(2) Except as provided in paragraph (f)(3) of this section, the PACE organization must respond to the appeal as expeditiously as the participant's health condition requires, but no later than 72 hours after it receives the appeal.

(3) The PACE organization may extend the 72-hour timeframe by up to 14 calendar days for either of the following reasons:

(i) The participant requests the extension.

(ii) The organization justifies to the State administering agency the need for additional information and how the delay is in the interest of the participant.

(g) Determination in favor of participant. A PACE organization must furnish the disputed service as expeditiously as the participant's health condition requires if a determination is made in favor of the participant on appeal.

(h) Determination adverse to participant. For a determination that is wholly or partially adverse to a participant, at the same time the decision is made, the PACE organization must notify the following:

(1) CMS.

(2) The State administering agency.

(3) The participant.

(i) Analyzing appeals information. A PACE organization must maintain, aggregate, and analyze information on appeal proceedings and use this information in the organization's internal quality assessment and performance improvement program.

[64 FR 66279, Nov. 24, 1999, as amended at 71 FR 71336, Dec. 8, 2006]

§ 460.134 Additional appeal rights under Medicare or Medicaid.

A PACE organization must inform a participant in writing of his or her appeal rights under Medicare or Medicaid managed care, or both, assist the participant in choosing which to pursue if both are applicable, and forward the appeal to the appropriate external entity.