

§ 466.88

(f) *Appeals.* The requirements and procedures for PRO review of changes as a result of DRG validation and the reconsideration, hearing and judicial review of PRO initial denial determinations are set forth in part 473 of this chapter.

[50 FR 15330, Apr. 17, 1985; 50 FR 41886, Oct. 16, 1985, as amended at 53 FR 6648, Mar. 2, 1988]

§ 466.88 Examination of the operations and records of health care facilities and practitioners.

(a) *Authorization to examine records.* A facility claiming Medicare payment must permit a PRO or its subcontractor to examine its operation and records (including information on charges) that are pertinent to health care services furnished to Medicare beneficiaries and are necessary for the PRO or its subcontractor to—

(1) Perform review functions including, but not limited to—

(i) DRG validation;

(ii) Outlier review in facilities under a prospective payment system; and

(iii) Implementation of corrective action and fraud and abuse prevention activities;

(2) Evaluate cases that have been identified as deviating from the PRO norms and criteria, or standards; and

(3) Evaluate the capability of the facility to perform quality review functions under a subcontract with the PRO.

(b) *Limitations on access to records.* A PRO has access to the records of non-Medicare patients if—

(1) The records relate to review performed under a non-Medicare PRO contract and if authorized by those patients in accordance with State law; or

(2) The PRO needs the records to perform its quality review responsibilities under the Act and receives authorization from the facility or practitioner.

(c) *Conditions of examination.* When examining a facility's operation or records the PRO must—

(1) Examine only those operations and records (including information on charges) required to fulfill the purposes of paragraph (a) of this section;

(2) Cooperate with agencies responsible for other examination functions under Federal or Federally assisted

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programs in order to minimize duplication of effort;

(3) Conduct the examinations during reasonable hours; and

(4) Maintain in its principal office written records of the results of the examination of the facility.

§ 466.90 Lack of cooperation by a health care facility or practitioner.

(a) If a health care facility or practitioner refuses to allow a PRO to enter and perform the duties and functions required under its contract with HCFA, the PRO may—

(1) Determine that the health care facility or practitioner has failed to comply with the requirements of § 474.30(c) of this chapter and report the matter to the HHS Inspector General; or

(2) Issue initial denial determinations for those claims it is unable to review, make the determination that financial liability will be assigned to the health care facility, and report the matter to the HHS Inspector General.

(b) If a PRO provides a facility with sufficient notice and a reasonable amount of time to respond to a request for information about a claim, and if the facility does not respond in a timely manner, the PRO will deny the claim.

§ 466.93 Opportunity to discuss proposed initial denial determination and changes as a result of a DRG validation.

Before a PRO reaches an initial denial determination or makes a change as a result of a DRG validation, it must—

(a) Promptly notify the provider or supplier and the patient's attending physician (or other attending health care practitioner) of the proposed determination or DRG change; and

(b) Afford an opportunity for the provider or supplier and the physician (or other attending health care practitioner) to discuss the matter with the PRO physician advisor and to explain the nature of the patient's need for health care services, including all factors which preclude treatment of the patient as an outpatient or in an alternative level of inpatient care.