

Medicare Complaints

- Grievances
- Appeals





Online Training Instructions

- Please remember to click on the notes icon on each slide. Double click to access expanded notes.
- This training is intended to be completed during the break between Basic Training Section 1 and Basic Training Section 2
- You are responsible to print the quiz for this training, complete the answers, and turn it in at the Basic Training Section 2 class.



Complaints Training Outcomes

- Explain Complaints & Processes
- Help Clients With Grievances & Appeals
- Follow CMS Complaint System for SHIP Counselors



Complaints

- Two Kinds of Complaints
 - Grievances
 - Appeals



Grievance

- Complaints of Dissatisfaction
 - Plan's Operations
 - Provider's Operations
- Problems With Health Plan or Provider
- Examples
 - Waiting Time for Appointments
 - Behavior of Doctor and Others
 - Cleanliness or Conditions of Office
 - Quality of Care



Quality of Care Concerns

- Medication Errors
- Unnecessary/Inappropriate Surgery or Treatment
- Discharged Too Soon
- Incomplete Discharge Instructions and/or Arrangements



Appeal

- You Can File an Appeal If You Believe
 - Medicare Should Have Paid but Didn't
 - Medicare Didn't Pay Enough
 - You Were Denied a Needed Service
 - In a Medicare Advantage Plan

How to Request an Appeal

- Original Medicare
 - Medicare Summary Notice
 - *Medicare and You*
- Medicare Advantage Plans
 - Health Plan Materials
- Medicare Part D
 - Health Plan Materials



Appeal in Original Medicare

- Ask Doctor or Provider for Information That Might Help Case
- Appeal Rights on Back of Medicare

Summary Notice (MSN):

- Why Medicare Didn't Pay
- How to Appeal
- How Long You Have to Appeal



Medicare Summary Notice (MSN)

- Sent To Original Medicare Beneficiary Every 3 Months
- Lists Details Of All Medicare Services And Amounts Billed To Beneficiary
- If You Disagree With Notice You May Appeal
- Appeal Information Is On The Notice



Medicare Summary Notice Handout



Appeal Levels in Original Medicare

- Redetermination
- Reconsideration
- Administrative Law Judge
- Medicare Appeals Council
- U.S. District Court Review



Original Medicare Fast Appeal

- Certain Care Settings Patients Have Right to Expedited (Fast) Appeals:
 - Home Health
 - Hospice
 - CORF
 - SNF
- Provider Must Give Notice of Rights
 - Explains Right to Independent Reviewer (QIO)



Original Medicare Fast Appeal

1. Patient Receives Non-Coverage Advance Notice

- Usually No Later Than 2 Days Before End of Covered Services

If You Disagree:

2. File Request With State QIO -

No Later Than Noon of the Calendar Day Following Receipt of Notice



Original Medicare Fast Appeal

3. Usually by Close of Business Same Day
QIO Notifies the Provider
4. Provider Must Give Patient Detailed Notice
Explaining Non-Coverage
5. Determination by QIO
No Later Than 72 Hours After Receipt of Request
For Expedited Determination

Medicare Advantage Appeals

- If Plan

- Will Not Pay for a Service
- Does Not Allow a Service
- Stops a Service

} Must Tell in Plan Information How to Appeal

- May Ask for Expedited Decision

- Plan Must Decide Within 72 Hours

- May Request Independent Review After Adverse Decision



MA Appeal Process

- Plan Reconsideration
- Independent Review Entity
- Administrative Law Judge
- Medicare Appeals Council
- Judicial Review



Special Rights

- If You File an Appeal
 - Have Right to Plan's Files About You
 - Your Case File
 - Plan May Charge a Reasonable Fee
 - For Copying and Mailing



To Get The Case File

- Call or Write The Plan
- For Case File Sent to Independent Review Entity (IRE)

– Write:

MAXIMUS Federal Services, Inc.
Medicare Managed Care & Pace
Reconsideration Project

Victor, NY 14564-1099

– Call 585-425-5210



MA Fast-Track Appeals

- Right When Services Are Ending Too Soon
 - Skilled Nursing Facility
 - Home Health Agency
 - Comprehensive Outpatient Rehabilitation Facility
- Provider or Plan Must Give Notice of Medicare Non-coverage (NOMNC)
 - At Least 2 Days Before Services End
- Plan Must Give *Detailed Explanation of Non-coverage*
- Decision From QIO Within 2 Days



Part D Problems

- Plans Must Have Procedures and Give Written Information on Procedures
 - For Standard and Expedited
 - Coverage Determinations
 - Appeals
 - Grievances
 - Quality of Care Complaints

Step 1 Before Part D Appeals

- Coverage Determinations & Exceptions
 - Opportunity to Challenge:
 - Exclusion of a Drug
 - Placement of a Drug on Higher Cost-sharing Tier
- Plans Must Notify Enrollees of Formulary And/or Tiered Cost Sharing Changes and the Right to Appeal





Coverage Determination & Exceptions

- Request Plan for Coverage Determination
- Involve Physicians, Family Member, Others to Assist Enrollee
- **Expeditious Determination** – If Serious Health Risk - Decision Must Be Made in 24 Hrs.
- **Standard Decisions** – Processed in 72 Hrs.
- **Independent Review Entity (IRE)** – Forwarded to IRE If Plan Doesn't Make a Determination Within Appropriate Timeframes



Requesting an Exception

- Request an Exception
 - Drugs Not on Plan's Formulary
 - Drug With Special Coverage Rules
- Contact the Plan
 - How to Submit Request
 - What Information to Submit
 - Prescribing Doctor
 - Must Submit Supporting Statement
 - Must Indicate Drug Is “Medically Necessary”



Coverage Exceptions

Exceptions Process – to Obtain a Drug at a Better Cost-sharing Level, or a Drug Not on Formulary May Be Requested If in Current Year:

- Drug Removed for Reasons Other Than Safety
- Prescribed a Medically Necessary Non-Formulary Drug
- Moved From Preferred to Non-preferred Cost Sharing Tier
- Prescribed More Expensive Tier Drug Because Lesser Tier Drugs Are Medically Inappropriate



Tiering Exception

- Gives Access to Non-preferred Drug
 - At Lower Cost of Drugs in the Preferred Tier
 - If Preferred Drug
 - Would Not Be As Effective
 - Would Have Adverse Effects



Formulary Exception

- Gives Access to Drugs
 - Not on Plan's Formulary
 - For Which Plan Has Special Coverage Rules
- Plan Determines Level of Cost Sharing



Approved Exceptions

- Valid for Remainder of Plan Year, As Long As
 - You Remain Enrolled in Plan
 - Physician Continues to Prescribe Drug
 - Drug Remains Safe for Treating Your Condition
- Plan Will Notify of Drug Coverage
 - For Following Year
 - At Time of Approval
 - At the End of Plan Year



Appeals

- Can Appeal Unfavorable Exception Decision
- Five Levels of Appeal
 - First Level Is Appeal to the Plan
- Will Receive Information Upon Enrollment
- Expedited Appeals Take Only a Few Days
- An Appointed Representative May Appeal
- Generally Must Be Made in Writing

Appeals Process

Begins When the Coverage
Determination Is Denied...



- **Standard Appeal** - Levels 1 and 2 – Plan or Independent Review Entity (IRE) Has 7 Days to Make a Decision
- **Expedited Appeal** – Based on an Urgent Health Condition, Decision Must Be Made by Plan or IRE in 72 Hours



Levels of Appeal

- Appeal to the Plan (Redetermination)
- Independent Review Entity Reconsideration
- Administrative Law Judge Hearing
- Medicare Appeals Council
- U.S. District Court Review



Required Notices

- After Every
 - Adverse Coverage Determination
 - Adverse Appeal Determination
- Include Information on Next Appeal Level
- Include Specific Instructions

SHIP Counselor Complaint Process

- Directed to CMS Customer Service Representative
- 30 Day Resolution
- May Tag “Urgent, Dire Need, Life-Threatening”
 - 24-48 Hour Resolution



Complaints / Casework Process
(Handout)

Medicare Complaints

