Centers for Medicare & Medicaid Services, HHS

§ 422.624

Paragraph (e)(1) of this section. The hospital must furnish this information as soon as possible, but no later than by close of business of the day the MA organization notifies the hospital of the request for information. At the discretion of the QIO, the hospital must make the information available by phone or in writing (with a written record of any information not transmitted initially in writing).

(4) Upon an enrollee’s request, the MA organization must provide the enrollee a copy of, or access to, any documentation sent to the QIO by the MA organization, including written records of any information provided by telephone. The MA organization may charge the enrollee a reasonable amount to cover the costs of duplicating the documentation for the enrollee and/or delivering the documentation to the enrollee. The MA organization must accommodate such a request by no later than close of business of the first day after the day the material is requested.

(1) Coverage during QIO expedited review. (1) An MA organization is financially responsible for coverage of services as provided in this paragraph, regardless of whether it has delegated responsibility for authorizing coverage or discharge determinations to its providers.

(2) The hospital determines that hospital services are no longer necessary, the hospital may not charge the enrollee for inpatient services received before noon of the day after the QIO notifies the enrollee of its review determination.

(g) Effect of an expedited QIO determination. The QIO determination is binding upon the enrollee, physician, hospital, and MA organization except in the following circumstances:

(1) Right to request a reconsideration. If the enrollee is still an inpatient in the hospital and is dissatisfied with the determination, he or she may request a reconsideration according to the procedures described in § 422.626(g).

(2) Right to pursue the standard appeal process. If the enrollee is no longer an inpatient in the hospital and is dissatisfied with this determination, the enrollee may appeal to an ALJ, the MAC, or a federal court, as provided for under this subpart.

§ 422.624 Notifying enrollees of termination of provider services.

(a) Applicability. (1) For purposes of §§ 422.624 and 422.626, the term provider includes home health agencies (HHAs), skilled nursing facilities (SNFs), and comprehensive outpatient rehabilitation facilities (CORFs).

(2) Termination of service defined. For purposes of this section and § 422.626, a termination of service is the discharge of an enrollee from covered provider
services, or discontinuation of covered provider services, when the enrollee has been authorized by the MA organization, either directly or by delegation, to receive an ongoing course of treatment from that provider. Termination includes cessation of coverage at the end of a course of treatment preauthorized in a discrete increment, regardless of whether the enrollee agrees that such services should end.

(b) Advance written notification of termination. Prior to any termination of service, the provider of the service must deliver valid written notice to the enrollee of the MA organization's decision to terminate services. The provider must use a standardized notice, required by the Secretary, in accordance with the following procedures—

(1) Timing of notice. The provider must notify the enrollee of the MA organization’s decision to terminate covered services no later than two days before the proposed end of the services. If the enrollee’s services are expected to be fewer than two days in duration, the provider should notify the enrollee at the time of admission to the provider. If, in a non-institutional setting, the span of time between services exceeds two days, the notice should be given no later than the next to last time services are furnished.

(2) Content of the notice. The standardized termination notice must include the following information:

(i) The date that coverage of services ends.

(ii) The date that the enrollee’s financial liability for continued services begins.

(iii) A description of the enrollee’s right to a fast-track appeal under §422.626, including information about how to contact an independent review entity (IRE), an enrollee’s right (but not obligation) to submit evidence showing that services should continue, and the availability of other MA appeal procedures if the enrollee fails to meet the deadline for a fast-track IRE appeal.

(iv) The enrollee’s right to receive detailed information in accordance with §422.626(e)(1) and (2).

(v) Any other information required by the Secretary.

(c) When delivery of notice is valid. Delivery of the termination notice is not valid unless—

(1) The enrollee (or the enrollee’s representative) has signed and dated the notice to indicate that he or she has received the notice and can comprehend its contents; and

(2) The notice is delivered in accordance with paragraph (b)(1) of this section and contains all the elements described in paragraph (b)(2) of this section.

(d) Financial liability for failure to deliver valid notice. An MA organization is financially liable for continued services until 2 days after the enrollee receives valid notice as specified under paragraph (c) of this section. An enrollee may waive continuation of services if he or she agrees with being discharged sooner than 2 days after receiving the notice.

§422.626 Fast-track appeals of service terminations to independent review entities (IREs).

(a) Enrollee’s right to a fast-track appeal of an MA organization’s termination decision. An enrollee of an MA organization has a right to a fast-track appeal of an MA organization’s decision to terminate provider services.

(1) An enrollee who desires a fast-track appeal must submit a request for an appeal to an IRE under contract with CMS, in writing or by telephone, by noon of the first day after the day of delivery of the termination notice. If, due to an emergency, the IRE is closed and unable to accept the enrollee’s request for a fast-track appeal, the enrollee must file a request by noon of the next day that the IRE is open for business.

(2) When an enrollee fails to make a timely request to an IRE, he or she may request an expedited reconsideration by the MA organization as described in §422.584.

(3) If, after delivery of the termination notice, an enrollee chooses to leave a provider or discontinue receipt of covered services on or before the proposed termination date, the enrollee may not later assert fast-track IRE appeal rights under this section.