

(iii) Any applicable M+C organization policy, contract provision, or rationale upon which the termination decision was based.

(iv) Facts specific to the enrollee and relevant to the coverage determination that are sufficient to advise the enrollee of the applicability of the coverage rule or policy to the enrollee's case.

(v) Any other information required by CMS.

(2) Upon an enrollee's request, the M+C organization must provide the enrollee a copy of, or access to, any documentation sent to the IRE by the M+C organization, including records of any information provided by telephone. The M+C organization may charge the enrollee a reasonable amount to cover the costs of duplicating the information for the enrollee and/or delivering the documentation to the enrollee. The M+C organization must accommodate such a request by no later than close of business of the first day after the day the material is requested.

(3) Upon notification by the IRE of a fast-track appeal, the M+C organization must supply any and all information, including a copy of the notice sent to the enrollee, that the IRE needs to decide on the appeal. The M+C organization must supply this information as soon as possible, but no later than by close of business of the day that the IRE notifies the M+C organization that an appeal has been received from the enrollee. The M+C organization must make the information available by phone (with a written record made of what is transmitted in this manner) and/or in writing, as determined by the IRE.

(4) An M+C organization is financially responsible for coverage of services as provided in paragraph (b) of this section, regardless of whether it has delegated responsibility for authorizing coverage or termination decisions to its providers.

(5) If an IRE reverses an M+C organization's termination decision, the M+C organization must provide the

enrollee with a new notice consistent with § 422.624(b).

(f) *Reconsiderations of IRE decisions.*

(1) If the IRE upholds an M+C organization's termination decision in whole or in part, the enrollee may request, no later than 60 days after notification that the IRE has upheld the decision that the IRE reconsider its original decision.

(2) The IRE must issue its reconsidered determination as expeditiously as the enrollee's health condition requires but no later than within 14 days of receipt of the enrollee's request for a reconsideration.

(3) If the IRE reaffirms its decision, in whole or in part, the enrollee may to appeal the IRE's reconsidered determination to an ALJ, the DAB, or a federal court, as provided for under this subpart.

(4) If on reconsideration the IRE determines that coverage of provider services should terminate on a given date, the enrollee is liable for the costs of continued services after that date unless the IRE's decision is reversed on appeal. If the IRE's decision is reversed on appeal, the M+C organization must reimburse the enrollee, consistent with the appealed decision, for the costs of any covered services for which the enrollee has already paid the M+C organization or provider.

PART 489—PROVIDER AGREEMENTS AND SUPPLIER APPROVAL

Part 489 is amended as set forth below:

■ 1. The authority citation for part 489 continues to read as follows:

Authority: Secs. 1102, 1819, 1861, 1864(m), 1866, and 1871 of the Social Security Act (42 U.S.C. 1302, 1395i-3, 1395x, 1395aa(m), 1395cc, and 1395hh).

■ 2. In § 489.20, paragraph (p) is revised to read as follows:

§ 489.20 Basic commitments.

The introductory text of § 489.20 is republished without change and paragraph (p) is revised to read as follows:

The provider agrees to the following:

* * * * *

(p) To comply with § 489.27 of this part concerning notification of Medicare beneficiaries of their rights associated with the termination of Medicare services.

* * * * *

■ 3. Section 489.27 is revised as follows:

§ 489.27 Beneficiary notice of discharge rights.

(a) A hospital that participates in the Medicare program must furnish each Medicare beneficiary, or an individual acting on his or her behalf, the notice of discharge rights required under section 1866(a)(1)(M) of the Act. The hospital must provide timely notice during the course of the hospital stay. For purposes of this paragraph, the course of the hospital stay begins with the provision of a package of information regarding scheduled preadmission testing and registration for a planned hospital admission. The hospital must be able to demonstrate compliance with this requirement.

(b) Notification by other providers. Other providers (as identified at § 489.2(b)) that participate in the Medicare program must furnish each Medicare beneficiary, or authorized representative, applicable CMS notices in advance of the termination of Medicare services, including the notices required under 42 CFR 422.624. These notices must be approved by the Office of Management and Budget prior to implementation under section 3506(c)(2)(A) of the Paperwork Reduction Act.

Dated: February 10, 2003.

Thomas A. Scully,
Administrator, Centers for Medicare & Medicaid Services.

Approved: February 25, 2003.

Tommy G. Thompson,
Secretary.

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