MASS ADVANTAGE
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APPEALS AND GRIEVANCES

Introduction

Mass Advantage members have the right to communicate dissatisfaction with the quality of care that they receive, the timeliness of services, or decisions made by Mass Advantage or its providers. CMS separates these into two categories: grievances and appeals.

A "grievance" is any expression of dissatisfaction by a member made verbally or in writing related to any aspect of the operations, activities or behavior of Mass Advantage or its delegated entities in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken.

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. Examples of grievances include complaints about:

- Timeliness, appropriateness, access to, and/or setting of a provided health service, procedure, or item.
- Any matter pertaining to the contractual relationship between the member and Mass Advantage.
- Availability, coverage, delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to our utilization review programs.
- Claims payment, handling, or reimbursement for health care services.
- Adequacy of facilities, providers, or other similar issues.
- If the member disagrees with our decision to process your appeal request for a service or to continue a service under the standard 30 calendar day time frame rather than the expedited 72-hour time frame.

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.

Providers must direct Mass Advantage members with complaints to Mass Advantage Member Services. to see the *How to File a Grievance* section below for specific instructions. Federal law guarantees a member's right to make complaints regarding concerns or problems with any part of their medical care as a plan member. The Medicare program has set forth requirements for the filing and processing of member complaints. If a member or authorized representative files a complaint, we are required to follow certain processes when we receive it. We must be fair in how we handle it, and we are not permitted to disenroll or penalize a member in any way for making a complaint.

How to File a Grievance

Generally, grievances should be filed directly with Mass Advantage, but for matters related to quality of care, members also have the opportunity to file such complaints with a Quality Improvement Organization (QIO).

Members are encouraged to contact Mass Advantage Member Services first in order to be provided with immediate assistance. Our staff will try to resolve any complaint over the telephone. If a written response is required or requested, one will be provided. Mass Advantage employs a formal, multi-disciplinary process to review member grievances.

When can a Grievance be filed?

Members may file the grievance within 60 calendar days after they had the experience for which they are submitting the grievance.

Filing a grievance with Mass Advantage

The process for filing a grievance is different from the process for coverage decisions and appeals. Members are encouraged to contact Mass Advantage promptly either by phone or in writing if they would like to file a grievance at the following numbers:

- HMO: 1-844-918-0114
- PPO: 1-844-915-0234
- TTY: 711

Mass Advantage may be able to provide an immediate response to complaints submitted by phone.

Member Services also has free language interpreter services available for non-English speakers.

Complaints can also be submitted in writing to:

Mass Advantage, P.O. Box 1285, Maryland Heights, MO 63043.

OR

By e-mail for grievances related to Part D Prescription Drugs to: MedDResponseTeam@magellanhealth.com.

OR

By fax at 1-888-904-1139

Expedited Grievance

Members have the right to request an expedited grievance if they disagree with Mass Advantage's decision to take an extension or decision to process an expedited level 1 appeal as a standard level 1 appeal.

Mass Advantage will process this grievance as an expedited grievance and will respond within twenty-four (24) hours of receipt.

Standard Grievances

If possible, Mass Advantage will respond immediately on grievances filed verbally. Also, if the Member's health condition requires us to answer quickly, we will do that.

Most complaints are answered within 30 calendar days. If we need more information and the delay is in the Member's best interest or if the Member requests additional time, Mass Advantage can take up to 14 more calendar days (44 calendar days total) to answer a complaint. If we need additional days for review, Mass Advantage will inform the Member writing.

If the Member requests a written response, they are required to file a written grievance. If the complaint is regarding a quality of care, Mass Advantage will respond in writing. Otherwise, we may provide a verbal response.

Filing a Grievance with Medicare

Members can submit a complaint about Mass Advantage Basic (HMO) directly to Medicare online at www.medicare.gov/MedicareComplaintForm/home.aspx.

Medicare takes all complaints seriously and will use this information to help improve the quality of the Medicare program.

Filing a grievance about quality of care to the Quality Improvement Organization

When a complaint is about the quality of care a Member has received, they have two extra options:

1. Members can make their complaint to the Quality Improvement Organization. Members can make a complaint about the quality of care directly to this organization (without making the complaint to Mass Advantage).
    a. The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.
    b. These complaints can be submitted to Kepro:
        i. Call: 1-888-319-8452
        Monday - Friday: 9:00 a.m. - 5:00 p.m.,
        Weekends-Holidays: 11 a.m.-3 p.m.
        Please note, representatives are not available on weekends and holidays to assist with quality of care concerns.
        ii. TTY: 1-855-843-4776
        iii. Send written grievance:
        Kepro, 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131
        If a Member makes a complaint to the Quality Improvement Organization, Mass Advantage will work with them to resolve the grievance.
2. Members can also make complaints to Mass Advantage and also to the Quality Improvement Organization, at the same time.

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Who May File a Grievance

A grievance may be filed by any of the following:

- The Member
- Someone else may file a grievance on behalf of the Member. A Member can name another person to act for them or as their "representative" to file a grievance on their behalf.
  - There may be someone who is already legally authorized to act as the Member's representative under State law.
  - If the Member would like a friend, relative, doctor or other provider, or other person to be their representative, they need to complete the "Appointment of Representative" form, available on our website at Appointment of Representative (http://www.massadvantage.com/providers/resources). The form must be completed and signed by the Member and by the person who will act on their behalf. A copy must also be filed with Mass Advantage.
  - Members may submit an equivalent written notice in place of the Appointment of Representative form, but it must include the following:
    - Member's name, address, and telephone number along with the individual being appointed
    - Member's Medicare Beneficiary Identifier or member number from the identification (ID) card, or plan ID number
    - The appointed representative's professional status or relationship to the Member
    - A written explanation of the purpose and scope of the representation (e.g. authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with claims, appeals, grievances.)
    - A statement that the Member is authorizing the representative to act on their behalf for the claim(s) at issue, and a statement authorizing disclosure of individually identifying information to the representative

- A statement by the individual being appointed that he or she accepts the appointment; and
- Is signed and dated by the Member and the individual being appointed.

Appeals

An appeal is a request to review and change a coverage decision (initial determination) Mass Advantage has made regarding adverse benefit determination (a decision unfavorable to the Member), or the amount of cost share assigned to the patient for a specific service. If a Member receives a denial letter informing or other adverse benefit determination and they are not satisfied with this decision, they may file an appeal.

Any party to an organization determination (including a reopened and revised determination), i.e., an enrollee, an enrollee's representative or physician.

For standard prior authorization appeals, a physician who is providing treatment to an enrollee may, upon providing notice to the enrollee, request a standard reconsideration on the enrollee's behalf without submitting a representative form.

You may contact Mass Advantage for additional information as to when standard prior authorization reconsiderations can be filed without a completed representative form.

Mass Advantage providers are not eligible to submit payment appeals (e.g., after the service has been rendered) in accordance with this section but must proceed through the claim dispute process described in the *Claims and Billing* section below.

Who can file an Appeal?

An appeal may be filed by any of the following:

- Member
- Member's Provider
- Another health care provider or prescriber.

- Member representative: Members can name another person to act as their "representative" to file an appeal on their behalf.
  - A member representative may be someone who is already legally authorized to act as the Member's representative under State law.
  - If the Member would like a friend, relative, doctor or other provider, or other person to be their representative, they need to complete the "Appointment of Representative" form, available on our website at Appointment of Representative (http://www.massadvantage.com/providers/resources). The form must be completed and signed by the Member and by the person who will act on their behalf. A copy must also be filed with Mass Advantage.
  - Members may submit an equivalent written notice in place of the Appointment of Representative form, but it must include the following:
    - Member's name, address, and telephone number along with the individual being appointed.
    - Member's Medicare Beneficiary Identifier or member number from the identification (ID) card, or plan ID number.
    - The appointed representative's professional status or relationship to the Member.
    - A written explanation of the purpose and scope of the representation. (e.g., authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with claims, appeals, grievances).
    - A statement that the Member is authorizing the representative to act on their behalf for the claim(s) at issue, and a statement authorizing disclosure of individually identifying information to the representative.
    - A statement by the individual being appointed that he or she accepts the appointment.
    - Is signed and dated by the Member and the individual being appointed.

When can an Appeal be filed?

Appeal requests must be made within 60 calendar days from the date of the denial letter or other adverse benefit determination. If a Member misses this deadline and have good cause, Mass Advantage may allow addition time to appeal. The Member will need to provide a written explanation why the appeal was not filed timely so Mass Advantage can determine if there is good cause to process the untimely appeal. Examples of good cause for missing the deadline may include a serious illness that prevented the Member from contacting us or if we provided incorrect or incomplete information about the deadline for requesting an appeal.

Where can an Appeal be filed?

To initiate an expedited or standard appeal the patient (or representative or doctor or other provider/prescriber) must contact Mass Advantage as follows:

- By Mail: Mass Advantage, P.O. Box 1285, Maryland Heights, MO 63043
- By e-mail for Part D Prescription Drugs: MedDResponseTeam@magellanhealth.com
- By fax:
  - Appeals For Medical Care: 1-888-656-7783
  - Appeals for Part D Prescription Drugs: 1-888-904-1139
- By Phone for expedited appeals only:
  - H7670 Plan 001 and 002 (HMO): 1-844-918-0114, TTY: 711
  - H9904 Plan 001 (PPO): 1-844-915-0234, TTY: 711

How to file an Appeal?

A written request should include:

- Member's name, Member ID Number (found on the insurance card) address and phone number. Mass Advantage may contact the member for additional information.
- The items or services for which a Member is requesting an appeal, the dates of service, and the reason(s) why the Member is appealing.

- If a Member has appointed a representative, they are required to include the name of the authorized representative and proof of representation.

Fast Decisions/Expedited Appeals

Members have the right to request a quick response and receive expedited decisions affecting their medical treatment in cases where applying the standard timeline for a decision to be made could seriously jeopardize:

- The Member's life or health
- The Member's ability to function

Requests for Expedited Appeals can be made in writing or by phone.

If a health plan or a doctor makes a request or supports a Member's request that their health requires an expedited appeal, Mass Advantage will automatically agree to provide an expedited decision. Mass Advantage will issue a decision as fast as possible, but no later than seventy-two (72) hours for a medical item or service plus 14 calendar days, if an extension is taken, after receiving the request.

If an appeal request is for a Medicare Part D or Medicare Part B prescription drug, Mass Advantage will answer within seventy-two (72) hours.

If a Member requests an expedited appeal without their doctor's support, Mass Advantage will decide whether the Member's health requires an expedited decision.

- If Mass Advantage determines that the Member's medical condition does not meet the requirements for an expedited decision, we will send written confirmation of the decision says so (using standard deadlines).
- This letter will inform the Member that if their doctor requests an expedited appeal, Mass Advantage will automatically render an expedited response.
- The letter will inform the Member of their right to file an expedited complaint about our decision to render a standard decision instead of the expedited coverage decision requested.

Standard Appeals

A standard appeal must be submitted in writing.

Mass Advantage will issue a decision as fast as possible, but no later than 30 calendar days after receiving a request for a medical item or service.

If we need more information and the delay is in the Member's best interest or if the Member requests additional time, Mass Advantage can take up to 14 more calendar days (44 calendar days total) to make a decision. If we need additional time, we will inform the Member in writing to explain the reasons for the extension and outline their right to file an expedited grievance if they disagree with the decision to extend the timeframe.

If the Member's request is for a Medicare Part D or Medicare Part B prescription drug, Mass Advantage will respond within seven (7) calendar days after receiving the request.

If the Member's request is for a Part D prescription drug payment redetermination, Mass Advantage will respond within (14) calendar days after receiving the request.

If the Member's request is for a payment reconsideration, Mass Advantage will respond within sixty (60) calendar days after receiving the request.

Request Appeals and Grievance Data

You have a right to request Mass Advantage general data regarding the number and handling of appeals and grievances members have filed with the plan. Please contact Member Services at:

- H7670 Plan 001 and 002 (HMO): 1-844-918-0114 TTY 711
- H9904 Plan 001 (PPO): 1-844-915-0234, TTY: 711

Regarding Hospital Discharge

There is a certain type of appeal that applies only to hospital discharges. If a member feels that the Mass Advantage coverage of a hospital stay is ending too soon, the member or his or her authorized representative can appeal directly and immediately to the Quality Improvement Organization (QIO).

Quality Improvement Organizations are assigned regionally by the Centers for Medicare and Medicaid Services (CMS).

The QIO for Massachusetts is Kepro. The QIO is a group of health professionals that are paid to handle this type of appeal from Medicare patients. When such an appeal is filed on time, the stay may be covered during the appeal review. One must act very quickly to make this type of appeal, and it will be decided quickly.

If a member believes that the planned discharge is too soon, the member or member's authorized representative may ask for a QIO review to determine whether the planned discharge is medically appropriate. "The Important Message from Medicare" document given to the member within two days of admission and copied to the member within two days of discharge provides the appeal information as well as the QIO name and telephone number.

To request a QIO review regarding a hospital discharge, the member or member's authorized representative must contact the QIO no later than noon the day of discharge. If this deadline is met, the member is permitted to stay in the hospital past the planned discharge date without financial liability. If the QIO reviews the case, it will review medical records and provide a decision within one calendar day after it has received the request and all of the medical information necessary to make a decision. If the QIO decides that the discharge date was medically appropriate, the member will have no financial liability until noon of the day after the QIO provides its decision. If the QIO decides that the discharge date was too soon and that continued confinement is medically appropriate, we will continue to cover the hospital stay for as long as it is medically necessary.

If the member or member's authorized representative does not ask the QIO for a review by the deadline, the member or authorized representative may ask Mass Advantage for an expedited appeal. If the member or authorized representative asks us for an expedited appeal of the planned discharge and stays in the hospital past the discharge date, he or she may have financial liability for services provided beyond the discharge date. This depends on the expedited appeal decision. If the expedited appeal decision is in the member's favor, we will continue to cover the hospital care for as long as it is medically necessary. If the expedited appeal decision is that continued confinement was not medically appropriate, we will not cover any hospital care that is provided beyond the planned discharge date, unless an IRE review overturns our decision.

Skilled Nursing Facility (SNF), Home Health Agency (HHA) or Comprehensive Outpatient Rehabilitation Facility (CORF) Services

There is another type of appeal that applies only when coverage will end for SNF, HHA or CORF services. If a member feels that coverage for these services is ending too soon, he or she can appeal directly and immediately to the QIO. As with hospital services, these services may be covered during the appeal review if filed on time.

If Mass Advantage and/or the care provider decides to end coverage for SNF, HHA or CORF a written Notice of Medicare Non-Coverage (NOMNC) must be delivered to the member at least two (2) calendar days before coverage ends. The member or authorized representative will be asked to sign and date this document. Signing the document does not mean that the member agrees to the decision, only that the notice was provided. After the NOMNC is completed, the provider must retain a copy in the provider's records.

Quality Improvement Organization (QIO) Review

For these types of services, members have the right by law to ask for an appeal of a termination of coverage. The member or member's authorized representative can ask the QIO to do an independent review of whether terminating coverage is medically appropriate.

The notice will provide the name and phone number of the appropriate QIO agency. If the member receives the termination notice two days before coverage is scheduled to end, the member must contact the QIO no later than noon of the day following the day the notice is received. If the notice is received more than two (2) days prior to the scheduled end in coverage, the QIO must be contacted no later than noon of the day before the scheduled termination of coverage.

If the QIO reviews the case, the QIO will ask for the member's opinion about why the services should continue. The response is not required in writing. The QIO will also look at medical information, talk to the doctor, and review other information that Mass Advantage provides to the QIO. It is very important that the provider immediately faxes all of the member's medical records to the QIO for their review. Mass Advantage will provide both the member and the QIO a copy of the explanation for termination of coverage of these services.

After reviewing all the information, the QIO will decide whether it is medically appropriate for coverage to be terminated on the date that has been set for the member. The QIO will make this decision within one full day after it receives the information necessary to decide. If the QIO decides in favor of the member, will continue to cover the stay for as long as medically necessary. If the QIO decides that our decision to terminate coverage was medically appropriate, the member will be responsible for paying the SNF, HHA or CORF charges after the termination date that appears on the advance notice. Neither Original Medicare nor Mass Advantage will pay for these services. If the member agrees to discontinue receiving services on or before the date given on the notice, there will be no financial liability.

If the member or authorized representative does not ask the QIO for a review in a timely manner, the member or authorized representative may request an expedited appeal. It is important to note that if the member or authorized representative requests an expedited appeal regarding termination and services continue to be provided, the member may have financial liability if services are provided beyond the termination date.

If Mass Advantage staff decides upon expedited appeal review those services are medically necessary to continue, we will continue to cover the care for as long as medically necessary. If the decision is not in the member's favor, we will not cover any of the care that was provided beyond the termination date, and the member may be financially responsible.

Independent Review Entity (IRE) Review

Mass Advantage will notify the member and provider in writing when an appeal has been forwarded to the IRE for review. The member may request a copy of the file that is provided to the IRE for review. The IRE will review the request and decide about whether Mass Advantage must provide the care or payment for the care in question. For appeals regarding payment of services already received, the IRE has up to sixty (60) calendar days to issue a decision. For standard appeals regarding medical care not yet provided, the IRE has up to thirty (30) calendar days to issue a decision.

For expedited appeals regarding medical care, the IRE has up to seventy-two (72) hours to decide. These timeframes can be extended by up to fourteen (14) calendar days if more information is needed and the extension is in the member's best interest.

The IRE will issue its decision in writing to the member (or authorized representative) and the plan. If the decision is not in the member's favor, the member may have the opportunity to pursue coverage of the services through the review of an Administrative Law Judge.

Administrative Law Judge (ALJ) Review

If the IRE decision is not in the member's favor, and if the dollar value of the contested benefit meets minimum requirements the member or authorized representative may ask for an Administrative Law Judge (ALJ) to review the case. The ALJ also works for the federal government. The IRE decision letter will instruct the member how to request an ALJ review.

During an ALJ review, the member may present evidence, review the record, and be represented by an attorney. The ALJ will not review the appeal if the dollar value of the medical care is less than the minimum requirement, and there are no further avenues for appeal. The ALJ will hear the case, weigh all the evidence and make a decision as soon as possible.

The ALJ will notify all parties of the decision. The party against which the decision is made can request a review by the Medicare Appeals Council/Departmental Appeal Board. The decision issued by the ALJ will inform the member how to request such a review.

Medicare Appeals Council (MAC)

The party against whom the ALJ decision is made has the right to request the review by the Medicare Appeals Council (MAC). This Council is part of the federal department that runs the Medicare program. The MAC does not review every case it receives. When it receives a case, the MAC decides whether to conduct the review. If they decide not to review the case, either party may request a review by a Federal Court Judge; however, the Federal Court Judge will only review cases when the amount in controversy meets the minimum requirement.

Federal Court

The party against whom the Medicare Appeals Council decision is made has the right to file the case with Federal Court if the dollar value of the services meets the minimum requirements. If the dollar value of the service in question is less, the Federal Court Judge will not review it and there is no further right of appeal.

Acting as an Authorized Representative

Mass Advantage will accept requests made by the member and/or his or her authorized representative or the prescribing physician or other prescriber or a non- participating provider involved in the member's care. A member may have any individual (relative, friend, advocate, attorney, congressional staff member, member of advocacy group, or suppliers, etc.) act as his or her representative, as long as the designated representative has not been disqualified or suspended from acting as a representative in proceedings before CMS or is otherwise prohibited by law.

In order to act as a representative, the member and representative must complete the Appointment of Representative Form, which can be found at Appointment of Representative (http://www.massadvantage.com/providers/resources).

A representative must sign the appointment within thirty (30) calendar days of the member's signature. The appointment remains valid for a period of one year from either the date signed by the party making the appointment or the date the appointment is accepted by the representative, whichever is later. The appointment is valid for any subsequent levels of appeal on the claim or service in question unless the member specifically withdraws the representative's authority.

If the requestor is the member's legal guardian or otherwise authorized under State law, no appointment is necessary. Mass Advantage will require submission of appropriate documentation, such as a durable power of attorney.

A physician who is providing treatment to a member (upon providing notice to the member) may request an appeal on the member's behalf without having been appointed as the member's representative.

A provider that has furnished services or items to a member may represent that member on the appeal; however, the provider may not charge the member a fee for representation. Further, the provider appointed must acknowledge in a signed, dated statement that the member will not be held financially responsible for payment for the services under review.

It is important to note that the appeals process will not commence until Mass Advantage receives a properly executed AOR.