

**§ 431.818**

period. These summary reports must include findings changed in the Federal re-review process.

(6) *Other data and reports.* The agency must report other requested data and reports in a manner prescribed by CMS.

**§ 431.818 Access to records: MEQC program.**

(a) The agency, upon written request, must mail to the HHS staff all records, including complete local agency eligibility case files or legible copies and all other documents pertaining to its MEQC reviews to which the State has access, including information available under part 435, subpart I, of this chapter.

(b) The agency must mail requested records within 10 working days of receipt of a request, unless the State has an alternate method of submitting these records that is approved by CMS or has received, on an as-needed basis, approval from CMS to extend this timeframe by 3 additional working days to allow for exceptional circumstances.

**§ 431.820 Corrective action under the MEQC program.**

The agency must—

(a) Take action to correct any active or negative case action errors found in the sample cases;

(b) Take administrative action to prevent or reduce the incidence of those errors; and

(c) By September 15 each year, submit to CMS a report on its error rate analysis and a corrective action plan based on that analysis. The agency must submit revisions to the plan within 60 days of identification of additional error-prone areas, other significant changes in the error rate (that is, changes that the State experiences that increase or decrease its error rate and necessitate immediate corrective action or discontinuance of corrective actions that effectively control the cause of the error rate change), or changes in planned corrective action.

**§ 431.822 Resolution of differences in State and Federal case eligibility or payment findings.**

(a) When a difference exists between State and Federal case eligibility or

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payment findings, the Regional Office will notify the agency by a difference letter.

(b) The agency must return the difference letter to the Regional Office within 28 calendar days of the date of the letter indicating either agreement with the Federal finding or reasons for disagreement and if the agency desires a conference to resolve the difference. This period may be shortened if the Regional Office finds that it is necessary to do so in order to meet a case completion deadline, and the State still has a reasonable period of time in which to respond to the letter. If the agency fails to submit the difference letter indicating its agreement or disagreement with the Federal findings within the 28 calendar days (or the shorter period designated as described above), the Federal findings will be sustained.

(c) If the Regional Office disagrees with the agency's response, a difference conference will be scheduled within 20 days of the request of the agency. If a difference cannot be resolved, the State may request a direct presentation of its position to the Regional Administrator. The Regional Administrator has final authority for resolving the difference.

**MEDICAID QUALITY CONTROL (MQC) CLAIMS PROCESSING ASSESSMENT SYSTEM**

SOURCE: Sections 431.830 through 431.836 appear at 55 FR 22170, May 31, 1990, unless otherwise noted.

**§ 431.830 Basic elements of the Medicaid quality control (MQC) claims processing assessment system.**

An agency must—

(a) Operate the MQC claims processing assessment system in accordance with the policies, sampling methodology, review procedures, reporting forms, requirements, and other instructions established by CMS.

(b) Identify deficiencies in the claims processing operations.

(c) Measure cost of deficiencies;

(d) Provide data to determine appropriate corrective action;

(e) Provide an assessment of the State's claims processing or that of its fiscal agent;