**MED D -** **Grievances in PeopleSafe for Health Plans, JE (formerly MHK Fusion)**

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**Description:** Guidance when a Medicare Part D beneficiary is expressing dissatisfaction or requesting to file a complaint with any aspect of a plan’s (Client’s) operations, activities, or behaviors.

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| **High Level Process** | |
| 1. [**Identify**](#_Identifying_a_Grievance_1) **if the caller is expressing dissatisfaction and a Grievance should be filed.**  * Ensure the caller is not calling concerning a [Coverage Determination](#_Coverage_Determinations_vs.). | **Reminder:**   * Utilize [Grievance Standard Verbiage](#_Grievance_Standard_Verbiage_1) when discussing Grievances with the beneficiary. * Ensure that the issue is a [valid Grievance](#HLPValidGRV). |
| 1. **Determine the following:**  * First, determine if the Grievance is [handled by CVS or the Client](#_Determine_if_Grievance_1). Refer to the CIF to determine if the Client has contracted with CVS Caremark to handle its MED D Grievances. * Second, determine if the [caller is qualified](#_Who_Can_File_2) to file a Grievance. * Third, determine if the [time limit for filing](#_Time_Limits_for) a Grievance has been reached. | **After three factors in Step 2 are determined:**   * If **CVS handles** the Grievance, the caller is authorized to file **AND** the time limit for filing has not been reached, proceed to [Step 3](#HLPStep3). * If **Client handles** the Grievance, the caller is authorized to file per the CIF **AND** the time limit for filing has not been reached, follow the Grievance process per the instructions in the CIF. |
| 1. **Determine if a** [**Quality of Care**](#_Quality_of_Care) **issue.** | |
| 1. **Determine if** [**First Call Resolution or New Grievance**](#_Grievance_Process)**.** | **Reminder:**   * Review the [First Call Resolution](#_First_Call_Resolution) examples. |
| 1. [**Create**](#_Creating_a_Resolved) **the Grievance in PeopleSafe.**  * Utilize the following to properly file the Grievance:   + [Grievance Categories and Definitions](#_Grievance_Categories_and_2)   + [Grievance Activity Codes](#_Grievance_Activity_Codes_1) | **Reminder:**   * Check for [previously submitted Grievances](#_Previously_Submitted_Grievances_1). * [Client-handled Grievances](#_Documenting_a_Client) do not follow the typical Grievance process. |

**When to File a Grievance**

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| **Identifying a Grievance** |

Icon - Important Be sure to reference the appropriate Work Instructions to determine if you can resolve the issue prior to filing a Grievance - refer to [MED D - Commonly Used Work Instructions Index (089595)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=45cc9b47-1035-4597-b0ca-52d3109f8c8d) and/or theSource.

CMS requires any dissatisfaction expressed by a beneficiary to be reported as a Grievance. This dissatisfaction is reported regardless if the issue is completely corrected, resolved, or education is provided to the beneficiary on the phone call.

**Note:** When a beneficiary expresses dissatisfaction, the plan has a responsibility to formally research and provide resolution to the issue. When you help resolve a beneficiary’s dissatisfaction, then you are an important advocate for the beneficiary. Reporting a Grievance is an important contribution to ensuring that our Clients are in compliance with CMS regulations. The Grievance process allows CVS Caremark to track and trend dissatisfactions so that we improve on both the beneficiary’s experience and the Client’s experience with our organization.

If the beneficiary calls with the same issue and the previous Grievance on that issue is closed, a Grievance must be filed (**Status Reason** “…Resolution” indicates the Grievance is closed). CMS does not limit the number of times a beneficiary can file a Grievance about the same issue.  
**Example:** Beneficiary complains about the IVR every time they call in.

If previous Grievance for this issue is closed, another Grievance must be filed.   
**Exception:** If the issue the beneficiary is complaining about was an FCR Grievance that was filed the same day of your call, another Grievance would not be filed. Document in PeopleSafe a reference to the Grievance filed earlier that same day.

Examples of when a Grievance **cannot** be filed:

* Sixty (60) days after the event that caused the dissatisfaction (date of occurrence)
* Caller is not eligible to file a Grievance
* LEP assessment
* Part B medication and **any action** associated with that medication (i.e., incorrect shipping address, poor customer service, etc.) Medicare Part B dissatisfaction is handled by the Plan that the beneficiary is enrolled with.

The table below will assist the CCR in determining if the beneficiary is expressing dissatisfaction.

In order to be deemed a MED D Grievance, the complaint must meet the following:

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| **Criteria** | **Information/Examples** |
| The beneficiary must express dissatisfaction or request to file a complaint with any aspect of a plan’s operations, activities, or behaviors.  **Note:** Differentiate between inquiry and emotion‑based tone that will trigger a Grievance. | Expressions of dissatisfaction may include a variety of behaviors:   * Profanity or yelling * Tone of voice, sighing between statements * A statement of dissatisfaction from the caller including words such as:   + “This is frustrating.”   + “I’m not happy <insert reason>”   + “This is making me upset.”   + “I’m not happy that you aren’t located in the USA.”   + Asking to file a Grievance   + Other expressions indicating unhappiness with some aspect of the plan.   Expressions of dissatisfaction may also be more subtle:   * Statements of confusion with a situation or process such as:   + “Why do I always have to…?”   + “I don’t feel like I’m being heard/understood.”   + “I’ve been through this before/over and over.”   + “I’ve called (X number of) times about this.”   Considerations to determine if member is dissatisfied may include:   * Even though you were able to resolve the reason for the call today, was the beneficiary not happy at the beginning of the call? * Even though you were able to assist, was the beneficiary given misleading information at some point prior to your interaction? |

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| **Coverage Determinations vs. Grievances** |

Icon - Important Be sure to reference the appropriate Work Instructions to determine if you can resolve the issue prior to filing a Grievance - refer to [MED D - Commonly Used Work Instructions Index (089595)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=45cc9b47-1035-4597-b0ca-52d3109f8c8d) and/or theSource.

Since Grievance procedures are separate and distinct from the procedures that apply to [MED D - Coverage Determinations and Redeterminations (Appeals) Landing Page (004825)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=1e7d7ad7-e1c1-4fa1-8258-215a1c0ff32b), it is critical to determine the nature of the beneficiary’s complaint.

* CCR must determine whether the coverage issues in a beneficiary’s complaint meet the definition of a Grievance, a Coverage Determination, or both and ensure that the beneficiary will be assisted using the [appropriate procedures (027480)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=06e8f82d-e7b7-4a60-9c81-3bf7c37aadbf).
* Plan sponsors are required to resolve a beneficiary’s coverage complaint or dispute using the appropriate procedures.
  + If a beneficiary addresses **two or more issues** during the call, each issue should be processed **separately** within the proper time frames.
  + If the coverage issue includes both a Grievance and Coverage Determination, ensure that documentation for a Grievance indicates dissatisfaction with the Coverage Determination process, and that a request for Coverage Determination has been submitted to the CD&A Department. **File the Grievance as a** [**Resolved Grievance - First Call Resolution**](#_Creating_a_Grievance_1)**,** then open a Coverage Determination **simultaneously**.

**EXAMPLES:**

* If a Tier Exception will lower the cost by removing the deductible or Coverage Gap, then the scenario is a Coverage Determination and not a Grievance.
* When a beneficiary calls to open a Grievance related to a subject matter which is **not clinically related** (e.g., pay premium bill), but part of the beneficiary’s issue references the inconvenience to start a Coverage Determination to obtain the medication, the CCR:
  + Opens the Grievance that is specific to the beneficiary’s issue.
  + Creates a CD&A RM Task (if the CD has not already been filed).
  + For Coverage Determination and PA refer to [MED D - Coverage Determinations and Redeterminations (Appeals) Landing Page (004825)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=1e7d7ad7-e1c1-4fa1-8258-215a1c0ff32b).

Icon - Important For instances when the CCR opens a Grievance and also has a beneficiary request for a Coverage Determination, [clear notes (011617) - Expired](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=b777e546-43ed-498e-8cff-e13a0db07607) are **required** to be entered in **PeopleSafe** in order for the Grievance team and CD&A team to be aware that both issues are being worked **separately** and **simultaneously**.

Icon - Important A beneficiary **CANNOT** file a Grievance about an appeal decision because the appeals process accounts for dissatisfaction with the CD denial/dismissal and any complaint about a decision would be handled within the formal Appeals Process. A beneficiary can only file a Grievance if the beneficiary states they are dissatisfied about the **process,** e.g., they have to wait additional time for a decision, or their physician has to complete additional paperwork.

In order to assist in determining the difference between a Grievance and a Coverage Determination, refer to [MED D - Grievance vs. Coverage Determination - Decision Matrix (027480)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=06e8f82d-e7b7-4a60-9c81-3bf7c37aadbf).

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| **Grievance Standard Verbiage (for use in Discussion with Beneficiary)** |

Icon - Important Be sure to reference the appropriate Work Instructions to determine if you can resolve the issue prior to filing a Grievance - refer to [MED D - Commonly Used Work Instructions Index (089595)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=45cc9b47-1035-4597-b0ca-52d3109f8c8d) and/or theSource.

**Reminder:** If dissatisfaction is identified, refer to the CIF to determine if grievances are handled by the Client.

**** I understand your frustration. Let me see what I can do to resolve your issue.

Take **one** of the following 3 actions:

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| **Who handles the Grievance?** | **Then…** |
| Client handles Grievances | Refer to [Documenting a Client-handled Grievance](#_08.10.18__Documenting). |
| CVS Caremark handles the Grievance and CCR **was able to fully resolve** the beneficiary’s issue | Do **NOT** mention the word grievance or inform the beneficiary you are filing a grievance. CMS mandates that all dissatisfaction be reported.   * File as [First Call Resolution](#_Creating_a_Grievance_1)     **DO NOT** ask:   * Do you want to file a Grievance? **OR** * Would you like to open a Grievance? |
| CVS Caremark handles the Grievance and CCR **was NOT able to fully resolve** the beneficiary’s issue | * Do as much as possible to ensure the beneficiary’s issue is resolved and has medication. * Advise the beneficiary that since you were unable to resolve the beneficiary’s dissatisfaction/issue, then you are sending the issue over to a dedicated department that will research and respond to the beneficiary within 30 calendar days. This department is called the Grievance department. The response to your issue may or may not change the outcome of what has occurred.   **DO NOT** ask:   * Do you want to file a Grievance? **OR** * Would you like to open a Grievance?   **Note:** If the beneficiary states they do not want a grievance filed, inform them that CMS mandates that all dissatisfaction be reported and that their issue may not be researched and resolved if the grievance is not filed. If they are still adamant that the grievance not be filed, document PeopleSafe that the beneficiary refused filing the grievance. |

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| **Determine if Grievance is Handled by CVS or Client** |

Icon - Important Be sure to reference the appropriate Work Instructions to determine if you can resolve the issue prior to filing a Grievance - refer to [MED D - Commonly Used Work Instructions Index (089595)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=45cc9b47-1035-4597-b0ca-52d3109f8c8d) and/or theSource.

**Note:**For Coverage Determination and PA process, refer to [MED D - Coverage Determinations and Redeterminations (Appeals) Landing Page (004825)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=1e7d7ad7-e1c1-4fa1-8258-215a1c0ff32b). If a beneficiary has a Grievance handled by the Client and a Coverage Determination handled by Caremark, use the RM Task process for the Coverage Determination and offer to warm transfer the beneficiary to the Client for the Grievance.

Before moving forward with the Grievance process, the CCR must refer to the CIF to determine if the Client has contracted with CVS Caremark to handle its MED D Grievances. If Client is delegated to handle the Grievance, refer to [Documenting a Client Grievance](#_Documenting_a_Client).

**Exception:** If CVS Caremark does not handle the Client’s Grievances and it’s a discrimination related complaint, refer to the If/Then table below.

**CVS Caremark may handle:**

* **ALL** Grievance categories for a Client
* **SPECIFIC** Grievance categories for a Client
* **NO** Grievance categories for a Client

In order to make the proper determination, the CCR **MUST** verify the Grievance details in the CIF.

**CCR Process Note:**

The CCR should always try to resolve the beneficiary’s issue and explain the Grievance process.

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| **If…** | **Then…** | |
| CCR needs to reach out to any of the following teams for assistance:   * Senior Team * Premium Billing * Clinical Care Services * SMST | CCR: The Grievance should still be filed if CVS Caremark handles Grievances for the Client.   * **If the call is not escalated (Assist):** It is the responsibility of the CCR to file the Grievance and notate the account appropriately. * **If the call is escalated (Procedural Transfer) and issue is resolved prior to transfer:** It is the responsibility of the CCR to file the Grievance and notate the account appropriately. It is the responsibility of the CCR to advise the Senior Representative if a Grievance has been filed. * **If the call is escalated (Procedural Transfer) and issue is NOT resolved prior to transfer:** It is the responsibility of the Senior Escalation Team to file the Grievance and notate the account appropriately.   Icon - Important In the event the call is highly escalated, the Grievance number does not have to be provided to the caller, it should be notated in the beneficiary’s account only.  For multiple Grievance categories, CCR should not file a Grievance for the issue they are transferring to another team for. The CCR is responsible for all other Grievances on the call.  **Exception:** If the beneficiary is upset with the cost of the medication and there is not a CD option that would lower the cost, transfer to Clinical **only** for alternatives. The CCR must file a First Call Resolution (Resolved) Grievance for Plan Design **prior** to making the transfer to Clinical. Advise the Clinical team you have filed a Grievance. | |
| CVS does NOT handle Grievances for the Client **AND** the call is regarding **DISCRIMINATION**  (Calling to complain about discrimination due to race, color, national origin, age, disability, or sex) | * Exhibit empathy for your caller. * Check the time of day to determine if the SRU is open. | |
| **If SRU is…** | **Then…** |
| Open  **M–F**  8:00AM – 5:00PM CST | * Warm transfer the caller to the SRU at 1-866-526-4075.   **Note:** SRU phone number can be shared with the caller, but Representative should not leave a message if option is presented.   * Provide the name of the caller, the caller’s ID number and nature of the complaint. * Bring on the caller and introduce to the SRU. * Release the call. * Add a note to the beneficiary’s account indicating a warm transfer to SRU unit per caller’s request. |
| Closed (After Hours) or if all lines are busy | Provide options to beneficiary:   * Notify the beneficiary of the Nondiscrimination Coordinator business hours at 1-866-526-4075. (Monday-Friday 8:00AM – 5:00PM CST)   + Beneficiary will need to provide their name, beneficiary ID, email address, phone number or TTY and reason for the call. * Beneficiary can choose an alternative way to file a complaint. Beneficiary must provide the following information:   + Name, Beneficiary ID, email address, phone number or TTY, and reason for the call.   **After Hours preference options include:**   * **Mail a letter to:** Nondiscrimination Coordinator * PO BOX 6590, Lee’s Summit, MO 64064-6590 * **Fax:** 1-855-245-2135   **Email:** Nondiscrimination@cvscaremark.com  **Use only as a last resort alternative**:   * **Call:** 1-866-526-4075   **Note:** SRU phone number can be shared with the caller, but CCR should not leave a message if option is presented. |

**REMINDER:** PeopleSafe will provide ***pop-up messages*** to ensure a Grievance is ***not*** submitted for ***unsupported*** MED D clients.

A screenshot of a computer error message

AI-generated content may be incorrect.

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| **Who Can File A Grievance?** |

Icon - Important Be sure to reference the appropriate Work Instructions to determine if you can resolve the issue prior to filing a Grievance - refer to [MED D - Commonly Used Work Instructions Index (089595)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=45cc9b47-1035-4597-b0ca-52d3109f8c8d) and/or theSource.

Before beginning the Grievance process, CCRs **MUST** verify they are speaking to the beneficiary, SHIP Counselor, an Appointed Representative, or the Power of Attorney.

**Notes:**

* A Grievance cannot be filed for a deceased beneficiary unless the purported representative has the authority to file a grievance (**Example:** Executor of an estate).
* If you have a Grievance or CD opportunity, authenticate the beneficiary and obtain permission for the caller to act on behalf of the beneficiary to complete process. If the beneficiary is unable to come to the phone to give permission, an AOR/POA is required.
* For Client-handled Grievances: If the caller is not the beneficiary and there is no AOR/POA on file, attempt to transfer to the Client. Refer to [Determine if Grievance is Handled by CVS or Client](#_Determine_if_Grievance) and [Documenting a Client-handled Grievance](#_Documenting_a_Client).

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| **If the person is…** | **Then…** | | |
| Informal Authorized Third-Party | When the beneficiary is present and is fully authenticated by speaking directly to the CCR and verifies that the third party is authorized to speak on their behalf, the third party may file a Grievance in the same way as it would be speaking directly to the beneficiary.   * Obtain the caller’s:   + Name   + Address   + Phone   + Relationship to member   + Icon - Important Include if member’s verbal authorization was provided     **Note:** **Filed by** will be **Beneficiary** in this case – refer to [Step 3](#Step3PS) in [Creating a Grievance in PeopleSafe](#_Creating_a_Resolved). |
| Prospective beneficiary    (someone who may potentially join the plan and does not have a future effective date) | The person cannot file a Grievance. | | |
| Disenrolled beneficiary | The person can file a Grievance on their own behalf. See [Creating a Grievance in PeopleSafe](#_Creating_a_Resolved) for guidance. | | |
| Beneficiary (includes new member whose enrollment is approved by CMS) | Determine the following: | | |
| **If Beneficiary…** | | **Then…** |
| Has account visible in PeopleSafe with a current or future effective date | | Continue with [filing a Grievance](#_How_to_File) if delegated. |
| Is expressing dissatisfaction about a previous PBM; however, is now active/enrolled with Caremark Mail Service  **Example**: Beneficiary is actively enrolled with *Florida Community Care* (a CVS Caremark mail order client). They were with *Florida Community Care* last year but used another PBM (not CVS Caremark). They call into our call center and express dissatisfaction about something that went wrong with the prior PBM and/or plan year. | | Continue with [filing a Grievance](#_How_to_File) if delegated.   * If appropriate, advise the member that they may reach out to their previous PBM with questions. |
| Is expressing dissatisfaction about a different plan (not the plan they are currently enrolled in)  **Example**: Beneficiary is actively enrolled with *Florida Community Care* (a CVS Caremark mail order client). They call into our call center and express dissatisfaction about the plan they had last year with *Health Plans R’ Us* (not a CVS Caremark mail order client). | | Advise the beneficiary to contact their previous Plan or PBM. |
| Power of Attorney (POA) or Legal Representative (Guardian) for the beneficiary | Refer [MED D - Appointed Representative Form (AOR) or Power of Attorney (POA) (021424)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=4008954a-0d95-4ea9-add2-3a7dfa02c718) in order to locate legal documentation information.   * **For Non-Health Plan:** Check the **View Comments** box on the **Medicare D Inquiry** tab to determine if the POA document is on file. * **For Health Plan:** Check High Priority Comments to determine if the POA document is on file. | | |
| **If…** | **Then…** | |
| POA is provided and on file | The caller can file a Grievance. | |
| POA is not on file | The caller can file a Grievance if the dissatisfaction is expressed on behalf of the beneficiary.   * Ensure the drop down in [Step 3](#Step3PS), **Filed By** is selected for **POA** and all applicable information is filled in. Fill out POA information using all capital letters for name and address. * If no POA on file, the Grievance Team will send a letter and a copy of the AOR form advising the caller and/or beneficiary to provide a copy of the POA or completed AOR form. * The documentation must be returned within 30 days otherwise the Grievance will be dismissed.   I understand you are stating dissatisfaction on behalf of the beneficiary. In order to formally resolve the dissatisfaction, I will need to have you provide a copy of the POA. Can you please provide me your address? | |
| **If address is...** | **Then...** |
| Provided | Advise the caller that they will receive a letter and a copy of the AOR form advising them to provide a copy of the POA or completed AOR form. The documentation must be returned within 30 days otherwise the Grievance will be dismissed. |
| Not Provided | The beneficiary will receive notification of the grievance requesting a copy of the POA. |
| **Health Plan Only:** POA is on file with the Health Plan | Contact Health Plan and determine if POA is on file. | |
| **If...** | **Then...** |
| On File | * Ask Health Plan to fax the POA to CVS Caremark at **1-866-552-6205**. * Document in PeopleSafe: Contacted Health Plan and confirmed POA is on file. * Proceed with filing a Grievance. |
| Not on File | The caller can file a Grievance.  Refer to the POA not on file section above. |
| Caller states POA is already on file with the Plan | The caller can file a Grievance.  Advise the caller that the Grievance Team will reach out to the Plan to obtain a copy of the POA. If POA is not on file, a **copy** of the POA will need to be provided. | |
| An Appointed Representative (AOR) (includes a Provider/Prescriber) | A new AOR does not have to be filed for every new issue if an AOR is on file that is not older than one year.   * **For Non-Health Plan:** Check the **View Comments** box on the **Medicare D Inquiry** tab to determine if the AOR document is on file and is not expired. * **For Health Plan:** Check High Priority Comments to determine if the AOR document is on file and is not expired.   **Notes:**   * Per CMS guidelines, AORs are only good for one year from the date of signature. * If a provider is wanting to file a grievance on behalf of a member about something the member experienced, they can, and it would fall under the same process as grievances received from a representative. An AOR or equivalent written authorization is needed for a grievance to be filed by a provider on a member’s behalf.   Icon - Important A Plan Member Authorization form or Personal Health Information (PHI) Authorization form is not acceptable to file a Grievance. | | |
| **If…** | **Then…** | |
| AOR is provided and on file | The caller can file a Grievance. | |
| AOR is not on file | The caller can file a Grievance if the dissatisfaction is expressed on behalf of the beneficiary.   * Ensure the drop down in [Step 3](#Step3PS), **Filed By** is selected for **AOR** and all applicable information is filled in. Fill out AOR information using all capital letters for name and address. * If no AOR on file, the Grievance Team will send an AOR form directly to the beneficiary and the caller.   + The caller may also download an [AOR form (021424)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=4008954a-0d95-4ea9-add2-3a7dfa02c718) from the Plan’s website.   + The AOR form must be returned within 30 days otherwise the Grievance will be dismissed.   I understand you are stating dissatisfaction on behalf of the beneficiary. In order to formally resolve the dissatisfaction, I will need to have you complete a MED D Appointed Representative (AOR) Form. Can you please provide me your address? | |
| **If address is...** | **Then...** |
| Provided | Advise the caller that they will receive a letter and a copy of the AOR form advising them to provide a copy of the POA or completed AOR form. The documentation must be returned within 30 days otherwise the Grievance will be dismissed. |
| Not Provided | The beneficiary will receive the AOR form to complete. |
| **Health Plan Only:** AOR is on file with the Health Plan | Contact Health Plan and determine if AOR is on file. | |
| **If...** | **Then...** |
| On File | * Ask Health Plan to fax the AOR to CVS Caremark at **1-866-552-6205**. * Document in PeopleSafe: Contacted Health Plan and confirmed AOR form is on file. * Proceed with filing a Grievance. |
| Not on File | The caller can file a Grievance.  Refer to the AOR not on file section above. |
| Caller states AOR is already on file with the Plan | The caller can file a Grievance.   * Advise the caller that the Grievance Team will reach out to the Plan to obtain a copy of the AOR. If AOR is not on file or has expired, a new form will be sent. | |
| SHIP Counselor | Can file if a unique SHIP ID is provided **and** the beneficiary or their representative has provided written or verbal permission for the SHIP Counselor to act and/or speak on their behalf. Refer to the [Medicare and Medicaid SHIP Counselor Unique ID List (077234)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=fadccc80-a0a1-449b-b5b0-056705aad9ec) job aid in theSource.  **Note:** Select **Beneficiary** under “Filed by” when filing a Grievance. Document in PeopleSafe that the SHIP unique ID was verified. Also note if verbal permission was provided by the beneficiary. | | |
| Executor of Estate | Death certificate must be submitted for deceased beneficiary. |
| A client representative  (beneficiary or their purported representative was **not on the line** to express dissatisfaction) | Cannot file a grievance unless the beneficiary or their purported representative (not the client representative) is the one who expressed the dissatisfaction.  If the client representative is trying to file a grievance as a courtesy to the beneficiary or their purported representative, but the beneficiary or their purported representative did not express dissatisfaction, it is not a valid grievance. | | |
| A client representative  (beneficiary or their purported representative are/were **on the line** to express dissatisfaction) | Can file a grievance since the beneficiary or their purported representative are the ones expressing dissatisfaction. | | |
| Provider | Cannot file a grievance if the dissatisfaction they are expressing is their own and not on the beneficiary’s behalf. Providers should file complaints to the Plans in accordance with the applicable Plans’ dispute resolution processes.   * If the provider feels the resolution determined by the Plans’ dispute resolution process is unsatisfactory, the provider may contact their local CMS Regional Office.   If the provider is expressing dissatisfaction on the beneficiary’s behalf, the provider can file a grievance the same way as a third-party caller. An AOR form would be needed unless the beneficiary is also on the line. Refer to [Informal Authorized Third-Party](#Informal_Authorized_Third_Party). | | |

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| **Time Limits for Filing a Grievance** |

Icon - Important Be sure to reference the appropriate Work Instructions to determine if you can resolve the issue prior to filing a Grievance - refer to [MED D - Commonly Used Work Instructions Index (089595)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=45cc9b47-1035-4597-b0ca-52d3109f8c8d) and/or theSource.

**CMS regulations state:**

“An enrollee may file a grievance with the Part D plan sponsor either orally or in writing **no later than 60 days** after the event or incident that precipitates the grievance.”

Therefore, if the elapsed time between the date of the event (or occurrence) and the date of reporting the Grievance is greater than 60 days, a Grievance should **NOT** be opened.

* Instead, the CCR should continue to work the issue until resolved without filing a grievance.

**Note:** If the event date is open to interpretation, choose the **most recent** reasonable date.

**REMINDER:** The system provides a **pop-up message** when a Grievance is **not** within the 60-day window.

A screenshot of a webpage

AI-generated content may be incorrect.

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| **Quality of Care** |

**Quality of Care** is an expression of dissatisfaction regarding the Part D Plan standard of health care including whether health care services have not been provided or have been provided in inappropriate settings. For a Part D Plan, an example of health care services is the beneficiary’s prescription medication.

Icon - Important Quality of Care must **ALWAYS** be filed as a New Grievance as it requires written follow up.

* Refer to the following sections within this document:
  + [Identifying a Grievance](#_Identifying_a_Grievance_1) to determine if a Grievance should be filed.

* + [Grievance Categories and Definitions](#_Grievance_Categories_and_2) ([Quality of Care](#C12)) to determine the Category and subcategory to select when filing a Quality of Care Grievance.
* Ensure that you take all steps necessary to ensure the beneficiary has medication before ending the call.
* Quality of Care Grievances **cannot** be filed as First Call Resolution.

**Quality of Care Decision Grid**

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| A Quality of Care Grievance **should NOT** be filed when: | A Quality of Care Grievance **MUST** be filed when (including, but not limited to): |
| * Coverage Determination and/or Redetermination denial * Beneficiary’s decision to not obtain the medication due to cost and no incorrect information had been given to the beneficiary regarding cost * Beneficiary’s neglect to order the medication * Order delayed due to state/national disaster and/or weather event (refer to [Disaster Recovery/Severe Weather Plan Member Talk Track Index (059779) - Expired](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=577c08f2-a95d-4c27-84a6-018e09039189)) * Beneficiary submits order but does not respond to a Plan request which places the order on hold (including, but not limited to):   + Beneficiary did not provide Expressed Consent (Ship Consent)   + High dollar co-pay call (co-pay above dollar threshold)   + Beneficiary has unpaid account balance | * Beneficiary’s medication delayed as a result of:   + Plan, prescriber, and/or pharmacy error   + Medication lost in transit/delivery * Incorrect Rx shipped * Mail Order issue such as cold pack broken, medication damaged * Plan did not update beneficiary’s address and medication shipped to incorrect address * Manufacturer backorder of medication and pharmacy did not reach out to prescriber for alternative * Beneficiary provided high copay approval; however, account was not updated, and medication did not ship * Expressed Consent (Ship Consent) process failure (i.e., system did not send a text/email or call) * Beneficiary did not receive the correct type/amount/instructions for the medication (not due to transition fill) (including, but not limited to):   + 90-day fill received 75 days of medication (excludes pre-packaged medications, such as eye drops)   + Incorrect dosage instructions * Mail Order Rx error (i.e., Auto Refill Program fails) * Retail Rx error |

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| **First Call Resolution Examples** |

Icon - Important Be sure to reference the appropriate Work Instructions to determine if you can resolve the issue prior to filing a Grievance - refer to [MED D - Commonly Used Work Instructions Index (089595)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=45cc9b47-1035-4597-b0ca-52d3109f8c8d) and/or theSource.

The following are examples of First Call Resolution. This is **not** an all-inclusive list - there may be other circumstances when a First Call Resolution may be filed. Refer to:

* [Med D - Compass Grievances: CCR - First Call Resolution Documentation Templates (Health Plans) (066744)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=0e126cf2-ca19-4e62-b84f-72733e77b8b9) (066744)
* [Med D - Compass Grievances: CCR - First Call Resolution Documentation Templates (NEJE) (066745)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=cb56c2af-d1ed-4e8a-a309-d0db70d8c751) (066745)

**Note:** Once you have selected the appropriate category, select the subcategory that best fits the scenario.

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| **CMS ISSUES**   * Pharmacy is excluded from the Medicare program * Manufacturer cost of drug increased * CMS auto or facilitated their enrollment into Part D plan against their wishes | **EXCEPTIONS COVERAGE DECISIONS**   * Drug requires a Prior Authorization (PA) or exception and not being notified * CD or RD process - paperwork, contacting prescriber, turnaround time * Not notified of expiring CD * Confusing CD or RD notices or denials * Having to file CD annually * Physician wrote prescription so additional approval should not be necessary |
| **CUSTOMER SERVICE**   * Long hold time * Call disconnected * Multiple transfers during call * Authentication process * Not being able to reach same Representative * Unable to reach Supervisor * Having to speak to Supervisor or Senior on every call because the CCR unable to assist * Unhappy due to not being able to understand CCR * Unhappy CCR is not located in the USA | **ENROLLMENT/DISENROLLMENT**   * Received multiple Residence Verification Forms (RVF) * Called to update address multiple times * Received RVF but did not move * Disenrolled but did not receive Out of Area (OOA) letter * Had to provide attestation for creditable coverage to avoid Late Enrollment Penalty (LEP)multiple times * Returned Declaration of Prior Prescription Drug Coverage form but received LEP - account shows no LEP * Received multiple LEP letters * LEP process – having to complete paperwork or calling * Received favorable appeal decision regarding LEP but charged LEP - account shows no LEP * Incorrect address on file – address now corrected * Explanation of Benefits - does not want to receive * Enrollment and/or disenrollment process * Multiple attempts to disenroll * Receiving COB letter annually * Did not receive plan materials, ID card * Plan materials confusing |
| **MARKETING**   * Price difference between Medicare Plan Finder/Plan website * Charged different price than displayed on Plan website * ACA 1557 discrimination insert in plan materials * Functionality or content on Client website (i.e., aetnamedicare.com, RxMedicarePlans.com, etc.) * Telemarketing calls |
| **PHARMACY**   * Order sent to address on file but not the correct address – no error * Order delayed due to ship consent - no pharmacy error * Automatic Refill Program (ARP) – scripts not enrolled * Prescription not eligible for ARP * Receives too many phone calls for orders * Received confusing letters from the mail service pharmacy * Pre-payment for mail service orders, particularly $0 copay orders * Unable to read prescription labels * Bottle size too big or too small * Upset with packaging * Refill date missing from label * Unable to cancel order * Medications sent in multiple orders * Lag time to see prescriptions on caremark.com * No savings through mail service pharmacy * Medication not available at mail service or retail pharmacy * Received correct medication but different size or color * Cost not provided prior to shipping * Consent process * Difficulty ordering medications on caremark.com * Pharmacy removed from network or not preferred pharmacy * Dispense As Written (DAW) requirements * Mail tag request when pharmacy error and approved to send * Turnaround time for mail tag * Dirty/Unclean pharmacy | **BENEFITS**   * Medication not eligible for tier exception * Plan changes for new plan year * General plan design – not for specific drug * Cost of medication increased with no plan error * Plan not paying towards cost of medication * Deductible or coverage gap * Tier exception is not applicable during the coverage gap * Cost too high after formulary exception approved * Tier change * Formulary and or/formulary change; not informed * Received transition fill and not full day supply; unhappy with TF process * Drug not covered by Med D law * Override policies * Not aware TrOOP started at $0 at beginning of plan year * Over-the-counter medications not covered * Specialty medications have 30 day quantity limit |
| **PREMIUM BILLING**   * Not receiving premium invoice * Difficulty setting up alternate payment method * Payment plan not set up despite previous request; no plan error * Alternate payment method stopped without request; no plan error * Disenrolled but still receiving an invoice * Premium increase * Issue paying premium at the pharmacy, payment portal, or through IVR * Unable to view premium payment history online * Inappropriate billing by pharmacy | **OTHER (IVR, Website)**   * IVR - content, frequency, timing, difficult to use, voice recognition * Hold time on IVR * Hold music * Wants phone answered by live representative * Plan unable to fax or email information * IVR providing information in Spanish |

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**How to File a Grievance**

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| **Grievance Process** |

Icon - Important Be sure to reference the appropriate Work Instructions to determine if you can resolve the issue prior to filing a Grievance - refer to [MED D - Commonly Used Work Instructions Index (089595)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=45cc9b47-1035-4597-b0ca-52d3109f8c8d) and/or theSource.

Icon - Important **Note:** All Grievances will be filed in PeopleSafe. There are two ways to file a Grievance:

* New Grievance (unresolved issue)
* First Call Resolution (resolved issue)
* **NEVER** enter any information into the **Case Notes** field.



If there is a [Quality of Care](#QoC) issue,Grievance **MUST** be filed as a New Grievance. **NEVER** file a First Call Resolution Grievance if there is a [Quality of Care](#QoC) issue.

Icon - Important When dealing with a Grievance situation, you will have one of the two situations below which requires you to use the appropriate tool to record the Grievance:

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| **Situation** | | **Issue Resolved?** | **Actions** |
| Issue Resolved (First Call Resolution)  Icon - Important **Reminder:** If there is a [Quality of Care](#QoC) issue,Grievance **MUST** be filed in PeopleSafe as a New Grievance. **NEVER** file a First Call Resolution Grievance if there is a [Quality of Care](#QoC) issue. DO NOT use **First Call Resolution** for a **Status** reason for [Quality of Care](#QoC). | | CCR can resolve the issue on the call (i.e., Beneficiary’s dissatisfaction was fully resolved during the initial call without any additional action/research needed by CVS).  **Note:** If an RM Task needs to be filed and/or the call needs to be transferred for the following reasons, the case can still be closed using First Call Resolution in PeopleSafe. Examples include (but are not limited to):   * Premium Billing Invoice (confirmed invoices were sent to correct address, duplicate requested by Beneficiary) * Sending duplicate plan material when initial material was sent properly * Any fulfillment request (**Examples:** ID card, mail order form, paper claim form) * Mail tag is allowed based on standard process and Senior submitted mail tag request (**Example:** non-beneficiary initiated refill) * CD&A task is closed, beneficiary is upset about process which Clinical Staff educated them on. | * If you are not transferring the call, use **First Call Resolution** as status reason. * If you are transferring the call to the following teams, provide them information regarding a potential Grievance: * Senior Team * Premium Billing * Clinical Care Services **Exception:** If the beneficiary is upset with the cost of the medication and there is not a CD option that would lower the cost, transfer to Clinical **only** for alternatives. The CCR must file a First Call Resolution (Resolved) Grievance for Plan Design **prior** to making the transfer to Clinical. Advise the Clinical team you have filed a Grievance. * SMST   **Notes:**   * Always check PeopleSafe for existing Grievances. * **DO NOT** enter another Grievance for the same Category if the Grievance is still open.   + If there is an open/in-progress Grievance, educate the member that the issue has been filed and advise of TAT.   + If there is an open Grievance and another Grievance in the same Category occurs, notate the account and send email to [DelegatedGrievance@CVSHealth.com](mailto:DelegatedGrievance@CVSHealth.com) and CC your supervisor     - It is the Category that determines the Grievance, not the subcategory.   + If the previous Grievance is closed/resolved, file a new Grievance.   **Examples:**   * Beneficiary is upset that they had to wait so long on hold, and then call got disconnected. This is ONE Grievance under the same category (Customer Service). * Beneficiary is unhappy that they have to pay a deductible, and also complains that the co-pay is too high - this is ONE Grievance under the same category (Benefits) even though it’s different subcategories. * If a beneficiary calls in about TAT on medication shipment, then calls two days later stating that the same medication arrived damaged, this is ONE Grievance if the initial Grievance is still open.   **Exception:** If a Grievance issue within a different Category comes up during the call, you **MUST** file a new Grievance. |
| Issue Requires Additional Research or Secondary Action (New Grievance) | CCR cannot resolve the issue on the call - examples include:   * A task submitted for other department’s action where the outcome is unknown * Pending account manager approval for PBO * Pending approval for mail tag * Waiting on call pull to determine if member’s request can be honored (i.e., refund on shipping) * Leaving a voicemail at a prescriber’s office, but member still does not have medication * Issue with previous CCR (rude, incomplete information provided, etc.) * Caller disconnects, CCR is unable to fully resolve or educate caller   **Note:** Always do whatever is possible to resolve the Beneficiary’s issue and/or educate the Beneficiary. | | * [Document the Grievance in PeopleSafe](#_Creating_a_Resolved):   + With detailed notes.   + Following all of the current procedures for filing a Grievance. * Select **New Grievance** as status reason.   + Submit the Grievance and document in PeopleSafe; include Grievance number. * **DO NOT** enter another Grievance for the same Category if the Grievance is still open.   + If there is an open/in-progress Grievance, educate the member that the issue has been filed and advise of TAT.   + If there is an open Grievance and another Grievance in the same Category occurs, notate the account and send email to [DelegatedGrievance@CVSHealth.com](mailto:DelegatedGrievance@CVSHealth.com) and CC your supervisor     - It is the Category that determines the Grievance, not the subcategory.   + If the previous Grievance is closed/resolved, file a new Grievance.   **Note:** DO NOT use **First Call Resolution** for a **Status** reason in PeopleSafe for a New Grievance. |

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| **Creating a Grievance in PeopleSafe** |

Icon - Important Be sure to reference the appropriate Work Instructions to determine if you can resolve the issue prior to filing a Grievance - refer to [MED D - Commonly Used Work Instructions Index (089595)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=45cc9b47-1035-4597-b0ca-52d3109f8c8d) and/or theSource.

Once the CCR has determined that it is appropriate to open a Grievance for a beneficiary, the following instructions should be followed to properly open the Grievance in **PeopleSafe**.

 If you determine a Standard open Grievance has already been submitted (and is not resolved) for the same category in PeopleSafe, advise the beneficiary a response will be received within 30 days from the original date. Do not submit a second Grievance; however, send an email to [DelegatedGrievance@CVSHealth.com](mailto:DelegatedGrievance@CVSHealth.com) and CC your supervisor. Document the beneficiary’s account to indicate that a Grievance has already been submitted for this issue.

 If creating a Grievance for more than one issue:

* If the issues fall under same [category](#_Grievance_Categories_and_1), then open one Grievance. For example, beneficiary is dissatisfied with the long hold time and multiple transfers’ both issues fall under the Customer Service category.
* If the issues fall under multiple [categories](#_Grievance_Categories_and_1), then a separate Grievance should be opened for each issue, under separate categories.

**If no record exists for the beneficiary in PeopleSafe**, reach out to the Senior Escalation Team to determine if a Grievance should be filed.

 If you are transferring the member to any of the following teams, do not file a Grievance for the issue you are transferring them for - the receiving CCR will file the Grievance:

* Senior Escalation Team
* Premium Billing
* Clinical Care Services  
  **Exception:** If the beneficiary is upset with the cost of the medication and there is not a CD option that would lower the cost, transfer to Clinical **only** for alternatives. The CCR must file a First Call Resolution (Resolved) Grievance for Plan Design **prior** to making the transfer to Clinical. Advise the Clinical team you have filed a Grievance.
* SMST

**Notes:**

* You should NEVER use the Downtime Procedures for a prospective beneficiary whose effective date with the plan has not been confirmed by CMS. You should never file a Grievance in this circumstance.
* If the caller disconnects or states they cannot stay on the phone to file the Grievance, the CCR **MUST** still proceed with filing the Grievance. The CCR **must still proceed** with filing the Grievance even if they reach the transferring team.

 **Ensure all information to file a Grievance is available prior to starting the below process.** If user navigates to **secondary** tabs OR clicks **Clear**, **Cancel** and **Grievance Summary** button after filling the mandatory fields user will see below pop-up with message “Are you sure you want to leave this page? You will lose all unsaved data entered or selected.”

A screenshot of a computer error message

AI-generated content may be incorrect.

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| **Step** | **Action** | | | | | | |
| **1** | Select the **Grievance** tab. | | | | | | |
| **If…** | | | **Then…** | | | |
| CVS handles Grievances | | | * A pop-up displays to check historical duplicate Grievances before filling this form: “Please check duplicate historical grievances before filing this form by selecting Grievance Summary button.”   + Click **OK**.   A screenshot of a computer  AI-generated content may be incorrect.   * Proceed to [Step 2](#Step2PS). | | | |
| Client handles Grievances | | | * A pop-up displays indicating that the “Member eligibility record indicates a non-supported client category.”   A screenshot of a computer error message  AI-generated content may be incorrect.   * Click **OK**. * Proceed to [Step 7](#Step7). Refer to [Documenting a Client-handled Grievance](#_Documenting_a_Client) section. | | | |
| **2** | Select **Grievance Summary** button to see historical grievances filed within the last 60 days.  A screenshot of a computer  AI-generated content may be incorrect.  **Result: Grievance Summary** screen appears.  A close-up of a table  AI-generated content may be incorrect. | | | | | | |
| **If…** | | **Then…** | | | | |
| [Grievance on file](#_Previously_Submitted_Grievances_1) | | Advise the member that a Grievance has already been filed and is in process. | | | | |
| Grievance not on file | | * Select **Add Grievance**.   A close-up of a computer screen  AI-generated content may be incorrect.   * Proceed to [Step 3](#Step3PS). | | | | |
| **3** | Populate the information in the **Grievance** screen using the table below as a guide.  **Note:** All fields are mandatory and must be filled in unless otherwise specified.  A screenshot of a computer  AI-generated content may be incorrect. | | | | | | |
| **Topic** | **Information/Examples** | | | | | |
| **Requester** | Select the appropriate option from this drop-down menu. | | | | | |
| **Filed By** | | | **Additional Notes** | | |
| Beneficiary | | | Requester field will pre-populate the Beneficiary’s first and last name, default address, and phone number on file ONLY IF **Beneficiary** is selected in the **Filed By** field.  A screenshot of a login form  AI-generated content may be incorrect.  **Note:** **Relationship**, **Address 2** and **Alternate Phone** fields are not mandatory. All other fields are mandatory. All fields are editable.  Select Beneficiary when an authenticated SHIP counselor makes the request or if the beneficiary gets on the phone and provides permission for the caller to file the Grievance.   * Document in PeopleSafe that the SHIP unique ID was verified and/or the name of the caller and beneficiary approval to speak on beneficiary’s behalf. * If the SHIP Counselor wants to be contacted with the resolution of the Grievance, [an AOR form (021424)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=4008954a-0d95-4ea9-add2-3a7dfa02c718) **must** be completed and a unique SHIP ID is provided. Refer to [Who Can File a Grievance](#_Who_Can_File_2) section above. | | |
| AOR  (including [prospective AOR](#AOR)) | | | A screenshot of a computer  AI-generated content may be incorrect.  **Note: Address 2** and **Alternate Phone** fields are not mandatory. All other fields are mandatory. All fields are editable.  If AOR is selected, verify whether an AOR is on file in **PeopleSafe**.   * Select the **Yes** radio button next to the **AOR Required** field. * Choose the applicable selection for relation from the “relationship” dropdown. * Refer to [Who Can File a Grievance?](#_Who_Can_File_2) * If caller does not provide address, enter the beneficiary’s address.   **Note:** A new AOR does not have to be filed for every new issue if an AOR is on file that is not older than one year.  Populate the following fields:    **Note:**  Please enter all information in CAPITAL LETTERS.   * Relationship * First Name * Last Name * Address1 * Address2 (Optional) * City * State * Zip * Phone * FAX (Optional) * Representative Documentation   + AOR Received w/Case (Select the appropriate radio button: **Yes** or **No**)   + AOR Received (Select the appropriate radio button: **Yes** or **No**)   + AOR Received Date     - Icon - Important Populate this field with the date and time the AOR was received (even if prior to today’s date).     - If AOR is not on file, do not populate this field.   Icon - Important **NEVER** complete the Suspension Start Date in the Representative Documentation section. | | |
| POA (including [prospective POA](#POA)) | | | A screenshot of a computer login  AI-generated content may be incorrect.  **Note: Address 2** and **Alternate Phone** fields are not mandatory. All other fields are mandatory. All fields are editable.  If POA is selected, verify whether a POA is on file in **PeopleSafe**.   * Select the **Yes** radio button next to the **POA on File** field. * Choose the applicable selection for relation from the “relationship” dropdown. * Refer to [Who Can File a Grievance?](#_Who_Can_File_2) * If caller does not provide address, enter the beneficiary’s address.   Populate the following fields:  **Note:**  Please enter all information in CAPITAL LETTERS.   * Relationship * First Name * Last Name * Address1 * Address2 (Optional) * City * State * Zip * Phone * FAX (Optional) * Representative Documentation   + POA Received w/Case (Select the appropriate radio button: **Yes** or **No**)   + POA Received (Select the appropriate radio button: **Yes** or **No**)   + POA Received Date     - Icon - Important Populate this field with the date and time the POA was received (even if prior to today’s date).     - If POA is not on file, do not populate this field.   Icon - Important **NEVER** complete the Suspension Start Date in the Representative Documentation section. | | |
| **R****elationship** | This field is mandatory if AOR/POA selected in **Requester** field.  Select one of the following:   * Member * Caregiver * Family * Friend * Other * Pharmacist * Pharmacy Representative * Physician * Physician Representative * POA * Relative/Family Member * Servicing Facility | | | | | |
| **Representative Documentation** | **AOR Required** defaults to “Yes” if AOR or POA is selected in **Requester** field.  AOR/POA on file:   * **No** is selected by default * **AOR/POA received date** is set to NULL   A white background with black and white clouds  AI-generated content may be incorrect.  **Note:** When **Yes** is selected, **AOR/POA received date** is set to “MM/DD/YYYY” (current date). Leave the date that populates.  A black and white box with black text  AI-generated content may be incorrect. | | | | | |
| **Grievance Number** | Generated after Grievance is submitted. | | | | | |
| **Category** | **Note:** Only the Categories that CVS is delegated to handle for the Client will show in the drop-down.  Select the appropriate **Category** based on the beneficiary’s issue and according to [Grievance Categories and Definitions](#_Grievance_Categories_and_2).    **CCR Process Note:** If the beneficiary is discussing an issue that covers multiple categories, the CCR **MUST** file a separate Grievance for each category. DO NOT file a second Grievance if the issues are under the same category but a different sub-category; use the most appropriate subcategory.  **Note:** If the **Category** is **Quality of Care** and a **Status Reason** of **First Call Resolution (FCR)** is selected, a pop up will appear advising this option is not available. **New Grievance (Pending Initial Review)** must be selected.  cid:image001.png@01D51C87.85D37C50 | | | | | |
| **Sub Category** | Each **Category** has a **Sub Category**.   * Select the appropriate **Sub** **Category** based on the beneficiary’s issue.   **REMINDER: Sub Category** drop-down menus change based on the **Category** that was selected. | | | | | |
| **Priority** | Select **Standard**. | | | | | |
| **Source** | Defaults to **Phone**.   * If the grievance was received via Chat, select **Phone**. | | | | | |
| **Date of Occurrence** | Enter the appropriate **Date of Occurrence** based on the information provided by the beneficiary.   * The **Date of Occurrence** is the date of the event that caused the beneficiary’s dissatisfaction.   Icon - Important The system automatically generates the time as 00:00. **DO NOT change the time** for the **Date of Occurrence**.  A screenshot of a computer screen  AI-generated content may be incorrect.  **EXAMPLE 1:** The beneficiary called MED D Customer Care a week ago and received poor customer service.   * The **Date of Occurrence** for this issue would be the date of the beneficiary’s previous call to Customer Care.   **EXAMPLE 2:** The beneficiary received a letter about a claim that was reprocessed which caused the beneficiary to owe additional money for a prescription.   * Claim Date = September 12, 2017 * Letter Date = October 27, 2017 * Today’s Date = November 12, 2017   + The **Date of Occurrence** for this issue would be the Letter Date which is the event that caused the beneficiary’s dissatisfaction and is within the 60-day window for filing a Grievance.   **REMINDER:** Grievances must be reported within **60 days** of the **Date of Occurrence**. It is extremely important that you confirm the correct Date of Occurrence has been populated especially during Welcome Season when the start of a new year has occurred. Make sure you enter the correct year.   * Refer to the[Time Limits for Filing a Grievance](#_Time_Limits_for_2). | | | | | |
| **Date Reported** | The system will auto-populate with the current date. | | | | | |
| **Manual Receive Date** | **CCR Process Note: DO NOT** use this. This field should only be used if filing a Grievance after the original call date.  **Exception:** This field is mandatory for filing Grievances after the original call date. | | | | | |
| **Status Reason** | This field is required for submission of the case.   * Always select **First Call Resolution** for this field if issue is fully resolved. **Exception:** http://sharepoint/sites/opscom/Operations%20Communication/Formatting/Icon%20-%20Important%20Information.png If AOR/POA is not on file, **Status Reason** must be **New Grievance**.   + Ensure documentation includes the resolution provided to the beneficiary. For example, “Educated beneficiary on Extra Help.” * Alwaysselect **New Grievance** for this field if issue is not resolved.     **Note:** **New Grievance (Pending Initial Review)** must be selected when:   * The **Category** is **Quality of Care**. * The **Source** selected is NOT **Phone**. * http://sharepoint/sites/opscom/Operations%20Communication/Formatting/Icon%20-%20Important%20Information.png AOR/POA is not on file.   If **Status Reason** of **First Call Resolution (FCR)** is selected for either of these, a pop up will appear advising this option is not available.  cid:image001.png@01D51C87.85D37C50 | | | | | |
| **Request in 60 days** | The systemwill auto-populate based on the **Date of Occurrence** selected by the CCR. | | | | | |
| **If the…** | | | | **Then…** | |
| **Yes** radio button is populated | | | | Continue with the filing the Grievance. | |
| **No** radio button is populated | | | | * Make every effort to resolve the beneficiary’s issue and do NOT file a Grievance. * **Proceed to** [**Step 4**](#Step4)**.** | |
| **Description of Issue** | New Grievance | | | | * Type a detailed description of the Beneficiary’s issue that describes their complaint with the plan in the **NotePad**. * Document why a Coverage Determination was not submitted if it seems like one could have been (i.e., if beneficiary states they want to talk to their MD first; beneficiary had approved non-formulary Coverage Determination already in place; drug is on formulary but is a Specialty drug, so Tier Exception is not able to be submitted; MD to submit a Redetermination for member, etc.) * Summarize this information in the **Description of** **Issue** field using the format illustrated below.   + Ensure the summary uses business appropriate language.   + The Grievance details can be viewed by the Plan, CMS, or may be viewed for such things as legal proceedings.   + Use discretion when describing any Beneficiary’s personal information.   http://sharepoint/sites/opscom/Operations%20Communication/Formatting/Icon%20-%20Important%20Information.png **DO NOT** put the word “approved” **ANYWHERE** in PeopleSafe.  **CCR Process Note:** **Always** start the Grievance description in PeopleSafe with the below statement:   * I have confirmed with the Beneficiary the following issue(s):  1. Issue details 2. Issue details 3. Issue details   http://sharepoint/sites/opscom/Operations%20Communication/Formatting/Icon%20-%20Important%20Information.png Do Not include notes that could be deemed vulgar, profane, or graphic in nature.   * If the caller insists on the use of vulgar or profane language in the issue description, then take the following actions:   + Our company policy is to submit a recap summary of the issue only and not a verbatim account of the incident. However, if you would like to submit a word-for-word account you can always submit your Grievance in writing.   + Submit a summary of the issue only. Do not submit a verbatim account of the incident.   A white rectangular frame with a black border  AI-generated content may be incorrect.  **EXAMPLE 1:**   * I have confirmed with the Beneficiary the following issue(s):  1. Beneficiary is dissatisfied with customer care s/he received on 2-25-20 from <CCR’s first name>. 2. Beneficiary stated the CCR kept interrupting them and disconnected the call.   http://sharepoint/sites/opscom/Operations%20Communication/Formatting/Icon%20-%20Important%20Information.png **Remove all special characters and bullet points from your notes**. Only periods and commas are permitted. | |
| First Call Resolution | | | | Be sure to use the full Reason, Action, Result template, if available:   * [Med D - Compass Grievances: CCR - First Call Resolution Documentation Templates (Health Plans) (066744)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=0e126cf2-ca19-4e62-b84f-72733e77b8b9) (066744) * [Med D - Compass Grievances: CCR - First Call Resolution Documentation Templates (NEJE) (066745)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=cb56c2af-d1ed-4e8a-a309-d0db70d8c751) (066745)   Ensure that Reason, Action, and Result are clearly documented in the Description of Issue:  A close up of a letter  AI-generated content may be incorrect.  **Icon - Important Information** This Description of Issue Result text will be the exact text copied for use for the Resolution field by the Grievance Team. It is **imperative** that Description of Issue is clearly documented.  http://sharepoint/sites/opscom/Operations%20Communication/Formatting/Icon%20-%20Important%20Information.png **Remove all special characters and bullet points from your notes**. Only periods and commas are permitted.  **Note:** Document why a Coverage Determination was not submitted if it seems like one could have been (i.e., if beneficiary states they want to talk to their MD first; beneficiary had approved non-formulary Coverage Determination already in place; drug is on formulary but is a Specialty drug, so Tier Exception is not able to be submitted; MD to submit a Redetermination for member, etc.) | |
| **Grievance Restate** | New Grievance | | | | In order to ensure the beneficiary’s issue was properly notated in PeopleSafe, the CCR **MUST** restate what has been typed in the **Description of Issue** field to the beneficiary.   * Edit the description if necessary. * There is no character limit in this field. * Select the **Yes** radio button.   **Note:** If the caller disconnects or states they cannot stay on the phone to file the Grievance, the CCR **MUST** still proceed with filing the Grievance. | |
| First Call Resolution | | | | **DO NOT** restate the Grievance, **DO NOT** provide a Grievance number - Beneficiary is not aware that a Grievance is being filed.   * Select the **No** radio button. | |
| **Written Response Requested** | Select the appropriate radio button based on the conversation with the beneficiary.   * **Icon - Important Information** **DO NOT** select **WRITTEN RESPONSE REQUESTED** for First Call Resolution. * Select **No** if the beneficiary does not request a written response.   + **Icon - Important Information** **DO NOT** select **WRITTEN RESPONSE REQUESTED** unless the beneficiaryinitiates a written request.     - Do **NOT** ask the beneficiary if they want a written response. * Select **Yes** if the beneficiary indicates they would like a written response. * Examples of statements made by the beneficiary when they would like a written response (not all inclusive):   + Will you send me a letter about this?   + You will send me something saying this is being looked at…right?   + Can you send me a letter regarding this issue? | | | | | |
| **4** | Have I fully answered and resolved your question(s) to your satisfaction? | | | | | | |
| **If…** | **Then…** | | | | | |
| Yes | Proceed to [Step 5](#Step5). | | | | | |
| No | * Ask additional probing questions to attempt to resolve remaining questions or concerns. * If unable to resolve the questions/concerns and all resources have been utilized - including the Supervisor or Senior Escalation Team - submit the Grievance.   Proceed to [Step 5](#Step5). | | | | | |
| **5** | Once all of the appropriate fields have been populated, click the **Submit** button.  A screenshot of a computer  AI-generated content may be incorrect.  **RESULT:**  “Grievance number <123456789> has been submitted successfully” pop-up displays.  **ECARE ONLY:** If the grievance was received from the beneficiary or their purported representative via email, send a copy of the email to the Grievance Team at [DelegatedGrievance@CVSHealth.com](mailto:DelegatedGrievance@CVSHealth.com).  **Ensure all information to file a Grievance is available prior to starting the below process.** If user navigates to **secondary** tabs OR clicks **Clear**, **Cancel** and **Grievance Summary** button after filling the mandatory fields user will see below pop-up with message “Are you sure you want to leave this page? You will lose all unsaved data entered or selected.”  A screenshot of a computer error message  AI-generated content may be incorrect. | | | | | | |
| **6** | Determine if a Coverage Determination is needed. | | | | | |
| **If…** | **Then…** | | | | | |
| Yes | Proceed to [MED D - CCR - Coverage Determinations and Redeterminations (Appeals) (004665)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=22f353ee-e739-4f78-be33-b64916337260).  **Note:** Any complaint about the CD **process** (e.g., upset with having to wait for a decision, prescriber has to complete paperwork, etc.) will always be a First Call Resolution - outcome will not change the Grievance. | | | | | |
| No | Proceed to [Step 7](#Step7). | | | | | |
| **7** | Thank you for calling <Name of Plan> today.  If at any time you have further questions about this conversation, please feel free to call Customer Care toll free at **< the toll-free number from the member’s CIF >, <24 hours a day, 7 days a week>**   * + **TTY users call <711>**      * Document and close the call according to current policies and procedures. Refer to [MED D - Call Documentation Including Viewing and Adding Comments in PeopleSafe (067665)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=e9cdb772-9c04-4e42-b87a-ae4d2c2e1f62). **PeopleSafe Call Notes Example:** Filed New Grievance for member upset about customer service. GR123456789 was filed.   **Note:**  All Grievances require documentation in addition to a [Grievance Activity Code](#_Grievance_Activity_Codes_1). | | | | | | |

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| **Grievance Questionnaire Process** |

This **Grievance Questionnaire** page appears when the CCR navigates to the **Capture Activity** page.

A screenshot of a computer

AI-generated content may be incorrect.

Follow the steps below to ensure you have entered a Grievance when appropriate:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Step** | **Action** | | | |
| **1** | Determine if a Grievance needs to be filed.  **Note:** If a Grievance is transferred to the Client for Grievance submission, select **No** to the initial question.  Repeat this process as needed for multiple Grievance scenarios. | | | |
| **If…** | **Then…** | | |
| A Grievance does not need to be filed  **Examples:**   * Call is transferred to the Client for Grievance submission * Already submitted during the call * Call was transferred to another team | 1. Select **No**. 2. Select **Continue** (or **OK** if beginning from the **Capture Activity** screen). 3. Result:  * If notes were entered in **Capture Activity**, the member’s account closes and returns to a blank Participant Inquiry screen for the next call. * If notes were **not** entered in **Capture Activity**, the **Log Activity Screen** appears.   + Fill in all required fields. | | |
| A First Call Resolution Grievance **or** Unresolved Grievance needs to be filed (**including** when an RM Task needs to be submitted) | Select **Yes**.  **Result:** Grievance Not Resolved/Resolved Same Day Grievance options appear.  A screenshot of a computer  AI-generated content may be incorrect. | | |
| **If…** | **Then…** | |
| Grievance Not Resolved | Is the Grievance already filed? | |
| **If…** | **Then…** |
| Yes  **Examples:**   * Grievance was submitted via RM Task * Already submitted during the call * Previous Grievance already on file | 1. Select **Continue** (or **OK** if beginning from the **Capture Activity** screen). 2. Result:  * If notes were entered in **Capture Activity**, the member’s account closes and returns to a blank Participant Inquiry screen for the next call. * If notes were **not** entered in **Capture Activity**, the **Log Activity Screen** appears. * Fill in all required fields. |
| No | 1. A pop-up will appear instructing the CCR to go to the **Grievance** tab to file the Grievance.     A screenshot of a computer  AI-generated content may be incorrect.   1. Proceed with filing an [Unresolved Grievance](#_Creating_a_Resolved). |
| Resolved One Day Grievance | Is the One Day Grievance already filed? | |
| **If…** | **Then…** |
| Yes  **Examples:**   * Already submitted during the call * Previous Grievance already on file | 1. Select **Continue** (or **OK** if beginning from the **Capture Activity** screen). 2. Result:  * If notes were entered in **Capture Activity**, the member’s account closes and returns to a blank Participant Inquiry screen for the next call. * If notes were **not** entered in **Capture Activity**, the **Log Activity Screen** appears. * Fill in all required fields. |
| No | 1. A pop-up will appear instructing the CCA to go to the **Grievance** tab to file the Grievance.   A screenshot of a computer  AI-generated content may be incorrect.   1. Proceed with filing an [First Call Resolution Grievance](#_Creating_a_Resolved). |

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| **Grievance Categories and Definitions** |

Icon - Important Be sure to reference the appropriate Work Instructions to determine if you can resolve the issue prior to filing a Grievance - refer to [MED D - Commonly Used Work Instructions Index (089595)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=45cc9b47-1035-4597-b0ca-52d3109f8c8d) and/or theSource.

The below categories **are for PeopleSafe only**. Examples were added for each category.

The CCR will use the chart below to help determine in what situations a beneficiary can file a Grievance. Use the links below for a more detailed description of each category and its respective subcategories, which are the available choices when completing a Grievance in PeopleSafe.

**Note:** Once you have selected the appropriate category, select the subcategory that best fits the scenario. If there are multiple issues under the same category but a different sub-category; use the most appropriate sub-category. For example, beneficiary is dissatisfied with the long hold time and multiple transfers; both issues fall under the Customer Service category. Use long hold-time as the sub-category.

* [Benefits](#C1)
* [CMS Issue](#C2)
* [Confidentiality](#C3)
* [Customer Service](#C4)
* [Enroll/Disenroll](#C5)
* [Exceptions/Coverage Decisions](#C6)
* [Fraud, Waste & Abuse](#C7)
* [Marketing](#C8)
* [Other](#C9)
* [Pharmacy](#C10)
* [Premium Billing](#C11)
* [Quality of Care](#C12)
* [Redetermination](#C13)

|  |  |  |
| --- | --- | --- |
| **CATEGORY** | **SUB-CATEGORY** | **DEFINITIONS/EXAMPLES** |
| **Benefits** | **Co-Pay/Coinsurance**  [MED D - Test Claim Index (021325)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=f20952af-741c-41d5-a343-6132374dfe64) | The beneficiary is unhappy with prescription co-pay/coinsurance for their plan in general (no specific medication provided).  The beneficiary is unhappy with the co-pay/coinsurance increase or tier change from a previous claim (specific medication provided).  The beneficiary is unhappy with the copay/coinsurance for a medication on the Specialty tier and a tier exception cannot be submitted.  **Note:** This excludes co-pays/coinsurance when beneficiary hasn’t met deductible or is in the coverage gap.  **EXAMPLES:**   * A beneficiary receives a prescription for Drug X and is told at the pharmacy that they must pay a 33% coinsurance for the drug (the coinsurance amount that applies to drugs in the plan “high-cost” or specialty tier). * The beneficiary is aware, and is not disputing, that Drug X is contained in the specialty tier. But the beneficiary would like the drug to be covered at the cost-sharing amount applicable to drugs in the preferred tier. The beneficiary is unhappy that the drug is exempt from the tier exception process. |
| **Coverage Gap**  [Accumulators or Accumulations (Deductible, Account Balance, MOOP, MAB) (064862)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=a22d707e-1643-448e-9968-f44d1a828038) | The beneficiary is unhappy with their coverage during the Coverage Gap (Donut Hole).  **EXAMPLE:** Beneficiary is in the coverage gap and is not disputing that they must pay X% coinsurance for brand name drugs but feels that drug costs should not change throughout the year. |
| **Deductible**  [Accumulators or Accumulations (Deductible, Account Balance, MOOP, MAB) (064862)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=a22d707e-1643-448e-9968-f44d1a828038) | The beneficiary is unhappy with their plan deductible for a prescription.   * If the CCR informs a beneficiary that they have not met their deductible and therefore has (**$X.XX**) cost share, then the CCR would choose Deductible and not co-pay/coinsurance as the Grievance category.   **EXAMPLE:** The beneficiary is dissatisfied they have to pay full price for the first fill of the medication because they have to meet a deductible and the Plan does not have enhanced coverage in the Deductible Stage. |
| **Formulary**  Refer to the CIF. | The beneficiary is unhappy that many common maintenance medications are not on the formulary or a medication was subject to a mid-year or year-over-year formulary change.  This excludes co-pay/coinsurance and deductible issues.  **EXAMPLE:** Beneficiary was taking Evista. Now a generic is available and only the generic is listed as a formulary drug. The beneficiary is unhappy with the formulary deletion of the brand name drug. |
| **TrOOP**  [MED D - Determining TrOOP Status (020814)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=ace20931-df5c-49f8-9b4a-df89aade1fa5) | The beneficiary is upset and disputing True Out-Of-Pocket costs actually paid vs. the information shown in the adjudication system.  **EXAMPLE:** Beneficiary insists that they spent $6350 in out-of-pocket total drug costs for the year. However, the plan’s adjudication system reflects that they have only paid $4500. The Plan determines that several claims were reversed. |
| **CMS Issue** | **Enrollment/Disenrollment delayed or denied**  [MED D - Blue MedicareRx (NEJE) - Resolution of Eligibility (030308)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=3b159d36-1f04-41f4-b5cf-7ea7f741a2d9) | Incorrect information has been provided by CMS or CMS is responsible for the delay in processing.  **EXAMPLE:** Beneficiary states they were dissatisfied that they are new to LIS and were temporarily enrolled in LINET and should be in Blue MedicareRx, but the Plan has no record of enrollment from CMS. |
| **Excluded pharmacy**  [MED D - Excluded Provider FAQs (025390)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=5dcee407-0b87-4550-87b0-f1303cf1e2b8) | The beneficiary’s dissatisfaction is due to a pharmacy being removed from the network because it was found to be on the Federal Exclusion list.  **EXAMPLE:** Beneficiary is upset that they must drive 10 miles farther because Brooks Pharmacy cannot fill their prescriptions due to being excluded by the Federal government. |
| **LIS updates**  [MED D - Low Income Subsidy (LIS) Informational Overview (018616)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=39c4d667-eb19-4bde-9ec0-bdcda34aa0dd) | The beneficiary’s dissatisfaction is due to incorrect information provided by CMS or a state Medicaid agency or a delay in updating LIS data by CMS or the State Medicaid agency in which the beneficiary resides.  **EXAMPLE:** Beneficiary states they were dissatisfied that they relocated to a nursing home in May and should now pay $0 for their medication. However, the LTC pharmacy is sending the beneficiary a bill. The Plan has not received a TRC or record of LIS update for the beneficiary. |
| **Premium option**  [MED D - Blue MedicareRx (NEJE) - SSA/RRB Premium Withholding (029089)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=9aed0668-9a47-41a1-adc1-81278ca4eaf8) | The beneficiary’s dissatisfaction is due to an error in the premium option that was made by CMS or SSA and ***not the Plan****.* **EXAMPLE:** Beneficiary is unhappy that CMS enrolled them into the Blue MedicareRx plan and they are now receiving an invoice from Blue MedicareRx. The beneficiary previously had Humana and the premium was deducted from their SSA benefit. |
| **Rx pricing**  [PeopleSafe - Determining the Reason for Contracted Medication Price Changes (064427)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=929bcc87-3cc7-4084-9fcc-95ae8325fcc5) | The beneficiary is dissatisfied with increases in the cost of a drug specifically due to the manufacturer’s pricing increase.  The beneficiary is dissatisfied with their LIS copays.  The beneficiary is dissatisfied with not being able to use a coupon/copay card for their Part D drug or with their Part D benefits.  **EXAMPLES:**   * Beneficiary is in the Premier plan and pays an X% coinsurance for a Tier 4 drug. * On 10/03/2019, the beneficiary paid $66 for Synthroid. On 11/01/2019, the copay was $78 for the same medication because the AWP increased. * The beneficiary is dissatisfied that their LIS copay increased from last year * The beneficiary is dissatisfied that they are unable to utilize coupons in addition to the Plans coverage benefits. |
| **Uncovered drugs**  [Med D - Excluded Drugs (017483)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=b1d1b8ec-a04f-4ea7-9275-b22c837e8505)  [MED D - CCR - Coverage Determinations and Redeterminations (Appeals) (004665)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=22f353ee-e739-4f78-be33-b64916337260) | * The beneficiary’s dissatisfaction is due to a drug being removed from the formulary as a result of its removal from the market by the FDA or removal by the manufacturer for safety or other reasons. * The drug is excluded from Part D coverage by Medicare law, (e.g., over-the-counter drugs).   **EXAMPLES:**   * Beneficiary expresses dissatisfaction that their Vitamin D is not covered by the plan even though the prescribing physician told the beneficiary that they must take it. * The beneficiary has a general complaint about the drug being excluded but does not argue that the Plan incorrectly classified/identified the requested drug as excluded from coverage; the drug is not excluded for the purpose for which it was prescribed; or the drug is covered by the Plan as a supplemental benefit after the Plan explains that it is an excluded drug. |
| **Confidentiality** | **HIPAA violation reported**  [HIPAA (Health Insurance Portability and Accountability Act) Grid - CVS (028920)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=5b354e50-0d15-42d0-b9c2-0711ea02d9ce) | * The beneficiary is upset that the plan communications or medications were sent to an incorrect address and another beneficiary received their Protected Health Information (PHI).   **OR**   * The beneficiary is upset that they received another beneficiary’s plan communications or medication.   **OR**   * The beneficiary is concerned that information is being shared without their consent.   **EXAMPLE:** Beneficiary receives their monthly EOB at their address; however, a different person’s name and medications are listed on the EOB. |
| **Customer Service** | **Call Handling**  [HIPAA (Health Insurance Portability and Accountability Act) Grid - CVS (028920)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=5b354e50-0d15-42d0-b9c2-0711ea02d9ce) | The beneficiary is unhappy with the HIPAA authentication process.  **EXAMPLE:** Beneficiary is unhappy that they provided their information to the IVR system and had to repeat the information to the CCR. |
| **Follow-through** | The beneficiary is upset that Customer Care did not follow-through on committed items.  **EXAMPLE:** Beneficiary is dissatisfied that they were told a return call would be placed back to the beneficiary within 72 hours; however, a call was never made, and no other communication occurred from the Plan. |
| **Incorrect/Incomplete information** | The beneficiary is upset because they were provided conflicting information from the CCR/other sources.  **EXAMPLE:** Beneficiary is dissatisfied that they have received three different co-pay amounts from three different CCRs. |
| **Long hold time** | The beneficiary is dissatisfied with the call’s hold time, resolution time, etc.  **EXAMPLE:** Beneficiary is upset they had to wait 10 minutes on hold while waiting to be transferred to the Plan’s dedicated team. |
| **Procedural Adherence -  Excludes mail order issues** | The CCR did not follow established procedures by failing to transfer the beneficiary to the correct department; by creating the wrong task or not creating task at all; or by **NOT** updating plan system when the CCR should have, etc.   **EXAMPLE:** Beneficiary contacted Care to update their address.   * CCR updated address on **Participant** tab in **PeopleSafe**. * The CCR did not update the **Medicare D Inquiry** tab or update the address in RxEnroll per the Work Instructions. * Beneficiary received EOB at the incorrect address. |
| **Rudeness** | The beneficiary states Customer Care provided rude service or used improper language.  **EXAMPLE:** Beneficiary states they were dissatisfied that the previous CCR spoke very fast and appeared to be in a hurry to get off the phone. |
| **Enroll/Disenroll** | **Disenroll process**  [MED D - Blue MedicareRx (NEJE) - Resolution of Eligibility (030308)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=3b159d36-1f04-41f4-b5cf-7ea7f741a2d9) | The beneficiary is dissatisfied with disenrollment process.  **EXAMPLE:** Beneficiary called Customer Care multiple times to disenroll and is still showing enrolled in the Plan. |
| **Enroll process**  Refer to CIF.  [MED D - Blue MedicareRx (NEJE) - Resolution of Eligibility (030308)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=3b159d36-1f04-41f4-b5cf-7ea7f741a2d9) | The beneficiary is dissatisfied with the enrollment process.  **EXAMPLE:** Beneficiary was enrolled into the Premier plan by an agent and was not aware of the enrollment until they received an invoice from the Plan. |
| **Effective date**  [MED D - Blue MedicareRx (NEJE) - Resolution of Eligibility (030308)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=3b159d36-1f04-41f4-b5cf-7ea7f741a2d9) | The beneficiary’s effective date is incorrect/incomplete.  **EXAMPLE:**   * Beneficiary states their Medicare started on May 1st.   + However, the beneficiary’s EGWP is telling them that the Medicare effective date is June 1st. |
| **LIS**  [MED D - Low Income Subsidy (LIS) Informational Overview (018616)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=39c4d667-eb19-4bde-9ec0-bdcda34aa0dd) | The beneficiary’s LIS status was incorrect or different from what is in the Plan’s system.  **EXAMPLE:** Beneficiary states that they should be LIS 3.   * However, the Plan is still charging the beneficiary LIS 1 co-pays despite receiving notification from CMS. |
| **Plan materials**  [MED D - Fulfillment Request (020534)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=147bab57-4d67-4743-9a27-63542e3b1919) | The beneficiary did not receive or is dissatisfied with the Plan materials that were received.  **Note:** Use this category for enrollment related materials such as an ANOC, EOC, Welcome Kit, ID card.  **EXAMPLES:**   * Beneficiary states that the Evidence of Coverage is difficult to understand. * Beneficiary states they did not receive their ID card. |
| **Wrong internal plan**  [MED D - Blue MedicareRx (NEJE) - Resolution of Eligibility (030308)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=3b159d36-1f04-41f4-b5cf-7ea7f741a2d9) | The beneficiary was enrolled in the wrong internal plan (Value Plus vs. Premier).  **EXAMPLE:** Beneficiary states they were dissatisfied they told Customer Care that they requested the Value Plus plan. However, the beneficiary received an invoice from the Premier plan. |
| **Wrong external plan**  [MED D - When to Refer to Social Security (SSA) and Medicare (CMS) (026165)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=c9e294cd-93c4-466f-a6d8-e850070eda25) | The beneficiary was enrolled in the wrong external plan (e.g., Humana vs. Blue MedicareRx).  **EXAMPLE:** Beneficiary states they were dissatisfied that they enrolled in the Blue MedicareRx Value Plus plan with 1-800-Medicare and received an ID card for a Humana PDP. |
| **Exceptions  Coverage Decisions  Note:** This is the Beneficiary’s dissatisfaction of going through the process. | **B vs. D** | The beneficiary is unhappy that their medication was subject to the B vs. D determination **process**.    **EXAMPLE:** The beneficiary states they were dissatisfied that their previous prescription drug plan paid for a specific medication and now our plan is having their prescriber submit a prior authorization before covering the medication. |
| **Formulary exception** | The beneficiary is unhappy with the formulary exception **process**.  **EXAMPLE:** The beneficiary states they were dissatisfied that the plan should cover all medications if prescribed by their physician and should not have to file an exception to get it covered. |
| **Prior Authorization process** | The beneficiary is unhappy with the Prior Authorization **process**. **EXAMPLES:**   * The beneficiary needs a PA for their medication due to an age restriction. * The beneficiary is dissatisfied the hospital did not bill their Part D plan when they received medications during out-patient surgery and now have to send in a paper claim form. |
| **Quantity Limit** | The beneficiary is unhappy with the Quantity Limit exception **process**.  **EXAMPLE:** The beneficiary states that the plan should cover any amount of medication prescribed by their physician. |
| **Step Therapy** | The beneficiary is unhappy with the Step Therapy exception **process**.  **EXAMPLE:** The beneficiary is not happy that the plan is having them try less expensive drugs before they will cover the higher tier medication. |
| **Tiering** | The beneficiary is unhappy with the Tier exception process.  **EXAMPLE:** The beneficiary is not happy that their prescriber has to be contacted to receive the medication at a lower tier. |
| **Fraud, Waste & Abuse** | **Alleged fraudulent use of  MED D plan**  [MED D - Transmission of Customer Care Fraud, Waste and Abuse (027643)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=5ae3449c-89af-4b3c-b3e8-fe2d334ea7e1) | The beneficiary has alleged fraudulent prescription issues or suspects fraudulent use of their plan.  **EXAMPLE:** Beneficiary has alleged their pharmacy is billing the plan for medications they were never prescribed or received. |
| **Marketing** | **Advertise inaccurate Rx prices**  [MED D - Test Claim Index (021325)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=f20952af-741c-41d5-a343-6132374dfe64) | The beneficiary is unhappy the plan is advertising inaccurate prescription prices.  **EXAMPLE:** Beneficiary states they were dissatisfied that the Plan’s website provided a co-pay of $10 for Synthroid but the beneficiary was charged a $24 co-pay at the pharmacy. |
| **Agent issues** | The beneficiary is unhappy an agent misrepresented the plan when enrolling the beneficiary.  **EXAMPLE:** Beneficiary states they were dissatisfied that the agent told him/her the Value Plus plan provided additional coverage during the coverage gap. However, this information is not correct because the Value Plus plan does not offer additional coverage during the coverage gap. |
| **Network falsely advertised** | The beneficiary is unhappy the plan is advertising inaccurate network coverage.  **EXAMPLE:** Beneficiary is dissatisfied that the pharmacy directory included with the ANOC stated Brooks Pharmacy is a preferred pharmacy. However, the pharmacist at Brooks Pharmacy stated that it was not a preferred pharmacy. |
| **Product/Service not covered falsely advertised** | The beneficiary is dissatisfied the plan is advertising inaccurate information on products/services.  **EXAMPLE:** Beneficiary states that the information they received about the Extra Care card provided a 20% discount on all items sold at CVS pharmacies. |
| **Other** | **IVR** | The beneficiary is dissatisfied with the IVR (i.e., hard to use, IVR options do not work, etc.).  **EXAMPLES:**   * Beneficiary is dissatisfied that we cannot leave the names of the medications on the beneficiary’s voicemail. * Beneficiary states they were dissatisfied that the IVR system does not accept their date of birth when it was provided to the IVR. |
| **Not receiving materials**  **DO NOT use for enrollment related plan materials such as ANOC, Welcome Kit, or EOC**  [MED D - Explanation of Benefits (EOB) (024834)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=8cc3e0b4-c2a9-4632-867f-d542c06e5465) | The beneficiary is dissatisfied because they did not receive an Explanation of Benefits (EOB) last month.  Excludes premium notices and enrollment/disenrollment notices.   **EXAMPLE:** Beneficiary is unhappy that they have not received an EOB for the past two months. |
| **Website**  **DO NOT use for Plan website issue**  [Caremark.com - Work Instruction/Job Aid Index (105672)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=8a2da44a-6336-454d-8deb-fca4a71ad69b) | The beneficiary is dissatisfied with the cvs.com or caremark.com website (i.e., Difficult to use, unable to login).  **EXAMPLE:** Beneficiary states they were dissatisfied that they were unable to order a prescription via their caremark.com account. |
| **Pharmacy** | **Dirty/unclean pharmacy** | The beneficiary complains a retail pharmacy (such as CVS, Walgreens, Rite Aid, Target, Wal-Mart, etc.) is dirty or unsanitary.  **EXAMPLE:** The beneficiary complained that the seats at their pharmacy are so dirty they cannot sit while waiting for their prescriptions to be filled. |
| **Mail Order**  [Mail Service Pharmacy Program Features and Benefits (004649)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=8759d30e-3b85-43d6-8f00-59d327f8f260)  [MED D - Expressed Consent (Ship Consent) (083036)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=3f0adae9-ad4d-4e9c-9707-301d785da1cf) | The beneficiary is dissatisfied with the mail order **process** (turnaround times, etc.).  **EXAMPLE:** The beneficiary complains about the consent hold process. |
| **Pharmacy out of network** | The beneficiary is dissatisfied that their retail pharmacy of choice is not part of the Plan’s pharmacy network.  **EXAMPLE:** The beneficiary is not happy that the pharmacy they have been using for years is not part of the plan’s network. |
| **Pharmacy out of service area** | The beneficiary is dissatisfied that their pharmacy of choice is out of their pharmacy service area.  **EXAMPLE:** Beneficiary is dissatisfied that they need to drive a far distance to get to the nearest in-network pharmacy. |
| **Refused to accept ID card or provide service** | The beneficiary is dissatisfied the retail pharmacy refused to accept their ID card or refused to provide service.  **EXAMPLE:** The beneficiary was told the pharmacy will not fill their prescription for a controlled substance. |
| **Retail Pharmacy** | The beneficiary is upset because of rude service by a pharmacist.  **EXAMPLE:** The beneficiary complained that the pharmacist would not provide any explanation regarding their new medication because the pharmacy was too busy. |
| **Premium Billing** | **Amount not what beneficiary expected**  [MED D - Blue MedicareRx (NEJE) - Premium Billing Invoice Requests (029463)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=3781318d-b570-4fb9-83c5-074b8db66b10) | The beneficiary is unhappy he received a premium bill with an amount that was different than what was expected.  **EXAMPLES:**   * The Amount Due on the beneficiary’s invoice included a Late Enrollment Penalty (LEP) as well as the plan premium. * Beneficiary states they were dissatisfied that they received an invoice for the amount that equals 2 months of premium. However, the beneficiary already mailed in the payment (payment and invoice crossed in the mail). |
| **Did not receive bill**  [MED D - Blue MedicareRx (NEJE) - Premium Billing Invoice Requests (029463)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=3781318d-b570-4fb9-83c5-074b8db66b10) | The beneficiary is dissatisfied about not receiving their premium invoice.  **EXAMPLE:** The beneficiary complained they are not receiving an invoice at the address they provided on their application. |
| **EFT issue  Note:** This would also include reoccurring credit card payments.  [MED D - Blue MedicareRx (NEJE) - Premium Billing Auto Pay Options and Education (029294)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=9529f4aa-b196-4c8d-8c5d-690da1233d94) | The beneficiary is complaining because their premium is **NOT** being deducted from the beneficiary’s bank account.  **EXAMPLE:** The beneficiary states they have submitted two EFT applications and are still receiving an invoice. |
| **SSA withholding**  [MED D - Blue MedicareRx (NEJE) - Premium Billing Auto Pay Options and Education (029294)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=9529f4aa-b196-4c8d-8c5d-690da1233d94) | The beneficiary is dissatisfied because their premium is **NOT** being deducted from their SSA benefit.  **EXAMPLE:** The beneficiary states they requested on their application that their premium to be deducted from their SSA benefit but is receiving an invoice. |
| **Quality of Care**  Refer to [Determining Quality of Care](#_Determine_if_Grievance). | **Mail Order Error**  [MED D - When to Transfer Calls to Clinical Care Services Clinical Counseling (117127)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=2dece3bc-2e73-469a-a273-786f861ed23b) | The beneficiary alleges is dissatisfied about a mail order error.  **EXAMPLES:**   * Mail order cold pack breaks in-transit and drug arrives spoiled. * The beneficiary shorted medication; prescription written for 30 pills but only received 20 pills. * Prescription bottle contains two different pills. |
| **Retail Rx Error**  [MED D - When to Transfer Calls to Clinical Care Services Clinical Counseling (117127)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=2dece3bc-2e73-469a-a273-786f861ed23b) | The beneficiary alleges a retail prescription error.  **EXAMPLE:** The beneficiary is unhappy that pharmacy dispensed 20mg when the prescription was written for 40mg. |
| **Member out of medication due to plan, pharmacy or prescriber error**  [Member Low or Out of Medication (046109)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=3b7dbf62-c6e3-494d-86af-4a5ff49a52af) | Manufacturer backorder with no notification, medication mailed to incorrect address, dosage error, medication stolen or lost in delivery.  **EXAMPLE:**   * The beneficiary relocated to winter home in FL and provided a temporary address to the CCR, but order was sent to MA. * Medication was not received on time and beneficiary was without medication. |
| **Mail order delay**  [Member Low or Out of Medication (046109)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=3b7dbf62-c6e3-494d-86af-4a5ff49a52af) | The beneficiary is dissatisfied that a Mail order delay caused the beneficiary to go without medication.  **EXAMPLE:** The beneficiary called to provide approval for high copay and CCR did not update account so order would process. |
| **Incorrect Rx shipped**  [MED D - When to Transfer Calls to Clinical Care Services Clinical Counseling (117127)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=2dece3bc-2e73-469a-a273-786f861ed23b)  [Order Reships (038651)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=1d44c6bc-e5ba-4f93-b5ab-0b733ad871d6) | The beneficiary is dissatisfied that they received the incorrect prescription.  **EXAMPLE:** Prescription was written for atorvastatin and beneficiary received lisinopril in error. |
| **Redetermination** | **Redetermination process** | The beneficiary is dissatisfied with the redetermination process.  **EXAMPLE:** The beneficiary states they were dissatisfied that the prescriber should not have to submit additional information for the denial of their coverage determination. |
| **Timeliness of redetermination response** | The beneficiary is dissatisfied that the Redetermination processing time was longer than the beneficiary expected.  **EXAMPLE:**  The beneficiary stated they were dissatisfied that the plan took a week/longer than expected to provide a decision for the redetermination. |

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| **Grievance Activity Codes** |

Icon - Important Be sure to reference the appropriate Work Instructions to determine if you can resolve the issue prior to filing a Grievance - refer to [MED D - Commonly Used Work Instructions Index (089595)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=45cc9b47-1035-4597-b0ca-52d3109f8c8d) and/or theSource.

Refer to [Log Activity/Capture Activity Codes (005164)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=bdac0c67-5fee-47ba-a3aa-aab84900cf78) for all MED D Activity Codes.

**PeopleSafe Codes:**

**1319 - Grievance Submitted** -Used when a Grievance is submitted on behalf of the beneficiary

**1320 - Grievance Client Handles** - Used when CIF indicates client handles all Grievance situations/processes

**1323** - **Grievance-Caller Not Eligible** – Used when caller is not eligible to file a Grievance

**1325 -** **Member refused transfer to Client**

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| **Previously Submitted Grievances** |

Icon - Important Be sure to reference the appropriate Work Instructions to determine if you can resolve the issue prior to filing a Grievance - refer to [MED D - Commonly Used Work Instructions Index (089595)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=45cc9b47-1035-4597-b0ca-52d3109f8c8d) and/or theSource.

**Icon - Important** If the beneficiary is calling regarding a phone call received from a grievance caseworker, the relevant call notes will not be listed in PeopleSafe. The call notes from the grievance caseworker will be listed in MHK Fusion. Refer to [MED D - MHK Fusion Work Instructions (HP, JE) (040888)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=000f52df-3238-4305-8158-b41ab631162d) as needed.

* If the beneficiary is dissatisfied with the service received from a grievance caseworker, file a grievance. Refer to [Grievance Categories and Definitions](#_Grievance_Categories_and).

**DO NOT** enter another Grievance for the same Category if the Grievance is still open.

* If there is an open/in-progress Grievance, educate the member that the issue has been filed and advise of TAT.
* If there is an open Grievance and another Grievance in the same Category occurs, notate the account and send email to [DelegatedGrievance@CVSHealth.com](mailto:DelegatedGrievance@CVSHealth.com) and CC your supervisor.
* It is the Category that determines the Grievance, not the subcategory.
* If the previous Grievance is closed/resolved, file a new Grievance.

When the CCR completes the Grievance submission, the item is now viewable on the beneficiary’s account in **PeopleSafe**.

* If the beneficiary calls back about a previously filed Grievance, case notes or other details added by the Grievance Department can be viewed.
* Select the **Grievance Summary** button to see historical grievances filed within the last 60 days.

A screenshot of a computer

AI-generated content may be incorrect.

Status of previously filed Grievance:

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| **Status Reason** | **Open or Closed** |
| CARE Resolution | Grievance is closed |
| Written Resolution | Grievance is closed |
| Manually Closed | Grievance is closed |
| Verbal and Written Resolution | Grievance is closed |
| Verbal Resolution | Grievance is closed |
| Member Withdrew Grievance | Grievance was withdrawn by the beneficiary or their purported representative |
| Pending AOR | Grievance is pended needing an AOR/POA documentation |
| Pending Exception Review | Grievance is open but in final review stage prior to closure |
| Research | Grievance is open and being researched |
| First Call Resolution | Grievance is open but pending review prior to closure |
| New Grievance | Grievance is open but pending initial review |
| No AOR/POA on File | Grievance was dismissed for lack of AOR/POA documentation |
| Past 60 day Filing Limit | Grievance was dismissed due to being filed past the timeframe allowed by CMS |
| Coverage Determination | Grievance was cancelled as a CD only issue |
| Duplicate | Grievance was cancelled as a duplicate filing |
| Non-grievance Item | Grievance was cancelled as it was not a valid grievance issue |
| Non-supported Category | Grievance was cancelled as the category is not delegated to CVS Caremark |
| Non-supported Client | Grievance was cancelled as the client is not delegated to CVS Caremark |

* Select the **View Detail** button to see details of the selected Grievance.

A screenshot of a computer

AI-generated content may be incorrect.

The following fields are **VIEW ONLY** and include any details documented by the Grievance Department:

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| **Topic** | **Information** |
| **Case Notes** | Any research notes added by the Grievance Department. |
| **Sub Tasks** | Tab not in use. |
| **Outbound Contact** | Notations regarding any attempted or successful Outbound Contact(s) regarding this issue.  Outbound contacts could be made to:   * Beneficiary * Pharmacy * Other parties related to the Grievance issue |
| **Attachments** | Any attachments received regarding this issue.  **EXAMPLE:**   * AOR form * POA * Email * FAX * Letter |
| **Correspondence** | Any correspondence sent to the person who filed the Grievance.  **EXAMPLE:**   * Letter |

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| **Withdrawal Request** |

 If a beneficiary contacts Customer Care and states a Grievance was filed, but they want to withdraw the Grievance, take one of the following actions:

1. If the beneficiary states they were never dissatisfied and previously called to ask a question only, add a call note stating the member requested to withdraw the Grievance and the reason why. An email should also be sent to [DelegatedGrievance@CVSHealth.com](mailto:DelegatedGrievance@CVSHealth.com) notifying the Grievance Team of the withdrawal request.
2. If the beneficiary states they did have an issue but want to withdraw the Grievance because it was resolved, inform the beneficiary that Medicare requires any and all types of dissatisfaction to be documented by the Plan. To ensure that the beneficiary’s issue was completely resolved, the beneficiary will receive an additional phone call or letter. Only if the beneficiary insists the grievance be withdrawn, send an email to [DelegatedGrievance@CVSHealth.com](mailto:DelegatedGrievance@CVSHealth.com) notifying the Grievance Team of the withdrawal request.

**Note:** If a Grievance is filed in error, alert your supervisor to review. The supervisor will send an email to [DelegatedGrievance@CVSHealth.com](mailto:DelegatedGrievance@CVSHealth.com) and provide reason why it should be cancelled.

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| **Documenting a Client-handled Grievance** |

Icon - Important Be sure to reference the appropriate Work Instructions to determine if you can resolve the issue prior to filing a Grievance - refer to [MED D - Commonly Used Work Instructions Index (089595)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=45cc9b47-1035-4597-b0ca-52d3109f8c8d) and/or theSource.

**Document using Activity Code 1320 (Grievance - Client Handles).**



Once the CCR has determined that the Client handles the Grievance, this is the process to document and relay information to the Client.

**Note:** If the caller disconnects or states they cannot stay on the phone and enough information has been gathered to support a Client-handled Grievance, the CCR **MUST** still proceed with documenting the account using Activity Code 1325 (Member Refuses Transfer to Client).

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| **Step** | **Action** | |
| **1** | Ensure that you have reviewed the CIF for any Client-specific Grievance processes and follow the Grievance process outlined in the CIF. | |
| **2** | CCR should attempt to fully resolve the beneficiary’s issue and ensure there is nothing else to assist with, then offer to warm transfer to the Client. | |
| **If…** | **Then…** |
| CCR is able to resolve the issue | I am glad we were able to resolve the reason for your call.  I apologize for any inconvenience. If there is nothing else I can assist you with today, I would like to provide you with the opportunity to speak directly with a representative from your Plan to help improve the process moving forward.  Proceed to [Step 3](#ClientGRVStep3). |
| CCR is NOT able to resolve the issue | I need to transfer you to a representative from your Plan for further assistance.  **Note:** Be sure to advise the Plan representative of any dissatisfaction on the call.  Proceed to [Step 3](#ClientGRVStep3). |
| **3** | Determine if the beneficiary accepted or refused the warm transfer to the Client. | |
| **If…** | **Then…** |
| Accepted transfer | Document in **Capture Activity** screen in PeopleSafe using Activity Code 1320, GRIEVANCE CLIENT HANDLES.  Proceed to [Step 4](#ClientStep4) for examples on how to document the account. |
| Refused transfer | Document in **Capture Activity** screen in PeopleSafe using Activity Code 1325, GRV-MEM REFUSE XFER TO CLIENT.  Proceed to [Step 4](#ClientStep4) for examples on how to document the account. |
| Client closed/After hours | Document in **Capture Activity** screen in PeopleSafe using Activity Code 1325, GRV-MEM REFUSE XFER TO CLIENT.  Proceed to [Step 4](#ClientStep4) for examples on how to document the account. |
| **4** | CCR **MUST** document the following:  **Reason:** <<Beneficiary’s dissatisfaction.>>   * Who did you speak to? Notate whether you spoke to anyone other than the member. * What are they calling about? * Notate additional comments or notes that may help the next time this beneficiary calls. * Include background information for the beneficiary’s call.   **Action:** <<Step(s) taken to attempt to resolve the issue before transfer to the Client.>>   * What happened on the call? * Notate what actions you took during the call (i.e., RM task created, beneficiary transferred, etc.).   **Result:** <<The beneficiary **accepted** or **refused** the transfer.>>   * What was the end result? * Notate actions taken to resolve the issue. * Notate what you did next if the issue was not resolved (i.e., transferred call to another department).   **Examples:**  **Grievance was resolved:**  **Reason:** Beneficiary was upset that their medication was denied, is going on vacation and will run out.  **Action:** Contacted Senior Escalation Team who put on a vacation override, contacted pharmacy and had them rerun the medication, claim paid, and beneficiary received medication.  **Result:** Offered beneficiary the opportunity to be warm transferred to the Client to document their dissatisfaction; the beneficiary <<declined warm transfer, 1325 **OR** accepted warm transfer, 1320>>.  **Grievance was not resolved:**  **Reason:** Beneficiary was upset that their plan is starting 10/1/18, it was supposed to start on 9/1/18.  **Action:** Unable to resolve this issue for the beneficiary as it is handled by the Client.  **Result:** Advised beneficiary I needed to warm transfer them to the Client to further assist in resolving this issue for the beneficiary, beneficiary <<accepted the warm transfer and I advised the Plan representative of the beneficiary’s dissatisfaction, 1320, **OR** beneficiary declined warm transfer, 1325 **OR** unable to transfer beneficiary due to Client being closed, advised to call back during normal business hours, 1325>>.  **Note:** If there are multiple Grievances, capture ALL information within one template. | |

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| **Escalation Process** |

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| **If the call is…** | **Then it is the responsibility of the…** |
| Not escalated (Assist) | CCR to file the Grievance and notate the account appropriately. |
| Escalated (Procedural Transfer) and issue is **resolved** prior to transfer | CCR to file the Grievance and notate the account appropriately. It is the responsibility of the CCR to advise the Senior Representative if a Grievance has been filed. |
| Escalated (Procedural Transfer) and issue is **NOT resolved** prior to transfer | Senior Escalation Team to file the Grievance and notate the account appropriately. |

Icon - Important In the event the call is highly escalated, the Grievance number does not have to be provided to the caller, it should be notated in the beneficiary’s account only.

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| **FAQs** |

Icon - Important Be sure to reference the appropriate Work Instructions to determine if you can resolve the issue prior to filing a Grievance - refer to [MED D - Commonly Used Work Instructions Index (089595)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=45cc9b47-1035-4597-b0ca-52d3109f8c8d) and/or theSource.

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| **Question** | **Answer/Resolution** | |
| What if a beneficiary prefers to file a Grievance in writing? | Determine if CVS handles the Grievance. | |
| **If…** | **Then…** |
| CVS handles | Beneficiary may submit a Grievance in writing to:  Grievance Department  P.O. Box 30016  Pittsburgh, PA 15222-0330  Beneficiary may fax the written Grievance to 866-217-3353.  **Note:** CCR to request that Beneficiary include membership ID number in the letter or fax. |
| Client handles | Follow the process outlined in the CIF. |
| When a Grievance is handled by the Client, what verbiage should be used since a Grievance cannot be offered? | Inform the beneficiary the issue is handled by the Client and warm transfer the call so the issue can be resolved. | |
| What if a beneficiary specifically states that they want to file a Grievance? | If the issue is resolved, inform the beneficiary that the Grievance was logged and reported. If the beneficiary requests a Grievance number, CCR to advise beneficiary to record date and time of call. | |
| What if the beneficiary states that a written response is required or asks for the Grievance number? | If the beneficiary requires a letter, the case would have to be filed in PeopleSafe as a New Grievance with normal documentation process including any resolution provided to the beneficiary. The note in PeopleSafe would be normal documentation for a Grievance filed in PeopleSafe along with the specific beneficiary request for a written response or Grievance number.  **Note:** Be sure to use the proper Grievance activity codes. | |
| How should a CCR educate a third-party calling on behalf of a beneficiary? | Two scenarios to consider when a third-party calls in:  **Note:** Refer to the [Who Can File A Grievance](#_Who_Can_File_2) section above  **Scenario 1:** The beneficiary is present and has authorized the third-party to speak on their behalf. Any Grievance would be handled in the same way it would be if speaking to the beneficiary. The call note should state that the beneficiary gave permission for the caller to speak on their behalf and to file the Grievance.  **Scenario 2:** The beneficiary is not present and/or third-party is not AOR or POA. A grievance may be opened for someone claiming to be the appointed representative prior to having the AOR/POA on file. | |

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| **Related Documents** |

**Parent Document:** CALL-0048, [Medicare Part D Customer Care Call Center Requirements-CVS Caremark Part D Services, L.L.C.](https://policy.corp.cvscaremark.com/pnp/faces/DocRenderer?documentId=CALL-0048)

**Abbreviations/Definitions:** [Customer Care Abbreviations, Definitions, and Terms Index (017428)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=c1f1028b-e42c-4b4f-a4cf-cc0b42c91606)

* [Med D - Compass Grievances: CCR - First Call Resolution Documentation Templates (Health Plans) (066744)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=0e126cf2-ca19-4e62-b84f-72733e77b8b9) (066744)
* [Med D - Compass Grievances: CCR - First Call Resolution Documentation Templates (NEJE) (066745)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=cb56c2af-d1ed-4e8a-a309-d0db70d8c751) (066745)
* MED D - Grievance vs. Coverage Determination - Decision Matrix
* MED D - Appointed Representative Form AOR or Power of Attorney POA
* [Medicare and Medicaid SHIP Counselor Unique ID List (077234)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=fadccc80-a0a1-449b-b5b0-056705aad9ec)
* [MED D - Coverage Determinations and Redeterminations (Appeals) Landing Page (004825)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=1e7d7ad7-e1c1-4fa1-8258-215a1c0ff32b)
* [MED D - Call Documentation Including Viewing and Adding Comments in PeopleSafe (067665)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=e9cdb772-9c04-4e42-b87a-ae4d2c2e1f62)
* Downtime Procedures

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