

date the MA organization receives the request for reconsideration.

(b) *Reversals by the independent outside entity*—(1) *Requests for service or item.* If the MA organization's determination is reversed in whole or in part by the independent outside entity, the MA organization must authorize or provide the service under dispute as expeditiously as the enrollee's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. The MA organization must inform the independent outside entity that the organization has effectuated the decision.

(2) *Requests for a Part B drug.* If, on reconsideration of a request for a Part B drug, the MA organization's determination is reversed in whole or in part by the independent outside entity, the MA organization must authorize or provide the Part B drug under dispute as expeditiously as the enrollee's health condition requires but no later than 24 hours from the date it receives notice reversing the determination. The MA organization must inform the outside entity that the organization has effectuated the decision.

(c) *Reversals other than by the MA organization or the independent outside entity*—(1) *General rule.* If the independent outside entity's expedited determination is reversed in whole or in part by the ALJ or attorney adjudicator, or at a higher level of appeal, the MA organization must authorize or provide the service under dispute as expeditiously as the enrollee's health condition requires, but no later than 60 days from the date it receives notice reversing the determination. The MA organization must inform the independent outside entity that the organization has effectuated the decision.

(2) *Reversals of decisions related to Part B drugs.* If the independent outside entity's determination is reversed in whole or in part by an ALJ/attorney adjudicator or at a higher level of appeal, the MA organization must authorize or provide the Part B drug under dispute as expeditiously as the enrollee's health condition requires but no later than 24 hours from the date it receives notice reversing the determination. The MA organization must inform the outside entity that the or-

ganization has effectuated the decision.

(3) *Effectuation exception when the MA organization files an appeal with the Council.* If the MA organization requests Council review consistent with § 422.608, the MA organization may await the outcome of the review before it authorizes or provides the service under dispute. A MA organization that files an appeal with the Council must concurrently send a copy of its appeal request and any accompanying documents to the enrollee and must notify the independent outside entity that it has requested an appeal.

[65 FR 40331, June 29, 2000, as amended at 68 FR 50859, Aug. 22, 2003; 80 FR 7962, Feb. 12, 2015; 82 FR 5125, Jan. 17, 2017; 84 FR 23882, May 23, 2019]

#### § 422.620 Notifying enrollees of hospital discharge appeal rights.

(a) *Applicability and scope.* (1) For purposes of §§ 422.620 and 422.622, 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 also includes critical access hospitals.

(2) For purposes of §§ 422.620 and 422.622, a discharge is a formal release of an enrollee from an inpatient hospital.

(b) *Advance written notice of hospital discharge rights.* For all Medicare Advantage enrollees, hospitals must deliver valid, written notice of an enrollee'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 enrollee's admission to the hospital.

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

(i) The enrollee'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 enrollee's right to request an immediate review, including a description of the process under § 422.622 and the availability of other appeals processes if the enrollee fails to meet the deadline for an immediate review.

(iii) The circumstances under which an enrollee 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) The enrollee's right to receive additional information in accordance with section § 422.622(e).

(v) Any other information required by CMS.

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

(i) 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, 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 an enrollee 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 enrollee (or enrollee'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 422.620(b) is delivered within 2 calendar days of discharge.

(d) *Physician concurrence required.* Before discharging an enrollee from the inpatient hospital level of care, the MA organization must obtain concurrence from the physician who is responsible for the enrollee's inpatient care.

[71 FR 68723, Nov. 27, 2006]

**§ 422.622 Requesting immediate QIO review of the decision to discharge from the inpatient hospital.**

(a) *Enrollee's right to an immediate QIO review.* An enrollee has a right to request an immediate review by the QIO when an MA organization or hospital (acting directly or through its utilization committee), with physician concurrence determines that inpatient care is no longer necessary.

(b) *Requesting an immediate QIO review.* (1) An enrollee who wishes to exercise the right to an immediate review 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 enrollee, or his or her representative, upon request by the QIO, must be available to discuss the case.

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

(4) An enrollee who makes a timely request for an immediate QIO review in accordance with paragraph (b)(1) of this section is subject to the financial liability protections under paragraph (f) of this section, as applicable.

(5) When an enrollee does not request an immediate QIO review in accordance with paragraph (b) of this section, he or she may request expedited reconsideration by the MA organization as described in § 422.584, but the financial liability rules of paragraph (f) of this section do not apply.

(c) *Burden of proof.* When an enrollee (or his or her representative, if applicable) requests an immediate review by a QIO, the burden of proof rests with the MA organization 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 MA organization should supply any and all information that a QIO requires to sustain the organization's discharge determination.

(d) *Procedures the QIO must follow.* (1) When the QIO receives the enrollee's request for an immediate review under paragraph (b), the QIO must notify the MA organization and the hospital that

the enrollee has filed a request for an immediate review.

(2) The QIO determines whether the hospital delivered valid notice consistent with § 422.620(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 enrollee (or his or her representative) who requested the immediate QIO review.

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

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

(7) If the QIO does not receive the information needed to sustain an MA organization'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 MA organization may be held financially liable for these services, as determined by the QIO.

(8) When the QIO issues its determination, the QIO must notify the enrollee, the MA organization, 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 an enrollee becomes fully liable for the services.
- (iv) Information about the enrollee's right to a reconsideration of the QIO's determination as set forth in § 422.626(f), including how to request a reconsideration and the time period for doing so.

(e) *Responsibilities of the MA organization and hospital.* (1) When the QIO notifies an MA organization that an en-

rollee has requested an immediate QIO review, the MA organization must, directly or by delegation, deliver a detailed notice to the enrollee 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 of why services are either no longer reasonable and necessary or are no longer covered.
- (ii) A description of any applicable Medicare coverage rule, instruction, or other Medicare policy including information about how the enrollee may obtain a copy of the Medicare policy from the MA organization.
- (iii) Any applicable MA organization policy, contract provision, or rationale upon which the discharge determination was based.
- (iv) Facts specific to the enrollee and relevant to the coverage determination sufficient to advise the enrollee of the applicability of the coverage rule or policy to the enrollee's case.
- (v) Any other information required by CMS.

(2) Upon notification by the QIO of a request for an immediate review, the MA organization must supply any and all information, including a copy of the notices sent to the enrollee, as specified in § 422.620(b) and (c) and paragraph (e)(1) of this section, that the QIO needs to decide on the determination. The MA organization must supply this information as soon as possible, but no later than noon of the day after the QIO notifies the MA organization that a request for an expedited determination has been received from the enrollee. The MA organization must make the information available by phone (with a written record made of any information not transmitted initially in writing) and/or in writing, as determined by the QIO.

(3) In response to a request from the MA organization, the hospital must supply all information that the QIO needs to make its determination, including a copy of the notices required as specified in § 422.620(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 close of business of the day the MA organization notifies the hospital of