/medicareinfo/observation-status

A Possible Partial Solution on the Horizon: The Improving Access to Medicare Coverage Act of 2017

A bipartisan group in Congress has introduced legislation in both Houses that has the potential to fix this problem with regard to follow-up SNF care. The Improving Access to Medicare Coverage Act of 2017 (S. 568/H.R. 1421) would provide that time spent in observation status be counted toward meeting the three-day prior inpatient stay requirement. For purposes of coverage of follow-up SNF care, this would render the observation/ inpatient distinction irrelevant. It would not, however, change the noncoverage of observation hospitalization under Medicare Part A.

Write your members of Congress.

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