

Subpart J—Expedited Determinations and Reconsiderations of Provider Service Terminations, and Procedures for Inpatient Hospital Discharges

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§ 405.1200 Notifying beneficiaries of provider service terminations.

(a) *Applicability and scope.* (1) For purposes of §§ 405.1200 through 405.1204, the term, provider, is defined as a home health agency (HHA), skilled nursing facility (SNF), comprehensive outpatient rehabilitation facility (CORF), or hospice.

(2) For purposes of §§ 405.1200 through 405.1204, a termination of Medicare-covered service is a discharge of a beneficiary from a residential provider of services, or a complete cessation of coverage at the end of a course of treatment prescribed in a discrete increment, regardless of whether the beneficiary agrees that the services should end. A termination does not include a reduction in services. A termination also does not include the termination of one type of service by the provider if the beneficiary continues to receive other Medicare-covered services from the provider.

(b) *Advance written notice of service terminations.* Before any termination of services, the provider of the service must deliver valid written notice to the beneficiary of the provider's decision to terminate services. The provider must use a standardized notice, as specified by CMS, in accordance with the following procedures:

(1) *Timing of notice.* A provider must notify the beneficiary of the decision to terminate covered services no later than 2 days before the proposed end of the services. If the beneficiary's services are expected to be fewer than 2 days in duration, the provider must notify the beneficiary at the time of admission to the provider. If, in a non-residential setting, the span of time between services exceeds 2 days, the notice must 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 beneficiary's financial liability for continued services begins;

(iii) A description of the beneficiary's right to an expedited determination under § 405.1202, including information about how to request an expedited determination and about a beneficiary's right to submit evidence showing that services must continue;

(iv) A beneficiary's right to receive the detailed information specified under § 405.1202(f); and

(v) Any other information required by CMS.

(3) *When delivery of the notice is valid.* Delivery of the termination notice is valid if—

(i) The beneficiary (or the beneficiary's authorized representative) has signed and dated the notice to indicate that he or she has received the notice and can comprehend its contents; and

(ii) 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.

(4) *If a beneficiary refuses to sign the notice.* The provider may annotate its notice to indicate the refusal, and the date of refusal is considered the date of receipt of the notice.

(5) *Financial liability for failure to deliver valid notice.* A provider is financially liable for continued services until 2 days after the beneficiary receives valid notice as specified under paragraph (b)(3) of this section, or until the service termination date specified on the notice, whichever is later. A beneficiary may waive continuation of services if he or she agrees with being discharged sooner than the planned service termination date.

§ 405.1202 Expedited determination procedures.

(a) *Beneficiary's right to an expedited determination by the QIO.* A beneficiary has a right to an expedited determination by a QIO under the following circumstances: