

§ 422.620

42 CFR Ch. IV (10-1-00 Edition)

later than upon expiration of an extension described in § 422.590(d)(2)).

(b) *Reversals by the independent outside entity.* If the M+C organization's determination is reversed in whole or in part by the independent outside entity, the M+C organization must authorize or provide the service under dispute as expeditiously as the enrollee's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. The M+C organization must inform the independent outside entity that the organization has effectuated the decision.

(c) *Reversals other than by the M+C organization or the independent outside entity.* If the independent review entity's expedited determination is reversed in whole or in part by the ALJ, or at a higher level of appeal, the M+C organization must authorize or provide the service under dispute as expeditiously as the enrollee's health condition requires, but no later than 60 days from the date it receives notice reversing the determination. The M+C organization must inform the independent outside entity that the organization has effectuated the decision.

[65 FR 40331, June 29, 2000]

§ 422.620 **How enrollees of M+C organizations must be notified of noncoverage of inpatient hospital care.**

(a) *Enrollee's entitlement.* Where an M+C organization has authorized coverage of the inpatient admission of an enrollee, either directly or by delegation (or the admission constitutes emergency or urgently needed care, as described in §§ 422.2 and 422.113), written notice of noncoverage under paragraph (c) of this section must be provided to each enrollee. An enrollee is entitled to coverage until at least noon the day after such notice is provided. If PRO review is requested under § 422.622, coverage is extended as provided in that section.

(b) *Physician concurrence required.* Before notice of noncoverage is provided as described in paragraph (c) of this section, the entity that makes the noncoverage/discharge determination (that is, the hospital by delegation or the M+C organization) must obtain the concurrence of the physician who is re-

sponsible for the enrollee's hospital care.

(c) *Notice to the enrollee.* In all cases in which a determination is made that inpatient hospital care is no longer necessary, no later than the day before hospital coverage ends, written notice must be provided to the enrollee that includes the following elements:

- (1) The reason why inpatient hospital care is no longer needed.
- (2) The effective date and time of the enrollee's liability for continued inpatient care.
- (3) The enrollee's appeal rights.
- (4) Additional information specified by HCFA.

[65 FR 40331, June 29, 2000]

§ 422.622 **Requesting immediate PRO review of noncoverage of inpatient hospital care.**

(a) *Enrollee's right to review or reconsideration.* (1) An enrollee who wishes to appeal a determination by an M+C organization or hospital that inpatient care is no longer necessary must request immediate PRO review of the determination in accordance with paragraph (b) of this section. An enrollee who requests immediate PRO review may remain in the hospital with no additional financial liability as specified in paragraph (c) of this section.

(2) An enrollee who fails to request immediate PRO review in accordance with the procedures in paragraph (b) of this section may request expedited reconsideration by the M+C organization as described in § 422.584, but the financial liability rules of paragraph (c) of this section do not apply.

(b) *Procedures enrollee must follow.* For the immediate PRO review process, the following rules apply:

- (1) The enrollee must submit the request for immediate review—
 - (i) To the PRO that has an agreement with the hospital under § 466.78 of this chapter;
 - (ii) In writing or by telephone; and
 - (iii) By noon of the first working day after he or she receives written notice that the M+C organization or hospital has determined that the hospital stay is no longer necessary.
- (2) On the date it receives the enrollee's request, the PRO must notify the

M+C organization that the enrollee has filed a request for immediate review.

(3) The M+C organization must supply any information that the PRO requires to conduct its review and must make it available, by phone or in writing, by the close of business of the first full working day immediately following the day the enrollee submits the request for review.

(4) In response to a request from the M+C organization, the hospital must submit medical records and other pertinent information to the PRO by close of business of the first full working day immediately following the day the organization makes its request.

(5) The PRO must solicit the views of the enrollee who requested the immediate PRO review.

(6) The PRO must make a determination and notify the enrollee, the hospital, and the M+C organization by close of business of the first working day after it receives all necessary information from the hospital, or the organization, or both.

(c) *Liability for hospital costs*—(1) *When the M+C organization determines that hospital services are not, or are no longer, covered.* (i) Except as provided in paragraph (c)(1)(ii) of this section, if the M+C organization authorized coverage of the inpatient admission directly or by delegation (or the admission constitutes emergency or urgently needed care, as described in §§ 422.2 and 422.112(c)), the organization continues to be financially responsible for the costs of the hospital stay when a timely appeal is filed under paragraph (a)(1) of this section until noon of the calendar day following the day the PRO notifies the enrollee of its review determination. If coverage of the hospital admission was never approved by the M+C organization (or the admission does not constitute emergency or urgently needed care, as described in §§ 422.2 and 422.112(c)), the M+C organization is liable for the hospital costs only if it is determined on appeal that the hospital stay should have been covered under the M+C plan.

(ii) The hospital may not charge the M+C organization (or the enrollee) if—

(A) It was the hospital (acting on behalf of the enrollee) that filed the request for immediate PRO review; and

(B) The PRO upholds the noncoverage determination made by the M+C organization.

(2) *When the hospital determines that hospital services are no longer required.* If the hospital determines that inpatient hospital services are no longer necessary, and the enrollee could not reasonably be expected to know that the services would not be covered, the hospital may not charge the enrollee for inpatient services received before noon of the calendar day following the day the PRO notifies the enrollee of its review determination.

[63 FR 35107, June 26, 1998; 63 FR 52614, Oct. 1, 1998]

Subpart N—Medicare Contract Determinations and Appeals

SOURCE: 63 FR 35113, June 26, 1998, unless otherwise noted.

§ 422.641 Contract determinations.

This subpart establishes the procedures for making and reviewing the following contract determinations:

(a) A determination that an entity is not qualified to enter into a contract with HCFA under Part C of title XVIII of the Act.

(b) A determination to terminate a contract with an M+C organization in accordance with § 422.510(a).

(c) A determination not to authorize a renewal of a contract with an M+C organization in accordance with § 422.506(b).

§ 422.644 Notice of contract determination.

(a) When HCFA makes a contract determination, it gives the M+C organization written notice.

(b) The notice specifies—

(1) The reasons for the determination; and

(2) The M+C organization's right to request reconsideration.

(c) For HCFA-initiated terminations, HCFA mails notice 90 days before the anticipated effective date of the termination. For terminations based on initial determinations described at