

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

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.

(f) *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) When the MA organization determines that hospital services are not, or are no longer, covered,

(i) If the MA organization authorized coverage of the inpatient admission directly or by delegation (or the admission constitutes emergency or urgently needed care, as described in §§ 422.2 and 422.112(c)), the MA organization continues to be financially responsible for the costs of the hospital stay when an appeal is filed under paragraph (a)(1) of this section until noon of the day after the QIO notifies the enrollee of its review determination, except as provided in paragraph (b)(5) of this section. If coverage of the hospital admission was never approved by the MA organization or the admission does not constitute emergency or urgently needed care as described in §§ 422.2 and 422.112(c), the MA organization is liable for the hospital costs only if it is determined on appeal that the hospital stay should have been covered under the MA plan.

(ii) The hospital may not charge the MA organization (or the enrollee) if—

(A) It was the hospital (acting on behalf of the enrollee) that filed the request for immediate QIO review; and

(B) The QIO upholds the non-coverage determination made by the MA organization.

(3) If the QIO determines that the enrollee still requires inpatient hospital care, the hospital must provide the enrollee with a notice consistent with § 422.620(c) of this subpart when the hospital or MA organization once again determines that the enrollee no longer requires inpatient hospital care.

(4) If the hospital determines that inpatient 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 OMHA for an ALJ hearing, the Council, or a Federal court, as provided for under this subpart.

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§ 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