

§ 422.564

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that do not involve organization determinations;

(ii) A procedure for making timely organization determinations; and

(iii) Appeal procedures that meet the requirements of this subpart for issues that involve organization determinations; and

(2) An M+C organization must ensure that all enrollees receive written information about the—

(i) Grievance and appeal procedures that are available to them through the M+C organization; and

(ii) Complaint process available to the enrollee under the PRO process as set forth under section 1154(a)(14) of the Act.

(3) In accordance with subpart K of this part, if the M+C organization delegates any of its responsibilities under this subpart to another entity or individual through which the organization provides health care services, the M+C organization is ultimately responsible for ensuring that the entity or individual satisfies the relevant requirements of this subpart.

(b) *Rights of M+C enrollees.* In accordance with the provisions of this subpart, enrollees have the following rights:

(1) The right to have grievances between the enrollee and the M+C organization heard and resolved, as described in § 422.564.

(2) The right to a timely organization determination, as provided under § 422.566.

(3) The right to request an expedited organization determination, as provided under § 422.570.

(4) If dissatisfied with any part of an organization determination, the following appeal rights:

(i) The right to a reconsideration of the adverse organization determination by the M+C organization, as provided under § 422.578.

(ii) The right to request an expedited reconsideration, as provided under § 422.584.

(iii) If, as a result of a reconsideration, an M+C organization affirms, in whole or in part, its adverse organization determination, the right to an automatic reconsidered determination made by an independent, outside entity

contracted by HCFA, as provided in § 422.592.

(iv) The right to an ALJ hearing if the amount in controversy is \$100 or more, as provided in § 422.600.

(v) The right to request DAB review of the ALJ hearing decision, as provided in § 422.608.

(vi) The right to judicial review of the hearing decision if the amount in controversy is \$1000 or more, as provided in § 422.612.

(c) *Limits on when this subpart applies.*

(1) If an enrollee receives immediate PRO review (as provided in § 422.622) of a determination of noncoverage of inpatient hospital care—

(i) The enrollee is not entitled to review of that issue by the M+C organization; and

(ii) The PRO review decision is subject only to the appeal procedures set forth in part 473 of this chapter.

(2) If an enrollee has no further liability to pay for services that were furnished by an M+C organization, a determination regarding these services is not subject to appeal.

(d) *When other regulations apply.* Unless this subpart provides otherwise, the regulations in 20 CFR, part 404, subparts J and R (covering, respectively, the administrative review and hearing process and representation of parties under title II of the Act), apply under this subpart to the extent they are appropriate.

§ 422.564 Grievance procedures.

(a) *General rules.* (1) Each M+C organization must provide meaningful procedures for timely hearing and resolution of grievances between enrollees and the organization or any other entity or individual through which the organization provides health care services under any M+C plan it offers.

(2) Grievance procedures must meet any guidelines established by HCFA.

(b) *Distinguished from organization determinations and appeals.* Grievance procedures are separate and distinct from organization determinations and appeal procedures, which address organization determinations.

(c) *Distinguished from the PRO complaint process.* Under section 1154(a)(14) of the Act, the PRO must review beneficiaries' written complaints about the

quality of services they have received under the Medicare program; this process is separate and distinct from the grievance procedures of the M+C organization.

§ 422.566 Organization determinations.

(a) *Responsibilities of the M+C organization.* Each M+C organization must have a procedure for making timely organization determinations (in accordance with the requirements of this subpart) regarding the benefits an enrollee is entitled to receive under an M+C plan, including basic benefits as described under § 422.100(c)(1) and mandatory and optional supplemental benefits as described under § 422.102, and the amount, if any, that the enrollee is required to pay for a health service. The M+C organization must have a standard procedure for making determinations, in accordance with § 422.568, and an expedited procedure for situations in which applying the standard procedure could seriously jeopardize the enrollee's life, health, or ability to regain maximum function, in accordance with §§ 422.570 and 422.572.

(b) *Actions that are organization determinations.* An organization determination is any determination made by an M+C organization with respect to any of the following:

(1) Payment for emergency services, post-stabilization care, or urgently needed services.

(2) Payment for any other health services furnished by a provider other than the M+C organization that the enrollee believes—

(i) Are covered under Medicare; or

(ii) If not covered under Medicare, should have been furnished, arranged for, or reimbursed by the M+C organization.

(3) The M+C organization's refusal to provide services that the enrollee believes should be furnished or arranged for by the M+C organization when the enrollee has not received the services outside the M+C organization.

(4) Discontinuation of a service, if the enrollee disagrees with the determination that the service is no longer medically necessary.

(c) *Who can request an organization determination.* Any of the parties listed in § 422.574 can request an organization de-

termination, with the exception that only the parties listed in § 422.570(a) can request an expedited determination.

§ 422.568 Standard timeframes and notice requirements for organization determinations.

(a) *Timeframe for requests for service.*

When a party has made a request for a service, the M+C organization must notify the enrollee of its determination as expeditiously as the enrollee's health condition requires, but no later than 14 calendar days after the date the organization receives the request for a standard organization determination. The M+C organization may extend the timeframe by up to 14 calendar days if the enrollee requests the extension or if the organization justifies a need for additional information and how the delay is in the interest of the enrollee (for example, the receipt of additional medical evidence from noncontract providers may change an M+C organization's decision to deny). The M+C organization must notify the enrollee of its determination as expeditiously as the enrollee's health condition requires, but no later than upon expiration of the extension.

(b) *Timeframe for requests for payment.*

The M+C organization must process requests for payment according to the "prompt payment" provisions set forth in § 422.520.

(c) *Written notification for denials.* If an M+C organization decides to deny service or payment in whole or in part, it must give the enrollee written notice of the determination.

(d) *Content of the notice.* The notice of any denial under paragraph (c) of this section must—

(1) State the specific reasons for the denial in understandable language;

(2) Inform the enrollee of his or her right to a reconsideration;

(3) Describe both the standard and expedited reconsideration processes, including the enrollee's right to and conditions for obtaining an expedited reconsideration for service requests, and the rest of the appeal process; and

(4) Comply with any other requirements specified by HCFA.

(e) *Effect of failure to provide timely notice.* If the M+C organization fails to provide the enrollee with timely notice