PURPOSE:

This procedure was established to address the requirements defined in the Chapter 13 Medicare Managed Care Manual guidelines for member appeals /reconsideration of adverse organizational determinations. (section 70).

EXPLANATION:

The Center for Medicare and Medicaid Services (CMS) has established policies for Medicare Advantage (MA) level appeals. The Kaiser Foundation Health Plan of Washington MA level appeal (reconsideration) process is one step in a larger multi-level Medicare Managed Care appeal process.

This document outlines the Kaiser Foundation Health Plan of Washington Medicare Advantage (MA) "standard" member appeal procedures related to scope, applicability and exceptions, guidelines, and procedures for Kaiser Foundation Health Plan of Washington Medicare member appeals of adverse organization determinations. An adverse organization determination is defined as: a decision by a health plan to deny, modify, reduce, or terminate payment, coverage, authorization or provision of health care services or benefits including the admission to or continued stay in a facility.

POLICY:

DESCRIPTION:

Kaiser Foundation Health Plan of Washington staff will follow Chapter 13 Medicare Managed Care Manual guidelines for member appeals of adverse organizational determinations (section 70), in responding to and documenting all requests from Medicare Advantage (MA) members.

PROCEDURES:

Guidelines

Case Documentation

The Member Appeals Administrative Specialist, Coordinator and practitioner reviewer will follow the System of Record Case Documentation procedures to enter the case into the System of Record for tracking and trending, and will complete the Customer Service case per the standard work procedures.

Roles in Member Appeals process
Member Appeals Administrative Specialist

- Upon receipt of the written appeal request, Member Appeals Administrative Specialist is the point of contact regarding the appeal request for the enrollee or the enrollee’s representative until the case is assigned to a Member Appeals Coordinator.
- Receive requests for Member Appeals: evaluate them for member eligibility, timeliness, appropriateness of appellant, and appeal-ability of request.
- Open and document the request in the System of Record and assign to a Member Appeals Coordinator for investigation.

Member Appeals Coordinator

- All appeals will be reviewed by a person (s) not involved in the initial determination, and not a subordinate of the initial practitioner reviewer.
- Collects, documents and analyzes all information relevant to the member’s request.
- Conducts a thorough investigation and documents findings.
- The Appeals Coordinator is responsible for assuring that the first level appeals process operates in a timely, efficient, and considerate manner.
- The Appeals Coordinator shall assist the member with the appeals process. The Coordinator will ensure that the process is accessible for members who are limited English speakers, who have literacy problems, or who have physical or mental disabilities that may impede their ability to file an appeal.
- Determines and documents coverage criteria using the member’s evidence of coverage and Medicare rules.
- Notifies the member of the decision using approved communication documents.
- If a member’s request is granted, in part or in full, the Appeals Coordinator is responsible for assuring and coordinating the implementation of the decision.

Practitioner Reviewer

- All appeals will be reviewed by a practitioner (s) not involved in the initial determination, and not a subordinate of the initial practitioner reviewer.
- Determines and documents medical criteria using the Medicare rules and health plan criteria & policy.

Member/Appellant/Enrollee

- Kaiser Foundation Health Plan of Washington Medicare Advantage members or their authorized representative must submit a written request for an appeal of an adverse organization determination within 60 days of the issuance of the determination. (See section 3.0 for ‘Good Cause Exception’ Guidelines)
- If the member also has an associated commercial plan (ie. FEHB, PEBB or other commercial plans) then the timelines will follow the commercial plan rules for acceptance of the appeal request.

Member’s Right to Submit Information

Members may submit written comments, documents, or other information relating to the appeal. Members are informed of this right, as well as the submission process, in the initial adverse organizational determination notification.

Member Access to Appeal Information

- Members will be provided, upon request, access to and copies of all documents, records, and other information relevant to the member’s appeal. Upon receipt of this request, the appeals coordinator will manage until fulfillment achieved.
• KPWA will provide, upon request, the names of the medical or vocational experts whose advice was obtained on behalf of the plan in connection with a member's adverse appeal determination, without regard to whether the advice was relied upon in making the benefit determination.

Required Timelines

• Request must be received from appellant within 60 days of the formal written initial adverse organization determination unless ‘good cause’ is documented. (see section 3.0 for ‘Good Cause Exception’ Guidelines)
• Preservice request must be resolved including effectuation within 30 days of receipt of request unless a 14 day extension has been implemented.
• Post service request must be resolved including effectuation within 60 days of receipt of request

PROCESS STEPS

A. Receipt of the Appeal Request

Member Appeals receives a written appeal request (letter, fax or e-mail) from a KPWA Medicare enrollee (or his/her authorized representative). (See CMS Chapter 13 of the Medicare Managed Care Manual for circumstances in which an oral request can be made.)

If the request is labeled in writing or verbally as urgent, emergent, or expedited please see separate procedure for ‘Expedited Medicare Member Appeals’.

Upon receipt of the written appeal request, the Administrative Specialist will:

1.0. Date stamp the request. Open a case in the System of Record and attach the request.

2.0 Member Eligibility Review

2.1. Review system documentation including the membership records, for the enrollment status of the Medicare enrollee to determine applicable appeal pathway and appeal review timeframe.

2.2. Determine if the enrollee is locked-in to their KPWA Medicare Advantage plan.

2.3. Document member’s coverage, plan information and language needs.

3.0. Timeliness of Request Review:

3.1. For Kaiser Foundation Health Plan of Washington Medicare enrollees, a written appeal request must be received by the Member Appeals within 60 calendar days of the date of the initial notice of adverse organization determination. However, if “good cause” is shown, KPWA may accept requests for standard reconsideration filed after 60 calendar days. (42CFR422.582(b)&(c)). The request for extension of the timeframe for filing appeal must be made in writing by the enrollee or authorized representative. Examples of circumstances where good cause may exist include (but are not limited to) the following situations: (must be documented in the System of Record)

3.1.1. The enrollee did not personally receive the adverse organization determination notice, or he/she received it late;

3.1.2. The enrollee was seriously ill, which prevented a timely appeal;

3.1.3. There was a death or serious illness in the enrollee’s immediate family;

3.1.4. An accident caused important records to be destroyed;
3.1.5 Documentation was difficult to locate within the time limits;

3.1.6 The enrollee had incorrect or incomplete information concerning the reconsideration process; or

3.1.7 The enrollee lacked capacity to understand the timeframe for filing a request for reconsideration.

3.2 If there is no record that the Medicare enrollee has been advised in writing of appeal rights in any previous review, the 60-day time frame restriction is waived, and the request must be processed as an appeal (providing that the enrollee’s request has been previously reviewed and his/her issues are appealable).

3.3 Other extenuating circumstances-(must be explained in the documentation). Consult with management to determine whether to accept.

3.4 Document date of initial adverse organization determination and the receipt date of the appeal request.

3.5 If the request for appeal is received by Member Appeals outside of the applicable appeal request timeframe and it does not meet any ‘good cause’ reason:

3.5.5 Document in the System of Record.

3.5.6 Enter the reason for late request as provided by requestor in System of Record or note ‘none given’.

3.5.7 The Member Appeals Administrative Specialist will send a ‘too late letter’ enrollee or enrollee’s representative in writing that his/her appeal request has been received too late for appeal.

3.5.8 The letter will include information on how to file a grievance if the enrollee or enrollee’s representative disagrees with KPWA’s closing the appeal case as too late to appeal.

3.5.9 Complete the case

3.5.9.1 The admin will enter the outcome as dismissal and outcome reason as “too late to appeal”.

3.5.9.2 Send the letter and attach copy to the case.

3.5.9.3 Enter close date and change status to complete

4.0 Qualified Appellant Review:

4.1. An appeal request must be submitted by a KPWA member/enrollee who received the adverse determination, unless the enrollee has authorized, in writing, another party, including a provider, to be his/her representative for the appeal review process. (CMS defines the parties and persons who may request a reconsideration in section 60.1.1 – Representatives Filing Appeals for Enrollees of CMS Revised Chapter 13 (3/3/06). Refer to this document for detailed information on who can request an appeal.)

*The treating clinician may represent the member in a pre service appeal without authorization.

4.2. If the appeal request is made by a provider, the request must be made specifically on behalf of the member by the treating clinician in order to be processed as a Medicare member appeal.

Note-this procedure does not apply if the initial adverse organizational determination holds the provider responsible.

4.3. It is noted that if the second party requesting the appeal is a non-Plan provider or the request is post service, he/she will need to sign a Waiver of Payment statement in which the provider promises that the enrollee will not be held responsible for charges incurred if CMS Designated External Review Organization rules in favor of KPWA. The Waiver of Payment statement is included in the appeal packet sent to CMS Designated External Review Organization.
4.4. If an unauthorized second party requests an appeal review, and no formal written authorization of representation has been received from the Medicare enrollee, written notification is sent to the unauthorized (second) party, informing him/her of this requirement along with the appropriate forms to be completed and returned. A copy of the request is saved in the System of Record.

4.5. Regulations and policies require that both parties complete and sign an

4.5.1 Authorization to Release Healthcare Information form if applicable. And

4.5.2 Medicare Appointment of Representative form in which the enrollee authorizes the second party to represent him/her in the appeal OR

4.5.3 A copy of guardianship documentation OR

4.5.4 A copy of the Durable Power of Attorney which authorizes the second party to represent the enrollee in the appeal. (Validate that it is current, in effect, and for health and financial care) OR

4.5.5 If none of the above are in force then document surrogacy if it is documented that the enrollee is incompetent to make their own health care decisions.

4.5.6 If the enrollee is deceased, the representative must provide written legal proof that he/she is the executor of the estate.

4.6. Regarding a representative's appointment by an enrollee. Unless revoked, an Appointment of Representative form is considered valid for one year from the date that the Appointment is signed by both the enrollee and the representative. Also, the representation is valid for the duration of the appeal. (See Section 60.1.1 - Representative Filing Appeals for Enrollees Revised Chapter 13, (3/3/06)

4.7. Advise the second party that the appeal will not be accepted by CMS Designated external review organization without appropriate authorization.

4.8. Document appellant relationship to member, request and receipt of authorizations.

4.9. Tracking for receipt of authorizations

4.9.1 During the initial 30 day timeframe, the Member Appeals Coordinator will make one telephone call to the second party reminding them that KPWA must have the required forms to process the appeal.

4.9.2 However, if KPWA does not receive this required documentation by the conclusion of the 30th day appeal timeframe, a 14 day extension letter is sent.

4.9.3 During the 14 day extension timeframe, the Member Appeals Coordinator will make one telephone call to the second party reminding them that KPWA must have the required forms to process the appeal.

4.9.4 At the end of the 14 day extension, if KPWA still has not received the required documentation, KPWA will forward a letter to CMS Designated external review organization requesting dismissal of the appeal case. 60.1.1 - Representatives Filing Appeals for Enrollees of CMS Revised Chapter 13 (3/3/06).

5.0. Appeal-ability Review:

5.1. The member must have been denied coverage in writing for part or all of a service by the Healthplan.

Distinguishing Between Appeals and Grievances (Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)

Appeal procedures must be used for complaints or disputes involving organization determinations. Grievance procedures are separate and distinct from organization determination and appeal procedures. Determine whether the issues in an enrollee’s complaint meet the definition of a grievance, an appeal, or both. The Medicare health plan then must resolve all enrollee’s complaints or disputes through the appropriate procedure to address the particular type of complaint.
For example, Medicare health plans must determine how to categorize complaints about co-payments on a case-by-case basis.

Appeal—complaints about co-payments when an enrollee believes that an Medicare health plan has required the enrollee to pay an amount for a health service that should be the Medicare health plan’s responsibility.

Grievance—

- Enrollee expresses general dissatisfaction about a co-payment amount.
- Complaints concerning an enrollee’s involuntary disenrollment initiated by the Medicare health plan.
- A change in premiums or cost sharing arrangements from one contract year to the next.
- Difficulty getting through on the telephone, the quality of care of services provided.
- Interpersonal aspects of care, such as rudeness by a provider or staff member, or failure to respect an enrollee’s rights.

The facts surrounding a complaint will determine whether the appeals or grievance process should be initiated. The following are offered as examples of when each process should begin:

Appeal

An enrollee who currently uses a particular heart specialist is dismayed to find out that the specialist he/she uses will no longer be a contracted provider with the Medicare health plan. The enrollee calls the health plan and complains. The enrollee states that he/she has tried other specialists before, was not satisfied, and therefore wants the health plan to continue coverage of the heart specialist. This complaint should be treated as a request for an organization determination, subject to the appeals process, on the basis that the enrollee believes that continued care with the particular heart specialist is required for his/her wellbeing.

Complaints concerning organization determinations are resolved through appeal procedures. Organization determinations primarily include complaints concerning the benefits to which an enrollee is, or believes he/she is, entitled, i.e., payment or provision of services. Additionally, an appeal might arise from a complaint when an enrollee disputes the calculation of his/her co-payment amount.

Grievance

An enrollee who currently does not use a particular heart specialist reads in his provider manual that the heart specialist is no longer in the plan’s network. The enrollee calls the plan to complain, even though it does not directly affect him at the current time because the enrollee does not currently see a heart specialist. In this instance, the complaint cannot be interpreted as a request for an organization determination. The complaint should therefore be handled as a grievance and forwarded to the appropriate department for handling.

A complaint about the appeal process (i.e. Denied expedited review or ...) will be set up as a grievance in Member Appeals. See separate procedure.

Complaints concerning the quality of medical care received under Medicare may be acted upon by the Medicare health plan, but also may be addressed through the QIO complaint process under §1154(a)(14) of the Act. (See also the QIO Manual chapter regarding the Beneficiary Complaint Process.) This process is separate and distinct from the Medicare health plan’s grievance process. For example, if an enrollee believes his/her physician misdiagnosed the enrollee’s condition, then the enrollee may file a complaint with the QIO in addition or in lieu of a complaint filed under the Medicare health plan’s grievance process. All grievances regarding quality of care, regardless of whether they are filed orally or in writing must be responded to in writing. When the Medicare health plan responds to an enrollee’s grievance in writing, it must include a description of the enrollee’s right to file the grievance with the QIO. For any grievance filed with the QIO, the Medicare health plan must cooperate with the QIO in resolving the grievance.
Mixed complaints - Grievance and Appeal

At times Medicare health plans will need to process complaints using the Medicare health plan's grievance procedures as well as its appeal procedures. For example, an enrollee might complain that because he/she had to wait so long to obtain a referral, he/she received services out of network. The enrollee’s complaint contains both an appealable request for payment as well as a grievance about the timeliness of services. Therefore, complaints must be reviewed on a case-by-case basis.

5.2.   Depending on the type of notice, obtain a copy of the adverse organizational determination received by the member, attach it to the case and document the date of notification of the previous adverse organizational determination.

5.2.1.  Denied referral requests, the Referral system (RMSQ)

5.2.2.  Copy of the Notice of Non-coverage,

5.2.3.  Clinical Review adverse organizational determination letter.

5.2.4.  Denied claims, the claims screen should also be accessed to determine the date when the claim was denied and when the denied EOB was sent to the enrollee.

5.2.5.  Attach a copy of initial adverse organizational determination notice and assign the case to the Member Appeals Coordinator.

5.3.   If no formal written initial adverse organizational determination is found-

5.3.1.  Date stamp the request and open a case in the System of Record with case type ‘Inquiry’. Or record the verbal request in the member’s words when appropriate.

5.3.2.  Member Appeals forwards the case to the appropriate area for resolution.

5.3.3.  Member Appeals notifies the enrollee or enrollee's representative by letter that his/her case is being transferred to the appropriate department for review, providing the name of the department and the department telephone number. This review constitutes an Organization Determination and if denied at this level will result in written appeal rights.

5.3.4.  Member Appeals attaches the enrollee’s letter to the System of Record case and closes the case.

B. Investigation of the Appeal

Once the member’s written request for appeal is received, the Appeals Coordinator will investigate by collecting, documenting and analyzing all relevant information and resolve the appeal. In the investigation, the Appeals Coordinator will consider the written and oral information submitted by the member as well as all investigational findings, and make responsible judgments based on these materials and findings, subject to the following stipulations:

1.0 Coverage Review: The Member Appeals Coordinator will review and document the following information in order to determine whether to cover the service requested:

1.1 Member’s evidence of coverage.

1.2 Criteria for coverage of the denied service including health plan criteria and policies, Medicare citations, National and Local Coverage Decisions.

1.3 Communications with the member as recorded in the Customer Service system or medical record.

1.4 Clinical review or pre authorization requests.

1.5 Claims related to the service whether paid, denied or pending.

1.6 Examine all of this information for possible process issues.
1.7 Appeals involving legal, contractual, and/or risk management issues: The Appeals Coordinator will consult with the Legal, Contracts, and/or Risk Management Departments as appropriate. These departments will advise the Appeals Coordinator on the potential ramifications of any decisions.

1.8 Determine and document the basis for coverage: if it is dependent on medical criteria or policy send for clinical review.

2.0. Practitioner Review:

2.1. The reviewing clinician will be a reviewer not involved with the initial decision, and not a subordinate of the initial reviewing clinician(s).

2.2. The member's request will be reviewed by or include a consultation with a health care clinician with the appropriate expertise in the field of medicine that encompasses the member's condition or disease.

2.3. Documentation of the consultation, including the consulting practitioner's name and qualifications will be included in the appeals case file if the adverse determination is upheld.

2.4. The clinician reviewer will record whether the service meets medical criteria or policy for coverage or warrants an exception based on medical need and provide a rationale for his/her decision.

C. Decision and Notification

1.0 Decision

1.1 The Member Appeal Coordinator will complete the case outcome and outcome reason based on his/her findings in their investigation and the medical review if needed. The coordinator will accept the judgment of the practitioner reviewer regarding medical appropriateness.

1.2 The case file prepared by the Member Appeal Coordinator will include:

1.2.1 An explanation of the decision, including the supporting coverage or clinical rationale.

1.2.2 The references to the specific MA plan provisions/Medicare coverage regulation(s) on which the benefit determination is based.

1.2.3 Any and all applicable internal rules, guidelines, protocols, or similar criteria used in the decision process.

1.2.4 The titles and qualifications of the individual(s) participating in the appeal review that were not involved with the initial decision, and not a subordinate of the initial reviewers.

1.2.5 A decision letter to the member, using one of the CMS approved or "deemed approved" template letters.

1.2.6 A case packet to be sent to the CMS Designated External Review Organization. for the next level of review, if Kaiser Foundation Health Plan of Washington upholds or partially upholds the adverse organizational determination.

2.0. Notification

The Appeals Coordinator will send a letter informing the member of the appeal decision within thirty (30) calendar days of receiving the member's request for a preservice review or 45 days if extension received, or 60 days for a post service review. The letter must be on a CMS approved or deemed approved template that includes:

2.1. A clear statement of the decision and the rationale for the decision.

2.2 As well as next steps in the appeal process.

2.3 Credentials of the physician reviewer, board certification and specialty of any physician(s) consulted.
2.4 The references to the specific MA plan provisions/Medicare coverage regulation(s) on which the benefit determination is based. As well as CMS citations related to the service.

3.0 If the decision is to uphold or partially uphold the adverse organizational determination, the Appeals Coordinator will automatically forward the case to CMS Designated external review organization for the next level of review and determination.

3.1 Open an External Case review and document according to System of Record instructions.

3.2 Prepare the case packet to include:

3.2.1 A completed Medicare Managed Care Reconsideration Background Data form.

3.2.2 Case Narrative

3.2.3 A copy of the member’s Evidence of Coverage in it’s entirety.

3.2.4 An explanation of the decision, including the supporting coverage or clinical rationale.

3.2.5 A copy of the relevant medical records used to make the determinations.

3.2.6 Any and all applicable internal rules, guidelines, protocols, or similar criteria used in the decision process.

3.2.7 The titles and qualifications of the individual(s) participating in the appeal review that were not involved with the initial decision, and not a subordinate of the initial reviewers.

3.2.8 A copy of all correspondence with the appellant including the initial decision letter as well as the reconsideration letter sent to the appellant, using one of the CMS approved or “deemed approved” template letters.

3.2.9 Attach a copy of the packet to the External Review case in the System of Record.

3.2.10 Close the 1st level appeal case.

3.3 Tracking External review- The Administrative Specialist will hold the external case in a pending status to track return of the decision and contact the CMS designated external review org. if there is a delay in response.

3.4 Receipt of External review decision

3.4.1 Admin attaches decision to the External review case.

3.4.2 If the External reviewer upholds the KPWA determination, the Administrative Specialist enters the Outcome – ‘Uphold’ and Outcome reason ‘same as appeal’ in the External case and closes it by entering the complete date and changing the pend status to complete. Email the Coordinator and Clinician reviewer with outcome.

3.4.3 If External reviewer overturns the KPWA determination, the Administrative Specialist Outcome – ‘Overturn’ and Outcome reason as appropriate, changes the pend status to effectuation/followup, enters the complete date and sends email with case result to the Coordinator, Preservice director, manager, clinician reviewers, and others who need to as needed such as Care manager or Behavior Health services.

**Effectuation**

1. If the initial adverse organizational determination is overturned as a result of an internal or external appeal review, the Member Appeals Coordinator must assure effectuation of the service approval as expeditiously as the enrollee’s health condition requires but no later than 30 calendar days from the date the request for reconsideration was received by KPWA for pre-service (or 44 days if extension is issued) and 60 calendar days for post-service appeal requests.

2. The Member Appeal Coordinator will initiate, track, and assure complete correction of an overturned decision and/or process issue.
3. For a pre-service request overturned by CMS’s designated external review organization authorization must be complete within 72 hours from the date the notice reversing the determination was received or provide the service as expeditiously as the enrollee’s health requires but no later than 14 calendar days from that date.

4. For requests of payment, overturned by CMS’s designated external review organization KPWA must pay for the services no later than 30 calendar days from the date it received notice reversing KPWA’s determination. The appropriate department is notified by the Member Appeals Coordinator for implementation of the request. The Member Appeals Coordinator’s request is made via a Customer Service system request.

5. The Member Appeals Coordinator sends written notification to External reviewer and to the Medicare enrollee within 30 calendar days, stating that the coverage is authorized. In cases involving skilled nursing facility stays, the Member Appeals Coordinator will notify Nursing Home Services, Home Health or Behavioral Health Services as needed of External reviewer’s overturn so that authorization of the services can be made.

6. Document the request and completion and notify appropriate entities.

7. Mark the case complete when all effectuation is complete.

APPLICABILITY:

This policy applies to standard preservice and post service member appeals for Kaiser Foundation Health Plan of Washington Medicare Advantage (H5050) and Kaiser Foundation Health Plan of Washington Options PPO Medicare Advantage plan (H2810) excluding the following:

Medicare ExpeditedAppeal requests (see procedure MA 002. Kaiser Foundation Health Plan of Washington will process requests on an expedited basis when requested and the treating or reviewing physician, with knowledge of the member’s medical condition, determines that the member’s life, health, or ability to regain maximum function could be jeopardized, or that severe pain would be prolonged.

Adverse organizational determinations that are provider responsibility.

SCOPE:

The policy applies to the handling of a member’s, or his/her representative (including the referring or referred-to physician), request to modify a previous organizational determination made by the health plan. When a adverse organizational determination is upheld at the Kaiser Foundation Health Plan of Washington Medicare Advantage appeal level, the appeal case file is automatically forwarded by the Kaiser Foundation Health Plan of Washington Appeals Coordinator to CMS's contracted Independent Review Entity for the next level of review.

DEFINITIONS:

Appeal: 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 as defined in 42 CFR 422.566(b). These procedures include reconsideration by the Medicare health plan and if necessary, an independent review entity, hearings before Administrative Law Judges (ALJs), review by the Medicare Appeals Council (MAC), and judicial review.

Complaint: Any expression of dissatisfaction to a Medicare health plan, provider, facility or Quality Improvement Organization (QIO) by an enrollee made orally or in writing. This can include concerns about the operations of providers or Medicare health plans such as: waiting times, the demeanor of health care personnel, the adequacy of facilities, the respect paid to enrollees, the claims regarding the right of the enrollee to receive services or receive payment for services previously rendered. It also includes a plan’s refusal to provide services to which the enrollee 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 and/or appeal process.

Effectuation: Compliance with a reversal of the Medicare health plan’s original adverse organization determination. Compliance may entail payment of a claim, authorization for a service, or provision of services.
Enrollee: A Medicare Advantage eligible individual who has elected a Medicare Advantage plan offered by an MA organization, or a Medicare eligible individual who has elected a cost plan or HCPP.

Grievance: Any complaint or dispute, other than one involving 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. An expedited grievance may also include a complaint that a Medicare health plan refused to expedite an organization determination or reconsideration, or invoked an extension to an organization determination or reconsideration time frame. 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.

Independent Review Entity: An independent entity contracted by CMS to review Medicare health plans’ adverse reconsiderations of organization determinations.

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.

Medicare Advantage Plan: A plan as defined at 42 CFR. 422.2 and described at 422.4.


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

- Payment for temporarily out of the area renal dialysis services, emergency services, post-stabilization care, or urgently needed services,
- 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,
- 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,
- Discontinuation of a service if the enrollee believes that continuation of the services is medically necessary, or
- 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.

REFERENCES:

Medicare managed Care Manual Chapter 13 sections 60-70

RESPONSIBILITIES:

TRAINING:

All Kaiser Foundation Health Plan of Washington Member Appeals staff will review Chapter 13 annually.

AUDIT:

Management will assure an internal audit of Medicare Member Appeal cases.

Review Services management team is responsible for implementation and oversight of this procedure and process.

REFERENCES:
1. NCQA UM 8 & 9
2. WAC 284-43-620
3. Medicare managed Care Manual 60-70

**Authorized HPD Authority:** Candace Carroll, Executive Director Review Services **Designated Content Expert:** Laura Colman, Manager, Review Services, Member Appeals

**Related Policies, Documents and References:**

**Documents which refer to this document:**

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