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

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**Description:** Guidance for when a Medicare Part D (Med 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 the following:**  * First, determine if the Grievance is [handled by CVS or the Client](#_Determine_if_Grievance_1). Refer to the CIF to determine if the Client has contracted with CVS Caremark to handle its MED D Grievances. * Second, determine if the [caller is qualified](#_Who_Can_File_2) to file a Grievance. * Third, determine if the [time limit for filing](#_Time_Limits_for) a Grievance has been reached. | **After three factors in Step 2 are determined:**   * If **CVS handles** the Grievance, the caller is authorized to file **AND** the time limit for filing has not been reached, proceed to [Step 3](#HLPStep3). * If **Client handles** the Grievance, the caller is authorized to file per the CIF **AND** the time limit for filing has not been reached, follow the Grievance process per the instructions in the CIF. |
| 1. **Determine if a** [**Quality of Care**](#_Quality_of_Care) **issue.** | |
| 1. **Create the Grievance in Compass.**  * Proceed to the following to work instruction to properly file the Grievance: * [Compass MED D - How to File a Grievance in Compass (066742)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=a1bfd5ce-4c26-4dbb-a851-188f548bdf81) | **Reminders:**   * Check for **previously submitted** **Grievances**. Refer to [Compass MED D - Viewing Grievance History in Compass (066743)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=cf46f2f7-d40c-4c65-9155-a37d4075ca22). * Client-handled Grievances do not follow the typical Grievance process. Refer to the “Creating a Non-Delegated Grievance in Compass” section of [Compass MED D - How to File a Grievance in Compass (066742)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=a1bfd5ce-4c26-4dbb-a851-188f548bdf81). |

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| Identifying a Grievance |

CMS (Centers for Medicare and Medicaid Services) requires any dissatisfaction expressed by a beneficiary to be reported as a Grievance. This dissatisfaction is reported regardless if the issue is completely corrected, resolved, or education is provided to the beneficiary on the phone call.

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

If the beneficiary calls with the same issue and the previous Grievance on that issue is closed, a Grievance must be filed (**Status Reason** “…Resolution” indicates the Grievance is closed).

CMS does not limit the number of times a beneficiary can file a Grievance about the same issue.  
**Example:** Beneficiary complains about the IVR (Interactive Voice Response) 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 a First Call Resolution (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.

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

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

The table below will assist the Customer Care Representative (CCR) in determining if the beneficiary is expressing dissatisfaction.

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

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

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| Coverage Determinations vs. Grievances |

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 (CD), 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,** then open a Coverage Determination **simultaneously**.

**EXAMPLES:**

* If a Tiering Exception will lower the cost by removing the deductible or Coverage Gap, then the scenario is a Coverage Determination and not a Grievance.
* When a beneficiary calls to open a Grievance related to a subject matter which is **not clinically related** (e.g., pay premium bill), but part of the beneficiary’s issue references the inconvenience to start a Coverage Determination to obtain the medication, the CCR:
* Opens the Grievance that is specific to the beneficiary’s issue
* Creates a CD&A Support Task (if the CD has not already been filed).
* For Coverage Determination and PA, refer to [Compass MED D - CCR - Coverage Determinations and Redeterminations (Appeals) (064997)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=a23bc09d-37f7-4105-ba57-d4e9d7f512ff).

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 **Compass** in order for the Grievance team and CD&A team to be aware that both issues are being worked **separately** and **simultaneously**.

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

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

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

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

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

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

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| **Who handles the Grievance?** | **Then…** |
| Client handles Grievances | Refer to the “Creating a Non-Delegated Grievance in Compass” section of [Compass MED D - How to File a Grievance in Compass (066742)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=a1bfd5ce-4c26-4dbb-a851-188f548bdf81). |
| CVS Caremark handles the Grievance and CCR **was able to fully resolve** the beneficiary’s issue | Do **NOT** mention the word grievance or inform the beneficiary you are filing a grievance. CMS mandates that all dissatisfaction be reported.   * File as First Call Resolution. Proceed to [Compass MED D - How to File a Grievance in Compass (066742)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=a1bfd5ce-4c26-4dbb-a851-188f548bdf81).     **DO NOT** ask:   * Do you want to file a Grievance? **OR** * Would you like to open a Grievance? |
| CVS Caremark handles the Grievance and CCR **was NOT able to fully resolve** the beneficiary’s issue | * Do as much as possible to ensure the beneficiary’s issue is resolved and has medication. * Advise the beneficiary that since you were unable to resolve the beneficiary’s dissatisfaction/issue, then you are sending the issue over to a dedicated department that will research and respond to the beneficiary within 30 calendar days. This department is called the Grievance department. The response to your issue may or may not change the outcome of what has occurred. * File as New Grievance. Proceed to [Compass MED D - How to File a Grievance in Compass (066742)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=a1bfd5ce-4c26-4dbb-a851-188f548bdf81).   **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 Compass that the beneficiary refused filing the grievance. |

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| Determine If Grievance Is Handled by CVS or Client |

**Note:** For Coverage Determination and PA (Prior Authorization) process, refer to [Compass MED D - CCR - Coverage Determinations and Redeterminations (Appeals) (064997)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=a23bc09d-37f7-4105-ba57-d4e9d7f512ff). If a beneficiary has a Grievance handled by the Client and a Coverage Determination handled by Caremark, use the Support Task process for the Coverage Determination and offer to warm transfer the beneficiary to the Client for the Grievance.

Before moving forward with the Grievance process, the CCR must refer to the CIF to determine if the Client has contracted with CVS Caremark to handle its MED D Grievances. If Client is delegated to handle the Grievance, refer to the “Creating a Non-Delegated Grievance in Compass” section of [Compass MED D - How to File a Grievance in Compass (066742)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=a1bfd5ce-4c26-4dbb-a851-188f548bdf81).

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

**CVS Caremark may handle:**

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

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

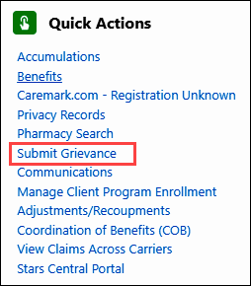
**CCR Process Note:**

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

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

**REMINDERS:**

* Compass may not provide a **Submit/Submit New Grievance** hyperlink in the **Quick Actions** panel for non-delegated MED D clients, to ensure a Grievance is not submitted in error. Refer to the “Creating a Non-Delegated Grievance in Compass” section of [Compass MED D - How to File a Grievance in Compass (066742)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=a1bfd5ce-4c26-4dbb-a851-188f548bdf81).
* If agent is not in an **Interaction Case**, Compass will not provide a **Submit Grievance** hyperlink in the **Quick Actions** panel.



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| Who Can File A Grievance? |

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

**Notes:**

* A Grievance cannot be filed for a deceased beneficiary unless the purported representative has the authority to file a grievance (**Example:** Executor of an estate).
* If you have a Grievance or CD opportunity, authenticate the beneficiary, and obtain permission for the caller to act on behalf of the beneficiary to complete the process. If the beneficiary is unable to come to the phone to give permission, an AOR/POA is required.
* For Client-handled Grievances: If the caller is not the beneficiary and there is no AOR/POA on file, attempt to transfer to the Client. Refer to the [Determine if Grievance is Handled by CVS or Client](#_Determine_if_Grievance) section and the “Creating a Non-Delegated Grievance in Compass” section of [Compass MED D - How to File a Grievance in Compass (066742)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=a1bfd5ce-4c26-4dbb-a851-188f548bdf81).

Refer to the table below:

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| **If the person is…** | **Then…** | | |
| Informal Authorized Third-Party | When the beneficiary is present and is fully authenticated by speaking directly to the CCR and verifies that the third party is authorized to speak on their behalf, the third party may file a Grievance in the same way as it would be speaking directly to the beneficiary.   * Obtain the caller’s: * Name * Address * Phone * Relationship to member * Icon - Important Include if member’s verbal authorization was provided | | |
| Beneficiary | Determine the following: | | |
| **If Beneficiary…** | | **Then…** |
| Has account visible in Compass with a current effective date | | Continue with filing a Grievance. Proceed to [Compass MED D - How to File a Grievance in Compass (066742)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=a1bfd5ce-4c26-4dbb-a851-188f548bdf81). |
| Is expressing dissatisfaction about a previous PBM (Pharmacy Benefits Manager); however, is now active/enrolled with Caremark Mail Service  **Example:**  Beneficiary is actively enrolled with **Florida Community Care** (a CVS Caremark mail order client). They were with **Florida Community Care** last year but used another PBM (not CVS Caremark). They call into our call center and express dissatisfaction about something that went wrong with the prior PBM and/or plan year. | | Continue with filing a Grievance. Proceed to Compass [MED D - How to File a Grievance in Compass (066742)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=a1bfd5ce-4c26-4dbb-a851-188f548bdf81).   * If appropriate, advise the member that they may reach out to their previous PBM with questions. |
| Is expressing dissatisfaction about a different plan (not the plan they are currently enrolled in)  **Example:** Beneficiary is actively enrolled with **Florida Community Care** (a CVS Caremark mail order client). They call into our call center and express dissatisfaction about the plan they had last year with **Health Plans R’ Us** (not a CVS Caremark mail order client). | | Advise the beneficiary to contact their previous Plan or PBM. |
| 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. Proceed to [Compass MED D - How to File a Grievance in Compass (066742)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=a1bfd5ce-4c26-4dbb-a851-188f548bdf81). | | |
| Future Beneficiary  (someone who has an account visible in Compass with a future effective date but plan is not yet started) | Beneficiary can still file a grievance about enrollment experience or future plan design. Continue with filing a Grievance. Proceed to [Compass MED D - How to File a Grievance in Compass (066742)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=a1bfd5ce-4c26-4dbb-a851-188f548bdf81). | | |
| Power of Attorney (POA) or Legal Representative (Guardian) for the Beneficiary | From the Medicare D Landing page, review **Medicare D Alerts** and **Privacy Records** to determine if a POA document is on file. Refer to the following work instruction for further information as needed: “Viewing Authorizations on File in Compass” section of [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). | | |
| **If…** | **Then…** | |
| POA is provided and on file | The caller can file a Grievance. | |
| POA is not on file | The caller can file a Grievance if the dissatisfaction is expressed on behalf of the beneficiary.   * If no POA on file, the Grievance Team will send a letter and a copy of the AOR form advising the caller and/or beneficiary to provide a copy of the POA or completed AOR form. * The documentation must be returned within 30 days otherwise the Grievance will be dismissed.   I understand you are stating dissatisfaction on behalf of the beneficiary. In order to formally resolve the dissatisfaction, I will need to have you provide a copy of the POA. Can you please provide me your address? | |
| **If address is...** | **Then...** |
| Provided | Advise the caller that they will receive a letter and a copy of the AOR form advising them to provide a copy of the POA or completed AOR form. The documentation must be returned within 30 days otherwise the Grievance will be dismissed. |
| Not Provided | The beneficiary will receive notification of the grievance requesting a copy of the POA. |
| **Health Plan Only:** POA is on file with the Health Plan | Contact Health Plan and determine if POA is on file. | |
| **If...** | **Then...** |
| On File | * Ask Health Plan to fax the POA to CVS Caremark at **1-866-552-6205**. * Document in Compass: Contacted Health Plan and confirmed POA is on file. * Proceed with filing a Grievance. |
| Not on File | The caller can file a Grievance.  Refer to the POA not on file section above. |
| Caller states POA is already on file with the Plan | The caller can file a Grievance.  Advise the caller that the Grievance Team will reach out to the Plan to obtain a copy of the POA. If POA is not on file, a **copy** of the POA will need to be provided. | |
| An Appointed Representative (AOR) (includes a Provider/Prescriber) | From the Medicare D Landing page, review **Medicare D Alerts** and **Privacy Records** 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 Compass” section of [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).  A new AOR does not have to be filed for every new issue if an AOR is on file that is not older than one year.   * **For Non-Health Plan:** Check the Medicare D Landing Page, **Medicare D Member Details** panel to determine if the AOR document is on file and is not expired. * **For Health Plan:** Check the Member Snapshot Landing Page, **Member Details** panel to determine if the AOR document is on file and is not expired.   **Notes:**   * Per CMS guidelines, AORs are only good for one year from the date of signature. * If a provider is wanting to file a grievance on behalf of a member about something the member experienced, they can, and it would fall under the same process as grievances received from a representative. An AOR or equivalent written authorization is needed for a grievance to be filed by a provider on a member’s behalf.   Icon - Important A Plan Member Authorization form or Personal Health Information (PHI) Authorization form is not acceptable to file a Grievance. | | |
| **If…** | **Then…** | |
| AOR is provided and on file | The caller can file a Grievance. | |
| AOR is not on file | The caller can file a Grievance if the dissatisfaction is expressed on behalf of the beneficiary.   * If no AOR on file, the Grievance Team will send an AOR form directly to the beneficiary and the caller. * The caller may also download an [AOR form (021424)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=4008954a-0d95-4ea9-add2-3a7dfa02c718) from the Plan’s website. * The AOR form must be returned within 30 days otherwise the Grievance will be dismissed.   I understand you are stating dissatisfaction on behalf of the beneficiary. In order to formally resolve the dissatisfaction, I will need to have you complete a MED D Appointed Representative (AOR) Form. Can you please provide me your address? | |
| **If address is...** | **Then...** |
| Provided | Advise the caller that they will receive a letter and a copy of the AOR form advising them to provide a copy of the POA or completed AOR form. The documentation must be returned within 30 days otherwise the Grievance will be dismissed. |
| Not Provided | The beneficiary will receive the AOR form to complete. |
| **Health Plan Only:** AOR is on file with the Health Plan | Contact Health Plan and determine if AOR is on file. | |
| **If...** | **Then...** |
| On File | * Ask Health Plan to fax the AOR to CVS Caremark at **1-866-552-6205**. * Document in Compass: Contacted Health Plan and confirmed AOR form is on file. * Proceed with filing a Grievance. |
| Not on File | The caller can file a Grievance.  Refer to the AOR not on file section above. |
| Caller states AOR is already on file with the Plan | The caller can file a Grievance.   * Advise the caller that the Grievance Team will reach out to the Plan to obtain a copy of the AOR. If AOR is not on file or has expired, a new form will be sent. | |
| SHIP Counselor | Can file if a unique SHIP ID is provided **and** the beneficiary or their representative has provided written or verbal permission for the SHIP Counselor to act and/or speak on their behalf. Refer to the [Medicare and Medicaid SHIP Counselor Unique ID List (077234)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=fadccc80-a0a1-449b-b5b0-056705aad9ec) job aid in theSource.  **Note:** Select **Beneficiary** under “Filed by” when filing a Grievance. Document in Compass that the SHIP unique ID was verified. Also note if verbal permission was provided by the beneficiary. | | |
| Executor of Estate | Death certificate must be submitted for deceased beneficiary. | | |
| A client representative  (beneficiary or their purported representative was **not on the line** to express dissatisfaction) | Cannot file a grievance unless the beneficiary or their purported representative (not the client representative) is the one who expressed the dissatisfaction.  If the client representative is trying to file a grievance as a courtesy to the beneficiary or their purported representative, but the beneficiary or their purported representative did not express dissatisfaction, it is not a valid grievance. | | |
| A client representative  (beneficiary or their purported representative are/were **on the line** to express dissatisfaction) | Can file a grievance since the beneficiary or their purported representative are the ones expressing dissatisfaction. | | |
| Provider | Cannot file a grievance if the dissatisfaction they are expressing is their own and not on the beneficiary’s behalf. Providers should file complaints to the Plans in accordance with the applicable Plans’ dispute resolution processes.   * If the provider feels the resolution determined by the Plans’ dispute resolution process is unsatisfactory, the provider may contact their local CMS Regional Office.   If the provider is expressing dissatisfaction on the beneficiary’s behalf, the provider can file a grievance the same way as a third-party caller. An AOR form would be needed unless the beneficiary is also on the line. Refer to [Informal Authorized Third-Party](#Informal_Authorized_Third_Party). | | |

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| Time Limits for Filing a Grievance |

**CMS regulations state:**

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

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

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

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

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



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| Quality of Care |

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

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

* Refer to the [Identifying a Grievance](#_Identifying_a_Grievance_1) section in this document to determine if a Grievance should be filed.
* Refer to the appropriate Grievance Categories section of [Compass MED D - How to File a Grievance in Compass (066742)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=a1bfd5ce-4c26-4dbb-a851-188f548bdf81) to determine the Category and Subcategory to select when filing a Quality of Care Grievance.
* Ensure that you take all steps necessary to ensure the beneficiary has medication before ending the call.
* Quality of Care Grievances **cannot** be filed as First Call Resolution.

**Quality of Care Decision Grid**

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| A Quality of Care Grievance **should NOT** be filed when: | A Quality of Care Grievance **MUST** be filed when (including, but not limited to): |
| * Coverage Determination and/or Redetermination denial * Beneficiary’s decision to not obtain the medication due to cost and no incorrect information had been given to the beneficiary regarding cost * Beneficiary’s neglect to order the medication * Order delayed due to state/national disaster and/or weather event (refer to [Compass - Disaster / State of Emergency Process (065969)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=b83eb4f0-7e62-4a71-9f34-7eb1ebdbe231)) * 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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| 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 - How to File a Grievance in Compass (066742)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=a1bfd5ce-4c26-4dbb-a851-188f548bdf81)

[Compass MED D - 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)

[Compass MED D – Grievances: CCR – First Call Resolution Documentation Templates (SSI PDP, SSI EGWP, and 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 (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 - 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/" \l "!/view?docid=a23bc09d-37f7-4105-ba57-d4e9d7f512ff)

[Compass - Call Documentation (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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