

§ 438.410

42 CFR Ch. IV (10-1-06 Edition)

§ 438.410 Expedited resolution of appeals.

(a) *General rule.* Each MCO and PIHP must establish and maintain an expedited review process for appeals, when the MCO or PIHP determines (for a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function.

(b) *Punitive action.* The MCO or PIHP must ensure that punitive action is neither taken against a provider who requests an expedited resolution or supports an enrollee's appeal.

(c) *Action following denial of a request for expedited resolution.* If the MCO or PIHP denies a request for expedited resolution of an appeal, it must—

(1) Transfer the appeal to the timeframe for standard resolution in accordance with § 438.408(b)(2);

(2) Make reasonable efforts to give the enrollee prompt oral notice of the denial, and follow up within two calendar days with a written notice.

§ 438.414 Information about the grievance system to providers and subcontractors.

The MCO or PIHP must provide the information specified at § 438.10(g)(1) about the grievance system to all providers and subcontractors at the time they enter into a contract.

§ 438.416 Recordkeeping and reporting requirements.

The State must require MCOs and PIHPs to maintain records of grievances and appeals and must review the information as part of the State quality strategy.

§ 438.420 Continuation of benefits while the MCO or PIHP appeal and the State fair hearing are pending.

(a) *Terminology.* As used in this section, "timely" filing means filing on or before the later of the following:

(1) Within ten days of the MCO or PIHP mailing the notice of action.

(2) The intended effective date of the MCO's or PIHP's proposed action.

(b) *Continuation of benefits.* The MCO or PIHP must continue the enrollee's benefits if—

(1) The enrollee or the provider files the appeal timely;

(2) The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

(3) The services were ordered by an authorized provider;

(4) The original period covered by the original authorization has not expired; and

(5) The enrollee requests extension of benefits.

(c) *Duration of continued or reinstated benefits.* If, at the enrollee's request, the MCO or PIHP continues or reinstates the enrollee's benefits while the appeal is pending, the benefits must be continued until one of following occurs:

(1) The enrollee withdraws the appeal.

(2) Ten days pass after the MCO or PIHP mails the notice, providing the resolution of the appeal against the enrollee, unless the enrollee, within the 10-day timeframe, has requested a State fair hearing with continuation of benefits until a State fair hearing decision is reached.

(3) A State fair hearing Office issues a hearing decision adverse to the enrollee.

(4) The time period or service limits of a previously authorized service has been met.

(d) *Enrollee responsibility for services furnished while the appeal is pending.* If the final resolution of the appeal is adverse to the enrollee, that is, upholds the MCO's or PIHP's action, the MCO or PIHP may recover the cost of the services furnished to the enrollee while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section, and in accordance with the policy set forth in § 431.230(b) of this chapter.

§ 438.424 Effectuation of reversed appeal resolutions.

(a) *Services not furnished while the appeal is pending.* If the MCO or PIHP, or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the

appeal was pending, the MCO or PIHP must authorize or provide the disputed services promptly, and as expeditiously as the enrollee's health condition requires.

(b) *Services furnished while the appeal is pending.* If the MCO or PIHP, or the State fair hearing officer reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, the MCO or the PIHP or the State must pay for those services, in accordance with State policy and regulations.

Subpart G [Reserved]

Subpart H—Certifications and Program Integrity

§ 438.600 Statutory basis.

This subpart is based on sections 1902(a)(4), 1902(a)(19), 1903(m), and 1932(d)(1) of the Act.

(a) Section 1902(a)(4) requires that the State plan provide for methods of administration that the Secretary finds necessary for the proper and efficient operation of the plan.

(b) Section 1902(a)(19) requires that the State plan provide the safeguards necessary to ensure that eligibility is determined and services are provided in a manner consistent with simplicity of administration and the best interests of the recipients.

(c) Section 1903(m) establishes conditions for payments to the State with respect to contracts with MCOs.

(d) Section 1932(d)(1) prohibits MCOs and PCCMs from knowingly having certain types of relationships with individuals excluded under Federal regulations from participating in specified activities, or with affiliates of those individuals.

§ 438.602 Basic rule.

As a condition for receiving payment under the Medicaid managed care program, an MCO, PCCM, PIHP, or PAHP must comply with the applicable certification, program integrity and prohibited affiliation requirements of this subpart.

§ 438.604 Data that must be certified.

(a) *Data certifications.* When State payments to an MCO or PIHP are based on data submitted by the MCO or PIHP, the State must require certification of the data as provided in § 438.606. The data that must be certified include, but are not limited to, enrollment information, encounter data, and other information required by the State and contained in contracts, proposals, and related documents.

(b) *Additional certifications.* Certification is required, as provided in § 438.606, for all documents specified by the State.

§ 438.606 Source, content, and timing of certification.

(a) *Source of certification.* For the data specified in § 438.604, the data the MCO or PIHP submits to the State must be certified by one of the following:

(1) The MCO's or PIHP's Chief Executive Officer.

(2) The MCO's or PIHP's Chief Financial Officer.

(3) An individual who has delegated authority to sign for, and who reports directly to, the MCO's or PIHP's Chief Executive Officer or Chief Financial Officer.

(b) *Content of certification.* The certification must attest, based on best knowledge, information, and belief, as follows:

(1) To the accuracy, completeness and truthfulness of the data.

(2) To the accuracy, completeness and truthfulness of the documents specified by the State.

(c) *Timing of certification.* The MCO or PIHP must submit the certification concurrently with the certified data.

§ 438.608 Program integrity requirements.

(a) *General requirement.* The MCO or PIHP must have administrative and management arrangements or procedures, including a mandatory compliance plan, that are designed to guard against fraud and abuse.

(b) *Specific requirements.* The arrangements or procedures must include the following:

(1) Written policies, procedures, and standards of conduct that articulate