

§ 417.598

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than the requirements for that previous period and the ACR for the next contract period results in an additional benefits package that is less in total value than that of the previous contract period.

(c) *Basis for denial.* HCFA does not approve a request for a withdrawal from a benefit stabilization fund if the withdrawal would allow the HMO or CMP to—

(1) Offer without charge the supplemental services it provides to its Medicare enrollees under the provisions of § 417.440 (b)(2) or (b)(3); or

(2) Refinance prior contract period losses or to avoid losses in the upcoming contract period.

(d) *Form of payment.* Payment of monies withdrawn from a benefit stabilization fund is made, in equal parts, as an additional amount to the monthly advance payment made to the HMO or CMP under § 417.584 during the period of the contract.

[58 FR 38075, July 15, 1993, as amended at 60 FR 46233, Sept. 6, 1995]

§ 417.598 Annual enrollment reconciliation.

HCFA's payment to an HMO or CMP may be subject to an enrollment reconciliation at least annually. HCFA conducts this reconciliation as necessary to ensure that the payments made do not exceed or fall short of the appropriate per capita rate of payment for each Medicare enrollee of the HMO or CMP during the contract period. The HMO or CMP must submit any information or reports required by HCFA to conduct the reconciliation.

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38080, July 15, 1993; 60 FR 46233, Sept. 6, 1995]

Subpart Q—Beneficiary Appeals

§ 417.600 Basis and scope.

(a) *Statutory basis.* (1) Section 1869 of the Act provides the right to a hearing and to judicial review for any individual dissatisfied with a determination regarding his or her Medicare benefits.

(2) Section 1876 of the Act provides for Medicare payments to HMOs and CMPs that contract with HCFA to en-

roll Medicare beneficiaries and furnish Medicare-covered health care services to them. Section 1876(c)(5) provides that—

(i) An HMO or CMP must establish grievance and appeals procedures; and

(ii) Medicare enrollees dissatisfied because they do not receive health care services to which they believe they are entitled, at no greater cost than they believe they are required to pay, have the following appeal rights:

(A) The right to an ALJ hearing if the amount in controversy is \$100 or more.

(B) The right to judicial review of the hearing decision if the amount in controversy is \$1000 or more.

(iii) The Medicare enrollee and the HMO or CMP are parties to the hearing and to the judicial review.

(b) *Scope.* This subpart sets forth—

(1) The appeals procedures, as required by section 1876(c)(5)(B) of the Act for Medicare enrollees who are dissatisfied with an "organization determination" as defined in § 417.606;

(2) The applicability of grievance procedures established by the HMO or CMP under section 1876(c)(5)(A) of the Act and § 417.604(a) for complaints that do not involve an organization determination;

(3) The responsibility of the HMO or CMP—

(i) To develop and maintain procedures; and

(ii) To ensure all Medicare enrollees have a complete written explanation of their grievance and appeal rights, the availability of expedited reviews, the steps to follow, and the time limits for each procedure; and

(4) The special rules that apply when a beneficiary requests immediate PRO review of a determination that he or she no longer needs inpatient hospital care.

[60 FR 46233, Sept. 6, 1995, as amended at 62 FR 23374, Apr. 30, 1997]

§ 417.602 Definitions.

As used in this subpart, unless the context indicates otherwise—

ALJ stands for administrative law judge.

RRB stands for Railroad Retirement Board.

[50 FR 1346, Jan. 10, 1985, and amended at 58 FR 38080, July 15, 1993; 60 FR 46233, Sept. 6, 1995]

§ 417.604 General provisions.

(a) *Responsibilities of the HMO or CMP.*

(1) The HMO or CMP must establish and maintain—

(i) Appeals procedures that meet the requirements of this subpart for issues that involve organization determinations; and

(ii) Grievance procedures for dealing with issues that do not involve organization determinations.

(2) The HMO or CMP must ensure that all enrollees receive written information about the grievance and appeals procedures that are available to them.

(b) *Limits on applicability of this subpart.* (1) If an enrollee requests immediate PRO review (as provided in § 417.605) of a determination of noncoverage of inpatient hospital care—

(i) The enrollee is not entitled to subsequent review of that issue under this subpart; and

(ii) The PRO review decision is subject to the appeals procedures set forth in part 473 of this chapter.

(2) Any determination regarding services that were furnished by the HMO or CMP, either directly or under arrangement, for which the enrollee has no further liability for payment are not subject to appeal.

(3) Services included in an optional supplemental plan under (§ 417.440(b)(2)) are subject only to a grievance procedure.

(4) Physicians and other individuals who furnish services under arrangement with an HMO or CMP have no right of appeal under this subpart, except as provided in §§ 417.609(c)(4) and 417.617(c)(4), which allow physicians and other health professionals to act on behalf of an enrollee in time-sensitive situations when an organization determination or reconsideration is being requested.

(c) *Applicability of other regulations.* Unless otherwise provided in this subpart, regulations at 20 CFR, part 404, subparts J and R, (pertaining respectively to conduct of hearings and rep-

resentation of parties under title II of the Act) are applicable under this subpart.

[60 FR 46233, Sept. 6, 1995, as amended at 62 FR 23374, Apr. 30, 1997]

§ 417.605 Immediate PRO review of a determination of noncoverage of inpatient hospital care.

(a) *Right to review.* A Medicare enrollee who disagrees with a determination made by an HMO, CMP, or a hospital that inpatient care is no longer necessary may remain in the hospital and may (directly or through his or her authorized representative) request immediate PRO review of the determination.

(b) *Procedures.* For the immediate PRO review process, the following rules apply:

(1) The enrollee or authorized representative must submit the request for immediate review—

(i) To the PRO that has an agreement with the hospital under § 466.78 of this chapter;

(ii) In writing or by telephone; and

(iii) By noon of the first working day after receipt of the written notice of the determination that the hospital stay is no longer necessary.

(2) On the date it receives the enrollee's request, the PRO must notify the HMO or CMP that a request for immediate review has been filed.

(3) The HMO or CMP must supply any information that the PRO requires to conduct its review and must make it available, by phone or in writing, by the close of business of the first full working day immediately following the day the enrollee submits the request for review.

(4) In response to a request from the HMO or CMP, the hospital must submit medical records and other pertinent information to the PRO by close of business of the first full working day immediately following the day the HMO or CMP makes its request.

(5) The PRO must solicit the views of the enrollee who requested the immediate PRO review (or the enrollee's representative).

(6) The PRO must make a determination and notify the enrollee, the hospital, and the HMO or CMP by close of business of the first working day after