

# The Who, What, Where, and When of Appeals and Grievances

Tufts Health Plan Senior Care Options

Reviewed March 2021



1

## Grievances defined

**“Any expression of discontent”**

Per CMS: A grievance is 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 or prescription drug services or benefits, regardless of whether remedial action is requested.

<https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Grievances>



2

## Member Rights

- You can file a complaint about services you got, other concerns or problems you have in getting health care, or the quality of the health care you got.
- If you're concerned about the quality of the care you received, you have the right to file a complaint.
- If you have a Medicare Advantage Plan, Medicare drug plan, or other Medicare health plan, call the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO), your plan, or both.

BFCC-QIO for MA & CT  
is **KEPRO**

<https://www.keproqio.com>

<https://www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf>



3

3

## What is the health plan's responsibility?

- As a Medicare plan, CMS requires that THP have:
  - A meaningful procedure for the timely resolution of grievances between enrollees and the plan or any of its delegated entities
  - A written grievance procedure, provided to members upon enrollment, involuntary disenrollment, annually and upon request
- In the plan's grievance process:
  - Enrollees are not required to use specific language to initiate a grievance
  - The Plan must consider grievances separately from inquiries, coverage requests or appeals – customer service representatives receive additional training to make these determinations and route them appropriately



4

4

## Types of grievances

- Administrative Grievance: A complaint concerning business processes of the health plan; These grievances may be resolved over the phone during the member's initial call, but can still be recorded as a grievance
- Clinical Grievance: A complaint concerning the quality of care a member received; These grievances may also be reviewed by Clinical Quality/QM after A&G completes their review
- Expedited Grievance: If a member disagrees with Tufts Medicare Preferred decision to extend the timeframe for a determination or Tufts Medicare Preferred refuses to grant an expedited OD, CD, or Appeal, this complaint is considered an expedited grievance

Appeals & Grievances reviews each grievance to determine what type it is and how it needs to be responded to



5

5

## What should I do if I receive a member complaint?

1. LISTEN.
2. Make sure you understand the complaint. Ask questions to check for understanding.
3. If you can offer one or more solutions, ask if the member would be interested or if the solution(s) would help.
4. Ask, "**Would you like to file this complaint as a grievance? That will allow Tufts Health Plan to document and investigate so we can improve our program.**"



6

6

## Filing a grievance

Assist the member in contacting  
Member Relations at **1-855-670-5934**

or

Document in CaseTrakker with a Grievance Note, then  
email to [AG\\_Coordinator\\_Team@tufts-health.com](mailto:AG_Coordinator_Team@tufts-health.com)

You are not responsible for categorizing, investigating or responding to member grievances, but the process must be offered to members for all complaints.

## What? – Reconsiderations

- Medicare Part C Reconsideration – Definition
  - An enrollee's first step in the appeal process after an adverse organization determination
  - A Medicare health plan or Independent Review Entity (IRE) may reevaluate an adverse OD, the findings upon which it was based, and any other evidence submitted or obtained
- Additional Part C Appeal Guidelines
  - Standard Part C Appeals must be submitted in writing
  - Expedited Appeals may be submitted orally by member or physician
  - Appeals must be filed within 60 calendar days from the denial notification unless "just cause" is shown
  - The member, their authorized representative, or treating provider can request a reconsideration (providers do not have to be an authorized representative to file an appeal on the member's behalf)

## What? – Reconsiderations

- Medicare Part D Reconsideration – Definition
  - The first level of the appeal process, which involves a Part D plan sponsor reevaluating an adverse coverage determination, the findings upon which it was based, and any other evidence submitted or obtained
- Additional Part D Appeal Guidelines
  - Standard Part D Appeals can be submitted orally or in writing
  - Expedited Appeals may be submitted orally by member or physician
  - Appeals must be filed within 60 calendar days from the denial notification unless “just cause” is shown
  - The Plan has to accept and process expedited Part D appeals 24/7
  - The member, their authorized representative, or treating provider can request a reconsideration (providers do not have to be an authorized representative to file an appeal on the member’s behalf)



9

9

## Where?

### Appeals

- Reconsideration decisions are made in a weekly multidisciplinary appeals committee
- All upheld Reconsiderations must be forwarded to the IRE
- Redetermination decisions are made by covering MD

### Grievances

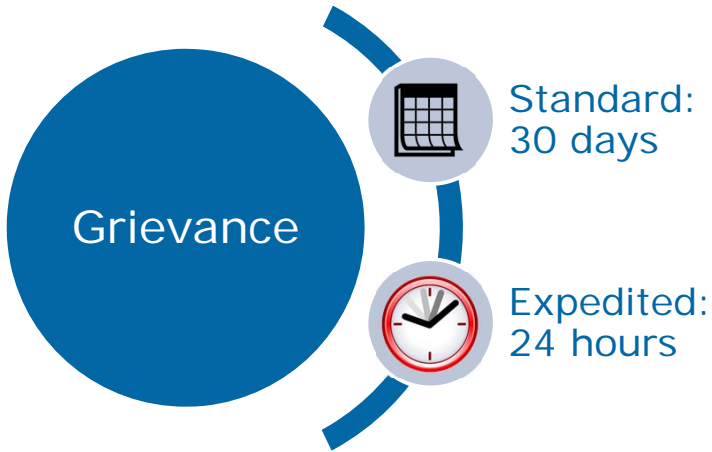
- Administrative Grievances can be responded to by phone or in writing
- Clinical Grievances and Grievances received in writing must always be responded to in writing



10

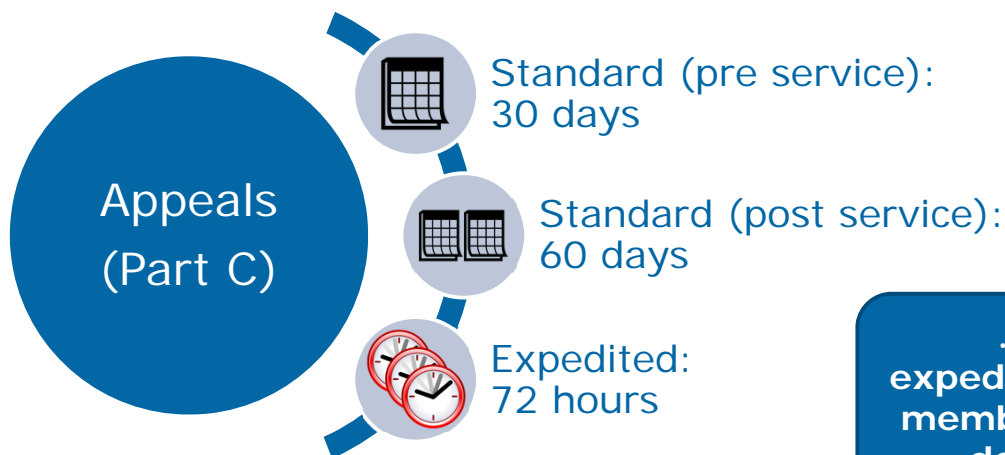
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## When? – Timeframes



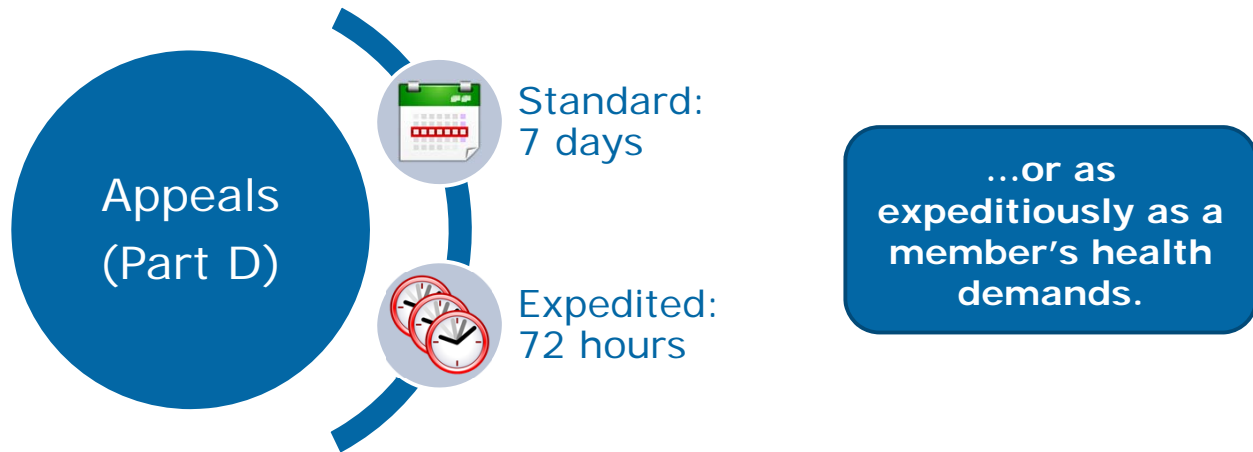
...or as expeditiously as a member's health demands.

## When? – Timeframes



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## When? – Timeframes



13

13

## Documentation **Do**s and **Do Not**s

### Do

- Document completely, clearly, concisely and accurately
- Document in a timely manner (in real time/on the date of communication)
- Use spellcheck/proper grammar
- Use only standardized, acceptable abbreviations
- Document with both current and future viewers/reviewers of the record in mind

### Do Not

- Document prior to the event
- Copy and paste emails into member records
- Editorialize or include unnecessary emotion
- Give excuses or place blame
- Explicitly document when issues are referred to Quality Management

14

14

## SCO Appeals & Grievances Contacts

For further information on filing an appeal or grievance – contact the **Tufts Health Plan SCO Member Services** at **1-855-670-5934**

For further information on filing an appeal through the Executive Office of Health and Human Services (EOHHS), contact the following:

Board of Hearings  
Office of Medicaid  
100 Hancock Street, 6th Floor  
Quincy, MA 02171  
Phone: 1-617-847-1204  
Fax: 1-617-847-1200

