

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 standards 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.

(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.

(3) The record of each integrated grievance or integrated appeal must be accurately maintained in a manner accessible to the State and available upon request to CMS.

(i) *Prohibition on punitive action.* Each applicable integrated plan must 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.

(j) *Information to providers and subcontractors.* The applicable integrated plan must provide information about the integrated grievance and integrated appeal system to all providers and subcontractors at the time they enter into a contract including, at minimum, information on integrated grievance, integrated reconsideration, and fair hearing procedures and timeframes as applicable. Such information must include the following:

(1) The right to file an integrated grievance and integrated reconsideration.

(2) The requirements and timeframes for filing an integrated grievance or integrated reconsideration.

(3) The availability of assistance in the filing process.

(k) *Review decision-making requirements—*(1) *General rules.* Individuals making decisions on integrated appeals and grievances must 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.

(2) *Integrated grievances.* Individuals making decisions on integrated grievances must be individuals who—

(i) Were neither involved in any previous level of review or decision-making nor a subordinate of any such individual; and

(ii) If deciding any of the following, have the appropriate clinical expertise in treating the enrollee's condition or disease:

(A) A grievance regarding denial of expedited resolution of an appeal.

(B) A grievance that involves clinical issues.

(3) *Integrated organization determinations.* 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 expertise in the field of medicine or health care that is appropriate for the services at issue, including knowledge of Medicare and Medicaid coverage criteria, before the applicable integrated plan issues the integrated organization determination decision. The physician or health care professional reviewing the request need not, in all cases, be of the same specialty or subspecialty as the treating physician or other health care provider. The physician or other health care professional must have 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.

(4) *Integrated reconsideration determinations.* Individuals making an integrated reconsideration determination must be individuals who—

(i) Were neither involved in any previous level of review or decision-making nor a subordinate of any such individual; and

(ii) If deciding an 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 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.

[84 FR 15835, Apr. 16, 2019, as amended at 84 FR 23883, May 23, 2019; 86 FR 6102, Jan. 19, 2021; 87 FR 27897, May 9, 2022; 88 FR 22335, Apr. 12, 2023]

#### § 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