

(f) *Coverage during QIC reconsideration process.* When a beneficiary requests an expedited reconsideration in accordance with the deadline specified in (b)(1) of this section, the provider may not bill the beneficiary for any disputed services until the QIC makes its determination.

[69 FR 69624, Nov. 26, 2004, as amended at 82 FR 5124, Jan. 17, 2017]

§ 405.1205 Notifying beneficiaries of hospital discharge appeal rights.

(a) *Applicability and scope.* (1) For purposes of §§ 405.1204, 405.1205, 405.1206, and 405.1208, the term “hospital” is defined as 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.

(2) For purposes of §§ 405.1204, 405.1205, 405.1206, and 405.1208, a discharge is a formal release of a beneficiary from an inpatient hospital.

(b) *Advance written notice of hospital discharge rights.* For all Medicare beneficiaries, hospitals must deliver valid, written notice of a beneficiary’s rights as a hospital inpatient, including discharge appeal rights. The hospital must use a standardized notice, as specified by CMS, in accordance with the following procedures:

(1) *Timing of notice.* The hospital must provide the notice at or near admission, but no later than 2 calendar days following the beneficiary’s admission to the hospital.

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

(i) The beneficiary’s rights as a hospital inpatient including the right to benefits for inpatient services and for post-hospital services in accordance with 1866(a)(1)(M) of the Act.

(ii) The beneficiary’s right to request an expedited determination of the discharge decision including a description of the process under § 405.1206, and the availability of other appeals processes if the beneficiary fails to meet the deadline for an expedited determination.

(iii) The circumstances under which a beneficiary will or will not be liable for charges for continued stay in the hospital in accordance with 1866(a)(1)(M) of the Act.

(iv) A beneficiary’s right to receive additional detailed information in accordance with § 405.1206(e).

(v) Any other information required by CMS.

(3) *When delivery of the notice is valid.* Delivery of the written notice of rights described in this section is valid if—

(i) The beneficiary (or the beneficiary’s representative) has signed and dated the notice to indicate that he or she has received the notice and can comprehend its contents, except as provided in paragraph (b)(4) of this section; 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 hospital may annotate its notice to indicate the refusal, and the date of refusal is considered the date of receipt of the notice.

(c) *Follow up notification.* (1) The hospital must present a copy of the signed notice described in paragraph (b)(2) of this section to the beneficiary (or beneficiary’s representative) prior to discharge. The notice should be given as far in advance of discharge as possible, but not more than 2 calendar days before discharge.

(2) Follow up notification is not required if the notice required under § 405.1205(b) is delivered within 2 calendar days of discharge.

[71 FR 68720, Nov. 27, 2006]

§ 405.1206 Expedited determination procedures for inpatient hospital care.

(a) *Beneficiary’s right to an expedited determination by the QIO.* A beneficiary has a right to request an expedited determination by the QIO when a hospital (acting directly or through its utilization review committee), with physician concurrence, determines that inpatient care is no longer necessary.

(b) *Requesting an expedited determination.*

(1) A beneficiary who wishes to exercise the right to an expedited determination must submit a request to the QIO that has an agreement with the hospital as specified in § 476.78 of this chapter. The request must be made no later than the day of discharge and may be in writing or by telephone.

(2) The beneficiary, or his or her representative, upon request by the QIO, must be available to discuss the case.

(3) The beneficiary may, but is not required to, submit written evidence to be considered by a QIO in making its decision.

(4) A beneficiary who makes a timely request for an expedited QIO review in accordance with paragraph (b)(1) of this section is subject to the financial liability protections under paragraphs (f)(1) and (f)(2) of this section, as applicable.

(5) A beneficiary who fails to make a timely request for an expedited determination by a QIO, as described in paragraph (b)(1) of this section, and remains in the hospital without coverage, still may request an expedited QIO determination at any time during the hospitalization. The QIO will issue a decision in accordance with paragraph (d)(6)(ii) of this section, however, the financial liability protection under paragraphs (f)(1) and (f)(2) of this section does not apply.

(6) A beneficiary who fails to make a timely request for an expedited determination in accordance with paragraph (b)(1) of this section, and who is no longer an inpatient in the hospital, may request QIO review within 30 calendar days after the date of discharge, or at any time for good cause. The QIO will issue a decision in accordance with paragraph (d)(6)(iii) of this section; however, the financial liability protection under paragraphs (f)(1) and (f)(2) of this section does not apply.

(c) *Burden of proof.* When a beneficiary (or his or her representative, if applicable) requests an expedited determination by a QIO, the burden of proof rests with the hospital to demonstrate that discharge is the correct decision, either on the basis of medical necessity, or based on other Medicare coverage policies. Consistent with paragraph (e)(2) of this section, the hospital

should supply any and all information that a QIO requires to sustain the hospital's discharge determination.

(d) *Procedures the QIO must follow.* (1) When the QIO receives the request for an expedited determination under paragraph (b)(1) of this section, it must immediately notify the hospital that a request for an expedited determination has been made.

(2) The QIO determines whether the hospital delivered valid notice consistent with § 405.1205(b)(3).

(3) The QIO examines the medical and other records that pertain to the services in dispute.

(4) The QIO must solicit the views of the beneficiary (or the beneficiary's representative) who requested the expedited determination.

(5) The QIO must provide an opportunity for the hospital to explain why the discharge is appropriate.

(6)(i) When the beneficiary requests an expedited determination in accordance with paragraph (b)(1) of this section, the QIO must make a determination and notify the beneficiary, the hospital, and physician of its determination within one calendar day after it receives all requested pertinent information.

(ii) When the beneficiary makes an untimely request for an expedited determination, and remains in the hospital, consistent with paragraph (b)(5) of this section, the QIO will make a determination and notify the beneficiary, the hospital, and the physician of its determination within 2 calendar days following receipt of the request and pertinent information.

(iii) When the beneficiary makes an untimely request for an expedited determination, and is no longer an inpatient in the hospital, consistent with paragraph (b)(6) of this section, the QIO will make a determination and notify the beneficiary, the hospital, and physician of its determination within 30 calendar days after receipt of the request and pertinent information.

(7) If the QIO does not receive the information needed to sustain a hospital's decision to discharge, it may make its determination based on the evidence at hand, or it may defer a decision until it receives the necessary

information. If this delay results in extended Medicare coverage of an individual's hospital services, the hospital may be held financially liable for these services, as determined by the QIO.

(8) When the QIO issues an expedited determination, the QIO must notify the beneficiary, the physician, and hospital of its decision by telephone, followed by a written notice that must include the following information:

- (i) The basis for the determination.
- (ii) A detailed rationale for the determination.
- (iii) An explanation of the Medicare payment consequences of the determination and the date a beneficiary becomes fully liable for the services.
- (iv) Information about the beneficiary's right to a reconsideration of the QIO's determination as set forth in § 405.1204, including how to request a reconsideration and the time period for doing so.

(e) *Responsibilities of hospitals.* (1) When a QIO notifies a hospital that a beneficiary has requested an expedited determination, the hospital must deliver a detailed notice to the beneficiary as soon as possible but no later than noon of the day after the QIO's notification. The detailed notice must include the following information:

- (i) A detailed explanation why services are either no longer reasonable and necessary or are otherwise no longer covered.
- (ii) A description of any applicable Medicare coverage rule, instruction, or other Medicare policy, including information about how the beneficiary may obtain a copy of the Medicare policy.
- (iii) Facts specific to the beneficiary and relevant to the coverage determination that are sufficient to advise the beneficiary of the applicability of the coverage rule or policy to the beneficiary's case.
- (iv) Any other information required by CMS.

(2) Upon notification by the QIO of the request for an expedited determination, the hospital must supply all information that the QIO needs to make its expedited determination, including a copy of the notices required as specified in § 405.1205 (b) and (c) and paragraph (e)(1) of this section. The hospital must furnish this information as

soon as possible, but no later than by noon of the day after the QIO notifies the hospital of the request for an expedited determination. 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).

(3) At a beneficiary's (or representative's) request, the hospital must furnish the beneficiary with a copy of, or access to, any documentation that it sends to the QIO, including written records of any information provided by telephone. The hospital may charge the beneficiary a reasonable amount to cover the costs of duplicating the documentation and/or delivering it to the beneficiary. The hospital must accommodate such a request by no later than close of business of the first day after the material is requested.

(f) *Coverage during QIO expedited review—*(1) *General rule and liability while QIO review is pending.* If the beneficiary remains in the hospital past midnight of the discharge date ordered by the physician, and the hospital, the physician who concurred with the discharge determination, or the QIO subsequently finds that the beneficiary requires inpatient hospital care, the beneficiary is not financially responsible for continued care (other than applicable coinsurance and deductible) until the hospital once again determines that the beneficiary no longer requires inpatient care, secures concurrence from the physician responsible for the beneficiary's care or the QIO, and notifies the beneficiary with a notice consistent with 405.1205 (c).

(2) *Timely filing and limitation on liability.* If a beneficiary files a request for an expedited determination by the QIO in accordance with paragraph (b)(1) of this section, the beneficiary is not financially responsible for inpatient hospital services (other than applicable coinsurance and deductible) furnished before noon of the calendar day after the date the beneficiary (or his or her representative) receives notification (either orally or in writing) of the expedited determination by the QIO.

(3) *Untimely request and liability.* When a beneficiary does not file a request for

an expedited determination by the QIO in accordance with paragraph (b) of this section, but remains in the hospital past the discharge date, that beneficiary may be held responsible for charges incurred after the date of discharge or as otherwise stated by the QIO.

(4) *Hospital requests an expedited review.* When the hospital requests a review in accordance with § 405.1208, and the QIO concurs with the hospital's discharge determination, a hospital may not charge the beneficiary until the date specified by the QIO.

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

(1) *Right to request a reconsideration.* If the beneficiary 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 § 405.1204.

(2) *Right to pursue the general claims appeal process.* If the beneficiary is no longer an inpatient in the hospital and is dissatisfied with this determination, the determination is subject to the general claims appeal process.

[71 FR 68721, Nov. 27, 2006]

§ 405.1208 Hospital requests expedited QIO review.

(a) *General rule.* (1) If the hospital (acting directly or through its utilization review committee) believes that the beneficiary does not require further inpatient hospital care but is unable to obtain the agreement of the physician, it may request an expedited determination by the QIO.

(2) When the hospital requests review, and the QIO concurs with the hospital's discharge determination, a hospital may not charge a beneficiary until the date specified by the QIO in accordance with 405.1206(f)(4).

(b) *Procedures hospital must follow.* (1) The hospital must (acting directly or through its utilization review committee) notify the beneficiary (or his or her representative) that it has requested that review.

(2) The hospital must supply any pertinent information the QIO requires to conduct its review and must make it

available by phone or in writing, by close of business of the first full working day immediately following the day the hospital submits the request for review.

(c) *Procedures the QIO must follow.* (1) The QIO must notify the hospital that it has received the request for review and must notify the hospital if it has not received all pertinent records.

(2) The QIO must examine the pertinent records pertaining to the services.

(3) The QIO must solicit the views of the beneficiary in question.

(4) The QIO must make a determination and notify the beneficiary, the hospital, and physician within 2 working days of the hospital's request and receipt of any pertinent information submitted by the hospital.

(d) *Notice of an expedited determination.* (1) When a QIO issues an expedited determination as stated in paragraph (c)(4) of this section, it must notify the beneficiary, physician, and hospital of its decision, by telephone and subsequently in writing.

(2) A written notice of the expedited initial determination must contain the following:

(i) The basis for the determination;

(ii) A detailed rationale for the determination;

(iii) A statement explaining the Medicare payment consequences of the expedited determination and date of liability, if any; and

(iv) A statement informing the beneficiary of his or her appeal rights and the timeframe for requesting an appeal.

(e) *Effect of an expedited determination.* The expedited determination under this section is binding upon the beneficiary, physician, and hospital, except in the following circumstances:

(1) *When a beneficiary remains in the hospital.* If the beneficiary is still an inpatient in the hospital and is dissatisfied with this determination, he or she may request a reconsideration according to the procedures described in § 405.1204. The procedures described in § 405.1204 will apply to reconsiderations requested under this section. If the beneficiary does not make a request in accordance with § 405.1204(b)(1), the timeframes described in § 405.1204(c)(3), the escalation procedures described in