

Note to reviewers: we also intend to add a cross reference to this Addendum in the Part C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance, as well as text at the end of Section 10 of the guidance indicating that Applicable Integrated Plans (as defined in 42 CFR 422.561) should refer to this Addendum for additional guidance related to integrated grievances and appeals.

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

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. 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.
 - 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.
- 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. 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

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>

C & D Guidance.

- 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
Reconsideration	Integrated Reconsideration

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 drugs.

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: 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 the requirements for a request for integrated grievance, integrated appeal, or integrated organization determination. Applicable integrated plans must also consider requirements for integrated appeals including state Medicaid requirements, in addition to Medicare Advantage requirements when determining the validity of a request for an integrated grievance, integrated organization determination, or integrated appeal.

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 drugs.

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 drugs.

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, in person and in writing, to present 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).
- (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).
- (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).

10.6.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).

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 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.

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 never covered by Part D 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 never covered by Part D 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 never covered by Part D 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 if the applicable integrated plan does not cover the Medicaid-covered drug.

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 deliver written confirmation of its decision within 2 calendar 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 § 422.633(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 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) * A provider who is not an assignee of the enrollee (meaning that the provider has not waived the ability to seek or collect payment from the enrollee) is providing treatment to the enrollee may, upon providing notice to the enrollee, request a standard or expedited pre-service integrated reconsideration on behalf of an enrollee.
- (3) * If a provider requests that the benefits continue while the integrated appeal is pending, pursuant to §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.

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(1).

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. Applicable integrated plans should apply the same process to assess a request to expedite a payment request as they do assess requests to expedite non-payment cases.
- (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(1)(2) and 422.631(c)(1).
- (4) * 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.
 - This information is instead of the information in the section titled “*Extension of Timeframe for Items and Services.*”
- (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, the plan it should refer to the regulatory requirements at 42 CFR § 422.422.631(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 is being reduced, suspended, or terminated (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 41.10.

(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, as long as it meets the requirements of 42 CFR § 422.631(d). As part of the information provided in the notice under 422.631(d)(1)(iii)(D), 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, <i>in alignment with state policy where applicable for Medicaid benefits, and EOB.</i>	<ul style="list-style-type: none"> • 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 <link to be added when available>.

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

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

* The following individuals and entities may request an integrated grievance, integrated organization determination, and integrated reconsideration, and are parties to the case, in accordance with 42 CFR 422.629(1):

- (1) The enrollee or his or her representative;
- (2) 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), or any other provider or entity (other than the applicable integrated plan) who has an appealable interest in the proceeding;
- (3) The legal representative of a deceased enrollee's estate; or
- (4) Subject to the other provisions of this section, any provider that furnishes, or intends to furnish, services to the enrollee. If the provider requests that the benefits continue while the integrated appeal is pending, pursuant to §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 provider who is providing treatment to the enrollee may, upon providing notice to the enrollee, request a standard or expedited pre-service integrated reconsideration on behalf of an enrollee.

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 oral integrated appeals (in both standard and expedited cases).
- 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.
- 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.
- 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 coverage criteria, before the MA organization issues the organization determination decision. (As in the Part C & D Guidance, the physician need not be of the same specialty or subspecialty as a treating physician.)
 - * 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. Enrollees will also receive notification from the IRE if the case is auto forwarded to the IRE (i.e. in cases where the integrated appeal is not decided in the enrollee’s favor). Applicable integrated plans may use the model Notice of Appeal Status <link to be added when available> to inform parties when a case has been forwarded to the IRE.
- 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”:
- * Following denial of expedited treatment of a request for an expedited level 1 integrated appeal, applicable integrated plans 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 it must deliver written confirmation of its decision within 2 calendar of the verbal notification in accordance with 42 CFR § 422.633(e)(2)(ii).
 - In providing notice of the denial of a request for an expedited level 1 integrated appeal must follow the Part C guidance but are encouraged to use the Letter about Your Right to Make a Fast Complaint <link to be added when available>. 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 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), are a physician or other appropriate health care professional who have the

appropriate 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 organization determination decision.

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 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 section titled “Extension of Timeframe,” for standard pre-service and expedited integrated reconsiderations for items and 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 and there is a reasonable likelihood that receipt of such information would lead to approval of the request, if received.

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 (must) 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 422.433(f)(4)(ii)(B) and 42 CFR § 438.420(c)).

Applicable integrated plans may choose to use the model Appeal Decision Letter <link to be added when available>.

* 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 not apply to applicable integrated plans. Applicable integrated plans must send the enrollee notice of all integrated reconsideration decisions (in accordance with 42 CFR § 422.633(f)(4)); applicable integrated plans may use the model Appeal Decision Letter for this notification available at <link to be added when available>.

50.10.1.a- Part C Notification Requirements

The guidance in Section 50.10.1 applies to applicable integrated plans except that:

- 1) In the section titled “Partially Favorable, Adverse, or Untimely Decisions” applicable integrated plans should follow the same process as other MA plans for sending case files to the IRE. However, applicable integrated plans *are* required to notify beneficiaries upon forwarding cases to the IRE in all cases in accordance with 42 CFR § 422.633(f)(4).
- 2) The notice must, in accordance with 42 CFR § 422.633(f)(4),
 - a. Be written in plain language and available in a language and format that is accessible to the enrollee.
 - b. Explain the resolution of and basis for the integrated reconsideration.
 - c. Include the date it was completed.
 - d. For integrated reconsiderations that are not resolved wholly in favor of the enrollee, the notice must also:
 - e. * Explain the next level of both the Medicaid and Medicare appeals process;
 - f. * The steps the enrollee needs to take to make the next level appeal under each program;
 - g. * Provide information on how the enrollee can obtain assistance in pursuing the next level of appeal under each program, and,
 - h. * 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 <include link when available>).
 - i. * As for other notification requirements, the applicable integrated plan may initially provide verbal notification of its decision, however it must deliver written confirmation of its decision within 2 calendar 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 of 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.

90.a – Effectuation

The guidance in Section 90 applies to applicable integrated plans except that in the table of Part C effectuations, the following requirements apply, in addition, for applicable integrated plans:

If the applicable integrated plan reverses its decision, or, for a Medicaid benefit, a State fair hearing reverses an applicable plan's integrated reconsideration decision, to deny, limit, or delay services that were not furnished while the integrated appeal was pending, 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 in lieu of the timeframes described in § 422.618(a). See 42 CFR § 422.634(d).