n03517

Appeals and Grievance Resolution Policy for Medicare Advantage – Part D Plans

Values

Accountability ● Integrity ● Service Excellence ● Innovation ● Collaboration

Abstract Purpose:

To define Network Health Insurance Corporation's (NHIC) Appeals and Grievance Process for members who have NHIC's Medicare Advantage - Part D policy, in accordance with the Centers for Medicare and Medicaid Services (CMS) and National Committee of Quality Assurance (NCQA) standards.

Policy Detail:

NHIC will establish and maintain procedures for standard and expedited appeals, and standard and expedited grievances in accordance with CMS regulations. Written information will be provided to members or their representatives in a culturally and linguistically appropriate manner, regarding appeal and grievance procedures that are available to them through the Medicare health plan and further appeal rights that are available to members through other entities. NHIC will monitor, track, and trend all appeals and grievances in a central database maintained by the Appeals and Grievance Department and will be reported quarterly to the QMC committee. All verbal or written appeals and grievances received at NHIC will be investigated and resolved in a consistent and timely manner, in accordance with CMS and NCQA standards. An expedited process will be implemented whenever a provider requests an urgent decision, or when a grievance or appeal has been determined to be of an urgent clinical nature. In accordance with 42 CFR 423.562(a)(5) for Part D Plans, NHIC will employ a medical director who is responsible for ensuring the clinical accuracy of all coverage determinations and redeterminations involving medical necessity. The medical director must be a physician with a current license to practice medicine in a State, Territory, Commonwealth of the United States, or the District of Columbia.

I. Definitions

A. Adverse Determination: Any situation where NHIC or its Delegated Entities decide not to provide or pay for a requested service, in whole or in part, will constitute an adverse determination. In addition, the decision to discontinue or reduce a previously authorized course of treatment automatically results in an adverse determination. This does not apply in situations where the member wants to continue receiving services already completed in accordance with the original organization determination.

B. Appeal: Any of the procedures that deal with the review of adverse coverage

determinations made by the Part D plan sponsor on the benefits under a Part D plan the member believes he or she is entitled to receive, including a delay in providing or approving the drug coverage (when a delay would adversely affect the health of the member), or on any amounts the member must pay for the drug coverage, as defined in §423.566(b). Appeal also includes the review of at-risk determinations made under a drug management program in accordance with § 423.153(f). These procedures include redetermination by the Part D plan sponsor, reconsiderations by the independent review entity (currently C2C Solutions, Inc), Administrative Law Judge (ALJ) hearings, reviews by the Medicare Appeals Council (MAC), and judicial reviews.

C. At-risk determination means a decision made under a plan sponsor's drug management program in accordance with § 423.153(f) that involves the identification of an individual as an at-risk beneficiary for prescription drug abuse; a limitation, or the continuation of a limitation, on an at-risk beneficiary's access to coverage for frequently abused drugs(that is, a beneficiary specific point-of-sale edit or the selection of a prescriber and/or pharmacy and implementation of lock-in, or); and information sharing for subsequent plan enrollments.

D. C2C Solutions, Inc: See independent Review Entity (IRE)

E. Complaint: A complaint may involve a grievance, coverage determination, or both. A complaint also may involve a late enrollment penalty (LEP) determination. Every complaint must be handled under the appropriate process.

F. Concurrent Care Appeal: An appeal of a denial, reduction or termination of coverage for an ongoing course of treatment for which coverage was previously approved. It does not apply to requests for extensions.

G. Coverage Determination: Any decision made by or on behalf of a Part D plan sponsor regarding payment or benefits to which an enrollee believes he or she is entitled.

H. Effectuation: Payment of a claim, authorization or provision of a benefit the plan sponsor has approved, or compliance with a complete or partial reversal of a Part D plan sponsor’s original adverse coverage determination.

I. Expedited Redetermination: Any member, member's representative, prescribing physician or other prescriber, may request that a Part D plan sponsor expedite the appeal of a coverage determination in situations where applying the standard time frame could jeopardize the member’s life, health, or ability to regain maximum function. A request for payment of a benefit already provided to a member is not eligible to be reviewed as an expedited redetermination.

J. Grievance: Any complaint or dispute, other than a coverage determination, at-risk determination, or a late enrollment penalty (LEP) determination, in which a member is expressing dissatisfaction with any aspect of the operations, activities, or behavior of the Part D plan sponsor, regardless of whether a remedial action is requested. A grievance may also include a complaint that a Part D plan sponsor refused to expedite a coverage determination or redetermination. Grievances may include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided item.

K. Independent Review Entity (IRE): An independent entity contracted by CMS to review Part D plan sponsor denials of coverage determinations. As of the date of this revision, the IRE is C2C Solutions, Inc.

L. Inquiry: Any oral or written request to a Part D plan sponsor or one of its contractors that does not involve a request for a coverage determination/ exception request.

M. Quality of Care Issue: A quality of care issue may be filed through NHIC's grievance process and/or a Quality Improvement Organization (QIO). A QIO must determine whether the quality of services (including both inpatient and outpatient services) provided by a Part D plan sponsor or its network of providers meets professionally recognized standards of health care, including whether appropriate health care services have not been provided or have been provided in inappropriate settings.

N. Quality Improvement Organization (QIO): Organizations comprised of practicing doctors and other health care experts under contract to the Federal government to monitor and improve the care given to Medicare enrollees. They review complaints raised by enrollees about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Medicare managed care plans, Medicare Part D prescription drug plans, and ambulatory surgical centers. The QIOs also review continued stay denials in acute inpatient hospital facilities as well as coverage terminations in skilled nursing facilities (SNFs), home health agencies (HHAs) and comprehensive outpatient rehabilitation facilities (CORFs).

O. Reconsideration: The second level of the appeal process which involves a reevaluation of the adverse redetermination, at-risk determination or untimely plan redetermination by the IRE.

P. Redetermination: The first level of the appeal process, which involves NHIC reevaluating an adverse coverage determination or at-risk determination, the findings upon which it was based, and any other evidence submitted or obtained.

Q. Representative: An individual either appointed by an enrollee or authorized under State or other applicable law to act on behalf of the enrollee in filing a grievance, requesting a coverage determination, or in dealing with any of the levels of the appeals process. Unless otherwise stated in part 423, subpart M of the Medicare Part D regulations, the representative has all of the rights and responsibilities of an enrollee in obtaining a coverage determination or in dealing with any of the levels of the appeals process, subject to the rules described in part 422, subpart M of the Medicare Part C regulations.

R. Tiering Exceptions: If NHIC utilizes a tiered cost-sharing structure to manage its Part D drug benefits, it must establish and maintain reasonable and complete exceptions procedures that permit members to obtain a non- preferred drug in a higher cost-sharing tier at the more favorable cost-sharing terms applicable to drugs in a lower cost-sharing tier.

II. Complaint Categories

A. Grievance Process:

1. NHIC must establish and maintain policies and procedures for tracking and addressing the timely resolution of all verbal and written member grievances including but not limited to the date of receipt, final disposition of the grievance and the date that the member was notified of the disposition. In addition, NHIC must track reasons for grievances

such as fraud and abuse, enrollment/disenrollment, benefit package, network access, marketing, customer service, confidentiality/privacy, or quality of care concerns.

2. A member must file a grievance no later than sixty (60) days after the event or incident that precipitates the grievance. However, a member who files a quality of care grievance with a QIO is not required to file the grievance within a specific time period. Therefore, quality of care grievances filed with a QIO may be filed and investigated beyond the 60-day time frame.

3. NHIC must promptly and correctly determine and inform the member whether a complaint is subject to its grievance procedures, its coverage determination procedures, or its redetermination procedures.

4. NHIC must respond to a member's grievance within twenty-four (24) hours if the complaint involves a refusal by NHIC to grant a member's request for an expedited coverage determination or an expedited redetermination, and the member has not yet received the service in dispute.

5. For other grievances, NHIC must notify all concerned parties of its decision as expeditiously as the case requires, based on the member's health status, but no later than thirty (30) calendar days after the date NHIC receives the verbal or written grievance. The day NHIC receives the grievance is considered day zero, and the 30-day period starts the day after the grievance is received.

6. NHIC may extend the thirty (30) day timeframe by fourteen (14) days if the member requests the extension or if NHIC justifies a need for additional information and documents how the delay is in the interest of the member. When NHIC extends the deadline, it must promptly notify the member in writing of the reasons for the delay.

7. NHIC must respond to all written grievances in writing (including facsimile). If the member verbally submits a grievance and requests a written response, NHIC must respond in writing.

8. NHIC must respond in writing to all grievances related to the quality of care. The response must include a description of the member's right to file a written complaint with the Quality Improvement Organization (QIO). If a complaint is submitted to the QIO, NHIC must cooperate with the QIO in resolving the complaint. For purposes of quality of care complaints, the member will be informed that the results of this investigation are confidential in accordance with federal law 42 U.S.C. 11112.

B. Appeal Process – General:

1. NHIC shall have policies, procedures, and systems in place that allows it to accept written and oral requests for standard and expedited redeterminations of adverse coverage determinations. Procedures will ensure the independence and impartiality of those involved in determining the resolution of appeals and grievances.

2. For purposes of an appeal, the following parties can submit an appeal for redetermination: The member, representative who is authorized to act on behalf of the member, or, upon providing oral or written notice to the

member, a physician (or their staff) who is treating a member and acting on the member's behalf. Except in the case of an incapacitated or incompetent member, a request for a redetermination from a representative is not valid until supported with an executed appointment of representative form or statement. It is NHIC's obligation to inform the enrollee and purported representative, in writing, that the request will not be considered until the appropriate documentation is provided.

3. Timeline for filing appeal: Except when the filing time frame is extended for good cause, the request must be filed within 60 calendar days from the date printed or written on the coverage determination denial notice. NHIC may choose to accept a request for redetermination filed beyond the sixty (60) day limit for good cause as described below. The request for redetermination and to extend the timeframe must be in writing and state why the request was not filed on time so that good cause can be evaluated by NHIC.

4. Good Cause Reasons/Extension: If a member or representative shows good cause, NHIC may extend the time frame for filing a request for redetermination as allowed by CMS. NHIC will consider the circumstance that kept the member or representative from making the request on time and whether any organizational actions might have misled the member. Examples of circumstances where good cause may exist include (but are not limited to) the following situations: The member did not personally receive the adverse organization determination notice, or he/she received it late; The member was seriously ill, which prevented a timely appeal; There was a death or serious illness in the member's immediate family; An accident caused important records to be destroyed; Documentation was difficult to locate within the time limits; The member had incorrect or incomplete information concerning the redetermination process; or the member lacked capacity to understand the time frame for filing a request for reconsideration.

    a. The party requesting the good cause extension may file the request with NHIC in writing, including the reason why the request was not filed timely. If NHIC denies a member's request for a good cause extension, the member may file a grievance with NHIC.

5. Opportunity to submit information: NHIC must provide the member, representative, or the prescribing physician or other prescriber, as appropriate, with a reasonable opportunity to present evidence and allegations of fact or law related to the issues in dispute by accepting evidence in writing, by telephone or fax, or by accepting evidence that is hand-delivered by members to NHIC's office.

6. Who must conduct redetermination: NHIC must designate someone other than the person involved in making the initial coverage determination to make a redetermination. If the original denial was based on a lack of medical necessity (i.e., the non-preferred or non-formulary drug was not medically necessary for treating the member's condition when compared with the preferred or formulary drug, or a determination was made that insufficient information was received to make such a determination, or the drug was denied because it was not

reasonable and necessary under section 1862(a)(1) of the Social Security Act), the redetermination must be performed by a physician with expertise in the field of medicine that is appropriate for the drug benefits at issue.

7. When reviewing the appeal, NHIC must take all of the evidence submitted orally and/or in writing into account including any aspect of clinical care when making a redetermination decision. In addition, upon a member's request, NHIC must provide the member with a copy of the contents of the case file, including, but not limited to, a copy of supporting medical records, physician title/specialty, and other pertinent information used to support the decision, subject to applicable Federal and state laws regarding confidentiality and disclosure for mental health records, medical records, or other health information per 45 CFR 164.500 et seq.

8. NHIC must make a redetermination decision and notify the member, and other parties as applicable, within the timelines allowed by CMS for standard and expedited appeals. If NHIC does not meet the required timelines, it must forward the complete file to the IRE within 24 hours of the expiration of the adjudication time frame.

    a. In addition, if required by current CMS Medicare regulations, NHIC must notify the member that it has forwarded his or her request to the IRE for review. NHIC must send the notification to the member within 24 hours of the expiration of the adjudication time frame. The notice must advise the member of his/her right to submit additional evidence to the IRE and must include information on how to contact the IRE. NHIC will utilize a model notice similar to what CMS developed for this purpose.

9. Dismissal: If a request for redetermination is filed beyond the 60-calendar day timeframe and good cause for late filing is not provided, NHIC will dismiss the person's redetermination request and provide the appellant with information on their right to request IRE review of the dismissal. Dismissal is also appropriate in other situations in which NHIC lacks jurisdiction to review the case, in accordance with CMS guidelines.

10. Withdrawal: The party who files a request for redetermination may submit a written or verbal request to NHIC asking to withdraw the request at any time before a decision is mailed. NHIC must provide a written dismissal notice to the party within three (3) calendar days from the date of the verbal request. If a withdrawal request is received before NHIC has made its redetermination decision, NHIC may dismiss the appeal. However, if the withdrawal request is received after NHIC has forwarded the case file to the IRE because NHIC did not provide notice of its decision within the appropriate timeframe, NHIC must forward the withdrawal request to the IRE for processing.

11. Concurrent Care: In the event that Network Health denies, reduces or terminates coverage for an ongoing course of treatment for which coverage was previously approved, Network Health will continue the member's previously approved coverage pending the outcome of an internal appeal.

III. Types of Appeals:

A. Standard Redetermination and Timelines -

1. Upon review of an adverse coverage determination, NHIC must provide written notice of its redetermination (i.e. make and place in the mail) as expeditiously as the member's health condition requires but no later than seven (7) calendar days from the date NHIC receives the request for a standard redetermination. The day NHIC receives the standard request is considered day zero per CMS, and the 7-day period starts the day after the request is received. Timelines may change based on current CMS Medicare regulations.

2. NHIC may not extend the applicable adjudication time frame by dispensing a temporary supply of the requested medication. NHIC must make reasonable and diligent efforts to obtain all necessary medical records and other pertinent information within the required time limits and document its attempts. Documentation should include: 1. A specific description of the required information; 2. The name, phone number, fax number, e-mail and/or mailing address, as applicable, for the point of contact at the plan; and 3. The date and time of each request, documented by date and time stamps on copies of a written request, call record, facsimile transmission or e-mail. If NHIC cannot obtain all relevant documentation, it must make the decision based on the evidence available.

3. If NHIC reverses its original coverage determination, it must send an approval notice to the member that is written in an understandable manner and must explain the conditions of the approval such as the duration of an approval; limitations associated with an approval; and/or any coverage rules applicable to subsequent refills.

4. Actions required if NHIC upholds the original coverage determination denial, in whole or in part, NHIC must notify the member in writing of its redetermination within the seven (7) calendar day period listed above as may be amended from time to time by CMS. The denial notice must be written in a manner that is understandable to the member, and must contain all required CMS requirements including but not limited to:

a. Stating the specific reason for the denial that takes into account the member's presenting medical condition, disabilities, and special language requirements, if any; and

b. A description of any applicable Medicare coverage rule or any other applicable Part D plan policy upon which the denial decision was based, including any specific formulary criteria that must be satisfied for approval. If the drug could be approved under the exception rules, the denial notice must explicitly state the need for a prescriber's supporting statement and clearly identify the type of information that should be submitted when seeking a formulary or tiering exception; and

c. Informing the member of his or her right to a reconsideration for adverse drug coverage redeterminations, describing both the standard and expedited reconsideration processes, including the member's right to, and conditions for, obtaining an expedited reconsideration and the rest of the appeals process;

d. NHIC must complete the applicable sections of the model Request for Reconsideration form and send it to the member (and physician or other prescriber when appropriate) with each adverse redetermination notice.

5. If the appeal is a review of an at-risk determination and NHIC upholds its denial, the case must be auto- forwarded to the independent review entity for review and resolution.

B. Effectuation if NHIC reverses its coverage determination:

1. Request for benefits: If, on redetermination of a request for benefits, NHIC reverses its coverage determination in a manner that is completely favorable to the member, NHIC must effectuate it as expeditiously as the member's health condition requires, but no later than seven (7) calendar days following the date it receives the request for a standard redetermination.

2. Request for payment: If, on redetermination of a request for payment, NHIC reverses its coverage determination, NHIC must authorize payment for the benefit within seven (7) calendar days from the date it receives the request for redetermination and make payment no later than thirty (30) calendar days from the date it receives the request.

3. At-risk determination: If, on redetermination of an at-risk determination made under a drug management program in accordance with § 423.153(f), the Part D plan sponsor reverses its at-risk determination, the Part D plan sponsor must implement the change to the at-risk determination as expeditiously as the enrollee's health condition requires, but no later than 7 calendar days from the date it receives the request for redetermination.

C. Effectuation if entity other than NHIC reverses coverage determination:

1. Requests for benefits. If, on appeal of a request for benefits, the determination made by NHIC is reversed in whole or in part by the IRE or at a higher level of appeal, NHIC must authorize or provide the benefit under dispute within seventy-two (72) hours from the date it receives the notice reversing the determination. NHIC must inform the IRE that NHIC has effectuated the decision.

2. Requests for payment. If, on appeal of a request for payment, the determination made by NHIC is reversed in whole or in part by the IRE or at a higher level of appeal, NHIC must authorize payment for the benefit within seventy-two (72) hours but make payment no later than thirty (30) calendar days from the date it receives notice reversing the coverage determination. NHIC must inform the IRE that NHIC has effectuated the decision

D. Expedited Redetermination and Timeline:

1. A member, representative, or treating physician may request an expedited redetermination in situations where applying the standard time frame could seriously jeopardize the enrollee's life, health, or ability to regain maximum function. A request for payment of a benefit already provided to an enrollee is not eligible to be reviewed as an expedited redetermination.

2. NHIC must establish and maintain procedures for expediting redeterminations, including but not limited to having on-call staff during

long holiday weekends, and having procedures in place that establish an efficient and convenient method for individuals to submit oral or written requests for expedited appeals, documenting oral requests (e.g.., entering oral requests into an internal tracking system), and maintaining the documentation in the case file.

3. NHIC must promptly determine if a request must be expedited. If the oral or written request is made by a physician or other prescriber or supported by a physician's or other prescriber's oral or written statement, it must grant the request to expedite if the physician or other prescriber indicates that the enrollee's life, health, or ability to regain maximum function could be jeopardized by applying the standard time frame for processing the redetermination request.

4. If NHIC approves a request to expedite a redetermination, it must complete the expedited redetermination and give notice of its decision as expeditiously as the member's health condition requires, but no later than 72 hours after receiving the request. NHIC must request any necessary medical information within twenty- four (24) hours of the initial request for an expedited redetermination. Regardless of whether NHIC requests or receives additional information, NHIC must make a determination based on the information it has received within the 72-hour period.

5. If NHIC denies a request for an expedited redetermination, it must automatically transfer the request to the standard redetermination process and provide the member with prompt oral notice of the denial and the member's rights. The oral notice must meet requirements i-iv described below. NHIC must subsequently mail a written notice to the member within three (3) calendar days following the oral notification. The written notice must:
    a. Explain that NHIC will automatically transfer and process the request using the 7-day time frame for standard redeterminations;
    b. Inform the member of the right to file an expedited grievance if he or she disagrees with the plan's decision not to expedite the redetermination;
    c. Inform the member of the right to resubmit a request for an expedited redetermination with the prescribing physician's or other prescriber's support, and explain that if the physician or other prescriber indicates that applying the standard time frame for making a determination could seriously jeopardize the member's life, health or ability to regain maximum function, the request will be expedited automatically; and
    d. Provide instructions about the grievance process and the applicable time frames.

6. Effectuation of the redetermination decision by NHIC or from a higher level of appeal will be completed in accordance with CMS regulations and timelines.

IV. Complaints that Contain Elements of Both Appeals and Grievances

A. Complaints may include both appeals and grievances. Complaints can be processed under the appeal procedures, under the grievance procedures, or both

depending on the extent to which the issues wholly or partially contain elements that are coverage determinations. If a member addresses two or more issues in one complaint, then each issue should be processed separately and simultaneously (to the extent possible) under the proper procedure.

B. A transaction with a member or a physician or other prescriber that involves a request for coverage of a drug that is either not a covered Part D drug (as defined in section 1860D-2(e)(1) of the Act) or is statutorily excluded from coverage under Part D may be handled as an inquiry, grievance, or appeal, depending on the nature of the transaction.

V. Distinguishing Between Appeals and Grievances:

A. Appeal procedures must be used for complaints or disputes involving coverage determinations. Grievance procedures are separate and distinct from coverage determinations and appeal procedures. NHIC must determine whether the issues in a member's complaint meets the definition of a grievance, an appeal or both. NHIC must then resolve all member's complaints or disputes through the appropriate procedure to address the particular type of complaint.

B. If a member is not disputing that a drug is not a covered Part D drug (as defined in 1860D-2(e)(1) of the Social Security Act) or is excluded under 1860D-2(e)(2) or 1860D-43 of the Act, but he/she is complaining about the policy that causes the drug to be excluded or not a covered Part D drug, the complaint should be processed as a grievance because it's a complaint about NHIC's benefit design structure. This complaint may occur after an inquiry is made, or it may be the initial transaction with the member, physician, or other prescriber. Decisions made under NHIC's grievance process are not subject to appeal.

C. In the event that NHIC misclassifies a grievance as an appeal and issues a denial notice and if the IRE determines that the complaint was misclassified as an appeal, the IRE must dismiss the appeal and return the complaint to NHIC for proper processing. NHIC must notify the member in writing that the complaint was misclassified and will be handled through NHIC's grievance process.

VI. Reopening Requests:

A. In the event that the IRE overturns a denial and NHIC disagrees with that determination based on Good Cause reasons as described below and in the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance, the Appeals and Grievance department will prepare a draft Reopening Request letter based on information and evidence provided by NHIC's care management, pharmacy, or other applicable departments, to support NHIC's Good Cause reasons for submitting the Reopening Request. The draft will be sent to applicable departments for review and input. Based on that input, a revised letter will be sent to NHIC's chief medical officer and general counsel for final approval as instructed. The Appeals and Grievance department will be responsible for sending the final Reopening Request letter to the IRE within the timelines described below and will follow up as warranted until a response is obtained by the IRE.

B. Timelines to submit a Reopening Request as outlined in the CMS chapter Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance are: Within 1 year from the date of the organization determination or reconsideration for any reason; Within 4 years from the date of the organization determination or reconsideration for good cause as defined in §120.3; At any time if there exists reliable evidence (i.e., relevant, credible, and

material) that the organization determination was procured by fraud or similar fault; At any time if the organization determination is unfavorable, in whole or in part, to the party thereto, but only for the purpose of correcting a clerical error on which that determination was based; or At any time to effectuate a decision issued under the coverage (National Coverage Determination (NCD)) appeals process.

C. Good Cause for Reopening: Good cause may be established when: There is new and material evidence that was not available or known at the time of the determination or decision and may result in a different conclusion; or the evidence that was considered in making the determination or decision clearly shows on its face that an obvious error was made at the time of the determination or decision. A change of legal interpretation or policy by CMS in a regulation, CMS ruling, or CMS general instruction, whether made in response to judicial precedent or otherwise, is not a basis for reopening a determination or hearing decision under this section. This provision does not preclude organizations from conducting reopening's to effectuate coverage (NCD) decisions.

D. NHIC will comply with all other CMS regulations governing Reopening and Revising Determinations and Decisions.

VII. Compliance with other Medicare Part D Prescription Drug Benefit regulations:

A. NHIC will incorporate procedures to comply with all other CMS, NCQA, or other applicable regulations governing Part D plans, as those regulations may be amended from time to time.

Regulatory Citations:

Code of Federal Regulations Title 42, Part 423, Subpart M, and the CMS chapter, Parts C & D Enrollee

Grievances, Organization/Coverage Determinations, and Appeals Manual.

Related Policies:

None

Related Documents:

None

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