network health

n05269

Appeal and Grievance Resolution Policy for Medicare Advantage and Medicare Advantage Prescription Drug Plans

Values

Accountability ● Integrity ● Service Excellence ● Innovation ● Collaboration

Abstract Purpose:

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

Policy Detail:

NHIC maintains procedures for standard and expedited (urgent) appeals, quality of care grievances (policy n00226) and standard and expedited (urgent) grievances in accordance with state and federal law, CMS regulations, Chapter 13 of the Medicare Managed Care Manual/Chapter 18 of the Medicare Prescription Drug Benefit Manual, and NCQA Health Plan standards and guidance. NHIC has an impartial process for resolving Member disputes and responding to Member requests to reconsider decisions made by the plan.

Communications regarding all available appeal and grievance procedures are provided to Members or their authorized representatives in a culturally and linguistically appropriate manner. In accordance with policy n05613 Language and Alternate Format Access Policy, NHIC follows all CMS rules, regulations and other guidelines to ensure Members or their authorized representatives with limited English proficiency are able to communicate with plan representatives regarding all levels of appeals and grievances.

I. **Distinguishing Between Appeals and Grievances:**

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

II. **Receipt and Documentation**

A. NHIC fully documents and investigates all appeals, including aspects of clinical care involved and documents any actions taken.

B. NHIC monitors, tracks, and trends appeals and grievances in a central database maintained by the Appeals and Grievance Department. Appeals and Grievances are to NHIC leadership as needed.

C. Members may designate an authorized representative to act on their behalf throughout the appeal or grievance process.

1. If an authorized representative is designated to act on behalf of the Member, appropriate documentation outlining appropriate authority must be provided to Network Health before the appeal or grievance can be processed.

D. The Member or their authorized representative may submit an appeal or grievance to NHIC within 60 calendar days after notification of the decision or the incident that precipitates the appeal or grievance.

1. NHIC may accept appeals or grievances beyond the 60 day timeframe in accordance with CMS good cause exceptions.

E. NHIC accepts appeals and grievances in verbal and written format and the Member or their representative may submit any additional supporting documentation for review.

1. A Member or authorized representative who files a quality-of-care grievance with a QIO is not required to file the grievance within a specific time period. Therefore, quality of care grievances filed with a QIO may be filed and investigated beyond the 60-day time frame.

F. All appeals and grievances received at NHIC are investigated and resolved in a consistent and timely manner, in accordance with CMS and NCQA standards.

G. The expedited process is followed when an expedited request is made by the Member's physician and/or whenever an appeal has been determined to be of an urgent/expedited clinical nature or should be downgraded to a standard appeal.

1. When a Member's appeal is downgraded to a standard timeframe, a notification is provided to the Member along with expedited grievance rights. The Member has continued coverage pending the outcome of an appeal.

III. **Plan Review**

A. NHIC employs at least one medical director who is responsible for ensuring the clinical accuracy of all organization determinations and reconsiderations involving medical necessity.

B. The medical director must be a physician with a current license to practice medicine in a State, Territory, Commonwealth of the United States or the District of Columbia.

C. When an appeal or grievance requires medical review, NHIC uses at least one practitioner of the same or similar specialty to review an appeal, and appoints a new practitioner to review the appeal who was not involved in the initial determination and is not a subordinate of the person involved with the initial determination.

D. Appeals and grievances related to benefits and coding and not requiring the review of clinical teams will be routed accordingly to the appropriate subject matter expert.

E. Review is conducted within the timeframes required for each process, as outlined below.

IV. **Grievances**

A. **Standard:** responded to as expeditiously as the Member's case requires, and no later than 30 calendar days from the date the oral or written request is received. under

1. The day NHIC receives the grievance is considered day zero, and the 30-day period starts the day after the grievance is received.

2. NHIC may extend the thirty (30) day standard timeframe by fourteen (14) days if the Member requests the extension or if NHIC justifies a need for additional information and documents how the delay is in the interest of the Member, in accordance with 42 CFR 422.564(e)(2).

B. **Expedited:** Must be responded to within 24 hours

C. NHIC will respond to all QOC grievances in accordance with policy n00226

V. **Appeals**

A. The timeframe for which NHIC is required to respond to an adverse organization determination (Part C) or adverse coverage determination (Part D) depends on the type of request. Below are the types of requests and timing of Organization Decision requirements.

1. **Standard:**

a. Part C Pre-service request- Within 30 calendar days after receipt of request

b. Part B Drug request - Within 7 calendar days after receipt of request

c. Part C Claims/Post-Service Requests- Within 60 calendar days after receipt of request

d. Part D Drug Request - Within 7 calendar days after receipt of request

2. **Expedited:**

a. Part C Pre-Service or Benefit - Within 72 hours after receipt of request

b. Part B Drug Request - Within 72 hours after receipt of request

c. Part D Drug Request - Within 72 hours after receipt of request

B. Network Health accepts requests for extensions due to good cause as set forth in Chapter 13 of the Medicare Managed Care Manual and in accordance with NHIC's Medicare Part C and D Procedure with the rules set forth in Chapter 13 of the Medicare Managed Care Manual and 42 CFR §§422.564(e)(2) or 423.564(e)(2).

VI. Dismissal or Withdrawal of an Appeal or Initial Determination Request

A. NHIC will dismiss requests for an initial determination under any of the following circumstances:

1. The individual or entity making the request is not permitted to request an initial determination under the applicable regulation.
2. NHIC determines that the individual or entity making the request failed to make a valid request for an initial determination that substantially complies with 42 CFR §§ 422.568(a) or 423.568(a). In addition, under Part D, a Member may not request a tiering exception for an approved non-formulary prescription drug. See: 42 CFR § 423.578(c)(4)(iii). In this circumstance, a plan would dismiss the request and issue a dismissal notice in accordance with the notice requirements at § 40.15.1.
3. The Member dies while the request is pending and the Member's spouse or estate has no remaining financial interest in the case and no other individual or entity with a financial interest in the case wishes to pursue the initial determination. Financial interest means having financial liability for the item(s) or service(s) underlying the coverage request.
4. The individual or entity who requested the review submits a timely verbal or written request for withdrawal of their request for an initial determination with NHIC.
5. When NHIC's dismissal is due to a timely withdrawal request, NHIC is required to dismiss the initial determination request and issue a dismissal notice in accordance with the notice requirements at section 40.15.1 in order to preserve the rights of other proper parties to the decision who may wish to request review of the dismissal. Withdrawn requests and dismissals will be reported separately in their distinct categories, per existing reporting requirements.

B. Dismissal Binding Unless Modified, Reversed or Vacated

1. NHIC's dismissal of an initial determination request is binding unless it is modified or reversed by NHIC upon appeal or the dismissal is vacated for good cause. Upon receipt of a request to review a dismissal, NHIC will conduct an appeal in accordance with §50 of this guidance, including the applicable adjudication timeframes for redeterminations and reconsiderations.

C. Requests for Review of a Dismissal of an Initial Determination Request

1. If a party appeals NHIC's dismissal of an initial determination request and NHIC determines that its dismissal was in error, NHIC reverses the dismissal and processes the request for coverage in accordance with applicable adjudication timeframes and notice requirements. The timeframe for the initial determination begins on the date/time of NHIC's decision to reverse its dismissal.
2. If a party appeals NHIC dismissal of an initial determination request and NHIC upholds its dismissal, there is no further right to appeal the dismissal to a higher-level adjudicator. However, in addition to the right to appeal a dismissal, a member has the right to request that NHIC vacate the dismissal action.

D. **Requests to Vacate Dismissal of an Initial Determination Request**

1. A plan may vacate its own dismissal if good cause is established within 6 months of the date of the notice of the dismissal. A plan may find good cause to vacate a dismissal if, for example, NHIC determines the dismissal was issued in error because the documentation in the administrative case file shows the reason for dismissing the request was incorrect. For examples of where good cause may exist. If a party submits a request to vacate a dismissal of an initial determination request and the request contains sufficient evidence or other documentation that supports a finding of good cause for vacating, NHIC makes a favorable good cause determination. Once NHIC makes a favorable good cause determination, it vacates its prior dismissal action and performs an initial determination consistent with the timeframes at § 40.10. Where a finding for good cause is made, NHIC should document the reason for that finding in the case file.

2. If NHIC does not find good cause to vacate the dismissal, the dismissal remains in effect. NHIC issues a letter (not a dismissal notice) explaining that good cause has not been established and the dismissal cannot be vacated. NHIC should explain in clear language why the information submitted with the request to vacate the dismissal does not establish good cause to vacate the dismissal action.

E. **Dismissal Notice**

1. When NHIC dismisses a level 1 appeal or initial determination request, NHIC will mail or otherwise transmit a written notice of the dismissal to the parties at their last known address by the conclusion of the applicable adjudication timeframe. The dismissal notice must state all of the following:

   a. The reason for the dismissal;

   b. The right to request that NHIC vacate the dismissal action; and

   c. The right to request review of the dismissal.

2. Consistent with the timeframe for requesting a timely appeal, a request for review of a dismissal must be filed with the IRE within 60 calendar days from the date of NHIC's dismissal notice.

VII. **Withdrawal:**

A. The party who files a request for reconsideration or grievance may submit a written request to NHIC asking to withdraw the request. If a written withdrawal request is received by NHIC before it has mailed its reconsideration decision, then NHIC may withdraw the appeal. However, if the withdrawal request is received after NHIC has forwarded a reconsideration case to Maximus, then NHIC must forward the withdrawal request to Maximus for processing. As of January 1, 2022, verbal withdrawal requests are permitted and a written notice of dismissal must be provided in response to all withdrawal requests, written or verbal

VIII. **Independent Review**

A. Part C organizational determinations appeals resulting in an upheld decision by Network Health will be forwarded to the designated Independent Review Entity (IRE) in accordance with all applicable regulations and timelines, along with all

required documentation.

1. If the IRE upholds NHIC's decision and a member evokes further appeal rights, NHIC will collaborate and follow all applicable guidelines.
2. If the IRE overturns an appeal, NHIC may request to reopen the appeal in accordance with the guidelines for reopening.
3. When NHIC's decisions is overturned or partially overturned by the IRE or other applicable entity, NHIC will process the claim, authorize or provide the service or benefits as expeditiously as the Member's health condition requires and no later than the timeframes as outlined in the guidance.

B. Part D when an organization determination results in an upheld appeal for Part D, the Member and/or provider are notified of their rights to submit directly to the Part D IRE.

IX. **Plan Response**

A. NHIC responds to all written and verbal appeals and grievances in writing. Members or their authorized presentative are notified of the organization's decision, along with applicable information regarding further appeal rights, the Members right to file a written compliant with the Quality Improvement Organization (QIO) within the timeframes outlined above.

B. All Appeal response notifications will include:

1. The reason for NHICs decision and as applicable reason for upholding or overturning the denial
2. Information and terms specific to the Members condition and request
3. References to the benefit provision, guideline, policy, protocol or other similar criterion on which the appeal or grievance decision is based.
4. The title, role or position of the person making the decision

C. Members are notified of their right of access to and copies of all documents relevant to the appeal, free of charge, upon request and upon request lists of titles and qualifications, including specialties, of individuals participating in the appeal review.

Definitions:

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

Appeal: As defined at 42 CFR §422.561 and §423.560, the procedures that deal with the review of adverse initial determinations made by NHIC on health care services or benefits under Part C or D the Member believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the Member) or on any amounts the Member must pay for a service or drug as defined in 42 CFR §422.566(b) and §423.566(b). These appeal procedures include a plan reconsideration or redetermination (also referred to as a level 1 appeal), a

reconsideration by an independent review entity (IRE) currently Maximus / C2C, adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (Council), and judicial review.

C2C Solutions, Inc: Part D IRE See *Independent Review Entity (IRE)*

Complaint: Any expression of dissatisfaction to a Medicare health plan, provider, facility or Quality Improvement Organization (QIO) by a Member 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 Members, the claims regarding the right of the Member to receive services or receive payment for services previously rendered. It also includes NHIC refusal to provide services to which the Member believes he or she is entitled. A complaint could be either an appeal or grievance, or a single complaint could include elements of both. Every complaint must be handled under the appropriate appeal and/or grievance process.

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

Dismissal: A decision not to review a request for a grievance, initial determination, or appeal because it is considered invalid or does not otherwise meet Medicare Advantage or Part D requirements.

Effectuation: Authorization or provision of a benefit that a plan has approved, payment of a claim or compliance with a complete or partial reversal of NHIC original adverse determination.

Expedited Appeal (Reconsideration): A Member, Member's representative or any physician or physician's office staff (regardless of whether the physician is affiliated with the Medicare health plan) may request that NHIC expedite an appeal when the Member or his/her physician believes that waiting for a decision under the standard timeframe could place the Member's life, health, or ability to regain maximum function in serious jeopardy. Expedited determinations may not be requested for cases in which the only issue involves a claim for payment for services that the Member has already received. However, if a case includes both a payment denial and a pre-service denial, the Member has a right to request an expedited appeal for the preservice denial. A Member or representative will receive a fast decision on expedited appeals that meet the above criteria within seventy-two (72) hours of receipt, except as allowed by CMS to extend the timeline.

Grievance: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. A grievance does not include, and is distinct from, a dispute of the appeal of an organization.

Independent Review Entity (IRE): An independent entity contracted by CMS to review adverse level 1 appeal decisions made by NHIC. Under Part C, an IRE can review plan dismissals (Maximus or C2C).

Inquiry: Any verbal or written request for information to a plan or its delegated entity that does not express dissatisfaction or invoke NHIC grievance, coverage or appeals process, such as a routine question about a benefit.

Maximus: See *Independent Review Entity (IRE)*

Member: An individual enrolled in a NHIC Medicare Advantage plan.

Organization Determination: Any determination made by NHIC with respect to any of the following:

1. Payment for temporarily out of the area renal dialysis services, emergency services, post-stabilization care, or urgently needed services;
2. Payment for any other health services furnished by a provider other than the Medicare health plan that the Member believes are covered under Medicare, or, if not covered under Medicare, should have been furnished, arranged for, or reimbursed by the Medicare health plan;
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 Member believes should be furnished or arranged for by the Medicare health plan;
4. Reduction, or premature discontinuation of a previously authorized ongoing course of treatment;
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 Member with timely notice of an adverse determination, such that a delay would adversely affect the health of the Member; or
6. For 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 Member had to pay for a service.

Post Service Appeal: Any written request to change an adverse determination for care or services that have already been received by the Member.

Pre-Service Appeal: Any written or verbally submitted request to change an adverse determination for care or service that the organization must approve, in whole or in part, in advance of the Member obtaining care or services.

Quality of Care Grievance: A grievance related to whether the quality of covered services provided by a plan or provider meets professionally recognized standards of health care, including whether appropriate health care services have been provided or have been provided in appropriate settings. A quality of care complaint may be filed through NHIC's grievance process and/or a Quality Improvement Organization (QIO). A QIO must determine whether the quality of services (including both inpatient and outpatient services) provided by a Medicare health plan or its network of providers meets professionally recognized standards of health care, including whether appropriate health care services have been provided and whether services have been provided in appropriate settings.

Quality Improvement Organization (QIO): Organizations comprised of practicing doctors and other health care experts under contract to the Federal government to monitor and improve the care given to Medicare Members. QIOs review complaints raised by Members about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities (SNFs), home health agencies, Medicare health plans, and ambulatory surgical centers. The QIOs also review continued stay denials for

Members receiving care in acute inpatient hospital facilities as well as coverage terminations in skilled nursing facilities, home health agencies, and comprehensive outpatient rehabilitation facilities (CORFs).

Reconsideration: Under Part C, the first level in the appeals process which involves a review of an adverse organization determination by an MA plan, the evidence and findings upon which it was based, and any other evidence submitted by a party to the organization determination, the MA plan or CMS. Under Part D, the second level in the appeals process which involves a review of an adverse coverage determination by an independent review entity (IRE), the evidence and findings upon which it was based, and any other evidence the Member submits or the IRE obtains. As used in this guidance, the term may refer to the first level in the Part C appeals process in which the MA plan reviews an adverse Part C organization determination or the second level of appeal in both the Part C and Part D appeals process in which an independent review entity reviews an adverse plan decision.

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

Reopening: A remedial action taken to change a binding determination or decision even though the determination or decision may have been correct at the time it was made based on the evidence of record.

Representative: Under Part C, as defined in §422.561, an individual appointed by a Member or other party, or authorized under state or other applicable law, to act on behalf of a Member or other party involved in a grievance, organization determination, or appeal. Under Part D §423.560 defines "representative" as an individual either appointed by a Member or authorized under state or other applicable law to act on behalf of the Member in filing a grievance, obtaining a coverage determination, or in dealing with any of the levels of the appeals process. For both Part C & Part D, unless otherwise provided in the applicable law, the representative will have all of the rights and responsibilities of a Member or other party, as applicable.

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

Withdrawal: A voluntary verbal or written request to rescind or cancel a pending grievance, initial determination, or appeal request submitted by the same party.

Regulatory Citations:

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

Code of Federal Regulations Title 42, Part 422, Subpart M, and Chapter 13 of the Medicare Managed Care Manual.

§1154(a)(14) of the Social Security Act for Quality of Care Complaints.

NCQA Standards UM8, UM9, UM12, ME7

Related Policies:

n00226 Quality of Care Complaint Policy

n05613 Language and Alternate Format Access Policy

Related Documents:

Medicare Part C Procedures

Medicare Part D Procedures

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