

(e) *Notice of determination.* HCFA gives the accreditation organization a formal notice that—

(1) States whether the request for approval has been granted or denied;

(2) Gives the rationale for any denial; and

(3) Describes the reconsideration and reapplication procedures.

(f) *Withdrawal.* An accreditation organization may withdraw its application for approval at any time before it receives the formal notice specified in paragraph (e) of this section.

(g) *Reconsideration of adverse determination.* An accreditation organization that has received notice of denial of its request for approval may request reconsideration in accordance with subpart D of part 488 of this chapter.

(h) *Request for approval following denial.* (1) Except as provided in paragraph (h)(2) of this section, an accreditation organization that has received notice of denial of its request for approval may submit a new request if it—

(i) Has revised its accreditation program to correct the deficiencies on which the denial was based;

(ii) Can demonstrate that the M+C organizations that it has accredited meet or exceed applicable Medicare requirements; and

(iii) Resubmits the application in its entirety.

(2) An accreditation organization that has requested reconsideration of HCFA's denial of its request for approval may not submit a new request until the reconsideration is administratively final.

Subpart E—Relationships With Providers

SOURCE: 63 FR 35085, June 26, 1998, unless otherwise noted.

422.200 Basis and scope.

This subpart is based on sections 1852(a)(1), (a)(2), (b)(2), (c)(2)(D), (j), and (k) of the Act; section 1859(b)(2)(A) of the Act; and the general authority under 1856(b) of the Act requiring the establishment of standards. It sets forth the requirements and standards for the M+C organization's relationships with providers including physicians, other health care professionals,

institutional providers and suppliers, under contracts or arrangements or deemed contracts under M+C private fee-for-service plans. This subpart also contains some requirements that apply to noncontracting providers.

§ 422.202 Participation procedures.

(a) *Notice and appeal rights.* An M+C organization that operates a coordinated care plan or network MSA plan must provide for the participation of individual physicians, and the management and members of groups of physicians, through reasonable procedures that include the following:

(1) Written notice of rules of participation including terms of payment, credentialing, and other rules directly related to participation decisions.

(2) Written notice of material changes in participation rules before the changes are put into effect.

(3) Written notice of participation decisions that are adverse to physicians.

(4) A process for appealing adverse participation decisions, including the right of physicians to present information and their views on the decision. In the case of a termination or suspension of a provider contract by the M+C organization, this process must conform to the rules in § 422.204(c).

(b) *Consultation.* The M+C organization must consult with the physicians who have agreed to provide services under an M+C plan offered by the organization, regarding the organization's medical policy, quality assurance program, and medical management procedures and ensure that the following standards are met:

(1) Practice guidelines and utilization management guidelines—

(i) Are based on reasonable medical evidence or a consensus of health care professionals in the particular field;

(ii) Consider the needs of the enrolled population;

(iii) Are developed in consultation with contracting physicians; and

(iv) Are reviewed and updated periodically.

(2) The guidelines are communicated to providers and, as appropriate, to enrollees.

(3) Decisions with respect to utilization management, enrollee education, coverage of services, and other areas in

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which the guidelines apply are consistent with the guidelines.

(c) An M+C organization that operates an M+C plan through subcontracted physician groups must provide that the participation procedures in this section apply equally to physicians within those subcontracted groups.

[64 FR 7981, Feb. 17, 1999]

§ 422.204 Provider credentialing and provider rights.

(a) *Basic requirements.* An M+C organization must follow a documented process with respect to providers and suppliers who have signed contracts or participation agreements that—

(1) For providers (other than physicians and other health care professionals) requires determination, and redetermination at specified intervals, that each provider—

(i) Licensed to operate in the State, and in compliance with any other applicable State or Federal requirements; and

(ii) Reviewed and approved by an accrediting body, or meets the standards established by the organization itself;

(2) For physicians and other health care professionals, including members of physician groups, covers—

(i) Initial credentialing that includes written application, verification of licensure and other information from primary sources, disciplinary status, eligibility for payment under Medicare, and site visits as appropriate. The application must be signed and dated and include an attestation by the applicant of the correctness and completeness of the application and other information submitted in support of the application;

(ii) Recredentialing at least every 2 years that updates information obtained during initial credentialing and considers performance indicators such as those collected through quality assurance programs, utilization management systems, handling of grievances and appeals, enrollee satisfaction surveys, and other plan activities, and that includes an attestation of the correctness and completeness of the new information; and

(iii) A process for receiving advice from contracting health care profes-

sionals with respect to criteria for credentialing and recredentialing; and

(iv) Requiring that, to the extent applicable, the requirements in paragraphs (a)(2)(i) and (a)(2)(iii) of this section are satisfied; and

(3)(i) Specify that basic benefits must be provided through, or payments must be made to, providers that meet applicable requirements of title XVIII and part A of title XI of the Act. In the case of providers meeting the definition of “provider of services” in section 1861(u), basic benefits may only be provided through such providers if they have a provider agreement with HCFA permitting them to provide services under original Medicare.

(ii) Ensures compliance with the requirements at § 422.752(a)(8) that prohibit employment or contracts with individuals (or with an entity that employs or contracts with such an individual) excluded from participation under Medicare and with the requirements at § 422.220 regarding physicians and practitioners who opt out of Medicare.

(b) *Discrimination prohibited*—(1) *General rule.* An M+C organization may not discriminate, in terms of participation, reimbursement, or indemnification, against any health care professional who is acting within the scope of his or her license or certification under State law, solely on the basis of the license or certification.

(2) *Construction.* The prohibition in paragraph (b)(1) of this section does not preclude any of the following by the M+C organization:

(i) Refusal to grant participation to health care professionals in excess of the number necessary to meet the needs of the plan’s enrollees (except for M+C private-fee-for-service plans, which may not refuse to contract on this basis).

(ii) Use of different reimbursement amounts for different specialties.

(iii) Implementation of measures designed to maintain quality and control costs consistent with its responsibilities.

(c) *Suspension or termination of contract.* An M+C organization that operates a coordinated care plan or network MSA plan providing benefits