# Compass MED D - How to File a Grievance in Compass

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**Description:** Guidance to be used when filing a Grievance in Compass.

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| Creating a Grievance in Compass |

Once the Customer Care Representative (CCR) has determined that it is appropriate to open a Grievance for a beneficiary, the instructions in this work instruction should be followed to properly open the Grievance in **Compass**. For assistance in determining when it is appropriate to file a Grievance, refer to [Compass MED D - When to File a Grievance in Compass (066741)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=8895dffc-cf45-44d4-b795-c4d95f7bd555).

If you determine a Standard open Grievance has already been submitted (and is not resolved) for the same category in Compass, advise the beneficiary a response will be received within 30 days from the original date.



Do not submit a second Grievance; instead, document the beneficiary’s account to indicate that a Grievance has already been submitted for this issue and proceed depending on the client:

* **HP and NEJE (MHK Fusion):** Send an email to [DelegatedGrievance@CVSHealth.com](mailto:DelegatedGrievance@CVSHealth.com) and CC your supervisor.
* **SSI PDP, SSI EGWP, and Aetna EGWP (MHK Nitro):** Alert your supervisor to review. Your supervisor will send an email to [MedicareOralGrievanceUnitMailbox@aetna.com](mailto:MedicareOralGrievanceUnitMailbox@aetna.com) notifying the Grievance team.

Refer to [Compass MED D - Viewing Grievance History in Compass (066743)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=cf46f2f7-d40c-4c65-9155-a37d4075ca22) as needed.

If creating a Grievance for more than one issue:



* If the issues fall under the same category, then open one Grievance.

**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, then a separate Grievance should be opened for each issue, under separate categories.

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

**Notes:**

* You should NEVER use the Downtime Procedures for a prospective beneficiary whose effective date with the plan has not been confirmed by CMS (Centers for Medicare and Medicaid Services). 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 even if they reach the transferring team.
* Be sure to clearly document that the caller was dissatisfied (i.e. dissatisfied, upset/unhappy, displeased, etc.). Mentioning the caller had “issues” or “concerns” or was “confused” is not clear dissatisfaction.

**There are two types of Grievances:**

* First Call Resolution (FCR): Resolved issue
* New Grievance (Pending Initial Review): Unresolved issue

For additional information regarding how to discuss Grievances with beneficiaries, refer to the “Grievance Standard Verbiage (for use in Discussion with Beneficiary)” section in [Compass MED D - When to File a Grievance in Compass (066741)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=8895dffc-cf45-44d4-b795-c4d95f7bd555).

Follow the steps below to File a Grievance:

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| **Step** | **Action** | | | | | |
| **1** | From the Member Snapshot Landing Page, navigate to the **Quick Actions** panel and proceed depending on the **Grievance** hyperlink available. | | | | | |
| **If the hyperlink is…** | | | | **Then…** | |
| Submit Grievance | | | | CVS handles the grievances (HP or NEJE client). Click **Submit Grievance**.  **Result:** A pop-up displays to check who is submitting the Grievance.  Proceed to [Step 2](#Step2). | |
| Submit New Grievance | | | | CVS handles the grievances (SSI PDP, SSI EGWP, or Aetna EGWP client). Click **Submit New Grievance**.  **Result:** A pop-up displays to check who is submitting the Grievance.  Proceed to [Step 2](#Step2). | |
| Submit Non-Delegated Grievance | | | | The client handles the grievances. Proceed to the [Creating a Non-Delegated Grievance in Compass](#_Creating_a_Non-Delegated_1) section.    **Note:** This link only appears for non-delegated Clients/Grievance types. | |
| No Grievance link is available, or the link is disabled | | | | Compass may not provide a **Submit/Submit New Grievance** hyperlink in the **Quick Actions** panel if:   * The client is a non-delegated MED D client. For non-delegated clients (i.e., clients that handle their own grievances), proceed to the [Creating a Non-Delegated Grievance in Compass](#_Creating_a_Non-Delegated_1) section below. * You are in a Research Case. Submit/Submit New Grievance hyperlinks are disabled when in a Research Case. You must open an Interaction Case to proceed. | |
| If you attempt to initiate the grievance under secondary coverage, Compass will not allow the grievance to continue and will display the following message. **Do not read to member:** “A grievance may only be filed in the primary line of coverage. Access the primary line of coverage to submit a grievance.” | | | | | |
| **2** | Verify the **Caller’s Name** and **Who is Calling** fields are correct.    **Notes:**   * The **Caller Name** and **Who is Calling** fields will auto-populate with information captured during the Authentication flow. * Agent can use the **Who is Calling** drop-down menu to change the auto-populated selection. For assistance, refer to the [If/Then table](#MemberSelf) below. * **PeopleSafe Call ID** is optional and not required (Client Specific). * If PeopleSafe Call ID is less than 10 digits, the following message displays: “PeopleSafe Call ID must be a 10-digit number”. * Click **Cancel** to exit. | | | | | |
| **If the caller is…** | | | | **Then…** | |
| Member/Self | | | | Click **Next** and proceed to the next step.  **Result:** The General Grievance Information screen displays. | |
| Not Member/Self | | | | An additional question will appear: “Is Power of Attorney/Appointment of Representative (POA/AOR) on file for the caller?”  **Note:** Refer to the following documents for additional information:   * To verify whether a POA or AOR is on file in Compass, refer to [Compass MED D - Appointed Representative Form (AOR) or Power of Attorney (POA) (061884)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=64c3fc62-48c3-4ad3-ae83-c736cebd521b). * To verify who can file a grievance on behalf of the member, refer to the “Who Can File a Grievance?” section of [Compass MED D - When to File a Grievance in Compass (066741)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=8895dffc-cf45-44d4-b795-c4d95f7bd555) for additional information. | |
| **If…** | **Then…** |
| POA/AOR is on file | * Select the **Power of Attorney (POA)** or **Appointment of Representative (AOR)** radio button. * Click **Next** and proceed to the next step.   **Result:** The General Grievance Information screen displays. |
| Neither on file | * Select the **Neither on File** radio button.   **Result:** An additional question will appear: “Has the member given verbal authorization to file a grievance?”   * Select the **Yes** or **No** radio button. * Click **Next** and proceed to the next step.   **Result:** The General Grievance Information screen displays. |
| **3** | Verify that the Grievance is being created for the member displayed in the **Member Details** panel.    **Notes:**   * All fields on the General Grievance Information screen are mandatory and must be filled in unless otherwise specified. * To exit Grievance without filing, click **Discard**. For assistance discarding a Grievance, refer to the [Grievance Scenario Guide](#_Grievance_Scenario_Guide). | | | | | |
| **4** | Review the **Grievance History** panel to see historical grievances filed within the last 60 days.   * If Grievance on file, advise the member that a Grievance has already been filed and is in process. Refer to [Compass MED D - Viewing Grievance History in Compass (066743)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=cf46f2f7-d40c-4c65-9155-a37d4075ca22) for additional information. * If Grievance is not on file, proceed to the next step.     **Note:** If the beneficiary calls with the same issue as a previous Grievance, refer to the table below: | | | | | |
| **If the previous Grievance on that issue...** | | **Then...** | | | |
| Is still open | | Do not file a new Grievance. Update the caller on the status of the Grievance.    **Example:** Beneficiary complains about the Interactive Voice Response (IVR) every time they call in. | | | |
| 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.  **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 Compass a reference to the Grievance filed earlier that same day. | | | |
| **5** | On the General Grievance Information screen, first verify the requester has expressed dissatisfaction by selecting the **Yes** or **No** radio button.   * If **Yes** is selected, proceed to the next step. * If **No** is selected, the following message will display: “A grievance should not be filed if the requestor did not express dissatisfaction. If the requestor is dissatisfied, change the answer to Yes.” | | | | | |
| **6** | Verify the Requester’s Name.    **Note:** The **Requestor Name** field will be pre-populated from the previous **Who is Submitting the Grievance** popup but can be changed if needed. | | | | | |
| **7** | Select **Phone** as the **Channel** the Grievance was filed through.  **HP and NEJE clients**    **SSI PDP, SSI EGWP, and Aetna EGWP clients**    **Notes:**   * The **Channel** selection will default to **Phone** and will classify the grievance as **First Call Resolution (FCR)**. * If the grievance Channel is **Fax**, **Email**, **Letter**, or **Chat**, the system will require the grievance to be submitted as a **New Grievance (Pending Initial Review)** instead of a First Call Resolution. | | | | | |
| **8** | 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.     **Note:** The Tool Tip next to **Date of Occurrence** displays the following message: “Date of Occurrence must be within 60 days of the date the grievance was reported.”   * If Date of Occurrence **is more than 60 calendar days before the current date**, the following message will display: “Date of Occurrence must be within 60 days of the date the grievance was reported.” * If Date of Occurrence **is after the term date of member's eligibility**, the system will prevent advancement to the next screen and display the following notification message: “Grievances cannot be filed for dates after the member's eligibility has terminated.”   **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 (Rx).   * Claim Date = September 12, 2023 * Letter Date = October 27, 2023 * Today’s Date = November 12, 2023 * The **Date of Occurrence** for this issue would be the Letter Date (October 27, 2023) which is the event that caused the beneficiary’s dissatisfaction. This date is within the 60-day window for filing a Grievance because it is less than 60 days before Today’s Date (November 12, 2023).   **REMINDER:** It is extremely important to confirm that 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” section in [Compass MED D - When to File a Grievance in Compass (066741)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=8895dffc-cf45-44d4-b795-c4d95f7bd555) for additional information. | | | | | |
| **9** | Select the **Primary Grievance Reason**. This will direct the system to take you through additional screens as needed to assist with addressing the member’s issue.  **Note:** The system will default to “Other”; click the drop-down menu to change the selection:   * **Customer Service –** For concerns regarding customer service given, including hold time and how a representative handled the call. * **Drug Coverage -** For concerns regarding drug coverage/cost. * **Marketing Correspondence -** For concerns regarding written correspondence mailed to the member. * **Order Management -** For concerns regarding the status of or issues with existing mail orders. * **Order Placement -** For concerns regarding placement of new mail orders. * **PA/Coverage Determination -** For concerns regarding the Coverage Determination process. * **Pharmacy Lookup -** For concerns regarding what pharmacies are nearby and/or in network. * **Other -** For concerns that do not fit into any above scenario.     Compass is dynamic and will guide the agent through filing the Grievance based on the **Primary Grievance Reason** selected.  **Example:** If you select “Drug Coverage” as the Primary Grievance Reason, the next screen will instruct you to select claims associated with the grievance: | | | | | |
| **10** | Select the applicable **Category** based on the beneficiary’s issue. Refer to the appropriate section below for additional information regarding the available Categories and Subcategories for each client:   * [Grievance Categories, Subcategories, and Definitions (HP & NEJE)](#_Grievance_Categories,_Subcategories) * [Grievance Categories and Subcategories (SSI PDP, SSI EGWP, and Aetna EGWP)](#_Toc152833038)   **At this time, you must select from the Categories available in the dropdown.** DO NOT click the "For other topics, view categories requiring client outreach or non-delegated grievance" link if it appears under the dropdown.  **Notes:**   * Only the Categories that CVS is delegated to handle for the Client will appear in the drop-down menu. * If **Category** is set to **Quality of Care** or **Marketing**,Compass will classify Grievance as a **New Grievance (Pending Initial Review)**.      * If the beneficiary is discussing an issue that covers multiple categories, the CCR **MUST** file a separate Grievance for each category. * To open a separate Grievance, from the **New Grievance** panel on the right side of the screen, select the **Primary Grievance Reason**. This will open a new **Grievance** tab so that you can submit multiple grievances: | | | | | |
| **11** | Select the applicable **Subcategory** based on the beneficiary’s issue.   * Each Category has related Subcategories. Refer to the appropriate section below for additional information regarding the available Categories and Subcategories for each client: * [Grievance Categories, Subcategories, and Definitions (HP & NEJE)](#_Grievance_Categories_and_2) * [Grievance Categories and Subcategories (SSI PDP, SSI EGWP, and Aetna EGWP)](#_Toc152833038) | | | | | |
| **If the requestor is…** | | | **Then…** | | |
| Discussing an issue that is under one category but different sub-categories | | | DO NOT file a second Grievance; select the most appropriate subcategory. | | |
| Calling about another topic that is not listed in the Category menu because it is handled by the client | | | Refer to the [Creating a Non-Delegated Grievance in Compass](#_Creating_a_Non-Delegated_1) section.  You will see messaging that indicates: “For other topics, view categories requiring client outreach or non-delegated grievance.”.  A screenshot of a computer  AI-generated content may be incorrect.  Medicare B categories are listed as a category along with other categories and sub-categories. | | |
| **12** | Select what the Grievance is related to.  Currently the Work Instruction hyperlink(s) on this screen are incorrect and **DO NOT** work. Do not refer to these work instructions or select the checkbox. Updated work instruction links are coming soon. | | | | | |
| **13** | After completing mandatory fields on the General Grievance Information screen, click **Next**.   * If **Grievance Priority** options appear, **Standard** will automatically be selected.   Do not update the **Grievance Priority** to Expedited. | | | | | |
| **14** | Complete the required information for the selected Grievance type.  **Note:** Compass is dynamic and will guide the agent. For assistance with completing the Grievance, refer to the appropriate work instruction linked to below: | | | | | |
| **If the selected Primary Grievance Reason is…** | | | **Then refer to…** | | |
| Customer Service | | | [Compass MED D - Primary Grievance Reason: Customer Service (066746)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=a4982956-e24d-424d-9d57-dd99ef9e5ced) | | |
| Drug Coverage | | | [Compass MED D - Primary Grievance Reason: Drug Coverage (066747)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=8cb1329d-0d57-4e03-8df2-291918becc65) | | |
| Marketing Correspondence | | | [Compass MED D - Primary Grievance Reason: Marketing Correspondence (066748)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=53a18303-a4e3-40c7-8f5f-e9f46a05e75f) | | |
| Order Management | | | [Compass MED D - Primary Grievance Reason: Order Management (066749)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=10240e6a-01fb-41b8-be3a-35c317c15085) | | |
| Order Placement | | | [Compass MED D - Primary Grievance Reason: Order Placement (066750)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=aab6f68d-c12e-4d37-b1ba-1dcd98952541) | | |
| PA/ Coverage Determination | | | [Compass MED D - Primary Grievance Reason: PA/Coverage Determination (066751)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=153eee1a-3190-42b6-92e9-cdb4443ba6d4) | | |
| Pharmacy Lookup | | | [Compass MED D - Primary Grievance Reason: Pharmacy Lookup (066752)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=32e10dca-4c56-4166-a9eb-97c7dde98d57) | | |
| Other | | | [Compass MED D - Primary Grievance Reason: Other (066753)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=c19fb88d-1b64-4c94-b53a-26e56fa9c0bd) | | |
| **15** | For every Grievance type, you will need to answer the question “Is the grievance resolved?” or “Did you fully address the member’s concerns?”   * If **Yes** is selected, Compass will classify the grievance as **First Call Resolution (FCR).** * **FCR:** 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). * If **No** is selected, Compass will classify the grievance as **New Grievance (Pending Initial Review).** * **New Grievance:** CCR cannot resolve the issue on the call (i.e., issue requires additional research or secondary action).     **Note:** Refer to the [First Call Resolution Examples](#_First_Call_Resolution) section below as needed.  **Reminder:** DO NOT select **Yes** for Quality of Care issues. If there is a Quality of Care issue,Grievance **MUST** be filed as a New Grievance. **NEVER** file a First Call Resolution Grievance if there is a Quality of Care issue. Refer to the “Quality of Care” section in [Compass MED D - When to File a Grievance in Compass (066741)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=8895dffc-cf45-44d4-b795-c4d95f7bd555) for additional information. | | | | | |
| **16** | For every Grievance type, complete the **Description of Issue** field.  **Note:** The **Description of Issue** field will display a “Character limit of 4000 characters”.   * If **Other** was selected for the **Primary Grievance Reason**,Compass will limit the **Description of Issue** field to a maximum of 1000 characters.   A screenshot of a computer  Description automatically generated | | | | | |
| **If…** | | | | **Then…** | |
| **First Call Resolution (FCR) –** resolved issue | | | | **DO NOT** restate the FCR Grievance, **DO NOT** provide a Grievance number - Beneficiary is **not aware** that a Grievance is being filed.  Be sure to use the full Reason, Action, Result template, if available, from the appropriate FCR Documentation Templates document:   * [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) * [Compass Med D - Grievances: CCR – First Call Resolution Documentation Templates (NEJE) (066745)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=cb56c2af-d1ed-4e8a-a309-d0db70d8c751) * [MED D - Compass Grievances: CCR - First Call Resolution Documentation Templates (SSI PDP, SSI EGWP, Aetna EGWP) (068896)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=b7f5a139-be8a-493a-8155-3932709e086e)   Ensure that Reason, Action, and Result are clearly documented in the **Description of Issue** field:    **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.  **Note:** Document why a Coverage Determination was not submitted if it seems like one could have been (**Examples:** 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, etcetera). | |
| **New Grievance (Pending Initial Review)** – unresolved issue | | | | * Summarize the Beneficiary’s issue in the **Description of** **Issue** field using the format illustrated in the Notes 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. * Document why a Coverage Determination was not submitted if it seems like one could have been (**Examples:** 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, etcetera).   **CCR Process Note: Always** start the Grievance description in Compass with the below statement:   * **I have confirmed with the Beneficiary the following issue(s):**  1. Beneficiary is dissatisfied with <Issue details> 2. <Issue details> 3. <Issue details>   **Note:** Make sure to document any actions taken to resolve the grievance issue(s).  **Remove all special characters and bullet points form the Description of Issue (DOI).** Only periods and commas are permitted in the DOI.  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.   **EXAMPLE 1:**   * I have confirmed with the Beneficiary the following issue(s):  1. Beneficiary is dissatisfied with customer care s/he received on 2-25-24 from <CCR’s first name>.   Icon - Important In order to ensure the beneficiary’s issue was properly notated in Compass, the CCR **MUST**restate what has been typed in the **Description of Issue**field to the beneficiary.  **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. | |
| **17** | For every Grievance type, indicate if a Written Response is requested.  **Icon - Important Information** **DO NOT** select **WRITTEN RESPONSE REQUESTED** for First Call Resolution (FCR) Grievances.   * Select **No** if the beneficiary does not request a written response.   **Icon - Important Information** **DO NOT** select **WRITTEN RESPONSE REQUESTED** unless the beneficiaryrequests a written response.   * Do **NOT** ask the beneficiary if they want a written response. * Select **Yes** if the beneficiary indicates they would like a written response. * If **Yes** is selected, **Compass** will classify the grievance as **New Grievance (Pending Initial Review)**.   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? | | | | | |
| **18** | For every Grievance type, you must verify the **Address**, **Phone Number**, and **Email Address** with the member, then click **Next**.  **Note:** You can make updates by clicking the **Update** hyperlink.    **Result:** The Grievance Summary displays. | | | | | |
| **19** | Review the **Grievance Summary** notes, then click **Submit**.  **Notes:**   * To return to the Processing screen, click **Previous**. * To exit Grievance without filing, click **Discard**. For assistance discarding a Grievance, refer to the [Grievance Scenario Guide](#_Grievance_Scenario_Guide) section below.   **Example:**    **Result:** A message will display at the top of the screen validating that the Grievance was submitted, and the Grievance tab will close.  **Example:** “Success! [Grievance Reason] (MedHOK ID# [Grievance ID number]) submitted”.   * [Grievance ID number] will be replaced by the Grievance ID number returned by MedHOK Fusion/Nitro. * [Grievance Reason] will be replaced by the Primary Grievance Reason for the grievance submitted.   The new Grievance will appear in the **Grievance History** panel if submitting additional Grievances.  The grievance must be complete prior to closing an Interaction Case. If the grievance is still in process, Compass will display the message “Incomplete grievance exists. You must complete or discard any grievance before closing the case” and will prevent the **Call Documentation** window from being opened." | | | | | |
| **20** | Determine if a Coverage Determination is needed. | | | | | |
| **If…** | **Then…** | | | | |
| Yes | Proceed to [Compass MED D - CCR - Coverage Determinations and Redeterminations (Appeals) (064997)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=a23bc09d-37f7-4105-ba57-d4e9d7f512ff).  **Note:** Any complaint about the CD **process** (e.g., upset with having to wait for a decision, prescriber has to complete paperwork, etcetera) will always be a First Call Resolution - outcome will not change the Grievance. | | | | |
| No | Proceed to the next step. | | | | |
| **21** | 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 (Client Information Form)>, <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 [Compass - Close an Interaction or Research Case (050011)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=0296717e-6df6-4184-b337-13abcd4b070b) and [Compass MED D - Call Documentation Job Aid (061758)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=433711aa-8fa6-447c-872b-bd69cd6cd7c0).   **Compass Case Notes Example:** Filed New Grievance for member upset about customer service. GR123456789 was filed.  **Note:** Grievances require documentation. | | | | | |

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| Grievance Questionnaire Process |

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

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| **Step** | **Action** | |
| **1** | Locate and click the **Close Case** button in the **Case Data** section.  **Result:** The Close Case window displays. | |
| **2** | Navigate to the bottom of the **Close Case** modal to access the **Grievance Questionnaire** section. | |
| **3** | Determine if a Grievance needs to be filed.   * **Is this a Grievance?**   **Note:** This question will appear even if a Grievance has already been submitted during the current Interaction Case.  Use table below as needed: | |
| **If…** | **Then…** |
| A Grievance is needed | Select the **Yes** radio button and proceed to the next step.  **Result:** Additional Grievance questions populate. |
| A Grievance does not need to be filed | Select **No**.  **Result:**   * If notes were entered in **Case Comments** and required fields are completed on the **Close Case** popup, click **Close Case**, the member’s account closes and returns to a blank **Search by Member** screen for the next call. * If notes were **not** entered in **Case Comments** and required fields have not been completed, the Case cannot be closed. * Fill in all required fields and enter **Case Comments** (50 Character minimum required). |
| **4** | Complete theAdditional Grievance questions.   * **Is Grievance Resolved?** * If Yes, select the **Resolved Grievance** radio button and proceed to the next question below. * If No, select the **Grievance Not Resolved** radio button and proceed to the next step. Proceed with filing an [Unresolved Grievance](#_Creating_a_Resolved).      * **Did you file the grievance, transfer the call to the Client, or transfer the call to the Senior Team?** * If **Yes** is selected, proceed to the next step.      * If **No** is selected, a pop-up will appear instructing the CCR to go “**Submit a grievance as outlined in TheSource. If you are unable to submit a grievance, warm transfer to the Senior Team.**” Proceed with filing a First Call Resolution Grievance. | |
| **5** | Click **Close Case** (bottom right of the Close Case window), to close the account once call documentation is complete.    **Result:** The member’s account closes and returns to a blank **Search by Member** screen for the next call.  **Notes:**   * If notes were **not** entered in **Case Comments** and required fields have not been completed, the Case cannot be closed. * Fill in all required fields and enter **Case Comments** (50 Character minimum required). | |

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| Creating a Non-Delegated Grievance in Compass |

Follow the steps below to File a Non-Delegated Grievance:

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| **Step** | **Action** | | |
| **1** | From the Member Snapshot Landing Page, navigate to the **Quick Actions** panel and click the **Submit Non-Delegated Grievance** hyperlink.  **Note:** The hyperlink will only appear for non-delegated Clients and Grievance types.    **Result:** The Non-Delegated Grievance page displays.  **Note:** The Submit Non-Delegated Grievance hyperlink will be disabled when in a Research Case. You must open an Interaction Case to proceed. | | |
| **2** | Verify that the Grievance is being created for the member displayed in the **Member Details** panel.    **Notes:**   * All fields on the Non-Delegated Grievance screen are mandatory and must be filled in unless otherwise specified. * The Non-Delegated Grievance will NOT have a **Grievance History** panel. Because they are Non-Delegated, completing this form will generate a service request instead of Grievance that is tracked in our systems. * To exit Grievance without filing, click **Discard**. For assistance discarding a Grievance, refer to the [Grievance Scenario Guide](#_Grievance_Scenario_Guide). | | |
| **3** | Verify **Who is Calling?** by selecting the appropriate radio button. | | |
| **4** | Select **Phone** as the **Channel** the Grievance was filed through. | | |
| **5** | 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.     **Note:** The Tool Tip next to **Date of Occurrence** displays the following message: “Date of Occurrence must be within 60 days of the date the grievance was reported.”   * If Date of Occurrence **is more than 60 calendar days before the current date**, the following message will display: “Date of Occurrence must be within 60 days of the date the grievance was reported.” * If Date of Occurrence **is after the term date of member's eligibility**, the system will prevent advancement to the next screen and display the following notification message: “Grievances cannot be filed for dates after the member's eligibility has terminated.”   **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, 2023 * Letter Date = October 27, 2023 * Today’s Date = November 12, 2023   + The **Date of Occurrence** for this issue would be the Letter Date (October 27, 2023) which is the event that caused the beneficiary’s dissatisfaction. This date is within the 60-day window for filing a Grievance because it is less than 60 days before Today’s Date (November 12, 2023).   **REMINDER:** It is extremely important to confirm that 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” section in [Compass MED D - When to File a Grievance in Compass (066741)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=8895dffc-cf45-44d4-b795-c4d95f7bd555) for additional information. | | |
| **6** | Select the applicable **Category** based on the beneficiary’s issue and according to the [Grievance Categories, Subcategories, and Definitions (HP & NEJE)](#_Grievance_Categories_and_2) section below. | | |
| **7** | Select the appropriate **Sub Category** based on the beneficiary’s issue.   * Each **Category** has related Sub Categories. Refer to the [Grievance Categories, Subcategories, and Definitions (HP & NEJE)](#_Grievance_Categories_and_2) section for definitions and examples of each Sub Category.     **Note:** If the beneficiary is discussing an issue that is under one category but different sub-categories, DO NOT file a second Grievance; select the most appropriate subcategory. | | |
| **8** | Complete the **Description of Issue** field.  **Note:** The **Description of Issue** field will display a “Character limit of 4000 characters”.   * If **Other** was selected for the **Primary Grievance Reason**,Compass will limit the **Description of Issue** field to a maximum of 1000 characters.   A screenshot of a computer  Description automatically generated | | |
| **If…** | | **Then…** |
| **First Call Resolution (FCR) –** resolved issue | | Icon - Important **DO NOT** restate the FCR Grievance, **DO NOT** provide a Grievance number - Beneficiary is **not aware** that a Grievance is being filed.  Be sure to use the full Reason, Action, Result template, if available, from the appropriate FCR Documentation Templates document:   * [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) * [Compass Med D - Grievances: CCR – First Call Resolution Documentation Templates (NEJE) (066745)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=cb56c2af-d1ed-4e8a-a309-d0db70d8c751) * [MED D - Compass Grievances: CCR - First Call Resolution Documentation Templates (SSI PDP, SSI EGWP, Aetna EGWP) (068896)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=b7f5a139-be8a-493a-8155-3932709e086e)   Ensure that Reason, Action, and Result are clearly documented in the **Description of Issue** field:    **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.  **Note:** Document why a Coverage Determination was not submitted if it seems like one could have been (**Examples:** 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.). |
| **New Grievance (Pending Initial Review) –** unresolved issue | | * Summarize the Beneficiary’s issue in the **Description of** **Issue** field using the format illustrated in the Notes 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. * Document why a Coverage Determination was not submitted if it seems like one could have been (**Examples:** 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.).   **CCR Process Note: Always** start the Grievance description in Compass with the below statement:   * **I have confirmed with the Beneficiary the following issue(s):**  1. Beneficiary is dissatisfied with <Issue details> 2. <Issue details> 3. <Issue details>   **Note:** Make sure to document any actions taken to resolve the grievance issue(s).  **Remove all special characters and bullet points from the Description of Issue (DOI).** Only periods and commas are permitted in the DOI.  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.   **EXAMPLE 1:**   * I have confirmed with the Beneficiary the following issue(s):  1. Beneficiary is dissatisfied with customer care they received on 2-25-24 from <CCR’s first name>.   Icon - Important In order to ensure the beneficiary’s issue was properly notated in Compass, the CCR **MUST**restate what has been typed in the **Description of Issue**field to the beneficiary.  **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. |
| **9** | For every Grievance type, you must verify the **Address**, **Phone Number** and **Email Address** with the member/caller.  Use table as needed: | | |
| **If Who’s Calling is…** | **Then…** | |
| Member/Self | * Verify the contact information and update if needed. * Proceed to the next step.     **Note:** You can make updates by clicking the **Update** hyperlink. | |
| Appointment of Representative/ Power of Attorney (AOR/POA)  Family Member/Third Party | * Verify the Requestor’s Information. * Proceed to the next step. | |
| **10** | Review the **Grievance** page, then click **Submit**.   * To exit Grievance without filing, click **Discard**. For assistance discarding a Grievance, refer to the [Grievance Scenario Guide](#_Grievance_Scenario_Guide) section below.     **Result:** A message will display at the top of the screen validating that the Grievance was submitted, and the Grievance tab will close. **Example:** “Success! Non-delegated grievance submitted”.  The grievance must be complete prior to closing an Interaction Case. If the grievance is still in process, Compass will display the message “Incomplete grievance exists. You must complete or discard any grievance before closing the case” and will prevent the **Call Documentation** window from being opened. | | |
| **11** | Determine if a Coverage Determination is needed. | | |
| **If…** | **Then…** | |
| Yes | Proceed to [Compass MED D - CCR - Coverage Determinations and Redeterminations (Appeals) (064997)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=a23bc09d-37f7-4105-ba57-d4e9d7f512ff).  **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 the next step. | |
| **12** | 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 [Compass - Close an Interaction or Research Case (050011)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=0296717e-6df6-4184-b337-13abcd4b070b) and [Compass MED D - Call Documentation Job Aid (061758)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=433711aa-8fa6-447c-872b-bd69cd6cd7c0).   **Compass Case Notes Example:** Filed New Grievance for member upset about customer service. GR123456789 was filed.  **Note:** All Grievances require documentation. | | |

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| Grievance Categories, Subcategories, and Definitions (HP & NEJE) |

The below categories are for CCRs entering grievances for **HP and NEJE clients in Compass only**. Examples were added for each category.

**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.

**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.

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 for HP and NEJE clients in Compass:

* [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)

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| --- | --- | --- |
| **CATEGORY** | **SUB-CATEGORY** | **DEFINITIONS/EXAMPLES** |
| **Benefits** | **Co-Pay/Coinsurance** | 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** | 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** | 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** | 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** | 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** | 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 (Low Income Subsidy) and were temporarily enrolled in LINET and should be in Blue MedicareRx, but the Plan has no record of enrollment from CMS. |
| **Excluded pharmacy** | 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** | 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 Long Term Care (LTC) pharmacy is sending the beneficiary a bill. The Plan has not received a TRC (Transaction Reply Code) or record of LIS update for the beneficiary. |
| **Premium option** | The beneficiary’s dissatisfaction is due to an error in the premium option that was made by CMS or SSA (Social Security Administration) 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** | 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.  **EXAMPLE:** Beneficiary is in the Value Plus 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** | * 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 (Food & Drug Administration) 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** | * 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 Explanation of Benefits (EOB) at their address; however, a different person’s name and medications are listed on the EOB. |
| **Customer Service** | **Call Handling** | 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, etcetera.  **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, etcetera.   **EXAMPLE:** Beneficiary contacted Care to update their address.   * CCR updated address on Member Snapshot Landing Page in **Compass**. * The CCR did not update the **Medicare D Landing Page** 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** | 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. | 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** | 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** | 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** | 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 (EOC) is difficult to understand. * Beneficiary states they did not receive their ID card. |
| **Wrong internal plan** | 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** | 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 (PA) **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** | 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** | 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, etcetera).  **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** | The beneficiary is dissatisfied because they did not receive an 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** | 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, etcetera) 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** | The beneficiary is dissatisfied with the mail order **process** (turnaround times, etcetera).  **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** | 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** | 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. |
| **Electronic Funds Transfer** **(EFT) issue  Note:** This would also include reoccurring credit card payments. | 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** | 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** | **Incorrect Rx Shipped** | The beneficiary is dissatisfied that they received the incorrect prescription.  **EXAMPLE:** Prescription was written for atorvastatin and beneficiary received lisinopril in error. |
| **Mail Order Delay** | 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. |
| **Mail Order Rx Error** | 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. |
| **Member out of medication due to plan, pharmacy, or prescriber error** | 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 (Florida) and provided a temporary address to the CCR, but order was sent to MA (Medical Assistant). * Medication was not received on time and beneficiary was without medication. |
| **Retail Rx Error** | The beneficiary alleges a retail prescription error.  **EXAMPLE:** The beneficiary is unhappy that pharmacy dispensed 20mg when the prescription was written for 40mg. |
| **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 Categories and Subcategories (SSI PDP, SSI EGWP, and Aetna EGWP) |

The below categories are for CCRs entering grievances for **SSI PDP, SSI EGWP, and Aetna EGWP clients** **in Compass only**.

**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.

Use the links below for a list of each category and its respective subcategories, which are the available choices when completing a Grievance for SSI PDP, SSI EGWP, and Aetna EGWP clients in Compass:

* [Access](#C1b)
* [Appearance of Facility](#C2b)
* [Billing](#C3b)
* [Claims Issue](#ClaimsIssue)
* [Coverage Determination/Redetermination](#C5b)
* [Customer Service](#C6b)
* [Enrollment/Disenrollment](#C7b)
* [Marketing](#C8b)
* [Member Materials](#C9b)
* [Plan Benefits](#C10b)
* [Privacy](#C11b)
* [Provider Customer Service](#C12b)
* [Quality of Care](#C13b)
* [Technology](#C14b)

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| **Category** | **Subcategory** |
| **Access** | Access to medications |
| Access to Other Pharmacies |
| Access to Par Pharmacies |
| Other Access/Availability |
| Pharmacy Participation Status |
| Refusal to fill |
| Wait Time in Pharmacy |
| **Appearance of Facility** | Office/Facility Dirty |
| Other Site Concern |
| Provider ADA Access |
| Unsafe Facility |
| **Billing** | Account adjustments not made |
| Incorrect billing |
| Late Enrollment Penalty |
| Late Payment |
| Payment not received |
| Payment not updated in system |
| **Claims Issue** | Claim Rework Project |
| Delay in Processing |
| Direct Member Reimbursement |
| Hospital Part D Medications |
| Incorrect Tier |
| LIS Issue |
| Other Pharmacy Claims Issue |
| **Coverage Determination/Redetermination** | Customer Service Hours |
| Other CD concerns |
| Other Redetermination concerns |
| Unhappy with Coverage Determination Process |
| Unhappy with deny to expedite |
| Unhappy with Redetermination Process |
| **Customer Service** | Case/Disease Management |
| Claim Processing |
| Damaged MOD Shipment |
| Delegated Vendor |
| Home assessment |
| Inadequate Chat Service |
| Inadequate Email Service |
| Inadequate Written Service |
| MOD Shipping delay |
| Other Customer Service |
| Outbound Call Campaign |
| Poor Customer Service |
| Poor Customer Service from MOD |
| Transfer issue |
| Unclear/incorrect information provided |
| Unresolved Service Inquires |
| Wait Time for a Representative |
| Web Information |
| **Enrollment/Disenrollment** | Account not showing eligible in all systems |
| Account should be active |
| Application processing delay/error |
| Cancellation not processed |
| Dissatisfied with enrollment process |
| Enrollment Not Processed |
| Incorrect demographics |
| Incorrect Enrollment |
| Involuntary Disenrollment |
| Mapping |
| Member in wrong plan |
| Other Cancellation Issue |
| Other Disenrollment Issue |
| Other Enrollment Issue |
| Out of area |
| Reinstatement error |
| Voluntary Disenrollment |
| **Marketing** | Agent administrative |
| Agent enrolled without consent |
| CMS Online |
| Dental Enrollment Issue |
| Effective date issue |
| Employer group enrollment issue |
| High pressure sales tactics |
| Incorrect plan issue |
| Medical benefit issue |
| Pharmacy benefit issue |
| Plan Website |
| Premium issue |
| Premium withhold issue |
| Provider network issue |
| Sales hold time for enrollment |
| Sales Incentive |
| Sales Meetings |
| Sold as supplemental |
| Special Enrollment Period issue |
| Telesales enrollment issue |
| Wrong election type issue |
| **Member Materials** | ANOC not received |
| Coupon booklet not received |
| Excessive mailings |
| Formulary |
| ID Card |
| Materials not available in language |
| Materials not received |
| Materials received late |
| Other coupon booklet issue |
| Written pharmacy directory |
| Written Plan Materials |
| Plan Benefits  Refer to the CIF. | Copay/Coinsurance |
| Coverage Gap |
| Deductible |
| Drug Coverage |
| Formulary |
| Pharmacy Network |
| Pharmacy Tiering |
| Quantity Limits/Step therapy |
| Refill too soon |
| **Privacy** | Misuse or disclosure |
| Potential Fraud |
| Privacy/HIPAA issue/Confidentiality |
| Unauthorized access |
| **Provider Customer Service** | Cultural and Linguistic Needs |
| Pharmacist Behavior |
| Pharmacy Delivery Staff |
| Pharmacy Staff |
| **Quality of Care** | Dispensing Error |
| Failure to Provide Counseling |
| MOD Medication error |
| Retail medication error |
| **Technology** | Automated outbound calls |
| Automated payment system |
| Hold music |
| Member Portal |
| Provider Portal |
| Telephonic Issues |
| Website Information issues |
| Website issues |

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| First Call Resolution Examples |

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)
* [Compass MED D - Grievances: CCR - First Call Resolution Documentation Templates (NEJE) (066745)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=cb56c2af-d1ed-4e8a-a309-d0db70d8c751)
* [MED D - Compass Grievances: CCR - First Call Resolution Documentation Templates (SSI PDP, SSI EGWP, Aetna EGWP) (068896)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=b7f5a139-be8a-493a-8155-3932709e086e)

Refer to the table below:

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| **CMS ISSUES (Health Plans and NEJE only)**   * 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, etcetera) * 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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| Withdrawal Request |

If a beneficiary contacts Customer Care and states a Grievance was filed, but they want to withdraw the Grievance, refer to the following scenarios:



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| **If the beneficiary states…** | **Then…** |
| 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. * Send an email to the appropriate email box to notify the Grievance Team of the withdrawal request: * **HP and NEJE (MHK Fusion):** [DelegatedGrievance@CVSHealth.com](mailto:DelegatedGrievance@CVSHealth.com) * **SSI PDP, SSI EGWP, and Aetna EGWP (MHK Nitro):** [MedicareOralGrievanceUnitMailbox@aetna.com](mailto:MedicareOralGrievanceUnitMailbox@aetna.com) |
| 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 the appropriate email box to notify the Grievance Team of the withdrawal request: * **HP and NEJE (MHK Fusion):** [DelegatedGrievance@CVSHealth.com](mailto:DelegatedGrievance@CVSHealth.com) * **SSI PDP, SSI EGWP, and Aetna EGWP (MHK Nitro):** [MedicareOralGrievanceUnitMailbox@aetna.com](mailto:MedicareOralGrievanceUnitMailbox@aetna.com) |

**Note:** If a Grievance is filed in error, alert your supervisor to review. The supervisor will send an email to the appropriate Grievance team and provide the reason why it should be cancelled.

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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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| Grievance Scenario Guide |

Refer to the grievance scenarios listed below as needed:

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| **Scenario** | **Action** |
| **Discard a Grievance** | Click **Discard** button.   * "Are you sure you wish to cancel this grievance?" to "Are you sure you wish to discard this grievance?" * Select the **Yes/No** radio button. * If **Yes**, Grievance is closed out and will not be submitted. * If **No**, agent will return the Grievance Summary screen.     If agent attempts to close a case with a grievance in process, Compass will display the message **"Incomplete grievance exists. You must complete or discard any grievance before closing the case.”** and will prevent the **Close Case** modal from being opened." |

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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? | * **For SSI PDP, SSI EGWP, and Aetna EGWP clients,** the beneficiary may submit a Grievance in writing to:   SilverScript Insurance Company Medicare Grievance Department  P.O. Box 14834 Lexington, KY 40512    Beneficiary may fax the written Grievance to 1-724-741-4956.    **Note:** CCR to request that Beneficiary include membership ID number in the letter or fax.   * **For HP and NEJE clients,** 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 will have to be filed in Compass as a New Grievance with normal documentation process including any resolution provided to the beneficiary. The note in Compass would be normal documentation for a Grievance filed in Compass along with the specific beneficiary request for a written response or Grievance number. | |
| 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? section in [Compass MED D - When to File a Grievance in Compass (066741)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=8895dffc-cf45-44d4-b795-c4d95f7bd555).  **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. Educate the third-party that only the beneficiary has the right to file a Grievance unless the third-party is an AOR or POA on the account. 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)

[Compass MED D - When to File a Grievance in Compass (066741)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=8895dffc-cf45-44d4-b795-c4d95f7bd555)

[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)

[Compass MED D - Grievances: CCR - First Call Resolution Documentation Templates (NEJE) (066745)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=cb56c2af-d1ed-4e8a-a309-d0db70d8c751)

[MED D - Compass Grievances: CCR - First Call Resolution Documentation Templates (SSI PDP, SSI EGWP, Aetna EGWP) (068896)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=b7f5a139-be8a-493a-8155-3932709e086e)

[Compass MED D - Viewing Grievance History in Compass (066743)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=cf46f2f7-d40c-4c65-9155-a37d4075ca22)

[MED D - Grievance vs. Coverage Determination - Decision Matrix Job Aid (027480)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=06e8f82d-e7b7-4a60-9c81-3bf7c37aadbf)

[Compass MED D - Appointed Representative Form (AOR) or Power of Attorney (POA) (061884)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=64c3fc62-48c3-4ad3-ae83-c736cebd521b)

[Medicare and Medicaid SHIP Counselor Unique ID List (077234)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=fadccc80-a0a1-449b-b5b0-056705aad9ec)

[Compass MED D - CCR - Coverage Determinations and Redeterminations (Appeals) (064997)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=a23bc09d-37f7-4105-ba57-d4e9d7f512ff)

[Compass - Close an Interaction or Research Case (050011)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=0296717e-6df6-4184-b337-13abcd4b070b)

[Compass MED D - Call Documentation Job Aid (061758)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=433711aa-8fa6-447c-872b-bd69cd6cd7c0)

[Compass and PeopleSafe - Downtime Procedures (027110)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=9e6c6901-f053-4575-9238-3f1f68feea78)

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