Medicare Part D: Coverage Determinations, Appeals & Grievances (CDAG)

Quality of Care Grievances and Appropriate Classification of Requests

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Overview

- Classification differences between , Grievance, Quality of Care Grievances, Coverage Requests, Inquiries, and Appeals
- Scenarios
- Non-Part D and Excluded Drugs Notice
- CDAG Resources

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Classification

- Grievance/ Quality of Care Grievances
- Coverage Requests
- Inquiries
- Appeals

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.

- There are no appeal rights associated with a grievance.
- Generally, a longer timeframe to notify enrollee or representative of the resolution.

Grievances (cont.)

Examples of grievances may include:

- An enrollee's involuntary disenrollment initiated by the plan.
- A change in premiums or cost sharing arrangements from one contract year to the next.
- Difficulty contacting plan via phone.
- Interpersonal aspects of care.
- The appeals process.
- Plan's denial of expedited coverage or appeal request.
- An expression of general dissatisfaction about a co-payment amount, but is not disputing the amount he or she paid.

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.

Coverage Requests

- A coverage request is a request for a coverage determination or an organization determination from an enrollee, their representative, prescriber, or provider for payment or provision of an item, service, or drug.

  Examples of coverage requests:

  – The enrollee calls the plan and says, "My pharmacy said you won't pay for drug X, but I need it."

  – Enrollee calls requesting a drug, item, or service.

  – Enrollee calls and argues that a drug is not excluded from Part D coverage for the indication for which it is being prescribed.

  – Enrollee calls and is upset because his/her specialist is no longer contracted with the plan and wants to continue care with the provider (out of network coverage).

Inquiry

A general question about benefits or coverage.

- No indication of a request for coverage;
- Not expressing dissatisfaction related to non-coverage;
- Not required to be recorded or reported; and
- Can be a part of a grievance, appeal or coverage request

Inquiry (cont.)

- Non-Part D Drugs
- Excluded Drugs

Part D Coverage Determination and Appeals Process

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Part D Denial Notice

- If a Part D plan sponsor denies, in whole or in part, a request for a Part D benefit or payment for a prescription drug purchased by an enrollee, it must provide written notice of its determination.
- The denial rationale must be specific to each individual case and written in a manner calculated for an enrollee to understand.


NOTICE OF DENIAL OF MEDICARE PART D PRESCRIPTION DRUG COVERAGE

AC1

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Part D Denial Notice (pages 2-3)

Slide 12

AC1 The updated Denial Notice will include language regarding the 14 day payment timeframe effective 1/1/19. The form used in this presentation appears to be the old form

Amber Casserly, 10/29/2018

Part D Pharmacy Notice

The pharmacy notice must be provided to the enrollee if the pharmacy receives a transaction response (rejected or paid) indicating the claim is not covered by Part D.

A few rejected claim scenarios that do not require issuance of this notice include:

- The claim rejects only because it does not contain all necessary data elements for adjudication.
- The drug in question is an over the counter (OTC) drug that is not covered by the enrollee's Part D plan sponsor.
- The prescription is written by a sanctioned provider who has been excluded from participation in the Medicare program.

See Chapter 18 of the Prescription Drug Benefit Manual for additional scenarios.

CDAG Resources

- Medicare Prescription Drug Benefit Manual, Ch.18 & Ch.13 consolidated (Update in 2018)
- HPMS Memos
  - Draft Part C & D Appeals Guidance (10/1/2018)
- MAXIMUS Reconsideration Process Manual
  http://www.medicareappeals.com/Portals/3/PDF/Recon%20Manual%2012-19-12.pdf
- 42 CFR Part 422, Subpart M
- Part D Appeals & Grievances Mailbox:
  Part_D_appeals@cms.hhs.gov

Medicare Part C: Organization Determinations, Appeals & Grievances (ODAG)

Quality of Care Grievances and Appropriate Classification of Requests

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December 3, 2018
ICE 2018 Annual Conference
San Francisco, CA

Overview

- What is a Quality of Care (QOC) Grievance?
- Processing QOC Grievances
- Appropriate Classification of Requests
- Best Practices
- ODAG Resources

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What is a 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 include:

- Enrollee believes they were misdiagnosed;
- Enrollee believes treatment was not appropriate;
- Enrollee believes the care provided (or lack thereof) adversely impacted, or had the potential to adversely impact, their health or well-being.

Processing QOC Grievances

- Staff should be trained to listen to the member's perception of care.
- Plan's quality department conducts review of QOC complaints.
- QOC grievances may be reviewed by a medical professional.
- Review determines if services received did not meet standards.

Processing QOC Grievances

- Written response required for QOC grievances within 30 days from request, plus 14-day extension if applicable (enrollee must be notified in writing of extension).
- The notice must:
  - Include a description of the enrollee's right to file a grievance with the BFCC-QIO and contact information for the BFCC-QIO; and
  - Be written in a manner that is understandable to the enrollee.

Processing QOC Grievances

- QOC best practices:
  - Complete quality review prior to sending response letter
  - Address all issues in the grievance including any quality of service issues
  - Track and trend QOC issues
- If enrollee files a complaint with the BFCC-QIO, plans and providers must cooperate and submit requested information as soon as possible and no later than 14 days.

Appropriate Classification of Requests

- Listen for key words to classify correctly.
  - "I need" vs. " I'm not satisfied with a decision" or "I dislike" vs. "I disagree with a copay."
- Ask probing questions, enrollees may not know terminology or what to ask for.
- Do not give members homework or tell them to call back with more information.
- If request is unclear after the call, follow up for additional information.

Appropriate Classification of Requests

- Is it an inquiry, grievance, organization determination, appeal—or more than one.
  - Process cases separately and simultaneously if more than one case is opened.
- During/after the call, document all information in the plan's system and send to appropriate departments.
- If able to resolve issue(s) during initial call, document the resolution in plan's system.

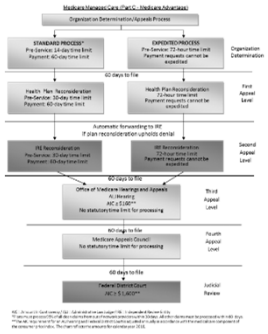
Best Practices

- Helpful tools for staff:
  - Checklists, workflow documents, reference materials
  - Training includes key words to listen for during calls
  - Guidance documents available for reference
  - Policies and procedures are up to date
- Management oversight includes:
  - Customer service calls
  - Classification of requests
  - Documentation in system (initial call notes, additional investigation, resolution, all letters)

Best Practices

- Ongoing scenario-based training and education—use actual cases that were mishandled or handled well.
- Perform internal audits of customer service and ODAG department functions from intake to resolution.
- Review the annual Medicare Part C and Part D Program Audit and Enforcement Report and use the findings to enhance trainings.

Part C Organization Determination and Appeals Process



ODAG Resources

- Medicare Managed Care Manual, Chapter 13*
- HPMS Memos
  - Draft Part C & D Appeals Guidance (10/1/2018)
  - 2017 Program Audit Enforcement Report (5/8/2018)
- MAXIMUS Reconsideration Process Manual
- 42 CFR Part 422, Subpart M
- Part C Appeals & Grievances Mailbox: Part_C_Appeals@cms.hhs.gov

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QUALITY OF CARE GRIEVANCES

ICE A&G Improvement Team Lead

Yolanda Morris

OBJECTIVES

- **Grievance Procedures**
- **Classifying quality of care grievances vs. quality of service**
- **Investigating Quality of Care Grievances**
  - **How do we respond in the Grievance Resolution Letter?**
- **What to do if member declines the right to file a grievance?**
- **What to do if provider of services does not provide a response to the grievance?**
- **Classification Best Practices for Call Logs: inquiry or oral grievance?**

WHAT MUST THE MEDICARE HEALTH PLANS INCLUDE IN ITS GRIEVANCE PROCEDURE?

- Each plan must provide meaningful procedures for timely hearing and resolving both standard and expedited grievances between enrollees and the Medicare health plan or any other entity or individual through which the Medicare health plan provides health care services.
- The ability to accept any information or evidence concerning the grievance orally or in writing not later than **60 days** after the event; and
- The requirement to respond within 24 hours to an enrollee's expedited grievance whenever:
  - A Medicare health plan extends the time frame to make an organization determination or reconsideration; or
  - A Medicare health plan refuses to grant a request for an expedited organization determination or reconsideration.

What if the dissatisfaction is not related to the care the member received?

If the grievance or complaint is not related to the dissatisfaction of the care the member received- the grievance or complaint would be resolved through the plan's grievance process. Here are some examples of problems that are typically dealt with through the grievance process:

- Problems getting an appointment, or having a long time for an appointment
- Disrespectful or rude behavior by doctors, nurses, or other plan clinic or hospital staff.

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Investigating quality of care grievances

- **Scenario:** A member contacts their plan and states they believe they were misdiagnosed by the hospital and as a result, experienced complications after the hospital discharge.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.

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Acknowledgement Letters for QOC Grievances

For quality of care grievance:
<Plan Name> Medicare Program s received your concerns on <spell out date>, regarding <Issue(s)>. Thank you for notifying us and giving us the opportunity to look into this situation. We have forwarded each of your concerns to the <Plan Name> Quality Improvem ent Departm ent for review. The Quality Departm ent will thoroughly investigate your concerns. A written response will be provided within 30 days of the receipt of your concern.

You have a right to file a complaint with the Quality Improvement Organization (QIO) for California, Livanta. You may contact the QIO in writing at the following address:

Livanta
BFCC-QIO Program
9090 Junction Drive, Suite 10
Annapolis Junction, MD 20701
Toll-free Number: 1-877-588-1123
TTY: 1-855-887-6668
Appeals: 1-855-694-2929
All other reviews: 1-844-420-6672]

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Best Practice Response in Resolution Letter to the Member for a QOC Grievance

This letter is a follow up to your complaint in which you expressed quality of care concerns regarding <Issue(s)>. Thank you for your patience during < Medicare Programs'> review of your complaint.

Your concerns were forwarded to our <name of quality department handling QOC cases> Department for review. The Quality Department <will/has> thoroughly <investigate/investigated> your concerns. The results of this investigation are confidential.]

[Use this language for quality of care grievance]
You have a right to file a complaint with the Quality Improvement Organization (QIO) for <State>, <QIO for State>. You may contact the QIO in writing at the following address:

<Livanta
BFCC-QIO Program
9090 Junction Drive, Suite 10
Annapolis Junction, MD 20701
Toll-free Number: 1-877-588-1123
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All other reviews: 1-844-420-6672>

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What if member declines the right to file a grievance?

- **Member expresses dissatisfaction**
- **Classification**
- **Documentation**
- **Resolution/Outcome**

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What to do if provider of service does not provide a response to the grievance?

- **Contracted Providers:** Contractual Obligation to cooperate and provide assistance and information to Plan to resolve Beneficiary grievance and comply with all laws, regulations, and policies around grievance procedures.
- **Non-Contracted Providers:** Best Practice for Plan to follow HPMS Guidance on Outreach for information.
- Outreach to request grievance response
  - Make three attempts
  - Use different types of outreach (phone, fax, email, mail)
  - Thorough documentation of outreach attempts

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Best Practices: Classification for Call Logs

GRIEVANCE	INQUIRY
Did the enrollee: • Complain about customer service? • Complain about the quality of care received? • Complain about mail delay? • Complain they did not receive their ID card/EOB/ANOC in the mail? • Complain that a service is not covered (but they do not need the service that's in question)? • Make a general complaint about service? • Complain about a provider?	Did the enrollee: • Ask a general question that does not involve an issue in the first two columns? • Ask how the EOB is developed (but doesn't want a specific service)? • Ask about coverage for a service, but does not want the service that's in question? • Ask a general question about a plan policy or in-network providers?

Best Practice: What to do next after inquiry or grievance classification

Next Steps: • If any of the issues raised in the grievance include quality-of-care concerns, written notice must explain the enrollee's right to file a complaint with the QIO and provide the address where the complaint can be filed. • Forward grievance to appropriate staff to resolve any issues. • Notify enrollee of the decision within 30 days of receipt of the grievance. • Response should address all issues raised in the initial grievance and any resolution to those issues. • For oral grievances that are resolved during the initial call, record the grievance and resolution for reporting purposes.	**Next Steps:** • Follow your internal policies and procedures for inquiries.

References

- ODAG Classification Job Aid
- Medicare Managed Care Manual, Chapter 13

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BENEFICIARY AND FAMILY CENTERED CARE QUALITY OF CARE REVIEWS

Jennifer Bitterman,
Director of Communications/PFE

ABOUT LIVANTA LLC

- Established in 2004; Privately-held, government contracting firm headquartered in Annapolis Junction, MD
- Livanta employs skilled professionals who specialize in:
  - Medical documentation and health care claims
  - Financial and compliance audits
  - Data analysis and management
  - Medicare medical review and appeals review programs

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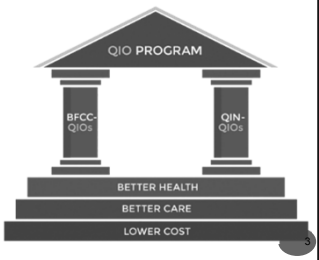
THE QIO PROGRAM STRUCTURE

The QIO Program is one of the largest federal programs dedicated to improving health quality at the local level.



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Beneficiary and Family Centered Care (BFCC)-QIOs

Two BFCC-QIOs manage beneficiary complaints, quality of care reviews, Emergency Medical Treatment and Labor Act (EMTA

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Quality Innovation Network (QIN)-QIOs

- HealthInsight
- Health Services Advisory Group
- Mountain-Pacific Quality Health Foundation
- Qualis Health

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Scope of QIO Review

- **§ 476.88 Examination of the operations and records of health care facilities and practitioners.**
  - **(a)*Authorization to examine records.*** A facility claiming Medicare (Title XVIII) payment must permit a QIO to examine its operation and records that are pertinent to health care services furnished to Medicare beneficiaries

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BFCC-QIO TASKS

- Admission Appeals
- Discharge Appeals
  - Patient Advocacy Program
- Quality of Care Reviews (QOC)
  - Immediate Advocacy
- Higher Weighted DRG Reviews
- Short Stay Reviews

QUALITY OF CARE REVIEW (QOC)

- If a beneficiary has a concern about the quality of care or other services they get from a Medicare provider, they may file a request for review
- Examples of requests include:
  - A mistake in a medication
  - No information/not enough information given when discharged
  - A change in condition that was not treated
  - Hospital/facility acquired infection
  - Improper or incomplete treatment

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QOC REVIEW PROCESS

- Accept complaints within 3 years of the date of service
- Discussion with beneficiary regarding concerns
- Medical Record requested and received
- Independent physician reviewer determines if the health care met the Standards of Care
- ~30 - 45 days from receipt of the complaint form, decision letter sent
- Right to Reconsideration (as of March 2017)

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Volume of Livanta Quality Reviews

Area 5 – 8/1/17-7/31/18		
# of Complaints	# of Immediate Advocacy Reviews	(%) of Total Beneficiary Complaints Resolved by Immediate Advocacy
1,572	907	57.70%

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Outcome of Quality of Care Reviews

Quality of Care Categories Area 5 – 8/1/17-7/31/18	# of Concerns	# of Concerns Confirmed
Total	2,280	412
C03: Apparently did not establish and/or develop an appropriate treatment plan	1,297	242
C02: Apparently did not make appropriate diagnoses and/or assessments	356	50
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	278	50
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	101	18

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Quality of Care Concern #1

The patient's representative reported that the patient was left unattended, got up, and fell. The patient's representative asked if he hit his head and was told that he did not. The family later discovered a red area on the back of his head. The doctor was there at the time and said that he had not been told. Was a post-fall assessment completed in a timely manner?

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Quality of Care Response #1

The patient is noted to have fallen on June 11th. The provider response highlighted a nurse's note regarding the fall. The note documents vital signs and a cursory physical examination performed by the nurse. The nurse documents that a physician evaluated the patient and ordered a CT of the head and ice pack to be applied to the back of the head. However, there is no documentation by the physician at the time of the assessment, its findings and plan of care. While it appears the patient was assessed in a timely manner, there should have been documentation by the physician after assessing the patient.

Quality of Care Concern #2

The patient reported that he presented to provider for chronic pain management in August of 2018. He received an injection of Toradol, which he had a reaction to that included nausea, pain, ears buzzing, and weakness for several days. He has an allergy to non-steroidal anti-inflammatory drugs (NSAIDs) of which the provider was aware. He felt that this medication should not have been administered.

Quality of Care Response #2

The patient reported symptoms following ketorolac that he attributed to allergy. In review of the medical record, it is not clear that these were actual allergic symptoms, and in fact likely represent symptoms of the patient's chronic pain syndrome, or possible an adverse drug reaction without true allergy.

However, the nowhere in the entire provided medical record is a list of current medications, allergies, nor adverse drug reactions. These are standard requirements for appropriate documentation of patient care.

IMMEDIATE ADVOCACY

Program whereby the beneficiary requests "real time assistance" for Medicare service issues within 6 months of the date of service.

- Durable Medical Equipment (DME) not delivered
- Home Health Nurse no-show
- Speak with a Clinician or Social Worker
- Questions regarding appropriate admission
- Available during care and immediately after care

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IMMEDIATE ADVOCACY EXAMPLE #1

Concern: Pulmonologist did not send her prescription refill order for her oxygen supplies to the correct provider.

Advocacy: Determined that the order was missing the correct diagnosis.

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IMMEDIATE ADVOCACY EXAMPLE #2

Concern: Physician's office continues to call in mail order refills for medications the patient no longer takes.

Advocacy: Nurse supervisor agreed to call the patient to perform a medication reconciliation.

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RELEASE OF INFORMATION TO THIRD PARTY

- QIOs and providers are both "covered entities" under the Health Insurance Portability and Accountability Act (HIPAA)
- Agreements between Livanta and providers allow sharing of protected health information (PHI) about Medicare beneficiaries to help those patients.

CONTACT INFORMATION

For general questions, contact:

Jennifer Bitterman
Director of Communications/PFE
jbitterman@livanta.com
240-712-4313

www.LivantaQIO.com

For clinical or case inquiries, contact:

Livanta Medicare HelpLine
(9-5 weekdays, 11-3 weekends and holidays)

1-877-588-1123

This material was prepared by Livanta LLC, the Medicare Quality Improvement Organization for BFCC Areas 1 and 5, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. 11-[illegible]

Quality of Care Grievances

Q & A

Panel Discussion

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Kristi Sugarman-Coats (CMS), Lucy Saldana (CMS), Jullin Kwok (CMS)