

Medicare Compliance FDR newsletter

Quarter 3, 2026

CMS updates Medicare appeals, grievance and determinations guidance

On July 6, 2026, the Centers for Medicare & Medicaid Services (CMS) announced an update to the **Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance**. The update includes guidance related to recent changes to Medicare Advantage organization determination and appeals processes. CMS indicated that the updated guidance is effective immediately.

Key updates include:

- CMS provided additional guidance and clarity around the five categories of decisions that may qualify as an organization determination
- Clarification on when adverse determinations are not subject to additional review
- Updated guidance to align with the 2026 Final Rule requirements for previously approved inpatient hospital admissions

While the CMS guidance addresses grievances, organization, coverage determinations and appeals, this newsletter focuses on requirements applicable to activities delegated to CVS Health FDRs.

The guidance also includes additional resources that provide links to applicable Part C and Part D regulations.

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Looking for resources?

Quick links

- **Medicare Managed Care Manual**
- **Medicare Prescription Drug Benefit Manual**
- **CVS Health Code of Conduct (updated December 2025)**

Exclusion list links:

- **OIG list of excluded individuals and entities (LEIE)**
- **GSA System for Award Management (SAM)**

Link not working? Go to **SAM.gov/SAM** to access the site directly.

First Tier, Downstream, and Related Entities (FDRs) may use these resources for additional information related to applicable requirements.

✦ **At-a-Glance: What FDRs should do**

- ✓ Review the **July 6, 2026** guidance and identify requirements that apply to your delegated activities.
- ✓ Review applicable policies and procedures related to organization determinations
- ✓ Continue following CVS Health® Medicare requirements, policies and procedures.
- ✓ Contact your CVS Health relationship manager with questions regarding services performed on behalf of CVS Health.

Key message: FDRs performing applicable Medicare-related functions should become familiar with the updates and continue following CVS Health requirements for delegated activities

Organization determinations CMS clarified guidance

An organization determination is a decision made by a Medicare Advantage plan, or an entity acting on its behalf, regarding coverage, authorization, provision, or payment of health care services. The guidance explains that Part C regulations identify five categories of decisions that may qualify as organization determinations.

What may be an organization determination?

CMS guidance explains that organization determinations include decisions about coverage, payment, authorization of services, continuation of care, and the timeliness of providing services or notifying members of adverse decisions.

What changed?

CMS did not create an entirely new definition of organization determination. They clarified that prior authorization and other utilization management decisions are organization determinations when they involve a coverage decision.

CMS specifically emphasized that approval or denial of a prior authorization or other utilization management request is an initial organization determination and must comply with applicable Medicare requirements, including required timeframes, notices, and appeal rights.

Why this matters for FDRs

FDRs performing organization determination activities on behalf of CVS Health should:

- Review applicable processes for identifying organization determinations.
- Ensure coverage and payment requests are routed to the appropriate area.
- Follow applicable CMS processing, notification and appeal requirements.
- Continue following CVS Health requirements, policies and procedures for delegated activities.

Key message: CMS clarified that prior authorization and other utilization management decisions are organization determinations when they involve coverage decisions. FDRs performing these delegated functions must ensure applicable Medicare organization determination requirements, including processing timeframes, member notifications, and appeal rights, are followed.



Approved inpatient admissions reopening requirements

The July 6, 2026 CMS guidance incorporates requirements from the 2026 Final Rule related to previously approved inpatient hospital admissions. Under the guidance, a previously approved inpatient hospital admission may not be reopened based on clinical information obtained after the original organization determination. Clinical information cannot be used as new and material evidence to establish good cause for reopening the approved admission.

What FDRs should know

For applicable Part C decisions:

- Relevant clinical information should be obtained and reviewed as part of the original organization determination process.
- Clinical information obtained after an inpatient hospital admission is approved cannot be used as new and material evidence to support reopening that decision.
- CMS establishes specific circumstances under which an approved decision may be reopened.

The guidance also states that when an MA organization approves a covered item or service through prior authorization, a pre-service determination or certain concurrent determinations, it may not later deny coverage based on lack of medical necessity. Reopening is limited to circumstances allowed under CMS requirements.

★ At-a-Glance: What FDRs should do

- ✓ Review applicable inpatient authorization and reopening processes.
- ✓ Ensure relevant clinical information is considered during the initial review.
- ✓ Understand the limitations that apply after an inpatient admission has been approved.
- ✓ Continue following CVS Health® requirements, policies and procedures for delegated utilization management activities.

Key message: An approved inpatient hospital admission cannot simply be reversed based on clinical information obtained after the original organization determination

Prior authorization and utilization management

CMS guidance addresses prior authorization and other utilization management requirements for coverage requests. When a coverage request involves a required prior authorization or other utilization management requirement, the decision to approve or deny the requested item, service or drug is an initial determination.

For more information review the **Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance**.

Supporting the review

When additional information is needed to make a coverage decision, the guidance states that the physician or prescriber should be contacted for information needed to support the request. Voluntary peer-to-peer discussions may also be used to gather additional information. However, these discussions should not be used to request changes to a pending request simply to increase the likelihood of approval.

What should FDRs do

- Follow applicable CVS Health prior authorization and utilization management processes.
- Obtain and review applicable information needed to support the organization determination.
- Follow applicable processing and notification requirements.
- Use CVS Health-approved organization determination notices and templates.
- If an appeal is received, follow established CVS Health routing procedures for plan handling.

Key message: FDRs performing delegated utilization management activities should focus on accurate and timely organization determinations and continue following CVS Health-approved processes and requirements.

Looking for resources?



Our relationship with you — a First Tier, Downstream or Related Entity (FDR) — is important to us. We need you to help fulfill our contracts with CMS. And you can rely on us for the teamwork and support you need.

Read our **Aetna FDR Guide**; it includes a toolbox of resources. If you need the **CVS Health FDR Guide**, contact us.

Past newsletters are available on the Medicare Compliance Attestation page **Aetna.com**

Need to report non-compliance or potential fraud, waste, and abuse (FWA)?

Here are the different ways to report:

- **Call** the CVS Health Ethics Line at **1-877-287-2040 (TTY: 711)**
- **Visit** **CVSHealth.com/Ethicsline**
- **Write to** Chief Compliance Officer, CVS Health, One CVS Drive, Woonsocket, RI 02895

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