FIVE BRAINS DIGITAL · ELEANOR CROFT

Admitted, or Observation?

The one question to ask before anyone leaves the hospital — and the three pieces of paper that decide who pays.

A hospital bed does not mean admitted. One word on the chart can be the difference between Medicare paying for the nursing home and you paying for all of it.

FREE · 16-POINT BODY TYPE · NO EMAIL REQUIRED

VERIFIED CURRENT AS OF AUGUST 2026

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SECTION 00

How to use this file

This guide is free, and it is built to be used in a hospital corridor at nine o'clock at night, which is where most people will need it.

The body text of this guide is set in 16 point. That is larger than an ordinary paperback, and it is deliberate — you may be reading this tired, in bad light, without your glasses. The notes inside the tinted boxes are 14 point, and the source list in Section 12 is 11.5 point, because it is reference matter rather than reading matter. We would rather tell you that than call the whole file large print and let you find out.

Two ways to use it

Printed. Print it and write on the ruled lines with a pen. The boxes in Section 10 are drawn squares, so a pen can tick them.

On a screen. Open it in any PDF reader that lets you add text or notes — Adobe Acrobat Reader, Apple Preview, or the markup tools built into most phones and tablets — and type onto the same lines.

> **Save a blank copy first.** Before you write anything, use **File → Save As** and give the copy a new name, such as *Mom hospital March.pdf*. Write on the copy. The original stays blank, so it is ready the next time — and there is usually a next time.

Why there are no fillable form boxes

A typed form field in a PDF can carry a maximum length set by whoever built the file, and when it does, it stops accepting characters without saying so. That defect is not hypothetical for us — it was found across this catalog and fixed in August 2026. Ruled lines have no such limit to get wrong, and they behave the same whether you print the file or type on it.

What this guide covers

Original Medicare — Part A and Part B. If your parent is on a **Medicare Advantage** plan, the notices in Section 04 still apply, but the appeal steps are different and run through the plan. This guide does not describe those steps, because we have not verified them. Call the number on the back of the plan card and ask for the plan's appeal process.

SECTION 01

The two words

Your mother is in a hospital bed. She has been there since yesterday. There is a wristband, a chart, a nurse, an IV pole.

She may not be admitted.

Medicare sorts every hospital stay into one of two categories, and the category is not decided by the bed. It is decided by a doctor's order and then reviewed by the hospital.

INPATIENT. Medicare.gov: “You're an inpatient starting when you're formally admitted to the hospital with a doctor's order.” The benchmark it gives: “An inpatient admission is generally appropriate when you're expected to need 2 or more midnights of medically necessary hospital care.”

OUTPATIENT GETTING OBSERVATION SERVICES. Medicare.gov describes observation as “Hospital outpatient services you get while your doctor decides whether to admit you as an inpatient or discharge you.”

The sentence that catches families

Medicare.gov puts it about as plainly as a government website ever puts anything:

> *“Even if you stay overnight in a regular hospital bed, you might be an outpatient.”*

Nobody announces it at the door. Some hospitals run a separate observation unit; many do not, and the bed, the wristband and the meal tray can look exactly the same either way. The distinction lives on the paperwork, and the paperwork is what Medicare pays from.

It can change while she is lying there

A stay can begin as an inpatient admission and be reclassified to outpatient observation partway through, after a review. That happens often enough that Medicare created a formal appeal process for it, which opened in February 2025 — see Section 05.

Which is why the question in Section 10 is not asked once. It is asked **every day**, and the answer is written down with a name and a time.

SECTION 02

What the difference costs

All figures below are the **2026** amounts published by Medicare.gov. They change every January. The year is printed here on purpose.

If she is an inpatient (Part A pays)

• **$1,736** deductible for each inpatient hospital benefit period, before Original Medicare starts to pay.
• Days 61–90: **$434** each day.
• Days 91 and beyond: **$868** each day while using the 60 lifetime reserve days.

If she is an outpatient on observation (Part B pays)

• **$283** annual Part B deductible, then coinsurance on each individual hospital service — each X-ray, each lab test, each bag of fluid, billed separately.

A short observation stay can land under the inpatient deductible. A long one, with a lot of tests, may not. That is not the expensive part.

The expensive part: the nursing home

This is the one that takes families by surprise, and it is the reason this guide exists.

For Medicare Part A to help pay for a skilled nursing facility afterward, Medicare.gov requires a qualifying hospital stay of **“at least 3 days in a row”** as an inpatient — counting the day of admission, but not the day of discharge.

> **Medicare.gov, in its own words:** “Time you spend at the hospital under observation or in the emergency room before you're admitted doesn't count toward the 3-day qualifying inpatient hospital stay, even if you're there overnight.”

So a person can spend four nights in a hospital bed, be moved to a nursing home for rehabilitation, and discover that Medicare owes nothing toward it — because those four nights were observation.

If she does qualify, here is what Medicare.gov says Part A covers in 2026, per benefit period:

- Days 1–20: **$0** each day, after the $1,736 deductible.
- Days 21–100: **$217** each day.
- Day 101 onward: **you pay all costs.**

If she does not qualify, **Medicare** pays nothing toward it. That is not the same as saying nobody does. Medicaid, a Medigap policy, or a long-term care insurance policy may apply — and Medicaid in particular is run by each state, with eligibility rules that differ considerably from one state to the next. Ask the facility for its daily private rate **before** she moves, and ask whether it takes Medicaid.

SECTION 03

The drug bill nobody warns you about

There is a second cost attached to observation status, and it arrives weeks later in an envelope.

While she is an outpatient, the pills she takes every morning at home — blood pressure, thyroid, whatever is in the daily pill organizer — are handed to her by a nurse. Those are called self-administered drugs, and Medicare treats them differently in an outpatient setting.

> **Medicare, CMS Product No. 11333, revised June 2020:** “In most cases, Part B generally doesn't pay for self-administered drugs used in the hospital outpatient setting.” And: “If you get self-administered drugs that aren't covered by Part B while in a hospital outpatient setting, the hospital may bill you for the drug.”

Hospital pricing for these is set by the hospital, not by the pharmacy down the road, and the two figures can be very far apart. Look at the line items rather than assuming a familiar prescription cost what it usually costs.

What you can do about it

Medicare's own publication says a Part D drug plan *may* cover these, and tells you how to try:

1. Ask for the **itemized** bill, not the summary. You need the line showing each drug and each date.

2. Submit an out-of-network claim to her Part D plan with that documentation attached.

3. If the plan says no, you can ask for an exception or appeal the decision.

> Medicare is careful about what it promises here, and so are we: the plan "might only reimburse you the in-network cost for the drug minus any deductibles, copayments, or coinsurance." This is worth doing. It is not a guaranteed refund.

The simplest prevention: if you know she is going in, bring her own labelled medications from home and ask the nurse whether she may take her own. Some hospitals allow it, some do not. Ask — do not assume either way.

SECTION 04

The three pieces of paper

Three notices exist. Each one is a legal requirement, each one carries a right, and each one gets handed over in a stack with the parking validation.

Ask for all three by name. Photograph them with your phone.

1. The Important Message from Medicare

Often just called **the IM**. Medicare.gov says you should get it “within 2 days of your admission and prior to your discharge.” It explains her rights as a hospital patient and it carries the instructions for the fast appeal in Section 06.

Two copies. If she has been there three days and nobody has handed you one, ask.

2. The MOON — form CMS-10611

The **Medicare Outpatient Observation Notice**. This is the one that tells you, in writing, that she is *not* admitted.

It is required by the NOTICE Act, enacted 6 August 2015. CMS says it is triggered when observation services run **“more than 24 hours”**, and must be delivered **“no later than 36 hours after observation services are initiated or, if sooner, upon release.”** CMS also requires that “An

oral explanation of the MOON must be provided” and “a signature must be obtained.”

> **Signing the MOON means you received it. It does not mean you agree with it.** CMS requires the hospital to obtain a signature acknowledging that the notice was received and explained. Sign it, keep your copy, and then ask the questions in Section 10 anyway.

3. The MCSN — form CMS-10868

The **Medicare Change of Status Notice**. This one is new: hospitals began delivering it on **14 February 2025**.

It is given when the hospital **changes** her from inpatient to outpatient getting observation services partway through the stay. CMS requires hospitals to “deliver the Medicare Change of Status Notice (MCSN) to all beneficiaries eligible for the expedited determination process.”

It carries a right to appeal. That right is Section 05, and it did not exist before 2025.

SECTION 05

If they change her status: the new appeal

This is the newest thing in this guide and the least known. It came out of a court case, *Alexander v. Azar*, and CMS issued the final rule on **11 October 2024**.

Who it is for: someone who was **admitted as an inpatient** and then **reclassified** by the hospital to outpatient getting observation services during the same stay.

The fast one — file before she leaves

Medicare.gov says the right to request this appeal began **14 February 2025**, and that you should follow the instructions on the Medicare Change of Status Notice. If nobody gave you one, contact the BFCC-QIO for your state directly — the numbers are in Section 07.

File while she is still in the hospital. Medicare.gov: “it's best to file an appeal while you're still in the hospital.”

How fast is the answer? The two Medicare sources word this differently, so here are both. Medicare.gov says the BFCC-QIO will “Make a decision and let you know what they decided about 2 days after you file your appeal.” The CMS fact sheet on the final rule says the BFCC-QIO “will render a determination within one day for appeals received before the beneficiary leaves the hospital.” Expect one to two days, and follow whatever the notice in your hand says.

The slower one — after she leaves

CMS says beneficiaries “who do not file an expedited appeal” may appeal after leaving the hospital, by comparable procedures but with “longer timeframes to file and for the BFCC-QIO to make decisions.” It is still worth filing. It is simply slower, and she will already have been moved by the time it is answered.

For stays that already happened — this door has closed

There was a one-time process for old stays going back to 2009. CMS states: “Effective January 2, 2026, the 365-calendar day timeframe for filing new patient status appeal requests for eligible hospital stays (the retrospective appeal process) has ended.”

A late request now needs documented good cause. On the dates, the two Medicare sources do not agree, so here are

both. CMS says: “We strongly encourage you to submit your request with a good cause explanation by April 1, 2026, to avoid any delays in processing.” Medicare.gov says: “Requests filed after May 15, 2026 will experience significant processing delays.” Treat the earlier date as the real one and file as soon as you can. If you believe you have good cause, the address CMS publishes is:

Q2 Administrators — CMS 4204-F Appeals
300 Arbor Lake Drive, Suite 1350
Columbia, SC 29223-4582

We are telling you a door has closed rather than leaving you to find out on your own. That is the point of writing the date next to everything.

SECTION 06

If they are sending her home too soon

Different problem, different appeal, and this one is older and very well established. Nobody tells you about it either.

If you are told she is being discharged and you believe she is not ready, you can ask for a review **before she goes**.

The deadline

Medicare.gov: follow the directions on the Important Message from Medicare “no later than the day you're scheduled to be discharged from the hospital.”

Not the day after. Not once she is home and it is obviously not working. **That day.**

What it gets you

> **Medicare.gov:** “If you ask for your appeal within this time frame, you can stay in the hospital while you wait to get the BFCC-QIO's decision. You won't have to pay for your stay (except for applicable coinsurance or deductibles).”

And it is quick. Medicare.gov says the decision comes “within one day of getting the requested information.”

That is the single most useful sentence in this guide. A phone call made on the right day gets the discharge reviewed, and Medicare's own wording above says what you owe while you wait. It does not promise the review will go your way — if the BFCC-QIO agrees with the hospital, costs after that decision can fall to her.

How to make the call go well

• Have her Medicare number and the hospital's name and city in front of you before you dial.
• Say the words: **“I want to file a fast appeal of the discharge.”**
• Write down the time you called and the name of the person you spoke to. Use the log in Section 09.
• Tell the hospital's nurse or case manager that you have filed.

SECTION 07

Your phone number, by state

Both appeals in Sections 05 and 06 go to the same place: the **Beneficiary and Family Centered Care Quality Improvement Organization**, the BFCC-QIO. Two companies hold the contract, split by region.

Find your state. Write the number on your hand if you have to.

Acentra Health

CT, MA, ME, NH, RI, VT — 888-319-8452
AL, FL, GA, KY, MS, NC, SC, TN — 888-317-0751
AR, LA, NM, OK, TX — 888-315-0636
CO, MT, ND, SD, UT, WY — 888-317-0891
AK, ID, OR, WA — 888-305-6759

Acentra publishes its hours as weekdays 9:00 a.m. to 5:00 p.m., and weekends and holidays 10:00 a.m. to 4:00 p.m., in all time zones. TTY 711. Messages can be left outside those hours.

Commence Health

NY, NJ, PR, VI — 866-815-5440
PA, MD, DE, DC, VA, WV — 888-396-4646
OH, IN, IL, MI, MN, WI — 888-524-9900
IA, MO, KS, NE — 888-755-5580
CA, AZ, NV, HI, GU, MP, AS — 877-588-1123

Commence Health was previously called Livanta. If someone at the hospital uses the old name, they mean the same organization. Commence does not publish its helpline hours in the same place, so we are not going to invent them.

Numbers and contractors change. These were read from the contractors' own published pages on **21 August 2026**. If a number does not connect, call **1-800-MEDICARE (1-800-633-4227)**, TTY 1-877-486-2048, and ask to be connected to the BFCC-QIO for your state. That number has not changed in decades.

Write yours here, before you need it:

SECTION 08

What the hospital owes you at discharge

Discharge planning is not a courtesy. For any hospital that takes Medicare, it is a condition of participation, written at **42 CFR 482.43**. Four parts of it are worth knowing by heart.

You are supposed to be in the room

The regulation requires a process that includes “the patient and his or her caregivers/support person(s) as active partners” in discharge planning. Not informed afterward. Partners.

They must help you choose

Under 482.43(a)(8) the hospital must “assist patients, their families, or the patient's representative in selecting a post-acute care provider by using and sharing data.” You may ask for that data. Quality ratings for the facilities on your list are a fair thing to request.

You get a list — and a disclosure

Under 482.43(d)(1) the hospital must give “a list of HHAs, SNFs, IRFs, or LTCHs that are available to the patient.”

And under 482.43(d)(3) it must disclose “any HHA or SNF to which the patient is referred in which the hospital has a disclosable financial interest.”

> **Ask this out loud:** “Does the hospital have a financial interest in any of the places on this list?” The regulation requires the discharge plan to identify such a referral, so this is a question you are entitled to have answered.

Your choice, and her wishes

Under 482.43(d)(2) the hospital “must inform the patient or the patient's representative of their freedom to choose among participating Medicare providers” and “must, when possible, respect the patient's or the patient's representative's goals of care and treatment preferences.”

The first bed offered is not the only bed. “This is the one that has a spot” is a starting point for a conversation, not the end of one.

SECTION 09

The daily log

Status can change without an announcement. Write it down every single day, with a name and a time. If you ever need to appeal, this page is your evidence, and a page like it is what people wish they had kept.

Patient name / hospital / room

Medicare number (write it here only on your own printed copy)

BFCC-QIO phone number for this state (Section 07)

Day 1 — date, status I was told, who told me, what time

Day 2 — date, status I was told, who told me, what time

Day 3 — date, status I was told, who told me, what time

Day 4 — date, status I was told, who told me, what time

SECTION 10

The questions, in order

Ask these of the nurse, the case manager, or the hospitalist. Ask them again tomorrow. Tick as you go.

Every day she is there

- ☐ “Is she **admitted as an inpatient** today, or is she an outpatient getting observation services?”
- ☐ “**Who** told me that, and **what time**?” Write it in Section 09.
- ☐ “Has her status **changed** at any point since she arrived?”
- ☐ “If she is on observation, what would need to be true for her to be admitted?”

About the paperwork (Section 04)

- ☐ “May I have a copy of the **Important Message from Medicare**?”
- ☐ “Has a **MOON** been issued? May I have a copy?”
- ☐ “Has a **Medicare Change of Status Notice** been issued?”
- ☐ Photograph every notice with your phone, front and back.

Before she is moved anywhere

- ☐ “How many **inpatient** days does she have, counting the admission day but not the discharge day?” (Section 02)
- ☐ “Does she meet the 3-day qualifying stay for skilled nursing coverage?”
- ☐ “May I see the **list** of facilities available to her?” (Section 08)
- ☐ “Does the hospital have a **financial interest** in any of them?”
- ☐ Ask the facility for its **private daily rate** — in case Medicare does not pay.
- ☐ “May I have the **itemized** bill, not the summary?” (Section 03)

If something is wrong

- ☐ Discharge feels too soon → call the BFCC-QIO **the day of discharge**. (Section 06)
- ☐ Status was changed from inpatient to observation → appeal **before she leaves**. (Section 05)

SECTION 11

What this guide is not

This guide is general information, not medical advice, and it is not a diagnostic tool. Only a qualified clinician can diagnose a condition. Never start, stop, or change a medication based on anything in this guide. Information here is current as of **August 2026**.

This guide is also not legal advice. Five Brains Digital is not a law firm, and no attorney-client relationship is created by downloading it. For advice about your own situation, talk to a licensed professional.

Five Brains Digital is not affiliated with, endorsed by, or sponsored by Medicare, the Centers for Medicare & Medicaid Services, Acentra Health, or Commence Health.

Three honest limits

1. It covers Original Medicare. Medicare Advantage plans use their own appeal processes. The notices in Section 04 still apply to Advantage enrollees, but the steps after that are the plan's, and we have not verified them, so we do not describe them.

2. Every figure here has a year on it. The dollar amounts in Section 02 are 2026 figures and will change in January. The phone numbers in Section 07 were read on 21 August 2026. Check the sources in Section 12 before you rely on a

number that matters.

3. It cannot tell you whether she should be an inpatient. That is a clinical judgment made by a doctor and reviewed against Medicare's criteria. What this guide does is make sure you know which one she is, when it changed, and what you are allowed to do about it.

Rules change and this file does not update itself. That is why every claim in it names the body that publishes it and the date it was read.

SECTION 12

Sources

Every factual claim in this guide comes from one of the following. All were read on **21 August 2026**.

Medicare.gov — “Inpatient or outpatient hospital status affects your costs.” Definitions of inpatient and observation, the two-midnight benchmark, the overnight sentence.

Medicare.gov — “Skilled nursing facility care.” The 3-day qualifying stay, the exclusion of observation and emergency room time, and the 2026 cost sharing.

Medicare.gov — “Medicare costs.” 2026 Part A deductible $1,736, days 61-90 $434, lifetime reserve $868, Part B deductible $283.

Medicare.gov — “Appeal when a hospital changes your status from inpatient to outpatient getting observation services.” The 14 February 2025 start date, the BFCC-QIO decision timing, and the 15 May 2026 processing-delay warning. Medicare.gov and CMS publish different dates on that last point; Section 05 gives both.

Medicare.gov — “Fast appeals.” The Important Message timing, the discharge-day deadline, who pays during the appeal, and the one-day decision.

CMS — Medicare Outpatient Observation Notice (MOON) fact sheet. The NOTICE Act of 6 August 2015, the 24-hour trigger, the 36-hour delivery deadline, the oral explanation and signature requirement.

CMS — FFS MCSN, form CMS-10868. The 14 February 2025 implementation date and the delivery requirement.

CMS — “Medicare Appeal Rights for Certain Changes in Patient Status” final rule fact sheet. The 11 October 2024 rule, the three appeal categories, the one-day expedited determination.

CMS — “Hospital Appeals - Change of Inpatient Status (Alexander v. Azar).” The 2 January 2026 close of the retrospective window, the 1 April 2026 good-cause encouragement, and the filing address.

Medicare, CMS Product No. 11333, revised June 2020 — “How Medicare Covers Self-Administered Drugs Given in Hospital Outpatient Settings.”

42 CFR 482.43, Condition of participation: Discharge planning, as published on eCFR. Paragraphs (a)(8), (d)(1), (d)(2) and (d)(3).

Acentra Health BFCC-QIO and **Commence Health BFCC-QIO** — published beneficiary helpline pages, for the regional telephone numbers in Section 07.

SECTION 13

If this was useful

This guide is free and it always will be. There is no email capture on it and nothing to unsubscribe from.

It was written by Eleanor Croft for Five Brains Digital, which publishes plain-language guides for the situations nobody prepares you for. If it helped, the honest thing we can tell you is what else exists, and what each one actually is.

Where this guide stops, these pick up

Now What? — the first weeks after a diagnosis or a crisis, when there are forty decisions and no order to them.

The First 90 Days — the stretch after the hospital, when somebody has to actually run the care.

Your First Meeting — what to bring and what to ask when you finally sit down with a professional.

When the Time Comes — the end-of-life paperwork and decisions, gathered in one place.

Is It Dementia and **When Dementia Turns to Aggression** — the questions families are afraid to ask out loud.

Protecting What You've Built and **Inheriting a Full House** — the money and the estate, in plain language.

The Decades Ahead and **Senior Discounts** — planning further out, and paying less along the way.

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