



## **CMA WEEKLY ALERT**

### **CHANGES IN MEDICARE ADVANTAGE GRIEVANCE AND APPEALS PROCESS**

As of March 22, 2005, significant changes were made to the Medicare Advantage (MA) grievance and appeals process which will help beneficiaries move through the process more efficiently. (70 Federal Register 4587, January 28, 2005). Grievances address matters such as hours and location of services, quality of staff, and staff and enrollee interactions. The appeals process is separate and addresses the appropriateness of a denial, reduction, or termination of a service or coverage.

#### **Grievances**

Grievances must be filed with the MA plan either orally or in writing. They must be filed no later than 60 days after the event or incident giving rise to the grievance. The MA plan must notify the enrollee of its decision as expeditiously as possible, based on the enrollee's health status, but no later than 30 days of receipt of the grievance.

MA organizations may extend the 30 day time frame by up to 14 days if the enrollee requests the extension, or if the organization justifies a need for extension and shows that the extension is in the interest of the enrollee. If the organization extends the deadline, it must notify the enrollee in writing of the reasons for the delay. All grievances submitted in writing must be responded to in writing. Grievances submitted orally may be responded to either orally or in writing, unless the enrollee requests a written response.

Grievances related to quality of care, regardless of how filed, must be responded to in writing and must include a description of the enrollee's right to file a written complaint with the Quality Improvement Organization (QIO). The MA organization must cooperate with the QIO in resolving the quality of care complaint.

#### **Appeals**

##### Organization Determinations

*Standard timeframes and notice* – The MA organization must issue a response as expeditiously as the enrollee's health condition requires, but no later than 14 calendar days after the day the organization receives a request for a standard review. The MA plan may extend the timeframe by up to 14 calendar days upon request of the enrollee or of the MA organization if it justifies the need for the extension and shows how the delay

is in the interest of the enrollee. If an MA organization decides to deny service or payment in whole or in part, or if an enrollee disagrees with an MA organization's decision to discontinue or reduce the level of care for an ongoing course of treatment, the organization must give the enrollee written notice of the determination.

*Expediting certain organizational determinations* – The MA organization must inform the enrollee of their right to file an expedited grievance if the enrollee disagrees with the MA organization's decision not to expedite.

*Timeframe and notice requirements for expedited organization determinations* – Expedited determinations must be completed within 72 hours. The MA organization may extend the 72-hour time period for making an expedited organization determination deadline by up to 14 calendar days if the enrollee requests it or if the organization justifies the need for extension and shows how the delay is in the interest of the enrollee. When the organization extends the deadline, it must notify the enrollee in writing of the reasons for the delay and inform the enrollee of the right to file an expedited grievance if he or she disagrees with the MA organization's decision to grant an extension.

### Standard Reconsideration

A party to an organization determination must ask for a reconsideration of the determination by making a written request to the MA organization that made the organization determination. The MA organization may adopt a policy for accepting oral requests. A party must file a request for reconsideration within 60 calendar days from the date of the notice of the organization determination. If a party shows good cause, the MA organization may extend the timeframe for filing a request for reconsideration. With respect to services, reconsiderations completely favorable to the enrollee must be issued as expeditiously as the beneficiary's health conditions requires, but not later than 30 calendar days from the date the MA organization received the request for a standard review.

*Expedited reconsiderations*- Expedited determinations must be completed within 72 hours. The MA organization may extend the 72 hour deadline by up to 14 calendar days if the enrollee requests the extension or if the organization justifies a need for additional information. The organization must notify the enrollee in writing with reason for the delay, provide an explanation of the enrollee's right to file an expedited grievance, and make its decision no later than upon the expiration of the extension.

### Right to a Hearing

If the amount remaining in controversy after reconsideration meets the threshold requirement established annually by the Secretary, any party to the reconsideration (except the MA organization) who is dissatisfied with the reconsideration determination has a right to a hearing before an Administrative Law Judge (ALJ). The amount remaining in controversy, which can include any combination of Part A and B services, is computed annually by the Secretary. In requesting an ALJ hearing, a party must file a

written request for a hearing with the entity specified in the Independent Review Entity's (IRE) reconsideration notice. Except when an ALJ extends the timeframe, a party must file a request within 60 days of the notice of a reconsideration determination. Any dissatisfied party, including the MA organization, may request Medicare Appeals Council (MAC) review of the ALJ decision or dismissal.

#### Medicare Appeals Council (MAC)

Any party to the hearing, including the MA organization, who is dissatisfied with the ALJ hearing decision, may request that the MAC review the ALJ's decision or dismissal.

#### Judicial Review

The amount in controversy for judicial review is to be established annually by the Secretary. Any party, including the MA organization, may request judicial review (upon notifying the other parties) of an ALJ's decision if the MAC denied the party's request for review.

#### Reopening and Revising Determinations and Decisions

An organization or reconsidered determination made by an MA organization, a reconsidered determination made by the IRE or the decision of the ALJ or the MAC that is otherwise final and binding may be reopened and revised by the entity that made the determination or decision.

#### Notification of Non-Covered Inpatient Hospital Care

Before discharging an individual or changing the level of care in an inpatient hospital setting, the MA organization must obtain the concurrence of the physician responsible for the enrollee's inpatient care. When applicable, the written notice of non-coverage must be issued no later than the day before hospital coverage ends.

The grievance and appeals changes outlined above add specificity and clarity to beneficiary protections in MA plans. As such, beneficiaries have at their disposal a more vigorous set of tools for complaint and appeals resolution, including expedited review.

For a more detailed look at these changes click [HERE](#). If you have further questions on this topic, please contact Brad Plebani in the Center for Medicare Advocacy's Connecticut office at 860-456-7790 or [bplebani@medicareadvocacy.org](mailto:bplebani@medicareadvocacy.org), or Vicki Gottlich or Alfred Chiplin in the Center's Washington, DC office at 202-216-0028, [vgottlich@medicareadvocacy.org](mailto:vgottlich@medicareadvocacy.org), [achiplin@medicareadvocacy.org](mailto:achiplin@medicareadvocacy.org).