Cal MediConnect Appeals & Grievance /Member Rights

L.A. Care HEALTH PLAN®

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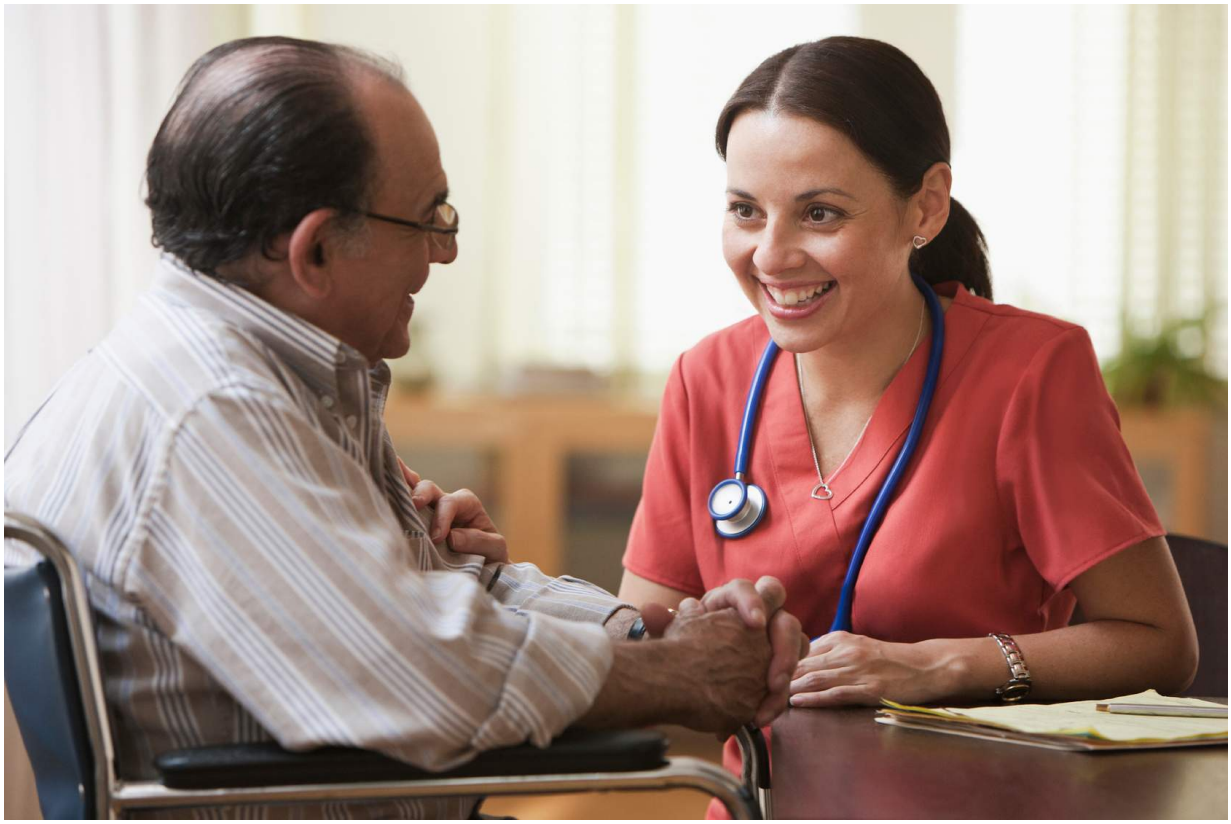
Welcome



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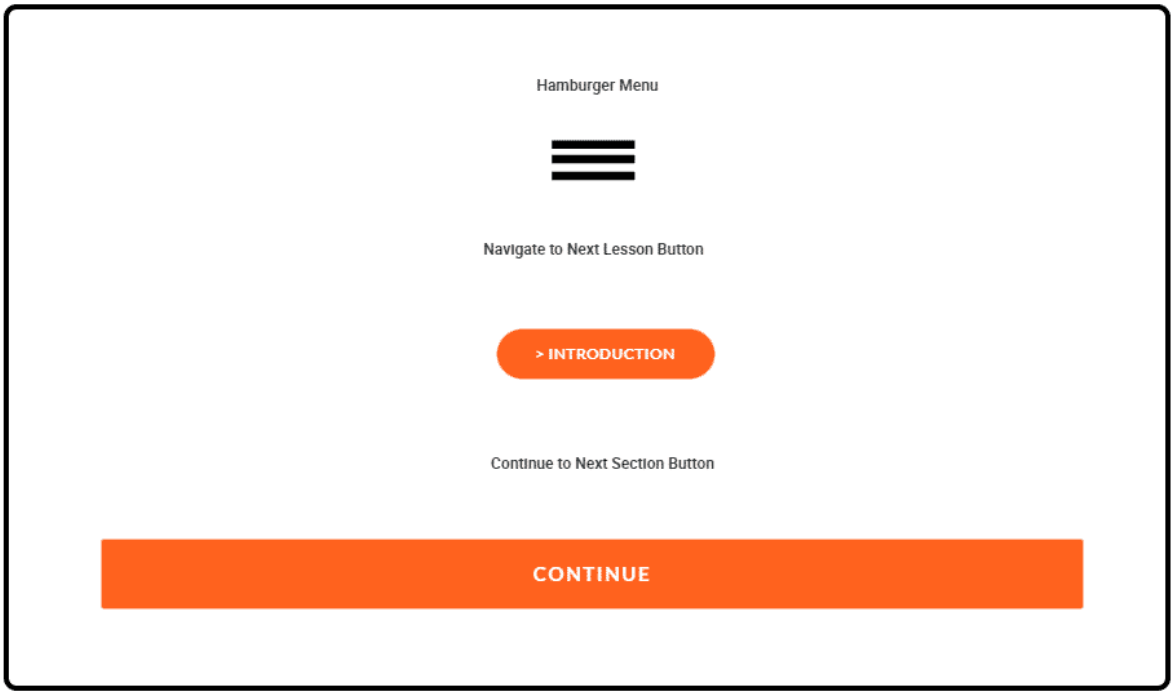
Welcome to CMC Appeals & Grievance Member Rights

We have a great deal of important information to cover, so let's get started. My name is Rob and my name is Janet, we will be your hosts during this course.

Located in the upper left hand corner you will find what we call the hamburger menu. You can track your progress, and see what topics you need to complete. You can always revisit pages you have previously completed. But you can not skip ahead in the training without interacting with all the content of each page.

The course is designed with an automatic bookmark mechanism. When you return to the course you will continue from your automatic bookmark.

Below is an image of the navigation buttons and icons used in this presentation. If you do not see the CONTINUE button it means you have not completed the lesson or you need to simply scroll down the page.

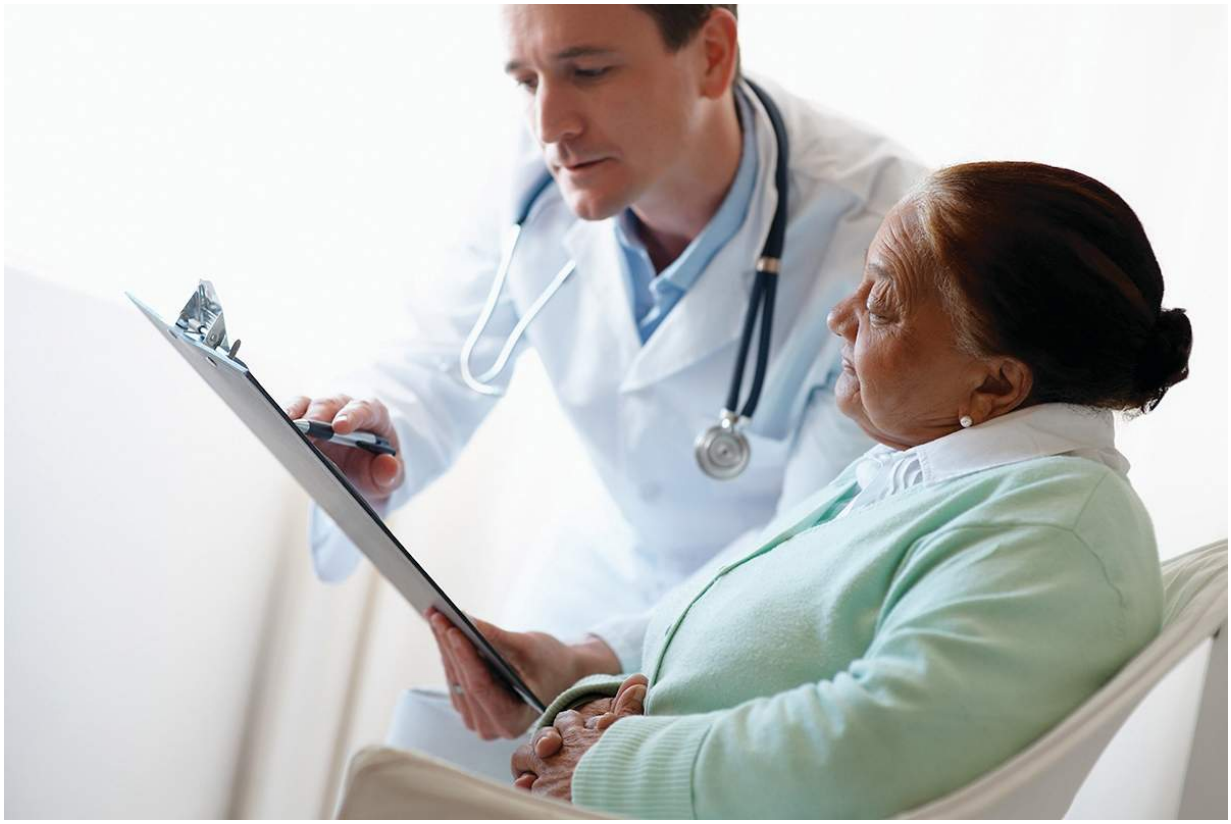


Navigation Buttons

Introduction

> INTRODUCTION

Introduction



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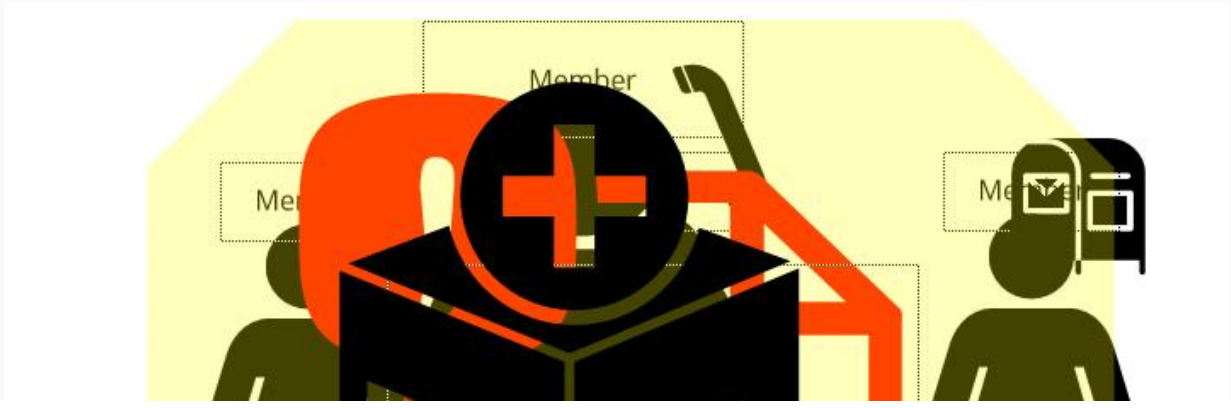
This learning module will provide you with an overview of Cal MediConnect Appeals & Grievances, including:

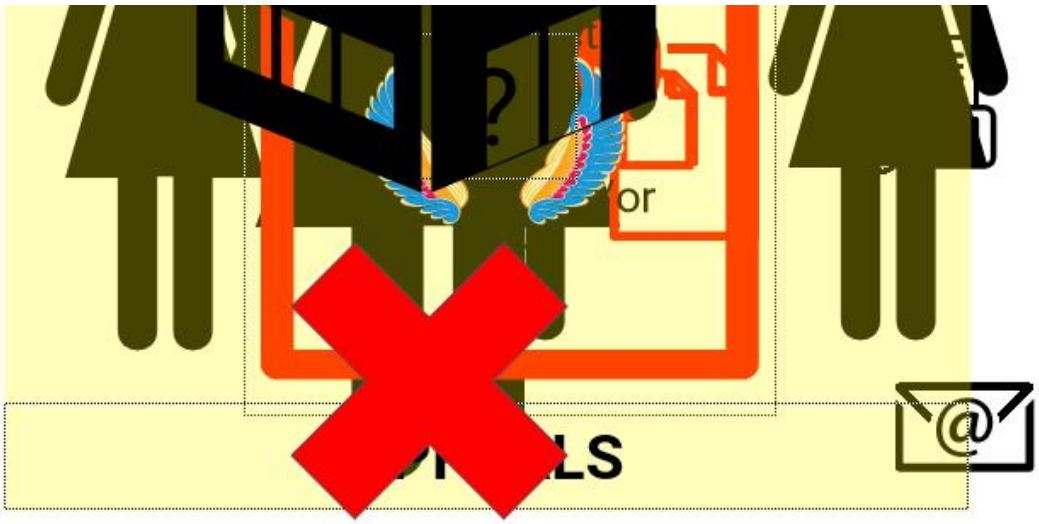
1. Understanding the definitions of an appeal and grievance
2. How to identify an appeal versus a grievance
3. Understanding the definition of an expedited appeal and/or grievance
4. Appeal & Grievance Timeliness Requirements
5. Member Rights and Responsibilities

Background

> BACKGROUND

Background





Complete the content above before moving on.

- L.A. Care Members have the right to file an Appeal and/or Grievance when dissatisfied with services, care and/or coverage
- Appeal and Grievances are not a delegated function. Therefore, all Appeals & Grievances must be forwarded to LA Care.
- Appeals and Grievances are important because:
    - Members have the opportunity to share their experience
    - They enable us to learn about Member perceptions of L.A. Care
    - We find opportunities for improving our services

Knowledge Check

Appeals and Grievances are important because:

Members have the opportunity to	share their experience
They enable us to learn about	Member perceptions of L.A. Care
We find opportunities for	improving our services

SUBMIT

Complete the content above before moving on.

Definition of Grievance

> DEFINITION

Definition of Grievance

For an audio overview on the definition of the term Grievance select the play arrow on the media player below.

Complete the content above before moving on.

The member may make a complaint, or the member's representative. The representative can be anyone designated by the member, including a doctor, family member, friend, lawyer, or any other person. The member or representative may submit a complaint or dispute verbally in person or on the phone, including TDD or TTY, or in writing, which includes traditional letters, faxes, and email. The member or representative may make this complaint to L.A. Care , to an L.A. Care contracted practitioner, or L.A. Care contracted facility. This shows our commitment to supporting members in exercising their grievance rights.

A grievance can be classified as an “expedited grievance” if there is a time sensitive element that if delayed could result in an adverse clinical outcome for the member. We will talk more about expedited grievances later.

A grievance can be about almost anything, including the timeliness, appropriateness, access to, and/or setting of a provided health service, procedure, or item. A grievance can also be about the quality of care a member received.

True or False

A grievance is an expression of dissatisfaction with L.A. Care, a Provider or Quality Improvement Organization (QIO), by a member regarding the operations, quality of service and/or care.

- True
- False

SUBMIT

Complete the content above before moving on.

Summary

1. Any expression of dissatisfaction to L.A. Care, Provider or Quality Improvement Organization (QIO), by a Member regarding the operations, quality of service and/or care.

2. A member, treating provider or their authorized representative may initiate the complaint or dispute, either verbally or in writing, to L.A. Care, a provider, or facility.

3. Contact LA Care to request an Appointment of Representative form

Definition of Appeal

> DEF APPEAL

Definition of Appeal

This definition will apply to Medicare Part C, the part of Medicare that is not prescription drugs. An appeal is made when L.A. Care, including one of L.A. Care's delegates such as a subcontracted health plan or a participating provider group, makes a determination that the member believes should have been made differently. The most common example of this is when a member does not receive prior authorization for a medical service. It can apply to a complete denial or a partial denial, or a delay in arranging or approving services. In these situations the member makes an appeal for the service to be authorized. The process of reviewing the decision is called Reconsideration. We will explore later the different levels of reconsideration which include internal to L.A. Care, an independent review entity, a hearing

before an Administrative Law Judge, a review by the Medicare Appeals Council, and judicial review.

Summary

- An Appeal is the member's first step to requesting a Service Authorization Request A&G/Coverage Determinations on the health care services a Member believes they are entitled to receive, including the delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the Member), or on any amounts the Member must pay for a service.
- Appeal requests initiated to review a Part C (medical covered benefits) Service Authorization Request A&G determination is a Reconsideration.
- Appeal requests initiated to review a Part D (Pharmacy covered benefits) adverse coverage determination is a Re-determination.

Informing Members of Appeal and Grievance Rights

> INFORMING

Informing Members of Appeal and Grievance Rights

Members are informed of their appeal and grievance rights, including the right to an expedited review:

1. at initial enrollment
2. upon notification of an adverse SARAG/Coverage Determination

3 upon notification of a service or coverage termination (e.g., hospital, CORF, HHA or SNF settings)

4 annually

Expedited Appeals

> EXPEDITED

Expedited Appeals

A member or member representative may request an expedited appeal. An expedited appeal is granted if the standard time for making a determination could seriously jeopardize the member's life, health, or ability to regain maximum function. While the member may request an expedited appeal, the Appeals and Grievance staff process the Physician Reviewer's determination on whether the appeal in question meets the requirements to be expedited.

1. Members have the right to request an expedited appeal
2. An expedited appeal is done if the standard time-frame for making a determination could seriously jeopardize the Member's life, health or ability to regain maximum function
3. L.A. Care's Physician Reviewers determine if the Appeal and/or Grievance meets the requirements for an expedited review
4. A decision must be made no later than 72 hours

Expedited Grievance

> EX GRIEVANCE

Expedited Grievance

A member or member representative may request an expedited grievance under specific circumstances. While the Member may request an expedited grievance, the Appeals and Grievance staff 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 whenever:

1. The time-frame to make a SARAG/coverage determination or reconsideration/re-determination is extended.
2. A request for an expedited review for an SARAG/coverage determination or reconsideration/re-determination is not granted
3. A response must be issued within 24 hours

Who May Request an Appeal

> REQUEST

Who May Request an Appeal?

1. A member

2. A treating/prescribing provider, however a prescribing provider does not have all the rights and responsibilities of an enrollee.

3. A member's authorized representative.

    - An Authorized Representative must complete a CMS approved Appointment of Representative (AOR) form.

Oversight and Quality Improvement

> OVERSIGHT

Oversight and Quality Improvement

Grievance and Appeal data is taken seriously by L.A. Care as an important source of information about how our members feel about L.A. Care and how we are delivering our services. The Quality Improvement Committee reviews regular reports of G&A activities and has authority to implement quality improvement activities as indicated by the data. Your participation in timely, accurate grievance and appeal handling is important to L.A. Care and our members.

1. Appeals and Grievances are tracked in a grievance tracking database.

2. Data is reviewed quarterly and presented to the various committees for service and quality improvement.

3. Committees review reports for Appeal and Grievance trends, as well as Overturn and Upheld rates.

Summary of Appeal and Grievance Timeliness Requirements

> SUMMARY

Summary of Appeal and Grievance Timeliness Requirements

The table below lists the timeline requirements for Grievances and Appeals. Please take a moment to study the table, in preparation for a Knowledge Check.

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

Summary of Appeal and Grievance Timeliness Requirements

Grievance

Anytime

5 calendar days Grievance

30 calendar days

24 hours

Appeal

60 days

5 calendar days Appeal

30 calendar days	72 hours

Complete the content above before moving on.

Member Rights

> MEMBER RIGHTS

Member Rights

The following list contains Member Rights:

1. Members have a right to get information in a way that meets their needs
2. Members are treated with respect, fairness, and dignity at all times
3. Members must receive timely access to covered services and drugs
4. Member's personal health information must be protected
5. Access to information about our plan, our network providers, and your covered services
6. Network providers cannot bill our Members directly for covered services
7. Members can elect to leave our Cal MediConnect plan at any time
8. Members have the right to make decisions about their health care

9 Members have the right to initiate complaints and to request L.A. Care to reconsider decisions we have made

Member Responsibilities

> RESPONSIBILI...

Member Responsibilities

Members have the responsibility to:

1. Read the Member Handbook to learn what is covered and what rules to follow to get covered services and drugs
2. Tell us about any other health or prescription drug coverage you have
3. Tell their doctor and other health care providers about enrollment with L.A. Care
4. Help their doctors and other health care providers give the best care by giving information they need about their health
5. Be considerate
6. Pay what is owed
7. Tell us when moving within or outside of the service area
8. Call Member Services for any questions and/or concerns

Improper Billing

> IMPROPER BIL...

Improper Billing

1. Federal law prohibits providers and suppliers from billing a member for covered services and/or supplies

2. Providers who improperly bill a member may be subject to sanctions by L.A Care, CMS, DHCS, and other federal/state regulatory bodies

Advance Directives

> DIRECTIVES

Directives

For information on Advanced Directives please contact
L.A. Care's Provider Solution Center at 866-522-2736

References

L.A. Care Health Plan Health Services Policy:
Complaint and Appeals Process for Members

Thank you for completing the CMC Appeals and Grievance instructional.

To exit the tutorial click the **Exit Course** button below.

EXIT COURSE