§ 422.626 Fast-track appeals of service terminations to independent review entities (IREs).

(a) Enrollee’s right to a fast-track appeal of an MA organization’s termination decision. An enrollee of an MA organization has a right to a fast-track appeal of an MA organization’s decision to terminate provider services.

(1) An enrollee who desires a fast-track appeal must submit a request for an appeal to an IRE under contract with CMS, in writing or by telephone, by noon of the first day after the day of delivery of the termination notice. If, due to an emergency, the IRE is closed and unable to accept the enrollee’s request for a fast-track appeal, the enrollee must file a request by noon of the next day that the IRE is open for business.

(2) When an enrollee fails to make a timely request to an IRE, he or she may request an expedited reconsideration by the MA organization as described in §422.584.

(3) If, after delivery of the termination notice, an enrollee chooses to leave a provider or discontinue receipt of covered services on or before the proposed termination date, the enrollee may not later assert fast-track IRE appeal rights under this section.
relative to the services or expect the services to resume, even if the enrollee requests an appeal before the discontinuation date in the termination notice.

(b) Coverage of provider services. Coverage of provider services continues until the date and time designated on the termination notice, unless the enrollee appeals and the IRE reverses the MA organization’s decision. If the IRE’s decision is delayed because the MA organization did not timely supply necessary information or records, the MA organization is liable for the costs of any additional coverage required by the delayed IRE decision. If the IRE finds that the enrollee did not receive valid notice, coverage of provider services by the MA organization continues until at least two days after valid notice has been received. Continuation of coverage is not required if the IRE determines that coverage could pose a threat to the enrollee’s health or safety.

(c) Burden of proof. When an enrollee appeals an MA organization’s decision to terminate services to an IRE, the burden of proof rests with the MA organization to demonstrate that termination of coverage is the correct decision, either on the basis of medical necessity, or based on other Medicare coverage policies.

(1) To meet this burden, the MA organization must supply any and all information that an IRE requires to sustain the MA organization’s termination decision, consistent with paragraph (e) of this section.

(2) The enrollee may submit evidence to be considered by an IRE in making its decision.

(3) The MA organization or an IRE may require an enrollee to authorize release to the IRE of his or her medical records, to the extent that the records are necessary for the MA organization to demonstrate the correctness of its decision or for an IRE to determine the appeal.

(d) Procedures an IRE must follow. (1) On the date an IRE receives the enrollee’s request for an appeal, the IRE must immediately notify the MA organization and the provider that the enrollee has filed a request for a fast-track appeal, and of the MA organization’s responsibility to submit documentation consistent with paragraph (e)(3) of this section.

(2) When an enrollee requests a fast-track appeal, the IRE must determine whether the provider delivered a valid notice of the termination decision, and whether a detailed notice has been provided, consistent with paragraph (e)(1) of this section.

(3) The IRE must notify CMS about each case in which it determines that improper notification occurs.

(4) Before making its decision, the IRE must solicit the enrollee’s views regarding the reason(s) for termination of services as specified in the detailed written notice provided by the MA organization, or regarding any other reason that the IRE uses as the basis of its review determination.

(5) An IRE must make a decision on an appeal and notify the enrollee, the MA organization, and the provider of services, by close of business of the day after it receives the information necessary to make the decision. If the IRE does not receive the information needed to sustain an MA organization’s decision to terminate services, it may make a decision on the case based on the information at hand, or it may defer its decision until it receives the necessary information. If the IRE defers its decision, coverage of the services by the MA organization would continue until the decision is made, consistent with paragraph (b) of this section, but no additional termination notice would be required.

(e) Responsibilities of the MA organization. (1) When an IRE notifies an MA organization that an enrollee has requested a fast-track appeal, the MA organization must send a detailed notice to the enrollee by close of business of the day of the IRE’s notification. The detailed termination notice must include the following information:

(i) A specific and detailed explanation why services are either no 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 the information about how the enrollee may obtain a copy of the
§422.641 Contract determinations.

This subpart establishes the procedures for making and reviewing the following contract determinations:

(a) A determination that an entity is not qualified to enter into a contract with CMS under Part C of title XVIII of the Act.

(b) A determination to terminate a contract with an MA organization in accordance with §422.510(a).

(c) A determination not to authorize a renewal of a contract with an MA organization in accordance with §422.506(b).

(g) Reconsiderations of IRE decisions.

(1) If the IRE upholds an MA organization’s termination decision in whole or in part, the enrollee may request, no later than 60 days after notification that the IRE has upheld the decision that the IRE reconsider its original decision.

(2) The IRE must issue its reconsidered determination as expeditiously as the enrollee’s health condition requires but no later than within 14 days of receipt of the enrollee’s request for a reconsideration.

(3) If the IRE reaffirms its decision, in whole or in part, the enrollee may appeal the IRE’s reconsidered determination to an ALJ, the MAC, or a Federal court, as provided for under this subpart.

(4) If on reconsideration the IRE determines that coverage of provider services should terminate on a given date, the enrollee is liable for the costs of continued services after that date unless the IRE’s decision is reversed on appeal. If the IRE’s decision is reversed on appeal, the MA organization must reimburse the enrollee, consistent with the appealed decision, for the costs of any covered services for which the enrollee has already paid the MA organization or provider.

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Subpart N—Medicare Contract Determinations and Appeals

SOURCE: 63 FR 35113, June 26, 1998, unless otherwise noted.

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