

**§ 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 organization 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 the enrollee believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the enrollee), or on 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, or under State law, 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.

[63 FR 35067, June 26, 1998, as amended at 65 FR 40328, June 29, 2000]

**§ 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 that do not involve organization determinations;

(ii) A procedure for making timely organization determinations;