

MEDICAL APPEAL AND GRIEVANCE DEFINITIONS

Appeal: Any procedure that deals with the review of an unfavorable determination on the health care services an 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. These procedures include reconsideration by the Medicare Advantage organization (in our case, GHP) and if necessary, an independent review entity, hearings before Administrative Law Judges (ALJs), review by the Medicare Appeals Council (MAC), and judicial review.

Appointed Representative: A person selected by an enrollee or other party, or permitted under State or other valid law, to act on behalf of an enrollee or other party involved in the appeal. Unless otherwise stated, the representative will have all of the rights and responsibilities of an enrollee or party in obtaining an organization determination or in dealing with any of the levels of the appeals process.

Complaint: Any statement of unhappiness with a Medicare Health Plan, provider, and place of service or Quality Improvement Organization (QIO) by an enrollee made orally or in writing. This can include concern about how providers or the Medicare Health Plan do business such as: waiting times, the behavior of health care personnel, the place of service, the respect given to enrollees, the claims regarding the right of the enrollee to receive services or receive payment for services already given. It also includes a plan's refusal to provide services that an enrollee believes they should receive. 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 correct grievance and/or appeal process.

Effectuation: The reversal of the Medicare Health Plan's original decision. This could be paying a claim, approving and/or providing a service.

Enrollee: For GHP, a Medicare Advantage eligible individual who has elected a Medicare Advantage plan.

Grievance: Any complaint or disagreement, other than one involving an unfavorable determination, stating unhappiness with how a Medicare health plan or associated individual or company provides health care services, whether or not regardless of any corrective action can be taken? An enrollee may make the complaint or dispute, either orally or in writing, to a Medicare health plan, provider, or place of service. An expedited grievance may also include a complaint that a Medicare health plan refused to expedite (decide quickly) an organization determination (original decision) or reconsideration, or allow an extension to an original decision or reconsideration time frame. In addition, grievances may include complaints regarding the timeliness, correctness, access to, and/or setting of a provided health service, procedure, or item. 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.

Independent Review Entity: An independent company contracted by CMS to review Medicare health plan's unfavorable decisions.

Inquiry: Any oral or written request to a Medicare health plan, provider, or facility, without an expression of dissatisfaction, e.g., a request for information or action by an enrollee.

Organization Determination: Any decision made by a Medicare health plan to any of the following:

- Payment for temporarily out of the area renal dialysis services, emergency services, post-stabilization care, or urgently needed services,
- Payment for any other health services furnished by a provider other than the Medicare health plan that the enrollee believes are covered under Medicare, or, if not covered under Medicare, should have been furnished, arranged for, or reimbursed by the Medicare health plan

- The Medicare health plan's refusing to provide or pay for services, in whole or in part, including the type or level of services, that the enrollee believes should be furnished or arranged for by the Medicare health plan,
- Discontinuation of a service if the enrollee believes that continuation of the services is medically necessary, or
- Failure of the Medicare health plan to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the enrollee with timely notice of an adverse determination, such that a delay would adversely affect the health of the enrollee.

Quality Improvement Organization (QIO): Company involving practicing doctors and other health care experts under contract to the Federal government to monitor and improve the care given to Medicare enrollees. QIOs review complaints raised by enrollees about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Medicare health plans, and ambulatory surgical centers. The QIOs also review continued stay denials for enrollees receiving care in acute inpatient hospital facilities as well as coverage terminations in SNFs, HHAs and CORFs.

Quality of Care Issue: A quality of care complaint may be filed through the Medicare health plan's grievance process and/or a QIO. A QIO must determine whether the quality of services (including both inpatient and outpatient services) provided by a Medicare health plan meets professionally known standards of health care, including whether proper health care services have been provided and whether services have been given in correct settings.

Reconsideration: An enrollee's first step in the appeal process after an adverse organization determination; a Medicare health plan or independent review entity may reevaluate an adverse organization determination, the findings upon which it was based, and any other evidence submitted or obtained.