AMERICAN COLLEGE OF PHYSICIAN ADVISORS

Medicare Change Of Status Notice (MCSN)

Created by the American College of Physician Advisors'
Observation Committee

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Learning Objectives

- At completion of the module, learners will be able to:
  - Understand the details of CMS 4204-F
  - Establish processes to set up new appeal workflow

CMS 4204-F

Appeal Rights

CMS 4204-F

- Effective October 11, 2024
- Implementation effective February 14, 2025
- This rule, by court order, is limited to a small subset of Medicare patients whose status is changed from Inpatient to Outpatient with Observation.
  - It is not for all Condition Code 44 changes
- Background
  - “The purpose of this final rule is to establish appeals processes to comply with a court order issued in the case *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). The processes will apply to certain Medicare beneficiaries who are initially admitted as hospital inpatients but are subsequently reclassified as outpatients receiving observation services during their hospital stay and meet other eligibility criteria.”

https://www.federalregister.gov/documents/2024/10/15/2024-23195/medicare-program-appeal-rights-for-certain-changes-in-patient-status

CMS 4204-F

Eligibility:

- Formally admitted as a hospital Inpatient AND
- Subsequently reclassified by the hospital as an **outpatient receiving observation services** AND
- Traditional Medicare beneficiaries who are
  - Either not enrolled in Part B coverage at the time of hospitalization OR
  - Have both Medicare Part A and B and stayed at the hospital for 3 or more consecutive days but were designated as Inpatients for fewer than 3 days

https://www.federalregister.gov/documents/2024/10/15/2024-23195/medicare-program-appeal-rights-for-certain-changes-in-patient-status

Financial Liability and Billing Protection

- If the beneficiary submits an appeal using the expedited process, the hospital cannot bill the patient until the Quality Improvement Organization (QIO) has made a final determination
- There is no financial liability protection during the appeal process
- If the QIO disagrees with the beneficiary:
  - Beneficiaries without Part B could be charged the full cost of the outpatient stay.
    - Coordination of benefits with secondary insurance if applicable
  - Beneficiaries with Part B could be responsible for the cost of the Part B coinsurance and applicable deductible for any covered services and the full cost of any non-covered services received during the appeals process.
- If the QIO agrees with the beneficiary:
  - Status returns to Inpatient, effective from the initial Inpatient order
  - Midnights count toward Part A Skilled Nursing Facility (SNF) coverage

MM13846 - Medicare Change of Status Notice Instructions

Medicare Change of Status Notice (MCSN)

Medicare

Patient name: _____
Patient number: _____
Hospital name: _____
Hospital address: _____

Medicare Change of Status Notice

Important! You're getting this notice because your hospital changed your status from "hospital inpatient" to "hospital outpatient receiving observation services."

The box marked below shows what applies to you:

☐ **While you're still in the hospital**, your hospital stay will now be billed to Medicare Part B instead of Part A.

Your hospital bill may be lower or higher than the Part A inpatient deductible. Your hospital can give you more information about billing.

After you leave the hospital, Medicare will not pay if you go to a skilled nursing facility.

☐ **While you're still in the hospital**, the hospital may charge you the full cost of your outpatient hospital stay because you don't have Medicare Part B.

After you leave the hospital, Medicare will not pay if you go to a skilled nursing facility.

https://www.cms.gov/files/document/mm13846-medicare-change-status-notice-instructions.pdf

https://www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative-bni/ffs-mcsn

Check top box if patient has Medicare Part B and hospital stay was at least 3 days

Check bottom box if patient does not have Medicare Part B

You Can Appeal

- You can appeal your status change to a Quality Improvement Organization right away. Quality Improvement Organizations are independent of Medicare.
- If you decide to appeal, your Quality Improvement Organization will look at your records and give you its decision about 2 days after you ask for an appeal.
- Call your Quality Improvement Organization to appeal at: _____
- You should ask for an appeal as soon as possible and before you leave the hospital.
- **After you leave the hospital, you still have appeal rights.** Call your Quality Improvement Organization.

What Happens After I Appeal?

- You'll get the appeal decision from the Quality Improvement Organization about 2 days after you appeal, even if you leave the hospital.
- If you decide to stay in the hospital beyond your planned discharge date you may be responsible for payment of services you get during the appeal process.
- If your appeal is favorable to you, Medicare may cover your skilled facility nursing stay after you leave the hospital.

https://www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative-bni/ffs-mcsn

CMS 4204-F

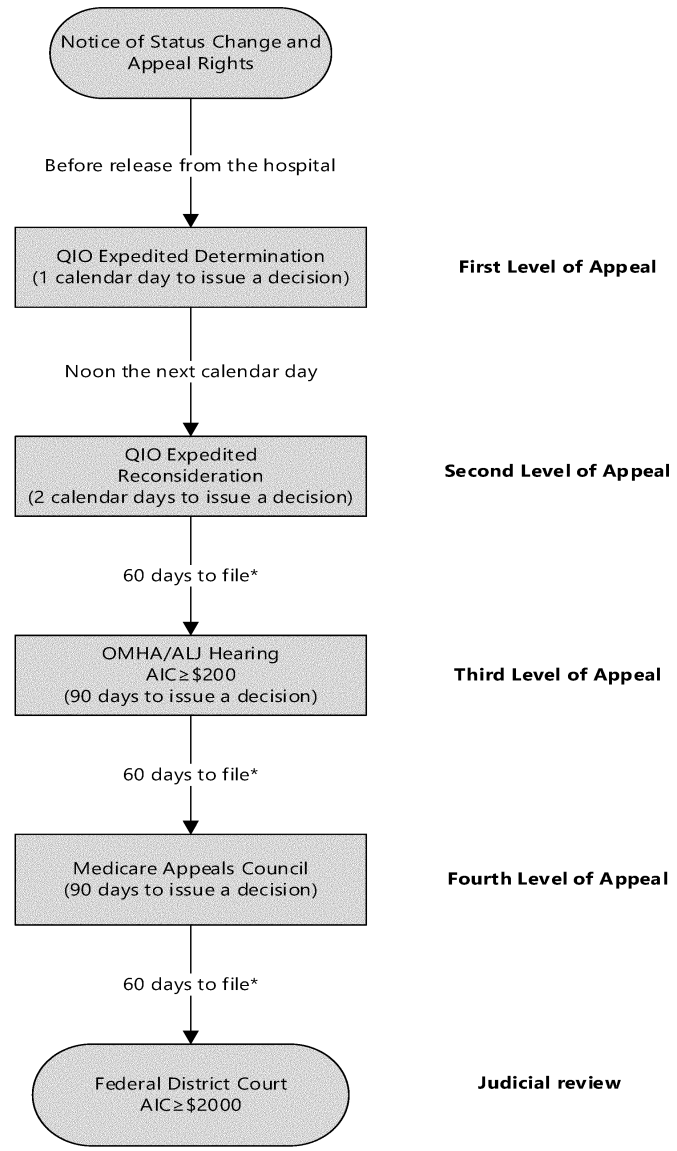
- There are three different appeal types:
  - Expedited Appeal
  - Standard Appeal
  - Retrospective Appeal

https://www.federalregister.gov/documents/2024/10/15/2024-23195/medicare-program-appeal-rights-for-certain-changes-in-patient-status

Expedited Appeal

- Utilized when beneficiary decides while they are still in the hospital
- The beneficiary can leave the hos determination is made but until t
  - …there is billing protection
  - …there is no financial liability p
- If the QIO agrees with the benefic returns to Inpatient level of care f initial Inpatient order

https://www.federalregister.gov/documents/2024/10/15/2024-23195/medicare-program-appeal-rights-for-certain-changes-in-patient-status



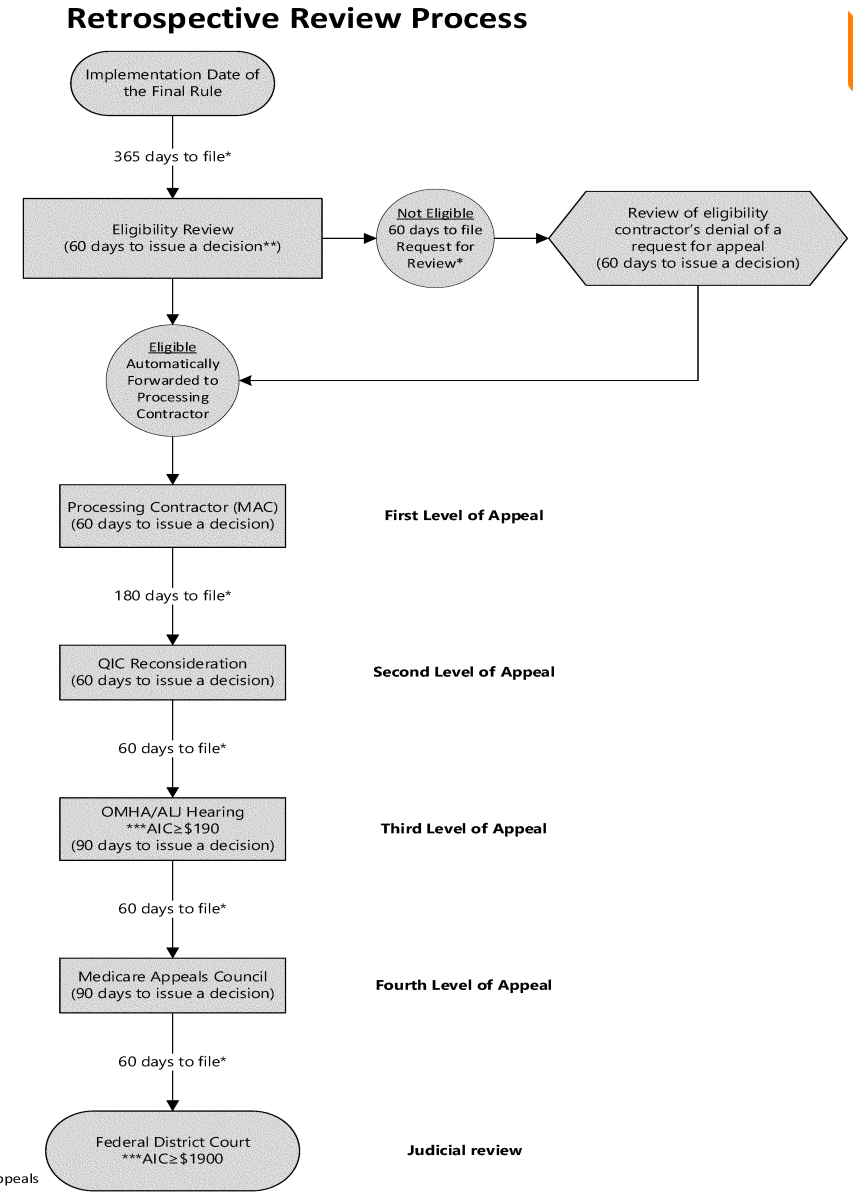
Standard Appeal

- Utilized when beneficiary decides to appeal after leaving the hospital
- No financial liability or billing protection during the appeal process

https://www.federalregister.gov/documents/2024/10/15/2024-23195/medicare-program-appeal-rights-for-certain-changes-in-patient-status

Retrospective Appeal Process

- While concurrent utilization/case management (UM/CM) team does not play an active role in this appeal, patients may contact the UM/CM departmen to enquire about the post-discharge appeal process.
- Patients should be instructed to contact the QIO directly.
- The hospital reviews the case when notified by the Q of the appeal determination.
- Applicable for certain beneficiaries to appeal denials Part A coverage of hospital services (and certain SNF services, as applicable), for specified inpatient hospitalizations involving status changes that occurre prior to the implementation of the prospective appea process, dating back to January 1, 2009.



AIC = Amount In Controversy
ALJ = Administrative Law Judge
MAC = Medicare Administrative Contractor
OMHA = Office of Medicare Hearings and Appeals
QIC = Qualified Independent Contractor
*Filing deadlines are calendar days from date of receipt of the notice/decision (presumed to be 5 days from the date of the notice, unless evidence to the contrary).
**Eligibility determination timeframes may be longer if additional documentation is required (such as medical records or claims information).
***The AIC requirement for an ALJ hearing and Federal District Court is adjusted annually in accordance with the medical care component of the consumer price index. The chart reflects the amounts for calendar year 2025, and is subject to change each calendar year.

https://www.federalregister.gov/documents/2024/10/15/2024-23195/medicare-program-appeal-rights-for-certain-changes-in-patient-status

MCSN

- Implementation Date: **February 14, 2025**
- Eligibility for **Expedited Determination process**:
  - Traditional Medicare beneficiary (not Medicare Advantage) AND
  - Reclassified from **Inpatient to Outpatient with observation services** while still in the hospital AND
  - Patient does not have Part B upon conversion from Inpatient to Observation OR
  - Patient has Medicare Part A and B and their hospital stay was at least 3 days from the Inpatient order date

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MCSN

Delivery

- Must be delivered after patients reach their third day in the hospital, counting from the original inpatient admission order.
  - The day of discharge does not count, think the SNF 3-day stay rule (count midnights)
  - If given the day of discharge, MCSN should be given at least 4 hours prior to discharge, however patients are not required to stay should they decide not to appeal (similar to the IMM).
- Explain form to patient/representative
- Ask patient/representative to sign the notice; provide a copy
- Follow normal Centers for Medicare and Medicaid Services (CMS) processes for language, assistive device, and remote delivery

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FAQ

- Does this apply to patients in Outpatient status (like outpatient surgery patients) who do NOT have an order for Observation services?
  - No. For example, some health systems utilize Outpatient Surgical Recovery status without an order for Observation services and in that case, this would not apply.
- Does it apply to patients changed from Inpatient to Outpatient with Observation services without Utilization Review Committee (URC) input?
  - No. Without URC input, the status change to Outpatient is not compliant and the initial Inpatient order would remain valid. Status changes must follow the compliant process at 42 CFR 482.30.
- If patient wins the appeal, when does the Inpatient stay start?
  - Inpatient hospitalization and midnights counted toward potential SNF coverage will start from the date of the original Inpatient order.

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References

- MM13846 - Medicare Change of Status Notice Instructions
  - https://www.federalregister.gov/documents/2024/10/15/2024-23195/medicare-program-appeal-rights-for-certain-changes-in-patient-status#footnote-4-p83241
- https://www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative-bni/ffs-mcsn
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