CMC01004: Cal Medi-Connect Appeals, Member Rights

CA Health Plan Compliance Training

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Optum

Introduction

Appeals & Grievances (A&G):

Health plan CMC members have the right to file an appeal and/or grievance when dissatisfied with services, care and/or coverage.

A&G ia not a delegated function. Therefore, all A&G must be forwarded to the health plan.

A&G is important because:

- ❑ Members are offered the opportunity to share their experience.
- ❑ They enable us to learn about member perceptions of the health plan and medical group.
- ❑ We find opportunities to improve our services.

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What is an Appeal?

Definition

- An appeal is a request to review a plan's decision including the procedures that follow with the review of an adverse coverage decision on services a member believes they are entitled to receive, timeliness of the service, or the amount member must pay out of pocket.
  - The most common example of this is when a member does not receive prior authorization for medical service and can apply to a complete or partial denial or delay in arranging or approving services.
  - In these situations, the member files an appeal for the service to be authorized.
  - The process of reviewing the decision is called Reconsideration.
- An appeal is the member's first step to requesting a Service Authorization Request (SAR) A&G/Coverage Determinations on the health care services the member believes they are entitled to, including the delay in providing, arranging for, or approving the health care services.
  - Initiated to review a Part C (medical covered benefits) SAR A&G determination is a Reconsideration.
  - Initiated to review a Part D (Pharmacy covered benefits) adverse coverage determination is a Re-determination.

Member Rights

Expedited appeals:

- Member or member's Appointment of Representative (AOR) has the right to request an expedited appeal.
  - The AOR must complete a CMS-approved form.
- An expedited appeal is granted if the standard timeframe to make a determination could seriously jeopardize the member's life, health, or ability to regain maximum function.
- Health plan's physician reviewers determine if the A&G meets the requirements for an expedited review.
- A decision must be made no later within 72 hours.

Expedited Appeals

Oversight and Quality Improvement (QI):

- A&G data is taken seriously by the health plan as an important source of information about how our members feel about the health plan and the delivery of services.
- The QI Committee routinely reviews reports of A&G activities and has authority to implement QI activities as indicated by the data. Participation in timely, accurate A&G handling is important to the health plan and our members.
  - A&G is tracked in a grievance tracking database.
  - Data is reviewed quarterly and presented to various committees for QI and service.
  - Committees review reports for A&G trends, as well as overturn and upheld rates.

What is an Expedited Grievance?

Definition

- The member or AOR may request an expedited grievance under specific circumstances. The A&G team process the Physician Reviewer's determination on whether the appeal in question meets the requirements to be expedited.
- Members have the right to request an expedited grievance when:
  - The timeframe to make a SARAG/coverage determination or reconsideration/re-determination is extended.
  - A request for an expedited review for an SARAG/coverage determination or reconsideration/re-determination is not granted.
  - A response must be issued within 24 hours.

Member Rights

A&G:

- Members are informed of their A&G rights, including the rights to an expedited review:
  - At initial enrollment.
  - Upon notification of an adverse coverage determination/SARAG.
  - Upon notice of a service or coverage termination (e.g. hospital, CORF, HHA or SNF settings)

Member Rights

Members:

- Have a right to get information in a way that meets their needs.
- Are treated with respect, fairness and dignity at all times.
- Must receive timely access to covered services and drugs.
- Personal health information must be protected.
- Must have access to and about our plan, network providers and covered services.
- Network providers cannot bill members directly for covered services.
- May elect to leave our CMC plan at any time.
- Have the right to make decisions about their health care.
- Have the right to initiate complaints and to request the health plan to reconsider decisions we have made.

A&G Timelines

Timeliness Requirements:

	Appeal	Grievance
Filing	60 days	Anytime
Acknowledgment	5 calendar days	5 calendar days
Standard Resolution	30 calendar days	30 calendar days
Expedited Resolution	72 hours	24 hours

Member Responsibility

Members have the responsibility to:

- ❑ Read the Member Handbook to learn what is covered and what rules to follow to obtain covered services and drugs.
- ❑ Report any other health or prescription drug coverage they have.
- ❑ Inform their doctor and other health care providers about enrollment with health plan.
- ❑ Help their doctors and other health care providers give the best care by giving information they need about their health.
- ❑ Inform us when moving within or outside of the service area.
- ❑ Contact Member Services for any questions and/or concerns.
- ❑ Pay what is owed.
- ❑ Be considerate.

Improper Billing

Members:

- Federal law prohibits providers and suppliers from billing a member for covered services and/or supplies.
- Providers who improperly bill a member may be subject to sanctions by CMS, DHCS, health plan, and other federal/state regulatory bodies.