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42 C.F.R. § 457.1260

Grievance system.

(a) *Statutory basis and definitions*—(1) *Statutory basis.* This section implements section 2103(f)(3) of the Act, which provides that the State CHIP must provide for the application of section 1932(a)(4), (a)(5), (b), (c), (d), and (e) of the Act (relating to requirements for managed care) to coverage, State agencies, enrollment brokers, managed care entities, and managed care organizations. Section 1932(b)(4) of the Act requires managed care plans to establish an internal grievance procedure under which an enrollee, or a provider on behalf of such an enrollee, may challenge the denial of coverage of or payment for covered benefits.

(2) *Definitions.* The following definitions from § 438.400(b) of this chapter apply to this section—

(i) Paragraphs (1) through (5) and (7) of the definition of "adverse benefit determination"; and

(ii) The definitions of "appeal", "grievance", and "grievance and appeal system".

(b) *General requirements.* (1) The State must ensure that its contracted MCOs, PIHPs, and PAHPs comply with the provisions of § 438.402(a), (b), and (c)(2) and (3) of this chapter with regard to the establishment and operation of a grievances and appeals system.

(2) An enrollee may file a grievance and request an appeal with the MCO, PIHP, or PAHP. An enrollee may request a State external review in accordance with the terms of subpart K of this part after receiving notice under paragraph (e) of this section that the adverse benefit decision is upheld by the MCO, PIHP, or PAHP.