CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 11210	**Date: January 21, 2022**
	Change Request 12546

SUBJECT: Expedited Review Process for Hospital Inpatients in Original Medicare

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update Section 200 in Chapter 30 of Publication (Pub.) 100-04. The section has been reformatted to improve readability and understanding. There are no substantive changes.

EFFECTIVE DATE: April 21, 2022
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 21, 2022

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	30/200/Expedited Determinations of Inpatient Hospital Discharges
R	30/200/200.1/Statutory Authority
R	30/200/200.2/Scope
N	30/200/200.2.1/Exceptions
R	30/200/200.3/Important Message from Medicare (IM)
R	30/200/200.3.1/Alterations to the IM
R	30/200/200.3.2/Completing the IM
N	30/200/200.3.3/Hospital Delivery of the IM
N	30/200/200.3.4/Required Delivery Timeframes
N	30/200/200.3.4.1/First IM
N	30/200/200.3.4.2/Follow up copy of the IM
N	30/200/200.3.5/Refusal to Sign the IM
N	30/200/200.3.6/Ensuring Beneficiary Comprehension
N	30/200/200.3.7/IM Delivery to Representatives
N	30/200/200.3.8/Notice Retention for the IM
R	30/200/200.4/Expedited Determination Process
R	30/200/200.4.1/Beneficiary Responsibilities
N	30/200/200.4.1.1/Timeframe for Requesting an Expedited Determination
N	30/200/200.4.1.2/Provide Information to BFCC-QIO
R	30/200/200.4.2/Beneficiary Liability During BFCC-QIO Review
R	30/200/200.4.3/Untimely Requests for Review
R	30/200/200.4.4/Hospital Responsibilities
N	30/200/200.4.5/The Detailed Notice of Discharge (DND)
R	30/200/200.5/BFCC-QIO Responsibilities
R	30/200/200.5.1/Receive Beneficiary Requests for Expedited Review
R	30/200/200.5.2/Notify Hospitals and Allow Explanation of Why Covered Services Should End
R	30/200/200.5.3/Validate Delivery of the IM
R	30/200/200.5.4/Solicit the Views of the Beneficiary
R	30/200/200.5.5/Solicit the Views of the Hospital
R	30/200/200.5.6/Make Determinations and Notify Required Parties

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
D	30/200/200.5.7/Customization
D	30/200/200.5.8/Retention of the Notices
R	30/200/200.6/Effect of a BFCC-QIO Expedited Determination
R	30/200/200.6.1/Right to Pursue an Expedited Reconsideration
R	30/200/200.6.2/Effect of a BFCC-QIO Expedited Determination on Continuation of Care
R	30/200/200.6.3/Right to Pursue the Standard Claims Appeal Process

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 11210	Date: January 21, 2022	Change Request: 12546

SUBJECT: Expedited Review Process for Hospital Inpatients in Original Medicare

EFFECTIVE DATE: April 21, 2022
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I. GENERAL INFORMATION

A. Background: Medicare beneficiaries who are hospital inpatients have a statutory right to appeal to a Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) for an expedited review when a hospital, with physician concurrence, determines that inpatient care is no longer necessary.

- Sections 1866(a)(1)(M),
- 1869(c)(3)(C)(iii)(III), and
- 1154(e) of the Act.

B. Policy: 42 Code of Federal Regulations Part 405.1205 and 405.1206

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
12546.1	Contractors shall review the process associated with the revised language as indicated in Chapter 30 of Pub.100-04.	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
12546.2	Medicare Learning Network® (MLN): CMS will market provider education content through the MLN Connects® newsletter shortly after CMS releases the CR. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 instructions for distributing the MLN Connects newsletter information to providers and link to relevant information on your website. You may supplement MLN content with your local information after we release the MLN Connects newsletter. Subscribe to the "MLN Connects" listserv to get MLN content notifications. You don't need to separately track and report MLN content releases when you distribute MLN Connects newsletter content per the manual section referenced above.	X				

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Janet Miller, janet.miller@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current

scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

Medicare Claims Processing Manual
Chapter 30 - Financial Liability Protections

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(Rev. 11210; Issued:01-21-2022)

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200 - Expedited *Determinations of Inpatient Hospital Discharges*

(Rev.11210; Issued:01-21-2022; Effective:04-21-2022; Implementation:04-21-2022)

Medicare beneficiaries who are hospital inpatients have a statutory right to appeal to a BFCC-QIO for an expedited review when a hospital, with physician concurrence, determines that inpatient care is no longer necessary.

200.1 – *Statutory Authority*

(Rev.11210; Issued:01-21-2022; Effective:04-21-2022; Implementation:04-21-2022)

- *Sections 1866(a)(1)(M),*
- *1869(c)(3)(C)(iii)(III), and*
- *1154(e) of the Act.*

This process was implemented through a final rule with comment period, CMS-1655-F (81 FR 56761, 57037 through 57052, August 22, 2016), effective October 1, 2016. The resulting regulations are located at 42 CFR Part 405.1205 and 405.1206).

There is a parallel process for beneficiaries enrolled in Medicare health plans. (See 42 CFR 422.620 - 422.622 and §100.1 in the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance.) Please see the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance for Medicare Advantage instructions.

200.2 - *Scope*

(Rev.11210; Issued:01-21-2022; Effective:04-21-2022; Implementation:04-21-2022)

The expedited determination process is available to beneficiaries in Original Medicare who are being discharged from a Medicare covered inpatient hospital stay. All beneficiaries receiving covered inpatient hospital care must receive an Important Message from Medicare (IM). This includes, but is not limited to, beneficiaries in the following circumstances:

- *Beneficiaries for whom Medicare is either the primary or secondary payer.*
- *Beneficiaries with brief inpatient hospital stays.*
- *Beneficiaries physically discharged from the hospital or discharged to a lower level of care (such as a Swing Bed) in the same hospital.*

NOTE:

For purposes of these instructions, the term "beneficiary" means either beneficiary or representative, when a representative is acting for a beneficiary.

Hospitals Affected by these Instructions. *These instructions apply to hospitals as well as Critical Access Hospitals (CAHs) per section 1861(e) and section 1861(mm) of the Social Security Act. CAHs, as well as psychiatric hospitals, are included in the scope of these instructions.*

200.2.1 - Exceptions

(Rev.11210; Issued:01-21-2022; Effective:04-21-2022; Implementation:04-21-2022)

The following situations are not eligible for an expedited determination. Hospitals should not deliver an IM in these instances.

- *When a beneficiary transfers to another hospital at the same level of care (e.g., a beneficiary transfers from one hospital to another while remaining a hospital inpatient).*

- *When beneficiaries exhaust their benefits (e.g., a beneficiary reaches the number of lifetime reserve days of the Medicare inpatient hospital benefit.)*

- *When beneficiaries end care on their own initiative (e.g., a beneficiary elects the hospice benefit).*

- *Condition Code 44 (CC44) (See Section 50.3 of Chapter 1 of the Medicare Claims Processing Manual)*

- *Physician does not concur with discharge. (See Section 220 of this chapter.)*

NOTE:

The IM should only be given when an inpatient admission is pending or has occurred. It should not be given 'just in case', such as a hospital delivering to all Medicare patients being treated in a hospital emergency room.

200.3 – *Important Message from Medicare (IM)*

(Rev.11210; Issued:01-21-2022; Effective:04-21-2022; Implementation:04-21-2022)

The IM is subject to the Paperwork Reduction Act (PRA) process and approval by the Office of Management and Budget (OMB). The IM may only be modified as per the accompanying instructions, as well as per guidance in this section. Unapproved modifications cannot be made to the OMB-approved, standardized IM. The notice and accompanying instructions may be found online at Hospital Discharge Appeal Notices.

200.3.1 - *Alterations to the IM*

(Rev.11210; Issued:01-21-2022; Effective:04-21-2022; Implementation:04-21-2022)

- *The IM must remain two pages. The notice can be two sides of one page or one side of two separate pages, but **must not** be condensed to one page.*

- *Hospitals may include their business logo and contact information on the top of the IM. Text may not be shifted from page 1 to page 2 to accommodate large logos, address headers, etc.*

- *Hospitals may include information in the optional "Additional Information" section relevant to the beneficiary's situation.*

NOTE:

Including information normally included in the Detailed Notice of Discharge (DND) in the "Additional Information" section does not satisfy a hospital's responsibility to deliver the DND, if otherwise required. See §200.4.5 'The Detailed Notice of Discharge (DND)'.

200.3.2 - *Completing the IM*

(Rev.11210; Issued:01-21-2022; Effective:04-21-2022; Implementation:04-21-2022)

Hospitals must use the OMB-approved IM (CMS-10065). Hospitals must add the following information in the corresponding blanks of the IM:

1. *Patient name*
2. *Patient number*
3. *BFCC-QIO contact information*

NOTE:
The Patient number may be a unique medical record or other provider-issued identification number. It may not be the Social Security Number, HICN or any other Medicare number issued to the beneficiary such as the MBI (Medicare Beneficiary Identifier).

200.3.3 - Hospital Delivery of the IM
(Rev.11210; Issued:01-21-2022; Effective:04-21-2022; Implementation:04-21-2022)

Hospitals must deliver the IM to all beneficiaries eligible for the expedited determination process per §200.2. An IM must be delivered even if the beneficiary agrees with the discharge.

- *The hospital must ensure that the beneficiary or representative signs and dates the IM to demonstrate that the beneficiary or representative received the notice and understands its contents. See 200.3.7 'Ensuring Beneficiary Comprehension'.*
- *Use of assistive devices may be used to obtain a signature.*
- *Electronic issuance of the IM is permitted.*

If a hospital elects to issue an IM viewed on an electronic screen before signing, the beneficiary must be given the option of requesting paper issuance over electronic issuance if that is what the beneficiary prefers. Regardless of whether a paper or electronic version is issued and regardless of whether the signature is digitally captured or manually penned, the beneficiary must be given a paper copy of the IM, as specified in 200.3.9, and the required beneficiary specific information must be inserted, at the time of notice delivery.

200.3.4- Required Delivery Timeframes
(Rev.11210; Issued:01-21-2022; Effective:04-21-2022; Implementation:04-21-2022)

200.3.4.1- First IM
(Rev.11210; Issued:01-21-2022; Effective:04-21-2022; Implementation:04-21-2022)

Hospitals must deliver the first copy of the IM at or near admission, but no later than 2 calendar days following the date of the beneficiary's admission to the hospital.

Hospitals may deliver the first copy of the notice if the beneficiary is seen during a preadmission visit, but not more than 7 calendar days in advance of admission.

A hospital must deliver the IM to all inpatients, including those in the hospital for a short stay.

- *Once the discharge date is planned, a hospital does not need discharge orders in advance of delivering the IM.*

Timing of First IM Delivery

Pre-Admission	*Up to 7 days before admission*
At Admission	*At admission*
After Admission	*Up to 2 days following admission*

200.3.4.2 - Follow-Up Copy of the IM
(Rev.11210; Issued:01-21-2022; Effective:04-21-2022; Implementation:04-21-2022)

Hospitals must deliver the follow up copy of the IM within 2 days of discharge. It may be given as late as four hours prior to discharge.

However, if delivery of the first IM is within 2 calendar days of the date of discharge, no follow-up notice is required. For example, if a beneficiary is admitted on Monday, the IM is delivered on Wednesday and the beneficiary is discharged on Friday, no follow-up notice is required.

- *A hospital may deliver a new copy of the IM (not a copy of the signed IM) during the required timeframes; however, the hospital must obtain the beneficiary's or representative's signature and date on the notice again at that time, or*

- *A hospital may deliver a copy of the signed, first IM with the date of delivery of the follow up copy indicated on the IM.*

Timing of Follow-Up IM Delivery

No sooner than:	*Two days before discharge*
No later than:	*Four hours prior to discharge*

Notes:

- *If two or fewer days have passed since delivery of the first IM, no follow-up IM is required.*

- *The follow-up IM may be copy of signed first IM and does not need to be re-signed.*

200.3.5 - Refusal to Sign the IM
(Rev.11210; Issued:01-21-2022; Effective:04-21-2022; Implementation:04-21-2022)

If the beneficiary refuses to sign the IM the provider should annotate the notice to that effect, and indicate the date of refusal on the notice. The date of refusal is considered to be the date of notice receipt. Beneficiaries who refuse to sign the IM remain entitled to an expedited determination.

200.3.6 - Ensuring Beneficiary Comprehension
(Rev.11210; Issued:01-21-2022; Effective:04-21-2022; Implementation:04-21-2022)

The OMB-approved standardized IM is available in English and Spanish. If the individual receiving the notice is unable to read its written contents and/or comprehend the required oral explanation, hospitals and CAHs must employ their usual procedures to ensure notice comprehension. Usual procedures may include, but are not limited to, the use of translators, interpreters, and assistive technologies. Hospitals and CAHs are reminded that recipients of Federal financial assistance have an independent obligation to provide language assistance services to individuals with limited English proficiency (LEP) consistent with section 1557 of the Affordable Care Act and Title VI of the Civil Rights Act of 1964. In addition, recipients of Federal financial assistance have an independent obligation to provide auxiliary aids and services to individuals with disabilities free of charge, consistent with section 1557 of the Affordable Care Act and section 504 of the Rehabilitation Act of 1973.

200.3.7 - IM Delivery to Representatives
(Rev.11210; Issued:01-21-2022; Effective:04-21-2022; Implementation:04-21-2022)

The IM may be delivered to a beneficiary's appointed or authorized representative.

Types of Representative

Appointed Representative	***Authorized Representative***
Appointed representatives are individuals designated by beneficiaries to act on their behalf. A beneficiary may designate an appointed representative via the "Appointment of Representative" form, the CMS-1696. See Chapter 29 of the Medicare Claims Processing Manual, section 270.1, for more information on appointed representatives.	*An authorized representative is an individual who, under State or other applicable law, may make health care decisions on a beneficiary's behalf (e.g., the beneficiary's legal guardian, or someone appointed in accordance with a properly executed durable medical power of attorney).*

***Notes**:*

- *However, if a beneficiary is temporarily incapacitated and there is no representative, a person (typically, a family member or close friend) whom the hospital has determined could reasonably represent the beneficiary, but who has not been named in any legally binding document, may be a representative for the purpose of receiving the IM. Such a representative should act in the beneficiary's best interests and in a manner that is protective of the beneficiary and the beneficiary's rights. Therefore, a representative should have no relevant conflict of interest with the beneficiary.*

- *In instances where the notice is delivered to a representative who has not been named in a legally binding document, the hospital must annotate the IM with the name of the staff person initiating the contact, the name of the person contacted, and the date, time, and method (in person or telephone) of the contact.*

Delivery to off-site representatives

If the IM must be delivered to a representative who is not physically present, the hospital is not required to personally deliver the IM or have the IM delivered via courier to the representative. The hospital must complete the IM as required and may instead telephone the representativeand then mail the IM. The date and time of the telephone call is considered the receipt date of the IM.

The hospital must complete all of the following actions.

1. *Verbally convey all contents of the IM;*

2. *Note the date and time this information is communicated verbally;*

3. *Annotate the "Additional Information" section to reflect that IM was communicated verbally to the representative; and*

4. *Annotate the "Additional Information" section with the name of the staff person initiating the contact, the name of the representative contacted by phone, the date and time of the telephone contact, and the telephone number called.*

5. *Mail a copy of the annotated IM to the representative the day telephone contact is made.*

A hard copy of the IM must be sent to the representative by certified mail, return receipt requested, or any other delivery method that can provide signed verification of delivery (e.g., FedEx, UPS). The burden is on the hospital to demonstrate that timely contact was attempted with the representative and that the notice was delivered.

If the hospital and the representative both agree, the hospital may send the notice by fax or e-mail; however, the hospital or CAH's fax and e-mail systems must meet the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy and security requirements.

200.3.8- Notice Retention for the IM
(Rev.11210; Issued:01-21-2022; Effective:04-21-2022; Implementation:04-21-2022)

The hospital or CAH must retain the signed IM in the beneficiary's medical record. The beneficiary receives a paper copy of the IM that includes all of the required information described in this section. Electronic notice retention is permitted.

Hospitals must also document delivery of the follow-up copy of the IM in the patient records, when applicable. For example, hospitals may use the "Additional Information" section of the IM to document delivery of the follow-up copy by adding a line for the beneficiary's or representative's initials and date.

200.4 - *Expedited Determination Process*
(Rev.11210; Issued:01-21-2022; Effective:04-21-2022; Implementation:04-21-2022)

200.4.1 - *Beneficiary Responsibilities*
(Rev.11210; Issued:01-21-2022; Effective:04-21-2022; Implementation:04-21-2022)

200.4.1.1 - Timeframe for Requesting an Expedited Determination
(Rev.11210; Issued:01-21-2022; Effective:04-21-2022; Implementation:04-21-2022)

A beneficiary who receives an IM and disagrees with the discharge may request an expedited determination by the appropriate BFCC-QIO for the state where the services were provided. The beneficiary must contact the BFCC-QIO by midnight of the day of discharge, before leaving the hospital. The beneficiary may contact the BFCC-QIO by telephone or in writing.

200.4.1.2 - Provide Information to BFCC-QIO
(Rev.11210; Issued:01-21-2022; Effective:04-21-2022; Implementation:04-21-2022)

The beneficiary must be available to answer questions or supply information requested by the BFCC-QIO. The beneficiary may, but is not required to, supply additional information to the BFCC-QIO that he or she believes is pertinent to the case.

200.4.2 - *Beneficiary Liability During BFCC-QIO Review*

(Rev.11210; Issued:01-21-2022; Effective:04-21-2022; Implementation:04-21-2022)

When the beneficiary makes a timely request for a BFCC-QIO expedited determination per §200.4.1.1, the beneficiary is not financially responsible for inpatient hospital services (except applicable coinsurance and deductibles) furnished before noon of the calendar day after the date the beneficiary receives notification of the expedited determination from the BFCC-QIO. Please see §200.5.6 for QIO notification requirements.

When Liability Begins

BFCC-QIO determination	***Liability begins***
Unfavorable to the beneficiary	*Noon of the day after the BFCC-QIO notifies the beneficiary of the decision.*
Favorable to the beneficiary	*Once the hospital again determines that the beneficiary no longer requires inpatient care, determines a new last date of coverage and notifies the beneficiary with a follow-up copy of the IM.*

200.4.3 - *Untimely Requests for Review*

(Rev.11210; Issued:01-21-2022; Effective:04-21-2022; Implementation:04-21-2022)

Untimely request timeframes

Beneficiary location	***BFCC-QIO determination***
Beneficiary in hospital *[may request expedited review anytime while in hospital]*	*BFCC-QIO will make its determination and notify the beneficiary, the hospital, and the physician of its determination within 2 calendar days after it receives all requested information.*
Beneficiary left hospital *[may request expedited review within 30 days of discharge]*	*BFCC-QIO will make its determination and notify the beneficiary, the hospital, and the physician of its determination within 30 calendar days after it receives all requested information.*

The coverage protections discussed in §200.4.2 do not apply to a beneficiary who makes an untimely request to the BFCC-QIO.

200.4.4 - *Hospital Responsibilities*

(Rev.11210; Issued:01-21-2022; Effective:04-21-2022; Implementation:04-21-2022)

When a hospital is notified by a BFCC-QIO of a beneficiary request for an expedited determination, the provider must perform all of the following actions.

1. *Deliver the beneficiary a DNC (see §200.4.5) as soon as possible, but no later than noon of the day after BFCC-QIO notification;*

2. *Supply the BFCC-QIO with copies of the IM and DNC as soon as possible, but no later than noon of the day after BFCC-QIO notification;*

3. *Supply all information, including medical records, requested by the BFCC-QIO. The BFCC-QIO may allow this required information to be supplied via phone, writing, or electronically. If supplied via phone, the provider must keep a written record of the information it provides within the patient record; and*

4. *Furnish the beneficiary, at their request, with access to or copies of any documentation it provides to the BFCC-QIO. The hospital may charge the beneficiary a reasonable amount to cover the costs of duplicating and delivering the documentation. This documentation must be provided to the beneficiary by close of business of the first day after the material is requested.*

200.4.5 - The Detailed Notice of Discharge (DND)
(Rev.11210; Issued:01-21-2022; Effective:04-21-2022; Implementation:04-21-2022)

The Detailed Notice of Discharge (DND) is subject to the Paperwork Reduction Act (PRA) process and approval by the Office of Management and Budget (OMB). The DND may only be modified as per the accompanying instructions, as well as per guidance in this section. Unapproved modifications cannot be made to the OMB-approved, standardized DND. The notice and accompanying instructions may be found online at https://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices

Hospitals are responsible for the delivery of the DND to beneficiaries who request an expedited determination by the BFCC-QIO.

The DND must contain all the following information:

1. *The facts specific to the beneficiary's discharge and provider's determination that coverage should end.*
2. *A specific and detailed explanation of why services are either no longer reasonable or necessary or no longer covered.*
3. *A description of, and citations to, the Medicare coverage rule, instruction, or other policies applicable to the review.*

The delivery must occur in person by noon of the day after the BFCC-QIO notifies the provider that the beneficiary has requested an expedited determination.

The DND does not require a signature but should be annotated in the event of a beneficiary's refusal to accept the notice upon delivery.

200.5 – *BFCC-QIO Responsibilities*
(Rev.11210; Issued:01-21-2022; Effective:04-21-2022; Implementation:04-21-2022)

200.5.1 – *Receive Beneficiary Requests for Expedited Review*
(Rev.11210; Issued:01-21-2022; Effective:04-21-2022; Implementation:04-21-2022)

BFCC-QIOs must be available to receive beneficiary requests for review 24 hours a day, 7 days a week.

200.5.2 – *Notify Hospitals and Allow Explanation of Why Covered Services Should End*
(Rev.11210; Issued:01-21-2022; Effective:04-21-2022; Implementation:04-21-2022)

When the BFCC-QIO receives a request from a beneficiary, the BFCC-QIO must immediately notify the provider of services that a request for an expedited determination was made. If the request is received after normal working hours, the BFCC-QIO should notify the provider as soon as possible on the morning after the request was made.

200.5.3 – *Validate Delivery of the IM*
(Rev.11210; Issued:01-21-2022; Effective:04-21-2022; Implementation:04-21-2022)

The BFCC-QIO should determine that IM delivery was valid if all of the following criteria are met:

- *The notice used is the OMB approved IM published by CMS.*
- *The notice was delivered timely per 200.3.4.*
- *The notice was signed and dated by the beneficiary.*

If the BFCC-QIO determines that the hospital did not deliver a valid notice, the BFCC-QIO will provide education to the hospital on valid notice requirements.

200.5.4 - *Solicit the Views of the Beneficiary*
(Rev.11210; Issued:01-21-2022; Effective:04-21-2022; Implementation:04-21-2022)

The BFCC-QIO must solicit views of the beneficiary who requested the expedited determination.

200.5.5 - *Solicit the Views of the Hospital*
(Rev.11210; Issued:01-21-2022; Effective:04-21-2022; Implementation:04-21-2022)

The BFCC-QIO must afford the provider an opportunity to explain why the discharge is appropriate.

200.5.6 – *Make Determination and Notify Required Parties*
(Rev.11210; Issued:01-21-2022; Effective:04-21-2022; Implementation:04-21-2022)

No later than one calendar day after it receives all requested information, the BFCC-QIO must make its determination on whether the discharge is appropriate based on medical necessity or other Medicare coverage policies.
The BFCC-QIO must perform the following actions.

1. *Notify the beneficiary, the beneficiary's physician, and the provider of services of its determination. This notification must include the rationale for the determination and an explanation of Medicare payment consequences and beneficiary liability.*

2. *Inform the beneficiary of the right to an expedited reconsideration by the BFCC-QIO and how to request a timely expedited reconsideration.*

3. *Make its initial notification via telephone and follow up with a written determination letter.*

NOTE:

If the BFCC-QIO does not receive supporting information from the hospital, it may make its determination based on the evidence at hand, or defer a decision until it receives the necessary information. If this delay results in continued services for the beneficiary, the provider may be held financially liable for these services as determined by the BFCC-QIO.

200.6 - *Effect of a BFCC-QIO Expedited Determination*

(Rev.11210; Issued:01-21-2022; Effective:04-21-2022; Implementation:04-21-2022)

The BFCC-QIO determination is binding unless the beneficiary pursues an expedited reconsideration per section 300 of this chapter.

200.6.1 – *Right to Pursue an Expedited Reconsideration*

(Rev.11210; Issued:01-21-2022; Effective:04-21-2022; Implementation:04-21-2022)

If dissatisfied with the expedited determination, the beneficiary may request an expedited reconsideration according to the procedures described in section 300 of this chapter.

200.6.2 – *Effect of a BFCC-QIO Determination on Continuation of Care*

(Rev.11210; Issued:01-21-2022; Effective:04-21-2022; Implementation:04-21-2022)

A beneficiary may choose to remain in the hospital beyond the last day of coverage, but may be liable for services after that day. The hospital should issue a Hospital-Issued Notice of Non-coverage (HINN 12) to inform the beneficiary of potential liability. Please see (https://www.cms.gov/Medicare/Medicare-General-Information/BNI/HINNs) for HINN delivery instructions.

200.6.3 – *Right to Pursue the Standard Claims Appeal Process*

(Rev.11210; Issued:01-21-2022; Effective:04-21-2022; Implementation:04-21-2022)

If the beneficiary is no longer an inpatient in the hospital and is dissatisfied with this determination, the determination is subject to the general claims appeal process (See Chapter 29 of this manual.).