

hospital services are no longer necessary, and the enrollee could not reasonably be expected to know that the services would not be covered, the hospital may not charge the enrollee for inpatient services received before noon of the calendar day following the day the QIO notifies the enrollee of its review determination.

[63 FR 35107, June 26, 1998; 63 FR 52614, Oct. 1, 1998, as amended at 70 FR 4740, Jan. 28, 2005; 70 FR 52027, Sept. 1, 2005]

§ 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 has been authorized by the MA organization, either directly or by delegation, to receive an ongoing course of treatment from that provider. Termination includes cessation of coverage at the end of a course of treatment preauthorized in a discrete increment, regardless of whether the enrollee agrees that such services should end.

(b) *Advance written notification of termination.* Prior to any termination of service, the provider of the service must deliver valid written notice to the enrollee of the MA organization's decision to terminate services. The provider must use a standardized notice, required by the Secretary, in accordance with the following procedures—

(1) *Timing of notice.* The provider must notify the enrollee of the MA organization's decision to terminate covered services no later than two days before the proposed end of the services. If the enrollee's services are expected to be fewer than two days in duration, the provider should notify the enrollee at the time of admission to the provider. If, in a non-institutional setting, the span of time between services exceeds two days, the notice should 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 enrollee's financial liability for continued services begins.

(iii) A description of the enrollee's right to a fast-track appeal under § 422.626, including information about how to contact an independent review entity (IRE), an enrollee's right (but not obligation) to submit evidence showing that services should continue, and the availability of other MA appeal procedures if the enrollee fails to meet the deadline for a fast-track IRE appeal.

(iv) The enrollee's right to receive detailed information in accordance with § 422.626 (e)(1) and (2).

(v) Any other information required by the Secretary.

(c) *When delivery of notice is valid.* Delivery of the termination notice is not valid unless—

(1) The enrollee (or the enrollee'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

(2) 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.

(d) *Financial liability for failure to deliver valid notice.* An MA organization is financially liable for continued services until 2 days after the enrollee receives valid notice as specified under paragraph (c) of this section. An enrollee may waive continuation of services if he or she agrees with being discharged sooner than 2 days after receiving the notice.

EFFECTIVE DATE NOTE: At 68 FR 20349, Apr. 4, 2003, § 422.624 was added. 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