

Appeals and Grievances

Community HealthFirst MA Special Needs Plan (HMO SNP)
Community HealthFirst MA Plan (HMO)
Community HealthFirst Medicare MA Pharmacy Plan (HMO)
Community HealthFirst MA Extra Plan (HMO)

As a Community HealthFirst Medicare Advantage Plan enrollee, you have the right to voice a complaint if you have a problem or concern about your health care or health care coverage.

The Federal Medicare program has rules about what you need to do to make a complaint and what Community Health Plan of Washington is required to do when we receive a complaint.

If you make a complaint, we are impartial in how we handle it. You cannot be disenrolled from your Community HealthFirst Medicare Advantage Plan or penalized in any way if you make a complaint.

This booklet is designed to help you understand:

- Your rights when you have a complaint,
- How to file an *appeal* or *grievance* when you have a complaint,
- How the *appeal* and *grievance* processes work.

We take your concerns seriously and consider them opportunities to improve care and service to our enrollees.

What are appeals and grievances?

Complaints can fall into two categories:

- *Appeals* and
- *Grievances*

Appeals

An *appeal* is when you want us to reconsider a decision we have made about what benefits are covered under your plan or what we will pay. For example, you might *appeal* if you think we:

- will not approve payment for care you believe should be covered;
- are stopping payment for care you need; or,
- have not paid for a particular medical procedure or other service you think should be covered.

You can also request a *coverage determination* on a Part D prescription drug through the *appeal* process.

A *coverage determination* is the first step you take in requesting a ruling on a Part D prescription drug benefit. When we make a *coverage determination*, we are making a decision whether or not to pay for a Part D drug and what your share of the cost is.

You have the right to ask us for an *exception* if you believe you need a drug that is not on our list of covered drugs (formulary) or believe you should get a drug at a lower cost to you. If you request an *exception*, your physician must provide a statement to support your request.

Grievances

A *grievance* is a complaint you make if you have a problem with your health care provider or the service we provide to you. For example, you would file a *grievance* if you have a concern about things such as:

- the quality of your care;
- waiting times for appointments or in the waiting room;
- your provider's behavior;
- the ability to reach someone by phone or get the information you need;

- the cleanliness or condition of your provider's office; or
- the courtesy of the service we provide you.

Filing an appeal

Appeals must be submitted within 60 calendar days from the notice of denial date.

This section explains:

- How to file an *appeal* if you have complaints about your medical coverage or Part D prescription drug benefits under a Community HealthFirst Medicare Advantage Plan, including:
 - If you are having a problem getting care or a Part D prescription drug that you believe is covered by your plan.
 - If we will not authorize payment for medical treatment or a Part D prescription drug your provider or other medical provider states is medically necessary and you believe this treatment is covered by your plan.
 - If you are being told that coverage for a treatment or service you have been getting will be reduced or stopped, and you feel this could harm your health.
 - If you have received care that you believe was covered by your plan while you were an enrollee, but we have refused to pay for this care.
- What the process involves.
- How long it takes for an *appeal* decision.
- What happens if an *appeal* is denied.
- Complaints specific to hospital discharge, skilled nursing facility, home health and comprehensive outpatient rehabilitation facility services coverage.

How do I file an appeal?

There are two kinds of *appeal*: *standard* and *expedited* (rush).

A *standard appeal* request must be in writing and sent to:

Community Health Plan of Washington
 Attn: Community HealthFirst Appeals
 1111 Third Avenue, Suite 400
 Seattle, WA 98101

An *expedited appeal* can be submitted in writing to the address above, or verbally by calling 1-800-942-0247 (TTY Relay: Dial 7-1-1). You should file an *expedited appeal* if your health or ability to function could be seriously harmed by waiting more than 72 hours (3 calendar days) for a decision.

You can also fax your request to: 1-206-613-8983 or deliver it in person to:

Community Health Plan of Washington
 1111 Third Avenue, Suite 400
 Seattle, WA 98101

Be sure to clearly state which type of *appeal* request you are making and include: your name, address, enrollee ID number, reasons for appealing, and any evidence you wish to attach. You may send in supporting medical records, providers' letters, or other information or documentation that supports your position. Call your provider if you need this information to help you with your *appeal*.

Who may file an appeal?

Only the member, their authorized representative, treating provider, or PCP may file a Part C *appeal*.

For Part D *appeals*, either the member, the member's authorized representative, or the prescribing physician may *appeal*.

How long does an appeal decision take?

Standard appeals are processed within: 30 calendar days from the date we receive your request, but may be extended to 44 calendar days if additional information is needed. You will receive notice of our decision in writing along with any supporting explanation.

Decisions on *expedited appeals* are made within: 72 hours of the receipt of the *appeal*. If we determine that the *appeal* should be standard instead, we will promptly call you with that decision and follow up with a written notice within 2 calendar days.

Decisions on *standard* Part D prescription drug coverage determination appeals are made within 7 calendar days.

Decisions on *expedited* Part D Prescription drug coverage determination appeals are made within 24 hours.

How does the decision process work?

Step 1:

In both kinds of *appeals*, the review is conducted by a the Plan Grievance Coordinator—this is someone other than the person who made the original coverage decision. You or your provider can request to examine your case file before and during the *appeal* process.

The Grievance Coordinator will gather information and consult with the Plan staff, specialists, providers and other appropriate parties to reach a decision.

After reviewing your *appeal* we will either decide to stay with the original decision, or change this decision and give you some or all of the care, benefit or payment you requested in the *appeal*.

Appeal decision findings based on a “lack of medical necessity” are made by a provider with expertise in the appropriate field of medicine.

Step 2:

If we turn down part or all of your Part C *appeal*, we will send your request to an independent review organization that has a contract with the Federal Government and is not part of the Plan. This organization will review your request and make a decision about whether we must give you the care or payment you want. You have the option of requesting an independent review if we turn down part or all of your Part D appeal.

Step 3:

If you are unhappy with the decision made by the independent review organization, you may ask for an Administrative Law Judge to consider your case and make a decision. The Administrative Law Judge works for the Federal Government.

Step 4:

If you, or we, disagree with the decision made by the Administrative Law Judge, either of us may be able to ask the Departmental Appeals Board to review your case. The Board is part of the federal department that runs the Medicare program.

Step 5:

If you, or we, do not agree with the decision made by the Departmental Appeals Board, and the amount in controversy is \$1,350 or more, either of us may request a Judicial Review through a civil action in a United States district court.

What to do if you think you are being discharged from the hospital too soon.

If you are hospitalized for any reason, you will be discharged from the hospital when your stay there is considered no longer medically necessary. The hospital will provide you with a document titled "An Important Message from Medicare". This message will outline the steps you will need to take to have your discharge date reviewed.

Step 1: Contact the QIO no later than noon on the first business day after you are given written notice that you are being discharged from the hospital. This deadline is very important, as meeting it allows you to stay in the hospital past your discharge date without having to pay for it yourself, while you wait to get a decision from the QIO.

Ask the QIO for a *fast review* or *fast track appeal* of your discharge. The QIO will request the Detailed Notice of Discharge to be completed by the health plan, review your medical information, determine whether it is medically appropriate for you to be discharged on the date that has been set for you. The QIO will make this decision within one full working day after it has received your request and all of the necessary medical information:

- If the QIO agrees with you, then we will continue to cover your hospital stay for as long as is medically necessary.
- If the QIO decides that your hospital stay is not medically appropriate, we will cover your hospital stay only until noon of the calendar day after the QIO gives you its decision.

Step 2:

If you do not meet the QIO request time deadline, you can ask us for an “*expedited appeal*” of your discharge. Please note that if you ask us for an *expedited appeal* of your discharge and you stay in the hospital past your discharge date, you may have to pay for the hospital care you receive past that date.

- If we review your medical information and decide that you need to stay in the hospital, we will continue to cover your hospital care for as long as is medically necessary.
- If we turn down part or all of your Part C appeal, we will send your request to an independent review organization that has a contract with the Federal Government and is not part of the Plan. This organization will review your request and make a decision about whether we must give you the care or payment you want.

Step 3:

You can *appeal* any bills for hospital care you receive as outlined earlier in the *appeals* process.

What to do if you think your coverage for skilled nursing facility, home health or comprehensive outpatient rehabilitation facility services are ending too soon.

If you are a patient in a skilled nursing facility (SNF), or are receiving services from a comprehensive outpatient rehabilitation facility (CORF) or home health agency (HHA), and they become no longer medically necessary, we will stop coverage for your SNF stay, or CORF or HHA services at that time. You will receive Notice of Medicare Non-Coverage (NOMNC) from the provider at least 2 calendar days before your coverage ends. If you believe that your coverage is ending too soon, you have the right to ask for an *appeal* through the QIO listed on the notice.

- You must act quickly and make your request to the QIO no later than noon of the day after you receive our written notice.

- If you get the notice and have more than 2 calendar days before your plan coverage for the SNF stay, or CORF or HHA services end, you must make your request no later than noon the day before the date that your Medicare coverage ends.

- The QIO will interview you, look at your medical information, talk to your provider and review Detailed Explanation of Non-Coverage (DENC) provided by us. The QIO will make their decision within one full day after it receives the necessary information:

- If the QIO agrees with you, then we will continue to cover your SNF stay, or CORF or HHA services, for as long as medically necessary.
- If the QIO denies your request and you continue to receive SNF care, or CORF or HHA services after the termination date stated in the original written notice you received from us, you will be responsible for paying any charges past the coverage termination date.

Step 1:

If you do not meet the QIO request time deadline, you can ask us for a *fast appeal* of your coverage termination date for your SNF stay or CORF or HHA services. Please note that if you ask us for a *fast appeal* and you continue with your SNF stay, or CORF or HHA services, you may have to pay for the charges you receive past the termination date. Whether you have to pay or not depends on our decision:

- If we review your medical information and decide that you need to continue to have these services covered, we will continue to cover them for as long as is medically necessary.
- If we turn down part or all of your Part C appeal, we will send your request to an independent review organization that has a contract with the Federal Government and is not part of the Plan. This organization will review your request and make a decision about whether we must give you the care or payment you want.

Request for an exception to covered prescription drugs.

This section explains what you can do if you have problems getting the prescription drugs you believe we should cover, including:

- If you are not getting a prescription drug that you believe may be covered by your plan.
- If you have received a Part D prescription drug you believe may be covered by your plan, but we have refused to pay for the drug.
- If we will not pay for a Part D prescription drug prescribed by your provider because it is not in our formulary.
- If you disagree with the amount that we require you to pay for a Part D prescription drug.
- If you are being told that coverage for a Part D prescription drug that you have been getting will be reduced or stopped.
- If there is a requirement that you try another drug before we pay for the drug your provider prescribed, or if there is a quantity or dose limit that you disagree with.

Step 1:

You can ask us to make an *exception* to our coverage rules by calling the Plan Pharmacy Services at 1-800-942-0247 (TTY Relay: Dial 7-1-1), from 8:00 a.m. to 8:00 p.m., 7 days a week. There are several types of coverage *exceptions* you can ask us to make:

- You can ask us to cover your drug even if it is not in our formulary.
- You can ask us to waive coverage restrictions or limits on your drug. For example, if your drug has a quantity limit, you can request that we waive the limit and cover a larger quantity.

- You can ask us to provide a higher level of coverage for your drug. For example, if your drug is considered a non-preferred brand drug, you can request it be covered as a preferred brand drug instead. This would lower the cost share amount you must pay for your drug.

Generally, we will only approve your request for a coverage *exception* if the alternative drugs or lower tiered drugs included on your plan's formulary would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

If a coverage *exception* request is approved, it is valid for the remainder of the plan calendar year so long as your physician continues to prescribe the drug for you and it continues to be safe and effective for treating your condition.

Step 2:

If we do not approve a coverage *exception* request, you can *appeal* the decision as outlined earlier in the *appeals* process.

Filing a grievance

Grievances are complaints that you may have about types of problems other than coverage, such as:

- Problems with the quality of medical care you receive.
- Problems with our Customer Service.
- Problems with the time you spend waiting on the phone, in a waiting room or in an exam room.
- Problems with getting appointments in a timely manner, or having to wait a long time to have your prescription filled.
- Disrespectful or rude behavior by pharmacists, providers or other medical staff.
- Cleanliness or condition of pharmacies, providers' offices, clinics or hospitals.

If you have one of these types of problems or other problems that are not specifically related to your benefit coverage, you have the right to file a *grievance*.

How do I file a grievance?

We will try to resolve any grievance you might have over the phone. If we cannot resolve your grievance over the phone, you can submit a formal *grievance*.

Like an appeal, there are two kinds of grievance requests, standard and expedited (rush), you can file with us. You should request an *expedited grievance* if your health or ability to function could be seriously harmed by waiting more than 72 hours (3 days) for a decision.

Grievances can be submitted verbally by calling 1-800-942-0247 (TTY Relay: Dial 7-1-1), or by writing to:

Community Health Plan of Washington
Attn: Community HealthFirst Grievance
Coordinator
1111 Third Avenue, Suite 400
Seattle, WA 98101

You can also fax your *grievance* to: 1-206-613-8983 or deliver in person to:

Community Health Plan of Washington
1111 Third Avenue, Suite 400
Seattle, WA 98101

Be sure to clearly indicate which type of *grievance* request you are making and include your name, address, enrollee ID number, reason for your *grievance* and any information or documentation that supports your position.

You can also send a *grievance* about quality issues directly to the QIO.

Who may file a grievance?

You can submit a *grievance* yourself, or designate a representative to submit the *grievance* for you. Your provider, however, may not file a *grievance* on your behalf.

How long does a grievance decision take?

Standard grievance requests are typically decided upon within 30 calendar days from the date we receive your request, but may be extended if additional information is needed. Grievances filed verbally are responded to verbally. Grievances filed in writing and all quality of care grievances are responded to in writing.

Decisions on expedited grievance submittals are made within 72 hours (3 calendar days) of the receipt of the request. If we determine that the grievance request should be standard instead, we will promptly call you with that decision and follow up with a written notice within 2 calendar days.

Decisions on Part D prescription drug *standard grievance* requests are made within 30 days.

Decisions on Part D prescription drug *expedited grievance* requests are made within 24 hours.

How does the grievance decision process work?

If you file a *grievance* with us, the Grievance Coordinator will gather information from you and any relevant parties.

If you file a *grievance* against a provider, he or she is responsible for cooperating in the investigation and providing information, including medical records if necessary.

Once the review is completed, we will tell you our decision verbally for grievances received verbally and in writing for grievances reviewed in writing and all quality of care grievances. Our explanation will include an explanation for the decision.

Confidentiality

All *appeals* and *grievances* will be treated in a confidential manner in accordance with state, local and federal guidelines regarding disclosure of information. All employees at the Plan, and any third-party administrators and business associates of the Plan, are governed by the Plan confidentiality requirements. Only those parties who have the appropriate authority to review our *appeals* and *grievance* files may have access to the documentation collected.

Definitions Related To Appeals:

Adverse Organization Determination – a decision by the Plan to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services or benefits including the admission to or continued stay in a health care facility.

Appeal - Any of the procedures that deal with the review of adverse organization determinations on the health care services an enrollee believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the enrollee), or on any amounts the enrollee must pay for a service as defined in 42 Code of Federal Regulations 422.566(b). These procedures include reconsideration by the Medicare Advantage (MA) organization and if necessary, an independent review entity, hearings before Administrative Law Judges (ALJs), review by the Departmental Appeals Board (DAB), and judicial review.

Assignee - A physician or other provider who has furnished a service to the enrollee and formally agrees to waive any right to payment from the enrollee for that service.

Authorized Representative - Any individual authorized by an enrollee, or a surrogate who is acting in accordance with state law on behalf of the enrollee, in order to obtain an organization determination or deal with any level of the *appeals* process. Representatives are subject to the rules described in 20 Code of Federal Regulations Part 404, Subpart R, unless otherwise stated in this chapter of the manual.

Effectuation - Compliance with a reversal of the Plan's original adverse organization determination. Compliance may entail payment of a claim, authorization for a service, or provision of services.

Independent Review Entity (IRE) - An independent entity contracted by the Center for Medicare & Medicaid Services (CMS) to review

Medicare Advantage organizations' denial of coverage determinations. Currently, this organization is MAXIMUS Federal Services, Inc.

Organization Determination - Any decision made by or on behalf of a Medicare Advantage organization regarding payment or services to which an enrollee believes he or she is entitled.

Reconsideration - An enrollee's first step in the *appeal* process; a Medicare Advantage organization or independent review entity may reevaluate an adverse organization determination, the findings upon which it was based, and any other evidence submitted or obtained.

Definitions Related To Grievances:

Adverse Organization Determination - Adverse organization determinations are those determinations on the health care services an enrollee believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the enrollee), or on any amounts the enrollee must pay for a service. These procedures include a reconsideration process by the Medicare Advantage organization and if necessary, an independent review entity, hearings before Administrative Law Judges, review by the Departmental Appeals Board, and judicial review. These would be appealed through the reconsideration process, not the *grievance* process.

Grievance - Any complaint or dispute, other than one involving an adverse organization determination (see the preceding definition), expressing dissatisfaction with the manner in which the Plan or a delegated entity provides health care services, regardless of whether any remedial action can be taken. An enrollee may make the complaint or dispute, either orally or in writing, to the Plan, a provider, or a facility. A *grievance* may also include a complaint that the Plan refused to expedite an organization determination or reconsideration, or invoked an extension to an organization determination or reconsideration time frames.

In addition, *grievances* may include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided health service, procedure, or item. *Grievance* issues may also include complaints that a covered health service procedure or item during a course of treatment did not meet accepted standards for delivery of health care. Other issues include, but are not limited to, aspects of interpersonal relationships such as rudeness of a provider or employee, breach of privacy rules, or failure to respect the enrollee's rights.

Grievances regarding potential quality of care issues will be processed according to the the Plan Quality of Care Complaint Policy and Procedure.

Expedited Grievance - If an enrollee files a *grievance* that an expedited initial service determination or *expedited appeal* request was placed in the standard process instead of being expedited, this *grievance* must be treated as an *expedited grievance* and processed within 72 hours (3 calendar days). If it is a Part D prescription drug expedited request that was denied, the *expedited grievance* must be processed within 24 hours.

Complaint - Any expression of dissatisfaction to a Medicare Advantage organization, provider, facility or QIO by an enrollee made orally or in writing. This can include concerns about the operations of providers, insurers, or Medicare Advantage organizations such as: waiting times, the attitude of health care personnel, the adequacy of facilities, the respect paid to enrollees, the claims regarding the right of the enrollee to receive services or receive payment for services previously rendered. It also includes the Medicare Advantage organization's refusal to provide services to which the enrollee believes he or she is entitled. A complaint could be either a *grievance* or an *appeal*, or a single complaint could include both. Every complaint must be handled under the appropriate *grievance* or *appeal* process.

Quality Improvement Organization (QIO) - Organizations comprised of practicing providers and other health care experts under contract to the

Federal Government to monitor and improve the care given to Medicare enrollees. They review complaints raised by enrollees about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Medicare managed care the Plan plans, and ambulatory surgical centers. A QIO also reviews continued stay denials in acute inpatient hospital facilities.

Quality of Care Issue - A quality of care issue may be filed through the Medicare Advantage organization's *grievance* process and/or a QIO. A QIO must determine whether the quality of services (including both inpatient and outpatient services) provided by a Medicare Advantage organization meets professionally recognized standards of health care, including whether appropriate health care services have not been provided or have been provided in inappropriate settings.

Grievances regarding potential quality of care issues will be processed according to the Quality of Care Complaint Policy and Procedure for Community Health Plan of Washington.