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

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Agenda

- Introductions
- Scenario Walkthrough
- Polling Questions
- Feedback on Application of Policy
- Wrap Up and Resources
- Questions and Answers

CMS Internal Collaboration- Policy and Audits

- **Division of Appeals Policy (DAP):** Develops regulations and manual guidance related to Part C and Part D appeals and grievances. Collaborates with other Medicare policy related components to resolve critical policy issues.
- **Division of Audit Operations (DAO):** Conducts program audits of sponsoring organizations that provide health and prescription drug benefits through the Medicare Advantage (Part C) and Prescription Drug (Part D) programs, as well as the Medicare-Medicaid Financial Alignment Initiative.

Scenario #1

"I received a denial notice for services I received on May 10th from a Specialist. When I first arrived at her office, I paid my co-payment of $35.00 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 office policy for wait-time is 20 minutes (I know because they have a sign that says so) but I waited for over 30 minutes! I would like to see if there is another Specialist that I can go to who values their patients' time."

Polling Question #1

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In Scenario #1, 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 this visit because the receptionist was rude”. Should the sponsoring organization open an appeal for the co-payment?

A. Yes

B. No

Polling Question #2

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In Scenario #1, the enrollee mentioned 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. Quality of Care (QOC) Grievance
B. Quality of Service (QOS) Grievance
C. Grievance
D. None of the above

Quality of Care Grievance

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- 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.

Polling Question #3

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For Quality of Care grievances received orally, how can a sponsoring organization provide QIO rights?

A. Written

B. Verbal

C. Both

Polling Question #4

In Scenario # 1, how should the overall request be classified?

A. Grievance
B. Coverage Request
C. Coverage Request and Quality of Care Grievance
D. Grievance and Inquiry

Scenario #2

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"My mom went to her Primary Care Physician (PCP) 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 by 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 medication would do the trick. Unfortunately, by Thursday, she could not keep any food or the 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."

Scenario #2 (continued)

"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 think she should owe them her co-pay because they released her when she was still sick.

I'm also upset because Mom is receiving a bill from the ambulance company for when she called them from her home. Aren't ambulance services covered under her insurance?"

Polling Question #5

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Are sponsoring organizations permitted to accept an oral request from an enrollee's representative when the enrollee has given the verbal ok for the representative to speak on his/her behalf?

A. Yes
B. No
C. Only if the representative is a family enrollee
D. I'm not sure

Appointment of Representation & Oral Request for Representation

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- Appointment of representation (AOR) must be in writing and oral appointment of representation is not permitted.
- If an oral request is made by a purported representative (there is no AOR on file) but the enrollee is with the purported representative and verbally confirms they want to file the request described, that request would be recorded and processed as a request from the enrollee and all written communication would go to the enrollee.

AOR & Oral Request for Representation (continued)

- If the purported representative wants to receive written communications, a written AOR must be on file.
- If a grievance is resolved orally during the same call and the enrollee is present, they would be considered notified of the resolution. This would also apply to Organization Determinations (OD) and Coverage Determinations (CD) approvals.

Polling Question #6

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In Scenario #2, to whom would the sponsoring organization send all applicable correspondence if they needed to follow-up on the original phone call?

A. The enrollee
B. The enrollee's representative
C. Both the enrollee and the representative

Polling Question #7

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For Scenario #2, how should the sponsoring organization classify the request?

A. Grievance
B. Grievance and Appeal
C. Quality of Care (QOC) Grievance, Reopening, and Inquiry
D. This request cannot be processed

Scenario #2 - Classification

- QOC Grievance
  - “my mom was still sick when discharged… I don’t think the doctors took seriously how ill she was”
  - “I don’t even think she should owe them her co-pay because they released her when she was still sick”.
- Reopening
  - “I don’t think you guys should pay for the first hospital visit…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?
- Inquiry
  - “Aren’t ambulance services covered under her insurance?”

Scenario #3

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 SNF services would be discontinued because she only requires custodial care.

The SNF issued the Notice of Medicare Provider Non-Coverage (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 NOMNC to request an expedited reconsideration of her mother's discharge.

Scenario #3 (continued)

The Member Service Representative (MSR) advised the daughter that the expedited appeal could not be filed on behalf of her mother at that 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.

Polling Question #8

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In scenario #3, what should the sponsoring organization have done with the request for an expedited reconsideration:

A. 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 termination from the SNF and offer to initiate a grievance
C. Process teh expedited reconsideration
D. All of the above

Polling Question #9

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In scenario #3, the MSR offered to file a grievance in response to the enrollee's representative's complaint about the sponsoring organization's process for appealing termination of SNF services. Is this the correct procedure?

A. Yes

B. No

Scenario #4

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"I was transferred to your line and don't know who I am speaking with but I am just trying to find out why I was not given my XOPENEX medication when I went to the pharmacy today."

The Customer 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 authorization request for this drug from her prescriber. The Customer Representative advised the enrollee he should contact his doctor immediately before the office closes for the weekend.

Polling Question #10

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In scenario #4, is this a inquiry or a coverage request?

A. Inquiry

B. Coverage Request

C. Neither

Polling Question #11

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In scenario #4, did the Customer Representative handle this call correctly?

A. Yes

B. No

Scenario #5

“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 representative asks the enrollee if she plans to continue with the course of treatment (physical therapy) and the enrollee states that she would. The enrollee states, “I just want to weigh my options at this point as I trust my doctor’s opinion.”

Polling Question #12

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In Scenario #5, how should the sponsoring organization classify this call?

A. Inquiry

B. Coverage Request

C. Appeal

D. Grievance

Polling Question #13

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In Scenario # 5, how should the sponsoring organization respond to the enrollee in this request?

A. 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

D. Nothing at this time

Scenario #6

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"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? Can I do that now?"

Polling Question #14

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In Scenario #6, how should the sponsoring organization classify this call?

A. Inquiry

B. Coverage Request

C. Appeal

D. Grievance

Polling Question #15

In Scenario #6, what actions should the sponsoring organization take in response to 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
D. Advise the enrollee to speak with the specialist about initiating a coverage request

Part C Resources

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- **Chapter 13 - Medicare Managed Care Beneficiary Grievances, Organization Determinations, and Appeals Applicable to Medicare Advantage Plans, Cost Plans, and Health Care Prepayment Plans (HCPPs), (collectively referred to as Medicare Health Plans):** https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c13.pdf

Part C Resources (continued)

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- **Updated Guidance on Outreach for Information to Support Coverage Decisions:** https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/HPMS-Guidance-on-Outreach-for-Information-to-Support-Coverage-Decisions-2017Feb22.pdf
- **Managed Medicare Appeals & Grievances:** https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/index.html

Part D Resources

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- **Part D Prescription Drug Benefit Manual(S) & Website**
  - Chapter 18 Part D Enrollee Grievances, Coverage Determinations, and Appeals: https://www.medicarepartdappeals.com/sites/default/files/PartDManualChapter18%2005%2012%2014v508.pdf

Part D Resources (continued)

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- **Chapter 6 Part D Drugs and Formulary Requirements:** https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Part-D-Benefits-Manual-Chapter-6.pdf
- **Medicare Prescription Drug Appeals & Grievances:** https://www.cms.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev/index.html

Contact Us

- **Medicare Enrollment and Appeals Group (MEAG)**
  - Part C appeals questions: Part_C_appeals@cms.hhs.gov
  - Part D appeals questions: Part_D_appeals@cms.hhs.gov
- **Medicare Part C and D Oversight and Enforcement Group**
  - **Part C and Part D Compliance and Audits website:** https://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/index.html
  - **Program Audits questions:** part_c_part_d_audit@cms.hhs.gov