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 nonresidential 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:

(1) For services furnished by a nonresidential provider, the beneficiary disagrees with the provider of those services that services should be terminated, and a physician certifies that failure to continue the provision of the service(s) may place the beneficiary's health at significant risk.

(2) For services furnished by a residential provider or a hospice, the beneficiary disagrees with the provider's decision to discharge the beneficiary.

(b) *Requesting an expedited determination.* (1) A beneficiary who wishes to exercise the right to an expedited determination must submit a request for a determination to the QIO in the State in which the beneficiary is receiving those provider services, in writing or by telephone, by no later than noon of the calendar day following receipt of the provider's notice of termination. If the QIO is unable to accept the beneficiary's request, the beneficiary must submit the request by noon of the next day the QIO is available to accept a request.

(2) The beneficiary, or his or her representative, must be available to answer questions or to supply information that the QIO may request to conduct its review.

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

(4) If a beneficiary makes an untimely request for an expedited determination by a QIO, the QIO will accept the request and make a determination as soon as possible, but the 72-hour

time frame under paragraph (e)(6) and the financial liability protection under paragraph (g) of this section do not apply.

(c) *Coverage of provider services.* Coverage of provider services continues until the date and time designated on the termination notice, unless the QIO reverses the provider's service termination decision. If the QIO's decision is delayed because the provider did not timely supply necessary information or records, the provider may be liable for the costs of any additional coverage, as determined by the QIO in accordance with paragraph (e)(7) of this section. If the QIO finds that the beneficiary did not receive valid notice, coverage of provider services continues until at least 2 days after valid notice has been received. Continuation of coverage is not required if the QIO determines that coverage could pose a threat to the beneficiary's health or safety.

(d) *Burden of proof.* When a beneficiary requests an expedited determination by a QIO, the burden of proof rests with the provider to demonstrate that termination of coverage is the correct decision, either on the basis of medical necessity, or based on other Medicare coverage policies.

(1) In order for the QIO to determine whether the provider has met the burden of proof, the provider should supply any and all information that a QIO requires to sustain the provider's termination decision, consistent with paragraph (f) of this section.

(2) The beneficiary may submit evidence to be considered by a QIO in making its decision.

(e) *Procedures the QIO must follow.* (1) On the day the QIO receives the request for an expedited determination under paragraph (b) of this section, it must immediately notify the provider of those services that a request for an expedited determination has been made.

(2) The QIO determines whether the provider delivered valid notice of the termination decision consistent with § 405.1200(b) and paragraph (f) of this section.

(3) The QIO examines the medical and other records that pertain to the services in dispute. If applicable, the QIO determines whether a physician has certified that failure to continue the provision of services may place the beneficiary's health at significant risk.

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

(5) The QIO must provide an opportunity for the provider/practitioner to explain why the termination or discharge is appropriate.

(6) No later than 72 hours after receipt of the request for an expedited determination, the QIO must notify the beneficiary, beneficiary's physician, and the provider of services of its determination whether termination of Medicare coverage is the correct decision, either on the basis of medical necessity or based on other Medicare coverage policies.

(7) If the QIO does not receive the information needed to sustain a provider's decision to terminate services, 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 provider services, the provider may be held financially liable for these services, as determined by the QIO.

(8) The QIO's initial notification may be by telephone, followed by a written notice including the following information:

(i) The rationale for the determination;

(ii) An explanation of the Medicare payment consequences of the determination and the date a beneficiary becomes fully liable for the services; and

(iii) Information about the beneficiary's right to a reconsideration of the QIO's determination, including how to request a reconsideration and the time period for doing so.

(f) *Responsibilities of providers.* (1) When a QIO notifies a provider that a beneficiary has requested an expedited determination, the provider must send a detailed notice to the beneficiary by close of business of the day of the QIO's notification. The detailed termination notice must include the following information:

(i) A specific and detailed explanation 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 citations to the applicable Medicare policy rules or 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; and

(iv) Any other information required by CMS.

(2) Upon notification by the QIO of the request for an expedited determination, the provider must supply all information that the QIO needs to make its expedited determination, including a copy of the notices required under § 405.1200(b) and under paragraph (f)(1) of this section. The provider must furnish this information as soon as possible, but no later than by close of business of the day the QIO notifies the provider of the request for an expedited determination. At the discretion of the QIO, the provider may 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 request, the provider must furnish the beneficiary with a copy of, or access to, any documentation that it sends to the QIO including records of any information provided by telephone. The provider may charge the beneficiary a reasonable amount to cover the costs of duplicating the documentation and/or delivering it to the beneficiary. The provider must accommodate such a request by no later than close of business of the first day after the material is requested.

(g) *Coverage during QIO review.* When a beneficiary requests an expedited determination in accordance with the procedures required by this section, the provider may not bill the beneficiary for any disputed services until the expedited determination process (and reconsideration process, if applicable) has been completed.

§ 405.1204 Expedited reconsiderations.

(a) *Beneficiary's right to an expedited reconsideration.* A beneficiary who is dissatisfied with a QIO's expedited determination may request an expedited reconsideration by the appropriate QIC.

(b) *Requesting an expedited reconsideration.* (1) A beneficiary who wishes to obtain an expedited reconsideration must submit a request for the reconsideration to the appropriate QIC, in writing or by telephone, by no later than noon of the calendar day following initial notification (whether by telephone or in writing) receipt of the QIO's determination. If the QIC is unable to accept the beneficiary's request, the beneficiary must submit the request by noon of the next day the QIC is available to accept a request.

(2) The beneficiary, or his or her representative, must be available to answer questions or supply information that the QIC may request to conduct its reconsideration.

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

(4) A beneficiary who does not file a timely request for an expedited QIC reconsideration subsequently may request a reconsideration under the standard claims appeal process, but the coverage protections described in paragraph (f) of this section would not extend through this reconsideration, nor would the timeframes or the escalation process described in paragraphs (c)(3) and (c)(5) of this section, respectively.

(c) *Procedures the QIC must follow.* (1) On the day the QIC receives the request for an expedited determination under paragraph (b) of this section, the QIC must immediately notify the QIO that made the expedited determination and the provider of services of the request for an expedited reconsideration.

(2) The QIC must offer the beneficiary and the provider an opportunity to provide further information.

(3) Unless the beneficiary requests an extension in accordance with paragraph (c)(6) of this section, no later than 72 hours after receipt of the request for an expedited reconsideration, and any medical or other records needed for such reconsideration, the QIC