Medicare Managed Care Grievances, Organization Determinations, and Appeals

Frequently Asked Questions (FAQs)

1. We're a contracted (in-network) provider with a Medicare Advantage plan and have been having trouble getting access to the appeals process outlined at 42 CFR 422 Subpart M. What can we do?

   Answer: Contract (in-network) providers appeal rights fall outside the Subpart M Medicare appeals process. Therefore, if a plan denies a contract provider's payment request, the request is not addressed under the Medicare beneficiary appeals process.

   Instead, appeal rights available to contract providers are negotiated between the health plan and its contract providers and/or are outlined in the contract terms between the health plan and its providers. Payment disputes between contract providers and health plans are resolved under the dispute resolution process set forth in the contractual arrangement the plan has with its contracted providers.

   Please contact your local CMS regional office regarding plan-specific complaints (see CMS.gov website for contact information: https://www.cms.gov/About-CMS/Agency-Information/RegionalOffices/index.html).

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2. Can an Appointment of Representative form be used for all grievances, initial determinations and appeals within one year?

   Answer: Yes, unless an appointment is revoked or the representative form indicates representation is limited to a specific request, an appointment is considered valid for any request for 1 year.

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3. Can the role of the medical director be delegated?

   Answer: No, per 42 CFR §422.562(a)(4) and §423.562(a)(5), an MA organization or Part D plan sponsor must employ a medical director who is responsible for ensuring the clinical accuracy of all organization or coverage determinations and reconsiderations or redeterminations involving medical necessity.

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4. If an enrollee contacts a plan with two grievances in the same call and they can both be resolved in the 30 day timeframe, can a plan send one letter with the resolution to both grievances?

   Answer: Yes, if an enrollee files two grievances at the same time and the plan can resolve both within 30 days, they can address both grievances in one response to the enrollee.

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5. Do Medicare Advantage plans use the Advanced Beneficiary Notice (ABN) when a provider believes an item or service may not be covered or is the ABN form invalid for these patients?

   Answer: The ABN is for Original Medicare (fee-for-service) beneficiaries. It is not used for Medicare Advantage enrollees. Providers/plans are not to issue advanced beneficiary notice of non-coverage (ABN) in the context of the Medicare Advantage (MA) program.
   Medicare health plans and providers are to follow the regulatory requirements related to the right of the enrollee to request an organization determination and to receive an appropriate notice in accordance with 42 CFR §§ 422.568 and 422.572.
   Please see go to "Guidance" section of the mailbox page to view the 2014 HPMS memo regarding improper ABN use.

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6. For verbal notification of a determination, does a good faith attempt count as notification of the decision and the written notification/confirmation must be sent within 3 calendar days of that attempt?

   Answer: No, an unsuccessful attempt or good faith effort to reach the enrollee verbally does not count as verbal notification of a decision. In situations where the member cannot be given verbal notification because the telephone number was incorrect, disconnected, or there was no voicemail system to leave a message (i.e., a good faith effort to reach the enrollee was made) explaining the conditions of the approval, the written notification still needs to reach the member within the 72 hour timeframe.

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7. At what point should plans dismiss an appeal?

   Answer: This would depend on why the request is being dismissed.

   - Missing or defective AOR - by the conclusion of appeal timeframe, plus any applicable extension (see (§20.2.1 of the Parts C & D Enrollee Grievance, Organization/Coverage Determination, and Appeals Guidance).

- Fails to file the reconsideration within the established timeframes and good cause for late filing has not been established. – no established timeframe, but should not exceed the appeal timeframe.
- Missing waiver of liability - by the conclusion of appeal timeframe, plus any applicable extension (see §50.1.1).
- The MA plan becomes aware that the enrollee has obtained the service before the plan completes its pre-service reconsideration (see §50.8).
- Any other circumstance where the MA plan lacks jurisdiction to review the case. – no established timeframe, but should not exceed the appeal timeframe.