

Medicare and Medicaid coverage criteria, before the applicable integrated plan issues the integrated reconsideration determination.

(1) *Parties.* (1) The following individuals or entities can request an integrated grievance, integrated organization determination, and integrated reconsideration, and are parties to the case:

(i) The enrollee.
(ii) The enrollee's representative, including any person authorized under State law.

(2) When the term "enrollee" is used throughout §§ 422.629 through 422.634, it includes providers that file a request and authorized representatives consistent with this paragraph, unless otherwise specified.

(3) 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.

(4) The following individuals or entities may request an integrated reconsideration and are parties to the case:

(i) 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).

(ii) Any other provider or entity (other than the applicable integrated plan) who has an appealable interest in the proceeding.

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§ 422.630 Integrated grievances.

(a) *General rule.* In lieu of complying with § 422.564, and the grievance requirements of §§ 438.402, 438.406, 438.408, 438.414, and 438.416 of this chapter, each applicable integrated plan must comply with this section. Each applicable integrated plan must provide meaningful procedures for timely hearing and resolving integrated grievances between enrollees and the applicable integrated plan or any other entity or individual through which the applicable integrated plan provides covered items and services.

(b) *Timing.* An enrollee may file an integrated grievance at any time with the applicable integrated plan.

(c) *Filing.* An enrollee may file an integrated grievance orally or in writing with the applicable integrated plan, or with the State for an integrated grievance related to a Medicaid benefit, if the State has a process for accepting Medicaid grievances.

(d) *Expedited grievances.* An applicable integrated plan must respond to an enrollee's grievance within 24 hours if the complaint involves the applicable integrated plan's—

(1) Decision to invoke an extension relating to an integrated organization determination or integrated reconsideration; or

(2) Refusal to grant an enrollee's request for an expedited integrated organization determination under § 422.631 or expedited integrated reconsideration under § 422.633.

(e) *Resolution and notice.* (1) The applicable integrated plan must resolve standard integrated grievances as expeditiously as the case requires, based on the enrollee's health status, but no later than 30 calendar days from the date it receives the integrated grievance.

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

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

(iii) All integrated grievances related to quality of care, regardless of how the integrated 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 with regard to Medicare covered services. For any complaint submitted to a QIO, the applicable integrated plan must cooperate with the QIO in resolving the complaint.

(2) The timeframe for resolving the integrated grievance may be extended by 14 calendar days if the enrollee requests an extension or if the applicable integrated plan justifies the need for additional information and documents how the delay is in the interest of the

enrollee. When the applicable integrated plan extends the timeframe, it must—

(i) Make reasonable efforts to promptly notify the enrollee orally of the reasons for the delay; and

(ii) Send written notice to the enrollee of the reasons for the delay immediately, but no later than within 2 calendar days of making the decision to extend the timeframe to resolve the integrated grievance. This notice must explain the right to file an integrated grievance if the enrollee disagrees with the decision to delay.

§ 422.631 Integrated organization determinations.

(a) *General rule.* An applicable integrated plan must adopt and implement a process for enrollees to request that the plan make an integrated organization determination. The process for requesting that the applicable integrated plan make an integrated organization determination must be the same for all covered benefits. Timeframes and notice requirements for integrated organization determinations for Part B drugs are governed by the provisions for Part B drugs in §§ 422.568(b)(2), 422.570(d)(2), and 422.572(a)(2).

(b) *Requests.* The enrollee, or a provider on behalf of an enrollee, may request an integrated organization determination orally or in writing, except for requests for payment, which must be in writing (unless the applicable integrated plan or entity responsible for making the determination has implemented a voluntary policy of accepting verbal payment requests).

(c) *Expedited integrated organization determinations.* (1) An enrollee, or a provider on behalf of an enrollee, may request an expedited integrated organization determination.

(2) The request can be oral or in writing.

(3) The applicable integrated plan must complete an expedited integrated organization determination when the applicable integrated plan determines (based on a request from the enrollee or on its own) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously

jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

(d) *Timeframes and notice—(1) Integrated organization determination notice.*

(i) The applicable integrated plan must send an enrollee a written notice of any adverse decision on an integrated organization determination (including a determination to authorize a service or item in an amount, duration, or scope that is less than the amount previously requested or authorized for an ongoing course of treatment) within the timeframes set forth in this section.

(ii) For an integrated organization determination not reached within the timeframes specified in this section (which constitutes a denial and is thus an adverse decision), the applicable integrated plan must send a notice on the date that the timeframes expire. Such notice must describe all applicable Medicare and Medicaid appeal rights.

(iii) Integrated organization determination notices must be written in plain language, be available in a language and format that is accessible to the enrollee, and explain the following:

(A) The applicable integrated plan's determination.

(B) The date the determination was made.

(C) The date the determination will take effect.

(D) The reasons for the determination.

(E) The enrollee's right to file an integrated reconsideration and the ability for someone else to file an appeal on the enrollee's behalf.

(F) Procedures for exercising enrollee's rights to an integrated reconsideration.

(G) Circumstances under which expedited resolution is available and how to request it.

(H) If applicable, the enrollee's rights to have benefits continue pending the resolution of the integrated appeal process.

(2) *Timing of notice—(i) Standard integrated organization determinations.* (A) The applicable integrated plan must send a notice of its integrated organization determination at least 10 days