

not bill the beneficiary for any disputed services until the QIC makes its determination.

**§ 405.1206 Expedited determinations for inpatient hospital discharges.**

(a) *Beneficiary's right to an expedited determination for an inpatient hospital discharge.* A beneficiary who has received a notice of noncoverage under section 1154(e)(1) of the Act and 42 CFR 412.42(c)(3) may request an expedited determination by the QIO when a hospital (acting directly or through its utilization review committee), with physician concurrence, determines that inpatient care is no longer necessary. A beneficiary who timely requests an expedited QIO review in accordance with paragraph (d)(1) of this section and who meets the conditions of section 1879(a)(2) of the Social Security Act (that is, the individual did not know, and could not reasonably have been expected to know, that payment would not be made for such items or services under part A or part B) may remain in the hospital with no additional financial liability until the QIO makes its determination.

(b) *When delivery of the notice is valid.*

(1) Except as provided in paragraph (b)(2) of this section, valid delivery of the notice of non-coverage requires that 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.

(2) 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.

(c) *Beneficiary's right to other review.*

(1) A beneficiary who fails to request an expedited determination in accordance with paragraph (d)(1) of this section, and remains in the hospital, may request an expedited review at any time during the course of his or her inpatient hospital stay. The QIO will issue a decision in accordance with paragraph (e)(5)(ii) of this section. The escalation procedures described in § 405.1204(c)(5) and the financial liability rules of paragraph (f)(2) of this section do not apply.

(2) A beneficiary who fails to request an expedited determination in accordance with paragraph (d)(1) of this section, and who is no longer an inpatient in the hospital, may request QIO review within 30 calendar days after receipt of the notice of noncoverage as provided under section 1154(e)(1) or at any time for good cause. The QIO will issue a decision in accordance with paragraph (e)(5)(iii) of this section. The escalation procedures described in § 405.1204(c)(5) and the financial liability rules of paragraph (f)(2) of this section do not apply.

(d) *Procedures the beneficiary must follow.* For the expedited appeal process, the following rules apply:

(1) The beneficiary must submit the request for an expedited determination—

(i) To the QIO that has an agreement with the hospital under part 475 of this chapter;

(ii) In writing or by telephone; and

(iii) By noon of the first working day after he or she receives written notice that the hospital has determined that the hospital stay is no longer necessary.

(2) The beneficiary (or his or her authorized representative), upon request by the QIO, must be prepared to discuss the case with the QIO.

(e) *Procedures the QIO must follow.* On the date that the QIO receives the beneficiary's request:

(1) The QIO must notify the hospital that the beneficiary has filed a request for immediate review.

(2) The hospital must supply any information, including medical records, that the QIO requires to conduct its review and must make it available, by phone or in writing, by the close of business of the first full working day after the day the beneficiary receives notice of the planned discharge.

(3) The QIO must examine the pertinent records pertaining to the services.

(4) The QIO must solicit the views of the beneficiary (or the beneficiary's authorized representative) who requested the expedited determination.

(5)(i) When the beneficiary requests an expedited determination in accordance with paragraph (d)(1) of this section, the QIO must make a determination and notify the beneficiary, the

hospital, and physician of its determination by close of business of the first working day after it receives all requested pertinent information.

(ii) When the beneficiary does not request an expedited determination in accordance with paragraph (d)(1) of this section, and remains an inpatient in the hospital, the QIO will make a determination and notify the beneficiary, the hospital, and physician of its determination within 2 working days following receipt of the request and pertinent information.

(iii) When the beneficiary does not request an expedited initial determination in accordance with paragraph (d)(1) of this section, and is no longer an inpatient in the hospital, the QIO will make a determination and notify the beneficiary, the hospital, and physician of its determination within 30 calendar days after receipt of the request and pertinent information.

(f) *Coverage during QIO expedited review.* (1) In general, if the beneficiary remains in the hospital after receiving the hospital issued notice of noncoverage, and the hospital, the physician who concurred in the hospital's determination on which the advanced written notice of termination was based, or the QIO subsequently finds that the beneficiary requires an acute level of inpatient hospital care, the beneficiary is not financially responsible for continued care until the hospital once again determines that the beneficiary no longer requires inpatient care, secures concurrence from the physician responsible for the beneficiary's care or the QIO and notifies the beneficiary.

(2) *Timely filing and limitation on liability.* If a beneficiary both files a request for an expedited determination by the QIO in accordance with paragraph (d)(1) of this section, and meets the conditions of section 1879(a)(2) of the Social Security Act (that is, the individual did not know, and could not reasonably have been expected to know, that payment would not be made for such items or services under part A or part B), the beneficiary is not financially responsible for inpatient hospital services furnished before noon of the calendar day after the date the beneficiary (or his or her representative) receives notification (either oral-

ly or in writing) of the expedited determination by the QIO.

(3) *Untimely filing.* When a beneficiary does not file a request for an expedited determination by the QIO in accordance with paragraph (d)(1) of this section, that beneficiary may be responsible for charges that extend beyond the date specified on the hospital's advance written notice of termination or as otherwise stated by the QIO.

(4) *Hospital requests expedited review.* When the hospital requests review in accordance with § 405.1208, and the QIO concurs with the hospital's decision, a hospital may not charge a beneficiary until the date specified by the QIO.

(g) *Notice of an expedited determination.* (1) When a QIO issues an expedited determination in accordance with paragraph (e)(5) of this section, the QIO must notify the beneficiary, physician, and hospital of its decision, by telephone and subsequently in writing.

(2) A written notice of the expedited 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;
- (iv) A statement informing the beneficiary of his or her subsequent appeal rights, and the timeframe for requesting a reconsideration by the QIC.

(h) *Effect of an expedited QIO determination.* The QIO determination is binding upon the beneficiary, physician, and hospital, except in the following circumstances:

(1) *When beneficiary remains in the hospital.* 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. If the beneficiary does not make a request in accordance with paragraph (d)(1) of this section, the timeframes described in § 405.1204(c)(3), the escalation procedures described in § 405.1204(c)(5), and the coverage rule described in § 405.1204(f) will not apply.

(2) *When beneficiary is no longer an inpatient in the hospital.* If the beneficiary

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is no longer an inpatient in the hospital and is dissatisfied with this determination, the determination is subject to the general claims appeal process.

### § 405.1208 Hospital requests expedited QIO review.

(a) *General rule.* 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.

(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

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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 paragraph (d)(1) of this section, the timeframes described in § 405.1204(c)(3), the escalation procedures described in § 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.

### 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.

#### § 405.1801 Introduction.

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

*Administrator* means the Administrator or Deputy Administrator of CMS.

*Administrator's review* means that review provided for in section 1878(f) of