

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 M+C 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 M+C 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.

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

(a) *Enrollee's right to a fast-track appeal of an M+C organization's termination decision.* An enrollee of an M+C organization has a right to a fast-track appeal of an M+C 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 M+C 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 M+C organization's decision. If the IRE's decision is delayed because the M+C organization did not timely supply necessary information or records, the M+C 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 M+C 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 M+C organization's decision to terminate services to an IRE, the burden of proof rests with the M+C 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 M+C organization must supply any and all information that an IRE requires to sustain the M+C 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 M+C 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 M+C 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 M+C organization and the provider that the enrollee has filed a request for a fast-track appeal, and of the M+C 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 M+C 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 M+C 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 M+C 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 M+C 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 M+C organization.* (1) When an IRE notifies an M+C organization that an enrollee has requested a fast-track appeal, the M+C 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 Medicare policy from the M+C organization.