

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