CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 13026	**Date: December 27, 2024**
	Change Request 13918

SUBJECT: Billing Instructions Related to Expedited Determinations Based on Medicare Change of Status Notifications (MCSNs)

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to provide billing instructions to hospitals and skilled nursing facilities regarding expedited determinations based on Medicare Change of Status Notifications (MCSNs).

EFFECTIVE DATE: October 11, 2024
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: February 15, 2025

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	1/Table of Contents
R	1/150/Limitation on Liability Notification and Coordination With Quality Improvement Organizations (QIOs)
R	1/150.2.2/General Responsibilities of QIOs and A/B MACs (A) Related to HINNs
R	1/150.2.3/Billing and Claims Processing Requirements Related to HINNs
R	1/150.3/ Skilled Nursing Facility (SNF), Home Health Agency (HHA), Hospice and Comprehensive Outpatient Rehabilitation Facility (CORF) Claims Subject to Expedited Determinations
R	1/150.3.2/General Responsibilities of QIOs and A/B MACs (A) Related to Expedited Determinations
R	1/150.3.3/Billing and Claims Processing Requirements Related to Expedited Determinations
N	1/150.4 - General Responsibilities of QIOs and A/B MACs (A) Related to Expedited Determinations Based on Medicare Change of Status Notifications (MCSNs)
N	1/150.4.1/Billing and Claims Processing Requirements Related to Expedited Determinations Following Appeal of Status Change

III. FUNDING:

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 13026	Date: December 27, 2024	Change Request: 13918

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EFFECTIVE DATE: October 11, 2024
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IMPLEMENTATION DATE: February 15, 2025

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to provide billing instructions to hospitals and skilled nursing facilities regarding expedited determinations based on Medicare Change of Status Notifications (MCSNs).

II. GENERAL INFORMATION

A. Background: This CR provides claims processing instructions to implement an expedited hospital status change appeals process required by final rule, CMS-4204-F. The resulting regulations are located at 42 CFR Part 405.1210 through 405.1212.

Expedited hospital status change appeals are afforded to certain beneficiaries in Original Medicare only who were initially admitted to a hospital as an inpatient by a physician but whose status during their stay was changed to an outpatient receiving observation services by the hospital's utilization review committee (URC) (thereby effectively denying Part A coverage for their hospital stay), and meet other conditions specified in the court order. Regulations at 42 CFR 405.1210(b) require hospitals to notify beneficiaries of their right to pursue an appeal regarding the decision to reclassify the beneficiary from an inpatient to an outpatient receiving observation services. The Medicare Change of Status Notice (CMS-10868) is the standardized notice to satisfy the notification requirement.

After receipt of the MCSN, eligible beneficiaries are given the opportunity to appeal, and may argue that their inpatient admission satisfied the relevant criteria for Part A coverage and that the hospital URC's determination to reclassify the beneficiary as an outpatient receiving observation services was therefore erroneous. The change in status from inpatient to outpatient may also affect coverage of the beneficiary's post-hospital extended care services furnished in a skilled nursing facility (SNF).

B. Policy: Hospitals and skilled nursing facilities shall reflect expedited determinations based on MCSNs as described in the Medicare Claims Processing Manual, chapter 1, section 150.4.

III. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
13918.1	The contractors shall be aware of the manual changes to publication 100-04, chapter 1, sections 150,150.2.2, 150.2.3,	X								

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	150.3, 150.3.2, 150.3.3, 150.4 and 150.4.1.									

IV. PROVIDER EDUCATION

Medicare Learning Network® (MLN): CMS will develop and release national provider education content and market it through the MLN Connects® newsletter shortly after we issue the CR. MACs shall link to relevant information on your website and follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 for distributing the newsletter to providers. When you follow this manual section, you don't need to separately track and report MLN content releases. You may supplement with your local educational content after we release the newsletter.

Impacted Contractors: A/B MAC Part A

V. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information:N/A

VI. CONTACTS

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VII. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

Medicare Claims Processing Manual
Chapter 1 - General Billing Requirements

Table of Contents
(Rev.13026 , Issued: 12-27-24)

150 - Limitation on Liability Notification and Coordination With Quality Improvement Organizations (QIOs)

(Rev.13026, Issued: 12-27-2024, Effective: 10-11-2024 , Implementation: 02-15- 2025)

The longstanding relationship between QIOs and *A/B MACs (A)* is defined in regulations at 42 CFR 476.80. Generally, these regulations require QIOs and *A/B MACs (A)* to have an agreement under which:

- QIOs inform *A/B MACs (A)* of the results of DRG validation of hospital inpatient claims
- QIOs inform *A/B MACs (A)* of initial determinations of cases subject to preadmission review and any changes to these determinations
- *A/B MACs (A)* ensure they do not pay claims subject to initial determinations until they receive notice from the QIO
- QIOs and *A/B MACs (A)* exchange data or information and otherwise coordinate to perform their functions.

Additionally, this relationship *has expanded over time* to include:

- Regulations regarding expedited determinations *of discharges*, found in 42 CFR 405, sections 1200-1208.
- *Regulations regarding expedited determinations based on Medicare Change of Status Notifications (MCSNs), found in 42 CFR 405, sections 1210-1212.*

The following subsections provide additional detail on the coordination between these parties. They also describe how various Medicare provider types reflect decisions of QIOs on claims they submit to Medicare *A/B MACs (A)* and how these decisions may affect the liability of Medicare beneficiaries for payment.

150.2.2 - General Responsibilities of QIOs and *A/B MACs (A)* Related to HINNs

(Rev.13026, Issued: 12-27-2024, Effective: 10-11-2024 , Implementation: 02-15- 2025)

Publication 100-10, The Quality Improvement Organization Manual, Chapter 7, provides detailed instructions regarding QIO responsibilities and procedures related to HINNs.

The *A/B MAC (A)* is responsible for making liability determinations in other cases (e.g., eligibility and reductions of payment). However, the *A/B MAC (A)* adjudicates claims, makes payment and sends beneficiaries Medicare Summary Notices in all cases, reflecting both QIO and *A/B MAC (A)* determinations on liability. This joint responsibility requires that the QIO notify the *A/B MAC (A)* of its denial determinations, all preadmission determinations, and diagnostic or procedural coding changes. The *A/B MAC (A)* does not issue a denial notice to the beneficiary or the hospital for cases that have been reviewed by the QIO. The QIO notifies the beneficiary and hospital.

NOTE: QIO determinations are binding and cannot be reversed by the *A/B MAC (A).*

150.2.3 - Billing and Claims Processing Requirements Related to HINNs

(Rev.13026, Issued: 12-27-2024, Effective: 10-11-2024 , Implementation: 02-15- 2025)

Where QIO review is done prior to billing (preadmission or admission HINN), the hospital reports the results of the QIO's review on the claim using special indicators. A set of condition codes were created to reflect these reviews. These *condition* codes, C1-C7, are known as the QIO approval indicator codes.

The *A/B MAC (A)* reviews these *condition* codes and makes determinations as follows:

- Code C1, C3, or C6 - Pay as billed.
- Code C4 - Do not pay, but process a no-payment bill.
- Blank or Code C5 - Return the claim to the provider for QIO review, unless the *A/B MAC (A)'s* agreement with the QIO requires sending it directly to the QIO.

Where the QIO review occurs after *A/B MAC (A)* processing (postpayment review), the QIO reports adjustments to the *A/B MAC (A)*. Currently there is no approved electronic format for this report.

150.3 - Skilled Nursing Facility (SNF), Home Health Agency (HHA), Hospice and Comprehensive Outpatient Rehabilitation Facility (CORF) Claims Subject to Expedited Determinations

(Rev.13026, Issued: 12-27-2024, Effective: 10-11-2024 , Implementation: 02-15- 2025)

In short, SNFs, HHAs, hospices and CORFs must give notice to Medicare beneficiaries of their right to expedited determinations when their period of covered care ends. Expedited determinations allow beneficiaries to challenge/appeal their provider's decisions to discharge, whereas the standard appeal process available after a claim is adjudicated allows beneficiaries to dispute payment denials. Detailed instructions regarding expedited determination notices are found in *chapter 30, section 260.*

150.3.2 - General Responsibilities of QIOs and *A/B MACs (A)* Related to Expedited Determinations

(Rev.13026, Issued: 12-27-2024, Effective: 10-11-2024 , Implementation: 02-15- 2025)

A. QIO Role

QIOs review expedited determination notices providers give beneficiaries, both as part of making decisions relative to coverage and to assure providers have given valid notice. The QIO is responsible for establishing contact with the provider, so that the beneficiary's medical records can used in making a determination, although QIOs can still make such decisions even if records are not available. The QIO makes a decision on coverage in answer to the beneficiary's request for review, relaying this decision back to the involved parties. If the beneficiary does not accept the QIO determination, they may request a reconsideration from a Qualified Independent Contractor (QIC).

B. *A/B MAC (A)* Role

A/B MACs (A) support beneficiaries and providers through an awareness of the expedited determination process and by performing routine duties potentially affected by this process--liability notice oversight, claims processing and medical review.

A/B MAC (A) medical review should never repeat or contradict the results of QIO review regarding coverage, since this would be duplicative and QIO decisions are binding, and QIOs are bound by the same coverage policy in making their determinations--even local policy. But the scope of these QIO decisions is limited to discharge, and medical review examines a much broader range of potential issues and periods of care. For example, a monthly SNF claim could include a discharge reviewed by a QIO, but it also contains other days of billing not related to discharge—the non-discharge period is not considered by the QIO, and would still be subject to medical review.

150.3.3 - Billing and Claims Processing Requirements Related to Expedited Determinations

(Rev.13026, Issued: 12-27-2024, Effective: 10-11-2024 , Implementation: 02-15- 2025)

As noted above, the outcome of expedited determinations and reconsiderations will be reported on Medicare claims to assure *A/B MAC (A)* adjudication of claims is consistent with QIO/QIC decisions. Note that the expedited review process is always completed prior to billing, and therefore does not directly affect established billing procedures, even demand billing, other than the use of indicators described below.

Special indicators are used on claims to reflect the outcome of QIO expedited determinations and QIC reconsiderations. Before the creation of the expedited review process, QIO related determinations were reflected only on hospital claims. A set of condition codes were used to reflect these determinations. These codes, C1- C7, are known as the QIO approval indicator codes.

With the advent of the expedited determination process, these QIO approval indicators are relevant to types of bill other than inpatient hospital claims. The QIO approval indicator codes described below are valid for Medicare billing on the following types of bill:

18x, 21x, 22x, 23x, 32x, 33x, 34x, 75x, 81x, 82x.

Since QIO expedited decisions and QIC reconsideration decisions have the same effect on providers and beneficiaries, the same QIO approval indicator codes will be used to report a decision by either entity. Providers should note that no indicators are required on discharge claims in the case where a generic notice is provided and the beneficiary does not request an expedited determination.

A Reporting of QIO/QIC Decisions Upholding a Discharge

Providers must also report indicators on claims when they receive notification of decisions which uphold the provider's decision to discharge the beneficiary from Medicare covered care. In these cases, providers submit a discharge claim for the billing period that precedes the determination according to all applicable claims instructions plus one additional data element. Providers must annotate these claims with condition code C4, defined as "Services Denied."

Beneficiaries are protected from liability for the period from the delivery of the expedited notice, usually two days before the end of coverage, to the end of the covered period written on the notice if the beneficiary requests an expedited determination timely. If the beneficiary does not request the determination timely, or if the determination process at the QIO is delayed, the beneficiary may be liable for services provided from the day after the end of the covered period until the date of the actual discharge.

In cases where the beneficiary may be liable, in addition to reporting condition code C4 providers must also report occurrence span code 76, defined as "patient liability period," along with the days of liability that have been incurred. Line items with dates of service falling within this patient liability period are reported with noncovered charges and, if they require HCPCS coding, with modifier –TS. *A/B MAC (A)* will deny these lines and hold the beneficiary liable.

In certain cases, an Advance Beneficiary Notice (ABN) may be issued simultaneously or immediately following the issuance of an expedited determination notice. These ABNs would pertain to continued services that the beneficiary wishes to receive despite the provider's intent to discharge the beneficiary. Any required physician orders continue to be needed for the services to continue. If these ABN situations result in a beneficiary's request for a demand bill to Medicare regarding continuing services after the QIO/QIC has upheld the discharge, providers must report condition code C4 on the demand bill. The demand bill must otherwise be prepared according to all other applicable instructions.

B Reporting of QIO/QIC Decisions Not Upholding a Discharge

When providers are notified of QIO/QIC decisions that authorize continued Medicare coverage and do not specify a coverage ending date, they must submit a continuing claim for the current billing or certification period according to all claims instructions for the applicable type of bill, plus a single additional data element. Providers must annotate these claims with condition code C7, which is defined "QIO extended authorization." This indicator will alert *A/B MAC (A)* that coverage of the services on the claim has already been subject to review.

In the circumstance, expected to be rare, when providers are notified of QIO/QIC decisions which authorize continued Medicare coverage only for a limited period of time, they must submit claims as follows:

- If the time period of coverage specified by the QIO/QIC extends beyond the end of the normal billing or certification period for the applicable type of bill, providers submit a continuing claim for that period according to all applicable claims instructions plus two additional data elements. Providers must annotate these claims with condition code C3, which is defined "QIO partial approval" and with occurrence span code M0, which is defined "QIO approved stay dates", along with the following dates—the beginning date of the coverage period provided by the QIO/QIC, and the statement through date of the claim.

- If the time period of coverage specified by the QIO/QIC does not extend to the end of the normal billing or certification period for the applicable type of bill, providers submit a discharge claim according to all applicable claims instructions plus two additional data elements. Providers must annotate these claims with condition code C3, which is defined "QIO partial approval" and with occurrence span code M0, which is defined "QIO approved stay dates" and the dates provided by the QIO/QIC.

NOTE: Regarding any decision that does not uphold a discharge, QIO/QIC decisions authorizing extended coverage cannot authorize delivery of services if there are not also the required physician orders needed to authorize the care.

C Billing Beneficiaries in Cases Subject to Expedited Determinations

Providers should note a significant difference between the use of expedited determination notices and the use of ABNs. As described in Claims Processing Manual, Chapter 1, section 60.3.1, in ABN or HHABN situations, all providers other than SNFs can bill beneficiaries for services subject to a demand bill while awaiting a Medicare determination on the coverage of the services. The same is not true in expedited determination situations. When a beneficiary requests an expedited determination timely, no funds may be collected until the provider receives notification of the QIO/QIC decision.

D Reporting Provider Liability Situations

Providers may be liable as a result of two specific situations in the expedited review process:

(1) if the provider is not timely in giving information to the QIO; and

(2) if the provider does not give valid notice to the beneficiary.

Since both these events occur after the point the provider has already determined discharge is imminent, there may be no actual liability, since there may be no medical need for additional care. However, if services are required, and either of these liability conditions apply, such services should be billed as noncovered line items using the –GZ modifier, which indicates the provider is liable, consistent with Section 60.4.2 of this chapter.

150.4 - General Responsibilities of QIOs and A/B MACs (A) Related to Expedited Determinations Based on Medicare Change of Status Notifications (MCSNs)

(Rev.13026, Issued: 12-27-2024, Effective: 10-11-2024 , Implementation: 02-15- 2025)

This section provides claims processing instructions to implement an expedited hospital status change appeals process required by final rule, CMS-4204-F.The resulting regulations are located at 42 CFR Part 405.1210 through 405.1212.

Expedited hospital status change appeals are afforded to certain beneficiaries in Original Medicare only who were initially admitted to a hospital as an inpatient by a physician but whose status during their stay was changed to an outpatient receiving observation services by the hospital's utilization review committee (URC) (thereby effectively denying Part A coverage for their hospital stay), and meet other conditions specified in the court order. Regulations at 42 CFR 405.1210(b) require hospitals to notify beneficiaries of their right to pursue an appeal regarding the decision to reclassify the beneficiary from an inpatient to an outpatient receiving observation services. The Medicare Change of Status Notice (CMS-10868) is the standardized notice to satisfy the notification requirement.

After receipt of the MCSN, eligible beneficiaries are given the opportunity to appeal, and may argue that their inpatient admission satisfied the relevant criteria for Part A coverage and that the hospital URC's determination to reclassify the beneficiary as an outpatient receiving observation services was therefore erroneous. The change in status from inpatient to outpatient may also affect coverage of the beneficiary's post-hospital extended care services furnished in a skilled nursing facility (SNF).

A. QIO Role

Once an eligible beneficiary has requested an appeal, the QIO reviews the records from the hospital relative to the change in status, and verifies that the provider has given valid

notice. The QIO is responsible for establishing contact with the provider, so that the beneficiary's medical records can used in making a determination, although QIOs can still make such decisions even if records are not provided. The QIO makes a decision on coverage in answer to the beneficiary's request for review of their change in status, relaying this decision back to the beneficiary or their representative, as well as the hospital. If the beneficiary does not agree with the QIO determination, they may request that the QIO conduct a reconsideration.

B. A/B MAC (A) Role

A/B MACs (A) support beneficiaries and providers through an awareness of the expedited determination process and by performing routine duties potentially affected by this process--liability notice oversight, claims processing and medical review.

A/B MAC (A) medical review should never repeat or contradict the results of QIO review regarding the change of status of the hospital claim, since this would be duplicative and QIO decisions are binding. But the scope of these QIO decisions is limited to the change in status, and medical review examines a much broader range of potential issues and periods of care. For example, a monthly SNF claim may follow a change of status reviewed by a QIO, but it also contains other days of billing that are subject to additional coverage criteria. Other issues not considered by the QIO may still be subject to medical review.

150.4.1- Billing and Claims Processing Requirements Related to Expedited Determinations Following Appeal of Status Change s

(Rev.13026, Issued: 12-27-2024, Effective: 10-11-2024 , Implementation: 02-15- 2025)

The outcome of expedited determinations and reconsiderations based on appeals of hospital status changes are reported on Medicare claims to assure A/B MAC (A) adjudication of claims is consistent with QIO decisions. Note that the expedited review process for timely submitted appeals is completed prior to billing, and therefore does not directly affect established billing procedures, even demand billing, other than the use of indicators described below.

Special indicators are used on claims to reflect the outcome of QIO expedited determinations and reconsiderations. A set of condition codes are used to reflect these determinations. These condition codes, C1- C7, are known as the QIO approval indicator codes.

With the advent of the expedited determination process based on appeals of hospital status changes, these QIO approval indicators are used in new ways on inpatient hospital claims and skilled nursing facility. The QIO approval indicator code uses described below are valid for Original Medicare billing on the following Types of Bill: 11x, 18x, and 21x.

Providers should note that no indicators are required on claims subject to a change in status where the beneficiary does not request an expedited determination.

A. QIO Decisions Upholding a Change in Status

Providers do not report indicators on claims when they receive notification of decisions which uphold the provider's change of the beneficiary's status from inpatient to outpatient. Providers do not annotate these claims with condition code C4 to reflect the QIO denial of the appeal, since the code is defined as "Services Denied" and hospital services are not denied but will be billed on outpatient Types of Bill. In these cases, SNF services will not be billed to Original Medicare because there is no qualifying hospital stay.

B. Reporting of QIO Decisions Reversing a Change of Status

When providers are notified of QIO decisions to reverse a change of status from inpatient to outpatient, hospitals must bill the beneficiary's stay using Type of Bill 011x. Hospitals must annotate these claims with condition code C6, which is defined "Admission preauthorization" and indicates the QIO has authorized the admission but has not reviewed the services provided. Hospital shall also add Remarks stating "MCSN" to specify the circumstance of the review. These indicators will alert A/B MAC (A) that the beneficiary's inpatient status has already been subject to review and upheld by the QIO.

When billing for a SNF stay where the 3-day qualifying hospital stay was subject to a change of status review, SNFs and swing bed providers must also add condition code C6 and Remarks "MCSN" to their Type of Bill 021x or 018x admission claims. These indicators will alert the A/B MAC (A) that the beneficiary's inpatient status has already been subject to review and upheld by the QIO for the qualifying hospital stay dates reported in occurrence span code 70.

C. Billing Beneficiaries in Cases Subject to Expedited Determinations Related to Expedited Determinations Following Appeal of Status Change

If an eligible beneficiary requests an appeal timely, they would not be billed during the QIO appeals process. However, if the appeal is untimely, the hospital may bill a beneficiary before this QIO process is complete. An eligible beneficiary may file a request for review by the QIO regarding the change in status after the timely filing deadline established in regulation (that is, the beneficiary may file the request after release from the hospital) but the QIO's determination will be provided on a different timeframe and the eligible beneficiary will not be entitled to protection from billing during this time.