days after the date the MA organization receives the request for reconsideration (or no later than upon expiration of an extension described in § 422.590(a)(1)).

(2) *Requests for payment*. If, on reconsideration of a request for payment, the MA organization completely reverses its organization determination, the organization must pay for the service no later than 60 calendar days after the date the MA organization receives the request for reconsideration.

(b) *Reversals by the independent outside entity*—(1) *Requests for service*. If, on reconsideration of a request for service, the MA organization's determination is reversed in whole or in part by the independent outside entity, the MA organization must authorize the service under dispute within 72 hours from the date it receives notice reversing the determination, or provide the service under dispute as expeditiously as the enrollee's health condition requires, but no later than 14 calendar days from that date. The MA organization must inform the independent outside entity that the organization has effectuated the decision.

(2) *Requests for payment*. If, on reconsideration of a request for payment, the MA organization's determination is reversed in whole or in part by the independent outside entity, the MA organization must pay for the service no later than 30 calendar days from the date it receives notice reversing the organization 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 determination is reversed in whole or in part by the ALJ, or at a higher level of appeal, the MA organization must pay for, authorize, or provide the service under dispute as expeditiously as the enrollee's health condition requires, but no later than 60 calendar 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 or that it has appealed 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 pays for, 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.

[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 Notifying enrollees of hospital discharge appeal rights.

(a) *Applicability and scope.* (1) For purposes of §§ 422.620 and 422.622, 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 also includes critical access hospitals.

(2) For purposes of §§ 422.620 and 422.622, a discharge is a formal release of an enrollee from an inpatient hospital.

(b) *Advance written notice of hospital discharge rights.* For all Medicare Advantage enrollees, hospitals must deliver valid, written notice of an enrollee'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 enrollee's admission to the hospital.

(2) *Content of the notice.* The notice of rights must include the following information:

(i) The enrollee's rights as a hospital inpatient, including the right to benefits for inpatient services and for post hospital services in accordance with 1866(a)(1)(M) of the Act.

(ii) The enrollee's right to request an immediate review, including a description of the process under § 422.622 and the availability of other appeals processes if the enrollee fails to meet the deadline for an immediate review.

(iii) The circumstances under which an enrollee will or will not be liable for charges for continued stay in the hospital in accordance with 1866(a)(1)(M) of the Act.

(iv) The enrollee's right to receive additional information in accordance with section § 422.622(e).

(v) Any other information required by CMS.

(3) *When delivery of notice is valid.* Delivery of the written notice of rights described in this section is valid if—

(i) The enrollee (or the enrollee's representative) has signed and dated the notice to indicate that he or she has received the notice and can comprehend its contents, except as provided in paragraph (b)(4) of this section; 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 an enrollee refuses to sign the notice.* The hospital may annotate its notice to indicate the refusal, and the date of refusal is considered the date of receipt of the notice.

(c) *Follow up notification.* (1) The hospital must present a copy of the signed notice described in paragraph (b)(2) of this section to the enrollee (or enrollee's representative) prior to discharge. The notice should be given as far in advance of discharge as possible, but not more than 2 calendar days before discharge.

(2) Follow up notification is not required if the notice required under 422.620(b) is delivered within 2 calendar days of discharge.

(d) *Physician concurrence required.* Before discharging an enrollee from the inpatient hospital level of care, the MA organization must obtain concurrence from the physician who is responsible for the enrollee's inpatient care.

[71 FR 68723, Nov. 27, 2006]