Sample Report

(Appendix 2)

Medicare Appeals and

Quality of Care Grievances

Organization X

April 1, 2016 to March 31, 2017

What kind of information is this?

When asked, the government requires **Organization X** to provide reports that describe **what happened** to formal complaints that **Organization X** received from their Medicare members. There are two types of formal complaints: **Appeals and Grievances.**

Medicare members have the right to file an appeal or grievance with their Medicare Advantage organization. The next few pages contain information about the appeals and quality of care grievances that **Organization X** received between April 1, 2016, and March 31, 2017.

Each organization will have different numbers of appeals and quality of care grievances, and these numbers can mean different things. For example, an organization might have a small number of appeals and quality of care grievances because the organization talks with members about their concerns and agrees to solutions. Alternatively, an organization might have a small number of appeals and quality of care grievances because its members are not aware of their right to file an appeal or grievance.

How big is **Organization X**?

Organization X has about 88,000 Medicare members.

(line 3 on the attached report)

Appeals Information beginning on Page 2
Quality of Care Grievance Information on Page 6

Information on Medicare Appeals
April 1, 2016 to March 31, 2017

What is an appeal?

An appeal is a formal complaint about **Organization X**'s decision not to pay for, not to provide, or to stop an item or service that a Medicare member believes she/he needs.

If a member cannot get an item or service that the member feels she/he needs, or if the organization has denied payment of a claim for a service the member has already received, the member can appeal. For example, a member might appeal **Organization X**'s decision to stop physical therapy, to deny a visit to a specialist, or to deny payment of a claim.

How many appeals did Organization X receive?

Organization X received 174 appeals from its Medicare members. About 2 out of every 1,000 Medicare members appealed **Organization X**'s decision not to pay for or provide, or to stop a service that they believed they needed.

(lines 2 and 4 on the attached report)

How many appeals did Organization X review?

Organization X reviewed 157 appeals during this time period.

(lines 5 through 8 on the attached report)

What happened?

From the **174** appeals it received from its members:
Organization X decided to pay for or to provide all services that the member asked for **41%** of the time.

Organization X decided not to pay for or to provide the services that the member asked for **49%** of the time.

Medicare members withdrew their request before **Organization X** issued a decision **10%** of the time.

Information on Expedited or "Fast" Appeals

April 1, 2016 to March 31, 2017

What is a "fast" or expedited appeal?

A Medicare member can request that **Organization X** review the member's appeal quickly if the member believes that his or her health could be seriously harmed by waiting for a decision about a service. This is called a request for an **expedited** or **"fast" appeal.**

Organization X's looks at each request and decides whether a "fast" appeal is necessary. By law, **Organization X** must consider an appeal as quickly as a member's health requires. If **Organization X** determines that a "fast" appeal is necessary, it must notify the Medicare member as quickly as the member's health requires but no later than 72 hours.

How many "fast" appeals did **Organization X** receive?

Organization X received **20** requests for "fast" appeal from its Medicare members.

(lines 14 through 16 on the attached report)

What happened?

When a member requested a "fast" review, **Organization X** agreed that a "fast" review was needed **75%** of the time.

Organization X did not agree to a "fast" review **25%** of the time. This number may include requests by members who the organization may not have believed were in danger or might suffer serious harm.

Information on Independent Review

April 1, 2016 to March 31, 2017

What is Independent Review of an appeal?

After a member has sent an appeal to **Organization X**, if the organization continues to decide that it should not pay for or provide all services that the member asked for, **Organization X** must send all of the information about the appeal to an independent review entity (IRE) that contracts with Medicare, not with **Organization X**.

An independent review provides an opportunity for a new, fresh look at the appeal outside of the organization. CMS' IRE goes over all of the information from **Organization X** and can consider any new information.

If the IRE does not agree with **Organization X**'s decision, **Organization X** must provide or pay for the services that the Medicare member requested.

There may be several reasons why the IRE decides to agree with either the Medicare member or **Organization X**. For example, the IRE may disagree with **Organization X** because the IRE may have had more information about the appeal.

Information on Independent Review

April 1, 2016 to March 31, 2017

How many appeals did the IRE consider?	The IRE considered **86** appeals from **Organization X**. (lines 9 through 13 on the attached report)
What happened?	The IRE agreed with the Medicare member's appeal **19%** of the time. This means that in **19%** of these cases, **Organization X** ended up paying for or providing all services that these members asked for.
	The IRE disagreed with the Medicare member's appeal **70%** of the time. This means that in **70%** of these cases, **Organization X** ended up **not** paying for or providing all services that these members asked for.
	Medicare members withdrew their request for independent review **9%** of the time.
	By June 01, 2017, **2%** of appeals were still waiting to be reviewed by the IRE.
	NOTE: These percentages may not add to 100% because sometimes the IRE dismisses an appeal.

Information on Quality of Care Grievances

April 1, 2016 to March 31, 2017

What is a quality of care grievance?

A grievance is a complaint that a Medicare member makes about the way **Organization X** provides care (other than complaints about requests for service or payment). A **grievance** about the **quality of care** is one kind of grievance. For example, a member can file a grievance about the quality of care when the member believes that the service the member received was not timely or correct, when the member had problems getting a service because of long waiting times or long travel distances, or when the wrong kind of doctor or hospital provided the service.

How many quality of care grievances did Organization X receive?

Organization X received **20** grievances about the quality of care. About **less than 1 out of every 1,000** Medicare members filed a grievance about the quality of care they received from **Organization X** doctors and hospitals.

(lines 2 and 4 under "Quality of Care Grievance Data" on the attached report)

Where can I get more information?

If you are a member of **Organization X**, you have the right to file an appeal or grievance.

You can contact **Organization X** at (insert phone number) to resolve a concern you may have or to get more information on how to file an appeal or grievance. (Be sure to include a phone number for the hearing impaired and your hours of operation.) You may also refer to your Evidence of Coverage for a complete explanation of your rights.

You also can contact a group of independent doctors in **STATE**, called a Quality Improvement Organization, at (insert QIO's phone number) for more information about quality of care grievances or to file a quality of care grievance.