Addendum to the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance for Applicable Integrated Plans

Updated August 2022

10.a – Introduction

This Addendum to the Part C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance (Part C & D Guidance)[1] provides guidance on the integrated grievances and appeals provisions set forth at 42 CFR §§ 422.629-634, which apply to applicable integrated plans as defined in 42 CFR 422.561, covering Medicare Part C and Medicaid benefits through the integrated grievances, integrated organization determinations, and integrated reconsiderations process. Important notes about this Addendum:

- Except as noted in this Addendum, all guidance in the Part C & D Guidance applies to applicable integrated plans.
    - Where the Part C & D Guidance refers to an MA plan or plan, it also applies to applicable integrated plans;
    - Where the Part C & D Guidance refers to an organization determination, initial determination, or coverage request, it also applies to integrated organization determinations; and
    - Where the Part C & D Guidance refers to a reconsideration or Level 1 Appeal, it also applies to integrated reconsiderations and integrated appeals.
    - Where the guidance applies to Part C, it also applies to all integrated reconsiderations, including those related to Medicaid coverage.
- This guidance Addendum does not apply to or address Medicare Part D procedures. Applicable integrated plans must follow all Part D requirements in 42 CFR Part 423, including the appeal requirements for Part D benefits.
- This Addendum contains an additional section not included in the Part C & D Guidance, Section 50.13, which provides guidance to applicable integrated plans on continuing benefits while an integrated appeal is pending. Section 50.13 applies to all integrated appeals in accordance with 42 CFR § 422.632.
- Pursuant to 42 CFR § 422.629(c), a State may, at its discretion, implement standards for timeframes or notice requirements that are more protective for the enrollee than required by the Addendum and the regulations for applicable integrated plans at 42 CFR §§ 422.630 through 422.634. For example, a state may require applicable integrated plans to issue integrated reconsideration determinations faster than the requirements at 42 CFR § 422.633. The applicable integrated plan's contract with the state under 42 CFR § 422.107 must include any standards that differ.
- Organization of this Addendum:
    - Section numbers in this Addendum correspond to section numbers in the Part C & D Guidance.

[1] The Part C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance can be found here: https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Parts-C-and-D-Enrollee-Grievances-Organization-Coverage-Determinations-and-Appeals-Guidance.pdf

- Guidance included in this Addendum supplements the Part C & D Guidance by noting, in corresponding sections, where requirements for applicable integrated plans differ from requirements from other MA plans due to differences in governing regulations, or by clarifying a requirement or process.
- Significant operational differences in processes compared to the Part C & D guidance are noted by an asterisk (*) throughout the Addendum.

10.1.a – Glossary

In this Addendum, the following terminology is used to substitute for analogous Medicare Part C terms:

Part C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance Terminology	**Addendum Terminology**
Medicare Advantage (MA) plan, Medicare Advantage Organization (MAO), Medicare cost plan or health care prepayment plan (HCCP)	Applicable Integrated Plan
Request for Organization Determination or Initial Determination	Request for Integrated Organization Determination
Organization Determination or Initial Determination	Integrated Organization Determination, or Level 1 Appeal
Reconsideration	Integrated Reconsideration or Integrated Appeal

Definitions in the Part C & D Guidance apply to applicable integrated plans, except for the following definitions that are modified, as indicated below, for applicable integrated plans. As used in the Part C & D Guidance and in this Addendum, the following terms should be read as follows in connection with applicable integrated plans:

Integrated Appeal: The procedures that deal with, or result from, adverse integrated organization determinations by an applicable integrated plan on the benefits both under Part C and under state Medicaid rules the enrollee believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the enrollee), or on any amounts the enrollee must pay for a service. See 42 CFR § 422.561. Integrated appeals do not include appeals related to Part D benefits.

Integrated appeals cover procedures that would otherwise be defined and covered, for non-applicable integrated plans, as an appeal defined in §422.561 or the procedures required for appeals in accordance with §§438.400 through 438.424 of this chapter. Such procedures include integrated reconsiderations. Subject to the guidance in this Addendum,

wherever the Part C & D Guidance refers to an "Appeal," the statements and guidance apply equally to integrated appeals for applicable integrated plans.

Dismissal: Dismissal includes a decision not to review a request for an integrated grievance, integrated appeal, or integrated organization determination because it is considered invalid or does not otherwise meet the requirements for a request for integrated grievance, integrated appeal, or integrated organization determination. Subject to the guidance in this Addendum (see, for example, Section 20.2.a and Section 50.9.1.a), wherever the Part C & D Guidance refers to a "Dismissal," the statements and guidance apply equally to integrated grievances, integrated appeals, and integrated organization determinations for applicable integrated plans.

Integrated Grievance: A dispute or complaint that would be defined and covered, for grievances filed by an enrollee in non-applicable integrated plans, under § 422.564 or §§ 438.400 through 438.416 of this chapter. Integrated grievances do not include appeals procedures and QIO complaints, as described in § 422.564(b) and (c). An integrated grievance made by an enrollee in an applicable integrated plan is subject to the integrated grievance procedures in §§ 422.629 and 422.630. Integrated grievances do not include grievances related to Part D benefits. Subject to the guidance in this Addendum, wherever the Part C & D Guidance refers to a "Grievance," the statements and guidance apply equally to integrated grievances for applicable integrated plans.

Integrated Reconsideration: A reconsideration that would otherwise be defined and covered, for a non-applicable integrated plan, as a reconsideration under § 422.580 and appeal under § 438.400(b) of this chapter. An integrated reconsideration is made by an applicable integrated plan and is subject to the integrated reconsideration procedures in §§ 422.629 and 422.632 through 422.634. Integrated reconsiderations do not include redeterminations related to Part D benefits. Subject to the guidance in this Addendum, wherever the Part C & D Guidance refers to a "Reconsideration," the statements and guidance apply equally to integrated reconsiderations for applicable integrated plans.

10.4.a – General Responsibilities of the Plan

The guidance in all subsections of Section 10.4 applies, in addition to the following requirements for applicable integrated plans:

(1) Provide the enrollee a reasonable opportunity to present, in person and in writing, evidence and testimony and make legal and factual arguments for integrated grievances, and integrated reconsiderations. The applicable integrated plan must inform the enrollee of the limited time available for presenting evidence sufficiently in advance of the resolution timeframe for integrated appeals as specified in this section if the case is being considered under an expedited timeframe for the integrated grievance or integrated reconsideration. See 42 C.F.R. § 422.629(d). The applicable integrated plan must also provide the enrollee information on how evidence and testimony should be presented.

(2) Provide an enrollee reasonable assistance in completing forms and taking other procedural steps related to integrated grievances and integrated appeals (note that this requirement is in addition to the requirements related to assisting enrollees in §422.562(a)(5)). See 42 C.F.R. § 422.629(e).

(3) Send to the enrollee written acknowledgement of integrated grievances and integrated reconsiderations upon receiving the request. See 42 C.F.R. § 422.629(g). Applicable integrated plans must comply with additional or revised timeframes for sending the acknowledgment, as specified in the state Medicaid contracts if the revised or additional timeframe is more protective of the enrollee

(4) Ensure that no punitive action is taken against a provider that requests an integrated organization determination or integrated reconsideration, or supports an enrollee's request for these actions. See 42 C.F.R. § 422.629(i).

(5) Ensure that individuals making decisions on integrated appeals and grievances take into account all comments, documents, records, and other information submitted by the enrollee or their representative without regard to whether such information was submitted or considered in the initial adverse integrated organization determination. See 42 C.F.R. § 422.629(k)(1).

(6) The applicable integrated plan must maintain records of integrated grievances and integrated appeals. Each applicable integrated plan that is a Medicaid managed care organization must review the Medicaid-related information as part of its ongoing monitoring procedures, as well as for updates and revisions to the State quality strategy. The record of each integrated grievance or integrated appeal must contain, at a minimum:

   i. A general description of the reason for the integrated appeal or integrated grievance.
   ii. The date of receipt.
   iii. The date of each review or, if applicable, review meeting.
   iv. Resolution at each level of the integrated appeal or integrated grievance, if applicable.
   v. Date of resolution at each level, if applicable.
   vi. Name of the enrollee for whom the integrated appeal or integrated grievance was filed.
   vii. Date the applicable integrated plan notified the enrollee of the resolution.

   See 42 C.F.R. § 422.629(h).

10.5.3.a – When Notification is Considered Delivered by the Plan

The guidance in Section 10.5.3 applies, except that applicable integrated plans must give written notice within *2* calendar days, after providing prompt oral notice, in the following

circumstances:

(1) The applicable integrated plan extends the timeframe for resolving a grievance (per 42 CFR § 422.631(e)(2)(ii)). See also Section 30.2.1.a– Notification Requirements for Integrated Grievance, below.

(2) The applicable integrated plan denies the enrollee's request to expedite an integrated reconsideration (per 42 CFR § 422.633(e)(4)). See also Section 50.2.2.a – How to Process Requests for Expedited Level 1 Integrated Appeals, below.

(3) The applicable integrated plan extends the timeframe for resolving an integrated reconsideration (per 42 CFR § 422.633(f)(3)(ii). See also Section 50.10.1.a- Part C Notification Requirements, below.

10.6.a – Outreach for Additional Information to Support Coverage Decisions

The guidance in Section 10.6 applies, except that the regulatory references for applicable integrated plans are different:

(1) For the content of the written denial notices: 42 CFR § 422.631(d) (for integrated organization determination notices) and § 422.633(f)) (for integrated reconsiderations).

(2) For the timing for requests to providers for additional information to make an expedited decision: 42 CFR § 422.631(d)(2)(iv)(C) (expedited integrated organization determinations) and § 422.633(e)(5) (for expedited integrated reconsiderations).

20.2.a – Appointment of Representative (AOR) Form or Equivalent Written Notice

The guidance in Section 20.2 applies to applicable integrated plans, except that for cases involving only a Medicaid-covered benefit, an applicable integrated plan may accept a written authorization from an enrollee that complies with state Medicaid requirements, even if such an authorization does not contain every element described under Section 20.2.

30.a – Integrated Grievances

The guidance in Section 30 applies to integrated grievances, except that:

(1) The regulatory references for the requirements for integrated grievances are 42 CFR §§ 422.629 and 422.630, for applicable integrated plans.

(2) Individuals making decisions on integrated grievances must be individuals who:

a. Were neither involved in any previous level of review or decision-making nor a subordinate of any such individual; and
b. If deciding any of the following, have the appropriate clinical expertise, including as defined by the state, in treating the enrollee's condition or disease:
    i. An integrated grievance regarding denial of expedited resolution of an integrated appeal.
    ii. An integrated grievance that involves clinical issues.

30.1.a– Classification between Integrated Grievances, Inquiries, Coverage Requests, and Integrated Appeals

The guidance in Section 30.1 applies to applicable integrated plans and the distinctions between integrated grievances and integrated appeals.
In addition to the examples listed in Section 30.1, additional examples of inquiries, integrated grievances, coverage requests, and integrated appeals relevant for applicable integrated plans include:

- Integrated grievances may include expressing dissatisfaction with the service of a personal care aide.
- Requests for an integrated organization determination (Coverage Requests) may include an enrollee stating that they would like additional service hours from a personal care aide.

30.1.1.a – Inquiries Related to Non-Part D and Excluded Drugs (Part D Only)

The guidance in Section 30.1.1 applies, with the following additional guidance for applicable integrated plans:
* When a Part D plan sponsor receives an inquiry (that is, a question that is not a request for a coverage determination) about a drug that is not a covered Part D drug or is an excluded drug, an applicable integrated plan should also check if the drug is covered by the enrollee's Medicaid benefit. If the drug is not a Part D drug or is an excluded drug and not covered by Medicaid, the plan should explain to the requestor the information listed in the bullet points of Section 30.1.1, as well as provide any additional information appropriate under state Medicaid policy. If the drug is not a Part D drug or is an excluded drug but is covered by Medicaid, the applicable integrated plans should explain the limits of Part D coverage and: 1) furnish the Medicaid benefit if covered by its Medicaid contract with the State; or 2) assist the enrollee in obtaining Medicaid coverage for the drug if the applicable integrated plan does not cover the Medicaid-covered drug (for example, if Medicaid drugs are carved out of the applicable integrated plan's benefit package). Applicable integrated plans can refer to 42 CFR 422.562(a)(5) for examples of assistance that it may provide.

30.2.a– Procedures for Handling an Integrated Grievance

* The guidance in Section 30.2 applies for processing an integrated grievance, except that an enrollee can file an integrated grievance *at any time*. In addition, the regulatory reference for integrated grievances for applicable integrated plans is at 42 CFR § 422.630(b).

30.2.1.a– Notification Requirements for Integrated Grievance

* The guidance in Section 30.2.1 applies for notification requirements for integrated grievances, except that where an applicable integrated plan extends the timeframe for resolving a grievance, while it may initially provide verbal notification of its decision it must send written confirmation of its decision within *2* calendar days of the verbal notification in accordance with 42 CFR § 422.630(e)(2)(ii).

30.3.1.a– Procedures for Handling a Quality of Care Integrated Grievance

The guidance in Section 30.3.1.1 applies except:

(1) * Integrated grievances may be filed at any time per 42 CFR § 422.630(b).

(2) * The regulatory reference for the 30-day timeframe for responding to a grievance and the authority for applicable integrated plans to extend the timeframe for responding to a grievance by an additional 14 days is at 42 CFR §§ 422.630(e).

(3) The regulatory reference for the requirement to cooperate with the Quality Improvement Organization (QIO) is at 42 CFR § 422.*630*(e)(1)(iii).

Applicable integrated plans that are D-SNPs must comply with 42 CFR §§ 422.562(a)(2)(ii) and (c) and 422.620 through 422.626 regarding QIO and Independent Review Entity (IRE) reviews of terminations of services furnished by providers of services and hospital discharges. For Medicaid-covered benefits, applicable integrated plans must also comply with any state Medicaid quality of care requirements.

40.1.a – Part C Integrated Organization Determinations

For applicable integrated plans, the guidance in Section 40.1 applies to integrated organization determinations, which include both Medicaid and Medicare Part C benefits. See definition of integrated organization determination at 42 CFR § 422.561.

40.6.a– Who May Request an Initial Determination.

The guidance in Section 40.6 applies with the following additional guidance for applicable integrated plans:

(1) Where an enrollee can make a request involving Medicare Part C, the enrollee may also make a request involving Medicaid coverage.
(2) The regulation controlling who is a party to an integrated appeal and who may request an integrated organization determination and integrated reconsideration is 42 CFR § 422.629(l).

40.8.a– How to Process Requests for Expedited Initial Determinations

The guidance in Section 40.8 applies with the following additional guidance for applicable integrated plans:

(1) Applicable integrated plans must use the same processes for Medicaid-related requests as used for Medicare-related requests. See 42 CFR § 438.402(a).
(2) * Payment requests are not treated differently than non-payment requests for expedited integrated determinations.
    a. Applicable integrated plans should apply the same process to assess a request to expedite a payment request as they do to assess requests to expedite non-payment cases. The standard for deciding whether to expedite a payment request is the same as for non-payment cases (e.g. the standard timeframe could seriously jeopardize the life or health or the enrollee, or their ability to regain maximum function, in accordance with 42 CFR 422.631(c)).[2] Decisions in payment cases:
        i. Must be provided as expeditiously as the enrollee's health condition requires, but no later than 72 hours from the date of the request, in accordance with 422.631(d)(2)(iv) (following the same timelines as are required for items and services in Section 40.8) unless an extension is taken.
        ii. May include an extension (in standard and expedited payment cases) that meet the criteria specified in 422.631(d)(2)(ii)).
    b. Note: providing notice of the decision does not mean the payment must be made to the enrollee within that timeframe; in accordance with 422.634(d), the payment must be authorized *or* provided within 72 hours, and thus authorizing the payment in the applicable integrated plan's system is sufficient action within 72 hours.
(3) In addition to the enrollee and the enrollee's representative, a physician or other provider on behalf of the enrollee may make the request for an expedited integrated determination. This information supplements the table with column headers "Who May Request an Expedited Determination" and "Plan Requirements," with respect to who may request an expedited integrated determination. See 42 CFR §§ 422.629(l)(2) and 422.631(c)(1).

[2] See 83 FR 54982 (November 1, 2018), page 55011, for a discussion of this policy, and the policy related to payment cases generally.

(4) * Instead of the information in the section titled "*Extension of Timeframe for Items and Services*" the applicable integrated plan may only extend the 72-hour timeframe for providing an expedited integrated organization determination for covered benefits by up to 14 additional days under the conditions listed in 42 CFR § 422.631(c)(2)(iii), specifically:

- The enrollee or provider requests the extension; or
- The applicable integrated plan can show that the extension is in the enrollee's interest; and
- There is a need for additional information and there is a reasonable likelihood that receipt of such information would lead to approval of the request, if received.

(5) With respect to the guidance for obtaining information from non-contract providers (at the end of the Part C guidance in Section 40.8), if an applicable integrated plan needs information from a non-contract provider it should follow the same procedures as indicated in Section 40.8. However, the plan should refer to the regulatory requirements at 42 CFR § 422.631(d)(2)(iv)(C) rather than the requirements at § 422.572 for additional details.

40.9.a – Who Must Review an Initial Determination

The guidance in Section 40.9 applies with the following additional guidance for applicable integrated plans:

(1) An appropriate healthcare professional reviewing a partially or fully adverse decision based on medical necessity must have knowledge of the Medicare and Medicaid coverage criteria (in addition to sufficient medical and other expertise, and a current and unrestricted license to practice within the scope of his or her profession).

(2) For integrated organization determinations:

a. If the applicable integrated plan expects to issue a partially or fully adverse medical necessity (or any substantively equivalent term used to describe the concept of medical necessity) decision based on the initial review of the request, the integrated organization determination must be reviewed by a physician or other appropriate health care professional with sufficient medical and other expertise, including knowledge of Medicare and Medicaid coverage criteria, before the applicable integrated plan issues the integrated organization determination.

b. Any physician or other health care professional who reviews an integrated organization determination must have a current and unrestricted license to practice within the scope of his or her profession.

40.12.1.a– Medicaid and Medicare Part C Notification Requirements

The guidance in Section 40.12 applies to applicable integrated plans, except where it is superseded by guidance detailed below.

(1) With respect to the guidance in the section titled "Denials and Discontinuation/Reduction of Previously Authorized Ongoing Course of Treatment," for applicable integrated plans:

- For integrated organization determination denials, applicable integrated plans must use the approved integrated denial notice, rather than the standard Integrated Denial Notice when issuing written denial notices to enrollees. The standardized integrated denial notice for applicable integrated plans is the Applicable Integrated Plan Coverage Decision Letter (Form CMS-10716), also known as the Coverage Decision Letter.

- Timing of sending the Coverage Decision Letter:

  - * In cases where the Applicable Integrated Plan is reducing, suspending or terminating a previously approved service (except in circumstances where an exception is permitted under §§431.213 and 431.214), the plan must send the notice least 10 days before the date of action (that is, before the date on which a termination, suspension, or reduction becomes effective), consistent with 42 CFR § 422.631(d)(2)(i)(A);

  - The Applicable Integrated Plan must send the Coverage Decision Letter in all other cases within the timeframes specified in Section 40.10.

(2) * Special instructions for payment denials: For cases involving payment denials where there is no member liability, applicable integrated plans must send the enrollee a notice of the denial. The notice does not have to be the OMB approved Coverage Decision Letter; it could instead be an Explanation of Benefits (EOB) or other notice. The notice should include that there is no member liability.

(3) * With respect to the guidance in the section titled "Enrollee and Non-contract Provider Payment Requests," because state Medicaid policies differ regarding direct reimbursement of enrollees, applicable integrated plans should consult state policy as noted in this table (guidance for applicable integrated plans is added in italics):

Requestor	Payment Approval	Payment Denial
Enrollee or Representative	Receives payment, *in alignment with state policy where applicable for Medicaid benefits,* and EOB.	• The enrollee or representative receives an IDN or an EOB. • Document must include notice of integrated appeal rights.

(4) With respect to the guidance in the section titled "Denial of a Request for an Expedited Integrated Organization Determination," applicable integrated plans' notice of the denial of a request for an expedited integrated organization determination must comply with the requirements listed in Section 40.12.1 except that the plan should use a specialized integrated notice for notifying the enrollee of the denial. Plans are encouraged to use the model notice, Letter about Your Right to Make a Fast Complaint available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/D-SNPs.

50.1.a– Who May Request a Level 1 Integrated Appeal

The guidance in Section 50.1 applies to applicable integrated plans except that:

1. The Part C table with column headings "Type of Request" and "Who May Request an Appeal" does not apply to applicable integrated plans and the following guidance applies instead:

Type of Request	Who May Request An Appeal
Standard or Expedited Reconsideration for a pre-service or previously approved service or item	• An enrollee (42 CFR § 422.629(l)(1)(i)); • An enrollee's representative (42 CFR § 422.629(l)(1)(i)); • A provider who is providing treatment to the enrollee may file an appeal on behalf of the enrollee.+ The provider must give the enrollee notice of filing the appeal. (42 CFR § 422.629(l)(1)(ii), and (l)(3)) ○ Note: If the provider requests that the enrollee continue to receive the previously approved service or item while the appeal is pending, see the additional information below.
Standard or Expedited Payment Reconsideration	• An enrollee (42 CFR § 422.629(l)(1)(i)); • An enrollee's representative (42 CFR § 422.629(l)(1)(i)); • The legal representative of a deceased enrollee's estate (42 CFR § 422.629(l)(1)(iii)); or • Non-contract provider (i.e. an assignee of the enrollee, that is, a physician or other provider who has furnished or intends to furnish a service to the enrollee and formally agrees to waive any right to payment from the enrollee for that service. See Section 50.1.1 for more detail on waiving the right to payment). *A provider may file a standard integrated reconsideration on behalf of the enrollee but may not file an expedited integrated reconsideration related to a payment request on behalf of the enrollee (42 CFR § 422.629(l) and 422.633(e)(1)(ii))*; • Any other provider or entity (other than the applicable integrated plan) determined to have an appealable interest in the proceeding (42 CFR § 422.629(l)(1)(i)).

[+]If the enrollee's records indicate that he or she has not previously visited the requesting provider, the applicable integrated plan should undertake reasonable efforts to confirm that the enrollee has received appropriate notification of the appeal.

2. If an individual is acting as a representative of the enrollee, the OMB-approved Form CMS-1696, Appointment of Representative (AOR), or another form that meets state and Medicare requirements, is acceptable. As noted in Section 20.2.a, for a case involving only a Medicaid-covered benefit, an applicable integrated plan may accept a written authorization from an enrollee that complies with state Medicaid requirements.

3. If the provider requests that the benefits continue while the integrated appeal is pending, pursuant to 42 CFR § 422.632 and consistent with State law, the provider must obtain the written consent of the enrollee to request the integrated appeal on behalf of the enrollee.

    a. If the provider does not provide the enrollee's written consent to continue benefits at the time that the request is made but the appeal is otherwise valid, the applicable integrated plan should begin processing the appeal.

    b. The consent must state that the enrollee has given the provider permission to request that the service or item continue while the appeal is pending. However, the applicable integrated plan should not provide continuation of benefits unless it receives the enrollee's written consent (delivered either via the provider or directly from the enrollee or their authorized representative requesting continuation of benefits).

    c. Such a request must be received within the timeframes specified in 42 CFR § 422.632(c) (or within the timeframe specified in the applicable integrated plan's contract with the state).

See section 50.13 for more information on continuing benefits during the appeal.

50.2.1.a– Guidelines for Accepting Level 1 Integrated Appeal Requests

The guidance in Section 50.2.1 applies to applicable integrated plans, except:

1) * Applicable integrated plans must accept integrated appeals filed orally (in both standard and expedited cases). Note, although non-contracted providers may also file an appeal orally, they must provide additional written documentation such as a waiver of liability in order for the appeal to go forward (see 42 CFR § 422.629(l)(1)(ii)).
2) The regulation that controls integrated reconsiderations is 42 CFR § 422.633 instead of §§ 422.578 through 422.582.
3) * An applicable integrated plan must extend the 60-day timeframe for the filing of a request for integrated reconsideration when party filing the request shows good cause for an extension. The request for integrated reconsideration and to extend the timeframe must—

a. be in writing; and

b. state why the request for integrated reconsideration was not filed on time.

c. See Section 50.3 for more details on exceptions for late filing, including examples of acceptable good cause.

4) * Upon request, the applicable integrated plan must also provide the enrollee and his or her representative the enrollee's case file (including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated in connection with the integrated appeal of the integrated organization determination), free of charge and in advance of making the integrated reconsideration decision. 42 CFR § 422.633(c).

5) In addition, if the State has established an external medical review process, the requirements of § 438.402(c)(1)(i)(B) apply to each applicable integrated plan that is a Medicaid managed care organization. See 42 CFR 422.633(b).

50.2.2.a – How to Process Requests for Expedited Level 1 Integrated Appeals

The guidance in Section 50.2.2 applies to applicable integrated plans. The following additional provisions also apply to applicable integrated plans:

1) In the table with column headings "Who May Request an Expedited Level 1 Integrated Appeal" and "Plan Requirements," physicians and providers or appropriate health care professionals may make requests for integrated reconsiderations.

2) With respect to the section titled "Action Following Acceptance of a Request for Expedited Level 1 Integrated Appeal," in the Part C table with column headings titled "Reconsideration Decisions" and "Processing Requirements for Expedited Reconsiderations" applicable integrated plans must:

   - In addition to ensuring that the person or persons conducting the integrated reconsideration were not involved in the integrated organization determination, where the issue is the denial of coverage based on a lack of medical necessity the integrated reconsideration must be made by a physician or other appropriate health care professional with expertise in the enrollee's condition or disease and knowledge of Medicare and Medicaid coverage criteria, before the applicable integrated plan issues the integrated reconsideration determination. (As in the Part C & D Guidance, the physician need not be of the same specialty or subspecialty as a treating physician.)
   - * In contrast to the instructions to MA plans (which do not require MA plans to send notification of adverse decisions to enrollees), applicable integrated plans must send an Appeal Decision notice in *all* cases including in cases where the applicable integrated plan's decision is partially favorable or adverse to the enrollee. In accordance with the requirements in 42 CFR 422.633(f)(4), this

notice must inform enrollees of their relevant appeal rights under Medicaid, including steps to take and how to obtain assistance.

- Enrollees will also receive notification from the IRE if the case is auto forwarded to the IRE (i.e. in cases where an integrated appeal involving Medicare coverage issues is not decided in the enrollee's favor).
- Applicable integrated plans may choose to use the model Appeal Decision Letter, available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/D-SNPs to inform parties when a case has been forwarded to the IRE, or may develop its own notice that complies with the requirements of 422.633(f)(4).

3) In the section titled "Extension of Timeframe for Items and Services" the second and third bullets in the list are replaced to conform with 42 CFR § 422.633(f)(3) as follows:

* The applicable integrated plan may only extend the 72-hour timeframe by up to 14 additional days if:

- The enrollee requests the extension; or
- The extension is justified and in the enrollee's interest; *and there is need for additional information and there is a reasonable likelihood that receipt of such information would lead to approval of the request, if received.*

4) In the section titled "Action Following Denial of a Request for an Expedited Level 1 Appeal":

- * If an applicable integrated plan denies a request to expedite a Level 1 Integrated Reconsideration it must send a written notice of enrollee's rights within *2* calendar days of the verbal notice of the denial to expedite the request, consistent with 42 CFR § 422.633(e)(4). As with other notice requirements, an applicable integrated plan may initially provide verbal notification of its decision to the enrollee but it must then deliver written confirmation of its decision within 2 calendar of the verbal notification in accordance with 42 CFR § 422.633(e)(4).
- In providing notice of the denial of a request for an expedited level 1 integrated appeal, applicable integrated plans must follow the Part C guidance but are encouraged to use the Letter about Your Right to Make a Fast Complaint available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/D-SNPs. Applicable integrated plans should not use the Notice of Right to an Expedited Grievance for Part C.

50.5.2.a–Enrollee Request for Case File Content

The guidance in Section 50.5.2 applies to applicable integrated plans except that the applicable integrated plan may not charge the enrollee for copying and mailing the case file, consistent with 42 CFR § 422.633(c). The case file should include medical records,

other documents and records, and any new or additional evidence considered, relied upon, or generated by the applicable integrated plan (or at the direction of the applicable integrated plan) in connection with the appeal of the integrated organization determination.

50.6.a– Who Must Conduct a Level 1 Integrated Appeal

The guidance in Section 50.6 applies to applicable integrated plans except that individuals making an integrated reconsideration determination must be individuals who:

1) Were neither involved in any previous level of review or decision-making nor a subordinate of any such individual; and
2) If the applicable integrated plan is deciding an integrated appeal of a denial that is based on lack of medical necessity (or any substantively equivalent term used to describe the concept of medical necessity), is a physician or other appropriate health care professional who has the appropriate clinical expertise, including any state-specific definition of "clinical expertise", in treating the enrollee's condition or disease, and knowledge of Medicare and Medicaid coverage criteria, before the applicable integrated plan issues the integrated reconsideration decision. As for MA plans, this does not require the physician to always have the same specialty training as the treating physician. For example, where there are few practitioners in a highly specialized field of medicine, a plan may not be able to hire a physician of the same specialty or sub-specialty to review adverse initial determinations.

50.7.1.a– Processing Timeframes

The guidance in Section 50.7.1 applies except as follows:

1) In the Parts C & D Level 1 Appeal Adjudication Timeframes table, for the "Type" columns with the headings "Type," "Part C," and "Part C with Extension," for standard integrated reconsiderations, payment cases must be adjudicated within *30* days, consistent with 42 CFR § 422.633(f)(1). This means that, with an extension, applicable integrated plans have a maximum of 44 days to adjudicate the case.
2) In the Parts C & D Level 1 Appeal Adjudication Timeframes table, for the "Type" columns with the headings "Type," "Part C," and "Part C with Extension," for expedited integrated reconsiderations, including post-service payment requests, must be adjudicated within *72 hours* days, consistent with 42 CFR § 422.633(f)(2) and (3). This means that, with an extension, applicable integrated plans have a maximum of 17 days to adjudicate the case. In the section titled "Extension of Timeframe," for standard pre-service and expedited integrated reconsiderations for items and services, including post-service payment requests (involving Medicare and Medicaid-covered services), consistent with 42 CFR § 422.633(f)(3), the applicable integrated plan may extend the timeframe by up to 14 calendar days only if:

- The extension is requested by the enrollee; or
- The extension is justified and in the enrollee's interest and there is a reasonable likelihood that receipt of such information would lead to approval of the request.

50.7.2.a – Effect of Failure to Meet the Timeframe for Level 1 Integrated Appeals

The guidance in Section 50.7.2 applies to applicable integrated plans except that:

1) If the plan fails to provide the enrollee a level 1 integrated appeal decision the timeframes specified (in 42 CFR § 422.633(f)), the applicable integrated plan must send a notice to the enrollee which explains:
    - The next level of both the Medicaid and Medicare appeals process,
    - The steps the enrollee needs to take to make the next level appeal under each program. This includes that, for Medicare appeals, the enrollee will not need to take any action because the applicable integrated plan will auto forward the case to the IRE, and for Medicaid cases the enrollee may choose to file for a state fair hearing or, if applicable, a Medicaid external medical review (see 42 CFR § 438.402(c)(1)(i)(B)),
    - Provide information on how the enrollee can obtain assistance in pursuing the next level of appeal under each program, and,
    - For Medicaid-covered benefits, explain that the enrollee can have the benefits continue while the appeal is pending, if applicable, and how the enrollee should make such a request (see 422.633(f)(4)(ii)(B) and 42 CFR § 438.420(c)).

    Applicable integrated plans may choose to use the model Appeal Decision Letter available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/D-SNPs.

* The text box in Section 50.7.2 that provides guidance that Part C plans are not required to send a notice to enrollees upon forwarding a case to the Part C IRE does <u>not apply to applicable integrated plans</u>. Applicable integrated plans must send the enrollee notice of all integrated reconsideration decisions.

- The contents of the notice must comply with the requirements in 42 CFR § 422.633(f)(4), including providing relevant information on the next level of appeal rights for both Medicare and Medicaid.
    - If the case involves a Medicare-covered benefit the notice must include that the applicable integrated plan has forwarded the case to the IRE;
    - If it is a Medicaid-covered benefit the notice must include information on the steps the enrollee must take to continue the Medicaid-benefit appeal with a State fair hearing;

- For cases involving a benefit that may be covered by both Medicare and Medicaid, the case should be forwarded to the IRE and the enrollee should also be informed of Medicaid appeal rights. The applicable integrated plan should identify, where appropriate, whether the benefit(s) at issue are covered by Medicare or Medicaid or potentially both.

- Applicable integrated plans may use the model Appeal Decision Letter for this notification, which provides model language for cases involving different types of services. The model is available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/D-SNPs.

50.9.1.a- Dismissals (Part C and Medicaid only)

The guidance in Section 50.9 applies to applicable integrated plans, however:

1) In evaluating whether to dismiss an integrated reconsideration, in cases involving only a Medicaid-covered benefit where an individual requests an integrated reconsideration on behalf of an enrollee applicable integrated plans must comply with both state (Medicaid) and Medicare requirements, as described in Section 20.2.a above, i. For Medicare requirements, see Section 20.2.
2) Under the section titled "Notice for Dismissal of a Reconsideration," the written notice of the dismissal must also include information on the member's Medicaid rights, if the case involves Medicaid benefits. In such cases, applicable integrated plans using the model Notice of Dismissal of Appeal Request referenced in Section 50.9 should add any relevant state-specific Medicaid information to the Notice.

50.10.1.a- Part C Notification Requirements

The guidance in Section 50.10.1 applies to applicable integrated plans except that, in the section titled "Partially Favorable, Adverse, or Untimely Decisions," when applicable integrated plans send case files to the IRE they must adhere to the following additional notice requirements::

1) In contrast to the guidance and regulation to MA plans (which does not require MA plans to send notification of adverse decisions to enrollees when the matter is forwarded to the IRE), applicable integrated plans must send an Appeal Decision notice in all cases, including in cases where the applicable integrated plan's decision is partially favorable or adverse to the enrollee and, if the matter is about a Medicare benefit, the file will be forwarded to the IRE for review. In accordance with the requirements in 42 CFR 422.633(f)(4), this notice must:
    - Be written in plain language and available in a language and format that is

accessible to the enrollee.

i. Translating the notice, providing it in a large font format, or including a multi-language insert are examples of providing the notice in a format *that* may make it accessible to an enrollee.

ii. Applicable integrated plans should also be sure to comply with any applicable state Medicaid reading level requirements.

- Explain the resolution of and basis for the integrated reconsideration.
- Include the date it was completed.
- For integrated reconsiderations that are not resolved wholly in favor of the enrollee, the notice must also:
- * Explain the next level of both the Medicaid and Medicare appeals process;
- * As discussed in Section 50.7.2.a above, explain the steps the enrollee needs to take to make the next level appeal under each program including that:
    - If the case involves a Medicare-covered benefit the notice must include that the applicable integrated plan has forwarded the case to the IRE;
    - If it is a Medicaid-covered benefit the notice must include information on the steps the enrollee must take to continue the Medicaid-benefit appeal with a State fair hearing;
    - For cases involving a benefit that may be covered by both Medicare and Medicaid (an overlap service), the case should be forwarded to the IRE and the enrollee should also be informed of Medicaid appeal rights. The applicable integrated plan should identify, where appropriate, whether the benefit(s) at issue are covered by Medicare or Medicaid.
- * Provide information on how the enrollee can obtain assistance in pursuing the next level of appeal under each program, and,
- * For Medicaid-covered benefits, explain that the enrollee can have the benefits continue while the appeal is pending, if applicable, and how the enrollee should make such a request (applicable integrated plans may choose to use the model Appeal Decision Letter, available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/D-SNPs). (Benefits will not continue at this stage of the appeal for Medicare-covered services. Please see Section 50.13.a for more information on continuation of Medicaid-covered benefits while the appeal is pending.)

2) * As for other notification requirements (for example, a notification where the applicable integrated plan is taking an extension), the applicable integrated plan may initially provide verbal notification of its decision to the enrollee, however it must deliver written confirmation of its decision within *2* calendar days of the verbal notification, in accordance with 42 CFR 422.633(f)(3)(ii).

50.13.a – Continuing Benefits While An Integrated Reconsideration Is Pending

**** NOTE:** Section 50.13 is a new guidance section, applicable only to applicable integrated plans*

This section applies to cases where an enrollee, or an enrollee's representative or provider, is appealing an applicable integrated plan's decision to reduce, terminate, or suspend a previously authorized Medicare Part C or Medicaid-covered service or item, in accordance with 42 CFR § 422.632.

1) The enrollee or an enrollee's representative or provider, may request that the enrollee continue to receive the previously authorized service or item at the previously authorized level while the integrated reconsideration is pending if:
    a. The request for continuation and the integrated reconsideration are both filed timely:
        i. For the service or item to continue, the enrollee must make the continuation request by the later of the following: within 10 calendar days after the applicable integrated plan sends the notice of its integrated organization determination ***or*** the intended effective date of the integrated organization determination.
        ii. As noted in Section 50.2.1 and 50.2.1a, enrollees must file integrated reconsiderations within 60 calendar days from the date of the notice of the initial determination. For requests received after the 60-day filing timeframe, please see §50.3 regarding good cause exceptions for late filing.
    b. The service or item was ordered by an authorized provider,
    c. The integrated appeal involves the termination, suspension or reduction of previously authorized services, and
    d. The period covering the initial authorization has not yet expired.
2) If the request to continue the service or items meets the above requirements, the applicable integrated plans must continue to provide the service or item, at the previously authorized level until:
    a. The enrollee withdraws the request for the integrated reconsideration;
    b. The applicable integrated plan issues an integrated reconsideration determination that is unfavorable to the enrollee;
    c. For Medicaid-covered services and items only:
        i. The enrollee fails to file a request for a State fair hearing and continuation of benefits, within 10 calendar days after the applicable integrated plan sends the notice of the integrated reconsideration;
        ii. The enrollee withdraws the appeal or request for a State fair hearing; or
        iii. A State fair hearing office issues a hearing decision adverse to the enrollee.
3) If the applicable integrated plan or the State fair hearing entity issues a decision that is

adverse to the enrollee, the applicable integrated plan or State agency may not pursue recovery for costs of services furnished by the applicable integrated plan while the integrated reconsideration was pending if the services were furnished solely under the requirements of 42 CFR 422.632.

4) If, after the integrated reconsideration decision is final, an enrollee requests that Medicaid services continue until a State fair hearing decision is made, state rules on recovery of costs, in accordance with the requirements of 42 CFR § 438.420(d), apply for costs incurred for items and services provided to the enrollee after the date that the integrated reconsideration decision was made.

Note: continuation of benefits rights under 42 CFR 422.632 are separate from and in addition to procedures discussed in Section 100 of the guidance regarding Provider Notices in Hospital, SNF, HHA, and CORF Settings.

90.a – Effectuation

In addition to the guidance in Section 90 (including the requirements listed in the table of Part C effectuations), the following requirements also apply for applicable integrated plans:

1. If an applicable integrated plan reverses its *own* integrated reconsideration to deny, limit, or delay a benefit that was <u>not furnished while the integrated appeal was pending</u>, the applicable integrated plan must authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires but no later than:

    - For a **standard** integrated reconsideration, *no later than the earlier of*:
        - 72 hours of making its decision (for an applicable integrated plan's decision) or receiving notice of the decision (for a State fair hearing decision) *or*,
            - *With the exception of a Part B drug, 30 calendar days after the date the applicable integrated plan receives the request for the integrated reconsideration (or no later than upon expiration of an extension described in § 422.633(f));*
            - *For a Part B drug, 7 calendar days after the date the applicable integrated plan receives the request for the integrated reconsideration.*
    - For an **expedited** reconsideration, 72 hours of when the applicable integrated plan received the request for the integrated reconsideration. Note: 42 CFR § 422.634(d) only applies in lieu of 42 CFR § 422.618(a), but *not* in lieu of 42 CFR § 422.619. The requirements of 42 CFR § 422.619 apply to applicable integrated plans.

2. *If a **State fair hearing** officer reverses an applicable integrated plan's integrated reconsideration decision to deny, limit, or delay **a Medicaid benefit** that was <u>not furnished while the integrated appeal was pending</u>, the applicable integrated plan must authorize or provide the disputed services promptly and as expeditiously as the enrollee's health*

condition requires but no later than 72 hours from the date it receives notice reversing the determination.

Note: in the case of a payment request, the payment does not need to be in the hands of the requester to be considered effectuated; authorization of the payment is sufficient.

3. If the Part C independent review entity, an administrative law judge or attorney adjudicator at the Office of Medicare Hearings and Appeals, or the Medicare Appeals Council reverses the integrated reconsideration to deny, limit, or delay services for a Medicare benefit, applicable integrated plans must follow Part C procedures described in Section 90 and required by 42 CFR §§ 422.618 and 422.619.

See 42 CFR § 422.634(d).