# MED D - Grievance vs. Coverage Determination - Decision Matrix

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**Description:** Provides some common scenarios that may require the Customer Care Representative (CCR) to open a Grievance, a Coverage Determination, or possibly both.

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| Guidance |

The Grievance process and the Coverage Determination process are two very different processes; therefore, it is critical to determine the nature of the beneficiary’s complaint.

**Note:** **ALWAYS refer to the CIF** prior to initiating a Coverage Determination or Grievance to determine if it is handled by CVS Caremark or the client.

**Note:** If the beneficiary declines to file a Coverage Determination that would have resolved their dissatisfaction (**Example:** A Tier Exception (TE) for the high cost of their specified drug while in the Initial Coverage Stage), a grievance should be filed. It should also be documented within the grievance and/or call note that the beneficiary refused to file a Coverage Determination.

If beneficiary expresses dissatisfaction on the process of having to file a Coverage Determination, file a First Call Resolution Grievance (Resolved) at the same time the Coverage Determination is initiated.



**Examples:**

* Having to contact the physician
* Waiting for the physician to respond to any requests by the CD&A department
* Waiting for a decision

When creating a grievance for **more than one issue:**

* If the issues fall under the same [category (007931)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=71364003-a41f-4b84-be24-1e85435462b2), then open one grievance.
* If the issues fall under multiple [categories (007931)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=71364003-a41f-4b84-be24-1e85435462b2), then a separate grievance should be opened for each issue, under separate categories.

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| Example Scenarios |

The following are common Grievance, Coverage Determination, and Appeal call scenarios which a CCR may encounter (these lists are not all-inclusive). It also provides possible scripting that can be leveraged to assist the caller and actions the CCR should take.

**Reminder:** Use the search feature (**CTRL**+**F**) to search for specific scenarios.

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| **You will…** | **…in any of the following situations:** |
| File a Coverage Determination  Refer to [MED D - CCR - Coverage Determinations and Redeterminations (Appeals) (004665)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=22f353ee-e739-4f78-be33-b64916337260) | * Beneficiary wants a drug filled that is not covered by the Plan. * Beneficiary states that the pharmacy could not fill their prescription as medication is not on the formulary. * Beneficiary is upset about paying out of pocket for a drug that should have been covered by the plan.   **Reminder:** Paper claims scenarios are considered Coverage Determinations – refer to [MED D - Researching and Submitting Paper Claims (112394)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=74dceac6-a55f-4504-ab6b-0866bb52c601).   * Beneficiary is upset about the amount of cost sharing or tier for a drug (and the drug is currently covered by the Formulary and not a Tier 1 or on the Specialty Tier). * Beneficiary contacts the plan because their prescription rejected at the pharmacy due to a Prior Authorization. * Beneficiary received a letter stating they received a transition or temporary fill and now must file a Prior Authorization or Formulary Exception for the next fill. * Beneficiary is inquiring why a Prior Authorization is required when it was not previously, and they need the drug now. * Beneficiary advises that they require more medication than is allowed by the Plan (e.g., needs 60 tablets for a 30 day supply and the plan only covers 30 tablets for a 30 day supply). * Beneficiary advises that they are being asked to take an alternative drug before the Plan will pay for the brand name drug. * Beneficiary wants the Plan to pay for a drug when the strength of the medication is not covered. * Beneficiary received a letter stating they received a fill for a non-formulary drug and now must file a Formulary Exception for the next fill. * Beneficiary requests coverage for a medication for which they have a prescription, but the medication is also sold over-the-counter.   **Reminder:** Paper claims scenarios are considered Coverage Determinations – refer to the following:   * [MED D - Researching and Submitting Paper Claims (112394)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=74dceac6-a55f-4504-ab6b-0866bb52c601) * [MED D - Determining TrOOP Status (020814)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=ace20931-df5c-49f8-9b4a-df89aade1fa5) * Beneficiary states that they were billed for a medication while receiving outpatient surgery and had to pay out of pocket.   **Reminder:** Paper claims scenarios are considered Coverage Determinations– refer to [MED D - Researching and Submitting Paper Claims (112394)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=74dceac6-a55f-4504-ab6b-0866bb52c601).   * Beneficiary is calling because their Coverage Determination was denied. * Beneficiary is enrolled in enhanced plan that provides coverage during the Deductible Stage. |
| File a Coverage Determination **AND** submit a Grievance  Refer to the following:   * [MED D - CCR - Coverage Determinations and Redeterminations (Appeals) (004665)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=22f353ee-e739-4f78-be33-b64916337260) * [MED D - Grievances in PeopleSafe for Health Plans, JE (formerly MHK Fusion) (040884)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=731c1bac-3039-46da-85e1-0e49a8c9721d) * [MED D - Grievances in MHK Nitro (SSI PDP, SSI EGWP, Aetna EGWP) (040885)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=17bed7cd-40e8-4e83-83a8-9d742d2605f8) | * Beneficiary is unhappy that the Plan made a formulary change for Drug <X> (this is the Grievance) and they want that drug covered (this is the Coverage Determination). * Beneficiary feels they paid a higher copay at the pharmacy than the last time they filled it (this is the Grievance). CCR previously confirmed the correct amount was paid, but it is determined that this medication is eligible for a Tiering Exception because it is a Tier 2-4 and there are no alternatives, and has enhanced coverage in the Deductible Stage or is not in this stage (this is the Coverage Determination). * Beneficiary is unhappy with a tier change from a previous claim (specific medication provided) (this is the Grievance) and wants to pay the previous tier copay (this is the Coverage Determination). * Beneficiary is requesting coverage for a medication (this is the Coverage Determination) and is dissatisfied the Plan must contact their physician for information (this is the Grievance). * Beneficiary is upset that they were not informed their Coverage Determination had expired (this is the Grievance) and need the medication (this is the Coverage Determination). * Beneficiary is upset that drug X moved from a lower tier to a higher tier in the new plan year (this is the Grievance) and they need the drug price to be lowered (this is the Coverage Determination). * Beneficiary is unhappy that drug is excluded (this is the Coverage Determination) incorrectly (this is the Grievance). |
| Submit a Grievance  Refer to the following:   * [MED D - Grievances in PeopleSafe for Health Plans, JE (formerly MHK Fusion) (040884)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=731c1bac-3039-46da-85e1-0e49a8c9721d) * [MED D - Grievances in MHK Nitro (SSI PDP, SSI EGWP, Aetna EGWP) (040885)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=17bed7cd-40e8-4e83-83a8-9d742d2605f8) | * Beneficiary is upset about the amount of cost sharing or tier for a drug that is a Tier 1 or on the Specialty Tier. * Beneficiary is unhappy with no coverage for a Med D excluded drug (but agreeing that the drug is excluded). * Beneficiary is dissatisfied that they paid a higher copay at the pharmacy than previously quoted by CCR. * Beneficiary is dissatisfied because the Plan must contact their physician for information regarding a Tier Exception. * Beneficiary is going on an extended vacation and is upset that they can only receive an additional <##> day supply of their medications.   **Note:**  Refer to the Client Information Form (CIF).   * Beneficiary is unhappy that they have to take extra steps to obtain coverage for a drug. * Beneficiary is upset about the Paper Claims process (e.g., dissatisfaction with having to fill out paperwork, obtaining additional info for the paper claim, etcetera) * Beneficiary thinks the Plan’s copays are too high for most of their medications and does not understand how a person on Medicare can afford these medications. * Beneficiary states they are on a limited income and should not be charged the high copays. * Beneficiary is angry that their co-pay and premiums amounts have increased. * Beneficiary is upset that they were not notified of a premium increase. * Beneficiary received Evidence of Coverage (EOC) and does not like the new copays. * Beneficiary is calling to express dissatisfaction about poor customer service (e.g., long wait time, received misinformation, poor service at retail pharmacy, etcetera). * Beneficiary is calling to express dissatisfaction about a mail order delay. * Beneficiary is calling to express dissatisfaction about plan materials (e.g., did not receive, confusing, etcetera). * Beneficiary is calling to express dissatisfaction that a drug is not on the formulary, but they do not need/take the drug at this time. * Beneficiary complains they are being charged a deductible and their drug is ineligible for a TE. * Beneficiary complains that their Annual Notice of Changes (ANOC) indicates an increase in all copays for all tiers in the upcoming plan year. * Beneficiary complains they do not like the general plan design (e.g., utilization rate, number of vacation overrides, etcetera). * Beneficiary is unhappy with coverage during the Deductible Stage and their plan does not offer enhanced coverage. * Beneficiary contacts the plan because their prescription rejected at the pharmacy and member is upset that they can’t fill the Rx sooner than the plan allows. * Beneficiary complains that they cannot get a Tier Exception for a Tier 1 & Specialty Tier medication. * Beneficiary complains that last year their medication did not require a prior authorization but this year it does (e.g., certain reject types, formulary changes, age-in to Medicare, etcetera). * Beneficiary complains about the process of filing a Coverage Determination, in general. * Beneficiary complains that the manufacturer cost of the medication is too high. * Beneficiary complains of not being notified of a formulary change. * Beneficiary expresses dissatisfaction that their enrollment information was not received in a timely manner. * Beneficiary expresses dissatisfaction that their ID card was not issued in a timely manner. * Beneficiary expresses dissatisfaction about overall plan benefits. * Beneficiary is upset that they must file a Coverage Determination every year when they have to take the medication long term (i.e., 5 years, for the rest of their life, etcetera). |

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| Related Documents |

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

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