A Conversation Around Classification of Part C and Part D Grievances and Coverage Requests

Angelique Morris, CM
Staci Paige, CM

Kaye Rabel: This conversation based session will provide participants with complex scenarios of incoming requests that include elements of Part C or Part D grievances and or requests. I am delighted to introduce Angelique Morris and Staci Paige.

[Applause]

Angelique Morris: Good afternoon everyone. I'm Angelique Morris and alongside me I have my colleague Staci Paige. And as the facilitator stated, we're going to have a conversation around classification of Part C and Part D grievances and coverage requests.

So during today's session we'll take a conversational approach to walk through six scenarios that are loosely based on examples that we have encountered in our program audits over the years. These scenarios come from the Part D coverage determination, appeals and grievance, and Part C, organization determination appeals and grievance program areas and are primarily related to classification of complex or multi-faceted requests. After each scenario is presented I will ask a series of poling questions, so please keep your devices handy. To get the most out of our discussion we're really looking for you to participate as we walk through the

processing of these complex cases, which will drive our conversation on the application of policy. By having Staci here, we have the benefit of hearing feedback directly from those who are responsible for developing the policy. And after the scenarios are presented we'll go through resources and then if time permits we'll allow the audience to ask questions.

So before we get started with our first scenario, it's important for you to understand each of our roles within CMS. As I mentioned Staci is with the Division of Appeals Policy, also known as DAP, within the Medicare enrollment and appeals group which is MEAG. Her division is the CMS lead for grievances and appeals policy and qualify independent contractor operations. DAP develops regulations and manual guidance, resolves critical policy issues related to C and D appeals and grievances and collaborates with other Medicare policy related components.

The Division of Audit Operations, which is DAO is a division within the Medicare Part C and D oversight and enforcement group which is MOEG. MOEG uses the policies and regulations to conduct oversight via the program audits. And we do this with the Medicare Advantage Prescription Drug Plans which are MAPDs, the Prescription Drug Plans which are PDPs, and the Medicare Advantage Medicare-Medicaid Plans which are MMPs and we do this at the parent organization level. DAO collaborates with MOEG at various stages of the audit process, including obtaining policy clarification for a particular audit, as well as participating in the program audit consistency team meeting discussions. The collaboration ensures consistent application and interpretation of policy requirements. We also collaborate in identifying industry trends and tracking continuous improvement ideas which will impact future policy changes.

So now that you know a little bit more about what Staci and I do, we actually are going to get started with our first scenario. So within this scenario and enrollee calls the sponsoring organization because she has

received a denial notice. When the customer service representative at the sponsoring organization answers the call, the enrollee states, "I received a denial notice for services received on May 10th from a specialist. When I first arrived at her office, I paid my co-payment of $35 but I don't think I should be responsible for the balance, let alone the co-payment for this visit because the receptionist was rude. Also the policy office or wait-time is 20 minutes, I know because they have a sign that says so. But I waited over 30 minutes. I would like to see if there is another specialist that I can go to who values their patients' time." So in scenario one, the enrollee is not disputing the amount of her co-payment but states, "I don't think I should be responsible for the co-payment for the visit because the receptionist was rude." Should the sponsoring organization open a PO for the co-payment? So A is yes and B is no.

Staci Paige: Alright. So most of you are correct, the answer is no, it would be an appeal if the enrollee was disputing the co-payment amount, so for example, if they said, the co-pay should be $20 instead of $35. Then the sponsoring organization would process that as an appeal request. In this scenario the enrollee is asking that the co-pay be waived and is not disputing the amount so it would be handled as a grievance.

Angelique Morris: Okay, thank you. We're going to move on to our second polling question. So also in scenario one, the enrollee mentions the receptionist was rude and the office policy for wait time is 20 minutes, however she waited for over 30 minutes. Should the sponsoring organization classify this portion of the enrollee's statement as A, a quality of care grievance; B, a quality of service grievance; C, a grievance; or D, none of the above?

Staci Paige: So for this question if we're looking at how to process, we would have the answer be C a standard grievance. So, for those who selected B, while a complaint is related to the service that the receptionist provided, we're looking at how to classify for processing purposes and not reporting purposes. So this would be classified or processed as a grievance. So

quality of service is still a correct answer for reporting purposes but when we're looking at processing it would be a grievance. So A would not be correct and most of you did not select A, because the quality of care provided by the treating specialist would mean it would be a quality of care grievance.

But before we go to the next polling question, I want to talk a little bit more about quality of care grievances. So quality of care grievances are a type of grievance that suggests services provided by a plan or provider do not meet professionally recognized standards of health care. And examples of quality of care grievances include any instances where an enrollee infers or states they believe they were misdiagnosed, treatment was not appropriate, or if they think care provided or lack of care adversely impacted or that the potential to adversely impact their health or well-being. As most of you know quality of care grievances may be submitted orally or in writing and all grievances related to quality of care regardless of how the grievance is filed must be responded to in writing. A written response to the enrollee must also include a description of the enrollee's right to file a written complaint with the quality improvement organization or the QIO. A continuation of that, the enrollee may file a complaint with the QIO in addition to, or in lieu of a complaint filed with the sponsoring organization.

Next slide please.

Angelique Morris: Thank you. So for polling question number three, for scenario one, for quality of care grievances received orally, how can a sponsoring organization provide QIO rights? A, written; B, verbal; or C, both.

Staci Paige: We have some trick questions here.

Angelique Morris: Yes. Definitely.

Staci Paige: So, the answer is A, written; however sponsoring organizations can provide verbal notification of QIO rights but have to follow up in writing within 30 days of receipt of the grievance. So, both is correct, but A is really what we're looking for since it is the requirement. But again, regardless of how they're filed must be responded to in writing and include a description of the QIO rights.

Angelique Morris: Okay. And polling question number four for scenario one. How should the overall request be classified? A, a grievance; B, a coverage request; C, a coverage request and a quality of care grievance; or D, a grievance and an inquiry?

Staci Paige: Give them a minute here for this one.

Angelique Morris: Yeah.

Staci Paige: Give you a little bit of time. Okay so there is a grievance in this scenario but there is also an inquiry in here. So for the grievance the enrollee said, "I paid my co-payment of $35 but I don't think I should be responsible for the balance or the co-payment for this visit because the receptionist was rude and I waited over 30 minutes." She's suggesting that the co-payment be waived, like we discussed earlier and is making a complaint about how she was treated by the receptionist, so that would be a grievance. So we've also classified this scenario as having an inquiry. Now we know that there are no processing or reporting requirements for inquiries but we still want to be sure and identify inquiries in these scenarios today because we understand that it can be challenging to make a distinction between inquiries and grievances, coverage requests or appeals. So generally an inquiry is just a request for information and responses to inquiries typically don't require an investigation or determination from the sponsoring organization. So examples of inquiries can include what happens during the review process, what is my co-pay for seeing a specialist? When can I expect to receive a decision? Or can you please

send me the forms that I need? So the inquiry in scenario one was when the enrollee said, "I would like to see if there is another specialist that I can go to who values their patients' time."

Angelique Morris: Right.

Staci Paige: This would not be a coverage request because the sponsoring organization can just provide the enrollee with the list of in-network specialists. So as we wrap up our first scenario I wanted to mention that the final classification of a call is usually dependent upon the facts and circumstances of each case. So while an inquiry is a request for information, the information is needed sometimes for the enrollee to make an informed decision about whether or not they want to request a coverage determination or an appeal. So in many instances dialogue happens between an enrollee and the member services representative and an inquiry can very easily turn into a grievance, request for coverage, or an appeal.

Angelique Morris: Yeah, thank you so much Staci. Alright, so we're going to go ahead and move on with our second scenario, which is a little bit more complex. So and enrollee's daughter contacts the sponsoring organization and during the call the enrollee provides verbal authorization for her daughter to speak on her behalf for this call only. There is no appointment of representative statement form on file. The enrollee's daughter states the following: "My mom went to her primary care physician this past Friday and was diagnosed with pneumonia and some sort of bacterial infection while in the office. Her PCP ordered an ambulance to have her immediately transported to ABC emergency room. Mom was admitted and treated at ABC hospital and released the following Tuesday with medication. Mom expressed that she really didn't feel that much better when she was released but we agreed the medicine would do the trick. Unfortunately, by Thursday she could not keep any food or medication down. Because I was at work when she called and she lives by herself, I

told her to call an ambulance, who took her to XYZ Hospital where she was admitted and stayed for five days. I don't think you guys should pay for the first hospital visit at ABC because my mom was still sick when discharged and I don't' think the doctors took seriously how ill she was. Also, the bill from ABC says she was discharged on Wednesday, but she really left on Tuesday. Are you going to look into the extra day for which they are billing? I don't' even thing she should owe them her co-payment because they released her when she was still sick. I am also upset because mom is receiving a bill from the ambulance company for when called them from her home. Aren't ambulance services covered under her insurance?"

Alright, so our first polling question. Are sponsoring organizations permitted to accept an oral request from an enrollee's representative when the enrollee has given the verbal okay for the representative to speak on his or her behalf? So A is yes; B is no; C only if he representative is a family enrollee; or D I'm not sure.

Staci Paige: I think there's a big enough margin there that we can –

Angelique Morris: Yes.

Staci Paige: So the answer is B, no. And we'll go over why on the next couple of slides. Here we go.

So, an appointment of representation must be in writing and oral appointment of representation is not permitted.

Angelique Morris: Mmm hmm.

Staci Paige: However, if an oral request is made by a purported rep, like there's no AOR on file, but the enrollee is with the representative when they verbally confirm that they want to file the request described, then that request

would be recorded and processed as a request from the enrollee and all written communication would then go to the enrollee. So if the representative does want to receive written communication on the request that was made then a written AOR must be on file. So sponsoring organization can say that they'll be sending out information or copies of an AOR. If a grievance is resolved orally during the same call and the enrollee is still present for the call, then they would be considered notified of the resolution. This would also apply to approvals for organization determinations and coverage determinations.

Angelique Morris: Alright, so our second polling question for scenario two. To whom would the sponsoring organization send all applicable correspondence if they needed to follow up on the original phone call?

Staci Paige: The answer is A, we just said the representative would have to submit an AOR form if they wanted to receive written correspondence.

Angelique Morris: Our next polling question; for scenario two, how should the sponsoring organization classify the request? A, a grievance; B, a grievance and appeal; C, a quality of care grievance, reopening and an inquiry; or D, this request cannot be processed.

Staci Paige: I'll give it a little bit of time since that was a pretty complex scenario. Okay, so it looks like it's kind of stabling out there.

Angelique Morris: Mmm hmm.

Staci Paige: Um, so the answer is C, it contains elements of a quality of care grievance, a reopening and an inquiry. Calls may contain elements of inquiries, grievances, requests for coverage determinations and appeals and can be processed under one or more of those procedures. So, when an enrollee or representative addresses two or more issues in one call, then each one should be processed separately and simultaneously under

the proper procedure. So because there was a lot happening in scenario two, we're going to go ahead and break down the classifications so you can kind of see where each one was.

So for the quality of care grievance, the daughter stated, "My mom was still sick when she was discharged, I don't think the doctors took seriously how ill she was and I don't even think she should owe them her co-pay because they released her when she was still sick." So like in the previous scenario, this wouldn't be an appeal because the daughter's not disputing the co-payment amount but is stating that she shouldn't have to pay because she believes the doctors did not provide appropriate care and her mother was still sick when she left the hospital so it would be a quality of care grievance.

For a reopening, the daughter says, "The bill from ABC says that Mom was discharged on Wednesday but she really left on Tuesday, are you going to look into the extra day for which they are billing?' So it appears that the daughter's giving new information that may not have been known at the time of the initial decision. So, depending on this and other circumstances related to this case, the sponsoring organization may consider reopening here.

And lastly, the inquiry. Which could very likely become an appeal depending upon how the member service representative responds, but the daughter states, "Aren't ambulance services covered under her insurance?" So the daughter is asking here about coverage services and so after the member services representative tells the daughter about the coverage for ambulance services, the daughter indicates that she understands why her mom's receiving the bill, then it would remain an inquiry. So again, as stated previously the final classification of how these cases are – or these calls happen is dependent upon the facts and circumstances and dialogue of each case.

Angelique Morris: Okay. Thank you Staci. Alright, we're going to move on to scenario three. For scenario three, Betty Smith has been in a skilled nursing facility, SNF, for the past seven days. After review of Betty's medical status, it was determined that the SNF services should be discontinued because she only requires custodial care. The SNF issues the Notice of Medicare Provider Non-Coverage, which is the NOMNC, on Monday for discharge to occur on Wednesday. Betty's daughter, the Power of Attorney on file, contacted the sponsoring organization on Monday night upon receipt of the notice to request an expedited reconsideration of her mother's discharge. The member service representative advised the daughter that the expedited appeal could not be filed on behalf of her mother at the time because she was calling in earlier than noon of the day following the advance termination notice which falls outside of the Medicare guidelines. The daughter expressed her dissatisfaction regarding the sponsoring organization's process for accepting expedited reconsiderations, so the MSR offered to file a grievance on her behalf. So in scenario three, what should the sponsoring organization have done with the request for an expedited reconsideration? So A is contact the QIO and inform the QIO that the enrollee wishes to file an immediate QIO review of a termination from a SNF; B, direct the enrollee's representative to the QIO to appeal the determination from the SNF and offer to initiate a grievance; C, process the expedited reconsideration; or D, all of the above.

Staci Paige: Okay. Alright. So the answer here is B. The enrollee or the enrollee's representative must submit a timely request for a fast-track review to the QIO no later than noon the day following receipt of the notice. So in this scenario the representative, the enrollee's rep called the sponsoring organization and did not call the QIO, so the services representative informed them that the appeal could not be processed because it was received too early. So when this happens, the sponsoring organization should inform the enrollee or the enrollee's representative to file an appeal with the QIO.

Angelique Morris: Okay, our next polling question. In scenario three, the MSR offered to file a grievance in response to the enrollee's representative complaint about the sponsoring organization's process for appealing termination of SNF services. Is this the correct procedure? A yes; B, no.

Staci Paige: Correct yes, so that is the correct procedure, they should explain the grievance procedures and then offer to initiate a grievance. Nice, good.

Angelique Morris: Thank you. Yeah.

Alright so we're halfway through our scenarios. Everyone is just doing a great job with dissecting the components of each scenario presented. So we're going to go ahead and move on to scenario four.

Staci Paige: Get the next slide please?

Angelique Morris: In scenario four, the enrollee contacts the sponsoring organizations for – and finally gets transferred to a customer service representative. He tells the customer service representative "I was transferred to your line and I don't know who I'm speaking with but I'm just trying to find out why I was not given my XOPENEX medication when I went to the pharmacy today." The customer service representative advised the enrollee that XOPENEX was denied at the pharmacy because the drug requires a prior authorization and the sponsoring organization has not received a prior auth request for the drug from her prescriber. The customer service representative advices the enrollee he should contact the doctor immediately before the office closes for the weekend.

Okay.

We're having a little bit of technical difficulty we're going to wait for that to come up and then –

Yay.

Alright, here we are. Okay. So in scenario four, the polling question is; is this an inquiry or a coverage request?

Staci Paige: Yep, that is correct. The answer is B it is a coverage request, because the enrollee was at the pharmacy counter to obtain the drug and is following up with the sponsoring organization. It's an indication that they're still attempting to get the drug and it would be treated as a coverage request. Great.

Angelique Morris: Alright.

Our next polling question for scenario four, did the customer service representative handle this call correctly? A, yes; or B, no.

Staci Paige: Yeah. They did not handle it correctly. If an enrollee calls the sponsoring organization and request a drug the plan should not advise the enrollee to contact their prescriber, but instead initiate a coverage determination and then begin outreach to the prescriber for any necessary information that's needed to satisfy any prior authorization requirements.

Angelique Morris: Good. Okay. Alright. And we're going to move on to scenario number five. For scenario five, the enrollee contacts the sponsoring organization customer service line and tells the customer service representative the following; "I have been going to a specialist because I hurt my knee and the doctor put me in physical therapy for six weeks. I have been going for four weeks now and my knee hasn't gotten any better. I think I may need a knee replacement. Can you tell me what the next steps are for getting the knee replacement?" The customer service rep asks the enrollee if she plans to continue with the course of treatment which is the physical therapy, and the enrollee states that she would. However, she just

wanted to weight her options at this point, but she does trust her doctor's opinion.

So for scenario five, how should the sponsoring organization classify this call?

Staci Paige: Inquiry, Coverage request, appeal, or a grievance? Alright, I like this. This is an inquiry and it's an example of how dialogue can change the classification of a call.

Mmm hmm.

So, because enrollees don't have to use any specific term or phrases to make a coverage request, initially the representative could be considering processing this as a request for coverage. However, a little bit later in the call, they learn that the enrollee is just trying to get information and weigh her options. So at this point it would be considered an inquiry and the representative should provide information to the enrollee regarding what the next steps are for getting a knee replacement. So after the information is provided it can either remain an inquiry or become a request for an OD. They might really decide that they want to move forward and ask for a knee replacement.

Angelique Morris: Okay. Cool.

So our next polling question for scenario five; how should the sponsoring organization respond to the enrollee in this request? So A is provide information about the coverage request process for a knee replacement and determine if the enrollee wants to move forward with the request; B, advise the enrollee to speak with the specialist about her concerns; C, ask the enrollee to call back once the physical therapy is complete; or D, nothing at this time.

Staci Paige: Okay, good. So the answer is A, the enrollee did make it clear that she wants information to weight her options, so it would be provided by the member service representative. The answer could also include B on top of A, the sponsoring organization can always advise the enrollee to speak with their specialist about their concerns to get answers to questions related to the procedure itself. So, A and B or just A, sorry.

Angelique Morris: Okay, thank you.

And now we are entering into our last scenario. And scenario six, the enrollee contacts the sponsoring organization customer service line and tells the customer service representative the following; "I have been going to a specialist because I hurt my knee and the doctor put me in physical therapy for six weeks. After four weeks of therapy, my knee hasn't gotten any better. How do I get authorization for a knee replacement? And can I do that now?

So in scenario six how should the sponsoring organization classify this call? A and inquiry; B a coverage request; C an appeal; or D a grievance?

Staci Paige: This is good. Yep, so this scenario is very, very similar to the last one except just one or two things that the enrollee said in this scenario than in the last one. The answer is B; this would be considered a coverage request. The enrollee said, "How do I get authorization for a knee replacement? And can I do that now?" So they should provide the information and then begin processing this as an organization determination.

Angelique Morris: Thank you. And our next polling question for scenario six; what actions should the sponsoring organization take in response to the enrollee's request? A, initiate a coverage request on behalf of the enrollee; B, contact the enrollee's provider to request medical documentation; C, provide information about the coverage request process and begin

processing a coverage request; or D, invite the enrollee to speak with the specialist about initiating a coverage request.

They're very quick today.

Staci Paige: I know,

The answer is C, so the sponsoring organization must provide information on the process and initiate a request for a knee replacement. The sponsoring organization can always advise the enrollee to speak with their specialist about concerns to get answers to questions related to the procedure itself. So similar to polling question 13, D can also apply here. If the enrollee wants to start the process to get a knee replacement, but something's needed from the doctor then at that point the sponsoring organization must initiate the request and then conduct outreach to get any necessary information.

Angelique Morris: Okay. Thank you. Thank you Staci. And so that does end our scenario based examples related to the classification of complex or multi-faceted requests. I really want to thank everyone for your participation in our discussion today and remaining engaged during our polling questions. I really hope you were able to gain some valuable information today from Staci here who comes from the Division of Appeals Policy. Now I'm just going to take a few moments to go over some Part C and D resources and contact information.

Alright, on the screen here you see our Part C Chapter 13 and that is our resource guidance. And we'll move on to the updated guidance on outreach for information to support coverage determinations and there's our web link there. And then the managed care appeals and grievances and that the web link there to the CMS site where you can find that information and that's all for Part C resources. And then our Part D resources we have our chapter 18 Part D enrollment grievance and

coverage determination manual. And then we have our Part C, excuse me, Part D drug and formulary requirements for chapter six. And then the Medicare prescription drug appeals and grievance and that also can be found on the CMS website. And for questions in regards to policy questions or if you have questions in regards to audits, so for policy questions for Part C you have the web link there and that does go to the Medicare enrollment and appeals group. And Part D you have the web link. And for your audit related questions it's Part C and D oversight and enforcement group and you have the web link as well. And then for the program audit questions. And that does conclude our presentation. Again I just want to thank everyone for your participation today.

Staci Paige: Thank you.

[Applause]

Kaye Rabel: Okay, we do have time to take some questions. If you have questions please step to the center mic, state your name and let us know the organization that you're from please.

Hi there.

There we go.

Derek Frye: Derek Fry from the BridgeField Group. It's interesting to see the polling results and how mixed the audience is in understanding these requirements. And these are compliance professionals, they're not even member service reps or somebody further down in the organization. So I'm wondering what additional steps can folks like that take to better understand these definitions? Or where might you point them?

Staci Paige: Um, honestly I think that the best place would be to submit a question to the Part C appeals mailbox. And I think that it's the best way to go

because there's a little bit more of an opportunity for us to ask questions if there are different scenarios that you may have. If there's something specific that you're looking at. So I would absolutely send questions to the Part C appeals mailbox.

Derek Frye: Thanks.

Kaye Rabel: Okay, any other questions? Okay thank you Angelique and Staci for a very interactive conversation around classification of grievances and coverage requests.

[Applause]

Alright, at this time we're going to do things a little differently. And we're going to keep it rolling with some polling and Staci's going to come out and we're going to test her knowledge with some CMS trivia.

Stacey Plizga: Okay I hope you all studied last night. There we go.

Okay, our first CMS trivia question. President Johnson's Medicare proposal would have covered physician services. Is that true or is that false? I'll give you a couple seconds here to figure out which answer you think is right. Alright, it looks like we're stabilizing a little bit here and the correct answer is B. Ohh, President Johnson's Medicare proposal would have covered hospital and other institutional services for the elderly. He did not propose coverage of physician services because of the opposition of organized medicine to government sponsored health insurance. Congressmen Wilbur Mills combined President Johnson's proposal to cover institutional care and called it Part A of Medicare with a voluntary program to pay for physician and other outpatient services and called it Part B of Medicare.

Okay the next question. President Regan proposed adding what benefits to Medicare? Was it unlimited hospital days? A limits on beneficiary out-of-pocket expenses? Expanded nursing home coverage? Or D, all of the above? These all of the above questions are kind of give aways huh? Because the correct answer is D, all of the above. President Regan proposed expanding Medicare to cover a number of additional services in the Medicare Catastrophic Coverage Act, or MCCA. Which was enacted in 1988. The new benefits were financed by increased premiums on Medicare beneficiaries. After upper income elderly complained about having to finance the new benefits, many of which they already received as retirement benefits from their former employers, the Congress repealed most of MCCA in 1989. Hmm.

Let's see what else we got here. In 1965, somebody's really fast, in 1965 what was the three-layer cake? Was is A, Medicare Part A, Medicare Part B, Medicaid; or was it B, Medicare, Medicaid, SSI; C, Social Security, private pension and retirement savings; or D Neapolitan? Alright, let's see here. The correct answer is A. Congressman Wilbur Mills, Chairman of the House Ways and Means Committee created what was called the three-layer cake by starting with President Johnson's Medicare proposal Part A, adding to it physician and other outpatient services Part B, and creating Medicaid which significantly expanded federal support for healthcare services for poor, elderly, disabled, and families with dependent children. Medicare became Title 18 of the Social Security Act and Medicaid became Title 19. Wow that was a long answer.

Alright let's go and do one more trivia question for you. Maternal and child health services were first added to the Social Security Act in which year? Was it 1935, 1965, 1980, or 1997? Hmm. Many of you didn't study last night? Because the correct answer is A, the Social Security Act was originally enacted into law in 1935. Title Five included federal funding to states for maternal and child health services. Title Five is administered today by the Health Resources and Services Administration in HHS. Oh.

Well, I was going to say very good. But actually not so very good. So you have some time to study during your break and we will come back here at exactly 2:15 so please be on time. Thank you.

[Break]

Welcome back everyone. Hope you enjoyed your break. The first thing that we are going to do, because we forgot to do it at the end of the last session is to evaluate the session with Angelique Morris and Staci Page which was A Conversation Around Classification of Part C and D. So if you could go ahead, if you'd like to evaluate that, go ahead and select A and complete the questions for that session.