

(4) *Records access.* The previous owner must agree to make its books and records and other necessary information available to the new owner and to HCFA to permit an accurate determination of costs for the final settlement of the contract period.

[50 FR 1346, Jan. 10, 1985, as amended at 56 FR 8853, Mar. 1, 1991; 58 FR 38079, July 15, 1993; 60 FR 45681, Sept. 1, 1995. Redesignated and amended at 63 FR 35067, 35106, June 26, 1998]

§ 422.553 Effect of leasing of an M+C organization's facilities.

(a) *General effect of leasing.* If an M+C organization leases all or part of its facilities to another entity, the other entity does not acquire M+C organization status under section 1876 of the Act.

(b) *Effect of lease of all facilities.* (1) If an M+C organization leases all of its facilities to another entity, the contract terminates.

(2) If the other entity wishes to participate in Medicare as an M+C organization, it must apply for and enter into a contract in accordance with subpart L of this part.

(c) *Effect of partial lease of facilities.* If the M+C organization leases part of its facilities to another entity, its contract with HCFA remains in effect while HCFA surveys the M+C organization to determine whether it continues to be in compliance with the applicable requirements and qualifying conditions specified in subpart K of this part.

[50 FR 1346, Jan. 10, 1985; 50 FR 20570, May 17, 1985, as amended at 58 FR 38079, July 15, 1993; 60 FR 45681, Sept. 1, 1995. Redesignated and amended at 63 FR 35067, 35106, June 26, 1998]

Subpart M—Grievances, Organization Determinations and Appeals

SOURCE: 63 FR 35107, June 26, 1998, unless otherwise noted.

§ 422.560 Basis and scope.

(a) *Statutory basis.* (1) Section 1852(f) of the Act provides that an M+C organization must establish meaningful grievance procedures.

(2) Section 1852(g) of the Act establishes requirements that an M+C orga-

nization must meet concerning organization determinations and appeals.

(b) *Scope.* This subpart sets forth—

(1) Requirements for M+C organizations with respect to grievance procedures, organization determinations, and appeal procedures.

(2) The rights of M+C enrollees with respect to organization determinations, and grievance and appeal procedures.

(3) The rules concerning notice of noncoverage of inpatient hospital care.

(4) The rules that apply when an M+C enrollee requests immediate PRO review of a determination that he or she no longer needs inpatient hospital care.

§ 422.561 Definitions.

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

Appeal means any of the procedures that deal with the review of adverse organization determinations on the health care services an enrollee is entitled to receive or any amounts the enrollee must pay for a service, as defined under § 422.566(b). These procedures include reconsiderations by the M+C organization, and if necessary, an independent review entity, hearings before ALJs, review by the Departmental Appeals Board (DAB), and judicial review.

Authorized representative means an individual authorized by an enrollee to act on his or her behalf in obtaining an organization determination or in dealing with any of the levels of the appeal process, subject to the rules described in 20 CFR part 404, subpart R, unless otherwise stated in this subpart.

Enrollee means an M+C eligible individual who has elected an M+C plan offered by an M+C organization, or his or her authorized representative.

Grievance means any complaint or dispute other than one involving an organization determination, as defined in § 422.566(b).

Physician has the meaning given the term in section 1861(r) of the Act.

§ 422.562 General provisions.

(a) *Responsibilities of the M+C organization.* (1) An M+C organization, with respect to each M+C plan that it offers, must establish and maintain—

(i) A grievance procedure as described in § 422.564 for addressing issues