

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

must notify the QIO, the beneficiary, the beneficiary’s physician, and the provider of services, of its decision on the reconsideration request.

(4) The QIC’s initial notification may be done by telephone, followed by a written notice including:

(i) The rationale for the reconsideration decision;

(ii) An explanation of the Medicare payment consequences of the determination and the beneficiary’s date of liability; and

(iii) Information about the beneficiary’s right to appeal the QIC’s reconsideration decision to OMHA for an ALJ hearing in accordance with subpart I of this part, including how to request an appeal and the time period for doing so.

(5) Unless the beneficiary requests an extension in accordance with paragraph (c)(6) of this section, if the QIC does not issue a decision within 72 hours of receipt of the request, the QIC must notify the beneficiary of his or her right to have the case escalated to OMHA for an ALJ hearing in accordance with subpart I of this part, if the amount remaining in controversy after the QIO determination meets the requirements for an ALJ hearing under § 405.1006.

(6) A beneficiary requesting an expedited reconsideration under this section may request (either in writing or orally) that the QIC grant such additional time as the beneficiary specifies (not to exceed 14 days) for the reconsideration. If an extension is granted, the deadlines in paragraph (c)(3) of this section do not apply.

(d) *Responsibilities of the QIO.* (1) When a QIC notifies a QIO that a beneficiary has requested an expedited reconsideration, the QIO must supply all information that the QIC needs to make its expedited reconsideration as soon as possible, but no later than by close of business of the day that the QIC notifies the QIO of the request for an expedited reconsideration.

(2) At a beneficiary’s request, the QIO must furnish the beneficiary with a copy of, or access to, any documentation that it sends to the QIC. The QIO may charge the beneficiary a reasonable amount to cover the costs of duplicating the documentation and/or de-

livering it to the beneficiary. The QIO must accommodate the request by no later than close of business of the first day after the material is requested.

(e) *Responsibilities of the provider.* A provider may, but is not required to, submit evidence to be considered by a QIC in making its decision. If a provider fails to comply with a QIC’s request for additional information beyond that furnished to the QIO for purposes of the expedited determination, the QIC makes its reconsideration decision based on the information available.

(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.

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§ 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.