

§ 422.566

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organization notified the enrollee of the disposition.

[68 FR 16667, Apr. 4, 2003, as amended at 70 FR 4738, Jan. 28, 2005]

§ 422.566 Organization determinations.

(a) *Responsibilities of the MA organization.* Each MA 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 MA 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 MA 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 MA organization with respect to any of the following:

(1) Payment for temporarily out of the area renal dialysis services, emergency services, post-stabilization care, or urgently needed services.

(2) Payment for any other health services furnished by a provider other than the MA 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 MA organization.

(3) The MA organization's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the enrollee believes should be furnished or arranged for by the MA organization.

(4) Discontinuation or reduction of a service if the enrollee believes that continuation of the services is medically necessary.

(5) Failure of the MA organization to approve, furnish, arrange for, or provide payment for health care services

in a timely manner, or to provide the enrollee with timely notice of an adverse determination, such that a delay would adversely affect the health of the enrollee.

(c) *Who can request an organization determination.* (1) Those individuals or entities who can request an organization determination are—

(i) The enrollee (including his or her authorized representative);

(ii) Any provider that furnishes, or intends to furnish, services to the enrollee; or

(iii) The legal representative of a deceased enrollee's estate.

(2) Those who can request an expedited determination are—

(i) An enrollee (including his or her authorized representative); or

(ii) A physician (regardless of whether the physician is affiliated with the MA organization).

[63 FR 35067, June 26, 1998, as amended at 65 FR 40329, June 29, 2000; 68 FR 50858, Aug. 22, 2003; 70 FR 4739, Jan. 28, 2005]

§ 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 MA 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 MA 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 MA organization's decision to deny). When the MA organization extends the timeframe, it must notify the enrollee in writing of the reasons for the delay, and inform the enrollee of the right to file an expedited grievance if he or she disagrees with the MA organization's decision to grant an extension.

(b) *Timeframe for requests for payment.* The MA organization must process requests for payment according to the

“prompt payment” provisions set forth in § 422.520.

(c) *Written notice for MA organization denials.* If an MA organization decides to deny service or payment in whole or in part, or if an enrollee disagrees with an MA organization’s decision to discontinue or reduce the level of care for an ongoing course of treatment, the organization must give the enrollee written notice of the determination.

(d) *Written notice for MA Organization denials.* If an enrollee requests an MA organization to provide an explanation of a practitioner’s denial of an item or service, in whole or in part, the MA organization must give the enrollee a written notice.

(e) *Form and content of the MA organization notice.* The notice of any denial under paragraph (d) of this section must—

(1) Use approved notice language in a readable and understandable form;

(2) State the specific reasons for the denial;

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

(4)(i) For service denials, describe both the standard and expedited reconsideration processes, including the enrollee’s right to, and conditions for, obtaining an expedited reconsideration and the rest of the appeal process; and

(ii) For payment denials, describe the standard reconsideration process and the rest of the appeal process; and

(5) Comply with any other notice requirements specified by CMS.

(f) *Effect of failure to provide timely notice.* If the MA organization fails to provide the enrollee with timely notice of an organization determination as specified in this section, this failure itself constitutes an adverse organization determination and may be appealed.

[65 FR 40329, June 29, 2000, as amended at 70 FR 4739, Jan. 28, 2005; 70 FR 52027, Sept. 1, 2005]

§ 422.570 Expediting certain organization determinations.

(a) *Request for expedited determination.* An enrollee or a physician (regardless of whether the physician is affiliated with the MA organization) may request that an MA organization expedite an organization determination involving

the issues described in § 422.566(b)(3) and (b)(4). (This does not include requests for payment of services already furnished.)

(b) *How to make a request.* (1) To ask for an expedited determination, an enrollee or a physician must submit an oral or written request directly to the MA organization or, if applicable, to the entity responsible for making the determination, as directed by the MA organization.

(2) A physician may provide oral or written support for a request for an expedited determination.

(c) *How the MA organization must process requests.* The MA organization must establish and maintain the following procedures for processing requests for expedited determinations:

(1) Establish an efficient and convenient means for individuals to submit oral or written requests. The MA organization must document all oral requests in writing and maintain the documentation in the case file.

(2) Promptly decide whether to expedite a determination, based on the following requirements:

(i) For a request made by an enrollee the MA organization must provide an expedited determination if it determines that applying the standard timeframe for making a determination could seriously jeopardize the life or health of the enrollee or the enrollee’s ability to regain maximum function.

(ii) For a request made or supported by a physician, the MA organization must provide an expedited determination if the physician indicates that applying the standard timeframe for making a determination could seriously jeopardize the life or health of the enrollee or the enrollee’s ability to regain maximum function.

(d) *Actions following denial.* If an MA organization denies a request for expedited determination, it must take the following actions:

(1) Automatically transfer a request to the standard timeframe and make the determination within the 14-day timeframe established in § 422.568 for a standard determination. The 14-day period begins with the day the MA organization receives the request for expedited determination.