

# Medicare Managed Care and Part D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance

## Frequently Asked Questions (FAQs)

1. This guidance still leaves Part C and Part D requirements separate that are just combined into the same section. Can CMS make more requirements be the same for Part C and Part D?

**Answer:** We merged requirements for Part C and D where permissible (given current regulations). When determining which areas of Part C and D could be combined, we took into consideration any impact the changes would have on plans and/or plan sponsors implementing those particular processes and procedures, in conjunction with the overall impact this revision would have. As future revisions are made to guidance, we will revisit areas where there is potential alignment for C & D.

2. We request CMS include more examples throughout the guidance.

**Answer:** We will be identifying opportunities to provide examples as a supplement to the guidance.

3. We noted inconsistencies in CMS's use of "days" and "calendar days" throughout the draft guidance.

**Answer:** Language provided in section 10.5.1, "Calculation of Days for Assessing Plan Timeliness," states "day/days are calendar days unless otherwise specified & includes weekends and holidays."

4. Is CMS planning to update any of the template Part C & Part D Appeals and Grievance model notices?

**Answer:** Yes. Model notices related to grievances and appeals have been revised to reflect changes in guidance.

5. Will CMS create more model letters or templates for plans to use?

**Answer:** No, CMS will not be providing additional model notices. Plans may design their own notification templates based on notice requirements provided within guidance.

6. Can CMS use the term "redetermination" for level 1 appeals for both Part C and D, and use "reconsideration" only for the Independent Review Entity (IRE) appeal level?

**Answer:** Changing these terms requires a regulatory change. CMS understands that use of the term “reconsideration” in Part C can cause some confusion, which is why we use the universal terms “level 1 appeal” and “level 2 appeal” in guidance.

7. There is some level of confusion with the term “coverage determination” instead of “coverage decision” being used where it is an initial determination and a level 1 appeal decision. We recommend a new term or adding the new term or current definition to the glossary table.

**Answer:** Throughout guidance, all references to “coverage determination” are applicable to an initial request for coverage for Part D only (not Part C) and do not refer to both an initial determination and level 1 appeal. The term “coverage decision” is used in circumstances where the term applies to both an initial determination and a level 1 appeal decision.

8. For Part C, which parts of the guidance apply to both pre-service and payment organization determinations?

**Answer:** Unless otherwise specified, guidance is applicable to both pre-service and payment organization determinations.

9. Which notification requirements does the “Good Faith Effort to Provide Verbal Notification” apply?

**Answer:** Section 10.5.4, “Good Faith to Provide Verbal Notification,” is applicable to any notification requirement for both Parts C and D.

10. Does the section “Outreach for Additional Information to Support Coverage Decisions” replace the HPMS memo on “Guidance on Outreach for Information to Support Coverage Decisions” issued February 2017?

**Answer:** Yes, this guidance supersedes all previous guidance related to Part C and Part D grievances, initial determinations and appeals.

11. 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.

12. 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.

13. This guidance states plans have to notify enrollees if their request is considered a grievance or an appeal. Does this apply to coverage requests and must the notification be in writing?

**Answer:** Notifying enrollees of classification for grievances and appeals may be verbal or in writing, and can be made at the time of the call or when the enrollee is notified of the decision. This guidance does not apply to coverage requests.

14. If an enrollee contacts a plan with two grievances in the same telephone call, and both grievances can 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; the plan can address both grievances in one response to the enrollee.

15. Can CMS clarify if every Part C decision to pay for or deny an item or service is an organization determination?

**Answer:** If a decision made by an MA plan is related to any of the five specific categories listed at 42 CFR §422.566(b), also described in section 40.1 of guidance, it is an organization determination.

16. Current guidance states that member reimbursements involving exceptions are not tolled pending supporting statements, please clarify if guidance has changed.

**Answer:** This guidance has not changed. Member requests for reimbursement are not eligible for tolling. See section 40.5.4 in guidance.

17. The guidance states for expedited decisions, if the plan initially provides verbal notification, then written confirmation must occur within 3 days of the verbal notification. Is the first day to provide written notification the day of, or the day after verbal notification is provided?

**Answer:** Day one is the day after verbal notification is provided.

18. If an enrollee requests a payment to be expedited, are plans required to expedite it?

**Answer:** Plans are not required to accept a request to expedite payment, but are also not prohibited from accepting and adjudicating within expedited timeframes. In other words, accepting a request to expedite payment is at the discretion of the plan.

19. Can pharmacists review Part D redeterminations? What if the redetermination results in an approval?

**Answer:** No, a pharmacist cannot review Part D redeterminations, even if the decision is favorable. Per 42 CFR §423.590(f)(2), when the issue is the denial of coverage based on a lack of medical necessity (or any substantively equivalent term used to describe the concept of medical necessity), the redetermination must be made by a physician with expertise in the field of medicine that is appropriate for the services at issue.

**For other appeals related questions, please contact:**

Part C Appeals: [Part\\_C\\_Appeals@cms.hhs.gov](mailto:Part_C_Appeals@cms.hhs.gov)

Part D Appeals: [PartD\\_Appeals@cms.hhs.gov](mailto:PartD_Appeals@cms.hhs.gov)

**Other mailboxes and resources:**

Part C/D Audit: [part\\_c\\_part\\_d\\_audit@cms.hhs.gov](mailto:part_c_part_d_audit@cms.hhs.gov)

Part C/D Compliance Program Policy: [Parts\\_C\\_and\\_D\\_CP\\_Guidelines@cms.hhs.gov](mailto:Parts_C_and_D_CP_Guidelines@cms.hhs.gov)

Part C/D Star Ratings: [PartCandDStarRatings@cms.hhs.gov](mailto:PartCandDStarRatings@cms.hhs.gov)

Part C Plan Reporting: [Partcplanreporting@cms.hhs.gov](mailto:Partcplanreporting@cms.hhs.gov)

Part D Plan Reporting: [partd-planreporting@cms.hhs.gov](mailto:partd-planreporting@cms.hhs.gov)

Part D benefits questions, please submit an email to [partdbenefits@cms.hhs.gov](mailto:partdbenefits@cms.hhs.gov)

Part D policy questions, please submit an email to [partdpolicy@cms.hhs.gov](mailto:partdpolicy@cms.hhs.gov)