**Instructions for Completing Grievance**

The **bolded** areas in the following Grievance Form should be completed with the patient’s personal information prior to filing the grievance.

The [text in brackets] in the form should be replaced to reflect the circumstances of the patient’s case. Please make sure to search the document for all brackets and replace that information with the patient’s before mailing the Grievance Form. Do not include this instruction sheet with your grievance.

**Remember:**

1. **The patient should** **sign the form** on the last page where indicated. If the patient cannot sign for him/herself, the Grievance should be signed by the patient’s authorized representative or, if none exists, the next of kin. (Indicate the individual’s relationship to the patient and include documentation for the representative if it exists.)
2. **Keep a copy** of the completed Grievance Form.
3. **Mail** the completed Grievance Form to the patient’s Medicare Advantage Plan’s grievance department. This address should be available either on the Plan’s website or in the paperwork the patient received upon enrollment.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Send questions, comments, or concerns about the Grievance Form to:

1. Email: Grievance@MedicareAdvocacy.org
2. Or Mail to:

Center for Medicare Advocacy

Attn: Justin Lalor, Esq.

PO Box 350

Willimantic, CT 06226

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***End of Instruction Page***

[**Today’s Date** *– Note: A grievance must be filed no later than 60 days after the incident leading to a grievance occurs.*]

**[Medicare Advantage Plan Name**](the “Plan”)

**[Address for the Plan’s Grievance Department from the Plan**]

**Re:** **Grievance** - Filed Pursuant to 42 C.F.R. § 422.564

**Enrollee:** **[Patient’s Name]** (the “Enrollee”)

**Member Number:** **[Patient’s Medicare Beneficiary Identifier (MBI) Number]**

 **Skilled Nursing Facility:** [**Name of SNF / nursing home** (the “SNF”)

**Incident Date(s):** [**Date(s) of Event(s) or Incident(s)]**(The “Incident Date(s)”)

This Grievance is filed with the Medicare Advantage Plan (the Plan) in accordance with the provisions of 42 C.F.R. § 422.564, Section 30 of the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, Appeals Guidance published by the Centers for Medicare & Medicaid Services (“CMS”), and the written grievance procedures published and disseminated by the Plan in accordance with law.

Specifically, the Enrollee is dissatisfied that the Plan has issued repeated, routine Notices of Medicare Non-Coverage (“NOMNC”) during the Enrollee’s Medicare-covered SNF stay that deny coverage when Medicare coverage criteria continued to be met. These NOMNCs have been legally inappropriate, distressing to the Enrollee and the Enrollee’s family, and issued with disregard for the facts and opinions of the Enrollee’s health care providers.

**The Enrollee Meets the Medicare Criteria for Skilled Nursing Facility Services**

**[Enrollee]**was admitted to the SNF on **[Admission Date]** after a hospital stay for [**details of medical condition**]**.**

At the SNF, the Enrollee **[continues/or continued]** to receive daily skilled care. **[Insert a description of the daily skilled nursing care and/or therapy that the patient has been receiving. For this section, detail the background of the SNF care for the patient in a concise but thorough way. You may want to include any physicians’ and/or therapists’ medical opinions about the necessity of the care, and the status of the patient during the time of the issuance of each Medicare denial/NOMNC**.]

**Summary of MA Plan’s Unreasonable Denials for Skilled Nursing Facility Care That Meets Medicare Coverage Criteria**

**[For this section, detail each Medicare denial / issuance of a NOMNC, any appeals that were pursued, and the results. Also include the effect that these NOMNCs and the appeal process has had on the patient, you, and your family.]**

**[EXAMPLE: Edit the information below as appropriate to fit the facts and circumstances. Remember to delete any language that does not relate to the patient.]**

**[*On January 1, 2022, Mary Smith, was issued a Notice of Medicare Non-Coverage (NOMNC) from the Plan informing her that the Plan believed Medicare coverage of her stay at the SNF would end as of January 3, 2022. The therapy team at Generic SNF Care Center categorically disagreed with that decision. Therapists said that without continued therapy, she would start to decline and would no longer be able to walk, visit her family and friends, make herself food, or go to the bathroom on her own again.***

***With the therapists’ support, the Enrollee appealed the NOMNC to KEPRO [or, if not KEPRO, Livanta, either of which is the Medicare appeals organization in the Enrollee’s state] on January 2 and received a favorable decision stating that termination of coverage was inappropriate.***

***Despite the medical opinions of the skilled providers working with the Enrollee and this favorable decision in accordance with Medicare law and regulations, the Plan issued another NOMNC on January 7. There had been no change in the Enrollee’s therapy, the therapists’ assessment of his/her rehabilitation, or any other relevant medical facts. Ignoring all of this, with the routine issuance of this second NOMNC, the Plan attempted to remove Medicare coverage starting on January 9. We once again appealed and were successful… .*]**

**GRIEVANCE:**

**[Edit this Section as appropriate to fit the individual’s facts and circumstances.]**

As described above, the Plan repeatedly ignored the individual facts and medical opinions of the Enrollee’s physicians, therapists, and other treating providers and continued to issue NOMNCs in order to improperly terminate coverage for the Enrollee’s medically necessary and reasonable care.

CMS guidelines specifically prohibit the issuance of routine written notices. The Medicare Claims Processing Manual, Chapter 30, Section 40.2.2 states the following:

In general, the “routine” use of written notices is not effective and therefore is not an acceptable practice. By “routine” use, CMS means giving written notice to beneficiaries **where there is no specific, identifiable reason to believe Medicare will not pay**. Notifiers should only give written notices to beneficiaries when there is some genuine doubt that Medicare will make payment. If the Medicare contractor identifies a pattern of routine notices in situations where such notices clearly are not valid, it will write to the notifier and remind it of these standards.

These repeated, routine NOMNCs caused the Enrollee, the Enrollee’s family, and the health care providers caring for the Enrollee unneeded stress, immense effort and resources, and precious hours in the appeals processes to respond to these frequent notices and deal with the financial implications of an improper denial of an appeal throughout these already difficult times.

The Plan has repeatedly ignored Medicare coverage and appeal rules and repeatedly issued inappropriate, routine NOMNCs, disregarding the facts of the Enrollee’s case. For this reason, the Enrollee is extremely dissatisfied with the conduct of the Plan in this case and would like a written response to these circumstances explaining how the Plan has not violated federal regulations and CMS guidelines in light of the foregoing facts and law.

Additionally, the Enrollee demands that the Plan stop issuing NOMNCs that lack specific, identifiable reasons, tied to the medical evidence at hand, to believe that Medicare will not pay. The Enrollee also demands that the Plan reimburse them for out-of-pocket expenses, time, and effort expended in order to deal with routine NOMNCs previously issued. Please contact me so that we can determine these costs and arrange for remedial compensation.

I look forward to your written response within thirty (30) days as required by 42 C.F.R. § 422.564(e). If you require any additional information, please contact me directly at **[your phone number, if you feel comfortable talking with the Medicare Advantage plan]** and at the address below.

Sincerely,

**[Enrollee’s *Signature*]**

**[Enrollee’s Name]**

**[Enrollee’s Address]**

***[You may also want to send a copy of the grievance to your regional Medicare office and to your Congressional representative and senators. If so, note on the Grievance Form that you have copied them as follows:]***

***cc:***

*[Address of your regional Medicare office]*

*[Name(s) and Address(es) of your Congressional Representative)/Senator(s)]*

*Center for Medicare Advocacy Attention: Attorney Justin Lalor, PO Box 350, Willimantic, CT 06226, or email Grievance@MedicareAdvocacy.org*

***[Important: If you are not the Enrollee, and the Enrollee is unable to sign the grievance, please remember to attach a copy of your fully executed Appointment of Representative Authorization Form along with this Grievance Letter.]***