Coordination of Integrated Appeals for Members in Fully Integrated Dual Eligible Special Needs Plans

Background and Purpose

All TennCare members are enrolled in managed care organizations (MCOs) for receipt of their TennCare benefits. Certain TennCare members who are dually eligible for both TennCare and Medicare may be enrolled in Fully Integrated Dual Eligible Special Needs Plans (or FIDE SNPs). FIDE SNPs are operated by the MCOs and are responsible for coordinating a member's Medicare and TennCare benefits in a seamless manner.

All TennCare members have the right to appeal an adverse benefit determination (i.e., a denial, termination, reduction, or suspension) of a covered TennCare benefit. Appeals of TennCare adverse benefit determinations are governed by TennCare Rules 1200-13-13-.11 and 1200-13-14-.11. In general, the appeals process begins when the member informs TennCare that he wishes to appeal an adverse benefit determination and may include a state fair hearing.[1]

When a member is enrolled in a FIDE SNP, they have the right to an integrated appeal process. Integrated appeal means the process that deals with or results from adverse integrated organization determinations ("adverse determination") by a FIDE SNP about the health care services the member believes they are entitled to receive.[2] Integrated organization determinations are FIDE SNP decisions about health care services, including denials of services and the amount the member must pay for a service. When a FIDE SNP makes an integrated organization determination, they evaluate the medical necessity of the service under both Medicare and Medicaid. If the service is denied under both Medicare and Medicaid, this is considered to be an adverse determination, and a notice is sent to the member.

If a member desires to appeal an adverse determination, federal regulations[3] require that the FIDE SNP process the member's initial appeal. Then, if the FIDE SNP's decision is not in the member's favor, the member has recourse through both Medicare and the State Medicaid agency. This policy describes the process by which members of FIDE SNPs seek that recourse.

Policy

A member must file an appeal of an adverse determination with the FIDE SNP. The appeal undergoes reconsideration at the FIDE SNP. If the issue is not resolved in the member's favor at reconsideration, the FIDE SNP will transfer the appeal to Medicare and TennCare. The appeals process is outlined below.

1. To appeal an adverse determination made by a FIDE SNP, the member must submit the appeal to the FIDE SNP within 60 days from the date of the adverse determination notice. The notice the member

[1] See TennCare Rules 1200-13-13-.11(2) and 1200-13-14-.11(2).
[2] See 42 C.F.R. § 422.561.
[3] See 42 C.F.R. §§ 422.629 – 422.634, and 438.402(a)

receives informing him of the adverse determination will include information about how to submit an appeal to the FIDE SNP. If a member tries to file an appeal with TennCare, it will be sent to the FIDE SNP for processing.

2. A member may request continuation of benefits during an integrated appeal.[4] The request must first be made to the FIDE SNP in accordance with federal regulations.

3. When a member submits an appeal to their FIDE SNP, the FIDE SNP will reconsider the adverse determination according to federal regulations[5]. This process is called integrated reconsideration. A member may request the FIDE SNP provide an expedited reconsideration. The reconsideration process will be completed within 30 days for standard appeals. For expedited appeals, the review will be completed within 72 hours.

4. If after reconsidering its adverse determination, the FIDE SNP fully resolves the issue in the member's favor, a written notice will be provided, and the member need not take further action.

5. If after reconsidering its adverse determination, the FIDE SNP upholds its earlier decision, it will electronically forward the appeal, including all documentation, both to TennCare and to the Medicare Independent Review Entity (IRE).

6. The Medicare IRE will be responsible for reviewing the medical necessity of the service under Medicare requirements[6], and TennCare will review the appeal for the medical necessity of the service under the TennCare program. These reviews will occur simultaneously. If the member is successful on appeal, the FIDE SNP will be responsible for payment under the appropriate program.

7. Upon receipt of the appeal by TennCare, the appeal process contained in TennCare Rules 1200-13-13-.11 and 1200-13-14-.11 will apply. The date the FIDE SNP received the valid appeal will be the appeal's start date. The FIDE SNP will have already reconsidered the requested service. State fair hearings will be conducted pursuant to the Uniform Administrative Procedures Act at T.C.A. 4-5-301 et seq.

Offices of Primary Responsibility

Office of the Chief Medical Officer

[4] See 42 C.F.R. § 422.632.
[5] See 42 C.F.R. § 422.633.
[6] See 42 C.F.R. §§ 422.634.

References

42 CFR §§ 422.561; 422.629 – 422.634
https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422#subject-group-ECFR5ebb4ff974abdb5

42 CFR §§ 438.400 – 438.424
https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-F

TennCare Rules 1200-13-13-.11 and 1200-13-14-.11
https://publications.tnsosfiles.com/rules/1200/1200-13/1200-13.htm

---

Original: 01/17/23: AB