1.0 Policy Statement

In accordance with applicable internal standards, external regulations and accreditation standards, Kaiser Foundation Health Plan, Inc. (KFHP) has established procedures for processing complaints from a Medicare member under the appropriate grievance and/or appeals process.

2.0 Purpose

This policy describes the minimum requirements needed to meet compliance for processing Medicare Part C grievances, organization determinations, and Health Plan reconsiderations, set forth by the Centers for Medicare and Medicaid Services (CMS), Code of Federal Regulations (CFR), and the National Committee for Quality Assurance (NCQA).

3.0 Scope/Coverage

This policy applies to all employees that process, manage, or direct Medicare member grievances and appeals in the following regions:

3.1 Southern California
3.2 Northern California
3.3 Hawaii
3.4 Georgia
3.5 Mid-Atlantic States
3.6 Northwest
3.7 Colorado
3.8 Washington

4.0 Contents

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5.0 General Provisions

5.1 Alternative Formats - Program representatives shall ensure all individuals have access to and can fully participate in the grievance system by providing assistance for those with a visual or other communicative impairment. Such assistance shall include, but is not limited to, telephone relay systems and other devices that aid disabled individuals to communicate. The Program representative shall ensure the alternative format offered to individuals results in effective communication. Alternative formats include large print, electronic documents, audio CDs, and Braille.

5.2 Arbitration – Any Medicare member’s claim that is not subject to the Medicare Appeals process or the Small Claims process, which is made against KFHP, Kaiser Foundation Hospitals, the Permanente Medical Groups, or any of their physicians, employees, or agents is subject to mandatory binding neutral arbitration. Members and their authorized representative may have the right to request arbitration, the terms of which depend on the member’s type of coverage, effective date of coverage and “opt out” actions. Members may be referred to their Evidence of Coverage for the complete arbitration provision, which includes how to initiate the arbitration, where to submit their request and any associated fees.

5.3 Case File Release – Members have the right to have reasonable access to and copies of documents relevant to their case(s), free of charge, upon request.

5.4 Civil Rights Complaints (Section 1557, Patient Protection and Affordable Care Act) – Kaiser Permanente complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The grievance procedures described in this policy provide a prompt and equitable review of complaints alleging any action prohibited by Section 1557 of the Patient Protection and Affordable Care Act. Kaiser Permanente has a designated Civil Rights Coordinator to coordinate compliance with Section 1557 of the Patient Protection and Affordable Care Act. Member Services Appeals and Grievances and the Civil Rights coordinator will jointly address any allegations of civil rights discrimination.

5.5 Confidentiality – KFHP protects the confidentiality of member information and records. KFHP uses and discloses member protected health information (PHI) according to Notices of Privacy Practices and the Federal HIPAA (Health Information Portability and Accountability Act of 1996) Privacy and Security policies. Program representatives must obtain HIPAA authorization from an individual when his/her written permission is required to use or disclose PHI in accordance with these policies and confidentiality regulations. Program
representatives will not respond to anyone other than the member or the member’s duly authorized representative regarding matters related to a member’s health care or condition until appropriate authorization has been received. Except under limited circumstances, Program representatives may only use, disclose, and request the minimum necessary PHI to accomplish the intended purpose. Program representatives shall verify the identity of individuals prior to releasing information.

5.6 **Conflicts of Interest** – KFHP ensures that all cases reviewed through the appeals and grievance process are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a Claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support a denial of benefits. Similarly, KFHP will not contract with a medical expert based on the expert’s reputation for outcomes in contested cases, rather than based on the expert’s professional qualifications.

5.7 **Documentation** – Program representatives shall ensure all member encounters (e.g. grievances, appeals, etc.) are appropriately documented in the Member Experience Tracking and Reporting System (METRS). Documentation should include the member’s reason for filing their request, and any additional information, clinical and non-clinical, provided with the request. Specifically, for intake of an appeal, the Program representative should document the member’s reason for appealing the previous decision; confirmation that the member received a denial for the service or item; and all information presented with the member’s appeal request that might include any actions taken since the initial denial. The initial appeal denial letter must be attached in METRS.

5.8 **File Retention** – KFHP will retain case files on all cases filed, including relevant materials reviewed to reach a decision, for a period of ten (10) years.

5.9 **Language Assistance** – Program representatives shall ensure members are provided access to interpreter and translation services at no cost.

5.10 **Visiting Member Program**: KFHP has a visiting member program that allows members to receive care from other regions. The KFHP region that is considered the member’s “home region” will be responsible for processing grievances regarding their (visited) region. Pre-service requests, including appeals, are managed by the home region.

6.0 **Provisions of Case Processing**

6.1 **Intake**

6.1.1 **Acceptance and Facilitation of a Case**; Members may file an expedited or standard grievance, organization determination or Health Plan reconsideration either verbally, by email, on-line through the Health Plan’s web site, in person, or in writing. A standard Health Plan reconsideration
must be submitted in writing, which can include email or on-line through the Health Plan’s web site (except for Georgia region).

6.1.1.1 Program representatives are responsible for ensuring members are afforded the right to provide additional information, which includes all written materials to support their grievance, organization determination, or Health Plan reconsideration.

6.1.1.2 For Expedited Health Plan reconsideration, the Program representative must also remind the member that a 14-calendar day extension can be given, if they feel additional time is needed.

6.1.2 Filing Timeframes and Methods:  
Grievances, organization determinations and Health Plan reconsiderations must be filed with the Health Plan within the CMS established timeframes, and must follow the required method for filing.

6.1.2.1 Grievances must be filed verbally or in writing within 60 calendar days of the event or incident.

6.1.2.2 Standard or Expedited organization determinations may be filed verbally or in writing, at any time.

6.1.2.3 Standard Health Plan reconsiderations must be filed in writing within 60 calendar days from the date of the adverse determination notice. For GA region both verbal and written will be accepted.

6.1.2.4 Expedited Health Plan reconsiderations must be filed verbally or in writing within 60 calendar days from the date of the adverse determination notice.

6.1.2.5 Good Cause: An extension may be granted if the member or authorized representative provides a good cause reason for not making the request on time, except in the case of repeat grievances.

6.1.2.5.1 Examples of circumstances where good cause may exist include (but are not limited to) the following situations:

6.1.2.5.1.1 The member was seriously ill, which prevented timely filing;

6.1.2.5.1.2 There was a death or serious illness in the member’s immediate family;

6.1.2.5.1.3 An accident caused important records to be destroyed;
6.1.2.5.1.4 Documentation was difficult to locate within the time limits;

6.1.2.5.1.5 The member had incorrect or incomplete information concerning the grievance or appeal process;

6.1.2.5.1.6 The member lacked capacity to understand the filing time frame; or

6.1.2.5.1.7 The member did not personally receive the adverse organization determination notice, or he/she received it late.

6.1.2.5.2 Requests for a good cause extension on grievances can be filed verbally or in writing.

6.1.2.5.3 Request for a good cause extension on Health Plan reconsiderations must be filed in writing.

6.1.2.5.4 If good cause is not provided or the Health Plan denies a good cause extension, the grievance or Health Plan reconsideration will be dismissed.

6.1.2.5.4.1 The Program representative shall provide written notification of the dismissal to the member or authorized representative.

6.1.2.6 Quick Reference: Filing Timeframes and Methods

<table>
<thead>
<tr>
<th>Level Type</th>
<th>Timeframe and Method</th>
<th>Good Cause Request</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grievance - Expedited &amp; Standard</td>
<td>Grievance may be filed verbally or in writing within 60 calendar days of the event or incident.</td>
<td>Can be submitted verbally or in writing.</td>
</tr>
<tr>
<td>Organization Determination - Expedited &amp; Standard</td>
<td>Request may be filed verbally or in writing at any time.</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Health Plan Reconsideration - Standard</td>
<td>Request must be filed in writing within 60 calendar days from the date of the adverse determination notice. For GA region both verbal and written will be accepted.</td>
<td>Must be submitted in writing.</td>
</tr>
<tr>
<td>Health Plan Reconsideration - Expedited</td>
<td>Request must be filed verbally or in writing within 60 calendar days from the date of the adverse determination notice.</td>
<td>Must be submitted in writing.</td>
</tr>
</tbody>
</table>

6.1.3 Authorized Representation: All KFHP members have the right to be represented by an individual to act on their behalf, upon receipt of appropriate legal authorization and/or documentation of the representative. The Centers for Medicare and Medicaid Services (CMS)
Form CMS-1696, or an equivalent written notice, is required for making the appointment of representation. In addition, Federal law strictly controls the release of Protected Health Information (PHI); therefore, the Authorization for Disclosure of Personal Health Information Form (PHI Form) is required for release of PHI.

6.1.3.1 A completed PHI form is valid only for the length of the case or subsequent grievance/appeals related to the case.

6.1.3.1.1 A new PHI form is required for any new, unrelated grievance or appeal submitted by an advocate, to then release the member’s PHI to the authorized representative.

6.1.3.1.2 If the AOR has been completed, but the PHI form has not, the member’s case may proceed. However, if the PHI form is not received by the conclusion of the case time frame, the resolution is sent to the member.

6.1.3.2 A member’s treating physician may make an expedited or pre-service Health Plan reconsideration request without submitting a representative form.

6.1.3.2.1 If the physician makes the request by phone, the Program representative should confirm during the call that the physician gave the member notice that he or she is acting on their behalf.

6.1.3.2.2 If the Health Plan reconsideration request comes from the member’s primary care physician, no member notice verification is required.

6.1.3.2.3 If the Health Plan reconsideration request comes from either an in-network (contract) physician or a non-contract physician, and the member’s records indicate he or she visited this physician at least once before, the Plan may assume the physician has informed the member about the request and no further verification is needed.

6.1.3.2.4 If this appears to be the first contact between the physician requesting the Health Plan reconsideration and the member, the Plan is to undertake reasonable efforts to confirm the physician has given the member appropriate notice.

6.1.3.2.5 The Medicare health plan may call the member and ask if he or she knows that this physician making the
request is acting on his or her behalf with his or her knowledge and approval.

6.1.3.3 Unless otherwise noted by the member, the completed authorized representative documentation is valid for one year from the date the appointment is signed by both the member and the representative.

6.1.3.4 A valid appointment of representative form submitted with a request that specifically limits the appointment to Medicare Part D prescription drug benefits is not valid for representation of Medicare Advantage (Part C) benefits. A separate CMS Form (CMS-1696) must be executed, or equivalent, if the appointee is representing the member in both Part C and D benefits.

6.1.3.5 The Program representative must make, and document reasonable efforts to secure a valid appointment of representation form or equivalent. If the completed documentation is not received by the conclusion of the case timeframe, plus applicable extension, the case will be dismissed.

6.1.3.6 A fourteen (14) day AOR wait time extension will be applied to expedited or pre-service organization determinations, expedited or pre-service Health Plan reconsiderations, and standard grievances that are pending authorized representative documentation, prior to dismissal of the case.

6.1.3.6.1 A written notification of the extension, is not required in this scenario.

6.1.3.6.2 If no authorization has been received after waiting the entire case timeframe plus the fourteen (14) days, the case will be dismissed.

6.1.4 Non-Contract Provider Waiver of Liability Statement

6.1.4.1 A Non-Contract Provider (NCP), on his or her own behalf may file a Health Plan reconsideration for a denied claim only if the NCP completes a Waiver of Liability (WOL) statement, which provides that the NCP will not bill the member regardless of the outcome of the appeal.

6.1.4.2 Physicians and suppliers who have executed a WOL are not required to complete the CMS-1696, Appointment of Representative form.

6.1.4.3 Notices/correspondence regarding the NCP’s appeal should be delivered to the NCP but not the member.
6.1.4.4 When a NCP files a request for a Health Plan reconsideration but does not submit a WOL or other documentation upon the Health Plan's request, the Program representative must make and document its reasonable efforts to secure the necessary WOL or other documentation.

6.1.4.4.1 The Health Plan should not undertake a review until or unless such form/documentation is obtained.

6.1.4.5 The time frame for acting on a provider appeal request commences when the properly executed WOL form and other documentation is received.

6.1.4.6 If the WOL form/documentation is not received by the conclusion of the appeal time frame; the case will be dismissed.

6.1.5 Contact Dates and Times: Except for certain expedited requests, the contact date and time is when the Health Plan receives a member's grievance, organization determination, or Health Plan reconsideration. All requests for expedited appeals must have a documented record of the date and time received. Program representatives must use the following guidelines for contact dates:

6.1.5.1 The date and time of the call for telephone calls;

6.1.5.2 The earliest KFHP date stamp for written correspondence;

6.1.5.3 The earliest incoming fax transmission date and time for faxes;

6.1.5.4 The date and time of the timestamp on e-mails.

6.1.5.4.1 The contact date and time for expedited grievances is when it is received by the Health Plan.

6.1.5.4.2 For expedited organization determinations and expedited Health Plan reconsiderations, the contact date & time is when the request is received by the appropriate office or department designated by the Health Plan to review expedited requests (e.g. Expedited Review Unit).

6.1.5.4.3 If authorized representative documentation is required, the timeframe for acting on a case commences when valid representative documentation is received by the Health Plan.
6.1.6 *Quick Reference: Contact Dates and Times*

<table>
<thead>
<tr>
<th>Level Type</th>
<th>Contact Date and Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grievance - Standard</td>
<td>When the case is received by the Health Plan.</td>
</tr>
<tr>
<td>Expedited Grievance</td>
<td>When the grievance is received by the Health Plan.</td>
</tr>
<tr>
<td>Organization Determination - Standard</td>
<td>When the case is received by the Health Plan.</td>
</tr>
<tr>
<td>Organization Determination - Expedited</td>
<td>When the request is received by the appropriate office or department designated by the Health Plan to review expedited requests (e.g. Expedited Review Unit).</td>
</tr>
<tr>
<td>Health Plan Reconsideration - Standard</td>
<td>When the case is received by the Health Plan.</td>
</tr>
<tr>
<td>Health Plan Reconsideration - Expedited</td>
<td>When the request is received by the appropriate office or department designated by the Health Plan to review expedited requests (e.g. Expedited Review Unit).</td>
</tr>
</tbody>
</table>

6.1.7 *Expeditied Requests:* Program representatives shall screen all requests immediately to identify if applying the standard processing timeframes for making an organization determination or Health Plan reconsideration decision could seriously jeopardize the member’s life, health, or ability to regain maximum function.

6.1.7.1 A member or authorized representative has the right to request an expedited organization determination or Health Plan reconsideration.

6.1.7.2 An expedited review must be automatically conducted if a physician indicates on behalf of the member (either orally or in writing), that applying the standard decision timeframe could seriously jeopardize the member’s life, health, or ability to regain maximum function.

6.1.7.3 Requests that may meet the expedited review criteria should be referred to the designated unit that handles expedited requests or to the designated clinical reviewer(s) to determine if it meets expedited review criteria.

6.1.7.4 A request for payment of a service already provided is not eligible for an expedited review, unless the request includes both a payment denial and pre-service denial.

6.1.8 *Denial of Request for Expedited Review*

6.1.8.1 A request that does not meet criteria for expedited review will be downgraded and processed in accordance with the procedures for standard review. The case contact date remains the same as the date of receipt by the appropriate office or department that handles expedited requests (e.g. Expedited Review Unit).
6.1.8.1.1 A subsequent written request is not required when a verbal request for an expedited Health Plan reconsideration is downgraded to standard review.

6.1.8.2 Provide verbal notification within 72 hours of denial for organization determinations and Health Plan Reconsiderations.

6.1.8.2.1 The Program representative shall inform the member or authorized representative of their right to file an expedited grievance, if they disagree with the Health Plan’s decision not to expedite the determination.

6.1.8.2.2 The Program representative shall inform the member or authorized representative that their request will be reviewed as expedited if the request is resubmitted with a supporting statement from their physician.

6.1.8.3 The Program representative shall provide subsequent written notification within three (3) calendar days of the verbal resolution.

6.1.9 QIO Fast-Track Appeals of Coverage Terminations in Certain Provider Settings (SNF, HHA, and CORF): A member or authorized representative appealing a hospital inpatient, home health agency (HHA), skilled nursing facility (SNF), or comprehensive outpatient rehabilitation facility (CORF) discharge of services has a right to a fast-track appeal from the Quality Improvement Organization (QIO) contracted by CMS to conduct fast-track appeals.

6.1.9.1 The member is responsible for contacting the QIO (within the specified timelines) if he or she wishes to obtain a fast-track appeal;

6.1.9.2 If the member and/or authorized representative does not make a timely request with the QIO, they may submit a request for an expedited Health Plan Reconsideration;

6.1.9.3 The QIO is responsible for immediately contacting the Health Plan and the provider if a member requests a fast-track appeal and for making a decision on the case by no later than close of business the day after the QIO receives the information necessary to make the decision; and

6.1.9.3.1 For purposes of the fast-track appeal process, a QIO may receive and review records from a provider or Health Plan. The Health Plan must comply with such requests for information by the QIO.
6.1.9.4 The Program representative must contact the QIO directly prior to initiating an expedited Health Plan reconsideration review for a SNF, HHA, and CORF appeal to ensure that there is not a concurrent QIO review in progress or a prior QIO decision.

6.1.9.4.1 If the QIO time frame for considering the appeal has elapsed, the Health Plan will process an expedited reconsideration.

6.1.10 Repeat Grievances: Members, or their authorized representative, have the right to file a repeat grievance on an issue and/or request that was previously resolved, if filed within 60 calendar days from the incident or event that caused the dissatisfaction.

6.1.10.1 Repeat grievances are processed using the same process guidelines and timeframes as grievances, with the following exceptions:

6.1.10.1.1 Repeat grievances are not eligible for good cause extensions beyond the 60-calendar day filing deadline.

6.1.10.1.2 For cases with non-appealable requests, the same decision maker from the initial grievance can render a decision.

6.2 Categorization (Leveling)

6.2.1 Levels: Program representatives shall categorize all Medicare member encounters using the following level classifications:

6.2.1.1 Inquiry: Any oral or written request to a Medicare health plan, provider, or facility, without an expression of dissatisfaction, e.g., a request for information or action by an enrollee. Inquiries are routine questions about benefits (i.e., inquiries are not complaints) and do not automatically invoke the grievance or organization determination process.

6.2.1.2 Grievance: Any oral or written complaint or dispute, other than an organization determination, expressing dissatisfaction with the manner in which a Medicare health plan or delegated entity 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 orally or in writing, to a Medicare health plan, provider, or facility.

6.2.1.3 Expedited Grievance: A complaint expressing dissatisfaction that a Medicare health plan refused to expedite an organization determination or Health Plan reconsideration, or invoked an
extension to an organization determination or reconsideration timeframe.

6.2.1.3.1 Expedited grievance requests should be referred to the designated unit that handles expedited reviews for processing.

6.2.1.3.2 Requests that are resubmitted with a supporting physician statement will be reviewed as expedited.

6.2.1.3.3 Deny Expedited Review: An expedited grievance filed when the Plan refuses to expedite a request, will be re-reviewed by the designated clinical reviewer(s) to determine if it meets expedited review criteria. This review will only occur when the standard case processing timeframe has not expired. If the request is approved, it will be upgraded to the expedited review process.

6.2.1.3.4 Dissatisfaction with a Health Plan Extension: Program representatives will respond to complaints related to a timeframe extension by providing the member with information about the reason for the extension.

6.2.1.3.5 Provide verbal resolution within 24 hours for expedited grievances.

6.2.1.3.6 Provide subsequent written notification within three (3) calendar days of the verbal resolution.

6.2.1.4 **Organization Determination:** Any determination made by a Medicare health plan with respect to any of the following:

6.2.1.4.1 Payment for temporarily out of the area renal dialysis services, emergency services, post-stabilization care, or urgently needed services;

6.2.1.4.2 Payment for any other health services furnished by a provider other than the Medicare health plan that the enrollee believes are covered under Medicare, or, if not covered under Medicare, should have been furnished, arranged for, or reimbursed by the Medicare health plan;

6.2.1.4.3 The Medicare health plan’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 the Medicare health plan;
6.2.1.4.4 Reduction, or premature discontinuation of a previously authorized ongoing course of treatment;

6.2.1.4.5 Failure of the Medicare health plan 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; or

6.2.1.4.6 Medicare Savings Accounts (MSA) only: Decisions regarding whether expenses, paid for with money from the MSA Bank Account or paid for out of pocket, constitute Medicare expenses that count towards the deductible; and, prior to satisfying the deductible, decisions as to the amount the enrollee had to pay for a service.

6.2.1.5 **Health Plan Reconsideration**: The member’s first step in the appeal process after an adverse organization determination; a Medicare health plan 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.

6.2.1.5.1 Continued coverage pending the outcome of the Appeal: For requests to continue an ongoing course of previously approved treatment, services will continue to be provided pending the outcome of the appeal. The member may be held financially responsible if the initial determination is upheld.

6.2.1.5.2 For an appeal filed within the appropriate timeframe on an adverse organization determination, where member is found to no longer have Health Plan benefits, the Plan must initiate and process the appeal based on Health Plan coverage at time of the initial determination.

6.2.1.6 **IRE Reconsideration**: A review by the independent review entity contracted by CMS to re-evaluate an adverse organization determination made by the Medicare health plan.

6.2.1.7 **ALJ Hearing**: A level of appeal available to Medicare members where an Administrative Law Judge (ALJ) re-evaluates the IRE decision to uphold the original adverse organization determination.
### 6.2.1.7.1
Requests received by the Health Plan for an ALJ hearing from a member must be forwarded immediately to the appropriate ALJ hearing office.

### 6.2.1.8
**Medicare Appeals Council:** Any party dissatisfied with the ALJ hearing decision (including the Medicare health plan) may request that the MAC review the ALJ’s decision or dismissal. The MAC conducts a de novo review and may either issue a final decision or dismissal, or remand the case to the ALJ with instructions on how to proceed with the case.

### 6.2.1.9
**Federal District Court:** Any party, including the Medicare health plan (upon notifying all the other parties), may request judicial review of an ALJ’s decision if the MAC adopted, modified, or reversed the ALJ decision.

### 6.2.2
**Cases with Multiple Issues/Requests:** Cases with multiple issues or requests will have each issue or request processed independently and simultaneously in accordance with the procedural requirements applicable to the specific issue or request, which may require creating multiple levels in METRS.

#### 6.2.2.1
Appropriate case leveling of issues or requests will be determined by a combination of the membership type, primary date of occurrence, and/or the substance of the case.

#### 6.2.2.2
Complaints may include both grievances and appeals (organization determinations and Health Plan reconsiderations). The grievance process and the appeals process are separate and distinct. A member complaint may contain a grievable issue and an appealable issue as well. KFHP determines whether the issues meet the definition of grievance, organization determination or Health Plan reconsideration, and resolve them within the appropriate process. If a member has two or more issues in one complaint, then each issue should be processed separately and simultaneously (to the extent possible) under the proper process.

### 6.2.3
**Dual Eligibility:** Members with dual coverage have additional rights that must be provided under a separate process based on that coverage (e.g., Medicaid, FEHBP). A separate case/level may be required when a member with dual membership files a complaint.

### 6.2.4
**Misclassified Cases**

#### 6.2.4.1
Should a case be misclassified and the Health Plan later determines that the incorrect letters were issued; the Program representative is responsible for notifying the member in writing.
that the issue was misclassified and will be handled through the appropriate process (e.g. level).

6.2.4.2 A resolution letter will be sent to the member under the correct case process.

6.2.4.3 The timeframe for processing the case through the correct process begins on the original date the case was received by the Health Plan, as opposed to the date the health plan discovers its error.

6.3 Acknowledgement

6.3.1 Acknowledgement Methods: All grievances and appeals will be acknowledged by the Program representative either verbally or in writing.

6.3.1.1 If all verbal acknowledgement requirements are not fulfilled during initial case intake, additional contact with the member must occur to properly acknowledge the request.

6.3.1.2 The Program representative should make, and document reasonable attempts to provide verbal acknowledgement.

6.3.1.3 Verbal acknowledgement and documentation must include (at minimum):

6.3.1.3.1 Notification to the member that his/her request has been received;

6.3.1.3.2 Date request was received;

6.3.1.3.3 Whether the request is a grievance or appeal;

6.3.1.3.4 Clarification of the request;

6.3.1.3.5 A description of the process, including relevant timeframes, and;

6.3.1.3.6 Contact information the member can use for case status or questions.

6.3.1.4 Written acknowledgement will be provided by using the approved acknowledgement letter template.

6.3.2 Acknowledgement Timeframes:

6.3.2.1 Grievances will be acknowledged within five (5) calendar days, from date of contact.

6.3.2.2 Expedited grievances will be acknowledged within 24 hours, from date & time of contact.
6.3.2.3 Organization determinations will be acknowledged within five (5) calendar days, from date of contact.

6.3.2.4 Health Plan reconsiderations will be acknowledged within five (5) calendar days, from receipt of written appeal.

6.3.2.5 Expedited organization determinations and Expedited Health Plan reconsiderations will be verbally acknowledged within 24 hours, from the date & time the request is received by the appropriate office or department designated to review expedited requests.

6.3.3 Quick Reference: Acknowledgement Timeframes and Methods

<table>
<thead>
<tr>
<th>Level Type</th>
<th>Timeframe</th>
<th>Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grievance - Standard</td>
<td>Within five (5) calendar days from date of receipt by the Health Plan.</td>
<td>Verbal or Written</td>
</tr>
<tr>
<td>Expedited Grievance</td>
<td>Within 24 hours from the time of receipt by the Health Plan.</td>
<td>Verbal</td>
</tr>
<tr>
<td>Organization Determination - Standard</td>
<td>Within five (5) calendar days from date of receipt by the Health Plan.</td>
<td>Written</td>
</tr>
<tr>
<td>Organization Determination - Expedited</td>
<td>Within 24 hours from the time of receipt by the designated department</td>
<td>Verbal</td>
</tr>
<tr>
<td>Health Plan Reconsideration - Standard</td>
<td>Within five (5) calendar days from the date written appeal is received by the Health Plan.</td>
<td>Written</td>
</tr>
<tr>
<td>Health Plan Reconsideration - Expedited</td>
<td>Within 24 hours from the time of receipt by the designated department</td>
<td>Verbal</td>
</tr>
</tbody>
</table>

6.4 Coding

6.4.1 Capturing all Issues and Requests: The Program Representative shall ensure all issues and requests raised by the member or authorized representative are properly coded in METRS. Each issue and request will be accounted for under the appropriate level.

6.5 Investigation

6.5.1 Reviewing all Issues and Requests: The Program representative shall complete a thorough review of the case synopsis, including any additional information provided by the member or authorized representative throughout the case, to ensure adequate investigation of all issues and requests is conducted. All investigatory actions shall be documented in METRS.
6.5.2 **Potential Quality of Care Issues:** Grievances that contain one or more potential quality of care issue will be referred to the Quality Department for investigation and review.

   6.5.2.1 The Quality Department’s oversight process assures that there are effective quality assurance systems in place for the potential quality of care referral activities. These activities will be handled in a manner consistent with federal and state law and organizational privacy and security policies and procedures governing the confidentiality of such information.

6.5.3 **Outreach Requirements for Supporting Clinical Documentation:** Reasonable and diligent efforts should be made as to obtain relevant medical records from Plan or non-Plan providers that will assist with the investigation and/or decision-making process, as early in the case review process as possible.

   6.5.3.1 A minimum of 2 outreach attempts should be made and must be documented and should include:

   6.5.3.1.1 A specific description of the required information;

   6.5.3.1.2 The name, phone number, fax number, e-mail, and/or mailing address, as applicable, for the point of contact; and

   6.5.3.1.3 Call records should include specific information about who was contacted, what was discussed/requested, and what information was obtained.

   6.5.3.2 If medical information is needed from non-contract providers to make a decision, the Program representative must request the necessary information from the non-contract provider within 24 hours of the initial request for an expedited organization determination.

6.5.4 **Medical Necessity Denials or Partial Denials:** At least one physician, practicing in the same or similar specialty must review cases involving medical necessity.

   6.5.4.1 The physician must not have been, or currently involved in the member’s care and treatment.

6.5.5 **Administrative Reviews:** Non-clinical issues should be forwarded to the designated administrative staff for review, and input as needed.

6.5.6 The reviewing supervisor, manager, or chief may not be involved, nor a subordinate in the subject matter.
6.5.7 Investigation documentation should include, but is not limited to the following:

6.5.7.1 The name, title and department of person(s) providing the information. Including specialty if applicable;
6.5.7.2 The name of the KP system used to obtain information (e.g., Health Connect Foundation System); and,
6.5.7.3 Clear and concise explanation of the substance of the question(s), issues(s), and/or request(s);
6.5.7.4 The date(s) of any/all actions taken,
6.5.7.5 All actions taken, including those affecting any aspect of clinical care involved (e.g., counseling, re-training, etc.) as appropriate;
6.5.7.6 Any/all required follow up instructions.

6.6 Decision/Committee Review

6.6.1 Case Review Preparation: Program representatives have overall responsibility for preparation and presentation of the request, to the applicable reviewers/decision-makers for a decision.

6.6.2 Reviews Involving Medical Necessity: Decision making for medical necessity requests, require physician review for final determination. Review and response by a physician, or other appropriate health care professional, with the same or similar specialty, should be included for this review.

6.6.2.1 Requests that involve benefit determinations, may be reviewed by non-physicians, designated by the Health Plan.

6.6.3 Appeal Decision Makers: Any person involved in the previous determination is not eligible to participate in the Health Plan reconsideration (appeal) level of that request.

6.6.3.1 A person involved in a subsequent level of review will not be a subordinate of any person involved in the initial determination.

6.6.4 Documentation of Decision/Committee Review: Decision documentation must be completed within METRS.

6.6.4.1 Decision making documentation should include, but is not limited to the following:

6.6.4.1.1 The date, and time of decision for expedited requests;
6.6.4.1.2 Decision and rationale;
6.6.4.1.3 Names and titles of decision makers;
6.6.4.1.4 Physician titles, including specialty/qualifications.

6.7 Extensions
6.7.1 Extensions are allowed if the member or authorized representative requests it, or the Health Plan justifies the need for information and documents how the delay is in the best interest of the member.

6.7.2 **Plan Initiated Extensions:** When the Health Plan grants itself an extension, it must notify the member or authorized representative in writing, of the reason(s) for the delay and inform them of their right to file an expedited grievance, if they disagree with the Health Plan’s decision to grant itself an extension.

6.7.2.1 When extensions are used, the organization must issue and effectuate its determination as expeditiously as the enrollee’s health condition requires, but no later than upon the expiration date of the extension.

6.7.3 **Pending Authorized Representative Documentation:** A fourteen (14) day AOR wait time extension will be applied to expedited and pre-service organization determinations, Health Plan reconsiderations, and standard grievances that are pending authorized representative documentation, prior to dismissal of the case.

6.7.4 **Allowable Extensions:** A fourteen (14) day extension is allowed on the following level types:

- 6.7.4.1 Grievances – Standard
- 6.7.4.2 Organization Determination – Standard – Pre-Service
- 6.7.4.3 Organization Determination – Expedited – Pre-Service
- 6.7.4.4 Health Plan Reconsideration – Standard – Pre-Service
- 6.7.4.5 Health Plan Reconsideration – Expedited – Pre-Service

6.7.5 **Extensions Not Allowed:** No extension or additional time is allowed on the following level types:

- 6.7.5.1 Expedited Grievances
- 6.7.5.2 Organization Determination – Standard – Post-Service
- 6.7.5.3 Health Plan Reconsideration – Standard – Post-Service

### 6.8 Resolution

6.8.1 **Resolution Letter Requirements:** A resolution letter will be sent on all cases that require written resolution notification and must comply with CMS notice requirements. The resolution letter will be sent as expeditiously as the member’s health requires, but no later than the designated case timeframe. The resolution letter will:

- 6.8.1.1 Provide the outcome for all issues and requests in a clear and concise manner, including any follow up information to assist the
member with next steps (e.g., upcoming appointments, confirm discussion with physician, etc.);

6.8.1.2 Include Quality Improvement Organization (QIO) language, if a potential quality of care issue was alleged, actual or perceived;

6.8.1.3 Include HIPAA (Health Insurance Portability and Accountability Act) language, if a complaint has been raised with allegations of breach of personal health information (PHI);

6.8.1.4 Provide a decision rationale for all denials;

- 6.8.1.4.1 Include the clinical reasons for a medical necessity denial based on physician review;
- 6.8.1.4.2 Identify any criterion, guideline or protocol used as the basis for decision, in sufficient detail including a clear and concise clinical explanation as to why the member does not meet the criterion, guideline or protocol.
- 6.8.1.4.3 If appropriate, the letter should tell the member any actions that the member needs to take to meet the criteria, guideline or protocol;
- 6.8.1.4.4 Include specific provisions in the contract or evidence of coverage for benefit denials;

6.8.1.5 Include any further available process rights, and other information on how to dispute the determination (e.g., how to initiate arbitration, Quality Improvement Organization review, IRE review, etc.).

6.8.1.6 Inform the member or authorized representative that the case has been forwarded to the IRE for final determination for all denied Health Plan reconsiderations.

6.8.1.7 Approval letters must include an explanation of how the request has been, or will be, effectuated. If applicable, an explanation of next steps must be included.

6.8.1.8 Send a separate letter to members that have dual coverage and have additional rights that their Medicare letter does inform them about (e.g., Medicaid), under the applicable level.

6.8.2 Verbal Resolution: A verbal notice will provide the member or authorized representative with a clear and concise explanation of the case outcome. Certain level types require a resolution letter to follow the verbal resolution. The following types of cases can be verbally resolved:
6.8.2.1 All expedited levels require a verbal resolution, followed by a written resolution.

6.8.2.2 Standard grievances are eligible for verbal resolution, with no written notice to the member, under the following circumstances:

6.8.2.2.1 Member initiated the case verbally;
6.8.2.2.2 Member does not request the response in writing;
6.8.2.2.3 Case does not contain a potential quality of care issue, actual or perceived;
6.8.2.2.4 Case does not contain a HIPAA complaint;
6.8.2.2.5 Case does not contain a complaint which occurred within a Kaiser Permanente hospital licensed space;
6.8.2.2.6 Case does not contain a complaint that requires written response based on a regulatory state requirement; and
6.8.2.2.7 We are able to speak directly with the member or authorized representative to provide verbal resolution.

6.8.2.3 Verbal resolution and documentation must include:

6.8.2.3.1 The outcome of all issues raised;
6.8.2.3.2 The decision;
6.8.2.3.3 The rationale for a denial, in whole or in part;
6.8.2.3.4 Appeal rights for the denial decision;
6.8.2.3.5 Provide rationale for denial along with any internal protocols or guidelines used in making the decision;
6.8.2.3.6 Provide any internal or external next steps available for further review/appeal of the decision.
6.8.2.3.7 Explain how the request will be effectuated if approved, in whole or in part.

6.8.2.4 Verbal resolution is provided as expeditiously as the member’s medical condition requires and no later than the required timeframe.

6.8.2.5 When contacting a member the Program representative must make, and document at least 2 attempts to provide verbal resolution.
6.8.2.5.1 If the member cannot be reached, leave a message stating that the case has been resolved, request a call back. Do not provide any PHI.

6.8.2.5.2 Grievances eligible for verbal resolution, require a written resolution, if after 2 attempts we are unable to speak directly with the member or authorized representative.

6.8.3 Verbal Resolution with Subsequent Written Resolution: Except for certain level types that only require written resolution, or meet verbal resolution criteria, a verbal resolution explaining the decision to the member must be followed by a written resolution.

6.8.4 Quick Reference: Resolution Timeframes and Methods

<table>
<thead>
<tr>
<th>Quick Reference: Resolution Timeframes and Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level Type</strong></td>
</tr>
<tr>
<td>Grievance - Standard</td>
</tr>
<tr>
<td>Expedited Grievance</td>
</tr>
<tr>
<td>Organization Determination - Standard - Pre-Service</td>
</tr>
<tr>
<td>Organization Determination - Standard - Post-Service</td>
</tr>
<tr>
<td>Organization Determination - Expedited - Pre-Service</td>
</tr>
<tr>
<td>Health Plan Reconsideration - Standard - Pre-Service</td>
</tr>
<tr>
<td>Health Plan Reconsideration - Standard - Post-Service</td>
</tr>
</tbody>
</table>
6.8.5 Untimely Resolution

6.8.5.1 If the Health Plan fails to resolve an expedited or standard organization determination within the resolution timeframe, this failure itself constitutes an adverse organization determination and may be appealed.

6.8.5.2 If the Health Plan fails to resolve a Health Plan reconsideration (expedited or standard) or a non-contract provider appeal within the resolution timeframe, this failure constitutes an affirmation of the adverse organization determination and the complete case file must be submitted to the Independent Review Entity (IRE).

6.8.5.2.1 There is no notice to the member or provider when untimely.

6.8.6 Withdrawals

6.8.6.1 A member or authorized representative may elect to withdraw a grievance or organization determination (verbally or in writing) at any time prior to notification to the member or authorized representative of the case outcome.

6.8.6.2 A member or authorized representative may withdraw a standard Health Plan reconsideration request any time before the decision is mailed, by submitting a written request for withdrawal. Requests for withdrawal of an expedited Health Plan reconsideration will be accepted verbally and/or in writing.

6.8.6.2.1 If the request for withdrawal is received after the Health Plan has submitted the appeal case file to the IRE, the Health Plan must forward the withdrawal request to the IRE for processing.

6.8.6.3 If there is a potential quality of care issue (PQI), the issue is forwarded to the Quality Department, even if the concerns have been withdrawn.
6.8.6.4 All withdrawal requests are documented and a closure letter confirming the withdrawal is sent to the member or authorized representative.

6.8.7 **Dismissals**

6.8.7.1 The Health Plan may dismiss a case for the following reasons:

6.8.7.1.1 If the authorized representative or waiver of liability documentation has not been received.

6.8.7.1.2 If good cause is not provided for untimely filing or the Health Plan denies a good cause extension.

6.8.7.1.3 If the request was authorized, scheduled, rendered, or paid prior to Member Services Grievance & Appeals receiving the request.

   6.8.7.1.3.1 If the request was satisfied by a party outside of, and after receipt by, Member Services Grievance & Appeals, the date and time that the request was authorized, scheduled, rendered, or paid should be captured within METRS as both our approval decision and effectuation date and time.

6.8.7.1.4 If the request is related to a pre-service Health Plan reconsideration and the Program representative becomes aware that the member has obtained the service/item before completing the reconsideration determination, staff must dismiss the request by sending the member a notice of dismissal.

6.8.7.1.5 If the member passed away.

6.8.7.2 A notice of dismissal must be provided when dismissing a Health Plan reconsideration.

   6.8.7.2.1 Members have the right to appeal directly with the IRE, if they disagree with the Health Plan reconsideration dismissal.

   6.8.7.2.2 The IRE will dismiss a standard pre-service Health Plan reconsideration, if the IRE receives information indicating that the service has already been obtained, after the Health Plan has forwarded the denied request to the IRE.
6.8.7.3 Members may file a grievance with the Health Plan if they are dissatisfied with a dismissal.

6.9 Effectuation

6.9.1 **Effectuation Timeframes:** CMS mandates that most Part C level types be effectuated within the case resolution timeframe.

6.9.1.1 Pre-service requests must be authorized or provided as expeditiously as the member’s health condition requires.

6.9.2 **Proof of Effectuation Documentation:** Appropriate proof of effectuation documentation must be attached in METRS. Include clear and complete documentation demonstrating the following:

6.9.2.1 Proof that the item or service was authorized or provided on a specific date and time (e.g. system screen shot), including referral number or other applicable authorization number.

6.9.2.2 Proof that payment was made and/or waiver of fees completed on a specific date (e.g. system screen shot), including check/reference number, amount paid or waived, and recipient.

6.9.3 **IRE Effectuation Requirements:** Upon completion of its reconsideration, the IRE issues a "reconsideration determination" notice to the appealing party, with a copy to the Plan and the CMS Regional Office.

6.9.3.1 For any overturn determination, the IRE notice will contain an explanation of how the member can obtain the disputed payment or covered service, and will be directed to the Plan to obtain the service or payment.

6.9.3.2 The Plan is required to submit to IRE a Statement of Compliance (SOC) attesting to effectuation of the decision.

6.9.3.2.1 The documentation must state when and how effectuation occurred (e.g. benefit authorization, payment made, etc.).

6.9.3.3 Proof of effectuation (e.g. screen shot or copy of check or referral/authorization) must also be submitted to the IRE to demonstrate compliance.

6.9.3.3.1 Notification to the IRE that the Plan intends to pay for or provide the benefit, or unidentified internal computer screen prints as the statement of compliance, do not meet the notice of effectuation requirement.
6.9.3.4 The IRE Approval Confirmation Letter must be issued to the member or authorized representative upon completion of the effectuation for a fully or partially favorable decision.

6.9.4 **Administrative Law Judge Effectuations:** Once a decision is made, the ALJ will issue his/her decision to the appealing party, with a copy to the Plan and the CMS Regional Office.

6.9.4.1 If the ALJ Hearing decision is to overturn the health plan’s denial, the health plan must pay for, authorize, or provide the service under dispute.

6.9.4.1.1 However, if the Health Plan requests a Medicare Appeals Council review of the ALJ decision, the health plan may await the outcome of the review before paying for, authorizing, or providing the service under dispute.

6.9.4.2 Written confirmation of the effectuation must be sent to the IRE using the appropriate form.

6.9.4.2.1 Written confirmation of the effectuation must be sent to the member using the approved letter.

6.9.4.2.1.1 The letter will include how the case has been effectuated along with the name, title and telephone number of the Program representative who implemented the IRE’s decision.

6.9.5 **Medicare Appeals Council Effectuations:** A copy of the MAC’s decision will be mailed to the parties if the organization determination is reversed in whole or in part.

6.9.5.1 The Health Plan must pay for, authorize, or provide the service under dispute.

6.9.6 **Federal District Court Judicial Review:** A copy of the Federal Court’s decision will be mailed to the parties if the organization determination is reversed in whole or in part.

6.9.4.1 The health plan must pay for, authorize, or provide the service under dispute.
### Quick Reference: Effectuation Timeframes Table

<table>
<thead>
<tr>
<th>Level Type</th>
<th>Timeframe</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grievance - Standard</td>
<td>As quickly as the member’s health requires, but no later than 45 calendar days from the date of receipt by the Health Plan.</td>
<td></td>
</tr>
<tr>
<td>Organization Determination - Standard - Pre-Service</td>
<td>Within 14 days from the date of receipt by the Health Plan, or 28 days if extension is applied.</td>
<td></td>
</tr>
<tr>
<td>Organization Determination - Standard - Post-Service</td>
<td>Within 60 calendar days from the date of receipt by the Health Plan.</td>
<td></td>
</tr>
<tr>
<td>Organization Determination - Expedited - Pre-Service</td>
<td>Within 72 hours from the time of receipt by the appropriate department, plus 14 days if an extension is applied.</td>
<td></td>
</tr>
<tr>
<td>Health Plan Reconsideration - Standard - Pre-Service</td>
<td>Within 30 calendar days from the date of receipt by the Health Plan, plus 14 days if extension is applied.</td>
<td>Non-contract provider appeals.</td>
</tr>
<tr>
<td>Health Plan Reconsideration - Standard - Post-Service</td>
<td>Within 60 calendar days from the date of receipt by the Health Plan.</td>
<td></td>
</tr>
<tr>
<td>Health Plan Reconsideration - Expedited - Pre-Service</td>
<td>Within 72 hours from the time of receipt by the appropriate department, plus 14 days if extension is applied.</td>
<td></td>
</tr>
<tr>
<td>Provider Appeal - Standard - Post-Service</td>
<td>Within 60 calendar days from the date of receipt by the Health Plan.</td>
<td>Fax SOC to the IRE within 14 calendar days from the date of effectuation.</td>
</tr>
<tr>
<td>IRE Reconsideration - Standard - Pre-Service</td>
<td>Authorize within 72 hours, or provide within 14 days from notice.</td>
<td>Fax SOC to the IRE within 14 calendar days from the date of effectuation.</td>
</tr>
<tr>
<td>IRE Reconsideration - Standard - Post-Service</td>
<td>Pay within 30 days from notice.</td>
<td>Fax SOC to the IRE within 14 calendar days from the date of effectuation.</td>
</tr>
<tr>
<td>IRE Reconsideration - Expedited - Pre-Service</td>
<td>Authorize or provide within 72 hours, from notice.</td>
<td>Fax SOC to the IRE within 14 calendar days from the date of effectuation.</td>
</tr>
<tr>
<td>ALJ Hearing</td>
<td>Pay for, authorize, or provide the service under dispute as expeditiously as the member’s health condition requires, but no later than 60 calendar days from the date it receives notice reversing the determination. However, if the health plan requests a Medicare Appeals Council review of an ALJ decision, the health plan may await the outcome of the review before paying for, authorizing, or providing the service under dispute.</td>
<td>Send written confirmation to the IRE within 14 calendar days from the date of effectuation.</td>
</tr>
<tr>
<td>Medicare Appeals Council</td>
<td>Pay for, authorize, or provide the service under dispute as expeditiously as the member’s health condition requires, but no later than 60 calendar days from the date it receives notice reversing the determination.</td>
<td>Send written confirmation to the IRE within 14 calendar days from the date of effectuation. Plan is not required to notify member.</td>
</tr>
<tr>
<td>Federal District Court</td>
<td>Pay for, authorize, or provide the service under dispute as expeditiously</td>
<td>Send written confirmation to the IRE within 14 days from the date of effectuation.</td>
</tr>
</tbody>
</table>
6.10 Reopening

6.10.1 Reopening and Revising Determination and Decisions. A reopening is a remedial action taken to change a final determination or decision even though the determination or decision was correct based on the evidence of record. That action may be taken by:

6.10.1.1 The Health Plan to revise the organization determination or reconsideration;

6.10.1.2 An IRE to revise the reconsideration determination;

6.10.1.3 An ALJ to revise the hearing decision; or

6.10.1.4 The MAC to revise the hearing or review decision.

6.10.1.5 If the Health Plan issues an adverse organization determination because it did not receive requested documentation during medical review and the party subsequently requests reconsideration with the requested documents, the Health Plan must process the request as a reopening.

6.10.2 Clerical Errors: The health plan must process clerical errors (which include minor errors and omissions) as reopening’s, instead of reconsiderations.

6.10.2.1 If the Health Plan receives a request for reopening and disagrees that the issue is a clerical error, the organization must dismiss the reopening request and advise the party of any appeal rights, provided the timeframe to request an appeal on the original denial has not expired.

6.10.2.2 Clerical error includes human and mechanical errors on the part of the party or the health plan such as:

6.10.2.2.1 Mathematical or computational mistakes;

6.10.2.2.2 Inaccurate data entry; or

6.10.2.2.3 Denials of claims as duplicates

6.10.3 Exhausting Appeals Rights: A case may not be reopened until all appeal rights are exhausted (except for clerical errors as described above).
6.10.3.1 The filing of a request for a reopening with the IRE, ALJ or MAC does not relieve the health plan of its obligation to make payment for, authorize, or provide services as specified in the Appeals process.

6.10.3.2 The Health Plan’s, IRE’s, ALJ’s, or MAC’s decision on whether to reopen is final and not subject to appeal.

6.10.4 Guidelines for Reopening:

6.10.4.1 Request must be made in writing;

6.10.4.2 Request for reopening must be clearly stated;

6.10.4.3 The request must include the specific reason for requesting the reopening (a statement of dissatisfaction is not grounds for a reopening, and should not be submitted); and

6.10.4.4 Request should be made within the timeframes permitted for reopening.

6.10.4.5 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.

6.10.4.5.1 This provision does not preclude organizations from conducting reopening’s to effectuate coverage NCD decisions.

6.10.5 Timeframes and Requirements for Reopening:

6.10.5.1 Reopening of Organization Determinations and Reconsiderations initiated by the Health Plan can occur:

6.10.5.1.1 Within 1 year from the date of the organization determination or reconsideration for any reason.

6.10.5.1.2 Within 4 years from the date of the organization determination or reconsideration for good cause.

6.10.5.1.3 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.

6.10.5.1.4 At any time if the organization determination is unfavorable, in whole or in part, to a party, but only for the purpose of correcting a clerical error on which that determination was based.
6.10.5.1.5 At any time to effectuate a decision issued under the coverage [National Coverage Determination (NCD)] appeals process.

6.10.5.2 Reopening by a Party: Reopening of organization determinations and reconsiderations by a party may occur:

6.10.5.2.1 Within 1 year from the date of the organization determination or reconsideration for any reason.

6.10.5.2.2 Within 4 years from the date of the organization determination or reconsideration for good cause.

6.10.5.2.3 At any time if the organization determination is unfavorable, in whole or in part, to the party, but only for the purpose of correcting a clerical error on which that determination was based.

6.10.5.3 Reopening IRE reconsiderations, ALJ hearing decisions and MAC reviews initiated by the IRE, ALJ, or the MAC:

6.10.5.3.1 Within 180 days from the date of the IRE reconsideration, ALJ hearing or MAC review decision, for good cause.

6.10.5.3.2 If the decision was procured by fraud or similar fault, the IRE, ALJ or MAC may reopen at any time.

6.10.5.4 Reopening IRE reconsiderations, ALJ hearing decisions and MAC reviews requested by a Party:

6.10.5.4.1 Within 180 days from the date of the IRE reconsideration, ALJ hearing or MAC review decision, for good cause.

6.10.6 Good Cause Reopening: Good cause may be established when:

6.10.6.1 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

6.10.6.2 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.

6.10.7 Notice Requirements for a Revised Determination or Decision:

6.10.7.1 Reopening initiated by the Health Plan, IRE, ALJ or the MAC:
6.10.7.1.1 When any determination or decision is reopened and revised, the Health Plan, IRE, ALJ or the MAC must mail its revised determination or decision to the parties involved at their last known address.

6.10.7.1.2 An adverse determination or decision must state the rationale and basis for the reopening and revision and any right to appeal and must also be provided to the member at their current location.

6.10.7.2 Reopening initiated at the request of a Party:

6.10.7.2.1 The Health Plan, IRE, ALJ or MAC must mail its revised determination or decision to the parties to that determination or decision at their last known address.

6.10.7.2.2 An adverse revised determination or decision must state the rationale and basis for the reopening and revision and any right to appeal.

6.10.7.2.3 If the member is the party which initiated the reopening, the adverse revised determination or decision must also be provided at his/her current location.

6.11 Independent Review Entity (IRE)

6.11.1 Forwarding Cases to the IRE: All expedited and standard Health Plan reconsiderations that are resolved upholding the initial adverse determination or are untimely in resolution, must be forwarded to the IRE. This includes the adverse determination portion of a partially approved appeal.

6.11.2 IRE Case Packet: The IRE has developed standardized forms for case file submission that must be used by the Program representative when submitting a case file packet for review:

6.11.2.1 Data Transmittal Cover Sheet
6.11.2.2 Reconsideration Background Data Form (RBDF)
6.11.2.3 Case Narrative

6.11.3 IRE Portal for Case Packet Submission:

6.11.3.1 Fill out the respective forms for the case type, which may not include all forms identified in section 6.11.2
6.11.3.2 Submit case information by attaching PDF documents
6.11.3.3 Attach confirmation email from the IRE, with Appeal Number
6.11.3.4 Ensure submission through portal is timely, to allow for back up submission in the event the portal is off line.

6.11.4 IRE Decisions: Upon completion of its reconsideration, the IRE will fax their "reconsideration determination" notice to the appealing party, with a copy to the Plan and the CMS Regional Office.

6.11.4.1 The IRE must conduct the reconsideration as expeditiously as the member's health condition requires but no later than Health Plan's time frames for processing reconsiderations.

6.11.4.2 Overturn: If the IRE agrees with the member and approves the original request(s), the notice will provide the appealing party with information about the "favorable" decision.

6.11.4.2.1 The overturn notice will contain an explanation of how the member can obtain the disputed payment or covered service, and he or she will be directed to the Health Plan to obtain the service or payment.

6.11.4.2.2 A notice to comply with the IRE reconsideration determination is also included. This notice details the Plan's responsibilities, including the time frame by which a compliance notice must be received by the IRE.

6.11.4.2.3 All overturn decisions should be reviewed with a manager/supervisor to determine if a request for a reopening review to contest the decision can be submitted.

6.11.4.2.4 If a decision notice is not received within the applicable IRE review timeframe, the Program representative should search for the appeal status on the IRE website using the IRE Appeal Number.

6.11.4.2.5 The IRE Appeal Number must be entered in to the designated field in METRS.

6.11.4.2.6 Approval of a Former Member: If a member's coverage terminates after the Health Plan reconsideration is processed, the Health Plan is legally responsible to authorize, provide or pay for all Medicare covered services. Program representatives will process with effectuation.

6.11.4.3 Uphold: If the IRE agrees with the Health Plan and denies the member’s request(s), the notice will provide the appealing party
with information about the “unfavorable” decision. There is no further correspondence required from the Plan.

6.11.4.4 Partial Approvals: If the IRE disagrees with a portion of the request, the IRE will issue a “partially favorable” decision notice. The Health Plan will proceed with effectuation of the approved portion of the request.

6.11.5 Processing a Part C Appeal Dismissal Case File Request from the IRE: When a member or authorized representative disagrees with the Plan’s decision to dismiss their request, the member may request an IRE review of the Health Plan’s dismissal.

6.11.5.1 When the IRE receives a dismissal review request from the member or authorized representative, the IRE will contact the Plan (via fax) and request a copy of the case file.

6.11.5.2 The Plan will have 24 hours from receipt of the case file request to forward the requested case file to the IRE.

6.11.5.2.1 Program Representatives should send the IRE an abbreviated case file that includes the following:

   6.11.5.2.1.1 The Medicare Managed Care Dismissal Case File Data Form;
   6.11.5.2.1.2 A Dismissal Case File Narrative;
   6.11.5.2.1.3 The organization determination documents;
   6.11.5.2.1.4 The appeal request documents;
   6.11.5.2.1.5 A copy of the Appeal Dismissal Notice;
   6.11.5.2.1.6 Documentation of attempts made to secure missing AOR documentation;
   6.11.5.2.1.7 Documentation of attempts made to secure good cause for an untimely filed appeal and/or reason good cause reason did not qualify for filing extension.

6.11.5.3 Timeframe for IRE Appeal Dismissal reviews:

   6.11.5.3.1 Within 72 hours (Expedited)
   6.11.5.3.2 Within 30 days (Pre-Service)
   6.11.5.3.3 Within 60 days (Post Service)
6.11.5.4 **Dismissal Overturn:** If the IRE decides that the Health Plan’s dismissal is not justified, the Plan will process the request.

6.11.5.5 **Requests for Additional Information (RFI):** A request for additional information is made at the IRE’s discretion. A case file deficiency typically undermines the validity of the Health Plan’s denial argument, hence missing information may result in an IRE overturn. The Plan will be asked to supply written information to answer a question, remedy a deficiency or obtain additional information required to resolve the appeal for the submitted case file. MAXIMUS will usually send the request via fax.

6.11.5.5.1 The response to the IRE should include a clear and concise response to any questions included in the RFI requestor;

6.11.5.5.2 Relevant medical records;

6.11.5.5.3 Any information relevant to the appeal to assist the ALJ with the decision making.

6.11.5.5.4 Timeframe to respond: In general, staff should follow the due dates noted in the IRE Request for Information form. However, the following timeframes are noted in the CMS regulations for sending a response with the additional information to the IRE:

6.11.5.5.4.1 Within 3 calendar days from date of request for expedited Health Plan reconsiderations;

6.11.5.5.4.2 Within 5 working days from date of request for pre-service Health Plan reconsiderations;

6.11.5.5.4.3 Within 10 working days from date of request for post-service Health Plan reconsiderations.

### 6.12 Administrative Law Judge (ALJ) Hearings

6.12.1 **Threshold Amount for Filing:** If the amount remaining in controversy meets the appropriate statutory threshold requirement, any party to the reconsideration, except the health plan, who is dissatisfied with the reconsidered determination, has a right to a hearing before an ALJ.

6.12.1.1 A request for an ALJ hearing must be in writing and must be filed with the entity specified in the IRE’s reconsideration notice.

6.12.1.2 The IRE will compile the reconsideration file and forward it to the appropriate ALJ hearing office.
6.12.2 **Filing Timeframe:** Except when an ALJ extends the timeframe, a party must file a request for an ALJ hearing, within sixty (60) days of the date of the notice of a reconsidered determination. Any request for a “good cause” extension must be in writing and state the reasons why the request was late. If the party shows good cause for missing the deadline, the ALJ may grant an extension.

6.12.3 **ALJ Hearing Participation by the Health Plan:** Member Services Appeals and Grievances staff will attend the hearing and present all evidence related to the case.

6.12.4 Following the hearing, the judge will take all matters into consideration and issue a written decision which will be sent to all parties in the reconsideration process (member/representative/health plan).

6.12.5 If the ALJ upholds KFHP’s decision, the member will be informed by the ALJ regarding other available appeal avenues including the Medicare Appeals Council (MAC) and Federal District Court (FDC), if the amount in controversy is met.

**6.13 Medicare Appeals Council (MAC) Review**

6.13.1 The MAC may grant or deny the request for review of the ALJ’s decision or dismissal. If it grants the request, it may either issue a final decision or dismissal, or send the case back to the ALJ with instructions on how to proceed with the case.

6.13.2 A request for a MAC review must be filed in writing to the MAC within sixty (60) days of the date of the receipt of the ALJ hearing decision or dismissal.

6.13.3 If the health plan requests a MAC review, it must concurrently notify the member by sending a copy of the request, as well as accompanying documents that it submits to the MAC. The health plan must also notify the IRE that it has requested a MAC review.

6.13.4 A copy of the MAC’s decision will be mailed to the parties.

**6.14 Federal District Court Judicial Review**

6.14.1 A judicial review of an ALJ’s decision may be requested if:

6.14.1.1 The MAC denied the parties’ request for review, and

6.14.1.2 The amount in controversy (AIC) is met.

6.14.2 Any party, including the health plan (upon notifying all other parties), may request judicial review of a MAC decision if:

6.14.2.1 The MAC denied the parties’ request for review; or
6.14.2.2 It is the final decision of CMS; and

6.14.2.3 The amount in controversy is met.

6.14.3 To request a judicial review, a party must file a civil action in a district court.

7.0 Definitions: For the purposes described in this policy and procedure, the following definitions are applicable:

7.0.1 **Acknowledgement:** The act of contacting the member and informing them that we received their case and setting expectations.

7.0.2 **Appeal:** Any of the procedures that deal with the review of adverse organization determinations on the health care services the 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 for services, decisions not to provide or pay for services that the enrollee believes may be covered by the health plan. These procedures include reconsiderations by the health plan, and if necessary, reconsiderations by the independent review entity (IRE), Administrative Law Judge (ALJ) hearings, review by the Medicare Appeals Council (MAC) and judicial reviews.

7.0.3 **Arbitration:** A contractual dispute resolution process in which a neutral arbitrator determines the final settlement of a Claim.

7.0.4 **Case:** A system record that captures all activities surrounding a member encounter and its associated events.

7.0.5 **Level Type:** Within KHFP complaints are categorized as a Medicare grievance, organization determination and reconsideration.

7.0.6 **Centers for Medicare & Medicaid Services (CMS):** Federal agency that administers the Medicare and Medicaid Programs.

7.0.7 **Claim:** Any request for payment or reimbursement of medical supplies or services which the Medicare member has already received. A Claim is not a “pre-service” request.

7.0.8 **Clerical Error:** A clerical error includes such human and mechanical errors as mathematical or computational mistakes, inaccurate coding and compute errors.

7.0.9 **Closed Case:** A Medicare grievance, organization determination or reconsideration which has been resolved by the health plan.

7.0.10 **Coding:** The act of assigning a category associated with the process level to ensure compliant case work and regulatory reporting.

7.0.11 **Complaint:** Any expression of dissatisfaction to the health plan, provider, facility or QIO by a member made orally or in writing. This can include concerns about the operations of providers, insurers, or health plan such as: waiting times, the demeanor of health care personnel, the adequacy of facilities, the respect paid to members, the claims regarding the right of the member to receive services or receive payment for services previously rendered. It also includes the health plan’s refusal to provide services the member believes he or she is entitled. A complaint
could be either a grievance or an appeal, or a single complaint could include elements of both. Every complaint must be handled under the appropriate grievance or appeal process.

7.0.12 **Complaint or Benefit Claim/Request Form:** A form available to members who wish to register a written grievance, organization determination or reconsideration.

7.0.13 **Complaint-Related Referral to Quality:** Any grievance, organization determination, or reconsideration that meets the criteria for a referral by the Member Services Appeals and Grievances Clinical Consultant to the responsible Quality Department.

7.0.14 **Decision:** A determination of how the member's request is resolved.

7.0.15 **Dual Covered:** A member who has dual enrollment in KFHP with Medicare (Cost or Senior Advantage) and Medicaid. The member will be identified in the membership system as having Senior Advantage or Cost membership through one Purchaser ID and coverage through a Medicaid program through another Purchaser ID.

7.0.16 **Effectuation:** The demonstration that the member has been provided payment of a claim, authorization for a service, or a provision of services.

7.0.17 **Enrollee:** A Medicare eligible individual who has elected a Medicare Advantage (MA) plan offered by KFHP.

7.0.18 **Expedited Review:** A review process used to render a decision involving an imminent or serious threat to the health of the member, including, but not limited to, severe pain, potential loss of life, limb or major bodily function. Expedited requests not meeting criteria are processed as a standard review process.

7.0.19 **Experimental/Investigational:** A service is experimental or investigational if:
1) The service is not recognized in accord with generally accepted medical standards as safe and effective for treating the condition in question, whether or not the service is authorized by law for use in testing or other studies on human patients; or
2) The service requires approval by any governmental authority prior to use and such approval has not been granted when the service is to be rendered.

7.0.20 **Extension:** Additional time allowed by Medicare regulations to reach a decision for certain level types if the member requests the extension or if the Health Plan justifies a need for additional information and documents how the delay is in the interest of the member (for example, the receipt of authorized representative documentation or non-Plan medical records).

7.0.21 **External Review:** For purposes of this policy and procedure, the external review process refers to the case review and decision process conducted by an external review entity (e.g. IRE, ALJ, MAC, Federal District Court) related to a grievance or appeal that has previously undergone a review by the Health Plan.

7.0.22 **Federal Member:** A KFHP member who is a Federal employee with coverage under the Federal Employee Health Benefits Program (FEHBP).

7.0.23 **Intake:** The process of gathering information relevant to set up the case for a member's grievance or appeal.

7.0.24 **Investigation:** The process whereby all relevant facts are compiled, documented, and reviewed in order to determine the appropriate resolution.
7.0.25 **Level Type:** Within KFHP Part C complaints are categorized as a grievance, organization determination or reconsideration.

7.0.26 **Life Threatening:** Diseases or conditions where the likelihood of death is high unless the course of the disease or condition is interrupted.

7.0.27 **Medical Necessity:** A service or supply that is appropriate and required to prevent, diagnose or treat a condition or clinical symptoms in accord with generally accepted professional standards of practice that are consistent with the standard of care in the medical community.

7.0.28 **Medicare Advantage (MA) program:** A type of Medicare health plan offered by a private company that contracts with Medicare to provide you with all your Part A and Part B benefits. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. If you’re enrolled in a Medicare Advantage Plan, most Medicare services are covered through the plan and aren’t paid for under Original Medicare. Most Medicare Advantage Plans offer prescription drug coverage.

7.0.29 **Medicare Cost Member:** A KFHP member who has assigned Medicare Part B benefits to KFHP.

7.0.30 **Post-service Request:** A request for payment or reimbursement of care or services the member has already received.

7.0.31 **Potential Quality of Care Issue (PQI):** Member expressed concern relating to the quality of care, which is not yet substantiated.

7.0.32 **Pre-service Request:** A request for the provision of care or services the member has not yet received.

7.0.33 **Program Representative:** A KFHP Member Services Appeals and Grievances employee responsible for processing and responding to member grievances, organization determination and appeals as outlined by KFHP in this Policy and Procedure.

7.0.34 **Repeat Complaint:** A grievance filed that contains the same complaints and/or requests that was previously filed and resolved.

7.0.35 **Quality Improvement Organization (QIO):** Organization comprised of practicing doctors and other health care experts under contract with the Federal government to monitor and improve the care given to Medicare members. The QIO reviews complaints raised by members about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities and home health. They also review continued stay denials in acute inpatient hospital facilities as well as coverage terminations in Skilled Nursing Facilities, Home Health and Comprehensive Outpatient Rehabilitation Facilities.

7.0.36 **Quality of Care Issue:** Grievance issues based off of the member's perspective pertaining to the clinical care, treatment plan or coordination of care. A quality of care issue may be filed through the health plan’s grievance process and/or the Quality Improvement Organization (QIO). The QIO must determine whether the quality of services (including both inpatient and outpatient services) provided by the health plan meets professionally recognized standards of health care, including
whether appropriate health care services have not been provided or have been
provided in inappropriate settings.

7.0.37 **Reopening:** A remedial action taken to change a final determination or decision
even though the determination or decision was correct based on the evidence of
record.

7.0.38 **Representative (Appointed/Authorized):** An individual appointed by a
Medicare member or other party, or authorized under state or other applicable
law, to act on behalf of a Medicare member or other party involved in an appeal.
Unless otherwise stated, the representative will have all of the rights and
responsibilities of a member or party in obtaining an organization determination or
in dealing with any of the levels of the appeals process, subject to the applicable
rules described in 42 CFR part 405.

7.0.39 **Resolution Letter:** A written notice of the resolution of the grievance,
organization determination, or reconsideration sent to the member or member’s
duly authorized representative with a clear and concise explanation of the KFHP
decision. If adverse in whole or in part, this notice will include information
regarding the member’s rights for further review, including how to pursue those
rights.

7.0.40 **Seriously Debilitating:** Diseases or conditions that cause major, irreversible loss
of function of the body or body part(s).

7.0.41 **Standard Review:** A review process used to render a decision involving requests
that are not an imminent or serious threat to the health of the member.

7.0.42 **Verbal Resolution:** A verbal notice of the outcome of a case. Verbal notice will
provide the member or representative with a clear and concise explanation of how
the Health Plan resolved the case.

7.0.43 **Waiver of Liability (WOL) Statement:** A written statement needed from a
non-contract provider (NCP) filing an appeal, which states that the member will
not be billed regardless of the outcome of the appeal.

8.0 **References / Appendices**

8.0.1 **Quick Reference: Case Processing Timeframes**

<table>
<thead>
<tr>
<th>Level Type</th>
<th>Intake</th>
<th>Contact Date and Time</th>
<th>Ack</th>
<th>Resolution</th>
<th>Effectuation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grievance Standard</td>
<td>60 days to file</td>
<td>When the case is received by the Health Plan.</td>
<td>5 days (written or verbal)</td>
<td>30 days (written or verbal) One-time 14-day Extension:  • Member’s request  • Plan applied, in the best interest of the member</td>
<td>As quickly as the member's health requires, but no later than 45 calendar days from the date of contact.</td>
</tr>
<tr>
<td>Expedited Grievance</td>
<td>60 days to file</td>
<td>When the case is received by the Health Plan.</td>
<td>24 hours (verbal)</td>
<td>24 hours verbal, written resolution within 3 days of verbal.</td>
<td>N/A</td>
</tr>
<tr>
<td>Organization Determination - Standard</td>
<td>At any time</td>
<td>When the case is received by the Health Plan.</td>
<td>5 days (written)</td>
<td>Pre-Service timeframe: 14 days (written or verbal) One-time 14-day Extension:  • Member’s request</td>
<td>By level resolution due date.</td>
</tr>
</tbody>
</table>
### Policy Title: Medicare Part C Grievances and Appeals

**Policy Number:** Medicare Grievances and Appeals Part C.MS.001

**Owner Department:** Member Services Grievances and Appeals

**Effective Date:** July 1, 2018

**Custodian:** Quality and Regulatory Operations

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<table>
<thead>
<tr>
<th>Organization Determination - Expedited</th>
<th>At any time</th>
<th>When the case is received by the appropriate office or department designated by the Health Plan to review expedited requests (e.g. Expedited Review Unit).</th>
<th>24 hours (verbal)</th>
<th>72 hours verbal, written resolution within 3 days of verbal.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health Plan Reconsideration - Standard</strong></td>
<td>60 days to file (written request)</td>
<td>When the case is received by the Health Plan.</td>
<td>5 days (Written)</td>
<td>Pre-Service timeframe: 30 days (written)</td>
</tr>
<tr>
<td><strong>Health Plan Reconsideration - Expedited</strong></td>
<td>60 days to file</td>
<td>When the case is received by the appropriate office or department designated by the Health Plan to review expedited requests (e.g. Expedited Review Unit).</td>
<td>24 hours (verbal)</td>
<td>72 hours verbal, written resolution within 3 days of verbal.</td>
</tr>
</tbody>
</table>

**One-time 14-day Extension:**
- Member's request
- Plan applied: in the best interest of the member; when waiting for AOR

**By level resolution due date.**

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### Policy Revision History

**Revision Dates:**

**August 23, 2018**