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CMS ISSUES NOTICE AND APPEAL INSTRUCTIONS TO HOSPITALS THAT RECLASSIFY PATIENTS FROM INPATIENTS TO OUTPATIENTS

As of February 14, 2025, hospitals[1] will be required to provide notice to patients who are admitted as inpatients but who are later reclassified as outpatients receiving observation services (referred to as "change in patient status"). These patients who receive a change in patient status may request an expedited determination from the Centers for Medicare & Medicaid Services ("CMS") contractors to appeal this decision. Although this final rule ("Final Rule") was issued on October 11, 2024, pursuant to a court order stemming from the class action 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), its implementation may be delayed if Congress reviews this regulation under the Congressional Review Act or if the Trump administration reverses the Final Rule.

A hospital's change in patient status determination can result in a patient's stay being denied under Medicare Part A, the patient facing financial responsibility for some or all of the hospital bill, as well as denial of coverage for any subsequent skilled nursing facility care due to no longer having a qualifying stay. This new rule applies only to certain patients with Traditional Medicare (non-Medicare Advantage members) who do not have Part B, or who have Part B but who have been in the hospital for at least three consecutive days.

To comply with the new regulation, hospitals must provide a reclassified Medicare patient with a Medicare Change of Status Notice ("MCSN") as soon as possible, but no later than four hours prior to discharge. Patients who receive an MCSN while in the hospital may appeal to the Beneficiary & Family Centered Care-Quality Improvement Organization through an expedited appeals process (CMS currently contracts with two quality improvement contractors to handle these appeals). Additionally, any Medicare patients who were reclassified from inpatient to outpatient receiving observation services on or after January 1, 2009, may file a "retrospective appeal" within 365 days of the date of the implementation of the Final Rule if the hospital did not file a Part A claim because of the change in status.

Unlike the traditional Medicare appeal process, CMS does not allow providers to appeal on behalf of Medicare patients or to represent the patients in these appeals. CMS asserts because the hospitals decide when to change the patient's status from inpatient to outpatient receiving observation services, the interests of the hospital may conflict with those of the patients. Nonetheless, while a provider may not act as an appointed representative for the patient under this new rule, CMS believes that it would be entirely appropriate for hospitals to lend assistance to beneficiaries by providing records, information and advice about the appeal and the appeal process.

If a patient requests expedited review, a hospital may not bill the patient until the appeal review is complete. There are detailed billing changes depending on whether the patient's appeal is successful.

PRACTICAL TAKEAWAYS

- Hospitals are required to provide MCSN when a patient is admitted as an inpatient and reclassified as an outpatient receiving observation services if that patient meets one of the following criteria:
  - A Medicare patient without Part B; or
  - A Medicare patient with Part B whose hospital stay was at least three days but was reclassified as an inpatient for less than three days.
- Medicare patients who meet the above criteria may request an expedited appeal of the change of status determination while still in the hospital or retroactively for hospital stays that were changed from inpatient to outpatient on or after January 1, 2009.
- If the Medicare patient is successful in the appeal, the hospital must refund Part B payments before billing Medicare for the inpatient stay. If the patient is not enrolled in Part B, the hospital must refund any patient payments for the outpatient services before billing Part A for the services provided.

If you have any questions or would like additional information on this topic, please contact:

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[1] Hospitals affected by this new rule include short or long-term inpatient services, acute or non-acute services, paid through IPPS or other reimbursement systems that pay for specialty services, including critical access hospitals.

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