DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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MEDICARE ENROLLMENT & APPEALS GROUP

DATE: December 30, 2019

TO: All Medicare Advantage Organizations, Prescription Drug Plans, Cost Plans, Medicare-Medicaid Plans (MMPs), and PACE Organizations

FROM: Jerry Mulcahy
Director, Medicare Enrollment and Appeals Group

SUBJECT: **Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance**

This memo is to announce updates to the Parts C & D Enrollee Grievance, Organization/Coverage Determination, and Appeals Guidance. Below are updates made to the guidance, which will be effective for plans and plans sponsors **January 1, 2020.** The guidance can be found at:

https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Parts-C-and-D-Enrollee-Grievances-Organization-Coverage-Determinations-and-Appeals-Guidance.pdf.

Questions regarding these updates or content related to the Parts C & D Enrollee Grievance, Organization/Coverage Determination, and Appeals Guidance may be submitted to https://appeals.lmi.org.

Updates to Parts C & D Enrollee Grievances, Organization/Coverage Determinations and Appeals Guidance

Section 10 - INTRODUCTION

Section 10.2: In "Part C Only" box, replace "*items or services*" with "*benefits*".

Section 10.4.2: Revise language in last sentence of first paragraph to read: CMS considers *the medical director* to be fulfilling their responsibility through the plan's established process for when a medical director must be involved.

Section 10.5.2: Revise first sentence to read: Plans must have processes in place to accept *requests (grievance,* coverage, and appeal requests) 24 hours a day, 7 days a week (including holidays).

Delete *"Coverage and appeal"* from second sentence in first paragraph.

Section 10.5.3: Revise section to read: Unless otherwise specified, written notification is considered delivered on the date (and time, if applicable) the plan or delegated entity has deposited the notice in the courier drop box *or external outgoing mail receptacle* (e.g., U.S. Postal Service or FedEx bin) or for electronic payments (i.e., EFTs), the date the plan distributes the funds for payment.

Add language after first paragraph that states: *Verbal notification is considered delivered on the date (and time, if applicable) a plan speaks directly to or leaves a voicemail for an enrollee or enrollee's representative. Plans may initially provide verbal notification prior to issuing written notification.*

For standard requests, if the plan successfully provides verbal notice (e.g., spoke with the person that submitted the request or was able to leave a voicemail message) and written notification is required, the plan must send written notice within 3 calendar days of the verbal notice. If the plan is not able to successfully provide verbal notice (i.e., when a plan has an enrollee's telephone number on file, but is unable to reach the enrollee at the number provided because, for example, it is either incorrect, out-of-service, or no person (or no voicemail system) answers), written notice must be sent within the applicable timeframe. Information regarding verbal notification for expedited requests can be found at §40.8 for initial determinations and §50.2.2 for level 1 appeals.

Delete subsection 10.5.4 – *Good Faith Effort to Provide Verbal Notification*.

Section 10.6: Revise last sentence in third paragraph to read: See §§422.568(d) and (e), 422.570(d), and 422.572(d) for denials related to Part A and B services, items *and Part B drugs*, and 423.568(f) and (g) for denials related to Part D benefits.

SECTION 40: COVERAGE DETERMINATIONS, ORGANIZATION DETERMINATIONS (INITIAL DETERMINATIONS) AND AT-RISK DETERMINATIONS

Section 40.1: Revise last paragraph to read: *In circumstances where there is a question whether or not the plan will cover an item or service, the enrollee, enrollee's representative, or the provider on behalf of the enrollee, has the right to request a pre-service organization determination (prior authorization) from the plan. Such pre-service requests to the plan (even if to an agent or contractor of the plan, such as a network provider) are requests for an organization determination and must comply with the applicable regulatory requirements.* Whenever an enrollee contacts an MA plan to request a service, the request itself indicates that the enrollee believes the MA plan should provide or pay for the service. However, when a provider declines to furnish a service requested by an enrollee, this is not an organization determination *because* the provider is making a treatment decision *(which may be based on the provider's judgment about whether the item or service should be part of the enrollee's treatment plan or whether the provider is willing to furnish the item or service, regardless of coverage by the plan).*

If the enrollee wishes to request information about coverage of the benefit, the enrollee must contact the MA plan to make a coverage request for the service in question, or the provider may make the coverage request on the enrollee's behalf. The MA plan must educate enrollees and providers that when there is a disagreement with a provider's decision to decline to furnish a service or a course of treatment, in whole or in part, the enrollee has a right to request and receive an organization determination from the MA plan *about whether coverage of the benefit would be provided; such determination about coverage would likely address if the item or service is medically necessary. Further, enrollees have the right to seek treatment from other providers (such as from another provider in the network).*

Section 40.4: Before last sentence under subtitle *"Asking a Plan Sponsor to Waive a PA or other UM Requirement"*, add: *Under § 423.568(b), (effective January 1, 2020), plans may toll (i.e., not begin) the timeframe by up to 14 calendar days after receipt of the request to receive the supporting statement (see §40.5.4).*

Section 40.5.3: Revise second sentence of second paragraph to read: However, when a benefit request must be resolved under the exceptions process, the adjudication timeframe *may be* tolled pending receipt of the prescriber's supporting statement *(see 42 CFR §423.568(b), 423.570(d)(1) and 423.572(a), effective January 1, 2020).*

Revise parenthetical in third paragraph to read: (i.e., the timeframe *may* not *be* tolled if the plan sponsor asks for additional information after it has received a written supporting statement)

Section 40.5.4: Revise second sentence of first paragraph to read: However, if the exception request involves benefits not yet received, the start of the timeframe *may be* tolled (i.e., not begin) until the plan sponsor receives the prescriber's supporting statement, *as described in more detail below*.

Add two paragraphs under bulleted list to read: *Beginning in plan year 2020, the plan must notify the enrollee (and the prescribing physician or other prescriber involved, as appropriate) of its decision no later than 72 hours (or 24 hours in the case of an expedited decision) after receipt of*

the prescriber's supporting statement or 14 calendar days after receipt of the request, whichever occurs first (see 42 CFR §423.568(b) and 423.570(d)(1)).

If the supporting statement is not received by the end of the 14 calendar days, then the plan sponsor must notify the enrollee (and prescriber, as appropriate) of its decision no later than 72 hours (24 for expedited cases) from the end of the 14 calendar days from receipt of the exception request.

Delete last paragraph that read: *Although the adjudication timeframe for these requests does not begin until the plan sponsor receives the supporting statement, the plan sponsor must not keep the request open indefinitely. If the plan sponsor does not receive the physician's or other prescriber's supporting statement indicating the required factors within a reasonable period of time, the plan sponsor should make its determination based on whatever evidence exists, if any. What determines a reasonable amount of time will depend on the facts and circumstance of each case; however, CMS does not believe it should exceed 14 calendar days, provided that the plan sponsor has contacted the enrollee and/or physician or other prescriber and clearly identified the information needed to process the request.*

Section 40.6: Revise first sentence to read: **Enrollees or their representatives may make a request for all types of *decisions about* coverage under both Part C and Part D.**

Revise second bullet in text box to read: Staff of said provider's/physician's office acting on said physician's behalf (e.g., request is on said physician's letterhead *or otherwise indicates staff is working under the direction of the provider*).

Section 40.8: Add sub-bullet under 5th bullet in table to read: *If a request is made by an enrollee, the plan must expedite the request if it determines that applying the standard timeframe could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.*

Under heading "Action Following Acceptance of a Request for Expedited Initial Determinations", revise "Part C Only" table to read:

Decision	Processing Requirements for Expedited Determinations
Favorable	• Provide notice* of favorable decision to the enrollee (and the physician involved, as appropriate) as expeditiously as the enrollee's health condition requires, but no later than: o 72 hours after receiving the request *for items and services*. o *24 hours after receiving the request for Part B drugs.* • The MA plan may notify the enrollee verbally or in writing and notification must be received by the enrollee within: o 72 hours *for items and services* (i.e., mailing the determination within 72 hours in and of itself is insufficient). o *24 hours for Part B drugs.*

Decision	Processing Requirements for Expedited Determinations
	• If the MA plan initially provides verbal notification of its decision, it *may* deliver written confirmation of its decision within 3 calendar days of the verbal notification.
Partially Favorable or Adverse	• Provide written notification* to the enrollee of the decision (and the physician involved, as appropriate) as expeditiously as the enrollee's health condition requires, but no later than: o 72 hours after receiving the request *for items and services*. o *24 hours for Part B drugs.* • If the MA plan initially provides verbal notification of its decision, it must deliver written confirmation of its decision within 3 calendar days of the verbal notification.

Revise heading "Extension of Timeframe" to read "Extension of Timeframe *for Items and Services*".

Revise first sentence under "Extension of Timeframe for Items and Services" heading to read: The MA plan may only extend the 72-hour timeframe *for items and services* up to 14 *additional* days if:

After the last paragraph under the "Extension of Timeframe" heading, add: *Part B drug timeframes cannot be extended.*

Section 40.10: Revise Part C table to state:

Type	Processing Timeframe	With Extension*
Pre-Service	14 calendar days	28 days
Part B Drug	*72 hours*	*N/A*
Payment	30 days**	N/A
Expedited: *Pre-Service*	72 hours	17 days
Expedited: Part B Drug	*24 hours*	*N/A*

*14-day extension if the enrollee requests the extension or if the MA plan justifies a need for additional information and documents how the delay is in the best interest of the enrollee. MA plan must notify enrollee in writing if extension is going to be taken and explain the reason for the delay. ***Note:*** *Part B drug and payment timeframes cannot be extended.* See: 42 CFR §422.568(b)(1) and (2).

Section 40.12.1: Revise first bullet under subheading "Denials and Discontinuation/Reduction of Previously Authorized Ongoing Course of Treatment" to state: A specific and detailed explanation of why the medical services, items *or Part B drugs* were denied, including a description of the applicable coverage rule or applicable plan policy (e.g., Evidence of Coverage provision) upon which the action was based, and a specific explanation about what information is needed to approve coverage must be included, if applicable;

Revise the last bullet under the same heading to state: An explanation of a provider's refusal to furnish an item, service, *or Part B drug* (if applicable).

SECTION 50: RECONSIDERATIONS AND REDETERMINATIONS (LEVEL 1 APPEALS)

Section 50.1: Revise Part C table to read:

Type of Request	Who May Request An Appeal
Standard Pre-Service Reconsideration	• An enrollee; • An enrollee's representative; • The enrollee's treating physician acting on behalf of the enrollee* or staff of physician's office acting on said physician's behalf (e.g., request is on said physician's letterhead *or otherwise indicates staff is working under the direction of the provider*); or • Any other provider or entity (other than the MA plan) determined to have an appealable interest in the proceeding.
Standard Payment Reconsideration	• An enrollee; • An enrollee's representative; • Non-contract provider (see §50.1.1 for non-contract provider payment appeals); • The legal representative of a deceased enrollee's estate; *or* • *Any other provider or entity (other than the MA plan) determined to have an appealable interest in the proceeding.*
Expedited Reconsideration	• An enrollee; • An enrollee's representative; • Any physician or staff of physician's office acting on said physician's behalf (e.g., request is on said physician's letterhead *or otherwise indicates staff is working under the direction of the provider*) acting on behalf of the enrollee.

Section 50.2.1: In the last bullet of this subsection, revise first sentence to read: *For standard requests,* the processing timeframe begins when the plan, any unit in the plan, or a delegated entity (including *those* not responsible for processing the request) receives a request.

Add a bullet at the end of this section to read: *For expedited requests, the processing timeframe begins when the appropriate department receives the request.*

Section 50.2.2: In table with heading of "Part C Only", revise the last sentence of the first paragraph to read: MA plans should have a process in place to distinguish between misdirected

requests that should go to the BFCC-QIO (see §§422.622(b) and 422.626(a)(1)) and valid requests to the MA plan (i.e., requests made because the *timeframe* for filing with the BFCC-QIO has expired).

In this section, under heading that states "Action Following Acceptance of a Request for Expedited Level 1 Appeal", change Part C table to read:

Reconsideration Decision	Processing Requirements for Expedited Reconsiderations
Favorable	• Ensure the person or persons conducting the reconsideration were not involved in the organization determination.* • As expeditiously as the enrollee's health condition requires, but no later than: • 72 hours after the request, the MA plan must: o Make the decision; and o Give notice to the enrollee (and the physician involved, as appropriate); and o Authorize or provide the service. ***Note:*** *The 72 hour timeframe for requests for items and services may be extended up to 14 additional days. Part B drug timeframes cannot be extended.* • Notification must be provided within the 72-hour timeframe (i.e., mailing the determination within 72 hours in and of itself is insufficient). • The MA plan may notify the enrollee verbally or in writing**. If the MA plan initially provides verbal notification of its decision, it must deliver written confirmation of its decision within 3 calendar days of the verbal notification. • Verbal or written notification of the decision must explain conditions of the approval including (but not limited to): o The duration of the approval; and o Limitations associated with the approval. • If the enrollee agrees, the MA plan may send the notice by fax or e-mail. Please see Medicare Marketing Guidelines regarding electronic communication with enrollees.
Partially Favorable or Adverse	• Ensure the person or persons conducting the reconsideration were not involved in the organization determination.* • As expeditiously as the enrollee's health condition requires, but no later than 72 hours after the request, the MA plan must: o Make the decision; and

Reconsideration Decision	Processing Requirements for Expedited Reconsiderations
	o Forward the case file to the IRE within 24 hours of its affirmation (see §50.12 for guidance on forwarding case files to the IRE). ***Note:*** *The 72 hour timeframe for requests for items and services may be extended up to 14 additional days. Part B drug timeframes cannot be extended.* • MA plans are not required to notify beneficiaries upon forwarding cases to the Part C IRE. Enrollees will receive notification from the IRE. MA plans opting to inform parties when a case has been forwarded to the IRE may use the model Notice of Appeal Status.

Revise heading "Extension of Timeframe" to read "Extension of Timeframe *for Items and Services*".

Revise first sentence under heading "Extension of Timeframe" to read: The MA plan may only extend the 72-hour timeframe up to 14 *additional* days if:

After the last paragraph under the "Extension of Timeframe" heading, add: *Part B drug timeframes cannot be extended.*

In the same subsection, under the heading "Action Following Denial of a Request for an Expedited Level 1 Appeal", change the first bullet to read: Transfer the request to the standard level 1 appeal process *(the timeframe begins the day the MA organization receives the request for expedited reconsideration)*;

Section 50.7.1: Revise "Parts C & D Level 1 Appeal Adjudication Timeframes to read:

Type	Part C	Part C with Extension	Part D
Standard Pre-Service or Benefit	30 days	44 days	7 days*
Expedited Pre-Service, Benefit *or Part B Drug*	72 hours	17 days**	72 hours*
Part B Drug	*7 days*	*N/A***	*N/A*
Payment	60 days	N/A	14 days

***Note:** Part D redetermination exception requests cannot be tolled for receipt of the prescribing physician's supporting statement.*
*** Part B drug timeframes cannot be extended.*

Under heading "Extension of Timeframe", Revise first sentence in "Part C Only" table to read: For standard pre-service and expedited reconsiderations *for items and services*, the MA plan may extend the timeframe by up to 14 calendar days only if:

Add sentence after last paragraph in "Part C Only" table under "Extension of Timeframe" heading to read: *Part B drug timeframes cannot be extended.*

SECTION 60: RECONSIDERATIONS BY THE INDEPENDENT REVIEW ENTITY (LEVEL 2 APPEAL)

Section 60.2: Revise first sentence of last paragraph to read: Requests may be made *by an enrollee, enrollee's representative, or prescribing physician or other prescriber (acting on behalf of an enrollee), upon providing notice to the enrollee* on the model Request for Reconsideration, or on any other written document.

Section 60.3: Revise "Processing Timeframes" table to read:

Type of Request	Part C	Part D*
Standard	**Pre-service:** 30 days **Payment:** 60 days **Part B Drugs:** 7 days	**Benefit:** 7 days **Payment:** 14 days
Expedited (Payment and Part B drug requests cannot be expedited)	72 hours	72 hours

SECTION 70: KEY ASPECTS OF ADMINISTRATIVE LAW JUDGE (ALJ)/ATTORNEY ADJUDICATOR, COUNCIL, AND JUDICIAL REVIEW

Section 70.1: Revise last sentence of footnote under table, "Who May Request a Review" to remove incorrect citation and read: See, for example, §423.2002 for information on the right to an ALJ hearing.

Section 70.3: In the table under the column that reads "If the applicable request form is not used, written requests should include the following:" and the row "Fourth Level: Council", the second bullet under the "Part C Only" heading, to read: Service(s)/item(s)/*Part B drug(s*) for which review is requested.

SECTION 100: PROVIDER NOTICES IN HOSPITAL, SNF, HHA, AND CORF SETTINGS (PART C ONLY)

Section 100: Moved note from section 100.2 to this section, which reads: ***Note:*** *HCPPs are not regulated by the rules in this section. Instead, HCPP enrollees follow the Original Medicare immediate review process (42 CFR 405 Subpart J and Chapter 30 of the Medicare Claims Processing Manual).*

Section 100.1: Last sentence in the first paragraph to read: For all MA enrollees, hospitals must deliver valid, written notice of an enrollee's rights as a hospital inpatient, including discharge

appeal rights, using the standardized form, CMS Form R-193, *An* Important Message from Medicare (IM).

Section 100.1.1: The first sentence of the paragraph under the "Note" to read: *Pursuant to §422.622(f)*, the MA plan is financially responsible for continued coverage of services during the BFCC-QIO review, regardless of whether it has delegated responsibility for authorizing coverage or discharge determinations to its providers.

Section 100.2: Before second to last sentence in first paragraph, added language that reads: *Enrollees must request an immediate review, by telephone or in writing by noon the day after the NOMNC is delivered; if, due to an emergency, the IRE is closed and unable to accept the enrollee's request for a fast-track appeal, the enrollee must file a request by noon of the next day that the IRE is open for business. If the enrollee misses the timeframe, the enrollee may request an expedited appeal from the plan.*

Revised and moved last paragraph in this section, to section 100. The paragraph read: ***Note:*** *Unlike 1876 Cost Plans, HCPPs are not regulated by the rules in this section and 42 CFR §422.624-626. HCPP enrollees follow the Original Medicare immediate review process (42 CFR 405 Subpart J and Chapter 30 of the Medicare Claims Processing Manual).*

Section 100.2.1: The first sentence of the paragraph under the "Note" to read: *Pursuant to §422.626(b)*, the MA plan is financially responsible for continued coverage of services during the BFCC-QIO review, regardless of whether it has delegated responsibility for authorizing coverage or discharge determinations to its providers.

Deleted: *Contract (network) hospitals and CAHs must follow the guidance for Original Medicare (fee-for-service) hospitals and CAHs found in Chapter 30 of the Medicare Claims Processing Manual.*

APPENDICES

Appendix 1: Text box with the heading "Standard Process" to read:

STANDARD PROCESS
Pre-Service: 14 day time limit
Payment: 60 day time limit
Part B Drug: 72 hour time limit

Text box under box with heading "Standard Process" to read:

Health Plan Reconsideration
Pre-Service: 30 day time limit
Payment: 60 day time limit
Part B Drug: 7 day time limit

Second text box under heading with "Standard Process" to read:

IRE Reconsideration
Pre-Service: 30 day time limit
Payment: 60 day time limit

Part B Drug: 7 day time limit

Third text box from the bottom of the chart, with heading "Office of Medicare Hearings and Appeals" to reflect updated 2020 AIC amounts and read:

Office of Medicare Hearings and Appeals
ALJ Hearing
AIC ≥ $170
No statutory time limit for processing

Last text box on the chart to reflect updated 2020 AIC amounts and read:

Federal District Court
AIC ≥ $1,670

Appendix 2: Second text box under heading with "Standard Process" to read:

Part D IRE
Standard Reconsideration
7 day time limit
Payment: 14 day time limit

Third text box under box with heading "Expedited Process" to reflect updated 2020 AIC amounts and read:

Office of Medicare Hearings and Appeals
ALJ Hearing
Expedited Decision
AIC ≥ $170
10 day time limit

Last text box on the chart to reflect updated 2020 AIC amounts and read:

Federal District Court
AIC ≥ $1,670

Appendix 3: Deleted last two sentences at the bottom of the page that read:

Part C Appeals Mailbox: *Part_C_Appeals@cms.hhs.gov*

Part D Appeals Mailbox: *PartD_Appeals@cms.hhs.gov*

Add sentence to the end of the page to read: ***For questions related to Parts C & D grievances, organization/coverage determinations, and appeals, please submit to:*** *https://appeals.lmi.org*.