

§ 417.604

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-

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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

it receives the information from the hospital, or the HMO or CMP, or both.

(c) *Financial responsibility.* (1) *General rule.* Except as provided in paragraph (c)(2) of this section, the HMO or CMP continues to be financially responsible for the costs of the hospital stay until noon of the calendar day following the day the PRO notifies the enrollee of its review determination.

(2) *Exception.* The hospital may not charge the HMO or CMP (or the enrollee) if—

(i) It was the hospital (acting on behalf of the enrollee) that filed the request for immediate PRO review; and

(ii) The PRO upholds the noncoverage determination made by the HMO or CMP.

[59 FR 59941, Nov. 21, 1994]

§ 417.606 Organization determinations.

(a) *Actions that are organization determinations.* An organization determination is any determination made by an HMO or CMP with respect to any of the following:

(1) Payment for emergency or urgently needed services.

(2) Any other health services furnished by a provider or supplier other than the HMO or CMP that the enrollee believes—

(i) Are covered under Medicare; and

(ii) Should have been furnished, arranged for, or reimbursed by the HMO or CMP.

(3) The HMO's or CMP's refusal to provide services that the enrollee believes should be furnished or arranged for by the HMO or CMP and the enrollee has not received the services outside the HMO or CMP.

(4) Discontinuation of a service (such as a skilled nursing facility discharge), if the enrollee disagrees with the determination that the service is no longer medically necessary.

(b) *Actions that are not organization determinations.* The following are not organization determinations for purposes of this subpart:

(1) A determination regarding services that were furnished by the HMO or CMP, either directly or under arrangement, for which the enrollee has no further obligation for payment.

(2) A determination regarding services included in an optional supplemental plan (see § 417.440(b)(2)).

(c) *Relation to grievances.* A determination that is not an organization determination is subject only to a grievance procedure under § 417.436(a)(2).

[59 FR 59942, Nov. 21, 1994, as amended at 62 FR 23374, Apr. 30, 1997]

§ 417.608 Notice of adverse organization determination.

(a) If an HMO or CMP makes an organization determination that is partially or fully adverse to the enrollee, it must notify the enrollee of the determination—

(1) Within 60 days of receiving the enrollee's request for payment for services; or

(2) As specified in § 417.609(c)(3) for expedited organization determinations.

(b) The notice must—

(1) State the specific reasons for the determination; and

(2) Inform the enrollee of his or her right to a reconsideration, including the right to and conditions for obtaining an expedited reconsidered determination.

(c) The failure to provide the enrollee with timely notification of an adverse organization determination as specified in paragraph (a) of this section or in § 417.609(b) (concerning time frames for expediting certain organization determinations) constitutes an adverse organization determination and may be appealed.

[50 FR 1346, Jan. 10, 1985, as amended at 59 FR 59942, Nov. 21, 1994; 62 FR 23375, Apr. 30, 1997]

§ 417.609 Expediting certain organization determinations.

(a) An enrollee, or an authorized representative of the enrollee, may request that an organization determination as defined in §§ 417.606(a)(3) and (a)(4) be expedited. The request may be made orally to the HMO or CMP.

(b) The HMO or CMP must maintain procedures for expediting organization determinations when, upon request from an enrollee or authorized representative of the enrollee, the organization decides that making the determination according to the procedures