Best Practices for Classifying Grievances, Appeals and Coverage Requests

Coretta Edmondson & Staci Paige

Division of Appeals Policy, Medicare Enrollment and Appeals Group, Center for Medicare, CMS

Destiny Gordon & Crescent Moore

BlueCross BlueShield of Tennessee

Objectives

- What is the difference?
- Classifying co-pay complaints
- Investigating Quality of Care grievances

What is the Difference?

What ***IS*** the difference between a grievance, coverage/ organization determination, appeal, and inquiry?

Grievances

An expression of ***dissatisfaction*** with any aspect of plan operations or activities or the way a plan or delegated entity provides Part C services or Part D benefits, regardless of whether remedial action is requested or can be taken.

Coverage/Organization Determination

Any ***decision*** made by or on behalf of a plan regarding payment or benefits to which an enrollee believes he or she is entitled.

Appeal

A review process that is initiated following a ***dispute*** of an adverse coverage or organization determination.

Inquiry

A general ***question*** about benefits or coverage.

- No indication of a request for coverage
- Not expressing dissatisfaction related to non-coverage

Co-Pay: Grievance vs. Appeal

Appeal: When an enrollee believes the plan has required the enrollee to pay an amount that should be paid for by the plan.

- "The co-pay charged to me is higher than it should be."
- "I was charged and I shouldn't have been. I don't have a co-pay for this service."

Co-Pay: Grievance vs. Appeal (cont.)

Grievance: General dissatisfaction of a co-pay amount or request to waive a co-pay to make up for a poor experience.

- "The office staff was rude, so I don't think I should have to pay my co-pay."
- "The doctor only spent 10 minutes with me and I expected more time. I shouldn't have to pay this co-pay."

Investigating Quality of Care Grievances

Scenario: A member contacts their plan and states they believe they were misdiagnosed by their doctor and, as a result, was sick longer than they should have been. The CSR classifies this as a QOC grievance.

A medical professional with the plan investigates the complaint and determines the member was correctly diagnosed and received appropriate treatment.

Polling Question

The next steps should be:

A. Close the case. The investigation is complete and no further action is needed.

B. Re-classify this as a regular grievance.

C. Send notice to the enrollee that the QOC investigation is complete and inform them of their right to file a grievance with the QIO.

D. Close the case and tell the enrollee the status if they call back.

Quality of Care Grievance

A type of grievance that suggests services provided by a plan or provider do not meet professionally recognized standards of health care. Examples of a quality of care grievance include any instances where an enrollee infers or states they believe:

- They were misdiagnosed;
- Treatment was not appropriate; and/or
- Care provided (or lack thereof) adversely impacted, or had the potential to adversely impact, their health or well-being.

QOC grievances may be reviewed by a medical professional.

Best Practices for Classifications

- Customer Service – Centralized
- Cross-Functional Training & Ongoing Education
- Root Cause Analysis Processes
- Part C and D Specifics
- References and Resources

Classifications Best Practices: 'Customer Service'

- Centralized call unit for members to get assistance
- Train to assist/triage member inquiries based on needs or requests
- Ask probing questions as members don't always know what to ask
- Do not give members homework, especially related to coverage decisions and complaints

Classifications Best Practices: Training and Education

- Familiarity with the guidance and prep training for your audience
- ***All*** staff trained on classifications and routing processes
  - Educate on risk of not doing so correctly (member access to care and audit findings)
  - Identify keywords in discussions with callers (i.e. need vs. not satisfied with a decision on a service or dislike vs. disagree with a copay)
- Avoid misclassifications when everyone understands the guidance: Be able to identify Coverage Requests, Appeals, Grievances, or multiples?

Classifications Best Practices: Training and Education (cont.)

- Ongoing scenario-based training and coaching referrals
- Train more than once to keep the requirements fresh
- Quality reviews should factor in classifications
  - This connects to performance and lessens errors for misclassifications
- CMS CDAG and ODAG training
- Take each scenario case by case for proper classification
- When in doubt, route…

Classifications Best Practices: Part C Coverage Request

- Staff trained to listen to the ‘member perception’ of needs. Keywords and probing questions assist in appropriate classifications.
- Follow up for any additional information needed for requests.

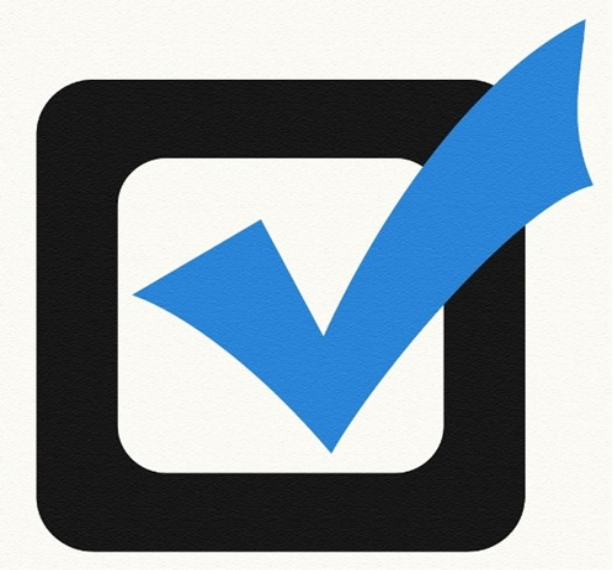
Classifications Best Practices: Polling Question

Member calls customer service concerned that he received a denial letter for a requested dental surgery. He is not pleased with the decision as he pays his premiums and does not use his benefits often. He wants this reviewed for coverage. He says he's having to blend fruits and vegetables because it pains him to chew/eat. He feels a nutri-blender should be covered by the plan and it's his only method of eating.

How would you classify this case?

A. Coverage Decision
B. Appeal, Grievance
C. Grievance, Appeal, Coverage Decision

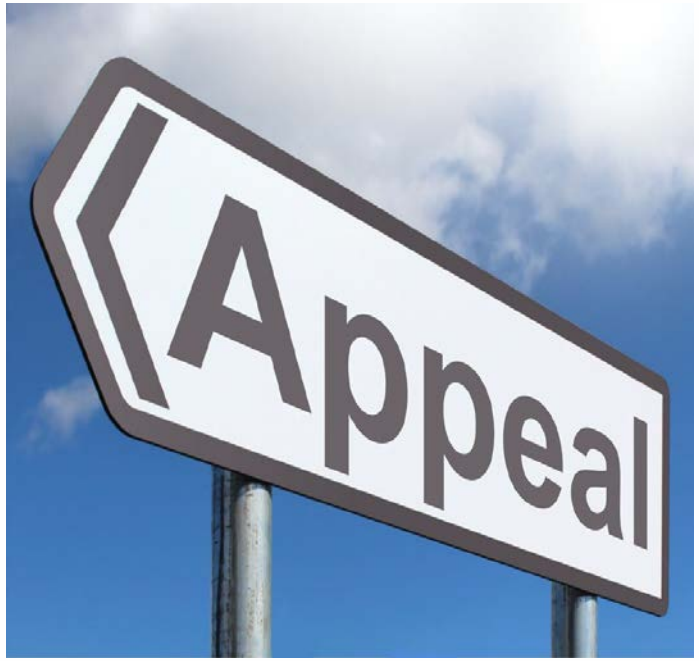
Classifications Best Practices: Polling Question Summary



- Coverage Decision: He's having to blend fruits and vegetables because it pains him to chew/eat. **He feels a nutri-blender should be covered by the plan and it's his only method of eating…**
- Appeal: He is not pleased with the decision. **He wants this reviewed for coverage.**
- Grievance: **He is not pleased with the decision** as he pays his premiums and does not use his benefits often.

Classifications Best Practices: Appeals

- Intake staff
  - Processes to immediately identify cases for appropriate classification, especially urgent or expedited (although the request may not clearly state it as such).
  - Knowing keywords for expedited identification: in urgent need of a service due to pain, expedited from MD, etc.
  - Train to understand the importance of member access to care.



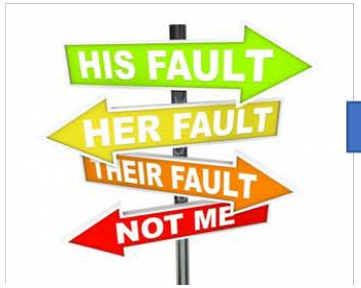
Classifications Best Practices: Grievances

Grievances: Centralized unit for Part C and D with intake processes for classifications.

Customer Service: Initial stop for help!

Grievance Intake: Classification and Assignment…

Grievance Analysts: Research to *confirm* and/or *provide* resolution!



- One team handles both Part C and D Grievances
- Minimizes errors in classifications and turnaround times
- Quickly identify potential misroutes of coverage requests and transfer them timely

Best Practices – Med D Coverage Determinations and Appeals (Slide 1 of 4)

- Centralized grievance management
- Established identification and routing process
- System access
  - Med D CDA documentation system
  - Med D CDA team recorded calls

Best Practices – Med D Coverage Determinations and Appeals (Slide 2 of 4)

- Training – upon hire and annually
  - Medicare Learning Network
  - Grievance training
  - Countermeasure tracking
  - Job Aids

Best Practices – Med D Coverage Determinations and Appeals (Slide 3 of 4)

- Quality Assurance
  - Primary and Appeal
  - Random sampling of cases
  - Monthly
  - Center of Excellence meeting

Best Practices – Med D Coverage Determinations and Appeals (Slide 4 of 4)

- System Configuration
  - Primary and appeal cases linked
  - Centralized document storage
  - Timeframe configuration

Resources and References

- Solid reference materials (online help, CMS resources) and systems (software programs)
- Contacts and ongoing communication in all departments for escalations
- Embedded Compliance staff as partner
- Utilize CMS Account Managers

Questions?

- Crescent_Moore@bcbst.com
- Destiny_Gordon@bcbst.com
- Part_C_Appeals@cms.hhs.gov
- PartD_Appeals@cms.hhs.gov