Policy Number:
N03402
Title:
NHIC-Grievance Resolution Policy and Procedure for Medicare Advantage Plans
Abstract Purpose:
To define the Network Health Insurance Corporation’s grievance process for its Medicare Advantage Plans.
Policy Detail:
POLICY

I. All verbal or written grievances received at Network Health Insurance Corporation (NHIC) will be investigated and resolved in a consistent and timely manner, in accordance with the guidelines outlined in Section 42 of The Code of Federal Regulations, §422.564, (Grievance Procedures). The grievance process meets all Centers for Medicare and Medicaid Services (CMS) guidelines and National Committee of Quality Assurance (NCQA) standards. An expedited process will be implemented whenever a grievance has been determined to be of an urgent clinical nature. All grievances will be monitored, tracked and trended in a central database maintained by the Customer Service Department and reported quarterly to the Quality Improvement Committees. A grievance may be made by or on behalf of our member.

II. APPLICABLE DEFINITIONS
A. Authorized Representative:
   1. Any individual authorized by an enrollee, or a surrogate who is acting in accordance with state law on behalf of the enrollee, in order to obtain an organization determination or deal with any level of the appeals process. Representatives are subject to the rules described in 20 CFR Part 404, Subpart R
B. Appointment of Representative Form:
   1. Documentation of authorization of an appointed representative to act on behalf of the member, may be in the form of a signed written authorization, or through legal documentation such as court ordered guardian or durable power of attorney.
C. Centers for Medicare and Medicaid Services (CMS):
   1. CMS is a Federal agency within the U.S. Department of Health and Human Services. Programs for which CMS is responsible include Medicare, Medicaid, State Children’s Health Insurance Program (SCHIP), Health Insurance Portability and Accountability Act (HIPAA), and Clinical Laboratory Improvement Act (CLIA).
D. Adverse Determination:
   1. A determination by or on behalf of a member that the treatment does not meet NHIC’s or Medicare’s requirements for medical necessity,
appropriateness, health care setting, level of care or effectiveness or experimental treatment recession of the policy or certificate, or coverage denial determination based on exclusion.

E. Appeal:
1. Any of the procedures that deal with the review of adverse organization determinations on the health care services an enrollee believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the enrollee), or on any amounts the enrollee must pay for a service. These procedures include reconsideration by NHIC and if necessary an Independent Review Entity (IRE), hearings before Administrative Law Judges (ALJs), review by the Medicare Appeals Council (MAC), and judicial review.

F. Expedited Appeal:
1. An enrollee, or any physician (regardless of whether the physician is affiliated with the Medicare health plan), may request that NHIC expedite an appeal when the enrollee or his/her physician believes that waiting for a decision under the standard timeframe could place the enrollee’s life, health, or ability to regain maximum function in serious jeopardy. Expedited organization determinations may not be requested for cases in which the only issue involves a claim for payment for services that the enrollee has already received. However, if a case includes both a payment denial and a pre-service denial, the enrollee has a right to request an expedited appeal for the pre-service denial. A member/member representative may receive a fast decision within seventy-two (72) hours.

G. Expedited Organization Determination:
1. An enrollee, or any physician (regardless of whether the physician is affiliated with NHIC), may request that NHIC expedite an organization determination when the enrollee or his/her physician believes that waiting for a decision under the standard timeframe could place the enrollee’s life, health, or ability to regain maximum function is in serious jeopardy. Expedited organization determinations may not be requested for cases in which the only issue involves a claim for payment for services that the enrollee has already received. However, if a case includes both a payment denial and a pre-service denial, the enrollee has a right to request an expedited appeal for the pre-service denial.

H. Grievance:
1. Any complaint or dispute, other than one involving an organization determination, expressing dissatisfaction with the manner in NHIC or delegated entity that provides health care services, regardless of whether any remedial action can be taken. An enrollee or their representative may make the complaint or dispute, either verbally or in writing, to NHIC. An expedited grievance may also include a complaint that NHIC refused to expedite an organization determination or reconsideration, or invoked an extension to an organization determination or reconsideration timeframe.
   In addition, grievances may include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided health service, procedure, or item. Grievance issues may also include complaints that a covered health service procedure or item during a course of treatment did not meet accepted standards for delivery of health care.

I. Organization Determination:
1. Any determination made by NHIC with respect to any of the following:
a. Payment for temporarily out of the area renal dialysis services, emergency services, post-stabilization care, or urgently needed services;
b. Payment for any other health services furnished by a non-contracted provider that the enrollee believes are covered under Medicare, or, if not covered under Medicare, should have been furnished, arranged for, or reimbursed by NHIC;
c. NHIC’s refusal to provide or pay for services, in whole or in part, including the type or level of services, that the enrollee believes should be furnished or arranged for by NHIC;
d. Discontinuation of a service if the enrollee believes that continuation of the services is medically necessary, or;
e. Failure of NHIC to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the enrollee with timely notice of an adverse determination, such that a delay would adversely affect the health of the enrollee.

J. Quality of Care Issue:
1. A quality of care complaint 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 Medicare health plan meets professionally recognized standards of health care, including whether appropriate health care services have been provided and whether services have been provided in appropriate settings.

K. Quality Improvement Department:
1. A department within NHIC made up of licensed nurses and physicians who review expedited appeal requests and make a determination based on if waiting for a standard decision could seriously harm the member’s health.

L. Quality Improvement Organization (QIO):
1. 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. QIOs review complaints raised by enrollees about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities (SNFs), home health agencies (HHAs), Medicare health plans, and ambulatory surgical centers. The QIOs also review continued stay denials for enrollees receiving care in acute inpatient hospital facilities as well as coverage terminations in SNFs, HHAs, and comprehensive outpatient rehabilitation facilities (CORFs). NHIC uses METASTAR for their QIO.

M. Reconsideration:
1. An enrollee’s first step in the appeal process after an adverse organization determination; NHIC or independent review entity may re-evaluate an adverse organization determination, the findings upon which it was based, and any other evidence submitted or obtained.

N. Inquiry:
1. Any verbal or written request to an organization, provider, or facility, without an expression of dissatisfaction, e.g., a request for information or action by an enrollee.

O. Member:
1. An eligible individual who has elected a Medicare Advantage plan offered by NHIC.
P. Medicare Member Advocate (MMA):
   1. The Plan Representative assigned to investigate and process all written grievances and appeals.

Q. Plan Representative:
   1. NHIC Representatives who are trained and experienced in addressing member’s grievances and appeals. This includes the Customer Service Representatives who are assigned to answer member telephone calls placed to the Customer Service Department as well as departmental Managers, MMAs, Quality Coordinators, or other designated employees of NHIC. In order to better service NHIC members, employees in each department who have member interaction are trained to receive member inquiries and grievances in order to allow response to occur in a timely manner.

PROCESS

I. Upon receiving a request for review, the MMA must correctly distinguish between an organization determination, reconsideration and grievance, as indicated in the Managed Care Manual Chapter 13, Section 10.1 & 20.2, and process the request through the appropriate procedure.

II. TIMEFRAME FOR PROCESSING GRIEVANCES
   A. The MMA is responsible for processing, investigating and responding to grievances as expeditiously as the case requires, based on the enrollee’s health, but no later than thirty (30) days after the date the organization receives the verbal or written grievance. The thirty (30)-day timeframe maybe extended by up to fourteen (14) days if the member requests the extension or if the organization justifies the need for additional information and documents how the delay is in the interest of the enrollee. The member will immediately be notified of the delay in writing.
   B. If the grievance involves a decision to invoke an extension related to an organization determination or reconsideration or the grievance involves a refusal to grant a member’s request for an expedited organization determination or expedited reconsideration, NHIC must respond to the member’s grievance within twenty-four (24) hours.

III. RECEIPT AND CASE ASSIGNMENT
   A. A Plan Representative receives a verbal or written grievance. All written grievances must be date stamped, even if received by a Plan Representative. The Plan Representative will forward the verbal or written grievance to the MMA who will complete a Complaint and Appeal Form (COAF). Verbal grievances will be documented in the Customer Service database using the correct subject and categories to assist with tracking, trending, and resolution.
   B. The MMA will date stamp, log all written grievances in the Grievance and Appeals database, and will assign a case number.

IV. WRITTEN GRIEVANCE INVESTIGATION
   A. The MMA assigned to the case will check the grievance to determine that it is either from the member or from a properly appointed representative of the member. If the grievance is not written by the member or an authorized representative, the MMA will send written notification to the unauthorized representative that NHIC cannot consider the request, without written documentation of the representative’s legal right to represent the member (see document #AG04-AOR-12/04). The written notification will include an Appointment of Representative (AOR) form so that appropriate authorization may be obtained (see document Form CMS 1696 (10/10).
B. The MMA conducts a thorough investigation ensuring that each issue listed is researched (or any other issue identified during his/her review).

C. If the MMA determines there is a clinical urgency, a quality of care issue, or if the grievance pertains to clinical care or access, the MMA will forward the case file to the Quality Improvement (QI) Department for the investigation process.
   1. The QI Department will investigate the grievance and will notify the MMA when the investigation is completed. The MMA will document the completion of the investigation in the Grievance and Appeals database, and will continue with the final response and case closure.

D. If the case must be extended beyond thirty (30) calendar days, the MMA will send written notification to the member/member representative of the delay (see document# NPP-AG17-12/04)

E. The MMA will document the substance of the grievance, all steps taken in the investigation (i.e. medical records request) and the final response will be documented in the Grievance and Appeals database

V. FINAL RESPONSE TO THE MEMBER/MEMBER REPRESENTATIVE
A. When the MMA has received all pertinent information to resolve the issue, a closure letter is prepared and sent to the member/member representative.
   1. All grievances, whether they are received in writing or verbally, will be responded to in writing.
   2. The final response for grievances related to quality of care will include the member’s right to file a written complaint with the QIO. The MMA will cooperate with the QIO in resolving the complaint.
   3. All closure letters will be carefully checked for content, spelling, and grammar to ensure that NHIC’s communication is clear, concise, accurate, and at an appropriate level of understanding
   4. Copies of closure letters involving all Quality of Service complaints against a contracted NHIC provider will be forwarded to the appropriate parties involved (i.e. practice manager, providers or facility) for review, tracking, and trending
   5. The member will receive a written response including the disposition of the grievance within forty-four (44) calendar days (see document #NPP-AG16-12/04 and #NPP-AG19-12/04).

6. In cases where the member/member representative has received billing statements from a provider’s office where the MMA has determined through research that there is no member liability other than the member’s copayment, and where the MMA has obtained either written or verbal proof from the provider that the appropriate adjustment has been made to the member’s account, the MMA will draft a closure letter notifying the member of the outcome and follow-up with the provider to ensure the member’s account is clear.

VI. CLOSURE OF CASE
A. The closure date and resolution are entered into the appropriate databases and documented on the COAF form.
B. Complete Grievance Checklist.
C. Print and file database call logs in the case file.
D. The completed file is retained in the Grievances and Appeals Department for future reference. Files may be destroyed after ten (10) years

VII. ISSUE TRACKING AND TRENDING PURPOSES
A. To ensure that problem areas are identified, shared among other NHIC Departments and resolved at the root cause by NHIC, the Customer Service
Manager reports trended issues identified within the Department through the following channels
1. Quality Management Committee
2. Vice President of Medicare
3. Service Subcommittee

VIII. TRACKING AND TRENDING PURPOSES
A. Grievance and Appeal tracking and trending databases will be maintained by the Customer Service Manager
B. Information regarding tracking grievances and appeals will include, but is not limited to, primary codes, secondary type codes, and severity level codes, if applicable.
C. The Customer Service Manager will prepare trending reports and analysis regarding the types and volume of grievances and appeals
D. Tracking and trending reports will be submitted to the Quality Management Committee as applicable.

Regulatory Body:
CMS

Regulatory Reason:
- CFR 42, §422.564, 422.566(b); 20 CFR Part 404, Subpart R
- Managed Care Manual Chapter 13

Policy Entity:
NHP/NHIC

Policy Discipline:
NHIC Medicare Operations

Origination Date:
01-13-2005

Replaces Policy:
NHP/NHIC-Grievance Resolution Policy and Procedure for Network PlatinumPlus

Next Review:
12-01-2013

Approval Information:
QMC

Approval Date:
02-14-2013

Policy Subject Matter Expert:
Skinner, Jeanne
jskinner@networkhealth.com

Network Health Values:
Service

Attached Files: