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Billing Instructions: Expedited Determinations Based on Medicare Change of Status Notifications

Related CR Release Date: December 27, 2024	**MLN Matters Number:** MM13918
Effective Date: October 11, 2024	**Related Change Request (CR) Number:** CR 13918
Implementation Date: February 15, 2025	**Related CR Transmittal Number:** R13026CP
Related CR Title: Billing Instructions Related to Expedited Determinations Based on Medicare Change of Status Notifications (MCSNs)	

Affected Providers

- Physicians
- Other providers billing Medicare Administrative Contractors (MACs) for hospital and skilled nursing facility (SNF) services they provide to Medicare patients

Action Needed

Make sure your billing staff knows about these changes:

- When patients are eligible to appeal a hospital status change
- Quality Improvement Organization (QIO) role in the appeals process
- Claims processing based on QIO appeal decision

Background

We give certain Original Medicare (also known as Fee-for-Service) patients expedited hospital status change appeals only if they're:

- Admitted to a hospital as an inpatient by a physician
- Changed to outpatient status receiving observation services by the hospital's Utilization Review Committee (URC), effectively denying Medicare Program Part A coverage for their hospital stay
- Compliant with other conditions found on the MCSN Beneficiary Notices Initiative page

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Per 42 CFR 405.1210(b), hospitals must notify patients of their appeal rights when the patient's status changes from inpatient to outpatient receiving observation services. The Medicare Change of Status Notice (MCSN) (CMS-10868) satisfies the requirement. See MLN Matters Article MM13846 for information on the MCSN process.

Patients receiving an MCSN may appeal and have the QIO review to determine if their inpatient admission satisfied relevant criteria for Part A coverage. Further, patients asking for an appeal will have the QIO review whether the URC's decision to change the patient from inpatient to outpatient receiving observation services was incorrect. These changes in status might also affect Medicare coverage of the patient's post-hospital extended care services provided by a SNF.

QIO Role

Once a patient requests an appeal, the QIO:

- Reviews hospital records related to the change in status
- Verifies that you've given valid notice

QIO responsibilities:

- Establish contact with you so they consider the patient's medical records as part of a determination (**Note:** QIOs can make determinations without records)
- Make a coverage decision to answer the patient's request for review of their change in status
- Relay the decision back to the patient or their representative, and the hospital

If the patient disagrees with the QIO determination, they may request a reconsideration by the QIO.

MAC Role

- Support patients and providers through awareness of the expedited determination process
- Perform routine duties potentially affected by the process:
  - Claims processing
  - Medical review

QIO decisions are binding. MAC medical review won't repeat or contradict QIO review results related to a change of status on a hospital claim. The QIO may only decide on change in status under this appeal process. Medical review examines a broader range of potential issues and periods of care. Issues not considered by the QIO may be subject to medical review.

Claims Processing Requirements

Medicare claims contain expedited appeal results so MACs may judge claims consistent with QIO decisions. The expedited review process has no effect on established billing procedures (even demand billing).

Condition codes C1–C7 reflect QIO approval indicator codes to show the outcome of QIO expedited determinations and reconsiderations. Due to the start of the expedited determination process based on appeals of hospital status changes, MACs use QIO approval indicators in new ways on inpatient hospital claims and SNF claims. The QIO approval indicator code uses described below are valid for Original Medicare billing on types of bill (TOBs) 11x, 18x, and 21x.

Note: Don't use indicators on claims subject to a status change if the patient doesn't request an expedited determination.

QIO Decisions Upholding a Change of Status: Provider Instructions

- Don't report indicators on claims if you receive notification that the QIO has upheld your change of the patient's status from inpatient to outpatient
- Don't mark these claims with condition code C4 to reflect the QIO appeal denial since we define C4 as "Services Denied," but in this case, we aren't denying hospital services since they'll be billed on an outpatient TOB
- In these cases, you won't bill SNF services to Medicare because there's no qualifying hospital stay

QIO Decisions Reversing a Change of Status: Provider Instructions

- Bill the patient's stay using TOB 011x.
- Mark the claim with condition code C6 "Admission preauthorization," and show the QIO has authorized the admission but not reviewed the services provided.
- Add Remarks stating "MCSN" specifying the review circumstance. These indicators alert MACs that the QIO has already reviewed and upheld the patient's inpatient status.
- When billing for a SNF stay where the 3-day qualifying hospital stay was subject to a change of status review, SNF and swing bed providers must also add condition code C6 and Remarks "MCSN" to TOB 021x or 018x admission claims. These indicators alert MACs that the QIO has already reviewed and upheld the patient's inpatient status for the qualifying hospital stay dates reported in occurrence code 70.

Untimely Appeals: Provider Instructions

Don't bill patients during the QIO appeals process if their appeal request was timely. However, if the appeal is untimely, you may bill a patient before the QIO process ends. The QIO will provide their decision on a different schedule.

Hospitals and SNFs will reflect expedited determinations based on MCSNs as described in the Medicare Claims Processing Manual, Chapter 1, section 150.4.

More Information

We issued CR 13918 to your MAC as the official instruction for this change. For more information, find your MAC's website.

Document History

Date of Change	Description
January 2, 2025	Initial article released.