

appeal request and any accompanying documents to the enrollee and must notify the independent outside entity that it has requested an appeal.

[63 FR 35107, June 26, 1998, as amended at 65 FR 40331, June 29, 2000; 68 FR 50858, Aug. 22, 2003]

§ 422.619 How an MA organization must effectuate expedited reconsidered determinations.

(a) *Reversals by the MA organization.* If on reconsideration of an expedited request for service, the MA organization completely reverses its organization determination, 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 after the date the MA organization receives the request for reconsideration (or no later than upon expiration of an extension described in § 422.590(d)(2)).

(b) *Reversals by the independent outside entity.* 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.

(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 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) *Effectuation exception when the MA organization files an appeal with the Medicare Appeals Council.* If the MA organization requests Medicare Appeals Council (the Board) 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 Board 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]

§ 422.620 How enrollees of MA organizations must be notified of non-covered inpatient hospital care.

(a) *Enrollee's entitlement.* (1) Where an MA organization has authorized coverage of the inpatient admission of an enrollee, either directly or by delegation (or the admission constitutes emergency or urgently needed care, as described in §§ 422.2 and 422.113), the MA organization (or hospital that has been delegated the authority to make the discharge decision) must provide a written notice of noncoverage when—

(i) The beneficiary disagrees with the discharge decision; or

(ii) The MA organization (or the hospital that has been delegated the authority to make the discharge decision) is not discharging the individual but no longer intends to continue coverage of the inpatient stay.

(2) An enrollee is entitled to coverage until at least noon of the day after such notice is provided. If QIO review is requested under § 422.622, coverage is extended as provided in that section.

(b) *Physician concurrence required.* Before discharging an individual or changing the level of care in an inpatient hospital setting, the MA organization must obtain the concurrence of the physician who is responsible for the enrollee's inpatient care.

(c) *Notice to the enrollee.* When applicable, the written notice of non-coverage must be issued no later than the day before hospital coverage ends. The written notice must include the following elements:

(1) The reason why inpatient hospital care is no longer needed or covered;

(2) The effective date and time of the enrollee's liability for continued inpatient care;

(3) The enrollee's appeal rights;

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(4) If applicable, the new lower level of care being covered in the hospital setting; and

(5) Any additional information specified by CMS.

[68 FR 16667, Apr. 4, 2003, as amended at 70 FR 4740, Jan. 28, 2005]

EFFECTIVE DATE NOTE: At 68 FR 20349, Apr. 4, 2003, § 422.620 was revised. This section contains information collection and record-keeping requirements and will not become effective until approval has been given by the Office of Management and Budget

§ 422.622 Requesting immediate QIO review of noncoverage of inpatient hospital care.

(a) *Enrollee's right to review or reconsideration.* (1) An enrollee who wishes to appeal a determination by an MA organization or hospital that inpatient care is no longer necessary must request immediate QIO review of the determination in accordance with paragraph (b) of this section. An enrollee who requests immediate QIO review may remain in the hospital with no additional financial liability as specified in paragraph (c) of this section.

(2) An enrollee who fails to request immediate QIO review in accordance with the procedures in paragraph (b) of this section may request expedited reconsideration by the MA organization as described in § 422.584, but the financial liability rules of paragraph (c) of this section do not apply.

(b) *Procedures enrollee must follow.* For the immediate QIO review process, the following rules apply:

(1) The enrollee must submit the request for immediate review—

(i) To the QIO that has an agreement with the hospital under parts 476 and 478 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 MA organization or hospital has determined that the hospital stay is no longer necessary.

(2) On the date it receives the enrollee's request, the QIO must notify the MA organization that the enrollee has filed a request for immediate review.

(3) The MA organization must supply any information 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 immediately following the day the enrollee submits the request for review.

(4) In response to a request from the MA organization, the hospital must submit medical records and other pertinent information to the QIO by close of business of the first full working day immediately following the day the organization makes its request.

(5) The QIO must solicit the views of the enrollee who requested the immediate QIO review.

(6) The QIO must make a determination and notify the enrollee, the hospital, and the MA organization by close of business of the first working day after it receives all necessary information from the hospital, or the organization, or both.

(c) *Liability for hospital costs—*(1) *When the MA organization determines that hospital services are not, or are no longer, covered.* (i) Except as provided in paragraph (c)(1)(ii) of this section, 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 organization continues to be financially responsible for the costs of the hospital stay when a timely appeal is filed under paragraph (a)(1) of this section until noon of the calendar day following the day the QIO notifies the enrollee of its review determination. 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 noncoverage determination made by the MA organization.

(2) *When the hospital determines that hospital services are no longer required.* If the hospital determines that inpatient