mln FACT SHEET
KNOWLEDGE • RESOURCES • TRAINING

Patient Status Appeals

Hospitals and skilled nursing facilities (SNFs) can submit new Medicare Part A claims for covered inpatient and SNF services (not previously covered under Part A) if they get a notice with a favorable or partially favorable patient status appeal decision under the new retrospective appeals process.

The final rule CMS-4204-F:

- Makes new patient status appeals available to certain patients
- Implements the court order 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 court order required CMS to establish new appeals procedures for certain patients in Original Medicare (also known as Fee-for-Service) who meet these conditions:

- Were admitted to the hospital as an inpatient on or after January 1, 2009
- Had their status changed by the hospital from inpatient to outpatient and after the status change the patient got observation services
- Received a Medicare Outpatient Observation Notice (MOON) or a Medicare Summary Notice (MSN) indicating that observation services aren't covered under Part A (Hospital Insurance) and
- The patient meets 1 of these 2 requirements:
  - Weren't enrolled in Medicare Part B coverage when hospitalized OR
  - Had Part B coverage when hospitalized and both occurred:
    - Stayed at the hospital for 3 or more days in a row but weren't an inpatient for 3 days
    - Were admitted to a SNF during the 30 days after the hospital stay (or it's been less than 30 days since the hospital stay)

See the Medicare Appeal Rights for Certain Changes in Patient Status Final Rule for background and final rule highlights information.

We issued the final rule on October 15, 2024, to implement these procedures, codified at 42 CFR 405.931–938. In these patient status appeals, eligible patients can argue that their hospital stay satisfied the relevant criteria for Part A inpatient coverage.

The denial of Part A coverage for the hospital stay in these cases may also affect coverage of the patient's post-hospital extended care services provided in a SNF. Per Section 1861(i) of the Social Security Act, patients must have a prior inpatient hospital stay of 3 consecutive days to be eligible for Medicare coverage of inpatient SNF care, known as the SNF 3-day rule. Under the new rules, a patient may also appeal their SNF services if the patient or family member made out of pocket payments for SNF services.

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
Medicare Learning Network®

New Retrospective Appeals Process

Retrospective appeal requests filed by patients must be received by the eligibility contractor no later than January 2, 2026. Appeals will be screened for eligibility, and then eligible requests will be forwarded to the Medicare Administrative Contractor (MAC) and processed under the new procedures in the rule, which are very similar to the existing 5-level claim appeals process. However, providers aren't parties to these appeals and may not represent patients in these new appeals.

Claim Submission Following a Favorable or Partially Favorable Appeal Decision

The MAC will issue a favorable or partially favorable patient status appeal decision if they determine:

- The patient met the applicable Part A hospital inpatient coverage requirements
- If SNF services are included in the appeal, some or all SNF services meet Part A coverage requirements

You'll get a copy of favorable or partially favorable decisions that will explain the effect of the decision, including your responsibilities. You aren't required but may submit claims to Medicare to determine the amount of benefits due under Part A for the covered services after refunding amounts received for the outpatient hospital services and, if applicable, any payments received from a patient or a family member for the SNF services now covered under Part A.

To determine Part A benefits for a favorable or partially favorable decision, we disregard the patient's reclassification as an outpatient getting observation services by the hospital.

SNF Claim Submission

We don't require SNFs to submit a Part A claim for payment of covered SNF services following a favorable or partially favorable patient status appeal. The SNF will get notice of the decision, and if it chooses to submit a claim to receive Part A payment, the SNF must do all of these:

- First, refund the patient or family member for all payments made by the patient or family member for the covered services
- After making the refund, submit the claim within 365 calendar days after the SNF gets the notice of a favorable or partially favorable appeal decision for the eligible party

Hospital Claim Submission

Patients Enrolled in Medicare Part B when Hospitalized

We don't require Part A claim submissions, but hospitals may submit a Part A inpatient claim to get Part A payment for covered services following a favorable or partially favorable appeal decision for a patient who was enrolled in Part B at the time of hospitalization. If the hospital doesn't submit a Part A inpatient claim, any previous Part B outpatient claim won't be adjusted or reopened, and the Part B payment for the outpatient services won't be recouped or offset. The hospital isn't required to refund any deductible or coinsurance payments received for the outpatient services if it doesn't submit a Part A inpatient claim in this situation.

The hospital will get notice of the favorable or partially favorable decision, and if it chooses to submit an inpatient claim for Part A payment, the hospital must do all of these:

- First, refund any payments received for the outpatient services (including any applicable deductible and coinsurance amounts received from any source) to prevent duplicate payment
- After making the refund, submit the claim within 365 calendar days after the hospital gets the notice of a favorable or partially favorable appeal decision for the eligible party

If not already completed by the provider, we'll recoup Medicare's payment for an existing Part B outpatient claim for the services at issue in the patient status appeal if it isn't refunded in full (and the Part B claim will be canceled) before processing the hospital's Part A inpatient claim.

Patients Not Enrolled in Part B When Hospitalized

Hospitals aren't required to but may submit a Part A inpatient claim to get Part A payment for covered services following a favorable or partially favorable appeal decision for a patient who wasn't enrolled in Part B at the time of hospitalization. The hospital will get notice of the favorable or partially favorable decision, and the hospital must refund any payments received from any source for outpatient services provided (including coinsurance and any deductible collected).

- Refunds are required even if the hospital doesn't submit a Part A claim.
- After making the refund, the hospital may then submit a claim within 365 calendar days after the hospital gets the notice of a favorable or partially favorable appeal decision for the eligible party.

This fact sheet implements the guidance to allow for provider claims submission under the new retrospective appeals process.

Claim Submission Instructions Starting January 1, 2025

SNF Services

- Submit a 21X type of bill (TOB) claim within the timeframe established in the patient status appeals rule (that's within 365 calendar days after the SNF gets its notice of a favorable or partially favorable appeal decision)
- Add condition code "W3" attesting this is a claim following an appeal that's been approved for processing for covered services, and the required refund has been issued to the patient or family member
- Add a treatment authorization code of "ALEXANDER" and the affirmed redetermination number on the appeal letter
  - We instruct providers billing an 837I to place the appropriate treatment authorization code above into Loop 2300 REF02 (REF01 = G1) as follows:

    REF*G1*ALEXANDER1-01234567890~

    NOTE: The 13 characters after the word "ALEXANDER" represent the affirmed redetermination number received on the appeal letter. This number begins with "1-," followed by 11 digits.

  - Providers billing via Direct Data Entry (DDE) or paper Claims are instructed to use a condition code "W3" and to use fields: 5/MAP1715 (for DDE) or Treatment Authorization field #63 (for paper) and the following format:

    ALEXANDER1-01234567890

    NOTE: The 13 characters after the word "ALEXANDER" represent the affirmed redetermination number received on the appeal letter. This number begins with "1-," followed by 11 digits.

Hospital Services

- Submit an 11X TOB claim within the timeframe established in the patient status appeals rule (that's within 365 calendar days after the hospital receives its notice of a favorable or partially favorable appeal decision)
- Add condition code "W3" attesting this is a claim following an appeal that's been approved for processing for covered services, and the required refund has been issued to the patient or other payor

- Add a treatment authorization code of “ALEXANDER” and the affirmed redetermination number received on the appeal letter
  - We instruct providers billing an 837I to place the appropriate treatment authorization code above into Loop 2300 REF02 (REF01 = G1) as follows:

    REF*G1*ALEXANDER1-01234567890~

    NOTE: The 13 characters after the word “ALEXANDER” represent the affirmed redetermination number received on the appeal letter. This number begins with “1-,” followed by 11 digits.
  - Providers billing via DDE or paper Claims are instructed to use a condition code “W3” and to use fields: 5/MAP1715 (for DDE) or Treatment Authorization field #63 (for paper) and the following format:

    ALEXANDER1-01234567890

    NOTE: The 13 characters after the word “ALEXANDER” represent the affirmed redetermination number received on the appeal letter. This number begins with “1-,” followed by 11 digits.

Resources

- Section 1814(a)(1) of the Social Security Act
- 42 CFR 405.934
- 42 CFR 424.51
- 42 CFR 489.20
- 42 CFR 489.21