NEW!
Observation Status Appeals

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Class Counsel in *Alexander v. Azar*

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About the Center for Medicare Advocacy

The Center for Medicare Advocacy is a non-profit, non-partisan law organization founded in 1986 that works to advance health equity, access to comprehensive Medicare, and quality health care. Based in Connecticut and Washington DC with additional attorneys in California, Maryland, Massachusetts, and Wisconsin.

- Attorneys, advocates, a nurse, communication and technical experts
- Education, legal analysis, writing, assistance, and advocacy
- Systemic Change - Policy and Litigation
  - Based on our experience with the problems of real people
- Medicare coverage and appeals expertise
- Medicare/Medicaid Third Party Liability Projects

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Agenda

- The problem
- The class action lawsuit
- Implementation – Who can appeal? How? When?
  - –Retrospective Appeals – starting January 1, 2025
  - –Prospective Appeals – starting February 14, 2025

This document is for informational purposes only and not intended as legal advice.

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The Problem

- Medicare requires 3-day **inpatient** (Part A) hospitalization for a covered nursing home stay. The 3 days does not include day of discharge.
  - Time in "outpatient observation status" (Part B) is not counted toward the 3 days.
  - 1 day (inpatient) + 2 days (observation) ≠ 3 days. **No nursing home coverage**.
  - 2 days (inpatient) + 3 days (observation) ≠ 3 days. **No nursing home coverage**.
- Also, people without Medicare Part B may owe full "sticker price" for **hospital** services.
- Medicare did not allow appeals of patient status.
  - Pay thousands or go without care.

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The Lawsuit

- CMA filed class action in November 2011. Co-counsel Justice in Aging and Wilson Sonsini Goodrich & Rosati. In litigation for a **LONG** time.
- **DECISION**: Medicare violates class members' constitutional rights when it does not allow them to appeal their patient status. Must create an appeals process for class members.
    - People who are **reclassified** from inpatient to observation while in hospital (among other criteria).
- **ORDER:** Create appeals for class members who did not have process available at the time (retrospective), and expedited appeals for class members going forward (prospective).

Alexander v. Azar, 613 F. Supp. 3d 559 (D. Conn. 2020), *aff'd sub nom. Barrows v. Becerra*, 24 F. 4th 116 (2d Cir. 2022)

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Implementation: 2 Types of Appeals

- **RETROSPECTIVE**: for class members who did not have appeal available at the time they were in hospital/nursing home.
  - Possible refunds of out-of-pocket payments from nursing homes, if win.
    - Or from hospitals for “no Part B” class members.
  - Cover hospitalizations from Jan. 1, 2009 – Feb. 14, 2025. Available for closed period.
- **PROSPECTIVE:** for class members who are in the hospital and wish to appeal reclassification from inpatient to observation.
  - Can qualify for Medicare-covered nursing home stay at a meaningful time, if win.
  - Will be available permanently
    - Final Rule, October 15, 2024: 89 Fed. Reg. 83240 (Oct. 15, 2024).

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RETROSPECTIVE APPEALS

- WHO can appeal?
- HOW can you appeal?
- WHEN can you appeal?

42 C.F.R. §§ 405.931-405.938

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RETROSPECTIVE APPEALS

- **WHO?** (Paraphrase)
  - Traditional Medicare beneficiary who was **reclassified** from hospital inpatient to "outpatient receiving observation services" on or after **January 1, 2009**; **AND**
  - Received a **notice** showing hospital not covered by Part A (either a "Medicare Summary Notice" [MSN] or a "Medicare Outpatient Observation Notice" [MOON]); **AND**
  - **EITHER**:
    - Stayed in hospital **at least 3 days, but was inpatient fewer than three days**, and was **admitted to a nursing home within 30 days** after leaving hospital.
  - **OR**:
    - **Was not enrolled in Part B** at time of hospitalization.

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RETROSPECTIVE APPEALS

- **HOW?**
  - Submit a request to the “Eligibility Contractor” – Q2 Administrators
  - **FORM**: “Request Form for Retrospective Appeal of Medicare Part A Coverage”
    - OR
  - Follow instructions listed on Medicare website (CMS.gov). Lists information to include.
  - Can be mailed or faxed, instructions on form and on website.

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RETROSPECTIVE APPEALS

- **HOW? (cont'd)**
  - Must include basic info (name, Medicare #, hospital and nursing home info, dates)
  - **HELPFUL** to include:
    - Hospital records; Nursing home records
    - Medicare Summary Notices listing hospital stay, nursing home stay; MOON (if got one)
    - Any bills or itemized statements from the nursing home; (and from the hospital, if applicable)
    - Proof of payment of out-of-pocket costs
  - **Send in as much as you can.** Try to be as complete as possible. You can supplement later.
  - Eligibility contractor also must help obtain required medical records.

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RETROSPECTIVE APPEALS

- **HOW? (cont'd)**
  - Can also include a written statement(s) about **why the inpatient admission was correct**.
    - Hospitalizations on or after October 1, 2013 – Two Midnight Rule:
      - Was there a reasonable expectation at time of doctor's inpatient admission order that you needed medically necessary hospital care crossing at least 2 midnights?
      - Factors considered can include medical history, medical needs, severity of signs and symptoms, medical predictability of adverse event.
    - Hospitalizations before October 2013:
      - Was there a reasonable expectation at time of doctor's inpatient admission order that you needed medically necessary hospital care for at least 24 hours?

42 C.F.R. § 412.3(d)(1); Medicare Benefit Policy Manual Ch. 1 § 10

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RETROSPECTIVE APPEALS

- **WHEN?**
  - Request **no later January 2, 2026.**
    - Also “good cause” for filing later (same as for other Medicare appeals)
      - Examples: your own “serious illness,” “death or serious illness in your immediate family,” “you didn’t understand how to file an appeal,” “physical, mental, educational, or other limitations (including limited understanding of English) that delayed or prevented you from filing your request on time. This may include delays because you had to get help from an outside resource (like your State Health Insurance Assistance Program (SHIP) or senior center).”

42 C.F.R. § 405.942(b)(2)-(3)

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RETROSPECTIVE APPEALS

- **WHAT CAN I DO NOW?**
  - **Gather records!** Comprehensive **hospital records** including documentation of:
    - Admission as inpatient
    - Orders for observation services
    - Diagnosis and treatment notes
    - Discharge notes and summaries
  - **Nursing home records**, showing care received (which must also meet Medicare coverage requirements), and info on out-of-pocket payments (bills, cashed checks, credit card statements)
    - Payments made by family, close friends, count as out-of-pocket costs.
  - ACCESSING HEALTH RECORD WEBSITE: https://triagecancer.org/state-laws/medical-records

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RETROSPECTIVE APPEALS

- **WHO CAN HELP OR REPRESENT YOU?**
  - Most existing rules about appointed representatives and authorized representatives apply**.**
    - You can appoint trusted family/friend, caregiver, advocate, lawyer, or someone else, as a representative: FORM or online. (tip: submit copy of form with each request and level of appeal)
    - Some people are already authorized: rep payee, guardian, power of att'y (include docs.)
    - If beneficiary is deceased, person who is authorized to act for the deceased may request appeal. Include proof of authority (e.g., proof you are executor of estate, or info on state law authorizing you to handle affairs if there is no estate).
  - **BUT***:* The hospital/nursing home **cannot *represent*** the patient in the appeal, or be a party to the appeal. However, they **can *help*** patients navigate the process, provide info, records.

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RETROSPECTIVE APPEALS

- The process:
  - **Eligibility Contractor** (Q2 Administrators): **decides if you are eligible to appeal**, generally in 60 days.
    - **If not eligible**: right to one more review from eligibility contractor; can provide additional info.
    - **If eligible**: automatically forwarded to →
  - **Appeal contractor**: decides if your hospitalization **should have remained inpatient**.
  - Then same as existing, standard Medicare appeals. 4 levels. Level 3 = Administrative Law Judge (ALJ) hearing. Possible judicial review. Follow instructions carefully.

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RETROSPECTIVE APPEALS – EXAMPLES

- Ms. B is enrolled in traditional Medicare. She had a bad fall at home and after going to the ER was hospitalized from June 30 – July 5, 2015. She was initially admitted as an inpatient, but she was reclassified as an outpatient receiving observation services on July 1, 2015. She then went to a nursing home on July 5, 2015, where she received four weeks of skilled care including physical and occupational therapy. Because she did not have a 3-day stay as an inpatient in the hospital, she did not qualify for Medicare coverage of the nursing home stay and paid around $10,000 out of pocket to the nursing home.
  - Is Ms. B eligible to appeal?

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RETROSPECTIVE APPEALS - EXAMPLES

- Yes, Ms. B should submit a request for a retrospective appeal!
  - She was reclassified from inpatient to observation after January 1, 2009.
  - She should have received both a Medicare Summary Notice from Medicare (by mail – also available online), and a MOON from the hospital, showing her hospital services were not covered by Part A.
  - She was in the hospital for at least 3 days but was an inpatient for fewer than 3 days.
- She also received skilled care at the nursing home and has out-of-pocket costs. Likely qualifies for Medicare coverage and has a good reason to appeal.
- To prepare: she should request hospital and nursing home records. Copy of notice. Record of payments. Could request written statement from doctor explaining why inpatient hospitalization appropriate.
- If wins, Medicare Part A covers nursing home stay. She should receive refund from nursing home minus any coinsurance amounts.

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RETROSPECTIVE APPEALS - EXAMPLES

- Mr. R. is in traditional Medicare. In 2018, he went to the ER for severe stomach pain and was hospitalized from April 17 - April 19. At the time, he was enrolled only in Medicare Part A and did not have Medicare Part B. He was admitted as an inpatient and then reclassified as an outpatient receiving observation services. The hospital gave him a “MOON” notice explaining he was on observation status. He later received a bill from the hospital for around $15,000. He told the hospital billing office he could not afford to pay that much and wound up paying around $5,000.
  - Is Mr. R. eligible to appeal?

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RETROSPECTIVE APPEALS - EXAMPLES

- Yes, Mr. R should submit a request for a retrospective appeal!
  - He was reclassified from inpatient to observation after January 1, 2009.
  - He received a MOON from the hospital, showing that his hospital services were not covered by Medicare Part A.
  - He was not enrolled in Medicare Part B at the time.
- He had out-of-pocket hospital costs.
- To prepare: he should request the hospital records, including a copy of the MOON. He should also gather records of the hospital bills and his ultimate payment to the hospital. He could request written statement from doctor explaining why the hospitalization was appropriate for inpatient admission.
- If he wins, Medicare Part A covers hospital stay. He should receive refund from hospital minus any deductible/coinsurance amounts.

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RETROSPECTIVE APPEALS- EXAMPLES

- Ms. K had Medicare A and B, was hospitalized after a fall from May 1 – 5, 2023. She was admitted as an inpatient and then reclassified as an outpatient receiving observation services on May 3. Without a 3-day inpatient stay, she could not find a nursing home she could afford after her hospitalization, and she was discharged home.
  - Ms. K is not eligible to appeal because she was not admitted to a nursing home within 30 days of her hospital discharge.
  - Retro appeals only concern services received.

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PROSPECTIVE APPEALS

42 C.F.R. §§ 405.1210 through 405.1212

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PROSPECTIVE APPEALS

- For **eligible** Medicare beneficiaries who wish to appeal reclassification from inpatient to observation
- Can be requested before leaving the hospital so that, if they win, they may be able to qualify for post-hospital nursing home coverage
- Appeals process will be operational on **February 14, 2025**
- Will be available permanently
- Expedited **and** standard appeals available

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Who is Eligible For Prospective Appeal Rights?

A person enrolled in **Traditional Medicare** (not Medicare Advantage) who is admitted as an inpatient, but later reclassified as an "outpatient receiving observation services"

AND EITHER

Spends at least 3 consecutive days in the hospital (not counting day of discharge)

* since they would be disqualified from covered stay in nursing home*

OR

Is not enrolled in Part B during the hospitalization

since they could be financially liable for entire hospital bill

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Hospitals Must Issue Notice of Appeal Rights to Eligible Patients

- NEW: **Medicare Change of Status Notice (MCSN)**

  Standardized notice informs of status change to “outpatient on observation” **and**

  - Hospital stay will be billed to Medicare Part B instead of Part A
  - Could impact their hospital bill – Part B 20% copay for items and services could be higher or lower than Part A inpatient deductible **TIP:** check with the billing department
  - Patient without Part B will be charged full cost
  - Medicare will not pay for skilled nursing home stay
  - **APPEAL RIGHTS**, how to appeal to the QIO (Appeal Contractor), what to expect

- **NOTE:** The MCSN is **separate and different from** other notices, such as the MOON (Medicare Outpatient Observation Notice)

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When Do Eligible Patients Receive Change of Status Notice?

- No later than 4 hours before release from the hospital and “as soon as possible” after patient is eligible to appeal.

Scenario #1 – Person admitted as inpatient on Monday, hospital changes status to outpatient observation on Tuesday. Discharged on Wednesday. Answer: MCSN not required because no 3-day stay.

Scenario #2 – Person admitted as inpatient on Monday, status changed on Tuesday. Discharged on Thursday. Answer: Patient should get notice on Wednesday, but no later than 4 hours prior to release on Thursday.

Scenario #3 – Person has *no Part B*. Admitted as inpatient on Monday, status changed on Tuesday. Discharged on Wednesday. Answer: Patient should get notice on Tuesday.

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How Do Eligible Patients Appeal?

- **Expedited determination request:** made in writing or by phone to QIO *before leaving hospital*

QIO (appeal contractor) must:

a) examine medical & other records (Hospital must furnish information no later than noon of following calendar day. At QIO's discretion, can be conveyed by phone)

b) ask for views of beneficiary (or representative)

c) allow hospital to explain why reclassification was appropriate

d) issue decision **within 1 calendar day** of receiving all requested pertinent information from hospital

e) notify patient, hospital & nursing home (if applicable) of decision by phone, followed by a written notice explaining basis/detailed rationale, payment consequences, & beneficiary's right to expedited reconsideration.

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How Do Eligible Patients Appeal? (Cont'd)

- **Expedited Reconsideration Request:** made in writing or by phone before noon of day following initial notification (whether by phone or in writing) of QIO's decision.

QIO (appeal contractor) must

a) offer eligible beneficiary & hospital an opportunity to provide further information

(Note: they may, but are not required to, submit evidence at this level)

b) issue reconsideration decision **within 2 calendar days** of receiving all requested pertinent information

c) notify patient, hospital & nursing home (if applicable) by phone, followed by a written notice explaining basis/detailed rationale, payment consequences, & beneficiary's right to ALJ hearing

Note: No financial liability protection during expedited appeals. BUT, hospital is prohibited from billing the patient until *expedited* process is complete.

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How Do Eligible Patients Appeal? (Cont'd)

- **Standard or "untimely" appeal request:** can be made at ***any time***
  - QIO has **2 calendar days** to issue initial decision and **3 calendar days** to issue reconsideration.
  - Billing protection does NOT apply to standard/untimely appeals.

Note: Expedited and "untimely" appeals follow the regulatory requirements and time frames for standard Medicare appeals at the next three levels of review: ALJ, MAC (Appeals Council), and Judicial Review.

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Who Can Help With Prospective Appeals?

- Can appoint authorized representative (e.g., trusted friend, relative, attorney)
- Providers cannot represent beneficiary, but can assist, support, answer questions, provide explanations, help beneficiaries contact SHIP, 1-800-Medicare, or the QIO
- At eligible beneficiary's (or representative's) request, hospital must furnish copy of, or access to, any documentation it has sent to the QIO, including written records of information provided by phone. Due by close of business of calendar after request is made. May charge a reasonable amount to cover copies and delivery costs.

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Medicare Criteria for Inpatient Hospital Coverage

- **Doctor's order:** Hospital must formally admit patient after a doctor orders inpatient care to treat their illness or injury
- **Two-Midnight Rule:** Reasonable expectation *at time of admission* that patient will need medically necessary hospital care spanning at least 2 midnights

Factors considered can include patient's medical history, medical needs, severity of signs and symptoms, medical predictability of adverse event, need for and availability of diagnostic studies that are appropriately outpatient services.

NOTE: QIOs "do not take into account other information (e.g., test results) which became available only after admission, except in cases where considering the post-admission information would support a finding that an admission was medically necessary."

Medicare Benefit Policy Manual, Ch. 1 § 10.

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Questions and Discussion

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