DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEDICARE ENROLLMENT & APPEALS GROUP

DATE: February 22, 2019

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

FROM: Jerry Mulcahy
Director, Medicare Enrollment & Appeals Group

SUBJECT: Release of Medicare Advantage and Prescription Drug Plan Appeals Guidance

This memo is to announce the release of the final Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance. On October 1, 2018, a draft version of the guidance was released with a request for comments. Over 100 responses were received. CMS thanks everyone who provided comments.

Attached please find the final version of the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance. For your reference, we have included a version showing changes from the draft released in October, 2018. Please note, this guidance supersedes all prior sub regulatory guidance related to Chapter 13 of the Medicare Managed Care Manual and Chapter 18 of the Prescription Drug Benefit Manual. While this is the most up to date Part C and Part D appeals guidance (effective 2019), any changes/updates from the prior Chapters 13 and 18 to this guidance are not expected to be audited until January, 2020, unless the clarified guidance is to the benefit of the plan. Below, please find a list of noteworthy changes from Chapters 13/18 to this revised guidance.

NEW GUIDANCE BASED ON REGULATORY CHANGES

40.3 – Part D At-Risk Determinations
This section is related to at-risk determinations made under a plan sponsor's drug management program.

40.5.1 – Tiering Exceptions
Revised guidance includes changes to existing tiering exceptions regulations.

50.7.1 – Level 1 Appeal Processing Timeframes
This section now indicates Part D payment timeframes will provide plans additional time to issue appeal decisions.

Section 50 – Part C Notification Requirements
Now included in guidance, Part C plans do not have to notify enrollees if their case is forwarded to the IRE.

UPDATES BY SECTION

10.5.1 – Calculation of Days for Assessing Plan Timeliness

No previous sub regulatory guidance defined how to calculate days or hours in order to correctly identify the expiration of a timeframe. Revised guidance clarifies what is considered "day one" of the timeframe and provides examples.

10.5.2 – When a Request is Considered Received by the Plan

Chapter 13 addressed when an expedited request is considered received by the plan. Revised guidance speaks to when both Part C and Part D standard and expedited requests are deemed received and further clarifies when it is received by a delegated entity or incorrect department within the plan.

10.5.4 – Good Faith Effort to Provide Verbal Notification

No previous sub regulatory guidance. Revised guidance communicates plans may satisfy a notification requirement by first providing verbal notice of its coverage decision to an enrollee, so long as it provides written notice thereafter.

10.6 – Outreach for Additional Information to Support Coverage Decisions

Previous guidance regarding outreach for additional information consisted of an HPMS memo titled "Updated Guidance on Outreach for Information to Support Coverage Decisions" issued February 22, 2017 indicating plans should adopt a best practice of making 3 attempts to obtain additional information. Revised guidance states plans are only required to make a minimum of one outreach attempt if they do not have all necessary information and are not required to conduct outreach prior to denying claims if they believe they have all the necessary information to make the decision. Final version also identifies best practices and physician role in outreach.

20.1 – Representatives Filing on Behalf of Enrollees

No previous guidance regarding verbal appointment of a representative. Revised guidance states enrollees cannot verbally appoint a representative and must submit a valid representative form.

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

Previous guidance stated a photocopy of an AOR had to be submitted with each request for a grievance, initial determination or appeal. Revised guidance states if plans have a copy of an AOR on file, it may be used for any request from the representative for one year from the date it is signed, and provides an example.

20.2.1 – Missing or Defective Representative Form

Previous guidance stated plans could dismiss if an appointment of representation form is not received within a "reasonable timeframe". Revised guidance provides clarification that a "reasonable timeframe" is the conclusion of the appropriate timeframe, plus extension, if applicable.

30 – Grievances

Previous guidance defined the term "complaint" as a dissatisfaction, similar to a "grievance". Revised guidance removes the term "complaint" to reduce confusion.

30.1 – Classification between Grievances, Inquiries, Coverage Requests, and Appeals

Revised guidance contains new language stating plans must inform enrollees if their issue is a grievance or an appeal. Notification may be verbal and at the time of the call or when the enrollee is notified of the decision and does not apply to requests for coverage or inquiries.

30.3 – Quality of Care Grievance

Previous guidance provided minimal information on quality of care grievances. Revised guidance provides a separate section and a description of quality of care grievances.

40.4 – Prior Authorization and Other Utilization Management Requirements

Chapter 13 did not address prior authorization. Revised guidance indicates a request for prior authorization is considered an organization determination.

40.5.4 – Adjudication Timeframes for Coverage Determinations Involving an Exception

Chapter 18 did not provide recommended timeframe to toll an exception request. Revised guidance recommends tolling should not exceed 14 calendar days when awaiting a supporting statement for exception requests.

50.9 – Part C Dismissals

Chapter 13 had limited guidance for dismissals outside of the HPMS memo, "Change in Part C Reconsideration Dismissal Procedures", issued September 10, 2013. Revised guidance includes a specific section for dismissals of reconsiderations as well as guidance from the HPMS memo, stating plans will not automatically forward dismissed cases to the IRE.

50.12.3 – Preparing the Case File for the Independent Review Entity

Revised guidance includes information regarding electronic submission of case files via the IRE web portal.

80.1 – Guidelines for a Reopening

Previous guidance specified enrollees must request a reopening in writing. Revised guidance states enrollees may request a reopening verbally or in writing.

80.3.2 – Timeframes for Processing a Reopening

Previous guidance had no recommended timeframe for plans to process a reopening. Revised guidance recommends reopening actions should be completed within 60 days from the receipt of the party's request for reopening.

80.4 – Reopening Based on Clerical Error

Chapter 18 stated Part D plan sponsors were required to process clerical errors as reopenings. Revised guidance states Part D plans are not required, but may, process clerical errors as reopenings.

80.6 – Notification Requirements for Reopenings

Previous guidance did not specify a change in the denial rationale was considered a revised determination. Revised guidance states a change in denial rationale constitutes a revised determination and requires notification to the parties of that determination.

UPDATES TO VARIOUS SECTIONS

- Modified formatting in final version to more clearly identify when guidance is applicable to Part C Only or Part D Only.

- Additional guidance regarding alternate formats and languages consistent with Section 1557 of the Affordable Care Act and Section 504 of the Rehabilitation Act of 1973.

Withdrawals of Grievances, Initial Determinations and Appeals

Previous guidance did not discuss withdrawn requests for grievances and initial determinations, and (for Part C) required withdrawal requests for reconsiderations to be made in writing. For redeterminations (Part D), previous guidance stated withdrawal requests may be accepted verbally if written confirmation was sent. Revised guidance adds withdrawn grievances and initial determinations and aligns Part C & Part D requirements for grievances, initial determinations and level 1 appeals.

Forwarding Untimely Cases to the IRE for a Fully Favorable Decision

Previous guidance in Chapter 18 indicated if a plan sponsor makes a fully favorable decision on a coverage determination in less than 24 hours after the end of the adjudication timeframe, they should effectuate and notify the enrollee of the favorable decision in lieu of forwarding the case to the IRE. Revised guidance makes this applicable to both Part C and Part D.

Enrollee/Representative Notification

New language added indicating if a representative makes a request, plans may send a copy of notices and other correspondence to the enrollee in addition to the representative.

Expediting Payment Requests

Plans may, but are not required to, accept requests for expedited payment (expedited timeframes apply).

Notification for Favorable Determinations

Previous guidance did not address how plans should notify enrollees of favorable determinations. Revised guidance includes recommendations for notification of favorable determinations.

A list of frequently asked questions based on comments received can be found on the CMS Medicare Managed Care Appeals and Grievances or the Prescription Drug Appeals and Grievances webpages. CMS will also be holding a webinar to discuss the consolidated guidance in spring 2019. Details regarding the webinar will be sent at a later date. For questions related to the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance, please submit to:

Part C Appeals: Part_C_Appeals@cms.hhs.gov

Part D Appeals: PartD_Appeals@cms.hhs.gov