# MED D - Grievances in MHK Nitro (SSI PDP, SSI EGWP, Aetna EGWP)

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

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| High Level Process | |
| 1. [**Identify**](#_Identifying_a_Grievance_1) **if the caller is expressing dissatisfaction and a Grievance should be filed.**  * Ensure the caller is not calling concerning a [Coverage Determination](#_Coverage_Determinations_vs.). | **Reminders:**   * Utilize [Grievance Standard Verbiage](#_Grievance_Standard_Verbiage_1) when discussing Grievances with the beneficiary. * Ensure that the issue is a [valid Grievance](#HLPValidGRV). |
| 1. **Determine if the** [**caller is qualified**](#_Who_Can_File_2) **to file a Grievance.** 2. **Determine if the** [**time limit for filing**](#_Who_Can_File_2) **a Grievance has been reached.** |  |
| 1. **Determine if a** [**Quality of Care**](#_08.20.20_Determining_Quality) **issue.** | |
| 1. **Determine if** [**First Call Resolution or New Grievance**](#_Grievance_Process)**.** | **Reminder:** Review the [First Call Resolution](#_First_Call_Resolution) examples. |
| 1. [**Create**](#_Creating_a_Resolved) **the Grievance in MHK Nitro.**  * Utilize the following to properly file the Grievance:   + [Grievance Category Topics and Examples](#_Grievance_Categories_and_2)   + [Grievance Activity Codes](#_Grievance_Activity_Codes_1) | **Reminder:**   * Check for [previously submitted Grievances](#_Previously_Submitted_Grievances_1) in MHK Nitro. |

# When to File a Grievance:

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| Identifying a Grievance |

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

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

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

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

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

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

* Sixty (60) days after the event that caused the dissatisfaction (date of occurrence)
* A complaint about the cost of a drug they need (This could be a tiering exception or an appeal)
* A complaint about coverage of a drug they need (This could be a coverage determination or an appeal)
* Caller is not eligible to file a Grievance
* LEP assessment
* Part B medication and **any action** associated with that medication (i.e., incorrect shipping address, poor customer service, etcetera)
  + If a beneficiary wants to file a Part B Grievance, they need to file that Grievance with their Part B carrier.

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

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

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

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| Coverage Determinations vs. Grievances |

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

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

**EXAMPLES:**

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

Icon - Important For instances when the CCR opens a Grievance and also has a beneficiary request for a Coverage Determination, [clear notes (068896)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=b7f5a139-be8a-493a-8155-3932709e086e) are **required** to be entered in both **MHK Nitro** and **PeopleSafe** in order for the Grievance team and CD&A team to be aware that both issues are being worked **separately** and **simultaneously**.

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



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

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

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

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

Take **one** of the following actions:

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

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| Who Can File A Grievance? |

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

**Notes:**

* A Grievance can only be filed for a deceased beneficiary by the Executor of the Estate.
* If you have a Grievance or Coverage Determination opportunity, an AOR/POA is required for the caller to act on behalf of the beneficiary, except as noted in the table below:

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| **If the person is…** | **Then…** |
| Prospective beneficiary    (someone who may potentially join the plan and does not have a future effective date) | The person cannot file a Grievance. |
| Disenrolled beneficiary | The person can file a Grievance on their own behalf. |
| Beneficiary (includes new member whose enrollment is approved by CMS) | If account is visible in PeopleSafe with a current or future effective date, the person can file a Grievance on their own behalf. |
| Power of Attorney (POA) or Legal Representative (Guardian) for the beneficiary | The person can file a Grievance on behalf of the beneficiary. |
| An Appointed Representative (AOR) (includes a Provider/Prescriber) | Check the **View Privacy Information** screen in PeopleSafe to determine if an AOR document is on file. Refer to the following work instruction for further information as needed: “Viewing Authorizations on File in PeopleSafe” section of [MED D - Appointed Representative Form (AOR) or Power of Attorney (POA) (021424)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=4008954a-0d95-4ea9-add2-3a7dfa02c718).  **If AOR is on file,** the person can file a Grievance on behalf of the beneficiary.   * A new AOR does not need to be filed for every new issue; however, per CMS guidelines, AORs are only good for one year from the date of signature.   **If AOR is not on file,** continue to assist the beneficiary and offer to send an AOR form. Enter the Grievance in MHK Nitro and notate that an AOR is needed. Once the Grievance is received, the Grievance team will mail the beneficiary an AOR form to complete.   * AORs sent by the Grievance team are housed in MHK Nitro and can be found under the **Communications** tab.   **Notes:**   * Per CMS guidelines, AORs are only good for one year from the date of signature. * If a provider is wanting to file a grievance on behalf of a member about something the member experienced, they can, and it would fall under the same process as grievances received from a representative. An AOR or equivalent written authorization is needed for a grievance to be filed by a provider on a member’s behalf.   Icon - Important A Plan Member Authorization form or Personal Health Information (PHI) Authorization form is not acceptable to file a Grievance. |
| Executor of Estate | Death certificate must be submitted for deceased beneficiary. |
| SHIP Counselor | Can file if a unique SHIP ID is provided **and** the beneficiary or their representative has provided written or verbal permission for the SHIP Counselor to act and/or speak on their behalf. Refer to the [Medicare and Medicaid SHIP Counselor Unique ID List (077234)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=fadccc80-a0a1-449b-b5b0-056705aad9ec) job aid in theSource.  **Note:** Select **Beneficiary** under “Filed by” when filing a Grievance. Document in PeopleSafe that the SHIP unique ID was verified. Also note if verbal permission was provided by the beneficiary. |
| Informal Authorized Third-Party | When the member is present and is fully authenticated by speaking directly to the CCR and verifies that the third party is authorized to speak on his or her behalf, the third party may file a Grievance in the same way as it would be speaking directly to the member.    **Filed by** will be **Beneficiary** in this case – refer to Step 12 in [Creating a Grievance in MHK Nitro](#_Creating_a_Resolved).  However, you should still notate the caller’s information as follows:   * + Name   + Address   + Phone   + Relationship to member   + Include that the member’s verbal authorization was provided |

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| Time Limits for Filing a Grievance |

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**CM****S regulations included in the beneficiary’s Evidence of Coverage (EOC) state:**

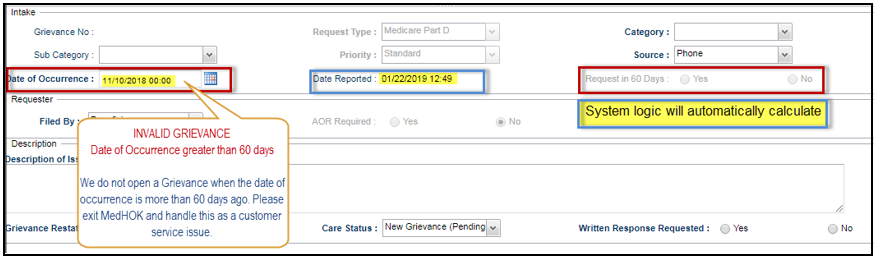
“An enrollee may file a grievance with the Part D plan sponsor either orally or in writing **no later than 60 days** after the event or incident that precipitates the grievance.”

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

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

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

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



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| Quality of Care |

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

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

* Refer to the following sections within this document:
  + [Identifying a Grievance](#_Identifying_a_Grievance) to determine if a Grievance should be filed.
  + [Grievance Category Topics and Examples](#_Grievance_Categories_and_2) to determine the Category and subcategory to select when filing a Quality of Care Grievance.
* Ensure that you take all steps necessary to ensure the beneficiary has medication before ending the call.
* Quality of Care Grievances **cannot** be filed as First Call Resolution.

**Quality of Care Decision Grid:**

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| **A Quality-of-Care Grievance should NOT be filed when:** | **A Quality-of-Care Grievance MUST be filed when (including, but not limited to):** |
| * Coverage Determination and/or Redetermination denial * Beneficiary’s decision to not obtain the medication due to cost * Beneficiary’s neglect to order the medication * Order delayed due to state/national disaster and/or weather event (Refer to [PeopleSafe - Disaster / State of Emergency Process (029795)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=09939158-0c4e-4f2b-a7c1-6d09a38d5231).) * Beneficiary submits order but does not respond to a Plan request which places the order on hold (including, but not limited to):   + Beneficiary did not provide Expressed Consent (Ship Consent)   + High dollar co-pay call (co-pay above dollar threshold)   + Beneficiary has unpaid account balance | * Beneficiary’s medication delayed as a result of:   + Plan, prescriber, and/or pharmacy error   + Medication lost in transit/delivery * Incorrect Rx shipped * Mail Order issue such as cold pack broken, medication damaged * Plan did not update beneficiary’s address and medication shipped to incorrect address * Manufacturer backorder of medication and pharmacy did not reach out to prescriber for alternative * Beneficiary provided high copay approval; however, account was not updated and medication did not ship * Expressed Consent (Ship Consent) process failure (i.e., system did not send a text/email or call) * Beneficiary did not receive the correct type/amount/instructions for the medication (not due to transition fill) (including, but not limited to):   + 90-day fill received 75 days of medication (excludes pre-packaged medications, such as eye drops)   + Incorrect dosage instructions * Mail Order Rx error (i.e., Auto Refill Program fails) * Retail Rx error |

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| First Call Resolution Examples |

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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 (SSI PDP, SSI EGWP, Aetna EGWP) (068896)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=b7f5a139-be8a-493a-8155-3932709e086e).

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| **ACCESS**   * Pharmacy is excluded from the Medicare program | **APPEARANCE OF FACILITY**   * Dirty/Unclean pharmacy |
| **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 | **CMS ISSUES**   * CMS Operations * CMS Policies/Procedures |
| **COVERAGE DETERMINATION (CD) & REDETERMINATION (RD) PROCESS**   * CD or RD process - paperwork, contacting prescriber, turnaround time * Not notified of expiring CD * Having to file CD annually * Physician wrote prescription so additional approval should not be necessary * Unhappy with coverage determination process * Unhappy with redetermination process | **CUSTOMER SERVICE**   * Plan unable to fax or email information * Hold time on IVR * Alternate payment method stopped without request; no plan error * Payment plan not set up despite previous request; no plan error * Difficulty setting up alternate payment method * Called to update address multiple times * 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 * Claim processing * Outbound call campaign * Unclear/incorrect information provided * Unresolved service inquiries * Wait time for a representative * Pharmacy participating status * 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 * Consent process * Mail tag request when pharmacy error and approved to send * Turnaround time for mail tag * Unable to cancel order * Medications sent in multiple orders * Medication not available at mail service or retail pharmacy * Received correct medication but different size or color * Pharmacy removed from network or not preferred pharmacy * Dispense As Written (DAW) requirements |
| **ENROLLMENT/DISENROLLMENT**   * CMS auto or facilitated their enrollment into Part D plan against their wishes * 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 * Enrollment and/or disenrollment process * Multiple attempts to disenroll * Account should be active * Application processing delay * Cancellation not processed * Enrollment not processed * Member in wrong plan * Out of area * Reinstatement error * Voluntary disenrollment * Involuntary disenrollment | **MARKETING (IF LED MEMBER TO ENROLL IN PLAN)**   * Telemarketing calls where member wants to be placed on Do Not Call list |
| **MEMBER MATERIALS**   * Confusing CD or RD notices or denials * Received multiple Residence Verification Forms (RVF) * ACA 1557 discrimination insert in plan materials * Explanation of Benefits - does not want to receive * Receiving COB letter annually * Did not receive plan materials, ID card * Plan materials confusing * Not receiving premium invoice * Disenrolled but still receiving an invoice * Received confusing letters from the mail service pharmacy * Unable to read prescription labels * Bottle size too big or too small * Upset with packaging * Refill date missing from label | **PLAN BENEFITS**   * Premium increase * Manufacturer cost of drug increased * Drug requires a Prior Authorization (PA) or exception and not being notified * 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 * Pre-payment for mail service orders, particularly $0 copay orders * No savings through mail service pharmacy * Cost not provided prior to shipping * Premium too high * Quantity Limits * Step therapy |
| **PRIVACY**   * Concerned that information is being shared without consent * Received another Beneficiary's mail or order, HIPAA violation | **PROVIDER CUSTOMER SERVICE**   * Inappropriate billing by pharmacy * Issue paying premium at the pharmacy, payment portal, or through IVR * Refusal to fill * Wait time in pharmacy * Access to participating pharmacies |
| **TECHNOLOGY**   * Price difference between Medicare Plan Finder/Plan website * Charged different price than displayed on Plan website * Functionality or content on Client website (i.e., aetnamedicare.com, RxMedicarePlans.com, etcetera) * Unable to view premium payment history online * IVR - content, frequency, timing, difficult to use, voice recognition * Hold music * Wants phone answered by live representative * IVR providing information in Spanish * Issue paying premium on the payment portal or through IVR * Lag time to see prescriptions on caremark.com * Difficulty ordering medications on caremark.com | |

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# How to File a Grievance:

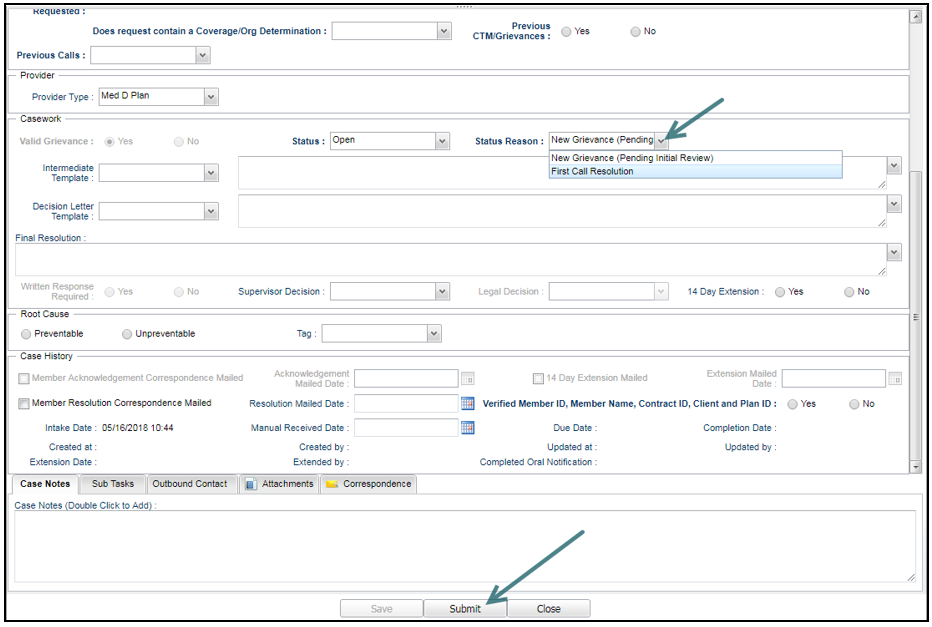
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| Grievance Process |

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

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

* New Grievance (unresolved issue)
* First Call Resolution (resolved issue)

**Note:** If you do not have access to MHK Nitro, once it is determined that a Grievance should be filed, transfer the caller to the Senior team to enter it in MHK Nitro. You should then follow up with your Supervisor to obtain access as needed.



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

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

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

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

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| Creating a Grievance in MHK Nitro |

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

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

 If you determine a Grievance has already been submitted (and is not resolved) for the same issue in MHK Nitro, advise the beneficiary a response will be received within 30 days from the original date. Do not submit a second Grievance. Document the beneficiary’s account to indicate that a Grievance has already been submitted for this issue.

 If creating a Grievance for more than one issue:

* If the issues fall under same [category](#_Grievance_Categories_and_2), then open one Grievance. For example, beneficiary is dissatisfied with the long hold time and multiple transfers’ both issues fall under the Customer Service category.
* If the issues fall under multiple [categories](#_Grievance_Categories_and_2), then a separate Grievance should be opened for each issue, under separate categories.

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

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

* Senior Escalation Team
* Premium Billing
* Clinical Care Services

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

* SMST

**Notes:**

* You should NEVER use the MHK Nitro Downtime Procedures for a prospective beneficiary whose effective date with the plan has not been confirmed by CMS. You should never file a Grievance in this circumstance.
* If you do not have access to MHK Nitro, once it is determined that a Grievance should be filed, transfer the caller to the Senior team to enter it in MHK Nitro. You should then follow up with your Supervisor to obtain access as needed.
* 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.

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| **Step** | **Action** | | |
| **1** | [Log in to MHK Nitro](https://federatione.cvshealth.com/affwebservices/public/saml2sso?SPID=CVSAetnaAPPSUID&RelayState=https://ap5.aetna.com/affwebservices/public/saml2sso?SPID=https://aetna.medhokapps.com/core).  **Note:** MHK Nitro is Single sign-on (SSO).   * If you are already logged into the CVS network with your User ID and Network password, you will not be prompted to login again. Proceed to [Step 4](#Step4MH). * If you are not already logged into the CVS network, proceed to [Step 2](#Step2MH). | | |
| **2** | Enter your **Username** and **Password** as appropriate. | | |
| **3** | Select **LOGIN**.  **Notes:**   * To reset your password, select the appropriate link under **Having issues logging in?** * [Clearing Your Cache (008655)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=cd7acfcb-ad36-4da3-b973-faf08afb7dea) will be required:   + Upon your first log in to MHK Nitro   + After every MHK Nitro Release   **Reminder:** Clear browsing history once a week to minimize issues.   * For all other technical issues, reach out to IT **after** clearing cache. | | |
| **4** | **Result:** The main system screen and pop-up appears. Click **OK**. | | |
| **5** | Click the **Search** button to open a search window.    **Result:** Member option opens. Select **Member**. | | |
| **6** | * The following search criteria are **required** in order to locate the member:   + **Member ID** or **HICN/MBI**   + **Source:** RxClaim * Click **Search**.   **Result:** Beneficiary’s information will display in the search window. | | |
| **7** | **Double click** on the appropriate line to open the beneficiary’s account. Unless the beneficiary is disenrolled, the current line of eligibility should be in black font.  Icon - Important NEVER use the line of eligibility in red font unless the beneficiary was disenrolled within the last 60 days. If the member was termed 61 or more days ago, handle the situation as an Inquiry in PeopleSafe.    **Result:** Beneficiary’s information will display. | | |
| **8** | Click the **Complaints** tab to determine if there are any current or previous CTM and Grievances on file.    Refer to the [Previously Submitted Grievances in MHK Nitro](#_Previously_Submitted_Grievances_1) section below as needed to review the previous Grievance(s) information and determine if a new Grievance should be filed.  **Note:** If the beneficiary calls with the same issue, 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 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 PeopleSafe a reference to the Grievance filed earlier that same day. |
| **9** | **Right click** in the **Grievance** section.    **Result:** Drop-down menu displays. | | |
| **10** | Select **Add** from the drop-down menu.    **Result:** The **Grievance Intake** screen will display. | | |
| **11** | On the **Select Eligibility Record** dialog box, double-click on the table row for the **plan year** **when the situation/incident occurred** to proceed with entry of the grievance.   * You **MUST** select the relevant plan year even if it is the only option available. DO NOT close the dialog box without making a selection, or the system will not assign eligibility to the case. | | |
| **12** | Populate the information in the **Grievance** screen using the table below as a guide.  **Note:** The CCR **MUST** select dropdown options starting at the **top left** and flowing to the right, then down to the next row. This will ensure the dropdowns will properly display starting with the Product Dropdown. | | |
| **Topic** | **Information/Examples** | |
| **Product Type** | Select **Medicare**. | |
| **Request Type** | **Part D Grievance** is auto selected. | |
| **Category** | Select the appropriate **Category** based on the beneficiary’s issue.  **CCR Process Note:** If the beneficiary is discussing an issue that covers multiple categories, the CCR **MUST** file a separate Grievance for each category. DO NOT file a second Grievance if the issues are under the same category but a different sub-category; use the most appropriate subcategory. | |
| **Sub Category** | Each **Category** has a **Sub Category**.   * Select the appropriate **Sub** **Category** based on the beneficiary’s issue.   **Example:** Shows the **Sub Categories** for the **Benefit Category**.  **REMINDER: Sub Category** drop-down menus change based on the **Category** that was selected. | |
| **Priority** | Select **Standard**. NEVER select **Expedited**.  **Note:** The system defaults to **Expedited** when a user clicks in the drop down but does not make a selection.   * Ensurethat you select **Standard**. | |
| **Date of Occurrence** | Click on the calendar and select 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:** If the date of occurrence is the same as the date reported, select the appropriate Date and Time to match the **Date Reported** field.      **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, 2021 * Letter Date = October 27, 2021 * Today’s Date = November 12, 2021   + The **Date of Occurrence** for this issue would be the Letter Date which is the event that caused the beneficiary’s dissatisfaction and is within the 60-day window for filing a Grievance.   **REMINDER:** Grievances must be reported within **60 days** of the **Date of Occurrence.** If after 60 days, handle the call as an Inquiry.   * Refer to [Time Limits for Filing a Grievance](#_Time_Limits_for_2). | |
| **Source** | Select **Phone**. | |
| **Date Reported** | **MHK Nitro** will auto-populate with the current date.  **Note:** If the date of the call is different than the date time the CCR is entering the case (**Date Reported** field), update the date and time of the Call in the **Manual Received Date** field. | |
| **Filed By** | Select the appropriate option from this drop-down menu. Refer to [Who Can File a Grievance?](#_Who_Can_File_2). | |
| http://sharepoint/sites/opscom/Operations%20Communication/Formatting/Icon%20-%20Important%20Information.png **Description of Issue** | New Grievance | * Select the **drop-down arrow** next to **Description of Issue** and select **New Grievance**. * Document why a Coverage Determination was not submitted if it seems like one could have been (e.g., if the beneficiary is offered a coverage determination but declines, stating 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.). * Type a detailed description of the Beneficiary’s issue that describes their complaint with the plan in the **NotePad**. * Summarize this information in the **Description of** **Issue** field.   + If not using template language, use the following beginning statement:   “I have confirmed with the Beneficiary the following issue(s): 1. Issue details 2. Issue details 3. Issue details”   * + 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 if the beneficiary indicates they would like a written response (do NOT proactively offer a written response). * Click the **Finish** button once complete.   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.   http://sharepoint/sites/opscom/Operations%20Communication/Formatting/Icon%20-%20Important%20Information.png **DO NOT USE** the following special characters in notes:   * Pipe/bar (|) (Shift + backslash) * Tilde (~) (Shift + accent) |
| First Call Resolution | * Select the **drop-down arrow** next to **Description of Issue** and select **First Call Resolution**. * Be sure to use the full Reason, Action, Result template, if available:   + [Med D - Compass Grievances: CCR - First Call Resolution Documentation Templates (SSI PDP, SSI EGWP, Aetna EGWP) (068896)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=b7f5a139-be8a-493a-8155-3932709e086e) * Click the **Finish** button once complete.   Ensure that Reason, Action, and Result are clearly documented in the Description of Issue:    **Icon - Important Information** This Description of Issue Result text will be the exact text copied for use for the Resolution field by the Grievance Team. It is **imperative** that Description of Issue is clearly documented.  http://sharepoint/sites/opscom/Operations%20Communication/Formatting/Icon%20-%20Important%20Information.png **DO NOT USE** the following special characters in notes:   * Pipe/bar (|) (Shift + backslash) * Tilde (~) (Shift + accent)     **Note:** Document why a Coverage Determination was not submitted if it seems like one could have been (i.e., if beneficiary states they want to talk to their MD first; beneficiary had approved non-formulary Coverage Determination already in place; drug is on formulary but is a Specialty drug so Tier Exception is not able to be submitted; MD to submit a Redetermination for member, etcetera). |
| **Grievance Restate** | In order to ensure the beneficiary’s issue was properly notated in MHK Nitro, the CCR **MUST** restate what has been typed in the **Description of Issue** field to the beneficiary.   * After restating the Description of Issue, edit the Description if necessary.   **Note:** There is no character limit in this field.   * Select the **Yes** radio button to confirm you restated the Description.   **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.    If the beneficiary wants to withdraw the Grievance, refer to the [process listed below](#withdraw). | |
| **Status Reason** | This field is required for submission of the case.   * Always select **First Call Resolution** for this field if issue is **fully resolved**.   + Ensure documentation includes the resolution provided to the beneficiary. For example, “Educated beneficiary on Extra Help.” * Alwaysselect **New Grievance** for this field if issue is **not resolved**.   + This field may be auto populated depending on what is selected in the Category/Subcategory field. Ensure in the following scenarios New Grievance (Pending Initial Review) is selected:     - Category is equal to **Quality of Care** or **Marketing**     - If the member asked for a Written Response to their Grievance     - When AOR/POA is not on file | |
| **Written Response Requested** | Do not make a selection; instead, document in the **Description of Issue** field if the beneficiary indicates they would like a written response.  **Do NOT proactively ask the beneficiary if they want a written response.** | |
| **13** | Have I fully answered and resolved your question(s) to your satisfaction? | | |
| **If…** | **Then…** | |
| Yes | Proceed to [Step 14](#Step14MH). | |
| No | * Ask additional probing questions to attempt to resolve remaining questions or concerns. * If unable to resolve the questions/concerns and all resources have been utilized - including the Supervisor or Senior Escalation Team - submit the Grievance.   Proceed to [Step 14](#Step14MH). | |
| **14** | Once all of the appropriate fields have been populated, click the **Submit** button.  **Result:**  CCR is navigated to the **360Member** screen and can view the **Grievance number** and see the **Status**.  **ECARE ONLY:** If the grievance was received from the beneficiary or their purported representative via email, send a copy of the email to the Grievance Team at [MedicareOralGrievanceUnitMailbox@aetna.com](mailto:MedicareOralGrievanceUnitMailbox@aetna.com). | | |
| **15** | * 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 **<1-866-235-5660>, <24 hours a day, 7 days a week>**    + **TTY users, call <711>.**      * Document and close the call according to current policies and procedures. Refer to [MED D - Call Documentation Including Viewing and Adding Comments in PeopleSafe (067665)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=e9cdb772-9c04-4e42-b87a-ae4d2c2e1f62). **PeopleSafe Call Notes Example:** Filed New Grievance for member upset about customer service. GR123456789 was filed.   **Note:** All Grievances require documentation in addition to a [Grievance Activity Code](#_Grievance_Activity_Codes_1). | | |

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| Grievance Categories and Subcategories |

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

The CCR will use the chart below to help determine in what situations a beneficiary can file a Grievance.

**Note:** Select the appropriate category topic in MHK Nitro that best fits the scenario.

|  |  |
| --- | --- |
| **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 |
| **CMS Issues** | CMS Operations |
| CMS Policies/Procedures |
| Other |
| **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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| Grievance Activity Codes |

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

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

**PeopleSafe Codes:**

* **1319 - Grievance Submitted** -Used when a Grievance is submitted on behalf of the beneficiary.
* **1320 - Grievance Client Handles** - Used when member expresses dissatisfaction and is transferred to the client to file the grievance.
* **1323 -** **Grievance-Caller Not Eligible** – Used when caller is not eligible to file a Grievance.
* **1325 - Grievance -** **Member Refuses Transfer to Client or Unable to Transfer -** Used when a grievance/complaint is expressed, and the CIF indicates that the Client handles grievances. The member refuses or is unable to be transferred.

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| Previously Submitted Grievances in MHK Nitro |

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.

If the beneficiary is calling regarding a phone call received from a grievance caseworker, the relevant call notes will not be listed in PeopleSafe. The call notes from the grievance caseworker will be listed in MHK Nitro. If the beneficiary is dissatisfied with the service received from a grievance caseworker, file a grievance. Refer to [Grievance Categories and Subcategories](#_Grievance_Categories_and).



 If the beneficiary is calling to check the status of an open grievance, transfer to the Senior Team for assistance after confirming the Grievance is open.

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

* If the beneficiary calls back about a previously filed Grievance, case notes or other details added by the Grievance Department can be viewed.

Complete the steps below:

|  |  |
| --- | --- |
| **Step** | **Action** |
| **1** | [Log in to MHK Nitro](https://federatione.cvshealth.com/affwebservices/public/saml2sso?SPID=CVSAetnaAPPSUID&RelayState=https://ap5.aetna.com/affwebservices/public/saml2sso?SPID=https://aetna.medhokapps.com/core).  **Note:** MHK Nitro is Single sign-on (SSO).   * If you are already logged into the CVS network with your User ID and Network password, you will not be prompted to login again – proceed to [Step 4](#Step4MH). * If you are not already logged into the CVS network, proceed to [Step 2](#Step2MH). |
| **2** | Enter your **Username** and **Password** as appropriate. |
| **3** | Select **LOGIN**. |
| **4** | Click **OK** on the main system screen pop-up. |
| **5** | Click the **Search** button to open a search window.    **Result:** Member option opens. Select **Member**. |
| **6** | * Enter the following search criteria:   + **Member ID** or **HICN/MBI** * Click **Search**.   **Result:** Beneficiary’s information will display in the search window. |
| **7** | **Double click** on the appropriate line to open the beneficiary’s account. Unless the beneficiary is disenrolled, the current line of eligibility should be in black font.  Icon - Important NEVER use the line of eligibility in red font unless the beneficiary was disenrolled within the last 60 days. If the member was termed 61 or more days ago, handle the situation as an Inquiry in PeopleSafe.    **Result:** Beneficiary’s information will display. |
| **8** | Click the **Complaints** tab to determine if there are any current or previous CTM and Grievances on file. |
| **9** | Right click on the appropriate Grievance item and select **View** to view the details of the submission. |
| **10** | Review any case notes or other details added by the Grievance Department in the **Complaint** screen:   * While the Grievance is being worked (status indicates “In Progress,” “Open,” or “Resolved” and status reason indicates either “Research,” “Written Resolution,” “Verbal Resolution” or “Written or Verbal Resolution”)   FCR Grievances (status indicates Care Resolution) |

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

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

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

1. If the beneficiary states they were never dissatisfied and previously called to ask a question only, add a call note stating the member requested to withdraw the Grievance and the reason why. Then alert your supervisor to review; the supervisor should send an email to [MedicareOralGrievanceUnitMailbox@aetna.com](mailto:MedicareOralGrievanceUnitMailbox@aetna.com) notifying the Grievance Team of the withdrawal request. Include the following information in the request:

* Date and Time of the Call with the withdrawal request
* Name of the person who submitted the withdrawal request
* Member ID
* MHK Case Number of the original Grievance

1. If the beneficiary states they did have an issue but wants 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, alert your supervisor to review; the supervisor should send an email to [MedicareOralGrievanceUnitMailbox@aetna.com](mailto:MedicareOralGrievanceUnitMailbox@aetna.com) notifying the Grievance Team of the withdrawal request. Include the following information in the request:

* Date and Time of the Call with the withdrawal request
* Name of the person who submitted the withdrawal request
* Member ID
* MHK Case Number of the original Grievance

**Note:** If a Grievance is filed in error, alert your supervisor to review. The supervisor will send an email to [MedicareOralGrievanceUnitMailbox@aetna.com](mailto:MedicareOralGrievanceUnitMailbox@aetna.com) notifying the Grievance Team and provide reason why it should be cancelled. The following information should be included in the request:

* Reason the Grievance should be cancelled
* Member ID
* MHK Case Number of the Grievance

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| Escalation Process |

Refer to the table below:

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

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

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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.

These FAQs pertain to both the PeopleSafe and MHK Nitro processes:

|  |  |
| --- | --- |
| **Question** | **Answer/Resolution** |
| What if a beneficiary prefers to file a Grievance in writing? | 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. |
| What if a beneficiary specifically states that they want to file a Grievance? | If the issue is resolved, inform the beneficiary that the Grievance was logged and reported. If the beneficiary requests a Grievance number, CCR to advise beneficiary to record date and time of call. |
| What if the beneficiary states that a written response is required or asks for the Grievance number? | If the beneficiary requires a letter, the case would have to be filed in MHK Nitro as a New Grievance with normal documentation process including any resolution provided to the beneficiary. The note in PeopleSafe would be normal documentation for a Grievance filed in MHK Nitro along with the specific beneficiary request for a written response or Grievance number.  **Note:** Be sure to use the proper MHK Nitro Grievance activity codes. |
| How should a CCR educate a third-party calling on behalf of a beneficiary? | Two scenarios to consider when a third-party calls in:  **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 (see [Who Can File A Grievance?](#_Who_Can_File_2) above).  **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. If no [AOR/POA (021424)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=4008954a-0d95-4ea9-add2-3a7dfa02c718) on file, offer to send form to third-party. |

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| Related Documents |

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

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

* [Med D - Compass Grievances: CCR - First Call Resolution Documentation Templates (SSI PDP, SSI EGWP, Aetna EGWP) (068896)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=b7f5a139-be8a-493a-8155-3932709e086e)
* [MED D - Grievance vs. Coverage Determination - Decision Matrix (027480)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=06e8f82d-e7b7-4a60-9c81-3bf7c37aadbf)
* [MED D - Appointed Representative Form (AOR) or Power of Attorney (POA) (021424)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=4008954a-0d95-4ea9-add2-3a7dfa02c718)
* [MED D - Coverage Determinations and Redeterminations (Appeals) Landing Page (004825)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=1e7d7ad7-e1c1-4fa1-8258-215a1c0ff32b)
* [MED D - Call Documentation Including Viewing and Adding Comments in PeopleSafe (067665)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=e9cdb772-9c04-4e42-b87a-ae4d2c2e1f62)

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

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