

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