

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

§ 405.1801

42 CFR Ch. IV (10–1–24 Edition)

§ 405.1204(c)(5), and the coverage rule described in § 405.1204(f) will not apply.

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

[69 FR 69624, Nov. 26, 2004, as amended at 71 FR 68722, Nov. 27, 2006]

Subparts K–Q [Reserved]

Subpart R—Provider Reimbursement Determinations and Appeals

AUTHORITY: Secs. 205, 1102, 1814(b), 1815(a), 1833, 1861(v), 1871, 1872, 1878, and 1886 of the Social Security Act (42 U.S.C. 405, 1302, 1395f(b), 1395g(a), 1395l, 1395x(v), 1395hh, 1395ii, 1395oo, and 1395ww).

SOURCE: 39 FR 34515, Sept. 26, 1974, unless otherwise noted. Redesignated at 42 FR 52826, Sept. 30, 1977.

EDITORIAL NOTE: Nomenclature changes to subpart R of part 405 appear at 79 FR 55031, Aug. 22, 2014.

§ 405.1801 Introduction.

(a) *Definitions.* As used in this subpart:

Administrator means the Administrator or Deputy Administrator of CMS.

Administrator review means that review provided for in section 1878(f) of the Act (42 U.S.C. 1395oo(f)) and § 405.1875.

Board means the Provider Reimbursement Review Board established in accordance with section 1878 of the Act (42 U.S.C. 1395oo) and § 405.1845.

Board hearing means that hearing provided for in section 1878(a) of the Act (42 U.S.C. 1395oo(a)), and § 405.1835.

CMS reviewing official means the reviewing official provided for in § 405.1834.

CMS reviewing official procedure means the review provided for in § 405.1834.

Contractor determination means the following:

(1) With respect to a provider of services that has filed a cost report under §§ 413.20 and 413.24 of this chapter, the

term means a final determination of the amount of total reimbursement due the provider, pursuant to § 405.1803 following the close of the provider's cost reporting period, for items and services furnished to beneficiaries for which reimbursement may be made on a reasonable cost basis under Medicare for the period covered by the cost report.

(2) With respect to a hospital that receives payments for inpatient hospital services under the prospective payment system (part 412 of this chapter), the term means a final determination of the total amount of payment due the hospital, pursuant to § 405.1803 following the close of the hospital's cost reporting period, under that system for the period covered by the final determination.

(3) For purposes of appeal to the Provider Reimbursement Review Board, the term is synonymous with the phrases “intermediary's final determination,” “final determination of the organization serving as its fiscal intermediary,” “Secretary's final determination” and “final determination of the Secretary,” as those phrases are used in section 1878(a) of the Act, and with the phrases “final contractor determination” and “final Secretary determination” as those phrases are used in this subpart.

(4) For purposes of § 405.376 concerning claims collection activities, the term does not include an action by CMS with respect to a compromise of a Medicare overpayment claim, or termination or suspension of collection action on an overpayment claim, against a provider or physician or other supplier.

Contractor hearing means that hearing provided for in § 405.1809.

Contractor hearing officer(s) means the hearing officer or panel of hearing officers provided for in § 405.1817.

Date of receipt means the date a document or other material is received by either of the following:

(1) *A party or an affected nonparty.* A party or an affected nonparty, such as CMS, involved in proceedings before a reviewing entity.

(i) As applied to a party or an affected nonparty, the phrase “date of receipt” in this definition is synonymous with the term “notice,” as that term is