

## § 422.564

## 42 CFR Ch. IV (10–1–23 Edition)

contracted by CMS, as provided in § 422.592.

(iv) The right to an ALJ hearing if the amount in controversy is met, as provided in § 422.600.

(v) The right to request Council review of the ALJ hearing decision, as provided in § 422.608.

(vi) The right to judicial review of the hearing decision if the amount in controversy is met, as provided in § 422.612.

(c) *Limits on when this subpart applies.*

(1) If an enrollee receives immediate QIO review (as provided in § 422.622) of a determination of noncoverage of inpatient hospital care the enrollee is not entitled to review of that issue by the MA organization.

(2) If an enrollee has no further liability to pay for services that were furnished by an MA organization, a determination regarding these services is not subject to appeal.

(d) *When other regulations apply.* (1) Unless this subpart provides otherwise and subject to paragraph (d)(2) of this section, the regulations in part 405 of this chapter (concerning the administrative review and hearing processes and representation of parties under titles II and XVIII of the Act) apply under this subpart to the extent they are appropriate.

(2) The following regulations in part 405 of this chapter, and any references thereto, specifically do not apply under this subpart:

(i) Section 405.950 (time frames for making a redetermination).

(ii) Section 405.970 (time frames for making a reconsideration following a contractor redetermination, including the option to escalate an appeal to the OMHA level).

(iii) Section 405.1016 (time frames for deciding an appeal of a QIC reconsideration, or escalated request for a QIC reconsideration, including the option to escalate an appeal to the Council).

(iv) The option to request that an appeal be escalated from the OMHA level to the Council as provided in § 405.1100(b), and time frames for the Council to decide an appeal of an ALJ's or attorney adjudicator's decision or an appeal that is escalated from the OMHA level to the Council as provided in § 405.1100(c) and (d).

(v) Section 405.1132 (request for escalation to Federal court).

(vi) Sections 405.956(b)(8), 405.966(a)(2), 405.976(b)(5)(ii), 405.1018(c), 405.1028(a), and 405.1122(c), and any other reference to requiring a determination of good cause for the introduction of new evidence by a provider, supplier, or a beneficiary represented by a provider or supplier.

(3) For the sole purpose of applying the regulations at § 405.1038(c) of this chapter, an MA organization is included in the definition of “contractors” as it relates to stipulated decisions.

[63 FR 35067, June 26, 1998, as amended at 65 FR 40329, June 29, 2000; 70 FR 4738, Jan. 28, 2005; 70 FR 52027, Sept. 1, 2005; 76 FR 21569, Apr. 15, 2011; 82 FR 5110, Jan. 17, 2017; 84 FR 15834, Apr. 16, 2019; 84 FR 26579, June 7, 2019; 86 FR 6101, Jan. 19, 2021]

### § 422.564 Grievance procedures.

(a) *General rule.* Each MA organization must provide meaningful procedures for timely hearing and resolving grievances between enrollees and the organization or any other entity or individual through which the organization provides health care services under any MA plan it offers.

(b) *Distinguished from appeals.* Grievance procedures are separate and distinct from appeal procedures, which address organization determinations as defined in § 422.566(b). Upon receiving a complaint, an MA organization must promptly determine and inform the enrollee whether the complaint is subject to its grievance procedures or its appeal procedures.

(c) *Distinguished from the quality improvement organization (QIO) complaint process.* Under section 1154(a)(14) of the Act, the QIO must review beneficiaries' written complaints about the quality of services they have received under the Medicare program. This process is separate and distinct from the grievance procedures of the MA organization. For quality of care issues, an enrollee may file a grievance with the MA organization; file a written complaint with the QIO, or both. For any complaint submitted to a QIO, the MA organization must cooperate with the QIO in resolving the complaint.

(d) *Method for filing a grievance.* (1) An enrollee may file a grievance with the MA organization either orally or in writing.

(2) An enrollee must file a grievance no later than 60 days after the event or incident that precipitates the grievance.

(e) *Grievance disposition and notification.* (1) The MA organization must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee's health status, but no later than 30 days after the date the organization receives the oral or written grievance.

(2) The MA organization may extend the 30-day timeframe by up to 14 days if the enrollee requests the extension or if the organization justifies a need for additional information and documents how the delay is in the interest of the enrollee. When the MA organization extends the deadline, it must immediately notify the enrollee in writing of the reasons for the delay.

(3) The MA organization must inform the enrollee of the disposition of the grievance in accordance with the following procedures:

(i) All grievances submitted in writing must be responded to in writing.

(ii) Grievances submitted orally may be responded to either orally or in writing, unless the enrollee requests a written response.

(iii) All grievances related to quality of care, regardless of how the grievance is filed, must be responded to in writing. The response must include a description of the enrollee's right to file a written complaint with the QIO. For any complaint submitted to a QIO, the MA organization must cooperate with the QIO in resolving the complaint.

(f) *Expedited grievances.* An MA organization must respond to an enrollee's grievance within 24 hours if:

(1) The complaint involves an MA organization's decision to invoke an extension relating to an organization determination or reconsideration.

(2) The complaint involves an MA organization's refusal to grant an enrollee's request for an expedited organization determination under § 422.570 or reconsideration under § 422.584.

(g) *Recordkeeping.* The MA organization must have an established process

to track and maintain records on all grievances received both orally and in writing, including, at a minimum, the date of receipt, final disposition of the grievance, and the date that the MA organization notified the enrollee of the disposition.

[68 FR 16667, Apr. 4, 2003, as amended at 70 FR 4738, Jan. 28, 2005]

#### § 422.566 Organization determinations.

(a) *Responsibilities of the MA organization.* Each MA organization must have a procedure for making timely organization determinations (in accordance with the requirements of this subpart) regarding the benefits an enrollee is entitled to receive under an MA plan, including basic benefits as described under § 422.100(c)(1) and mandatory and optional supplemental benefits as described under § 422.102, and the amount, if any, that the enrollee is required to pay for a health service. The MA organization must have a standard procedure for making determinations, in accordance with § 422.568, and an expedited procedure for situations in which applying the standard procedure could seriously jeopardize the enrollee's life, health, or ability to regain maximum function, in accordance with §§ 422.570 and 422.572. For an applicable integrated plan, beginning January 1, 2021, the MA organization must comply with §§ 422.629 through 422.634 in lieu of §§ 422.566(c) and (d), 422.568, 422.570 and 422.572 with regard to the procedures for making determinations, including integrated organization determinations and integrated reconsiderations, on a standard and expedited basis.

(b) *Actions that are organization determinations.* An organization determination is any determination made by an MA organization with respect to any of the following:

(1) Payment for temporarily out of the area renal dialysis services, emergency services, post-stabilization care, or urgently needed services.

(2) Payment for any other health services furnished by a provider other than the MA organization that the enrollee believes—

(i) Are covered under Medicare; or

(ii) If not covered under Medicare, should have been furnished, arranged