DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C5-01-14
Baltimore, Maryland 21244-1850

CENTER FOR MEDICARE

Medicare Appeal Rights for Certain Changes in Patient Status Final Rule
(CMS-4204-F)
Fact Sheet

On October 11, 2024, the Centers for Medicare & Medicaid Services (CMS) issued a final rule that establishes appeals processes for certain people in Traditional Medicare who are initially admitted to a hospital as an inpatient but, subsequently, reclassified by the hospital as an outpatient receiving observation services during their hospital stay, and who meet other eligibility criteria.

The final rule can be downloaded from the Federal Register at:
https://www.federalregister.gov/public-inspection/current.

Background

Alexander v. Azar was a nationwide class action case filed in 2011 that sought to require the Secretary of the U.S. Department of Health and Human Services (HHS) to provide Medicare appeal rights to challenge a patient's placement as an outpatient receiving observation services. In March 2020, the United States District Court for the District of Connecticut issued a decision, ruling that beneficiaries are not entitled to appeal rights for their placement by hospitals as outpatients receiving observation services. However, the court directed the HHS Secretary to create additional appeals processes for a specified class of people with Medicare who are initially admitted as hospital inpatients but are subsequently reclassified by the hospital as outpatients receiving observation services, and who meet other conditions specified in the order. The government appealed, and the United States Court of Appeals for the Second Circuit affirmed the district court's decision in January 2022.

The class includes beneficiaries who either had, or will have, Part A benefits denied for hospital inpatient services and Skilled Nursing Facility (SNF) care as a result of the hospital's reclassification. The class also includes beneficiaries who were reclassified and did not have Part B coverage at the time of hospitalization.

The court ordered the Secretary to create additional appeals processes for such beneficiaries, including an expedited appeals process that is substantially similar to the existing hospital discharge appeals, for class members who appeal while they are in the hospital, and a retrospective review process for beneficiaries who met the conditions for the class prior to the implementation of the prospective appeals process.

Final Rule Highlights

Expedited Appeals:
CMS is establishing an expedited appeals process for eligible beneficiaries who disagree with the hospital's decision to reclassify their status, while they are still in the hospital, from inpatient to outpatient receiving observation services (resulting in a denial of coverage for the hospital stay

under Part A). These beneficiaries will be able to file an appeal with a Beneficiary & Family Centered Care-Quality Improvement Organization (BFCC-QIO). The BFCC-QIO will independently review the beneficiary's patient record to determine whether the inpatient admission satisfied the relevant criteria for Part A coverage. After receiving patient records from the hospital, the BFCC-QIO will render a determination within one day for appeals received before the beneficiary leaves the hospital.

Standard Appeals:
CMS is also establishing a standard appeals process, for eligible beneficiaries who do not file an expedited appeal, that will allow them to pursue an appeal regarding the hospital's decision to reclassify their status from inpatient to outpatient receiving observation services (resulting in a denial of coverage for the hospital stay under Part A). In some cases, this may happen after the processing of the hospital's Part B outpatient claim and any denial of SNF coverage. This process will follow similar procedures to the expedited appeals process but with longer timeframes to file and for the BFCC-QIO to make decisions.

Retrospective Appeals:
CMS is also establishing a retrospective process that applies to beneficiaries with hospital admissions on or after January 1, 2009, involving status changes before the implementation of the prospective appeals processes discussed above. Consistent with the court's order, the beneficiary must demonstrate eligibility for an appeal as a class member and show that the initial inpatient admission satisfied the relevant criteria for Part A coverage. Under this process, CMS will use an "eligibility contractor," which will be an existing appeals contractor to serve as a single point of contact for incoming beneficiary retrospective appeal requests and as a gatekeeper in determining eligibility for an appeal. Beneficiaries will have 365 calendar days from the implementation date of the final rule to gather any related documentation and file an appeal request. Appeals following the eligibility determination will generally mirror the existing five level claim appeals procedures.

Based on broad overall support for the proposed rule, issued in the Federal Register on December 27, 2023[1], CMS is generally finalizing the appeals processes as proposed, while making small modifications after consideration of public comments (e.g., extending certain timeframes, clarifying language related to hospital billing and payments made for SNF services, and making technical corrections).

These appeals processes will be available to beneficiaries after an operational implementation period. CMS is projecting implementation beginning early in 2025. Once confirmed, implementation dates will be announced on CMS.gov and/or Medicare.gov.

[1] https://www.federalregister.gov/documents/2023/12/27/2023-28152/medicare-program-appeal-rights-for-certain-changes-in-patient-status.