Chapter 9: What to do if you have a problem or complaint (coverage decisions, appeals, grievances)

[The plan should refer Participants to other parts of the handbook using the appropriate chapter number, section, and/or page number. For example, "see Chapter 9, Section A, page 1." An instruction [plan may insert reference, as applicable] is listed next to each cross reference throughout the handbook.]

What’s in this chapter?

This chapter has information about coverage decisions and your grievance and appeal rights. Read this chapter to find out what to do if:

* You have a problem with or complaint about your plan.
* You need a service, item, or drug that your Interdisciplinary Team (IDT) or plan has said the plan will not pay for.
* You disagree with a decision that your IDT or plan has made about your care.
* You think your covered services and items are ending too soon.

**If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation.** This chapter is broken into different sections to help you easily find information about what to do for your problem or concern.

If you are facing a problem with your health or long-term services and supports

You should get the health care, drugs, and long-term services and supports that your Interdisciplinary Team (IDT) determines are necessary for your care, whether included in your Life Plan (LP) or because a need arose outside of your LP. **If you are having a problem with your care, you can call the Independent Consumer Advocacy Network (ICAN) at 1-844-614-8800 for help.** This chapter explains the different options you have for different problems and complaints, but you can always call ICAN to help guide you through your problem.

For additional resources to address your concerns and ways to contact them, see Chapter 2 [*plan should insert reference, as appropriate*] for more information on ombudsman programs.

[*Plan must update the Table of Contents to this document to accurately reflect where the information is found on each page after plan adds plan-customized information to this template.*]

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Section 1: Introduction

## Section 1.1: What to do if you have a problem

This chapter tells you what to do if you have a problem with your plan or with your services or payment. Medicare and Medicaid approved these processes. Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

## Section 1.2: What do the legal terms mean?

There are difficult legal terms for some of the rules and deadlines in this chapter. Many of these terms can be hard to understand, so we have used simpler words in place of certain legal terms. We use abbreviations as little as possible.

For example, we will say:

* “Coverage decision” rather than “organization determination,” “benefit determination,” “at-risk determination,” or “coverage determination”
* “Fast coverage decision” rather than “expedited determination”

Understanding and knowing the meaning of the proper legal terms can help you communicate more clearly, so we provide those too.

Section 2: Where to call for help

## Section 2.1: Where to get more information and help

Sometimes it can be confusing to start or follow the process for dealing with a problem. This can be especially true if you do not feel well or have limited energy. Other times, you may not have the knowledge you need to take the next step.

### You can get help from the Independent Consumer Advocacy Network

If you need help, you can always call the Independent Consumer Advocacy Network (ICAN). The state created ICAN is an ombudsman program that to help you with appeals and other issues. ICAN can answer your questions and help you understand what to do to handle your problem. See Chapter 2 [*plan should insert reference, as appropriate*] for more information on ombudsman programs.

ICAN is not connected with us or with any insurance company or health plan. ICAN can help you understand your rights and how to share your concerns or disagreement. ICAN can also help you in communicating your concerns or disagreement with us. The toll-free phone number for ICAN is 1-844-614-8800. The services are free.

### You can get help from the State Health Insurance Assistance Program

You can also call your State Health Insurance Assistance Program (SHIP). The SHIP is a state program that gets funding from the federal government. In New York State, the SHIP is called the Health Insurance Information, Counseling, and Assistance Program (HIICAP). HIICAP counselors can answer your questions and help you understand what to do to handle your problem. The HIICAP is not connected with us or with any insurance company or health plan. The HIICAP has trained counselors and services are free. The HIICAP phone number is 1-800-701-0501.

### Getting help from Medicare

You can also call Medicare directly for help with problems. Here are two ways to get help from Medicare:

* Call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. The call is free.
* Visit the Medicare website (<http://www.medicare.gov>).

# Section 3: Problems with your coverage

## Section 3.1: Deciding whether you should file an appeal or a grievance

**If you have a problem or concern, you only need to read the parts of this chapter that describe the process for your type of concern.** The chart below will help you find the right section of this chapter for appeals and grievances.

|  |  |
| --- | --- |
| **Is your problem or concern about your coverage?**  (This includes problems about whether particular services, items, or prescription drugs are covered or not, the way in which they are covered, and problems related to payment for services, items, or prescription drugs.) | |
| **Yes.** My problem is about  coverage.  Go to **Section 4: “Coverage decisions and appeals”** on page <xx>. | **No.** My problem is not about  coverage.  Skip ahead to **Section 10: “How to file a grievance”** on page <xx>. |

# Section 4: Coverage decisions and appeals

## Section 4.1: Overview of coverage decisions and appeals

The process for asking for coverage decisions and making appeals deals with problems related to your benefits and coverage. It also includes problems with payment.

### What is a coverage decision?

A coverage decision is an initial decision your Interdisciplinary Team (IDT), the plan, or an authorized specialist makes about your benefits and coverage or about the amount the plan will pay for your medical services, items, or drugs. The IDT, plan, or authorized specialist is making a coverage decision whenever it decides what is covered for you and how much the plan will pay. Authorized specialists include dentists, optometrists, ophthalmologists, and audiologists.

If you or your provider is not sure if a service, item, or drug is covered by the plan, either of you can ask for a coverage decision before the provider gives the service, item, or drug.

### What is an appeal?

An appeal is a formal way of asking us to review a decision made by your IDT, the plan, or an authorized specialist and change it if you think a mistake was made. For example, the IDT, plan, or authorized specialist might decide that a service, item, or drug that you want is not covered. If you or your provider disagree with that decision, you can appeal.

**NOTE:** You are a member of your IDT. You can appeal even if you participated in the discussions that led to the coverage decision that you wish to appeal.

## Section 4.2: Getting help with coverage decisions and appeals

### Who can I call for help asking for coverage decisions or making an appeal?

You can ask any of these people for help:

* Call **Participant Services** at <phone number>.
* Call your **Care Manager** at <phone number>.
* Call the **Independent Consumer Advocacy Network (ICAN)** for free help. ICAN is an independent organization. It is not connected with this plan. The phone number is 1-844-614-8800.
* Call the **Health Insurance Information, Counseling, and Assistance Program (HIICAP)** for free help. The HIICAP is an independent organization. It is not connected with this plan. The phone number is 1-800-701-0501.
* Talk to **your** **provider**. Your provider can ask for a coverage decision or appeal on your behalf.
* Talk to a **friend or family member** and ask him or her to act for you. You can name another person to act for you as your “representative” to ask for a coverage decision or make an appeal.
* Anyone can help you request a coverage determination or an appeal.
* Only someone you designate in writing can represent you during your appeal. If you want a friend, relative, or other person to be your representative during your appeal, you can either complete an “Appointment of Representative” form or you can write and sign a letter indicating who you want to be your representative.
* To get an “Appointment of Representative” form, you can call Participant Services.
* You can also get the form on the Medicare website at <https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf> [plan may also insert: or on our website at <web address **or** link to form>]. The form gives the person permission to act for you. You must give us a copy of the signed form; OR
* You can write a letter and either send it to us or have the person listed in the letter as your representative send it to us.
* **You also have the right to ask a lawyer** to act for you. You may call your own lawyer, or get the name of a lawyer from the local bar association or other referral service. Some legal groups will give you free legal services if you qualify. If you want a lawyer to represent you, you will need to fill out the Appointment of Representative form.
  + However, **you do not need to have a lawyer** to ask for any kind of coverage decision or to make an appeal.

## Section 4.3: Which section of this chapter will help you?

There are four different types of situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We separate this chapter into different sections to help you find the rules you need to follow. **You only need to read the section that applies to your problem:**

* **Section 5 on page <xx>** gives you information on what to do if you have problems about services, items, and drugs (but **not** Medicare Part D drugs). For example, use this section if:
  + You are not getting medical care you want, and you believe the plan covers this care.
  + The Interdisciplinary Team (IDT), plan, or authorized specialist did not approve services, items, or drugs that your provider wants to give you, and you believe this care should be covered.
    - **NOTE:** Only use Section 5 if these are drugs **not** covered by Part D. Drugs in the *List of Covered Drugs* with a [plan should insert symbol used in the List of Covered Drugs to indicate Medicaid covered drugs] are **not** covered by Part D. See Section 6 on page <xx> for instructions about the Part D drug appeals process.
  + You got services or items you think should be covered, but the IDT, plan, or authorized specialist decided that the plan will not pay for this care.
  + You got and paid for services or items that you thought were covered, and you want the plan to pay you back.
  + You are being told that coverage for care you have been getting will be reduced or stopped, and you disagree with the decision.
    - **NOTE:** If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, you need to read a separate section of this chapter because special rules apply to these types of care. See Sections 7 and 8 on pages <xx> and <xx>.
* **Section 6 on page <xx>** gives you information about Part D drugs. For example, use this section if:
  + You want to ask the plan or your IDT to make an exception to cover a Part D drug that is not on the plan’s *List of Covered Drugs* (Drug List).
  + You want to ask the plan or your IDT to waive limits on the amount of the drug you can get.
  + You want to ask the plan or your IDT to cover a drug that requires prior approval.
  + The plan or your IDT did not approve your request or exception, and you or your provider think we should have.
  + You want to ask the plan to pay for a prescription drug you already bought. (This is asking the plan or your IDT for a coverage decision about payment.)
* **Section 7 on page <xx>** gives you information on how to ask us to cover a longer inpatient hospital stay if you think the provider is discharging you too soon. Use this section if:
  + You are in the hospital and think the provider asked you to leave the hospital too soon.
* **Section 8 on page <xx>** gives you information if you think your home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

If you’re not sure which section you should use, please call Participant Services at <phone number>.

If you need other help or information, please call the Independent Consumer Advocacy Network (ICAN) at 1-844-614-8800.

Section 5: Problems about services, items, and drugs (but not Medicare Part D drugs)

## Section 5.1: When to use this section

This section is about what to do if you have problems with your coverage for your medical, behavioral health, and long-term care services. You can also use this section for problems with drugs that are **not** covered by Part D. Drugs in the *List of Covered Drugs* with a [plan should insert symbol used in the List of Covered Drugs to indicate Medicaid covered drugs]are **not** covered by Part D. Use Section 6 of this chapter for information about Part D drug appeals.

This section tells what you can do if you are in any of the five following situations:

### You think the plan covers a medical, behavioral health, or long-term care service that you need but are not getting.

**What you can do:** You can ask your Interdisciplinary Team (IDT), the plan, or an authorized specialist to make a coverage decision. Go to Section 5.2 on page <xx> for information on asking for a coverage decision. If you disagree with that coverage decision, you can file an appeal.

### The IDT, plan, or authorized specialist did not approve care your provider wants to give you, and you think it should have.

**What you can do:** You can appeal the decision to not approve your services. Go to Section 5.3 on page <xx> for information on making an appeal.

### You got services or items that you think the plan covers, but the IDT, plan, or authorized specialist decided that the plan will not pay.

**What you can do:** You can appeal the decision that the plan will not pay. Go to Section 5.3 on page <xx> for information on making an appeal.

### You got and paid for services or items you thought were covered, and you want the plan to reimburse you for the services or items.

**What you can do:** You can ask the IDT, plan, or authorized specialist to authorize the plan to pay you back. Go to Section 5.5 on page <xx> for information on asking for payment.

### The IDT, plan, or authorized specialist changed or stopped your coverage for a certain service, and you disagree with the decision.

**What you can do:** You can appeal the decision to change or stop the service. Go to Section 5.3 on page <xx> for information on making an appeal.

**NOTE:** If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, special rules apply. Read Sections 7 or 8 on pages <xx> and <xx>to find out more.

## Section 5.2: Asking for a coverage decision

### How to ask for a coverage decision to get a medical, behavioral health, or long-term care service

### If there is a service, item, or drug that you feel you need, ask your Interdisciplinary Team (IDT), the plan, or an authorized specialist to approve that service, item, or drug for you. You can do this by contacting your Care Manager and telling him/her that you want a coverage decision. Or you can call, write, or fax us, or ask your representative or provider to contact us and ask for a coverage decision.

* You can call us at: <phone number>. TTY users call: <phone number>.
* You can fax us at: <fax number>
* You can write to us at: <insert address>

Once you’ve asked, the IDT, plan, or authorized specialist will make a coverage decision.

### How long does it take to get a coverage decision?

It usually takes up to 3 business days after you asked. If you do not receive a decision within 14 calendar days, you can appeal.

Sometimes the IDT, plan, or authorized specialist needs more time to make a decision. In this case, you will get a letter telling you that it could to take up to 14 more calendar days. The letter will explain why more time is needed.

There are three exceptions to the decision deadline described above:

* For coverage decisions about continuing or adding to your current health care services, you will get a decision within 1 business day.
* For coverage decisions about home health care services after an inpatient hospital stay, you will get a decision within 1 business day. However, if the day after your request is a weekend or holiday, you will get a decision within 72 hours.
* For coverage decisions on a service, item, or drug that you already got, you will get a decision within 14 calendar days.

### Can I get a coverage decision faster?

**Yes**. If you need a response faster because of your health, ask for a “fast coverage decision.” If the IDT, plan, or authorized specialist approves the request, you will get a decision within 24 hours.

However, sometimes the IDT, plan, or authorized specialist needs more time. In this case, you will get a letter telling you that it could to take up to 14 more calendar days. The letter will explain why more time is needed.

The legal term for “fast coverage decision” is “expedited determination.”

**If you want to ask for a fast coverage decision, you can do one of three things:**

* Call your Care Manager;
* Call Participant Services at <phone number> or fax us at <fax number>; or
* Have your provider or your representative call Participant Services.

**Here are the rules for asking for a fast coverage decision:**

You must meet the following two requirements to get a fast coverage decision:

1. You can get a fast coverage decision **only if you are asking for coverage for a service, item, or drugyou have not yet received.** (You cannot get a fast coverage decision if your request is about payment for a service, item, or drug you already got.)
2. You can get a fast coverage decision **only if the standard 3 business day deadline could seriously jeopardize your life, health, or ability to attain, maintain or regain maximum function.**

* If your provider says that you need a fast coverage decision, you will automatically get one.
* If you ask for a fast coverage decision without your provider’s support, the IDT, plan, or authorized specialist will decide if you get a fast coverage decision.
  + If the IDT, plan, or authorized specialist decides that your health does not meet the requirements for a fast coverage decision, you will get a letter. The IDT, plan, or authorized specialist will also use the standard 3 business day deadline instead.
  + This letter will tell you that if your provider asks for the fast coverage decision, you will automatically get a fast coverage decision.
  + The letter will also tell how you can file a “fast grievance” about the decision to give you a standard coverage decision instead of a fast coverage decision. For more information about the process for filing grievances, including fast grievances, see Section 10 on page <xx>.

### If the coverage decision is Yes, when will I get the service, item, or drug?

If the coverage decision is **Yes**, that means you are approved to get the service, item, or drug. If possible, you will receive or start to receive the approved service, item, or drug within 3 business days from the date of our decision. If the service, item, or drug cannot reasonably be provided within 3 business days, your IDT will work with the provider to make sure you get the approved service, item, or drug as quickly as possible.

### If the coverage decision is No, how will I find out?

If the answer is **No**, you will receive a letter explaining why. The plan or your IDT will also notify you by phone.

* If the IDT, plan, or authorized specialist says **No**, you have the right to ask us to change the decision. You can do this by making (or “filing”) an appeal. Making an appeal means asking our plan to review the decision to deny coverage.
* If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (read the next section for more information).

## Section 5.3: Level 1 Appeal for services, items, and drugs (but not Medicare Part D drugs)

### What is an appeal?

An appeal is a formal way of asking us to review the coverage decision and change it if you think there was a mistake. If you or your provider disagree with the decision, you can appeal. In all cases, you must start your appeal at Level 1.

If you need help during the appeals process, you can call the Independent Consumer Advocacy Network (ICAN) at 1-844-614-8800. ICAN is not connected with us or with any insurance company or health plan.

### What is a Level 1 Appeal?

A Level 1 Appeal is the first appeal to <plan name>. Our plan will review your coverage decision to see if it is correct. The reviewer will be someone at our plan who is not part of your Interdisciplinary Team (IDT) and was not involved in the original coverage decision. When we complete the review, we will give you our decision in writing. If you need a fast decision because of your health, we will also try to notify you by phone.

If we do not decide the Level 1 Appeal in your favor, we will automatically forward your appeal to the Integrated Administrative Hearing Office for a Level 2 Appeal.

### How do I make a Level 1 Appeal?

At a glance:How to make a Level 1 Appeal

You, your doctor, or your representative may put your request in writing and mail or fax it to us. You may also ask for an appeal by calling us.

* Ask **within 60 calendar days** of the decision you are appealing. If you miss the deadline for a good reason, you may still appeal.
* If you appeal because you were told that a service you currently get will be changed or stopped, **you have fewer days to appeal** if you want to keep getting that service while your appeal is processing.
* Keep reading this section to learn about what deadline applies to your appeal.
* To start your appeal, you, your provider, or your representative must contact us. You can call us at <phone number> or you may appeal in writing. For additional details on how to reach us for appeals, see Chapter 2 [plan may insert reference, as applicable].
* You can ask us for a “standard appeal” or a “fast appeal.”
* If you are asking for a fast appeal, you should call us at <toll-free number>. TTY users should call <TTY number>.
* If you are asking for a standard appeal, make your appeal in writing or call us.
* You may use the Appeal Request Form that is attached to the Coverage Determination Notice.
* You can submit a request to the following address: <insert address>
* You may also ask for an appeal by calling us at <toll-free number>. TTY users should call <TTY number>.

The legal term for “fast appeal” is “expedited appeal.”

### Can someone else make the appeal for me?

**Yes**. Anyone can make the appeal for you, but only someone you designate in writing can represent you during your appeal. To make someone your representative, you must complete an “Appointment of Representative” form or write and sign a letter indicating who you want to be your representative. The form or letter gives the other person permission to act for you.

* To get an “Appointment of Representative” form, call Participant Services and ask for the form. You can also get the form on the Medicare website at <https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf> [plan may also insert: or on our website at <web address **or** link to form>]. The form gives the person permission to act for you. You must give us a copy of the signed form; OR
* You can write a letter and either send it to us or have the person listed in the letter as your representative send it to us.

### How much time do I have to make an appeal?

You must ask for an appeal **within 60 calendar days** from the date on the letter that you received informing you of the coverage decision.

If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of a good reason are: you had a serious illness, or we gave you the wrong information about the deadline for requesting an appeal.

**NOTE:** If you appeal because you were told that a service you currently get will be changed or stopped, **you have fewer days to appeal** if you want to keep getting that service while your appeal is processing. Read “Will my benefits continue during Level 1 Appeals” on page <xx> for more information.

### Can I get a copy of my case file?

**Yes**. Call Participant Services at <phone number> and ask for a copy of your case file. We will provide a copy of your case file at no cost to you.

### Can my provider give you more information about my appeal?

**Yes**, you and your provider may give us more information to support your appeal.

### How will we make the appeal decision?

We take a careful look at all of the information about your request for coverage of services or items. Then, we check to see if all the rules were followed when the IDT, plan, or authorized specialist said **No**to your request. The reviewer will be someone who is not on your IDT and was not involved in making the original decision.

If we need more information, we may ask you or your provider for it.

### When will I hear about a “standard” appeal decision?

If your appeal is about Medicaid prescription drugs, we must give you our answer within 7 calendar days from the date we received the appeal. For all other appeals, we must give you our answer within 30 calendar days from the date we received the appeal. We will give you our decision sooner if your health condition requires us to do so.

* However, if you ask for more time or if we need to gather more information, we can take up to 14 more calendar days. If we decide to take additional time to make the decision, we will send you a letter that explains why we need more time.
* If you believe we should not take extra time, you can file a “fast grievance” about our decision to take extra time. When you file a fast grievance, we will respond to your grievance within 24 hours. For more information about the process for filing grievances, including fast grievances, see Section 10 on page <xx>.
* If we do not give you an answer to your “standard” appeal within 7 calendar days (for Medicaid prescription drug appeals) or 30 calendar days (for all other appeals), or by the end of the extra time (if it was taken), we will automatically send your case to Level 2 of the appeals process. You will be notified when this happens. For more information about the Level 2 Appeal process, go to Section 5.4 on page <xx>.

**If our answer is Yes** to part or all of what you asked for, we must approve the coverage within 7 calendar days after we get your Medicaid prescription drug appeal or 30 calendar days after we get your other type of appeal.

**If our answer is No** to part or all of what you asked for, we will send you a letter. The letter will tell you that we sent your case to the Integrated Administrative Hearing Office for a Level 2 Appeal. For more information about the Level 2 Appeal process, go to Section 5.4 on page <xx>.

### When will I hear about a “fast” appeal decision?

If you ask for a fast appeal, we will give you an answer within 72 hours after we get your appeal. We will give you our answer sooner if your health requires us to do so.

* However, if you ask for more time or if we need to gather more information, we can take up to 14 more calendar days. If we decide to take extra time to make the decision, we will send you a letter that explains why we need more time.
* If you believe we should not take extra time, you can file a “fast grievance” about our decision to take extra time. When you file a fast grievance, we will respond to your grievance within 24 hours. For more information about the process for filing grievances, including fast grievances, see Section 10 on page <xx>.
* If we do not give you an answer to your appeal within 72 hours or by the end of the extra time (if it was taken), we will automatically send your case to Level 2 of the appeals process. You will be notified when this happens. For more information about the Level 2 Appeal process, go to Section 5.4 on page <xx>.

**If our answer is Yes** to part or all of what you asked for, we must authorize or provide the coverage within 72 hours after we get your appeal.

**If our answer is No** to part or all of what you asked for, we will try to contact you by phone or in person. We will also send you a letter. The letter will tell you that we sent your case to the Integrated Administrative Hearing Office for a Level 2 Appeal. For more information about the Level 2 Appeal process, go to Section 5.4 on page <xx>.

### Will my benefits continue during Level 1 Appeals?

If the IDT, plan, or authorized specialist decided to change or stop coverage for a service, item, or drug that you currently get, we will send you a notice before taking the proposed action.

If you disagree with the action, you can file a Level 1 Appeal. We will continue covering the service, item, or drug if you ask for a Level 1 Appeal **within 10 calendar days of the postmark date on our notice or by the intended effective date of the action**, whichever is later.

If you meet this deadline, you can keep getting the service, item, or drug with no changes while your appeal is pending. All other services, items, or drugs (that are not the subject of your appeal) will also continue with no changes.

## Section 5.4: Level 2 Appeal for services, items, and drugs (but not Medicare Part D drugs)

### If the plan says No at Level 1, what happens next?

If we say **No** to part or all of your Level 1 Appeal, we will automatically send your case to Level 2 of the appeals process for review by the Integrated Administrative Hearing Office.

### What is a Level 2 Appeal?

A Level 2 Appeal is the second appeal, which is done by the Integrated Administrative Hearing Office (IAHO). The IAHO is an independent organization that is not connected to <plan name>. The IAHO is part of the FIDA Administrative Hearing Unit at the State Office of Temporary and Disability Assistance (OTDA).

**What will happen at the Level 2 Appeal?**

We will automatically send any Level 1 denials (in whole or in part) to the IAHO for a Level 2 Appeal. We will notify you that your case was sent to Level 2 and that the IAHO will be in touch. The notice will also provide the contact information for the IAHO in the event that you do not hear from them to schedule your Level 2 Appeal hearing. You should receive a Notice of Administrative Hearing from the IAHO at least 10 calendar days before your hearing date. Your hearing will be conducted by a Hearing Officer in-person or on the phone. You may ask us for a copy of your case file by calling Participant Services at <phone number>.

Your Level 2 Appeal will either be a “standard” appeal or it will be a “fast” appeal. If you had a fast appeal at Level 1, you will automatically have a fast appeal at Level 2. Additionally, if the IAHO determines that you need a fast appeal, they will give you one. Otherwise, you will have a standard appeal.

**Standard Level 2 Appeal:** If your standard appeal is about Medicaid prescription drugs, the IAHO must give you an answer within 7 calendar days of when it gets your appeal. For all other standard appeals, the IAHO must give you an answer within [insert 90 in demonstration year one; insert 62 in demonstration years two and three] calendar days from the date you asked for an appeal with our plan. The IAHO will give you a decision sooner if your health condition requires it.

**Fast Level 2 Appeal:** The IAHO must give you an answer within 72 hours of when it gets your appeal.

### Will my benefits continue during Level 2 Appeals?

If you qualified for continuation of benefits when you filed your Level 1 Appeal, your benefits for the service, item, or drug under appeal will also continue during Level 2. Go to page <xx> for information about continuing your benefits during Level 1 Appeals.

All other services, items, and drugs (that are not the subject of your appeal) will also continue without any changes.

### How will I find out about the decision?

When the IAHO makes a decision, it will send you a letter that explains its decision and provides information about your further appeal rights. If you qualified for a fast appeal, the IAHO will also tell you the decision by phone.

* If the IAHO says **Yes** to part or all of what you asked for, we must authorize the items or services immediately (within no more than 1 business day from the date of the decision).
* If the IAHO says **No** to part or all of what you asked for, it means that they agree with the Level 1 decision. This is called “upholding the decision.” It is also called “turning down your appeal.” You can further appeal the IAHO’s decision.

### If the IAHO’s decision is No for all or part of what I asked for, can I make another appeal?

### If you disagree with the IAHO’s decision, you may appeal that decision further to the Medicare Appeals Council (MAC) for a Level 3 Appeal. The IAHO’s decision is not automatically forwarded to the MAC. Instead, you will have to request that appeal. Instructions on how to file an appeal with the MAC will be included in the IAHO’s decision notice.

See Section 9 on page <xx> for more information on additional levels of appeal.

## Section 5.5: Payment problems

<Plan name> has rules for getting services, items, and drugs. One of the rules is that the services, items, and drugs that you get must be covered by our plan. Another rule is that you must get your services, items, and drugs from providers that our plan works with. Additionally, there are sometimes rules requiring that you get approval to get an item or service before you get it. Chapter 3 [plan may insert reference, as applicable] explains the rules, including special rules for when you first join the plan. If you follow all of the rules, then we will pay for your services, items, and drugs.

If you are not sure if we will pay for a service, item, or drug, ask your Care Manager. Your Care Manager will be able to tell you if we will likely pay for the service, item, or drug, or if you need to ask us for a coverage decision.

If you choose to get a service, item, or drug that is not covered by our plan, or if you get a service, item, or drug from a provider that our plan does not work with, then we will not automatically pay for the service, item, or drug. In that case, you may have to pay for the service, item, or drug yourself.

If you want to ask us for payment, start by reading Chapter 7: “Asking us to pay a bill you have gotten for covered services, items, or drugs.” Chapter 7 describes the situations in which you may need to ask us for reimbursement or to pay a bill you got from a provider. It also tells how to send us the paperwork that asks us for payment.

### What if I followed the rules for getting services, items, and drugs, but I got a bill from a provider?

We do not allow providers to bill you for covered services, items, and drugs. This is true even if we pay the provider less than the provider charges for a covered service, item, or drug. You are never required to pay the balance of any bill. [*Plan with cost sharing inserts*: The only amount you should be asked to pay is the copay for [*insert service, item, and/or drug categories that require a copay*].]

If you get a bill [*plan with cost sharing inserts*: that is more than your copay] for covered services, items, or drugs, send the bill to us. **You should not pay the bill yourself.** We will contact the provider directly and take care of the problem.

### Can I ask to be paid back for a service, item, or drug I paid for?

Remember, if you get a bill [*plan with cost sharing inserts*: that is more than your copay] for a covered service, item, or drug, you should not pay the bill yourself. But if you are billed by mistake and pay the bill, you can get a refund if you followed the rules for getting services, items, and drugs.

If you are asking to be paid back, you are asking the plan or your Interdisciplinary Team (IDT) for a coverage decision. The plan or your IDT will decide if the service, item, or drug you paid for is covered, and will check to see if you followed all the rules for using your coverage.

* If the service, item, or drug you paid for is covered and you followed all the rules, we will reimburse you for the cost of the service, item, or drug within 60 calendar days after we get your request.
* If you haven’t paid for the service, item, or drug yet, we will send the payment directly to your provider. When we send the payment, it’s the same as saying **Yes** to your request for a coverage decision.
* If the service, item, or drug is not covered, or you did not follow all the rules, we will send you a letter telling you that we will not pay for the service, item, or drug, and explaining why.

### What if the plan or your IDT says the plan will not pay?

If you do not agree with the plan or your IDT’s decision, **you can make an appeal**. Follow the appeals process described in Section 5.3 on page <xx>. When you follow these instructions, please note:

* If you make an appeal for reimbursement, we must give you our answer within 60 calendar days after we get your appeal.
* If you are asking us to pay you back for a service, item, or drug you already got and paid for yourself, you cannot ask for a fast appeal.

If we answer **No** to your appeal, we will automatically send your case to the Integrated Administrative Hearing Office (IAHO). We will notify you by letter if this happens.

* If the IAHO reverses the decision and says we should pay you, we must send the payment to you or to the provider within 30 calendar days. If the answer to your appeal is **Yes** at any stage of the appeals process after Level 2, we must send the payment you asked for to you or to the provider within 60 calendar days.
* If the IAHO says **No** to your appeal, it means they agree with the decision not to approve your request. (This is called “upholding the decision.” It is also called “turning down your appeal.”) You may appeal this decision to the Medicare Appeals Council, as described in Section 9 on page <xx>.

# Section 6: Medicare Part D drugs

## Section 6.1: What to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your coverage as a Participant of our plan includes many prescription drugs. Most of these drugs are “Part D drugs.” There are a few drugs that Medicare Part D does not cover but that Medicaid may cover. **This section only applies to Part D drug appeals.**

The *List of Covered Drugs* (Drug List), includes some drugs with a [plan should insert symbol used in the List of Covered Drugs to indicate Medicaid covered drugs]. These drugs are **not** Part D drugs. Appeals or coverage decisions about drugs with [plan should insert symbol used in the List of Covered Drugs to indicate Medicaid covered drugs] symbol follow the process in **Section 5** on page <xx>.

### Can I ask for a coverage decision or make an appeal about Part D prescription drugs?

**Yes.** Here are examples of coverage decisions you can ask <plan name> or your Interdisciplinary Team (IDT) to make about your Part D drugs:

* You ask the plan or your IDT to make an exception such as:
  + Asking the plan or your IDT to cover a Part D drug that is not on our *List of Covered Drugs* (Drug List).
  + Asking the plan or your IDT to waive a restriction on our coverage for a drug (such as limits on the amount of the drug you can get).
* You ask the plan or your IDT if a drug is covered for you (for example, when your drug is on our Drug Listbut we require you to get approval before we will cover it for you).

**NOTE:** If your pharmacy tells you that your prescription cannot be filled, you will get a notice explaining who to contact for a coverage decision.

* You ask the plan or your IDT to decide that the plan must pay for a prescription drug you already bought. This is asking for a coverage decision about payment.

The legal term for a coverage decision about your Part D drugs is “coverage determination.”

If you disagree with a coverage decision made by the plan or your IDT, you can appeal. This section tells you how to ask for coverage decisions **and** how to request an appeal.

Use the chart below to help you decide which section has information for your situation:

|  |  |  |  |
| --- | --- | --- | --- |
| **Which of these situations are you in?** | | | |
| Do you need a drug that isn’t on our Drug List or need us to waive a rule or restriction on a drug we cover?  **You can ask us to make an exception.**  (This is a type of coverage decision.)  Start with **Section 6.2** on page <xx>. Also see Sections 6.3 and 6.4 on pages <xx> and <xx>. | Do you want us to cover a drug on our Drug List and you believe you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need?  **You can ask us for a coverage decision.**  Skip ahead to **Section 6.4** on page <xx>. | Do you want to ask us to pay you back for a drug you already got and paid for?  **You can ask us to pay you back.** (This is a type of coverage decision.)  Skip ahead to **Section 6.4** on page <xx>. | Have we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for?  **You can make  an appeal.**  (This means you  are asking us to reconsider.)  Skip ahead to **Section 6.5** on page <xx>. |

## Section 6.2: What is an exception?

An exception is permission to get coverage for a drug that is not normally on our *List of Covered Drugs* or to use the drug without certain rules and limitations. If a drug is not on our *List of Covered Drugs* or is not covered in the way you would like, you can ask the plan or your Interdisciplinary Team (IDT) to make an “exception.”

When you ask for an exception, your prescriber will need to explain the medical reasons why you need the exception.

Here are examples of exceptions that you or your prescriber can ask the plan or your IDT to make:

1. Covering a Part D drug that is not on our *List of Covered Drugs* (Drug List)*.*
2. Removing a restriction on our coverage. There are extra rules or restrictions that apply to certain drugs on our Drug List (for more information, go to Chapter 5 [plan may insert reference, as applicable]).

* The extra rules and restrictions on coverage for certain drugs include:
* [Omit if plan does not use generic substitution.] Being required to use the generic versionof a drug instead of the brand name drug.
* [Omit if plan does not use prior *authorization*.] Getting approval before the plan will cover the drug for you. (This is sometimes called “prior authorization.”)
* [Omit if plan does not use step therapy.]Being required to try a different drug first before the plan will cover the drug you are asking for. (This is sometimes called “step therapy.”)
* [Omit if plan does not use quantity limits] Quantity limits. For some drugs, the plan limits the amount of the drug you can have.

The legal term for asking for removal of a restriction on coverage for a drug is sometimes called asking for a “formulary exception.”

## Section 6.3: Important things to know about asking for exceptions

### Your prescriber must tell us the medical reasons

Your prescriber must give the plan or your Interdisciplinary Team (IDT) a statement explaining the medical reasons for requesting an exception. The decision about the exception will be faster if you include this information from your prescriber when you ask for the exception.

Typically, our Drug List includes more than one drug for treating a particular condition. These are called “alternative” drugs. If an alternative drug would be just as effective as the drug you are asking for and would not cause more side effects or other health problems, the plan or your IDT will generally notapprove your request for an exception.

### <Plan name> or your IDT will say Yes or No to your request for an exception

* If the plan or your IDT says **Yes** to your request for an exception, the exception usually lasts until the end of the calendar year. This is true as long as your provider continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
* If the plan or your IDT says **No**to your request for an exception, you can ask for a review of the decision by making an appeal. Section 6.5 on page <xx> tells how to make an appeal.

The next section tells you how to ask for a coverage decision, including an exception.

## Section 6.4: How to ask for a coverage decision about a Part D drug or reimbursement for a Part D drug, including an exception

At a glance*:* How to ask for a coverage decision about a drug or payment

Call, write, or fax your Care Manager or Participant Services. Or ask your representative or prescriber to ask for a coverage decision for you. You will get an answer on a standard coverage decision within 72 hours. You will get an answer on reimbursing you for a Part D drug you already paid for within 14 calendar days.

* If you are asking for an exception, include the supporting statement from your prescriber.
* You or your prescriber may ask for a fast decision. (Fast decisions usually come within 24 hours.)
* Read this section to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

### What to do

* Ask for the type of coverage decision you want. Call, write, or fax your Care Manager or Participant Services to make your request. You, your representative, or prescriber can do this. You can call Participant Services at <phone number>. You can call your Care Manager at <phone number>.
* You, your prescriber, or your representative can ask for a coverage decision. You can also have a lawyer act on your behalf.
* Read Section 4 on page <xx> to find out how to give permission to someone else to act as your representative.
* You do not need to give your prescriber written permission to ask for a coverage decision on your behalf.
* If you want to ask the plan to pay you back for a drug, read Chapter 7 [plan may insert reference, as applicable] of this handbook. Chapter 7 describes times when you may need to ask for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for the cost of a drug you have paid for.
* If you are asking for an exception, provide the “supporting statement.” Your prescriber must give the plan or your Interdisciplinary Team (IDT) the medical reasons for the drug exception. We call this the “supporting statement.”
* Your prescriber can fax or mail the statement to us. Or your prescriber can speak with us on the phone, and then fax or mail a statement.

### If your health requires it, ask for a “fast coverage decision”

The “standard deadlines” will apply unless the plan or your IDT have agreed to use the “fast deadlines.”

* A **standard coverage decision** means the plan or your IDT will give you an answer within 72 hours after your prescriber’s statement is received.
* A **fast coverage decision** means the plan or your IDT will give you an answer within 24 hours after your prescriber’s statement is received.

The legal term for “fast coverage decision” is “expedited coverage determination.”

You can get a fast coverage decision **only if you are asking for a drug you have not yet received**. (You cannot get a fast coverage decision if you are asking us to pay you back for a drug you already bought.)

You can get a fast coverage decision **only if using the standard deadlines could cause serious harm to your health or hurt your ability to function**.

* + If your prescriber says that your health requires a “fast coverage decision,” the plan or your IDT will automatically agree to give you a fast coverage decision, and the letter will tell you that.
* If you ask for a fast coverage decision on your own (without your prescriber’s support), the plan or your IDT will decide whether you get a fast coverage decision.
* If the plan or your IDT decides that your medical condition does not meet the requirements for a fast coverage decision, the standard deadline will be used instead. You will get a letter telling you that. The letter will tell you how to file a grievance about the decision to give you a standard decision. You can file a “fast grievance” and get a response to your grievance within 24 hours. For more information about the process for filing grievances, including fast grievances, see Section 10 on page <xx>.

### Deadlines for a “fast coverage decision”

* If the plan or your IDT is using the fast deadlines, you will get an answer within 24 hours. This means within 24 hours after the plan or your IDT gets your request. Or, if you are asking for an exception, 24 hours after the plan or your IDT gets your prescriber’s statement supporting your request. You will get an answer sooner if your health requires it.
* If the plan or your IDT does not meet this deadline, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your request.
* **If the answer is Yes** to part or all of what you asked for, we must give you the coverage within 24 hours after your request is received or your prescriber’s supporting statement is received.
* **If the answer is No** to part or all of what you asked for, you will receive a letter explaining why. The letter will also explain how you can appeal our decision.

### Deadlines for a “standard coverage decision” about a drug you have not yet received

* If the plan or your IDT is using the standard deadlines, you will get an answer within 72 hours after your request is received. Or, if you are asking for an exception, after your prescriber’s supporting statement is received. You will get an answer sooner if your health requires it.
* If the plan or your IDT does not meet this deadline, we will send your request on to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your request.
* **If the answer is Yes** to part or all of what you asked for, we must approve or give the coverage within 72 hours of your request or, if you are asking for an exception, your prescriber’s supporting statement.
* **If the answer is No** to part or all of what you asked for, you will receive a letter explaining why. The letter will also explain how you can appeal the decision.

### Deadlines for a “standard coverage decision” about payment for a drug you have already bought

* The plan or your IDT must give you an answer within 14 calendar days after your request is received.
* If the plan or your IDT does not meet this deadline, we will send your request to Level 2 of the appeals process. At level 2, an Independent Review Entity will review your request.
* **If the answer is Yes** to part or all of what you asked for, we will make payment to you within 14 calendar days after your request is received.
* **If the answer is No** to part or all of what you asked for, you will receive a letter explaining why. The letter will also explain how you can appeal the decision.

## Section 6.5: Level 1 Appeal for Part D drugs

* To start your appeal, you, your prescriber, or your representative must contact us.

At a glance:How to make a Level 1 Appeal

You, your prescriber, or your representative may put your request in writing and mail or fax it to us. You may also ask for an appeal by calling us.

* Ask **within 60 calendar days** of the decision you are appealing. If you miss the deadline for a good reason, you may still appeal.
* You, your prescriber, or your representative can call us to ask for a fast appeal.
* Read this section to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.
* If you are asking for a standard appeal, you can make your appeal by sending a request in writing. You may also ask for an appeal by calling us at <phone number>.
* If you want a fast appeal, you may make your appeal in writing or you may call us.
* Make your appeal request **within 60 calendar days** from the date on the notice that tells you the decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. For example, good reasons for missing the deadline would be if you have a serious illness that kept you from contacting us or if we gave you incorrect or incomplete information about the deadline for requesting an appeal.

The legal term for an appeal to the plan about a Part D drug coverage decision is plan “redetermination.”

* You have the right to ask us for a copy of the information about your appeal. To ask for a copy, call Participant Services at <phone number>.

If you wish, you and your prescriber may give us additional information to support your appeal.

### If your health requires it, ask for a “fast appeal”

* If you are appealing a decision the plan or your IDT made about a drug you have not yet received, you and your prescriber will need to decide if you need a “fast appeal.”
* The requirements for getting a “fast appeal” are the same as those for getting a “fast coverage decision” in Section 6.4 on page <xx>.

### Our plan will review your appeal and give you our decision

The legal term for “fast appeal” is “expedited redetermination.”

* We take another careful look at all of the information about your coverage request. We check to see if all the rules were followed when the plan or your IDT said **No**to your request. We may contact you or your prescriber to get more information. The reviewer will be someone who did not make the original coverage decision.

### Deadlines for a “fast appeal”

* If we are using the fast deadlines, we will give you our answer within 72 hours after we get your appeal, or sooner if your health requires it.
* If we do not give you an answer within 72 hours, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your appeal.
* **If our answer is Yes** to part or all of what you asked for, we must give the coverage within 72 hours after we get your appeal.
* **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No** and tells how to appeal our decision.

### Deadlines for a “standard appeal”

* If we are using the standard deadlines, we must give you our answer within 7 calendar days after we get your appeal, or sooner if your health requires it, except if you are asking us to pay you back for a drug you already bought. If you are asking us to pay you back for a drug you already bought, we must give you our answer within 14 calendar days after we get your appeal. If you think your health requires it, you should ask for a “fast appeal.”
* If we do not give you a decision within 7 calendar days, or 14 days if you asked us to pay you back for a drug you already bought, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your appeal.
* **If our answer is Yes** to part or all of what you asked for:
* If we approve a request for coverage, we must give you the coverage as quickly as your health requires, but no later than 7 calendar days after we get your appeal or 14 days if you asked us to pay you back for a drug you already bought.
* If we approve a request to pay you back for a drug you already bought, we will send payment to you within 30 calendar days after we get your appeal request.
* **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No**and tells how to appeal our decision.

## Section 6.6: Level 2 Appeal for Part D drugs

If we say **No**to part or all of your appeal, you can choose whether to accept this decision or make another appeal. If you decide to go on to a Level 2 Appeal, the Independent Review Entity (IRE) will review our decision.

At a glance:How to make a Level 2 Appeal

If you want the Independent Review Entity to review your case, your appeal request must be in writing.

* Ask **within 60 calendar days** of the decision you are appealing. If you miss the deadline for a good reason, you may still appeal.
* You, your prescriber, or your representative can request the Level 2 Appeal.
* Read this section to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.
* If you want the IRE to review your case, your appeal request must be in writing. The letter we send about our decision in the Level 1 Appeal will explain how to request the Level 2 Appeal.
* When you make an appeal to the IRE, we will send them your case file. You have the right to ask us for a copy of your case file by calling Participant Services at <phone number>.
* You have a right to give the IRE other information to support your appeal.
* The IRE is an independent organization that is hired by Medicare. It is not connected with the plan and it is not a government agency.
* Reviewers at the IRE will take a careful look at all of the information related to your appeal. The organization will send you a letter explaining its decision.

The legal term for an appeal to the IRE about a Part D drug is “reconsideration.”

### Deadlines for “fast appeal” at Level 2

* If your health requires it, ask the Independent Review Entity (IRE) for a “fast appeal.”
* If the IRE agrees to give you a “fast appeal,” it must give you an answer to your Level 2 Appeal within 72 hours after getting your appeal request.
* If the IRE says **Yes** to part or all of what you asked for, we must authorize or give you the drug coverage within 24 hours after we get the decision.

### Deadlines for “standard appeal” at Level 2

* If you have a standard appeal at Level 2, the Independent Review Entity (IRE) must give you an answer to your Level 2 Appeal within 7 calendar days after it gets your appeal, or 14 days if you asked us to pay you back for a drug you already bought.
* If the IRE says **Yes** to part or all of what you asked for, we must authorize or give you the drug coverage within 72 hours after we get the decision.
* If the IRE approves a request to pay you back for a drug you already bought, we will send payment to you within 30 calendar days after we get the decision.

### What if the Independent Review Entity says No to your Level 2 Appeal?

**No** means the Independent Review Entity (IRE) agrees with our decision not to approve your request. This is called “upholding the decision.” It is also called “turning down your appeal.”

If you want to go to Level 3 of the appeals process, the drugs you are requesting must meet a minimum dollar value. If the dollar value is less than the minimum, you cannot appeal any further. If the dollar value is high enough, you can ask for a Level 3 appeal. The letter you get from the IRE will tell you the dollar value needed to continue with the appeal process.

# Section 7: Asking us to cover a longer hospital stay

When you are admitted to a hospital, you have the right to get all hospital services that we cover that are necessary to diagnose and treat your illness or injury.

During your covered hospital stay, your doctor, Interdisciplinary Team (IDT), and the hospital staff will work with you to prepare for the day when you leave the hospital. They will also help arrange for any care you may need after you leave.

* The day you leave the hospital is called your “discharge date.”
* Your doctor, IDT, or the hospital staff will tell you what your discharge date is.

If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay. There is a special, faster process for appealing hospital discharge decisions. It is handled by the Medicare-designated Quality Improvement Organization (QIO). It is highly recommended that you use the faster process instead of the regular appeal process described in Section 5 on page <xx>. However, both options are available to you. This section tells you how to ask for a QIO appeal, and also reminds you about your appeal option with the plan.

## Section 7.1: Learning about your Medicare rights

Within two days after you are admitted to the hospital, a caseworker or nurse will give you a notice called “An Important Message from Medicare about Your Rights”. If you do not get this notice, ask any hospital employee for it. If you need help, please call Participant Services at <toll-free number>. You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

Read this notice carefully and ask questions if you don’t understand. The “Important Message” tells you about your rights as a hospital patient, including your rights to:

* Get Medicare-covered services during and after your hospital stay. You have the right to know what these services are, who will pay for them, and where you can get them.
* Be a part of any decisions about the length of your hospital stay.
* Know where to report any concerns you have about the quality of your hospital care.
* Appeal if you think you are being discharged from the hospital too soon.

You should sign the Medicare notice to show that you got it and understand your rights. Signing the notice does **not** mean you agree to the discharge date that may have been told to you by your doctor or hospital staff.

Keep your copy of the signed notice so you will have the information in it if you need it.

* To look at a copy of this notice in advance, you can call Participant Services at <toll-free number>. You can also call 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. The call is free.
* You can also see the notice online at <https://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html>.
* If you need help, please call Participant Services or Medicare at the numbers listed above.

## Section 7.2: Quality Improvement Organization (QIO) Level 1 Appeal to change your hospital discharge date

If you want us to cover your inpatient hospital services for a longer time, you must request an appeal. This section tells you how to ask for a Level 1 Appeal with the Quality Improvement Organization. The Quality Improvement Organization will do a Level 1 Appeal review to see if your planned discharge date is medically appropriate for you.

In New York, the Quality Improvement Organization is called Livanta. To make a Level 1 Appeal to change your discharge date, call Livanta at **1-866-815-5440.**

### Call right away!

Call the Quality Improvement Organization **before** you leave the hospital and no later than your planned discharge date. “An Important Message from Medicare about Your Rights” contains information on how to reach the Quality Improvement Organization.

* If you call before you leave, you are allowed to stay in the hospital afteryour planned discharge date without paying for it while you wait to get the decision on your appeal from the Quality Improvement Organization.

At a glance:How to make a Level 1 Appeal to change your discharge date

Call the Quality Improvement Organization for your state at **1-866-815-5440** and ask for a “fast review”.

Call before you leave the hospital and before your planned discharge date.

* If you do not call to appeal, and you decide to stay in the hospital after your planned discharge date, you may have to pay all of the costs for hospital care you get after your planned discharge date.
* If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our plan instead. For details, see Section 7.4 on page <xx>.

We want to make sure you understand what you need to do and what the deadlines are.

* **Ask for help if you need it**. If you have questions or need help at any time, please call Participant Services at <toll-free number>. You can also call the Health Insurance Information, Counseling and Assistance Program (HIICAP) at 1-800-701-0501. You may also call the Independent Consumer Advocacy Network (ICAN) at 1-844-614-8800.

### What is a Quality Improvement Organization?

It is a group of doctors and other health care professionals who are paid by the federal government. These experts are not part of our plan. They are paid by Medicare to check on and help improve the quality of care for people with Medicare.

### Ask for a “fast review”

You must ask the Quality Improvement Organization for a **“fast review”** of your discharge. Asking for a “fast review” means you are asking the organization to use the fast deadlines for an appeal instead of using the standard deadlines.

The legal term for “fast review” is “immediate review.”

### What happens during the fast review?

* The reviewers at the Quality Improvement Organization will ask you or your representative why you think coverage should continue after the planned discharge date. You don’t have to prepare anything in writing, but you may do so if you wish.
* The reviewers will look at your medical record, talk with your provider, and review all of the information related to your hospital stay.
* By noon of the day after the reviewers tell us about your appeal, you will get a letter that gives your planned discharge date. The letter explains the reasons why your provider, the hospital, and we think it is right for you to be discharged on that date.

The legal term for this written explanation is called the “Detailed Notice of Discharge.” You can get a sample by calling Participant Services at <toll-free number>. You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users call 1-877-486-2048.) Or you can see a sample notice online at <https://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html>

### What if the answer is Yes?

* If the Quality Improvement Organization says **Yes** to your appeal, we must keep covering your hospital services for as long as they are medically necessary.

### What if the answer is No?

* If the Quality Improvement Organization says **No** to your appeal, they are saying that your planned discharge date is medically appropriate. If this happens, our coverage for your inpatient hospital services will end at noon on the day after the Quality Improvement Organization gives you its answer.
* If the Quality Improvement Organization says **No** and you decide to stay in the hospital, then you may have to pay for your continued stay at the hospital. The cost of the hospital care that you may have to pay begins at noon on the day after the Quality Improvement Organization gives you its answer.
* If the Quality Improvement Organization turns down your appeal and you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal.

## Section 7.3: Quality Improvement Organization (QIO) Level 2 Appeal to change your hospital discharge date

If the Quality Improvement Organization has turned down your appeal and you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. You will need to contact the Quality Improvement Organization again and ask for another review.

Ask for the Level 2 review **within 60 calendar days** after the day when the Quality Improvement Organization said **No** to your Level 1 Appeal. You can ask for this review only if you stayed in the hospital after the date that your coverage for the care ended.

In New York, the Quality Improvement Organization is called Livanta. You can reach Livanta at **1-866-815-5440.**

* Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

At a glance:How to make a Level 2 Appeal to change your discharge date

Call the Quality Improvement Organization for your state at **1-866-815-5440** and ask for another review.

* Within 14 calendar days of receipt of your request for a second review, the Quality Improvement Organization reviewers will make a decision.

### What happens if the answer is Yes?

* We must pay you back for our share of the costs of hospital care you got since noon on the day after the date of your first appeal decision. We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary.
* You must continue to pay your share of the costs and coverage limitations may apply.

### What happens if the answer is No?

It means the Quality Improvement Organization agrees with the Level 1 decision and will not change it. The letter you get will tell you what you can do if you wish to continue with the appeal process.

If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your stay after your planned discharge date.

## Section 7.4: What happens if I miss an appeal deadline?

If you miss the Level 1 appeal deadline with the Quality Improvement Organization, you can still file an appeal directly with our plan. Follow the same process described in Section 5 on page <xx>, which is also summarized below.

### Level 1 Alternate Appeal to change your hospital discharge date

If you miss the deadline for contacting the Quality Improvement Organization, you can file an appeal with our plan. Ask us for a “fast review.” A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

* During this review, we take a look at all of the information about your hospital stay. We check to see if the decision about when you should leave the hospital was fair and followed all the rules.

At a glance:How to make a Level 1 Alternate Appeal

Call our Participant Services number and ask for a “fast review” of your hospital discharge date.

We will give you our decision within 72 hours.

* We will use the fast deadlines rather than the standard deadlines for giving you the answer to this review. This means we will give you our decision as fast as your condition requires but no later than 72 hours after you ask for a “fast review.”
* **If we say Yes to your fast review,** it means we agree that you still need to be in the hospital after the discharge date. We will keep covering hospital services for as long as it is medically necessary. It also means that we agree to pay you back for our share of the costs of care you got since the date when we said your coverage would end.
* **If we say No to your fast review,** we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends on the day we said coverage would end.
* If you stayed in the hospital after your planned discharge date, then **you may have to pay the full cost** of hospital care you got after the planned discharge date.
* To make sure we were following all the rules when we said **No**to your fast appeal, we will send your appeal to the Integrated Administrative Hearing Office. When we do this, it means that your case is automatically going to Level 2 of the appeals process.

The legal term for “fast review” or “fast appeal” is “expedited appeal.”

### 

### Level 2 Alternate Appeal to change your hospital discharge date

If we do not agree with you that your hospital discharge date should be changed, we will send the information for your Level 2 Appeal to the Integrated Administrative Hearing Office (IAHO) within 2 business days of the Level 1 decision being reached. If you think we are not meeting this deadline or other deadlines, you can file a grievance. Section 10 on page <xx> tells how to file a grievance.

During the Level 2 Appeal, the IAHO reviews the decision we made when we said **No**to your “fast review.” This organization decides whether the decision we made should be changed.

At a glance:How to make a Level 2 Alternate Appeal

You do not have to do anything. The plan will automatically send your appeal to the Integrated Administrative Hearing Office (IAHO).

* The IAHO does a “fast review” of your appeal. The reviewers give you an answer within 72 hours.
* The IAHO is not connected with our plan.
* A Hearing Officer from the IAHO will take a careful look at all of the information related to your appeal of your hospital discharge.
* If the IAHO says **Yes** to your appeal, then we must pay you back for our share of the costs of hospital care you have received since the date of your planned discharge. We must also continue our coverage of your hospital services for as long as it is medically necessary.
* If the IAHO says **No** to your appeal, it means they agree with us that your planned hospital discharge date was medically appropriate.
* The letter you get from the IAHO will tell you what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled the Medicare Appeals Council (MAC). Section 9 of this chapter has more information about additional appeal levels.

# Section 8: What to do if you think your home health care, skilled nursing care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon

This section is about the following types of care only:

* Home health care services.
* Skilled nursing care in a skilled nursing facility.
* Rehabilitation care you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major operation.
* With any of these three types of care, you have the right to keep getting covered services for as long as your provider or Interdisciplinary Team (IDT) says you need it.
* When we decide to stop covering any of these, we must tell you before your services end. When your coverage for that care ends, we will stop paying for your services.

If you think we are ending the coverage of your care too soon, **you can appeal our decision**. There is a special, faster process for appealing these types of coverage decisions. It is handled by the Medicare-designated Quality Improvement Organization (QIO). It is highly recommended that you use the faster process instead of the regular appeal process described in Section 5 on page <xx>. However, both options are available to you. This section tells you how to ask for a QIO appeal, and also reminds you about your appeal option with the plan.

## Section 8.1: We will tell you in advance when your coverage will be ending

You will get a notice at least two days before we stop paying for your services. This is called the “Notice of Medicare Non-Coverage”.

* The written notice tells you the date when we will stop covering your services.
* The written notice also tells you how to appeal this decision.

You or your representative should sign the written notice to show that you got it. Signing it does **not** mean you agree with the plan that it is time to stop getting services.

When your coverage ends, we will stop paying for your services.

## Section 8.2: Quality Improvement Organization (QIO) Level 1 Appeal to continue your care

If you think we are ending coverage of your services too soon, you can file an appeal. This section tells you how to ask for a Level 1 Appeal with the Quality Improvement Organization.

Before you start your appeal, understand what you need to do and what the deadlines are.

* **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a grievance. Section 10 on page <xx> tells you how to file a grievance.)
* **Ask for help if you need it**. If you have questions or need help at any time, please call Participant Services at <phone number>. Or call the Health Insurance Information, Counseling and Assistance Program (HIICAP) at 1-800-701-0501.

During a Level 1 Appeal, the Quality Improvement Organization will review your appeal and decide whether to change the decision we made. In New York, the Quality Improvement Organization is called Livanta. You can reach Livanta at **1-866-815-5440**.Information about appealing to the Quality Improvement Organization is also in the Notice of Medicare Non-Coverage*.* This is the notice you got when you were told we would stop covering your care.

At a glance:How to make a Level 1 Appeal to ask the plan to continue your care

Call the Quality Improvement Organization for your state at **1-866-815-5440** and ask for a “fast-track appeal.”

Call before you leave the agency or facility that is providing your care and before your planned discharge date.

### What is a Quality Improvement Organization?

It is a group of doctors and other health care professionals who are paid by the federal government. These experts are not part of our plan. They are paid by Medicare to check on and help improve the quality of care for people with Medicare.

### What should you ask for?

Ask them for a “fast-track appeal.” This is an independent review of whether it is medically appropriate for us to end coverage for your services.

### What is your deadline for contacting this organization?

* You must contact the Quality Improvement Organization no later than noon of the day after you got the written notice telling you when we will stop covering your care*.*
* If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to us instead. For details about this other way to make your appeal, see Section 8.4 on page <xx>.

The legal term for the written notice is “Notice of Medicare Non-Coverage”. To get a sample copy, call Participant Services at <phone number> or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or see a copy online at <https://www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.html>

### What happens during the Quality Improvement Organization’s review?

* The reviewers at the Quality Improvement Organization will ask you or your representative why you think coverage for the services should continue. You don’t have to prepare anything in writing, but you may do so if you wish.
* When you ask for an appeal, the plan must write a letter to you and the Quality Improvement Organization explaining why your services should end.
* The reviewers will also look at your medical records, talk with your provider, and review information that the plan has given to them.
* **Within one full day after reviewers have all the information they need, they will tell you their decision.** You will get a letter explaining the decision.

The legal term for the letter explaining why your services should end is “Detailed Explanation of Non-Coverage.”

### What happens if the reviewers say Yes?

* If the reviewers say **Yes** to your appeal, then we must keep providing your covered services for as long as they are medically necessary.

### What happens if the reviewers say No?

* If the reviewers say **No** to your appeal, then your coverage will end on the date we told you. We will stop paying our share of the costs of this care.
* If you decide to keep getting the home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the date your coverage ends, then you will have to pay the full cost of this care yourself.

## Section 8.3: Quality Improvement Organization (QIO) Level 2 Appeal to continue your care

If the Quality Improvement Organization said **No**to the Level 1 Appeal **and** you choose to continue getting care after your coverage for the care has ended, you can make a Level 2 Appeal.

During the Level 2 Appeal, the Quality Improvement Organization will take another look at the decision they made at Level 1. If they say they agree with the Level 1 decision, you may have to pay the full cost for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the date when we said your coverage would end.

In New York, the Quality Improvement Organization is called Livanta. You can reach Livanta at 1-866-815-5440. Ask for the Level 2 review **within 60 calendar days** after the day when the Quality Improvement Organization said **No** to your Level 1 Appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

At a glance:How to make a Level 2 Appeal to require that the plan cover your care for longer

Call the Quality Improvement Organization for your state at 1-866-815-5440 and ask for another review.

Call before you leave the agency or facility that is providing your care and before your planned discharge date.

* Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.
* The Quality Improvement Organization will make its decision within 14 calendar days of receipt of your appeal request.

### What happens if the review organization says Yes?

* We must pay you backfor our share of the costs of care you got since the date when we said your coverage would end. We must continue providing coveragefor the care for as long as it is medically necessary.

### What happens if the review organization says No?

* It means they agree with the decision they made on the Level 1 Appeal and will not change it.
* The letter you get will tell you what to do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

## Section 8.4: What if you miss the deadline for making your Level 1 Appeal?

If you miss the Level 1 appeal deadline with the Quality Improvement Organization, you can still file an appeal directly with our plan. Follow the same process described in Section 5 on page <xx>, which is also summarized below.

### Level 1 Alternate Appeal to continue your care for longer

If you miss the deadline for contacting the Quality Improvement Organization, you can file an appeal with our plan. Ask us for a “fast review.” A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

At a glance:How to make a Level 1 Alternate Appeal

Call our Participant Services number and ask for a “fast review.”

We will give you our decision within 72 hours.

* During this review, we take a look at all of the information about your home health care, skilled nursing facility care, or care you are getting at a Comprehensive Outpatient Rehabilitation Facility (CORF). We check to see if the decision about when your services should end was fair and followed all the rules.
* We will use the fast deadlines rather than the standard deadlines for giving you the answer to this review. We will give you our decision as quickly as your condition requires but not later than 72 hours after you ask for a “fast review.”
* **If we say Yes** to your fast review, it means we agree that we will keep covering your services for as long as it is medically necessary. It also means that we agree to pay you back for our share of the costs of care you got since the date when we said your coverage would end.
* **If we say No** to your fast review, we are saying that stopping your services was medically appropriate. Our coverage ends as of the day we said coverage would end.

If you continue getting services after the day we said they would stop, **you may have to pay the full cost** of the services.

To make sure we were following all the rules when we said **No**to your fast appeal, we will send your appeal to the Integrated Administrative Hearing Office. When we do this, it means that your case is automatically going to Level 2 of the appeals process.

The legal term for “fast review” or “fast appeal” is “expedited appeal.”

### Level 2 Alternate Appeal to continue your care for longer

If we do not agree with you that your services should continue, we will send the information for your Level 2 Appeal to the Integrated Administrative Hearing Office (IAHO) within 2 business days of the Level 1 decision being reached. If you think we are not meeting this deadline or other deadlines, you can file a grievance. Section 10 on page <xx> tells how to file a grievance.

During the Level 2 Appeal, the IAHO reviews the decision we made when we said **No**to your “fast review.” This organization decides whether the decision we made should be changed.

At a glance:How to make a Level 2 Alternate Appeal to require that the plan continue your care

You do not have to do anything. The plan will automatically send your appeal to the Integrated Administrative Hearing Office (IAHO).

* The IAHO does a “fast review” of your appeal. The reviewers give you an answer within 72 hours.
* The IAHO is not connected with our plan.
* A Hearing Officer from the IAHO will take a careful look at all of the information related to your appeal.
* If the IAHO says **Yes** to your appeal,then we must pay you back for our share of the costs of care. We must also continue our coverage of your services for as long as it is medically necessary.
* If the IAHO says **No** to your appeal, it means they agree with us that stopping coverage of services was medically appropriate.

The letter you get from the IAHO will tell you what you can do if you wish to continue with the review process. It will give you details about how to go on to a Level 3 Appeal with the Medicare Appeals Council. Section 9 on page <xx> has more information about additional appeal levels.

# Section 9: Taking your appeal beyond Level 2

## Section 9.1: Next steps for services, items, and drugs (not Medicare Part D drugs)

If you made a Level 1 Appeal and a Level 2 Appeal as described in Sections 5, 7, or 8, and both your appeals have been turned down, you may have the right to additional levels of appeal. The letter you get from the Integrated Administrative Hearing Office (IAHO) will tell you what to do if you wish to continue the appeals process.

Level 3 of the appeals process is a review by the Medicare Appeals Council. After that, you may have the right to ask a federal court to look at your appeal.

If you need assistance at any stage of the appeals process, you can contact the Independent Consumer Advocacy Network (ICAN). The phone number is 1-844-614-8800.

## Section 9.2: Next steps for Medicare Part D drugs

If you made a Level 1 Appeal and a Level 2 Appeal for Medicare Part D drugs as described in Section 6, and both your appeals have been turned down, you may have the right to additional levels of appeal. The letter you get from the Independent Review Entity will tell you what to do if you wish to continue the appeals process.

Level 3 of the appeals process is an Administrative Law Judge (ALJ) hearing. The person who makes the decision in a Level 3 appeal is an ALJ or an attorney adjudicator. If you want an ALJ or attorney adjudicator to review your case, the drugs you are requesting must meet a minimum dollar amount. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, you can ask an ALJ or attorney adjudicator to hear your appeal.

If you do not agree with the ALJ or attorney adjudicator’s decision, you can go to the Medicare Appeals Council. After that, you may have the right to ask a federal court to look at your appeal.

If you need assistance at any stage of the appeals process, you can contact the Independent Consumer Advocacy Network (ICAN). The phone number is 1-844-614-8800.

# Section 10: How to file a grievance

### What kinds of problems should be grievances?

“Filing a grievance” is another way of saying “making a complaint.” The grievance process is used for certain types of problems only,such as problemsrelated to quality of care, waiting times, and customer service. Here are examples of the kinds of problems handled by the grievance process.

### Grievances about quality

At a glance*:* How to file a grievance

You can file an internal grievance with our plan and/or an external grievance with an organization that is not connected to our plan.

To file an internal grievance, call Participant Services or send us a letter.

There are different organizations that handle external grievances. For more information, read Section 10.2 on page <xx>.

* You are unhappy with the quality of care, such as the care you got in the hospital.

### Grievances about privacy

* You think that someone did not respect your right to privacy, or shared information about you that is confidential.

### Grievances about poor customer service

* A health care provider or staff was rude or disrespectful to you.
* <Plan name> staff treated you poorly.
* You think you are being pushed out of the plan.

### Grievances about accessibility

* You cannot physically access the health care services and facilities in a provider’s office.
* Your provider does not give you a reasonable accommodation you need such as an American Sign Language interpreter.

### Grievances about waiting times

* You are having trouble getting an appointment, or waiting too long to get it.
* You have been kept waiting too long by providers, pharmacists, or other health professionals or by Participant Services or other plan staff.

### Grievances about cleanliness

* You think the clinic, hospital or provider’s office is not clean.

### Grievances about language access

* Your provider does not provide you with an interpreter during your appointment.

### Grievances about communications from us

* You think we failed to give you a notice or letter that you should have received.
* You think the written information we sent you is too difficult to understand.

### Grievances about the timeliness of our actions related to coverage decisions or appeals

* You believe that we are not meeting our deadlines for making a coverage decision   
  or answering your appeal.
* You believe that, after getting a coverage or appeal decision in your favor, we are not meeting the deadlines for approving or giving you the service or paying you back for certain services.
* You believe we did not forward your case to the Integrated Administrative Hearing Office or Independent Review Entity on time.

### Are there different types of grievances?

**Yes**. You may file an internal grievance and/or an external grievance. An internal grievance is filed with and reviewed by our plan. An external grievance is filed with and reviewed by an organization that is not affiliated with our plan. If you need help filing an internal and/or external grievance, you can call the Independent Consumer Advocacy Network (ICAN) at 1-844-614-8800.

## Section 10.1: Internal grievances

To file an internal grievance, call Participant Services at <toll-free number>. You can make the grievance at any time unless it is about a Part D drug. If the grievance is about a Part D drug, you must make it **within 60 calendar days** after you had the problem you want to complain about.

* + If there is anything else you need to do, Participant Services will tell you.
  + You can also write your grievance and send it to us.If you put your grievance in writing, we will respond to your grievance in writing.
  + [Insert additional description of the procedures (including time frames) and instructions about what Participants need to do if they want to use the process for filing a grievance, including a fast grievance.]

The legal term for “fast grievance” is “expedited grievance.”

We answer most grievances within 30 calendar days. If possible, we will answer you right away. If you call us with a grievance, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.

* If you need a response faster because of your health, we will give you an answer within 48 hours after we get all necessary information (but no more than 7 calendar days from the receipt of your grievance).
* If you are filing a grievance because we denied your request for a “fast coverage decision” or a “fast appeal,” we will automatically give you a “fast grievance” and respond to your grievance within 24 hours.
* If you are filing a grievance because we took extra time to make a coverage decision, we will automatically give you a “fast grievance” and respond to your grievance within 24 hours.

If we need more information and the delay is in your best interest, or if you ask for more time, we can take up to 14 more calendar days to answer your grievance. We will tell you in writing why we need more time.

**If we do not agree** with some or all of your grievance, we will tell you and give you our reasons. We will respond whether we agree with the grievance or not. If you disagree with our decision, you can file an external grievance.

## Section 10.2: External grievances

### You can tell Medicare about your grievance

You can send your grievance (complaint) to Medicare. The Medicare Complaint Form is available at: <https://www.medicare.gov/MedicareComplaintForm/home.aspx>.

Medicare takes your complaints seriously and will use this information to help improve   
the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the plan is not addressing   
your problem, please call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call   
1-877-486-2048. The call is free.

Your grievance will be sent to the Medicare and Medicaid team overseeing our plan and the FIDA-IDD Program.

### You can tell the New York State Department of Health about your grievance

To file a grievance with the New York State Department of Health (NYSDOH), call the NYSDOH Helpline at 1-866-712-7197. Your grievance will be sent to the Medicare and Medicaid team overseeing our plan and the FIDA-IDD Program.

### You can file a grievance with the Office for Civil Rights

You can file a grievance with the Department of Health and Human Services’ Office for Civil Rights if you think you have not been treated fairly. For example, you can file a grievance about disability access or language assistance. The phone number for the Office for Civil Rights is 1-800-368-1019. TTY users should call 1-800-537-7697. You can also visit <http://www.hhs.gov/ocr> for more information.

You may also contact the local Office for Civil Rights office at:

[The plan should insert contact information for the OCR regional office.]

You may also have rights under the Americans with Disability Act and under [plan may insert relevant state law.] You can contact the Independent Consumer Advocacy Network (ICAN) for assistance. The phone number is 1-844-614-8800.

### You can file a grievance with the Quality Improvement Organization

When your grievance is about quality of care, you also have two choices:

* If you prefer, you can make your grievance about the quality of care directly to the Quality Improvement Organization (without making the grievance to us).
* Or you can make your grievance tous **and**to the Quality Improvement Organization. If you make a grievance to this organization, we will work with them to resolve your grievance.

The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients. To learn more about the Quality Improvement Organization, see Chapter 2.

In New York, the Quality Improvement Organization is called Livanta. The phone number for Livanta is **1-866-815-5440**.