

SCAN Health Plan Appeals, Grievances and Complaints Expectations

First Tier, Downstream, or Related Entity (FDR): Please complete all fields in yellow.

Go Live Date: DATE

Health Plan:	SCAN Health Plan
First Tier, Downstream, or Related Entity (FDR) Name:	FDR Name
Line of business:	<input checked="" type="checkbox"/> Medicare <input checked="" type="checkbox"/> Dual/DSNP
FDR Grievance & Appeal Contact Information: *If any contact information is changed, the FDR will inform the health plan within 3 business days.	Appeals Phone Number: PHONE NUMBER Appeals Email: EMAIL Appeals Fax Number: FAX NUMBER Grievances Phone Number: PHONE NUMBER Grievances Email: EMAIL Grievances Fax Number: FAX NUMBER Weekend and Holiday Support Phone Number: PHONE NUMBER Weekend and Holiday Support Email: EMAIL Weekend and Holiday Support Fax Number: FAX NUMBER Appeal and Grievance Escalations Name: NAME Appeal and Grievance Escalations Phone Number: PHONE NUMBER Appeal and Grievance Escalations Email: EMAIL Appeal and Grievance Escalations Fax Number: FAX NUMBER New Direct Member Reimbursement Requests Email: EMAIL New Pre-Service Organization Determination Email: EMAIL Organization Determination Escalations: CONTACT NAME and EMAIL *On-call contact information is required for expedited support. Response needed on expedited cases within 4 hours.

<p>SCAN G&A contact information</p>	<p>SCAN Grievance and Appeal Department: Email: GADINBOX@scanhealthplan.com and Cc: alerts950@scanhealthplan.com Fax: 562-989-0958 Escalated contacts: Mariah Emerich – m.emerich@scanhealthplan.com Megan Myers - m.myers@scanhealthplan.com Renee Doan - r.doan@scanhealthplan.com Mariah Emerich: 541-771-5610</p>
<p>Definitions (All definitions are from the Parts C&D Enrollee Grievances, Org/Coverage Determinations, and Appeals Guidance)</p>	<p>Appeal: As defined at 42 CFR §422.561 and §423.560, the procedures that deal with the review of adverse initial determinations made by the plan on health care services or benefits under Part C or D the enrollee believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the enrollee) or on any amounts the enrollee must pay for a service or drug as defined in 42 CFR §422.566(b) and §423.566(b). These appeal procedures include a plan reconsideration or redetermination (also referred to as a level 1 appeal), a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (Council), and judicial review.</p> <p>Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO): Organizations comprised of practicing doctors and other health care experts under contract to the federal government to monitor and improve the care given to Medicare enrollees. The BFCCQIOs review enrollee complaints about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities (SNFs), home health agencies (HHAs), Medicare managed care plans, Medicare Part D prescription drug plans, and ambulatory surgical centers. The BFCC-QIOs also review continued stay denials in acute inpatient hospital facilities as well as coverage terminations in SNFs, HHAs,</p>

and comprehensive outpatient rehabilitation facilities (CORFs). In some cases, the BFCC-QIO can provide informal dispute resolution between the health care provider (e.g., physician, hospital, etc.) and enrollee.

Dismissal: A decision not to review a request for a grievance, initial determination, or appeal because it is considered invalid or does not otherwise meet Medicare Advantage or Part D requirements.

Effectuation: Authorization or provision of a benefit that a plan has approved, payment of a claim or compliance with a complete or partial reversal of a plan's original adverse determination

Enrollee: An eligible individual who has elected a Medicare Advantage, Prescription Drug, or cost plan or health care prepayment plan (HCPP).

First Tier Entity (FDR): An FDR is any party that enters into a written arrangement, acceptable to CMS, with an MAO or Part D plan sponsor or applicant to provide administrative services or health care services to a Medicare eligible individual under the MA program or Part D program. (See, 42 C.F.R. § 423.501).

Grievance: 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 items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. A grievance does not include, and is distinct from, a dispute of the appeal of an organization determination or coverage determination or an LEP determination.

Independent Review Entity (IRE): An independent entity contracted by CMS to review adverse level 1 appeal decisions made by the plan. Under Part C, an IRE can review plan dismissals.

Inquiry: Any verbal or written request for information to a plan or its delegated entity that does

not express dissatisfaction or invoke a plan's grievance, coverage or appeals process, such as a

routine question about a benefit.

Non-Contract Provider: A provider or supplier that does not contract with a MA organization to provide services covered by the MA plan.

Quality of Care Grievance: A grievance related to whether the quality of covered services provided by a plan or provider meets professionally recognized standards of health care, including whether appropriate health care services have been provided or have been provided in appropriate settings.

Reconsideration: Under Part C, the first level in the appeals process which involves a review of an adverse organization determination by an MA plan, the evidence and findings upon which it was based, and any other evidence submitted by a party to the organization determination, the MA plan or CMS. Under Part D, the second level in the appeals process which involves a review of an adverse coverage determination by an independent review entity (IRE), the evidence and findings upon which it was based, and any other evidence the enrollee submits or the IRE obtains. As used in this guidance, the term may refer to the first level in the Part C appeals process in which the MA plan reviews an adverse Part C organization determination or the second level of appeal in both the Part C and Part D appeals process in which an independent review entity reviews an adverse plan decision.

Reopening: A remedial action taken to change a binding determination or decision even though the determination or decision may have been correct at the time it was made based on the evidence of record. **Representative:** Under Part C, as defined in §422.561, an individual appointed by an enrollee or other party, or authorized under state or other applicable law, to act on behalf of an enrollee or other party involved in a grievance, organization determination, or appeal. Under Part D §423.560 defines “representative” as an individual either appointed by an enrollee or authorized under state or other applicable law to act on behalf of the enrollee in filing a grievance, obtaining a coverage determination, or in dealing with any of the levels of the appeals process. For both Part C & Part D, unless

otherwise provided in the applicable law, the representative will have all of the rights and responsibilities of an enrollee or other party, as applicable.

Withdrawal: A voluntary verbal or written request to rescind or cancel a pending grievance initial determination, or appeal request submitted by the same party.

Applicable Integrated Plans ONLY:

Integrated Appeal: The procedures that deal with, or result from, adverse integrated organization determinations by an applicable integrated plan on the benefits both under Part C and under state Medicaid rules the enrollee believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the enrollee), or on any amounts the enrollee must pay for a service. See 42 CFR § 422.561. Integrated appeals do not include appeals related to Part D benefits. Integrated appeals cover procedures that would otherwise be defined and covered, for non-applicable integrated plans, as an appeal defined in §422.561 or the procedures required for appeals in accordance with §§438.400 through 438.424 of this chapter. Such procedures include integrated reconsiderations. Subject to the guidance in this Addendum, wherever the Part C & D Guidance refers to an “Appeal,” the statements and guidance apply equally to integrated appeals for applicable integrated plans.

Dismissal: Dismissal includes a decision not to review a request for an integrated grievance, integrated appeal, or integrated organization determination because it is considered invalid or does not otherwise meet the requirements for a request for integrated grievance, integrated appeal, or integrated organization determination. Subject to the guidance in this Addendum (see, for example, Section 20.2.a and Section 50.9.1.a), wherever the Part C & D Guidance refers to a “Dismissal,” the statements and guidance apply equally to integrated grievances, integrated appeals, and integrated organization determinations for applicable integrated plans.

Integrated Grievance: A dispute or complaint that would be defined and covered, for grievances filed by an enrollee in non-applicable integrated plans, under § 422.564 or §§ 438.400 through 438.416 of this chapter. Integrated grievances do not include appeals procedures and QIO complaints, as described in § 422.564(b) and (c). An integrated grievance made by an enrollee in an applicable integrated plan is subject to the integrated grievance procedures in §§ 422.629 and 422.630. Integrated grievances do not include grievances related to Part D benefits. Subject to the guidance in this Addendum, wherever the Part C & D Guidance refers to a “Grievance,” the statements and guidance apply equally to integrated grievances for applicable integrated plans.

Integrated Reconsideration: A reconsideration that would otherwise be defined and covered, for a non-applicable integrated plan, as a reconsideration under § 422.580 and appeal under § 438.400(b) of this chapter. An integrated reconsideration is made by an applicable integrated plan and is subject to the integrated reconsideration procedures in §§ 422.629 and 422.632 through 422.634. Integrated reconsiderations do not include redeterminations related to Part D benefits. Subject to the guidance in this Addendum, wherever the Part C & D Guidance refers to a “Reconsideration,” the statements and guidance apply equally to integrated reconsiderations for applicable integrated plans.

Member and Non-Contracted Provider Appeals/Reconsideration Process	
Reconsideration Process	Requirements
Case type	Reconsiderations
Special Instructions	On-call contact information is required for expedited support. Response needed on expedited cases within 4 hours.
Handling of Duplicate Org Determinations	If a provider or member submits a duplicate authorization within 65-calendar days from the date of the original determination, the FDR will forward the request to the plan to be handled as a reconsideration and advise the provider that additional information must be submitted through the appeals process.

	<p>Duplicate Org Determination: Per the Parts C&D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance – a party to an adverse initial determination has the right to a reconsideration (referred to as a Level 1 appeal). Therefore, if a member disputes an adverse pre-service organization determination, “the case must be handled using the federally mandated appeals process.” If new or additional information is received after the plan or FDR has made and communicated an adverse pre-service OD, the information must be generally treated as an appeal if it is received within the 65 calendar days allotted for submission of a request for reconsideration or if good cause exists for untimely submission of an appeal.</p>
Delegation	<input type="checkbox"/> FDR <input checked="" type="checkbox"/> Health Plan <input type="checkbox"/> Supplemental Vendor
Appeal Filing limitation	65 calendar days from the date of the initial determination. Health plan will determine timely filing.
Standard Appeal Acknowledgement Turnaround Requirement <i>Acknowledgement not required for expedited</i>	1 business day
Turnaround Time for FDR to provide an Expedited Appeal Denial Packet	Within 4 hours the FDR will provide the denial packet – prior auth request, criteria, denial letter and all related medical records.
Turnaround time for FDR to provide a Standard Appeal Denial Packet	Within 3 business day the FDR will provide the denial packet – prior auth request, criteria, denial letter and all related medical records or the claim form, EOB/EOP/RA and denial criteria.
Extension Process	The Health Plan will determine if an extension can be granted.
Internal Health Plan Overturn	<p>For standard pre-service cases: If the decision of the health plan is to overturn, the FDR will effectuate within 1 business day for standard requests or 24 hours for expedited requests.</p> <p>For post-service cases: The FDR acknowledges the request within 1 business day and makes payment by the 7th calendar day.</p> <p>If the FDR is disputing the overturn, requests must be submitted to the email below within 72 hours:</p>

	<p>Mariah Emerich – m.emerich@scanhealthplan.com Megan Myers - m.myers@scanhealthplan.com Renee Doan - r.doan@scanhealthplan.com</p>
<p>IRE/Maximus and External Overturn</p>	<p>The FDR is not delegated for this function and will assist the Health Plan as needed and upon request.</p> <p>For pre-service cases: If the decision of the external entity is to overturn, the FDR will effectuate within 1 business day for standard pre-service requests or 24 hours for expedited requests.</p> <p>For post-service cases: The FDR acknowledges the request within 1 business day and makes payment by the 7th calendar day.</p> <p>External review decisions including the IRE, ALJ, MAC, or judicial review are final and cannot be disputed.</p>
<p>Appeal Requests Received at the FDR</p>	<p>Verbal Receipt:</p> <p><u>Standard:</u> If the FDR Contact Center receives a verbal request for a standard appeal, the FDR Contact Center should advise the member to submit the appeal to the Health Plan in writing.</p> <p><u>Expedited:</u> If the FDR Contact Center receives a verbal request for an expedited appeal, the FDR Contact Center should warm transfer the caller to the Health Plan’s contact center to intake the expedited appeal.</p> <p>Written Receipt:</p> <p><u>Expedited:</u> If the FDR receives a written request for an expedited appeal, the FDR should forward the expedited request to the health plan within 4 hours via secure email.</p> <p><u>Standard:</u> If the FDR receives a written request for a standard appeal, the FDR will forward the expedited request to the health plan within 1 business day via secure email.</p>

	The case should not be worked by the FDR Appeal team until the case is sent back to the FDR by the Health Plan to proceed in assisting with case review.
Mailing Policy	Please provide the Health Plan with a copy of the FDR mailing policy for notification and check mailing for effectuation.
Dismissal Workflow	FDR will not dismiss the case. Appeals and grievances are not delegated.
Vacate Workflow	FDR will not vacate the case. Appeals and grievances are not delegated. Vacate: A member’s ability to appeal the dismissal of the initial appeal request. A dismissal of an initial determination is binding unless modified or reversed by the plan. A member or their representative may ask the plan or an IRE to vacate dismissal. If good cause is established, the plan or the IRE may vacate a dismissal.

Member Complaint/Grievances Process

Case type	Grievance
Special Instructions for Case Entry <i>n/a if no special rules</i>	On-call contact information is required for expedited support. Response needed on expedited cases within 4 hours.
Delegation	<input type="checkbox"/> FDR <input checked="" type="checkbox"/> Health Plan <input type="checkbox"/> N/A
Grievance Filing limitation	Health Plan will determine timely filing.
Standard Grievance Acknowledgement Turnaround Requirement <i>Acknowledgement not required for expedited</i>	1 business day
Turnaround Time for FDR to provide an Expedited Grievance Packet	4 hours to respond to the plan. When disputing the managed care denial or extension decision. An expedited grievance may also include a complaint that a Medicare health plan refused to expedite an organization determination or reconsideration or invoked an extension to an organization determination or reconsideration time frame. Example: Over an enrollee’s objections, a Medicare health plan determines that it requires additional medical records from a health provider to decide on a request for an organization determination. The enrollee’s objection to the extension that the Medicare health plan granted to allow it to wait for the medical records should

	be classified as an expedited grievance and processed within 24 hours.
Turnaround Time for FDR to provide a Standard Grievance Packet	5 calendar days unless an extension is requested and can be granted up to 10 calendar days for complex cases.
Extension Process	The Health Plan will determine if an extension can be granted.
Grievance Requests Received at the FDR	<p>Verbal Receipts: If the FDR Contact Center receives a verbal request, the FDR Contact Center will warm transfer the call to SCAN's Contact Center to intake the grievance.</p> <p>Written Receipts: <u>Expedited:</u> If the FDR receives a written request for an expedited grievance, the FDR will forward the expedited request to the health plan within 4 hours via secure email.</p> <p><u>Standard:</u> If the FDR receives a written request for a standard grievance, the FDR will forward the standard request to the health plan within 1 business day via secure email.</p> <p>The case should not be worked on by the FDR Grievance team until the case is sent back to FDR by the Health Plan to proceed in assisting with case review.</p>

New Direct Member Reimbursement (DMR)

Requests are occasionally sent to the incorrect department and need to be redirected to the correct location. This is the process the Health Plan will follow when they receive a misdirected direct member reimbursement that is the FDR's responsibility to process.

Case type	Direct Member Reimbursement (DMR)
Delegation	<input checked="" type="checkbox"/> FDR <input type="checkbox"/> Health Plan <input type="checkbox"/> N/A
Standard DMR Acknowledgement Turnaround Requirement	Respond to the health plan within 1 business day acknowledging receipt and initial processing of the DMR.
Processing Turnaround Requirements for the DMR by the FDR	30 days clean, 60 days unclean
Workflow:	<p>If the FDR is at risk for the service:</p> <p>If misdirected to SCAN, the request will be forwarded to the appropriate department at the</p>

	<p>FDR for processing (listed on page 1 of this document). SCAN is not dictating the result of the DMR, only requesting that the request be processed and a decision issued to the member.</p> <p>According to Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance, all member requests for reimbursement must be processed and a decision including appeal rights issued to the member.</p> <p>If the DMR is missing any relevant information, the FDR will outreach to member and/or provider to attempt to obtain the missing information according to CMS best practices.</p>
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New Pre-Service Organization Determination

Requests are occasionally sent to the incorrect department and need to be redirected to the correct location. This is the process the FDR is directed to follow.

Case type	New Pre-Service Organization Determination (Prior Auth)
Delegation	<input checked="" type="checkbox"/> FDR <input type="checkbox"/> Health Plan <input type="checkbox"/> N/A
Standard Acknowledgement Turnaround Requirement	1 business day
Turnaround Time for an Expedited Appeal	72 hours
Turnaround time for a Standard	14 calendar days, 28 days with extension
Workflow:	<p>If the FDR is at risk for the service:</p> <p>If misdirected to SCAN, the request will be forward to the appropriate department at the FDR for processing (listed on page 1 of this document). SCAN is not dictating the result of the authorization, only requesting that the request be processed and a decision issued to the member.</p> <p>According to Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance, all member requests for authorization must be processed and a decision including appeal rights issued to the member.</p> <p>If the authorization is missing any relevant information, the FDR will outreach to member and/or provider to attempt to obtain the missing information according to CMS best practices.</p>

FDR Signature – Name & Title	Signature
Date of Signature	Date
SCAN Signature – Name & Title	
Date of Signature	