

paragraph (c) of this section. An enrollee may waive continuation of services if he or she agrees with being discharged sooner than 2 days after receiving the notice.

[68 FR 16667, Apr. 4, 2003, as amended at 75 FR 19812, Apr. 15, 2010]

§ 422.626 Fast-track appeals of service terminations to independent review entities (IREs).

(a) *Enrollee's right to a fast-track appeal of an MA organization's termination decision.* An enrollee of an MA organization has a right to a fast-track appeal of an MA organization's decision to terminate provider services.

(1) An enrollee who desires a fast-track appeal must submit a request for an appeal to an IRE under contract with CMS, in writing or by telephone, by noon of the first day after the day of delivery of the termination notice. If, due to an emergency, the IRE is closed and unable to accept the enrollee's request for a fast-track appeal, the enrollee must file a request by noon of the next day that the IRE is open for business.

(2) When an enrollee fails to make a timely request to an IRE, he or she may request an expedited reconsideration by the MA organization as described in § 422.584.

(3) If, after delivery of the termination notice, an enrollee chooses to leave a provider or discontinue receipt of covered services on or before the proposed termination date, the enrollee may not later assert fast-track IRE appeal rights under this section relative to the services or expect the services to resume, even if the enrollee requests an appeal before the discontinuation date in the termination notice.

(b) *Coverage of provider services.* Coverage of provider services continues until the date and time designated on the termination notice, unless the enrollee appeals and the IRE reverses the MA organization's decision. If the IRE's decision is delayed because the MA organization did not timely supply necessary information or records, the MA organization is liable for the costs of any additional coverage required by the delayed IRE decision. If the IRE finds that the enrollee did not receive

valid notice, coverage of provider services by the MA organization continues until at least two days after valid notice has been received. Continuation of coverage is not required if the IRE determines that coverage could pose a threat to the enrollee's health or safety.

(c) *Burden of proof.* When an enrollee appeals an MA organization's decision to terminate services to an IRE, the burden of proof rests with the MA organization to demonstrate that termination of coverage is the correct decision, either on the basis of medical necessity, or based on other Medicare coverage policies.

(1) To meet this burden, the MA organization must supply any and all information that an IRE requires to sustain the MA organization's termination decision, consistent with paragraph (e) of this section.

(2) The enrollee may submit evidence to be considered by an IRE in making its decision.

(3) The MA organization or an IRE may require an enrollee to authorize release to the IRE of his or her medical records, to the extent that the records are necessary for the MA organization to demonstrate the correctness of its decision or for an IRE to determine the appeal.

(d) *Procedures an IRE must follow.* (1) On the date an IRE receives the enrollee's request for an appeal, the IRE must immediately notify the MA organization and the provider that the enrollee has filed a request for a fast-track appeal, and of the MA organization's responsibility to submit documentation consistent with paragraph (e)(3) of this section.

(2) When an enrollee requests a fast-track appeal, the IRE must determine whether the provider delivered a valid notice of the termination decision, and whether a detailed notice has been provided, consistent with paragraph (e)(1) of this section.

(3) The IRE must notify CMS about each case in which it determines that improper notification occurs.

(4) Before making its decision, the IRE must solicit the enrollee's views regarding the reason(s) for termination of services as specified in the detailed

written notice provided by the MA organization, or regarding any other reason that the IRE uses as the basis of its review determination.

(5) An IRE must make a decision on an appeal and notify the enrollee, the MA organization, and the provider of services, by close of business of the day after it receives the information necessary to make the decision. If the IRE does not receive the information needed to sustain an MA organization's decision to terminate services, it may make a decision on the case based on the information at hand, or it may defer its decision until it receives the necessary information. If the IRE defers its decision, coverage of the services by the MA organization would continue until the decision is made, consistent with paragraph (b) of this section, but no additional termination notice would be required.

(e) *Responsibilities of the MA organization.* (1) When an IRE notifies an MA organization that an enrollee has requested a fast-track appeal, the MA organization must send a detailed notice to the enrollee by close of business of the day of the IRE's notification. The detailed termination notice must include the following information:

(i) A specific and detailed explanation why services are either no longer reasonable and necessary or are no longer covered.

(ii) A description of any applicable Medicare coverage rule, instruction or other Medicare policy including citations, to the applicable Medicare policy rules, or the information about how the enrollee may obtain a copy of the Medicare policy from the MA organization.

(iii) Any applicable MA organization policy, contract provision, or rationale upon which the termination decision was based.

(iv) Facts specific to the enrollee and relevant to the coverage determination that are sufficient to advise the enrollee of the applicability of the coverage rule or policy to the enrollee's case.

(v) Any other information required by CMS.

(2) Upon an enrollee's request, the MA organization must provide the enrollee a copy of, or access to, any docu-

mentation sent to the IRE by the MA organization, including records of any information provided by telephone. The MA organization may charge the enrollee a reasonable amount to cover the costs of duplicating the information for the enrollee and/or delivering the documentation to the enrollee. The MA organization must accommodate such a request by no later than close of business of the first day after the day the material is requested.

(3) Upon notification by the IRE of a fast-track appeal, the MA organization must supply any and all information, including a copy of the notice sent to the enrollee, that the IRE needs to decide on the appeal. The MA organization must supply this information as soon as possible, but no later than by close of business of the day that the IRE notifies the MA organization that an appeal has been received from the enrollee. The MA organization must make the information available by phone (with a written record made of what is transmitted in this manner) and/or in writing, as determined by the IRE.

(4) An MA organization is financially responsible for coverage of services as provided in paragraph (b) of this section, regardless of whether it has delegated responsibility for authorizing coverage or termination decisions to its providers.

(f) *Responsibilities of the provider.* If an IRE reverses an MA organization's termination decision, the provider must provide the enrollee with a new notice consistent with § 422.624(b) of this subpart.

(g) *Reconsiderations of IRE decisions.*

(1) If the IRE upholds an MA organization's termination decision in whole or in part, the enrollee may request, no later than 60 days after notification that the IRE has upheld the decision that the IRE reconsider its original decision.

(2) The IRE must issue its reconsidered determination as expeditiously as the enrollee's health condition requires but no later than within 14 days of receipt of the enrollee's request for a reconsideration.

(3) If the IRE reaffirms its decision, in whole or in part, the enrollee may

appeal the IRE's reconsidered determination to OMHA for an ALJ hearing, the Council, or a Federal court, as provided for under this subpart.

(4) If on reconsideration the IRE determines that coverage of provider services should terminate on a given date, the enrollee is liable for the costs of continued services after that date unless the IRE's decision is reversed on appeal. If the IRE's decision is reversed on appeal, the MA organization must reimburse the enrollee, consistent with the appealed decision, for the costs of any covered services for which the enrollee has already paid the MA organization or provider.

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REQUIREMENTS APPLICABLE TO CERTAIN INTEGRATED DUAL ELIGIBLE SPECIAL NEEDS PLANS

SOURCE: 84 FR 15835, Apr. 16, 2019, unless otherwise noted.

§ 422.629 General requirements for applicable integrated plans.

(a) *Scope.* The provisions in this section and in §§ 422.630 through 422.634 set forth requirements for unified appeals and grievance processes with which applicable integrated plans must comply. Beginning January 1, 2021, these provisions apply to an applicable integrated plan in lieu of §§ 422.564, 422.566(c) and (d), and 422.568 through 422.590, and 422.618(a) and §§ 438.404 through 438.424 of this chapter; provisions governing Part B drugs in §§ 422.568(b)(2), 422.570(d)(2), 422.572(a)(2), 422.584(d)(1), 422.590(c), and 422.590(e)(2) apply to an applicable integrated plan.

(b) *General process.* An applicable integrated plan must create integrated processes for enrollees for integrated grievances, integrated organization determinations, and integrated reconsiderations.

(c) *State flexibilities.* A State may, at its discretion, implement standards for timeframes or notice requirements that are more protective for the enrollee than required by this section and §§ 422.630 through 422.634. The contract under § 422.107 must include any stand-

ards that differ from the standards set forth in this section.

(d) *Evidence.* The applicable integrated plan must do the following:

(1) Provide the enrollee—

(i) 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; and

(ii) Information on how evidence and testimony should be presented to the plan.

(2) Inform the enrollee of the limited time available for presenting evidence sufficiently in advance of the resolution timeframe for appeals as specified in this section if the case is being considered under an expedited timeframe for the integrated grievance or integrated reconsideration.

(e) *Assistance.* In addition to the requirements in § 422.562(a)(5), the applicable integrated plan must provide an enrollee reasonable assistance in completing forms and taking other procedural steps related to integrated grievances and integrated appeals.

(f) *Applicable requirements.* The requirements in §§ 422.560, 422.561, 422.562, 422.566, and 422.592 through 422.626 apply to an applicable integrated plan unless otherwise provided in this section or in §§ 422.630 through 422.634.

(g) *Acknowledgement.* The applicable integrated plan must send to the enrollee written acknowledgement of integrated grievances and integrated reconsiderations upon receiving the request.

(h) *Recordkeeping.* (1) 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.

(2) 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.