



MEDICARE ENROLLMENT & APPEALS GROUP

DATE: July 19, 2024

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

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

This memo announces the Centers for Medicare and Medicaid Services (CMS)'s publishing an update to the Parts C & D Enrollee Grievance, Organization/Coverage Determination, and Appeals Guidance.

The manual update covers several areas-- including incorporating recent changes to 42 CFR § 422.566(d), which requires that a denial based on a medical necessity determination must be reviewed by a physician or other appropriate health care professional with expertise in the field of medicine or health care that is appropriate for the service at issue. The update also clarifies who may act or be appointed as a representative, and indicates that enrollees, their representatives, or providers on behalf of enrollees, have the right to voluntarily request plan approval on any service, item, or Part B drug which they believe are, or should be, covered by the plan—including non-covered services, items, and Part B drugs and those for which the plan does not require prior authorization. In addition, CMS made certain terminology changes in the manual, such as refraining from using the term “pre-service” when discussing authorization requests generally, to ensure consistency with the regulatory terminology of 42 CFR Part 422, Subpart M and to enhance recognition that organization determinations may occur prior to, during, and after a particular benefit is furnished to an enrollee.

This guidance is issued for Medicare Advantage Organizations, Prescription Drug Plans, Cost Plans, Medicare-Medicaid Plans (MMPs), PACE Organizations, enrollees and other parties interested in the MA program.

The updated guidance is effective immediately.

The full guidance and can be found [here](#) at:

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

If there appear to be differences between statute or regulations and the manual, the statute or regulations control over the manual (and any other guidance). Therefore, interested parties should also consult the applicable statutes, regulations, and final rules.

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>.

Guidance excerpts follow, with substantive updates in red, italicized font.

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

20 – Representatives

20.1 – Representatives Filing on Behalf of Enrollees

Individuals who represent enrollees may either be appointed or authorized (for purposes of this guidance, both are referred to as “representatives”) to act on behalf of the enrollee in filing a grievance, requesting an initial determination, or in dealing with any of the levels of the appeals process.

Who Can Act or be Appointed as a Representative	Requirement for Representation
Any individual <i>appointed by the enrollee</i> (e.g., relative, friend, advocate, attorney)	The enrollee must submit Form CMS-1696 , Appointment of Representative (AOR) or an equivalent written notice (hereinafter, collectively referred to as a representative form).
An individual authorized <i>under state or other applicable law</i> . [*] Could include, but is not limited to: <ul style="list-style-type: none">• Court appointed guardian• Individual with durable power of attorney• A health care proxy• A person designated under a health care consent statute• Executor of an estate	<ul style="list-style-type: none">• A representative form is not required.• Authorized individual must produce appropriate legal papers supporting his or her status under state <i>or other applicable</i> law.

^{*}Plans with service areas comprising more than one state should be aware of the different state representation requirements and are responsible for determining whether a person or entity who asserts surrogate status is an appropriate surrogate under state law.

When verbally submitting grievances, initial determinations, and reconsiderations, when applicable, enrollees cannot verbally appoint a representative and must submit a valid representative form. However, if a purported representative makes a verbal request and the enrollee verbally confirms they want to file the request described by the purported representative, the request must be documented and processed as a request from the enrollee, not a representative. All communication (written and verbal) must be delivered to the enrollee until valid, written representative documentation is on file – e.g., a representative form or appropriate legal papers supporting an authorized individual’s status under state law. In these instances, plans are not required to make efforts to obtain a written representative form.

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20.2.1 – Missing or Defective Representative Form

When a request for a *grievance*, initial determination, or level 1 appeal is filed by a person claiming to be a representative, but the party does not provide the valid representative documentation to show that the individual is authorized to act on the enrollee's behalf, the plan should:

- For expedited requests, develop procedures to ensure that expedited requests are not inappropriately delayed.
- Inform the enrollee and purported representative, in writing, that the *grievance*, coverage request, or appeal is not valid until documentation is provided.
- Make and document its reasonable efforts to secure the necessary representative documentation.

The plan must not issue a decision until or unless such documentation is obtained. The plan is not required to undertake a review until or unless such documentation is obtained, but may choose to begin the review while continuing efforts to obtain the representative documentation. The timeframe for acting on a *grievance*, coverage request, or appeal begins when the representative documentation is received.

If the plan does not receive representative documentation by the conclusion of the applicable timeframe, plus any applicable extension, the following apply:

Dismissal of coverage and appeal requests: The request is dismissed because the person or entity making the request is not permitted to request a coverage decision or appeal or is not a proper party. The plan must mail or otherwise transmit a written dismissal notice to the enrollee (or other proper party) and should also send the notice to the person asserting representative status. The dismissal notice must state all of the following: (1) the reason for the dismissal; (2) the right to request that the plan vacate the dismissal action; and (3) the right to request review of the dismissal. The notice should also explain how the invalid request can be cured and that the request will be processed if the enrollee or representative submits a properly executed form. See 42 CFR §§ 422.568(g) and (h), 422.582(f) and (g), 423.568(i) and (j), 423.582(e) and (f).

See §50.9 for additional information regarding reconsideration dismissal procedures.

Grievances: MA plans and Part D plans are not required to process grievances when the person or entity making the grievance is not permitted by 42 CFR §§ 422.564 or 423.564. In circumstances where necessary representative documentation is missing, and not received by the end of the grievance processing period, the plan should notify the enrollee and the purported representative that the plan is unable to process the grievance. This notice should include instructions on how the enrollee, or a valid representative, may resubmit the grievance.

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30 – Grievances

A grievance is an expression of dissatisfaction with any aspect of the operations, activities, or behavior of a plan or its delegated entity in the provision of health care or prescription drug services or benefits, regardless of whether remedial action is requested. The regulations at 42 CFR §422.564(a) and 423.564(a) require each plan to have meaningful procedures for the timely resolution of grievances between enrollees and the plan or any of its delegated entities. Plans must provide all enrollees with written grievance procedures upon initial

enrollment, involuntary disenrollment, annually, and upon request. The plan must also notify enrollees about any changes to its grievance procedures 30 days in advance of the effective date of the change.

The grievance process is only available to enrollees or their representatives. Providers should file complaints to plans in accordance with the plans' dispute resolution processes and, if resolution is unsatisfactory, may contact their local CMS Regional Office. Decisions made under the grievance process are not subject to appeal.

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30.2 – Procedures for Handling a Grievance

Procedures for processing a grievance are as follows:

Filing Method	Filing Deadline	Processing Requirements
In writing	No later than 60 days after the incident that precipitates the grievance*	<p>Plans must:</p> <ul style="list-style-type: none"> Complete the investigation as expeditiously as the case requires, based on the enrollee's health status, but no later than 30 days of receipt of the request, or within 24 hours for expedited grievances. <ul style="list-style-type: none"> Note: Plans may take a 14-day extension if the enrollee requests the extension or if the plan justifies a need for additional information and documents how the delay is in the best interest of the enrollee. Plans must promptly notify the enrollee in writing if the extension is going to be taken and explain the reason for the delay. See: 42 CFR §§422.564(e)(2) or 423.564(e)(2). Accept any information or evidence concerning the grievance. Take prompt, appropriate action, including a full investigation if necessary. Provide a response to all grievances raised in the written request. Have procedures for tracking and maintaining records about the receipt and disposition of grievances. Be able to log or capture enrollees' grievances in a centralized location that is readily accessible. The record should include documentation of all telephone calls, correspondence, and case notes related to the grievance. Expedite the grievance if: <ul style="list-style-type: none"> It is related to a decision not to grant an enrollee's request to expedite an initial determination or appeal, and (for Part D Only) the enrollee has not yet obtained the drug; or <p>Part C Only: it involves an MA plan's decision to extend a timeframe related to an organization determination or appeal.</p>
Verbal	Same as in writing.	Same as in writing; however, if a verbal grievance can be resolved during the same call by the customer service representative, the plan must document details of the resolution and proceed to log and report the call as a grievance.

*A plan may, but is not required to, accept and process a grievance that is filed after the 60-day deadline *or submitted with missing or defective representative documentation*. If the plan chooses not to accept *the invalid* filing, the plan *should notify the enrollee of the plan's decision to not accept* the grievance.

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30.3.1 – Procedures for Handling a Quality of Care Grievance

Quality of care grievances submitted to the plan may be made verbally or in writing and must be submitted no later than 60 days after the incident that precipitates the grievance. A plan may, but is not required to, accept and process a grievance that is filed after the 60-day deadline. If the plan chooses not to accept untimely filing, they may dismiss the grievance. Plans may take a 14-day extension and must notify the enrollee in writing if the extension is going to be taken and explain the reason for the delay. See: 42 CFR §§422.564(e)(2) or 423.564(e)(2).

Plans must investigate and respond to the quality of care grievance in writing within 30 days of receipt, or as expeditiously as the enrollee's health condition requires.

Written notice must:

- Include a description of the enrollee's right to file a written complaint with the BFCC-QIO and contact information for the BFCC-QIO; and
- Be written in a manner that is understandable to the enrollee.

If the enrollee's representative submits a request, the representative must be notified in lieu of the enrollee. Plans may send written notice to both the representative and enrollee, but are not required.

For grievances submitted to the BFCC-QIO, plans must cooperate with the BFCC-QIO and comply with requirements at 42 CFR Part 476 regarding timely submission of requested information to the BFCC-QIO if an enrollee files a grievance with the BFCC-QIO and the plan.

***Note:** When a plan decides to not process a quality of care grievance submitted by a person purporting to be an enrollee's representative but who failed to timely submit the necessary representative documentation, the plan should, but is not required to, investigate the quality of care grievance. The plan is not required to notify the enrollee of the outcome of the grievance since the grievance was not properly filed.*

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40 – Coverage Determinations, Organization Determinations (Initial Determinations) and At-Risk Determinations

A coverage determination/organization determination (hereafter referred to as an initial determination¹) is a decision made by the plan, or its delegated entity, on a request for coverage (payment or provision) of an item, service, or drug.

Plans must adhere to all applicable requirements set forth in 42 CFR Part 422, Subpart M and Part 423,

¹ *When necessary, this manual also generally differentiates between the types of initial determinations including prior authorizations; voluntary requests for items, services, and/or Part B drugs (as applicable); Part D coverage requests; and requests for payment (Part C) or reimbursement (Part D).*

Subpart M when making initial determinations regardless of whether:

- *Coverage is requested for an item/service/drug that is subject to a plan's prior authorization requirement;*
- *Coverage is requested for an item/service/drug that is NOT subject to a plan's prior authorization requirement;*
- *A plan makes a decision related to coverage of an item/service/drug without first receiving a party's request for coverage;*
- *A plan receives a request for coverage before the provision of the item/service/drug that is the subject of the request to the enrollee;*
- *A plan receives a request for coverage during or after the provision of the item/service/drug that is the subject of the request to the enrollee; and/or*
- *A plan's decision related to coverage of an item/service/drug will be issued during or after the provision of the item/service/drug to the enrollee.*

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40.4 – Prior Authorization and Other Utilization Management Requirements

Part C Only

An enrollee, enrollee's representative, or a provider on behalf of the enrollee, has the right to voluntarily request plan approval (either prior or concurrent to receiving services) in circumstances where there is a question whether the plan will cover a service, item, or Part B drug. An enrollee's right to voluntarily receive plan approval extends to any service, item, or Part B drug which the enrollee believes is or should be covered by the plan (this includes non-covered services, items and Part B drugs services and those for which the plan does not require prior authorization (PA) as a condition for coverage in its annual Evidence of Coverage).

When a plan processes a coverage request that involves **mandatory** PA or other utilization management (UM) requirement, such as step therapy for Part B drugs, the plan's determination on whether to grant approval of a service, **item**, or **Part B or D** drug for an enrollee constitutes an initial determination and is subject to appeal. In addition, if a plan denies coverage of a service, **item**, or **Part B or D** drug because the enrollee failed to seek PA or failed to comply with similar limits on coverage, the denial also constitutes an initial determination and is subject to appeal.² Partially adverse determinations include coverage decisions in which the MA plan approves a PA request at a reduced level (or approves an altogether different service, **item**, or **Part B or D** drug) than the **service**, **item**, or **Part B or D** drug requested. Thus, the adjudication timeframe, notice, and other requirements applicable to coverage determinations or organization determinations under [Part 422, Subpart M](#) & [Part 423, Subpart M](#) apply to requests that involve a PA or other UM requirements in the same manner that they apply to all coverage requests. If an enrollee requests coverage of a service, **item**, or **Part B or D** drug, the plan **is to respond to the PA request**, and should contact the physician or prescriber for information needed to satisfy the PA, in accordance with the outreach guidance at [§10.6](#). Plans, however, should not use peer-to-peer discussions to solicit substantive modification to pending PA requests in order to improve likelihood for approval (e.g. a peer-to-peer discussion suggesting the physician or prescriber modify a pending PA request to a lower level of service in order to receive plan approval). Coverage and medical

² For Part D, this denial would occur after an enrollee has formally requested a coverage determination with a Part D plan sponsor because, as indicated in [§40.2](#) above, the presentation of a prescription at the pharmacy counter is not considered a request for a coverage determination unless a plan sponsor chooses to treat it as such.

necessity decisions are initial determinations subject to notification and appeal requirements. MA plans may not interfere with an enrollee's right to receive a requested initial determination or obstruct the enrollee's access to the appeal process by any means.

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40.6 – Who May Request an Initial Determination

Enrollees or their representatives may make a request for all types of decisions about coverage under both Part C and Part D. Other parties that may request an initial determination include:

Type of Request	Who May Request
Part C, Standard Request <i>for Item, Service, or Part B Drug</i>	<ul style="list-style-type: none"> Contract or non-contract provider/physician that furnishes, or intends to furnish, services to the enrollee. 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).
Part C, Expedited Request	<ul style="list-style-type: none"> A physician or staff of said physician's office acting on said physician's behalf (e.g., request is on said physician's letterhead).
Part C, Payment Request	<ul style="list-style-type: none"> Contract or non-contract providers.
Part D, Standard or Expedited Request	<ul style="list-style-type: none"> An enrollee's prescribing physician or other prescriber*. Staff of said prescriber's office acting on said prescriber's behalf (e.g., request is on said prescriber's letterhead or comes from the prescriber office fax machine).
Part D, Payment Request	<ul style="list-style-type: none"> For direct member reimbursement, only an enrollee or an enrollee's representative (which may be the prescribing physician or other prescriber*) may request reimbursement under Part D.

** Pursuant to § 423.560, "other prescriber" means a health care professional other than a physician who is authorized under State law or other applicable law to write prescriptions. It is the Part D plan sponsor's responsibility to identify the types of health care professionals that have prescribing authority in the states in which the Part D plan sponsor operates.*

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40.9 – Who Must Review an Initial Determination

If a plan initially reviews a request and expects to issue a partially or fully adverse decision based on medical necessity, the review must be completed by a physician, as defined in section 1861(r) of the Act, or other appropriate healthcare professional who has:

- Sufficient medical and other expertise;

- Knowledge of the Medicare coverage criteria; and
- A current and unrestricted license to practice within the scope of his or her profession in a State, Territory, Commonwealth of the United States (that is, Puerto Rico), or the District of Columbia.

Part C Only

With respect to the reviewing healthcare professional's medical and other expertise, the reviewer's expertise must be in the field of medicine or health care that is appropriate for the services at issue. The reviewer must apply the prudent layperson standard (as described in 42 CFR §422.113(b)(1)) when making determinations regarding emergency services.

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40.12.1 – Part C Notification Requirements

Item, Service, or Part B Drug Approvals

For favorable decisions on a request *for an item, service, or Part B drug*, notice may be provided verbally or in writing to the requesting party. Verbal or written notice of a favorable decision should explain any conditions of the approval, such as the duration of the approval. As a best practice, MA plans are encouraged to provide written notice of favorable decisions (again, including any applicable conditions/parameters of the approval). If a provider submits the request on behalf of the enrollee, the MA plan must notify the enrollee as well as the provider of its determination. If the enrollee's representative submits a request, the representative must be notified in lieu of the enrollee. Plans may provide notice to both the representative and enrollee, but are not required. If the enrollee agrees, the MA plan may send the notice by fax or e-mail. Please see Medicare *Communications and Marketing Guidelines* regarding electronic communication with enrollees.

Denials and Discontinuation/Reduction of Previously Authorized Ongoing Course of Treatment

A written denial notice is required to be sent to the enrollee (and physician/provider involved, as appropriate) whenever an MA plan's determination is partially or fully adverse to the enrollee. For Part C organization determination denials, MA plans must use approved notice language when issuing written denial notices to enrollees.

The standardized denial notice is the Notice of Denial of Medical Coverage or Payment (Form CMS-10003-NDMCP), also known as the Integrated Denial Notice (IDN). MA plans may use a separate written notice of denial document, such as a plan-generated claims statement to the enrollee or provider, but must use the approved standard language. An example of a plan generated statement is an Explanation of Benefits (EOB), detailing what the MA plan has paid on the enrollee's behalf, and/or the enrollee's liability for payment.

If an MA plan uses its existing system-generated notification (i.e., EOB) regarding payment denials as its written notice of determination, the MA plan must ensure that the EOB contains the OMB-approved language of the IDN verbatim in its entirety and meets the content requirements as described in the IDN form instructions and listed below. When issuing an EOB in place of the IDN, the MA plan must notify the enrollee via the EOB within the required timeframe. When providing the decision, the MA plan must also take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any (see Section 10.4.4 for additional information).

***Note:** The Advanced Beneficiary Notice of Non-Coverage (ABN), Form (CMS-R-131) does not comply with MA organization determination requirements of 42 CFR, Part 422, Subpart M and, therefore, shall not be used by MA plans or contracted providers. When a MA plan wishes to inform an enrollee that a service is not covered, in whole or in part, it must issue the IDN or include the same OMB-approved standardized language in its EOB. If a provider believes an item, service or Part B drug may not be covered, the provider must advise the enrollee to request prior authorization from the MA plan or the provider may request prior authorization on the enrollee's behalf. The failure to provide notice via the OMB-approved standardized language contained in the IDN or via a clear exclusion in the plan's EOC, consistent with the beneficiary protection provisions in Chapter 4, means the enrollee is not liable for items, services or Part B drugs provided by a contracted provider or upon referral from a contracted provider (see Chapter 4, Section 160, of the Medicare Managed Care Manual for more information on beneficiary protections related to plan-directed care, including enrollee liability protections).*

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40.15 – Dismissal of an Initial Determination Request

Plans must dismiss requests for an initial determination under any of the following circumstances:

- The individual or entity making the request is not permitted to request an initial determination under the applicable regulation.
- The plan determines that the individual or entity making the request failed to make a valid request for an initial determination that substantially complies with 42 CFR §§ 422.568(a) or 423.568(a). *A valid request as contemplated in §§ 422.568(a) and 423.568(a) includes sufficient information to identify the enrollee to allow the plan to adjudicate the request (or, at a minimum, make contact with the enrollee to clarify the request), including a full name or member ID number and at least one means of contact (e.g., address, telephone number, email).* In addition, under Part D, an enrollee may not request a tiering exception for an approved non-formulary prescription drug. See: 42 CFR § 423.578(c)(4)(iii). In this circumstance, a plan would dismiss the request and issue a dismissal notice in accordance with the notice requirements at § 40.15.1.
- The enrollee dies while the request is pending and the enrollee's spouse or estate has no remaining financial interest in the case and no other individual or entity with a financial interest in the case wishes to pursue the initial determination. Financial interest means having financial liability for the item(s) or service(s) underlying the coverage request.
- The individual or entity who requested the review submits a timely verbal or written request for withdrawal of their request for an initial determination with the plan.

When the plan's dismissal is due to a timely withdrawal request, the plan is required to dismiss the initial determination request and issue a dismissal notice in accordance with the notice requirements at section 40.15.1 in order to preserve the rights of other proper parties to the decision who may wish to request review of the dismissal.

The guidance in 40.15 does not alter reporting requirements. Withdrawn requests and dismissals should continue to be reported separately in their distinct categories, per existing reporting requirements.

NOTE: The above list of circumstances (taken from the applicable regulations) under which a plan must dismiss a request for an initial determination is exhaustive. A plan may not deem a request invalid or dismiss a request for an initial determination for any reason not explicitly included in 42 CFR §§ 422.568(g) and 423.568(i), as applicable.

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50.1 – Who May Request a Level 1 Appeal

Part C

Type of Request	Who May Request An Appeal
Standard Reconsideration: <i>Requests for Item, Service, or Part B Drug</i>	<ul style="list-style-type: none"> • 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 Reconsideration: <i>Payment</i>	<ul style="list-style-type: none"> • An enrollee; • An enrollee’s representative; • Non-contract provider (see <u>§50.1.1</u> 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	<ul style="list-style-type: none"> • 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.

*If the enrollee’s records indicate that he or she has not previously visited the requesting physician, the MA plan should undertake reasonable efforts to confirm that the enrollee has received appropriate notification of the appeal.

Part D

Type of Request	Who May Request An Appeal
Standard or Expedited Redetermination	<ul style="list-style-type: none"> • An enrollee; • An enrollee's representative; • An enrollee's prescribing physician or other prescriber* acting on behalf of the enrollee**; or • Staff of a physician's office acting on a physician's behalf (e.g., request is on the office's letterhead)
<i>Standard Payment Redetermination</i>	<ul style="list-style-type: none"> • <i>For direct member reimbursement, only an enrollee or an enrollee's representative (which may be the prescribing physician or other prescriber*) may appeal an adverse reimbursement decision under Part D.</i>

** Pursuant to § 423.560, "other prescriber" means a health care professional other than a physician who is authorized under State law or other applicable law to write prescriptions. It is the Part D plan sponsor's responsibility to identify the types of health care professionals that have prescribing authority in the states in which the Part D plan sponsor operates.*

***If the enrollee's records indicate that he or she has not previously visited the requesting physician or prescriber, the plan sponsor should undertake reasonable efforts to confirm that the enrollee has received appropriate notification of the appeal.*

50.1.1 – Requirements for Provider Claim Appeals (Part C Only)

The appeal provisions set forth at 42 CFR Part 422 Subpart M and described in this guidance are designed to protect enrollee and non-contract provider rights related to grievances, organization determinations, and appeals *and non-contracted provider rights related to organization determinations and appeals*.

A non-contract provider, on his or her own behalf, may request a reconsideration (*i.e., an appeal*) for a denied claim only if the non-contract provider completes a Waiver of Liability (WOL) statement, which provides that the non-contract provider will not bill the enrollee regardless of the outcome of the appeal).

If an appeal is submitted, the WOL must be filed with the appeal. The appeal should include other supporting documentation (e.g., copy of remittance advice/notice and clinical records claim). Non-contract providers who have executed a WOL are not required to complete the representative form because the provider is not representing the enrollee, and thus does not need a written representative form. Furthermore, because the enrollee no longer has an appealable interest under 42 CFR Part 422 Subpart M, plan notices/correspondence regarding the noncontract provider's appeal would be delivered to the non-contract provider and not the enrollee. If the WOL isn't filed with the appeal, the plan should make and document reasonable efforts to obtain the WOL. The plan is not required to undertake a review of the appeal until or unless the form is obtained, but it may choose to begin the review while continuing efforts to obtain a WOL. The adjudication timeframe begins when the WOL is received by the plan. If the plan does not receive the WOL by the end of the adjudication timeframe the plan issues a dismissal notice per the dismissal procedures set forth in this guidance. See §50.9.

A non-contracted provider who has furnished a service to an enrollee, *and submitted the WOL*, can be a party to an organization determination, in accordance with 42 C.F.R. § 422.574(b). Thus, pursuant to 42 C.F.R. § 422.578, a non-contracted provider may request that an organization determination be reconsidered by the plan. Even reconsideration requests submitted by non-contracted providers that relate to the type or level of service furnished to the enrollee must be reviewed in accordance with the administrative appeal processes outlined in 42 C.F.R. Part 422, Subpart M.

In the following examples a non-contracted provider who is the enrollee's assignee, *and who has submitted the WOL*, must be afforded full administrative appeals rights in accordance with 42 C.F.R. Part 422 Subpart M:

- **Diagnosis code/DRG payment denials.** A non-contracted provider submits a claim to a plan. The plan initially approves the claim, which is considered a favorable organization determination (see 42 C.F.R. 422.566(b)). The plan later reopens and revises the favorable organization determination and denies the DRG code on the basis that a different DRG code should have been submitted and recoups funds.
- **Downcoding.** A plan approves coverage for inpatient services from a non-contracted provider, which is considered a favorable organization determination (see 42 C.F.R. 422.566(b)). The plan later reopens and revises the favorable organization determination (e.g., retrospective review) and determines the enrollee should have received outpatient services.
- **Bundling issues and disputed rate of payment.** Pre- and post-pay bundling and global payment determinations. For example, denial of procedure codes -- as mutually exclusive to another paid procedure code, or due to inclusion in a previously paid global surgical package.
- **Level of care or rate of payment denials.** Payment of a reduced fee schedule amount for a course of treatment. For example, a provider bills a procedure code for a visit but the plan reimburses based on a lower level of care.

Further, even if the plan partially pays for coverage (i.e., denies coverage as requested but approves or pays for part of the service), a non-contracted provider who according to 42 C.F.R. §422.574(b) is a party to the organization determination may request reconsideration under the Medicare administrative appeals process; a non-contracted provider does not need to receive zero payment to request a reconsideration or to otherwise access the Subpart M appeals process.

Note: Providers can use electronic signatures on WOL documentation when it is submitted through the plan's secure portal, provided the portal meets all applicable regulatory and CMS website requirements.

An authorized party (e.g., billing agency) may submit a payment appeal request on behalf of a non-contracted provider without a valid AOR when the billing agency can provide evidence the provider furnished the billing agency authority to prepare a claim and receive payment on behalf of the provider or that the billing agency otherwise has authority to pursue appeals. Nevertheless, the billing agency may not sign the WOL on behalf of the provider.

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50.8 – Service, Item or Drug Received Prior to Notice of Decision

During the processing of an appeal of a denied coverage request, if an MA plan or a Part D sponsor learns (by any means, including by receipt of a claim or reimbursement request) that the enrollee received the item/service/drug that is the subject of the appeal, the MA plan or Part D sponsor must finish adjudicating the appeal request and issue a substantive decision consistent with the applicable requirements of 42 CFR Part 422, Subpart M or Part 423, Subpart M.

If applicable, the MA plan or Part D sponsor must separately process and issue a decision on any related claim or reimbursement request.

Medicare Parts C and D regulations do not permit an MA plan or Part D sponsor to dismiss an otherwise valid, timely appeal request of an adverse coverage decision solely because an enrollee is concurrently receiving or has already received the item/service/drug that is the subject of the appeal. MA plans or Part D sponsors may only dismiss appeal requests for the reasons listed at 42 CFR §§ 422.582(f) and 423.582(e) (see section 50.9 of this manual for more details).

50.9 – Dismissal of a Level 1 Appeal Request

Plans must dismiss *a level 1* appeal request under any of the following circumstances:

- The individual or entity making the request is not a proper party to the appeal under the applicable regulation. This includes the following situations: If an individual requests a reconsideration on behalf of an enrollee, but a properly executed appointment of representative form has not been filed (and there is no other documentation to show that the individual is legally authorized to act on the enrollee's behalf), the MA plan is obligated to make attempts to secure the missing documentation (see §20.2.1).
- If a non-contracted provider requests a reconsideration of a denied claim (i.e., post-service appeal) but fails to provide a waiver of liability statement indicating that it will not bill the enrollee regardless of the outcome of the appeal, the MA plan should make attempts to secure the missing documentation prior to dismissing the request. Please note: a prior reconsideration request by a physician who is providing treatment to an enrollee, upon providing notice to the enrollee, is considered a valid request.
- When the plan determines the party failed to make a valid request for an appeal that substantially complies with the applicable regulation for making a valid request for a level 1 appeal. For example, when the party fails to file the level 1 appeal within the proper filing timeframe in accordance with the applicable regulation. *A valid request as contemplated in §§ 422.582(a) and 423.582(a) includes sufficient information to identify the enrollee to allow the plan to adjudicate the request (or, at a minimum, make contact with the enrollee to clarify the request), including a full name or member ID number or at least one means of contact (e.g., address, telephone number, email).*
- When the enrollee dies while the appeal is pending and the enrollee's spouse or estate has no remaining financial interest in the case and no other individual or entity with a financial interest in the case wishes to pursue the level 1 appeal. Financial interest means having financial liability for the item(s) or service(s) underlying the coverage request.
- When the individual or entity that requested the reconsideration submits a timely written request to

withdraw their request for a level 1 appeal.

When the dismissal is the result of a timely withdrawal request, the plan is required to mail or otherwise transmit a dismissal notice in accordance with the notice requirements in section 50.9.1 in order to preserve the rights of other proper parties to the decision who may wish to request review of the dismissal. The dismissal notice will explain that the withdrawal request is the reason for dismissal. For reporting purposes, this scenario is categorized as a withdrawal in reporting to CMS.

The guidance in section 50.9 does not alter reporting requirements. Withdrawn requests and dismissals should continue to be reported separately in their distinct categories, per existing reporting requirements.

***NOTE:** The above list of circumstances (taken from the applicable regulations) under which a plan must dismiss a request for a level 1 appeal is exhaustive. A plan may not deem a request invalid or dismiss a request for a level 1 appeal for any reason not explicitly included in 42 CFR §§ 422.582(f) and 423.582(e), as applicable.*

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60.6 – Dismissal of a Level 2 Appeal *Request*

The IRE must dismiss a level 2 appeal *request* under any of the following circumstances:

- The individual or entity making the request is not a proper party to the appeal under the applicable regulation
- When the IRE determines the party failed to make a valid request for an appeal that substantially complies with the applicable regulation for making a valid request.
- Part D only: When the party fails to file the appeal within the proper filing timeframe in accordance with the applicable regulation and there is no good cause for the late filing.
- When the enrollee dies while the appeal is pending and the enrollee's spouse or estate has no remaining financial interest in the case and no other individual or entity with a financial interest in the case wishes to pursue the reconsideration or redetermination. Financial interest means having financial liability for the item(s) or service(s) underlying the coverage request.
- When the party that requested the appeal submits a timely request for withdrawal of the request for reconsideration.

***NOTE:** The above list of circumstances (taken from the applicable regulations) under which the IRE must dismiss a level 2 appeal is exhaustive. The IRE may not deem a request invalid or dismiss a level 2 appeal for any reason not explicitly included in 42 CFR §§ 422.592(d) and 423.600(g), as applicable.*