CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 12934	**Date: October 31, 2024**
	Change Request 13846

NOTE: This Transmittal is no longer sensitive and is being re-communicated November 21, 2024. The Transmittal Number, date of Transmittal and all other information remains the same. This instruction may now be posted to the Internet.

SUBJECT: Medicare Change of Status Notice (MCSN) Manual Instructions

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to set forth the guidance for expedited determinations when a beneficiary is reclassified from an inpatient to an outpatient receiving observation services.

EFFECTIVE DATE: November 15, 2024 - 30 days after regulation publication date
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: February 14, 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
N	30/Table of Contents
N	30/450/Expedited Determinations When a Beneficiary is Reclassified from an Inpatient to an Outpatient Receiving Observation Services
N	30/450/450.1/Authority
N	30/450/450.2/Scope
N	30/450/450.3/Medicare Change of Status Notice (MCSN)
N	30/450/450.3.1/Alterations to the MCSN
N	30/450/450.3.2/Hospital Delivery of the MCSN
N	30/450/450.3.3/Required Deliver Timeframes of the MCSN
N	30/450/450.3.4/Refusal to Sign the MCSN
N	30/450/450.3.5/Ensuring Beneficiary Comprehension
N	30/450/450.3.6/MCSN Delivery to Representatives
N	30/450/450.3.7/Notice Retention for the MCSN
N	30/450/450.4/Expedited Determination Process
N	30/450/450.4.1/Beneficiary Responsibilities
N	30/450/450.4.1.1/Timeframes for Requesting an Expedited Determination
N	30/450/450.4.1.2/Provide Information to BFCC-QIO
N	30/450/450.4.2/Beneficiary Liability During BFCC-QIO Review
N	30/450/450.4.3/Hospital Responsibilities
N	30/450/450.5/BFCC-QIO Responsibilities
N	30/450/450.5.1/Receive Beneficiary Requests for Expedited Review
N	30/450/450.5.2/Notify Hospitals
N	30/450/450.5.3/Validate Delivery of the MCSN
N	30/450/450.5.4/Solicit the Views of the Beneficiary
N	30/450/450.5.5/Solicit the Views of the Hospital
N	30/450/450.5.6/Make Determinations and Notify Required Parties
N	30/450/450.6/Effect of a BFCC-QIO Expedited Determination
N	30/460/Expedited Reconsiderations
N	30/460/460.1/Beneficiary Responsibilities/
N	30/460/460.1.1/Timeframe for Requesting an Expedited Reconsideration
N	30/460/460.1.2/Provide Information to the BFCC-QIO

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N	30/460/460.1.3/Beneficiary Liability During BFCC-QIO
N	30/460/460.2/Hospital Responsibilities
N	30/460/460.3/BFCC-QIO Responsibilities
N	30/460/460.3.1/Receive Beneficiary Requests for Expedited Reconsiderations
N	30/460/460.3.2/Notify Hospitals
N	30/460/460.3.3/Solicit the Views of the Beneficiary
N	30/460/460.3.4/Solicit the Views of the Hospital
N	30/460/460.3.5/Make Determination and Notify Required Parties
N	30/460/460.4/Effect of a BFCC-QIO Expedited Reconsideration

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: 12934	Date: October 31, 2024	Change Request: 13846

NOTE: This Transmittal is no longer sensitive and is being re-communicated November 21, 2024. The Transmittal Number, date of Transmittal and all other information remains the same. This instruction may now be posted to the Internet.

SUBJECT: Medicare Change of Status Notice (MCSN) Manual Instructions

EFFECTIVE DATE: November 15, 2024 - 30 days after regulation publication date
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: February 14, 2025

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to set forth the guidance for expedited determinations when a beneficiary is reclassified from an inpatient to an outpatient receiving observation services.

II. GENERAL INFORMATION

A. Background:

Medicare beneficiaries with Original Medicare who have been reclassified by a hospital from an inpatient to an outpatient receiving observation services and meet additional criteria have a right to appeal their status change to a Beneficiary and Family Centered Care-Quality Improvement Organization (BFCC-QIO). This process was implemented through a final rule CMS-4204-F, effective November 15, 2024. The resulting regulations are located at 42 CFR Part 405.1210 -through 405.1212. The expedited determination process is available to beneficiaries in Original Medicare who, after formally being admitted as an inpatient, have subsequently been reclassified by the hospital as an outpatient receiving observation services. The reclassification must have happened while the beneficiary was still in the hospital, and also met one of the following criteria:

- For beneficiaries with Medicare Part B, their stay in the hospital must last at least three days.
- For beneficiaries that do not have Medicare Part B, no three day stay is required to qualify for this expedited appeals process.

Hospitals must deliver the MCSN to all beneficiaries eligible for the expedited determination process.

- The hospital must ensure that the beneficiary or representative signs and dates the MCSN to demonstrate that the beneficiary or representative received the notice and understands its contents.
- Use of assistive devices may be used to obtain a signature.
- Electronic issuance of the MCSN is permitted.

Hospitals must deliver the MCSN as soon as possible after a beneficiary is eligible for this process, but no later than four hours prior to discharge.

For beneficiaries with Medicare Part B, the notice must be delivered as soon as possible after the hospital reclassifies the beneficiary from inpatient to outpatient receiving observation services and the third day in the hospital is reached.

For beneficiaries without Medicare Part B coverage, hospitals must deliver the notice as soon as possible after the change in status from inpatient to outpatient receiving observation services because a three-day hospital stay is not required for these beneficiaries to be eligible for this expedited appeals process.

B. Policy: Final rule CMS-4204-F, effective November 15, 2024

42 CFR Part 405.1210-405.1212

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	
13846.1	Contractors shall review the process associated with the Medicare Change of Status Notice as indicated in the Pub.100-04, Chapter 30, Sections 250-260.	X								QIC, QIO

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 30 - Financial Liability Protections

Table of Contents

(Rev. 12934; Issued: 10-31-24)

450 - Expedited Determinations When a Beneficiary is Reclassified from an Inpatient to an Outpatient Receiving Observation Services

(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

Medicare beneficiaries with Original Medicare who have been reclassified by a hospital from an inpatient to an outpatient receiving observation services and meet additional criteria (See 450.2 of this section) have a right to appeal their status change to a Beneficiary and Family Centered Care-Quality Improvement Organizations (BFCC-QIO).

450.1 –Authority

(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

This process was implemented through a final rule, CMS-4204-F, effective November 15, 2024. The resulting regulations are located at 42 CFR Part 405.1210 through 405.1212.

450.2 - Scope

(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

The expedited determination process is available to beneficiaries in Original Medicare who, after formally being admitted as an inpatient, have subsequently been reclassified by the hospital as an outpatient receiving observation services. The reclassification must have happened while the beneficiary was still in the hospital, and also met one of the following criteria:

- *For beneficiaries with Medicare Part B, their stay in the hospital must last at least three days.*
- *For beneficiaries that do not have Medicare Part B, no three day stay is required to qualify for this expedited appeals process.*

NOTE:

For purposes of these instructions, the term "beneficiary" means either beneficiary or representative, when a representative is acting on a beneficiary's behalf.

Hospitals Affected by these Instructions. *These instructions apply to any facility providing care at the inpatient hospital level, whether that care is short-term or long-term, acute or non-acute, paid through a prospective payment system or other reimbursement basis, limited to specialty care or providing a broader spectrum of services. This definition includes critical access hospitals (CAHs).*

450.3 – Medicare Change of Status Notice (MCSN)

(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

The Medicare Change of Status Notice (MCSN) is subject to the Paperwork Reduction Act (PRA) process and approval by the Office of Management and Budget (OMB). The MCSN may only be modified as per the accompanying instructions, as well as per guidance in this section. Unapproved modifications cannot be made to the OMB-approved, standardized MCSN. The notice and accompanying instructions may be found online at https://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices

450.3.1 Alterations to the MCSN

(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

- *The MCSN must remain two pages. The notice can be two sides of one page or one side of two separate pages but **must not** be condensed to one page.*

- *Hospitals may include their business logo and contact information on the top of the MCSN. Text may not be shifted from page one to page two to accommodate large logos, address headers, etc.*

- *Hospitals may include information in the optional "Additional Information" section relevant to the beneficiary's situation.*

450.3.2 - Hospital Delivery of the MCSN
(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

Hospitals must deliver the MCSN to all beneficiaries eligible for the expedited determination process per §450.2.

- *The hospital must ensure that the beneficiary or representative signs and dates the MCSN to demonstrate that the beneficiary or representative received the notice and understands its contents. See §450.3.6 'Ensuring Beneficiary Comprehension'.*

- *Use of assistive devices may be used to obtain a signature.*

- *Electronic issuance of the MCSN is permitted.*

  If a hospital elects to issue an MCSN viewed on an electronic screen before signing, the beneficiary must be given the option of requesting paper issuance over electronic issuance if that is what the beneficiary prefers. Regardless of whether a paper or electronic version is issued and regardless of whether the signature is digitally captured or manually penned, the required beneficiary specific information must be inserted, and the beneficiary must be given a paper copy of the MCSN at the time of notice delivery.

450.3.3 - Required Delivery Timeframes of the MCSN
(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

Hospitals must deliver the MCSN as soon as possible after a beneficiary is eligible for this process per §450.2, but no later than four hours prior to discharge.

For beneficiaries with Part B, the notice must be delivered as soon as possible after the hospital reclassifies the beneficiary from inpatient to outpatient receiving observation services and the third day in the hospital is reached.

For beneficiaries without Medicare Part B coverage, hospitals must deliver the notice as soon as possible after the change in status from inpatient to outpatient receiving observation services because a three day hospital stay is not required for these beneficiaries to be eligible for this expedited appeals process.

450.3.4 - Refusal to Sign the MCSN
(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

If the beneficiary refuses to sign the MCSN, the hospital should annotate the notice to that effect and indicate the date of refusal on the notice. The date of refusal is considered to be the date of notice receipt. Beneficiaries who refuse to sign the MCSN remain entitled to an expedited determination.

450.3.5 - Ensuring Beneficiary Comprehension
(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

The OMB-approved standardized MCSN is available in English, Spanish, and additional languages as they become available. If the individual receiving the notice is unable to read its written contents and/or comprehend the required oral explanation, hospitals and CAHs must employ their usual procedures to ensure notice comprehension. Usual procedures may include, but are not limited to, the use of translators, interpreters, and assistive technologies. Hospitals and CAHs are reminded that recipients of federal financial assistance have an independent obligation to provide language assistance services to individuals with limited English proficiency (LEP) consistent with section 1557 of the Affordable Care Act and Title VI of the Civil Rights Act of 1964. In addition, recipients of federal financial assistance have an independent obligation to provide auxiliary aids and services to individuals with disabilities free of charge, consistent with section 1557 of the Affordable Care Act and section 504 of the Rehabilitation Act of 1973.

450.3.6 - MCSN Delivery to Representatives
(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

The MCSN may be delivered to a beneficiary's appointed or authorized representative.

Type Of Representative

Appointed Representative	***Authorized Representative***
An appointed representative is an individual designated by a beneficiary to act on the beneficiary's behalf. A beneficiary may designate an appointed representative via the "Appointment of Representative" form CMS-1696 (or a similar written instrument containing the required elements under 42 CFR 405.910). See Chapter 29 of the Medicare Claims Processing Manual, section 270.1, for more information on appointed representatives.	*An authorized representative is an individual who, under state or other applicable law, may make health care decisions on a beneficiary's behalf (e.g., the beneficiary's legal guardian, or someone appointed in accordance with a properly executed durable medical power of attorney).*

Notes:

- *If a beneficiary is temporarily incapacitated and there is no appointed or authorized representative, a person (typically, a family member or close friend) whom the hospital has determined could reasonably represent the beneficiary, but who has not been named in any legally binding document, may be a representative for the purpose of receiving the MCSN. Such a representative should act in the beneficiary's best interests and in a manner that is protective of the beneficiary and the beneficiary's rights. There should be no relevant conflict between the representative's and the beneficiary's interests.*

- *In instances where the notice is delivered to a representative who has not been named in a legally binding document, the hospital must annotate the MCSN with the name of*

the staff person initiating the contact, the name of the person contacted, and the date, time, and method (in person or telephone) of the contact.

Delivery to off-site representatives

If the MCSN must be delivered to a representative who is not physically present, the hospital is not required to personally deliver the MCSN or have the MCSN delivered via courier to the representative. The hospital must complete the MCSN as required and may telephone the representative instead, and then also mail the MCSN. The date and time of the telephone call is considered the receipt date of the MCSN.

The hospital must complete all of the following actions under this delivery method:

1. *Verbally convey all contents of the MCSN.*
2. *Note the date and time this information is communicated verbally.*
3. *Annotate the "Additional Information" section to reflect that the MCSN was communicated verbally to the representative.*
4. *Annotate the "Additional Information" section with the name of the staff person initiating the contact, the name of the representative contacted by phone, the date and time of the telephone contact, and the telephone number called.*
5. *Mail a copy of the annotated MCSN to the representative the day telephone contact is made.*

The burden is on the hospital to demonstrate that timely contact was attempted with the representative and that the notice was delivered.

If the hospital and the representative both agree, the hospital may send the notice by fax or e-mail; however, the hospital or CAH's fax and e-mail systems must meet the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy and security requirements.

450.3.7- Notice Retention for the MCSN
(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

The hospital or CAH must retain the signed MCSN in the beneficiary's medical record. The beneficiary or their representative receives a paper copy of the MCSN that includes all of the required information described in this section. Electronic notice retention is permitted.

450.4 Expedited Determination Process
(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

450.4.1 - Beneficiary Responsibilities
(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

450.4.1.1 - Timeframes for Requesting an Expedited Determination
(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

A beneficiary who receives an MCSN and disagrees with the status change may request an expedited determination by the appropriate BFCC-QIO for the state where the services were provided. The beneficiary may contact the BFCC-QIO by telephone or in writing.

For timely requests:

The beneficiary must contact the BFCC-QIO before leaving the hospital for a timely request.

For untimely requests:

The beneficiary may contact the BFCC-QIO at any time, including after a related claim has been filed with the Medicare Administrative Contractor (MAC).

450.4.1.2 - Provide Information to BFCC-QIO
(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

The beneficiary must be available to answer questions or supply information requested by the BFCC-QIO. The beneficiary may, but is not required to, supply additional information to the BFCC-QIO that he or she believes is pertinent to the case.

450.4.2 - Beneficiary Liability During BFCC-QIO Review
(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

A hospital may not bill a beneficiary who has timely filed an expedited determination until the review process is complete.

450.4.3 - Hospital Responsibilities
(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

When a hospital is notified by a BFCC-QIO of a beneficiary request for an expedited determination, the hospital must perform all of the following actions.

1. *Supply the BFCC-QIO with a copy of the MCSN as soon as possible, but no later than noon of the day after BFCC-QIO notification.*

2. *Supply all information, including medical records, requested by the BFCC-QIO. The BFCC-QIO may allow this required information to be supplied via phone, writing, or electronically. If supplied via phone, the provider must keep a written record of the information it provides within the patient record.*

3. *Furnish the beneficiary, at their request, with access to or copies of any documentation it provides to the BFCC-QIO. The hospital may charge the beneficiary a reasonable amount to cover the costs of duplicating and delivering the documentation. This documentation must be provided to the beneficiary by close of business of the first day after the material is requested.*

450.5 – BFCC-QIO Responsibilities
(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

450.5.1 – Receive Beneficiary Requests for Expedited Review
(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

BFCC-QIOs must be available to receive beneficiary requests for review 24 hours a day, seven days a week.

450.5.2 – Notify Hospitals
(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

When the BFCC-QIO receives a request from a beneficiary, the BFCC-QIO must immediately notify the hospital that a request for an expedited determination was made. If the

request is received after normal working hours, the BFCC-QIO should notify the hospital as soon as possible on the morning after the request was made.

450.5.3 – Validate Delivery of the MCSN
(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

The BFCC-QIO should determine that MCSN delivery was valid if all of the following criteria are met:

- *The notice used is the OMB approved MCSN published by CMS.*
- *The notice was delivered timely per §450.3.3.*
- *The notice was signed and dated by the beneficiary.*

If the BFCC-QIO determines that the hospital did not deliver a valid notice, the BFCC-QIO will instruct the hospital to reissue the notice.

450.5.4 - Solicit the Views of the Beneficiary
(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

The BFCC-QIO must solicit the views of the beneficiary who requested the expedited determination.

450.5.5 - Solicit the Views of the Hospital
(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

The BFCC-QIO must provide the hospital an opportunity to explain why the reclassification of the beneficiary from an inpatient to an outpatient receiving observation services was appropriate.

450.5.6 – Make Determination and Notify Required Parties
(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

For timely requests *(received before the beneficiary leaves the hospital):*
The BFCC-QIO must make its determination no later than one calendar day after it receives all requested pertinent information from the hospital.

For untimely requests *(received after the beneficiary leaves the hospital):*
The BFCC-QIO must make its determination no later than two calendar days after it receives all requested pertinent information from the hospital.

The BFCC-QIO must perform the following actions for timely and untimely requests.

1. *Notify the beneficiary, the hospital, and SNF (if applicable) of its determination. This notification must include the rationale for the determination and an explanation of Medicare payment consequences and beneficiary liability.*
2. *Inform the beneficiary of the right to an expedited reconsideration by the BFCC-QIO and how to request a timely expedited reconsideration.*
3. *Make its initial notification via telephone and follow up with a written determination letter.*

NOTE: *If the BFCC-QIO does not receive supporting information from the hospital, it may make its determination based on the evidence at hand or defer a decision until it receives the necessary information.*

450.6 - Effect of a BFCC-QIO Expedited Determination
(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

The BFCC-QIO determination is binding for payment purposes on the beneficiary, hospital, and MAC, unless the beneficiary pursues an expedited reconsideration per section 460 of this chapter.

460- Expedited Reconsiderations
(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

A beneficiary who is dissatisfied with a QIO determination may request an expedited reconsideration by the BFCC-QIO.

460.1- Beneficiary Responsibilities
(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

460.1.1- Timeframe for Requesting an Expedited Reconsideration
(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

A beneficiary who is dissatisfied with a BFCC-QIO's expedited determination may request an expedited reconsideration. The beneficiary may contact the BFCC-QIO by telephone or in writing.

- ***For timely requests**:*

The beneficiary must contact the BFCC-QIO no later than noon of the calendar day following receipt of the initial notification (whether by telephone or in writing).

- ***For untimely requests**:*

The beneficiary may contact the BFCC-QIO anytime, including after a related claim has been filed with the MAC.

460.1.2- Provide Information to the BFCC-QIO
(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

The beneficiary must be available to answer questions or supply information requested by the BFCC-QIO. The beneficiary may, but is not required to, supply additional information to the BFCC-QIO that he or she believes is pertinent to the case.

460.1.3- Beneficiary Liability During BFCC-QIO
(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

A hospital may not bill a beneficiary who has timely filed an expedited reconsideration until the review process is complete.

460.2- Hospital Responsibilities
(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

A hospital is required to submit any and all documentation requested by the BFCC-QIO during the expedited determination process, as described in §450.4.3. The hospital may, but is not required to, submit evidence to the BFCC-QIO to be considered in the reconsideration

decision. If a hospital fails to comply with a QIO's request for additional information, the BFCC-QIO makes its reconsideration decision based on the information available.

460.3- BFCC-QIO Responsibilities
(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

460.3.1- Receive Beneficiary requests for Expedited Reconsiderations
(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

BFCC-QIOs must be available to receive beneficiary requests for review 24 hours a day, seven days a week.

460.3.2- Notify Hospitals
(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

When the BFCC-QIO receives a request from a beneficiary, the BFCC-QIO must immediately notify the hospital that a request for an expedited reconsideration was made. If the request is received after normal working hours, the BFCC-QIO should notify the hospital as soon as possible on the morning after the request was made.

460.3.3- Solicit the Views of the Beneficiary
(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

The BFCC-QIO must solicit the views of the beneficiary who requested the expedited reconsideration.

460.3.4- Solicit the Views of the Hospital
(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

The BFCC-QIO must provide the hospital an opportunity to provide information not submitted for the expedited redetermination.

460.3.5- Make Determination and Notify Required Parties
(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

***For timely requests**:*

The BFCC-QIO must make its reconsideration determination no later than two calendar days after it receives all requested pertinent information from the hospital.

***For untimely requests**:*

The BFCC-QIO must make its reconsideration determination no later than three calendar days after it receives all requested pertinent information from the hospital.

460.4- Effect of a BFCC-QIO Expedited Reconsideration
(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

The BFCC-QIO reconsideration determination is binding for payment purposes on the beneficiary, hospital, and MAC, unless the beneficiary requests a hearing by an ALJ in accordance with 42 CFR part 478 subpart B.