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By Nina Youngstrom

Three days after an 85-year-old man was admitted to a Pennsylvania hospital as an inpatient in late 2016 when his wife brought him to the emergency room, his status was changed to observation, but nobody told them—not even when he was discharged directly to a skilled nursing facility (SNF).

The family is now stuck with a $30,000 bill for his SNF stay, where he was sent to work on activities of daily living. Furious at the hospital, the family, through its attorney, appealed the SNF charges, so far in vain, and now will ask an administrative law judge (ALJ) to compel Medicare to cover the SNF charges because the hospital didn't notify the patient he was in observation. The attorney, Ryan Webber, knows this may be tilting at windmills, but it's a viable strategy because never communicating the patient-status change means it wasn't executed, he contends.

"My argument is that he was in the hospital for at least three days, and if they changed his status to observation, they didn't follow proper procedure," says Webber, with Keystone Elder Law in Mechanicsburg, Pa. "He should be considered as having been admitted and should qualify for post-hospital care."

Meanwhile, for their part, SNFs on April 30 must comply with new advance beneficiary notice (ABN) requirements and are now more vulnerable to regulatory sanctions for failures in this area.

CMS requires hospitals to have a utilization review committee to review admissions for medical necessity (42 CFR Sec. 482.30), and if their status is changed to outpatient, with or without observation services, hospitals must inform patients within two days of the status change or before discharge, says Ronald Hirsch, M.D., vice president of education and regulations for R1 Physician Advisory Services. Hospitals may use condition code 44 to change inpatient admissions to outpatient with observation with the approval of the treating physician and a physician on the UR committee (before the patient is discharged). Hospitals also must abide by the 2015 Notice of Observation Treatment and Implication for Care Eligibility (NOTICE) Act, which requires them to inform patients they are outpatients receiving observation services, not inpatients, if they receive more than 24 hours of observation, and explain how that affects their wallets. CMS created the Medicare Outpatient Observation Notice (MOON) for this purpose, and while its use wasn't mandated until March 8, 2017, about five months after his client's hospital visit, Webber says the NOTICE Act was in effect.

Hospital Probably Didn't Bill Medicare

"We were not told the financial implications of the hospital status or reasons for the status change," Webber says. "They initially ran lab tests, did psych evaluations and some therapy in the hospital, but we don't have any sort of records that say why his status would have been changed. There were no UR committee notes, no condition code 44 provisions, nothing that said, 'After a review of the files, this patient was inappropriately admitted, and we will follow correct procedure and give notice.'"

There's a good chance the hospital realized its mistake and did right by Medicare, not billing it for the inpatient admission because it wasn't medically necessary, Webber says. That's probably the case because the patient's

bill was credited for the entire hospital stay, he says. But Webber is looking for relief on the SNF front.

So far, he hasn't had any luck at the first two levels of appeal, redetermination and reconsideration. Next he will request an ALJ hearing. There's a credible argument to be made that because the hospital didn't complete the final step of the status change, which is notifying the patient, the hospital stay is still inpatient, and therefore Medicare should cover the Part A stay in the SNF, Webber says.

It may bolster his case that compliance with the steps of condition code 44 are not optional, Hirsch says. "If a patient is formally admitted as inpatient with a written admission order that is authenticated by the admitting physician and it is determined that the correct status should have been outpatient, all the steps must be followed or the patient remains inpatient," Hirsch says. "The only caveat is that CMS has stated that if the initial admission order is a verbal order and the physician does not authenticate it, the 'admission order never occurred and the stay may be billed as outpatient Part B.' That is a huge loophole that may actually explain what happened here."

Also, maybe the ALJ will be persuaded that because the SNF would have been able to tell from the common working file that the hospital either never filed a claim or the patient was in observation, Medicare wouldn't cover the charges and the patient should have been informed, Webber says. Isn't the SNF required to inform patients of financial liability when admissions aren't covered and get their signatures on ABNs?

That question, it turns out, doesn't have a simple answer, although CMS has streamlined the ABN process, says attorney Paula Sanders, with Post & Schell in Harrisburg, Pennsylvania. Starting April 30, SNFs must use a new ABN, according to *MLN Matters* MM10567. "With this revision, CMS is discontinuing the five Skilled Nursing Facility (SNF) Denial Letters (namely, the Intermediary Determination of Noncoverage, the UR Committee Determination of Admission, the UR Committee Determination on Continued Stay, the SNF Determination on Admission and the SNF Determination on Continued Stay), and the Notice of Exclusion from Medicare Benefits (NEMB-SNF), Form CMS-20014," the *MLN Matters* explains.