

Medicare Advantage Grievance and Appeal Process

- Differs from commercial process
- Dictated by Federal Law
- Distinctions between Part C and Part D

What is a Complaint?

- ***Complaint***--Any member expression of dissatisfaction to the plan, a provider, a facility or a Quality Improvement Organization (QIO), whether orally or in writing.
- A complaint could be either a grievance or an appeal, or a single complaint could include both. Every complaint must be handled under the appropriate grievance or appeal process.

What is a Grievance?

- ***Grievance***--Any complaint or dispute -- other than one involving an organization determination -- expressing dissatisfaction with the *manner* in which the plan or a delegated entity provides health care services, regardless of whether any remedial action can be taken.
- ***Expedited Grievance***-- A grievance will be expedited only if a physician, orally or in writing, supports that the standard time frame for a grievance would seriously jeopardize the life or health of the member, or would jeopardize the ability to regain maximum function. When expedited, a decision will be made within 72 hours of a request for a service or continuation of a service.

Filing a Grievance

If a member has a complaint, s/he should first call Member Services at 1-877-241-2583 (for BCBSM) or 1-800-450-3680 (for BCN Advantage).

If the plan is unable to resolve the complaint over the phone, the member will receive a written response usually within 30 days (unless an extension is required).

The member should contact the plan within 60 days of the incident or event that prompted the complaint.

What is an Organizational Determination (Part C)?

- ***Organization Determination***--Any decision made by or on behalf of the Medicare Advantage plan regarding payment or services to which a member believes s/he is entitled.
- ***Expedited Organization Determination***--Any organization determination made within 72 hours of a request for a service or continuation of a service. This generally occurs when the decision not to provide or continue the approval of a service could potentially jeopardize the life or health of the member.

Requesting an Organization Determination

- A member has the right to ask the plan to provide or pay for a service s/he thinks should be covered, provided, or continued.
- A plan must respond to the request within 14 days of receipt, unless an extension is required.
- If a member believes his/her health could be seriously harmed by waiting for a decision about a service, the member should an expedited determination.
- The plan must notify the member of its decision within 72 hours if it determines the member's life or health could be seriously harmed, or if a physician supports the request and indicates that the member may be harmed by waiting the standard 14 days adjudication period.
- **If the request is denied by the plan, the member will be notified in writing the reason for the denial and advised of further appeal rights.**

What is an Appeal?

- ***Appeal***—An appeal is a reconsideration of an adverse organization determination regarding the health care services a member believes s/he is entitled to receive or on any amounts the member must pay for a service.
- ***Expedited Appeal*** – An appeal will be expedited and a decision made within 72 hours if a physician, orally or in writing supports that the standard time frame for a grievance or appeal would seriously jeopardize the life or health of the member, or would jeopardize the ability to regain maximum function.

Who may file an appeal?

- The enrollee (including his or her representative);
- An assignee of the enrollee (i.e., a physician or other provider who has furnished a service to the enrollee and formally agrees to waive any right to payment from the enrollee for that service);
- The legal representative of a deceased enrollee's estate; or
- Any other provider or entity (other than the Medicare health plan) determined to have an appealable interest in the proceeding.

Appointment of Representative

- A member may appoint a relative, friend, advocate, attorney or physician to act as their representative. A representative who is appointed by the court or who is active in accordance with State law may also file an appeal. To appoint a representative the member must complete an Appointment of Representative form. Generally, an appeal submitted without an Appointment of Representative form by a provider on behalf of the member cannot be considered until the plan receives proof of the appointment. The form can be found at <http://www.bcbsm.com/pdf/medicare/cms1696.pdf>
- For incapacitated or legally incompetent enrollees where there are appropriate legal papers or other legal authority, such supporting documentation may be submitted as evidence of representation.

Appealing Coverage Determinations

- If a member request for an organization determination to provide or pay for a service is denied, the decision can be appealed.
- There are **five levels** of appeal available.

Appealing Coverage Determinations – Level One

1. Appeal through the plan by requesting “reconsideration”

A member must request this appeal within 60 calendar days from the date of the notice of the organization determination.

A written reconsideration request must be sent to the plan and include:

- The member’s name, address, and the health insurance claim (HIC) number
- The specific service and/or item(s) for which a reconsideration is being requested, including dates of service.
- The reasons for appealing and any evidence the member wishes to attach
- The member’s signature or that of the appointed representative.

If someone other than the member is making the request, documentation identifying the individual’s authority to act on behalf of the member, such as a completed “Appointment of Representative” form must be included.

Appealing Coverage Determinations – Level One

If the member is enrolled in a BCBSM plan, the request should be sent to:

Medicare Plus Blue or Prescription Blue
Attn: Grievance and Appeals
27000 W. 11 Mile Road, H404
Southfield, MI 48034
Telephone: 1-800-545-7100 (TTY: 1-800-579-0235)

For BCN Advantage members, the request should be sent to:

Blue Care Network
Attn: BCN Advantage Grievances and Appeals Unit
PO Box 5043; Mail Code C-248
Southfield, MI 48086-5043
Telephone: 1-800-450-3680 (TTY: 1-800-430-3211)
Fax: 1-888-458-0716

Appealing Coverage Determinations – Level One

Adjudication periods for requests to appeal:

- 30 calendar days for a standard service request;
- 60 days for a payment request;
- 72 hours for an expedited request

The time frame for completing standard service and expedited requests may be extended by up to 14 calendar days.

Appealing Coverage Determinations – Level Two

2. Review by an Independent Review Entity

If the plan again denies the request for reconsideration, the appeal is **automatically** sent to an Independent Review Entity (IRE) for review. The review will be expedited if the IRE determines that your life or health may be seriously jeopardized by waiting for a standard decision.

The member may submit additional information to the IRE. The IRE must receive the information 10 days after receipt of the IRE letter acknowledging receipt of the case file. A copy of the submission must be provided to the plan.

Appealing Coverage Determinations – Level Two

Adjudication periods for IRE:

- 30 days for a standard service request for coverage;
- 60 days for a payment request;
- 72 hours for expedited requests for coverage

The time frame for completing standard service and expedited requests may be extended by up to 14 calendar days.

Appealing Coverage Determinations – Level Three

3. Hearing with an Administrative Law Judge

If the member disagrees with the IRE's decision, s/he can request a hearing with an Administrative Law Judge (ALJ) by filing a written request within 60 calendar days from the date of the notice of the IRE decision.

To get an ALJ hearing, the projected value of the denied coverage or payment request must meet a minimum dollar amount (the member may be able to combine claims to meet the minimum dollar amount).

If the ALJ decides in the member's favor, the plan has the right to appeal this decision by asking for a review by the Medicare Appeals Council.

Appealing Coverage Determinations – Level Four

4. Review by the Medicare Appeals Council.

If a member disagrees with the ALJ's decision, s/he can request a review by the Medicare Appeals Council (MAC). The request must be made to the MAC in writing within 60 calendar days from the date of the notice of the ALJ's decision. The MAC determines whether or not to review the case. If it decides not to review the case, either the member or the plan may ask for a review by a Federal court.

Appealing Coverage Determinations – Level Five

5. Review by a Federal court.

If the member disagrees with the MAC's decision, s/he can request a review by a Federal court within 60 days from the date of the notice of the MAC's decision. To receive a review by a Federal court, the projected value of the denied coverage or payment request must meet a minimum dollar amount. The MAC's decision will include the amount.

Medicare Parts C and D Compared

- 5 step appeals process in both programs (plan review; independent review; ALJ, MAC; Federal court)
- Organization Determination referred to as Coverage Determination in Part D
- Shorter adjudication timeframes under Part D
- Different auto-forwarding rules
- MA-PD plans must have both processes in place

Coverage Determinations and Exceptions under Part D

- A Coverage Determination is a decision the plan makes about the prescription drug benefits to which a member is entitled under the plan, and the amount that a member is required to pay for a drug.
- An Exception is a type of Coverage Determination that, if approved, allows you to get a drug that is not on your plan's formulary, or get a non-preferred drug at the preferred cost-sharing level.
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Coverage Determinations (cont'd)

A member has the right to seek an exception if s/he:

- believes a drug is necessary that is not on our formulary;
- believes the drug should be available at a lower copayment; or
- is seeking an exception to the step therapy or prior authorization requirement for a drug.

Coverage Determinations (cont'd)

- Members may ask for a tier exception for tier 3 drugs only (e.g. a member's copay for a tier 3 drug is reduced to the copay of a tier 2 drug when the physician can provide clinical information that indicates a member can not take any other formulary drug option for his/her condition).
- Members cannot ask for a tiering exception for a drug in the Specialty tier.
- Members cannot obtain a brand-name drug at the copayment that applies to generic drugs.

A doctor must provide a statement to support the member's request for all tiering exceptions.

Coverage Determinations (cont'd)

- Members may not seek coverage determinations or exceptions for medications not covered under Medicare Part D such as:
 - Barbiturates
 - Benzodiazepines
 - fertility drugs
 - drugs for weight loss or weight gain
 - drugs for hair growth
 - over-the-counter drugs
 - prescription vitamins (except prenatal vitamins and fluoride preparations)

Coverage Determinations (cont'd)

- Adjudication periods for Coverage Determinations:
 - 72 hours for a standard request; or
 - 24 hours for an expedited request (sometimes referred to as “fast” request).
- For those decisions that require documentation from the prescribing physician the time frame does not start until that documentation is submitted. If no documentation is submitted the request will not be approved.
- An expedited determination is only available when waiting for a standard decision could seriously harm the member’s health or ability to function. Fast decisions apply only to requests for Part D drugs that the member has not received. A fast decision is not available for requests for member reimbursement.

Coverage Determinations (cont'd)

- Call BCBSM at 1-800-545-7100 (TTY 1-800-579-0235) 8:30 a.m. to 5:30 p.m. to request a coverage determination by telephone or submit the Coverage Determination Form located at <http://www.bcbsm.com/pdf/medicare/2007/MedicareRxDeetermination.pdf> by fax to 248-350-4448 or mail.
- For BCN Advantage Members, the form can be found at http://www.bcbsm.com/pdf/bcna_standard_MRF.pdf and must be mailed or faxed to MedImpact at 858-578-9732. The Pharmacy Help Desk, 800-788-2949, can assist with any questions regarding the status of the request.

Auto-Forwarding to IRE

Part C versus Part D

- Part C – all adverse plan determinations made on appeal must be automatically forwarded to IRE
- Part D – no automatic forwarding of adverse determinations unless adjudication timeframe was missed by the plan

Alternative Resources

- Medicare Advantage Plans and Medicare Cost Plans: How to File a Complaint (Grievance or Appeal) available at <http://www.medicare.gov/Publications/Pubs/pdf/11312.pdf>
- Medicare Prescription Drugs Appeals and Grievances available at http://www.cms.hhs.gov/MedPrescriptDrugApplGriev/01_Overview.asp#TopOfPage
- Medicare Part D Appeals Process Flow Chart available at <http://www.cms.hhs.gov/MedPrescriptDrugApplGriev/Downloads/PartDAppealsFlowchart.pdf>
- Part C Managed Care Organization Determination / Appeal Process available at <http://www.cms.hhs.gov/MMCAG/Downloads/Flow.pdf>