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

**Note: This version of Chapter 9 should be used by plans with Medi-Cal products that are subject to Knox-Keene licensure requirements.**

[Plans should refer members 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 [plans may insert reference, as applicable] is listed next to each cross reference throughout the handbook.]

[In cases where members should contact a department other than Member Services (for example, a grievance and appeals unit), plans should revise the instructions about contacting Member Services.]

What’s in this chapter?

This chapter has information about your 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 medication that your plan has said it will not pay for.
* You disagree with a decision your plan has made about your care.
* You think your covered services are ending too soon.
* You have a problem or complaint with your long-term services and supports, which include Multipurpose Senior Services Program (MSSP)[Plan shall change “Multipurpose Senior Services Program (MSSP)” to the term “Care Planning and Management (CPM)”, once the plan’s county has transitioned MSSP into Managed Care], Community-Based Adult Services (CBAS), and Nursing Facility (NF) services.

**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 what you are looking for.

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 doctor and other providers determine are necessary for your care as a part of your care plan. **If you are having a problem with your care, you can call the Cal MediConnect Ombuds Program at 1-855-501-3077 for help.** This chapter explains the different options you have for different problems and complaints, but you can always call the Cal MediConnect Ombuds Program to help guide you through your problem. For additional resources to address your concerns and ways to contact them, see Chapter 2 [plans should insert reference, as appropriate]for more information on ombudsman programs.

[Plans 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 Medi-Cal 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 about the legal terms?

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:

* “Making a complaint” rather than “filing a grievance”
* “Coverage decision” rather than “organization determination,” “benefit determination,” “at-risk determination,” or “coverage determination”
* “Fast coverage decision” rather than “expedited determination”

Knowing the proper legal terms may 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 Cal MediConnect Ombuds Program

If you need help, you can always call the Cal MediConnect Ombuds Program. The Cal MediConnect Ombuds Program is an ombudsman program that can answer your questions and help you understand what to do to handle your problem. The Cal MediConnect Ombuds Program is not connected with us or with any insurance company or health plan. They can help you understand which process to use. The phone number for the Cal MediConnect Ombuds Program is 1-855-501-3077. The services are free. See Chapter 2 [plans should insert reference, as appropriate] for more information on ombudsman programs.

### You can get help from the Health Insurance Counseling and Advocacy Program

You can also call the Health Insurance Counseling and Advocacy Program (HICAP). HICAP counselors can answer your questions and help you understand what to do to handle your problem. HICAP is not connected with us or with any insurance company or health plan. HICAP has trained counselors in every county, and services are free. The HICAP phone number is 1-800-434-0222.

### Getting help from Medicare

You can 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: 1-877-486-2048. The call is free.
* Visit the Medicare website at <http://www.medicare.gov>.

### You can get help from the California Department of Managed Health Care

In this paragraph, the term “grievance” means an appeal or complaint about Medi-Cal services, your health plan, or one of your providers.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at [insert health plan's telephone number] and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-HMO-2219)** and a TTY line **(1-877-688-9891)** for the hearing and speech impaired. The department's Internet Web site [**http://www.hmohelp.ca.gov**](http://www.hmohelp.ca.gov)has complaint forms, IMR application forms and instructions online.

[Plans may insert similar sections for the QIO or additional resources that might be available.]

# Section 3: Problems with your benefits

## Section 3.1: Should you use the process for coverage decisions and appeals? Or do you want to make a complaint?

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The chart below will help you find the right section of this chapter for problems or complaints.

| **Is your problem or concern about your benefits or coverage?**  (This includes problems about whether particular medical care, long-term services and supports, or prescription drugs are covered or not, the way in which they are covered, and problems related to payment for medical care or prescription drugs.) | |
| --- | --- |
| **Yes.** My problem is about  benefits or coverage.  Go to **Section 4: “Coverage decisions and appeals”** on page <xx>. | **No.** My problem is not about  benefits or coverage.  Skip ahead to **Section 10: “How to make a complaint”** 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. You are not responsible for Medicare costs except Part D copays.

### What is a coverage decision?

A coverage decision is an initial decision we make about your benefits and coverage or about the amount we will pay for your medical services, items, or drugs. We are making a coverage decision whenever we decide what is covered for you and how much we pay.

If you or your doctor are not sure if a service, item, or drug is covered by Medicare or Medi-Cal, either of you can ask for a coverage decision before the doctor gives the service, item, or drug.

### What is an appeal?

An appeal is a formal way of asking us to review our decision and change it if you think we made a mistake. For example, we might decide that a service, item, or drug that you want is not covered or is no longer covered by Medicare or Medi-Cal. If you or your doctor disagree with our decision, you can 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 **Member Services** at <phone number>.
* Call the **Cal MediConnect Ombuds Program** for free help. The Cal MediConnect Ombuds Program helps people enrolled in Cal MediConnect with service or billing problems. The phone number is 1-855-501-3077.
* Call the **Health Insurance Counseling and Advocacy Program (HICAP)** for free help. HICAP is an independent organization. It is not connected with this plan. The phone number is 1-800-434-0222.
* Call the **Help Center at the Department of Managed Health Care (DMHC)** for free help. The DMHC is responsible for regulating health plans. The DMHC helps people enrolled in Cal MediConnect with appeals about Medi-Cal services or billing problems. The phone number is 1-888-466-2219. Individuals who are deaf, hard of hearing, or speech-impaired can use the toll-free TTY number, 1-877-688-9891.
* Talk to **your doctor or other provider**. Your doctor or other 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.
* If you want a friend, relative, or other person to be your representative, call Member Services and ask for the “Appointment of Representative” form. You can also get the form by visiting <https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf> [plans 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.
* **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. You can ask for a legal aid attorney from the Health Consumer Alliance at 1-888-804-3536.
* However, **you do not have 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 if you have problems about services, items, and drugs (but **not** Part D drugs). For example, use this section if:
  + You are not getting medical care you want, and you believe our plan covers this care.
  + We did not approve services, items, or drugs that your doctor 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*, also known as the Drug Listwith a [plans should insert symbol used in the Drug List to indicate Medi-Cal covered drugs] are not covered by Part D. See Section 6 on page <xx> for Part D drug appeals.
  + You got medical care or services you think should be covered, but we are not paying for this care.
  + You got and paid for medical services or items you thought were covered, and you want to ask us 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 our 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 us to make an exception to cover a Part D drug that is not on our Drug List.
  + You want to ask us to waive limits on the amount of the drug you can get.
  + You want to ask us to cover a drug that requires prior approval.
  + We did not approve your request or exception, and you or your doctor or other prescriber thinks we should have.
  + You want to ask us to pay for a prescription drug you already bought. (This is asking 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 doctor is discharging you too soon. Use this section if:
  + You are in the hospital and think the doctor 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 Member Services at <phone number>.

If you need other help or information, please call the Cal MediConnect Ombuds Program at 1-855-501-3077.

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

## Section 5.1: When to use this section

This section is about what to do if you have problems with your benefits for your medical, behavioral health, and long-term services and supports (LTSS). You can also use this section for problems with drugs that are **not** covered by Part D. Drugs in the Drug List with a [plans should insert symbol used in the Drug List to indicate Medi-Cal covered drugs]are **not** covered by Part D. Use Section 6 for Part D drug Appeals.

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

### You think we cover medical, behavioral health, or long-term services and supports (LTSS) you need but are not getting.

**What you can do:** You can ask us to make a coverage decision. Go to Section 5.2 on page <xx> for information on asking for a coverage decision.

### We did not approve care your doctor wants to give you, and you think we should have.

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

### You got services or items that you think we cover, but we will not pay.

**What you can do:** You can appeal our decision not to 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 us to reimburse you for the services or items.

**What you can do:** You can ask us to pay you back. Go to Section 5.5 on page <xx> for information on asking us for payment.

### We reduced or stopped your coverage for a certain service, and you disagree with our decision.

**What you can do:** You can appeal our decision to reduce 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 medical, behavioral health, or certain long-term services and supports (MSSP [Plan shall change MSSP to CPM once the plan’s county has transitioned MSSP into Managed Care], CBAS, or NF services)

To ask for a coverage decision, call, write, or fax us, or ask your representative or doctor to ask us for a decision.

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

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

After you ask and we get all of the information we need, it usually takes 5 business days for us to make a decision. If we do not give you our decision within 14 calendar days, you can appeal.

Sometimes we need more time, and we will send you a letter telling you that we need to take up to 14 more calendar days. The letter will explain why more time is needed.

### Can I get a coverage decision faster?

**Yes**. If you need a response faster because of your health, ask us to make a “fast coverage decision.” If we approve the request, we will notify you of our decision within 72 hours.

However, sometimes we need more time, and we will send you a letter telling you that we need 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.”

**Asking for a fast coverage decision:**

* Start by calling or faxing to ask us to cover the care you want.
* Call us at <phone number> or fax us at <fax number>.
* Find other details on how to contact us in Chapter 2 [plans may insert reference, as applicable].

You can also ask your provider or your representative to request a fast coverage decision for you.

**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 care or an item you have not yet received**. (You cannot get a fast coverage decision if your request is about payment for care or an item you already got.)
2. You can get a fast coverage decision **only if the standard 14 calendar day deadline could cause serious harm to your health or hurt your ability to function**.

* If your doctor says that you need a fast coverage decision, we will automatically give you one.
* If you ask for a fast coverage decision without your doctor’s support, we will decide if you get a fast coverage decision.
* If we decide that your health does not meet the requirements for a fast coverage decision, we will send you a letter. We will also use the standard 14 calendar day deadline instead.
* This letter will tell you that if your doctor asks for the fast coverage decision, we will automatically give a fast coverage decision.
* The letter will also tell how you can file a “fast complaint” about our decision to give you a standard coverage decision instead of a fast coverage decision. For more information about the process for making complaints, including fast complaints, see Section 10 on page <xx>.

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

You will be approved (pre-authorized) to get the service or item within 14 calendar days (for a standard coverage decision) or 72 hours (for a fast coverage decision) of when you asked. If we extended the time needed to make our coverage decision, we will approve the coverage by the end of that extended period.

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

If the answer is **No**, we will send you a letter telling you our reasons for saying **No**.

* If we say **No**, you have the right to ask us to change this decision by making an appeal. Making an appeal means asking us to review our 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 (not Part D drugs)

### What is an Appeal?

An appeal is a formal way of asking us to review our decision and change it if you think we made a mistake. If you or your doctor or other provider disagree with our decision, you can appeal.

In most cases, you must start your appeal at Level 1. If you do not want to first appeal to the plan for a Medi-Cal service, if your health problem is urgent or involves an immediate and serious threat to your health, or if you are in severe pain and need an immediate decision, you may ask for an Independent Medical Review from the Department of Managed Health Care at [www.hmohelp.ca.gov](http://www.dmhc.ca.gov/?referral=hmohelp.ca.gov). Go to page <xx> for more information. If you need help during the appeals process, you can call the Cal MediConnect Ombuds Program at 1-855-501-3077. The Cal MediConnect Ombuds Program is not connected with us or with any insurance company or health plans.

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 (see page <xx>).
* If you appeal because we told you 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 in process (see page <xx>).
* Keep reading this section to learn about what deadline applies to your appeal.

### What is a Level 1 Appeal?

A Level 1 Appeal is the first appeal to our plan. We will review our coverage decision to see if it is correct. The reviewer will be someone who did not make the original coverage decision. When we complete the review, we will give you our decision in writing.

If we tell you after our review that the service or item is not covered, your case can go to a Level 2 Appeal.

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

* To start your appeal, you, your doctor or other provider, or your representative must contact us. You can call us at <phone number>. For additional details on how to reach us for appeals, see Chapter 2 [plans may insert reference, as applicable].
* You can ask us for a “standard appeal” or a “fast appeal.”
* If you are asking for a standard appeal or fast appeal, make your appeal in writing or call us.
  + You can submit a written request to the following address:<insert address>
  + You can submit your request online at: <insert plan’s online appeal address>
  + You may also ask for an appeal by calling us at <toll-free number>.
* We will send you a letter within 5 calendar days of receiving your appeal letting you know that we received it.

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

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

**Yes**. Your doctor or other provider can make the appeal for you. Also, someone besides your doctor or other provider can make the appeal for you, but first you must complete an Appointment of Representative form. The form gives the other person permission to act for you.

To get an Appointment of Representative form, call Member Services and ask for one, or visit <https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf> [plans may also insert: or our website at <web address **or** link to form>].

**If the appeal comes from someone besides you or your doctor or other provider**, we must get the completed Appointment of Representative form before we can review the appeal.

### 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 we sent to tell you our 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 we told you 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**. Ask us for a copy by calling Member Services at <phone number>.

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

**Yes**, you and your doctor 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 medical care. Then, we check to see if we were following all the rules when we said **No**to your request. The reviewer will be someone who did not make the original decision.

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

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

We must give you our answer within 30 calendar days after we get your appeal. We will give you our decision sooner if your health condition requires us to.

* If we do not give you an answer to your appeal within 30 calendar days, we will automatically send your case to Level 2 of the appeals process if your problem is about coverage of a Medicare service or item. You will be notified when this happens.
* If your problem is about coverage of a Medi-Cal service or item, you will need to file a Level 2 Appeal yourself. 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 or give the coverage within 30 calendar days 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. If your problem is about coverage of a Medicare service or item, the letter will tell you that we sent your case to the Independent Review Entity for a Level 2 Appeal. If your problem is about coverage of a Medi-Cal service or item, the letter will tell you how to file a Level 2 Appeal yourself. 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 your answer within 72 hours after we get your appeal. We will give you our answer sooner if your health requires us to do so.

* If we do not give you an answer to your appeal within 72 hours, we will automatically send your case to Level 2 of the appeals process if your problem is about coverage of a Medicare service or item. You will be notified when this happens.
* If your problem is about coverage of a Medi-Cal service or item, you will need to file a Level 2 Appeal yourself. 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 send you a letter. If your problem is about coverage of aMedicareservice or item, the letter will tell you that we sent your case to the Independent Review Entity for a Level 2 Appeal. If your problem is about coverage of a Medi-Cal service or item, the letter will tell you how to file a Level 2 Appeal yourself. 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 we decide to change or stop coverage for a service or item that was previously approved, we will send you a notice before taking the action. If you disagree with the action, you can file a Level 1 Appeal and ask that we continue your benefits for the service or item. You must **make the request on or before the later of the following** in order to continue your benefits:

* Within 10 days of the mailing date of our notice of action; or
* The intended effective date of the action.

If you meet this deadline, you can keep getting the disputed service or item while your appeal is processing.

## Section 5.4: Level 2 Appeal for services, items, and drugs (not 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 send you a letter. This letter will tell you if the service or item is usually covered by Medicare or Medi-Cal.

* If your problem is about a Medicareservice or item, we will automatically send your case to Level 2 of the appeals process as soon as the Level 1 Appeal is complete.
* If your problem is about a Medi-Cal service or item, you can file a Level 2 Appeal yourself. The letter will tell you how to do this. Information is also below.

### What is a Level 2 Appeal?

A Level 2 Appeal is the second appeal, which is done by an independent organization that is not connected to our plan.

### My problem is about a Medi-Cal service or item. How can I make a Level 2 Appeal?

There are two ways to make a Level 2 appeal for Medi-Cal services and items: (1) Filing a complaint or Independent Medical Review or (2) State Hearing.

**(1) Independent Medical Review**

You can file a complaint with or ask for an Independent Medical Review (IMR) from the Help Center at the California Department of Managed Health Care (DMHC). By filing a complaint, the DMHC will review our decision and make a determination. An IMR is available for any Medi-Cal covered service or item that is medical in nature. An IMR is a review of your case by doctors who are not part of our plan or a part of the DMHC. If the IMR is decided in your favor, we must give you the service or item you requested. You pay no costs for an IMR.

You can file a complaint or apply for an IMR if our plan:

* Denies, changes, or delays a Medi-Cal service or treatment because our plan determines it is not medically necessary.
* Will not cover an experimental or investigational Medi-Cal treatment for a serious medical condition.
* Will not pay for emergency or urgent Medi-Cal services that you already received.
* Has not resolved your Level 1 Appeal on a Medi-Cal service within 30 calendar days for a standard appeal or 72 hours for a fast appeal.

**NOTE:** If your provider filed an appeal for you, but we do not get your Appointment of Representative form, you will need to refile your appeal with us before you can file for a Level 2 IMR with the Department of Managed Health Care.

You are entitled to both an IMR and a State Hearing, but not if you have already had a State Hearing on the same issue.

In most cases, you must file an appeal with us before requesting an IMR. See page <xx> for information, about our Level 1 appeal process. If you disagree with our decision, you can file a complaint with the DMHC or ask the DMHC Help Center for an IMR.

If your treatment was denied because it was experimental or investigational, you do not have to take part in our appeal process before you apply for an IMR.

If your problem is urgent or involves an immediate and serious threat to your health or if you are in severe pain, you may bring it immediately to the DMHC’s attention without first going through our appeal process.

You must **apply for an IMR within 6 months** after we send you a written decision about your appeal. The DMHC may accept your application after 6 months for good reason, such as you had a medical condition that prevented you from asking for the IMR within 6 months or you did not get adequate notice from us of the IMR process.

To ask for an IMR:

* Fill out the Independent Medical Review Application/Complaint Form available at: <https://www.dmhc.ca.gov/fileacomplaint/submitanindependentmedicalreviewcomplaintform.aspx> or call the DMHC Help Center at 1-888-466-2219. TTY users should call 1-877-688-9891.
* If you have them, attach copies of letters or other documents about the service or item that we denied. This can speed up the IMR process. Send copies of documents, not originals. The Help Center cannot return any documents.
* Fill out the Authorized Assistant Form if someone is helping you with your IMR. You can get the form at https://www.dmhc.ca.gov/FileaComplaint/IndependentMedicalReviewComplaintForms.aspx or call the Department’s Help Center at 1-888-466-2219. TTY users should call 1-877-688-9891.
* Mail or fax your forms and any attachments to:

Help Center  
Department of Managed Health Care  
980 Ninth Street, Suite 500  
Sacramento, CA 95814-2725  
FAX: 916-255-5241

If you qualify for an IMR, the DMHC will review your case and send you a letter within 7 calendar days telling you that you qualify for an IMR. After your application and supporting documents are received from your plan, the IMR decision will be made within 30 calendar days. You should receive the IMR decision within 45 calendar days of the submission of the completed application.

If your case is urgent and you qualify for an IMR, the DMHC will review your case and send you a letter within 2 calendar days telling you that you qualify for an IMR. After your application and supporting documents are received from your plan, the IMR decision will be made within 3 calendar days. You should receive the IMR decision within 7 calendar days of the submission of the completed application. If you are not satisfied with the result of the IMR, you can still ask for a State Hearing.

If the DMHC decides that your case is not eligible for IMR, the DMHC will review your case through its regular consumer complaint process. Your complaint should be resolved within 30 calendar days of the submission of the completed application. If your complaint is urgent, it will be resolved sooner.

**(2) State Hearing**

You can ask for a State Hearing for Medi-Cal covered services and items. If your doctor or other provider asks for a service or item that we will not approve, or we will not continue to pay for a service or item you already have and we said no to your Level 1 appeal, you have the right to ask for a State Hearing.

In most cases **you have 120 days to ask for a State Hearing** after the “Your Hearing Rights” notice is mailed to you.

**NOTE:** If you ask for a State Hearing because we told you that a service you currently get will be changed or stopped, **you** **have fewer days to submit your request** if you want to keep getting that service while your State Hearing is pending. Read “Will my benefits continue during Level 2 appeals” on page <xx>for more information.

There are two ways to ask for a State Hearing:

1. You may complete the "Request for State Hearing" on the back of the notice of action. You should provide all requested information such as your full name, address, telephone number, the name of the plan or county that took the action against you, the aid program(s) involved, and a detailed reason why you want a hearing. Then you may submit your request one of these ways:
   * To the county welfare department at the address shown on the notice.
   * To the California Department of Social Services:

State Hearings Division   
P.O. Box 944243, Mail Station 9-17-37   
Sacramento, California 94244-2430

* + To the State Hearings Division at fax number 916-651-5210 or 916-651-2789.

1. You can call the California Department of Social Services at 1-800-952-5253. TTY users should call 1-800-952-8349. If you decide to ask for a State Hearing by phone, you should be aware that the phone lines are very busy.

### My problem is about a Medicare service or item. What will happen at the Level 2 Appeal?

An Independent Review Entity (IRE) will carefully review the Level 1 decision and decide whether it should be changed.

* You do not need to request the Level 2 Appeal. We will automatically send any denials (in whole or in part) to the IRE. You will be notified when this happens.
* The IRE is hired by Medicare and is not connected with this plan.
* You may ask for a copy of your file by calling Member Services at <phone number>.

The IRE must give you an answer to your Level 2 Appeal within 30 calendar days of when it gets your appeal. This rule applies if you sent your appeal before getting medical services or items.

* However, if the IRE needs to gather more information that may benefit you, it can take up to 14 more calendar days. If the IRE needs extra days to make a decision, it will tell you by letter.

If you had a “fast appeal” at Level 1, you will automatically have a fast appeal at Level 2. The IRE must give you an answer within 72 hours of when it gets your appeal.

* However, if the IRE needs to gather more information that may benefit you, it can take up to 14 more calendar days. If the IRE needs extra days to make a decision, it will tell you by letter.

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

If your problem is about a service or item covered by Medicare, your benefits for that service or item will **not** continue during the Level 2 appeals process with the Independent Review Entity.

If your problem is about a service or item covered by Medi-Cal and you ask for a State Hearing, your Medi-Cal benefits for that service or item can continue until a hearing decision is made. You must ask for a hearing **on or before the later of the following** in order to continue your benefits:

* Within 10 days of the mailing date of our notice to you that the adverse benefit determination (Level 1 appeal decision) has been upheld; or
* The intended effective date of the action.

If you meet this deadline, you can keep getting the disputed service or item until the hearing decision is made.

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

If your Level 2 Appeal was an Independent Medical Review, the Department of Managed Health Care will send you a letter explaining the decision made by the doctors who reviewed your case.

* If the Independent Medical Review decision is **Yes**to part or all of what you asked for, we must provide the service or treatment.
* If the Independent Medical Review decision is **No** to part or all of what you asked for, it means they agree with the Level 1 decision. You can still get a State Hearing. Go to page <xx> for information about asking for a State Hearing.

If your Level 2 Appeal was a State Hearing, the California Department of Social Services will send you a letter explaining its decision.

* If the State Hearing decision is **Yes**to part or all of what you asked for, we must comply with the decision. We must complete the described action(s) within 30 calendar days of the date we received a copy of the decision.
* If the State Hearing decision is **No** to part or all of what you asked for, it means they agree with the Level 1 decision. We may stop any aid paid pending you are receiving.

If your Level 2 Appeal went to the Medicare Independent Review Entity (IRE), it will send you a letter explaining its decision.

* If the IRE says **Yes** to part or all of what you asked for in your standard appeal, we must authorize the medical care coverage within 72 hours or give you the service or item within 14 calendar days from the date we get the IRE’s decision. If you had a fast appeal, we must authorize the medical care coverage or give you the service or item within 72 hours from the date we get the IRE’s decision.
* If the IRE says **No** to part or all of what you asked for, it means they agree with the Level 1 decision. This is called “upholding the decision.” It is also called “turning down your appeal.”

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

If your Level 2 Appeal was an Independent Medical Review, you can request a State Hearing. Go to page <xx> for information about asking for a State Hearing.

If your Level 2 Appeal was a State Hearing, you may ask for a rehearing within 30 days after you receive the decision. You may also ask for judicial review of a State Hearing denial by filing a petition in Superior Court (under Code of Civil Procedure Section 1094.5) within one year after you receive the decision. You cannot ask for an IMR if you already had a State Hearing on the same issue.

If your Level 2 Appeal went to the Medicare Independent Review Entity (IRE), you can appeal again only if the dollar value of the service or item you want meets a certain minimum amount. The letter you get from the IRE will explain additional appeal rights you may have.

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

## Section 5.5: Payment problems

We do not allow our network providers to bill you for covered services and items. This is true even if we pay the provider less than the provider charges for a covered service or item. You are never required to pay the balance of any bill. [Plans with cost sharing insert: 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 [plans with cost sharing insert: that is more than your copay] for covered services and items, send the bill to us. **You should not pay the bill yourself.** We will contact the provider directly and take care of the problem.

For more information, start by reading Chapter 7: “Asking us to pay [plans with cost sharing, insert: our share of] a bill you have gotten for covered services or drugs.” Chapter 7 describes the situations in which you may need to ask 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.

### Can I ask you to pay me back for [insert if plan has cost sharing: your share of]a service or item I paid for?

Remember, if you get a bill [plans with cost sharing insert: that is more than your copay] for covered services and items, you should not pay the bill yourself. But if you do pay the bill, you can get a refund if you followed the rules for getting services and items.

If you are asking to be paid back, you are asking for a coverage decision. We will see if the service or item you paid for is a covered service or item, and we will check to see if you followed all the rules for using your coverage.

* If the service or item you paid for is covered and you followed all the rules, we will send [*insert:* payment *or,* if plan has cost sharing, our share of the cost] to your provider for the service or item within 60 calendar days after we get your request. Your provider will then send payment to you.
* If you haven’t paid for the service or item yet, we will send the payment directly to the provider. When we send the payment, it’s the same as saying **Yes** to your request for a coverage decision.
* If the service or item is not covered, or you did not follow all the rules, we will send you a letter telling you we will not pay for the service or item, and explaining why.

### What if we say we will not pay?

If you do not agree with our 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   
  30 calendar days after we get your appeal.
* If you are asking us to pay you back for a service or item you already got and paid for yourself, you cannot ask for a fast appeal.

If we answer **No** to your appeal and the service or item is usually covered by Medicare, we will automatically send your case to the Independent Review Entity (IRE). We will notify you by letter if this happens.

* If the IRE reverses our 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 IRE says **No** to your appeal, it means they agree with our decision not to approve your request. (This is called “upholding the decision.” It is also called “turning down your appeal.”) The letter you get will explain additional appeal rights you may have. You can appeal again only if the dollar value of the service or item you want meets a certain minimum amount. See Section 9 on page <xx> for more information on additional levels of appeal.

If we answer **No** to your appeal and the service or item is usually covered by Medi-Cal, you can file a Level 2 Appeal yourself (see Section 5.4 on page <xx>). [Plans should edit as needed and/or provide additional instructions on the process for Level 2 payment appeals.]

# Section 6: 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 benefits as a member of our plan include coverage for 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 Medi-Cal may cover. **This section only applies to Part D drug appeals.**

The Drug List includes some drugs with a [plans should insert symbol used in the Drug List to indicate Medi-Cal covered drugs]. These drugs are **not** Part D drugs. Appeals or coverage decisions about drugs with [plans should insert symbol used in the Drug List to indicate Medi-Cal 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 us to make about your   
Part D drugs:

* You ask us to make an exception such as:
* Asking us to cover a Part D drug that is not on the plan’s Drug List
* Asking us to waive a restriction on the plan’s coverage for a drug (such as limits on the amount of the drug you can get)
* You ask us if a drug is covered for you (for example, when your drug is on the plan’s Drug Listbut we require you to get approval from us 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 how to contact us to ask for a coverage decision.

* You ask us to 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 we have made, you can appeal our decision. 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 Drug Listor to use the drug without certain rules and limitations. If a drug is not on our Drug List or is not covered in the way you would like, you can ask us to make an “exception.”

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

Here are examples of exceptions that you or your doctor or another prescriber can ask us to make:

1. Covering a Part D drug that is not on our Drug List.

* [Plans without cost sharing delete:] If we agree to make an exception and cover a drug that is not on the Drug List, you will need to pay the cost-sharing amount that applies to [insert as appropriate: all of our drugs OR drugs in [insert exceptions tier] *OR* drugs in[*insert exceptions tier*] for brand name drugs or[*insert exceptions tier*]for generic drugs].
* You cannot ask for an exception to the copay or coinsurance amount we require you to pay for the drug.

1. 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 [plans 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 plan approval before we will agree to 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 we will agree to 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, we limit the amount of the drug you can have.
* [Plans with no cost sharing, delete this bullet.] If we agree to make an exception and waive a restriction for you, you can still ask for an exception to the copay amount we require you to pay for the drug.

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 doctor or other prescriber must tell us the medical reasons

Your doctor or other prescriber must give us a statement explaining the medical reasons for requesting an exception. Our decision about the exception will be faster if you include this information from your doctor or other 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, we will generally notapprove your request for an exception.

### We will say Yes or No to your request for an exception

* If we say **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 doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
* If we say **No**to your request for an exception, you can ask for a review of our decision by making an appeal. Section 6.5 on page <xx> tells how to make an appeal if we say **No**.

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

### What to do

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

Call, write, or fax us to ask, or ask your representative or doctor or other prescriber to ask. We will give you an answer on a standard coverage decision within 72 hours. We will give you 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 doctor or other prescriber.
* You or your doctor or other 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.
* Ask for the type of coverage decision you want. Call, write, or fax us to make your request. You, your representative, or your doctor (or other prescriber) can do this. You can call us at <phone number>.
* You or your doctor (or other prescriber) or someone else who is acting on your behalf 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 doctor or other prescriber written permission to ask us for a coverage decision on your behalf.
* If you want to ask us to pay you back for a drug, read Chapter 7 [plans 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 our share of the cost of a drug you have paid for.
* If you are asking for an exception, provide the “supporting statement.” Your doctor or other prescriber must give us the medical reasons for the drug exception. We call this the “supporting statement.”
* Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone, and then fax or mail a statement.

### If your health requires it, ask us to give you a “fast coverage decision”

We will use the “standard deadlines” unless we have agreed to use the “fast deadlines.”

* A **standard coverage decision** means we will give you an answer within 72 hours after we get your doctor’s statement.
* A **fast coverage decision** means we will give you an answer within 24 hours after we get your doctor’s statement.

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 doctor or other prescriber tells us that your health requires a “fast coverage decision,” we 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 doctor’s or other prescriber’s support), we will decide whether you get a fast coverage decision.
* If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will use the standard deadlines instead.
  + We will send you a letter telling you that. The letter will tell you how to make a complaint about our decision to give you a standard decision.
  + You can file a “fast complaint” and get a response to your complaint within 24 hours. For more information about the process for making complaints, including fast complaints, see Section 10 on page <xx>.

### Deadlines for a “fast coverage decision”

* If we are using the fast deadlines, we must give you our answer within 24 hours. This means within 24 hours after we get your request. Or, if you are asking for an exception, 24 hours after we get your doctor’s or prescriber’s statement supporting your request. We will give you our answer sooner if your health requires it.
* If we do 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 our answer is Yes** to part or all of what you asked for, we must give you the coverage within 24 hours after we get your request or your doctor’s or prescriber’s statement supporting your 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**. 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 we are using the standard deadlines, we must give you our answer within 72 hours after we get your request. Or, if you are asking for an exception, after we get your doctor’s or prescriber’s supporting statement. We will give you our answer sooner if your health requires it.
* If we do 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 our answer is Yes** to part or all of what you asked for, we must approve or give the coverage within 72 hours after we get your request or, if you are asking for   
  an exception, your doctor’s or prescriber’s supporting statement.
* **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**. The letter will also explain how you can appeal our decision.

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

* We must give you our answer within 14 calendar days after we get your request.
* If we do 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 our answer is Yes** to part or all of what you asked for, we will make payment to you within 14 calendar days.
* **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**. The letter will also explain how you can appeal our decision.

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

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

At a glance:How to make a Level 1 Appeal

You, your doctor or 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 doctor or 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 we sent to tell you our decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make you 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.
* You have the right to ask us for a copy of the information about your appeal. To ask for a copy, call Member Services at <phone number>.

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

If you wish, you and your doctor or other 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 our plan made about a drug you have not yet received, you and your doctor or other 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>.

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

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

* We take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said **No**to your request. We may contact you or your doctor or other 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**.

### 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 doctor or other 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 Member 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 this 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 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 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. This section tells you how to ask.

## 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 Member 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 should 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 Member 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 should 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 Member Services or Medicare at the numbers listed above.

## Section 7.2: 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. A Quality Improvement Organization will do the Level 1 Appeal review to see if your planned discharge date is medically appropriate for you. In California, the Quality Improvement Organization is called <state-specific QIO name>.

To make an appeal to change your discharge date call <state-specific QIO name> at: <toll-free number>.

### 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 after your 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 <phone number> 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>.
* Because hospital stays are covered by both Medicare and Medi-Cal, if the Quality Improvement Organization will not hear your request to continue your hospital stay, or you believe that your situation is urgent, involves an immediate and serious threat to your health, or you are in severe pain, you may also file a complaint with or ask the California Department of Managed Health Care (DMHC) for an Independent Medical Review. Please go to Section 5.4 on page <xx> to learn how to file a complaint and ask the DMHC for an Independent Medical Review.

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 Member Services at <phone number>. You can also call the Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222. Or you can call the Cal MediConnect Ombuds Program at 1-855-501-3077.

### 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 doctor, 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 doctor, 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 Member 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 should 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 as described in the next section.

## Section 7.3: 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 California, the Quality Improvement Organization is called <state-specific QIO name>. You can reach <state-specific QIO name> at: **<toll-free number>.**

* 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 <phone number> 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.

You may also file a complaint with or ask the DMHC for an Independent Medical Review to continue your hospital stay. Please go to Section 5.4 on page <xx> to learn how to file a complaint with and ask the DMHC for an Independent Medical Review.

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

If you miss appeal deadlines, there is another way to make Level 1 and Level 2 Appeals, called Alternate Appeals. But the first two levels of appeal are different.

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

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking 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 Member 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 within 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 Independent Review Entity. 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

We will send the information for your Level 2 Appeal to the Independent Review Entity (IRE) within 24 hours of when we give you our Level 1 decision. If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 10 on page <xx> tells how to make a complaint.

During the Level 2 Appeal, the IRE 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 Independent Review Entity.

* The IRE does a “fast review” of your appeal. The reviewers usually give you an answer within 72 hours.
* The IRE is an independent organization that is hired by Medicare. This organization is not connected with our 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 of your hospital discharge.
* If the IRE says **Yes** to your appeal, then we must pay you back for our share of the costs of hospital care you got 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 IRE 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 IRE 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 by a judge.

You may also file a complaint with and ask the DMHC for an Independent Medical Review to continue your hospital stay. Please go to Section 5.4 on page <xx> to learn how to file a complaint with and ask the DMHC for an Independent Medical Review. You can ask for an Independent Medical Review in addition to or instead of a Level 3 Appeal.

# 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 the doctor 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 care.

If you think we are ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask for an appeal.

## 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 care. This is called the “Notice of Medicare Non-Coverage”.

* The written notice tells you the date when we will stop covering your care.
* 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 the care.

When your coverage ends, we will stop paying [insert if plan has cost sharing: our share of the cost for your care.]

## Section 8.2: Level 1 Appeal to continue your care

If you think we are ending coverage of your care too soon, you can appeal our decision. This section tells you how to ask for an appeal.

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 complaint. Section 10 on page <xx> tells you how to file a complaint.)
* **Ask for help if you need it**. If you have questions or need help at any time, please call Member Services at <phone number>. Or call your State Health Insurance Assistance Program at <phone number>.

During a Level 1 Appeal, a Quality Improvement Organization will review your appeal and decide whether to change the decision we made. In California, the Quality Improvement Organization is called <state-specific QIO name>. You can reach <state-specific QIO name> at: <phone number>.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 <phone number> 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>.
* If the Quality Improvement Organization will not hear your request to continue coverage of your health care services or you believe that your situation is urgent or involves an immediate and serious threat to your health or if you are in severe pain, you may file a complaint with and ask the California Department of Managed Health Care (DMHC) for an Independent Medical Review. Please go to Section 5.4 on page <xx> to learn how to file a complaint with and ask the DMHC for an Independent Medical Review.

The legal term for the written notice is “Notice of Medicare Non-Coverage.”   
To get a sample copy, call Member 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 doctor, and review information that our 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: Level 2 Appeal to continue your care

If the Quality Improvement Organization said **No**to the 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 California, the Quality Improvement Organization is called <state-specific QIO name>. You can reach <state-specific QIO name> at: <phone number>. 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 <phone number> 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 a Level 3 Appeal, which is handled by a judge.
* You may file a complaint with and ask the DMHC for an Independent Medical Review to continue coverage of your health care services. Please go to Section 5.4 on page <xx> to learn how to ask the DMHC for an Independent Medical Review. You can file a complaint with and ask the DMHC for an Independent Medical Review in addition to or instead of a Level 3 Appeal.

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

If you miss appeal deadlines, there is another way to make Level 1 and Level 2 Appeals, called Alternate Appeals. But the first two levels of appeal are different.

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

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking 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 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 within 72 hours after you ask for a “fast review.”

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

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

We will give you our decision within   
72 hours.

* **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 “Independent Review Entity.” 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

We will send the information for your Level 2 Appeal to the Independent Review Entity (IRE) within 24 hours of when we give you our Level 1 decision. If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 10 on page <xx> tells how to make a complaint.

During the Level 2 Appeal, the IRE 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 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 Independent Review Entity.

* The IRE does a “fast review” of your appeal. The reviewers usually give you an answer within 72 hours.
* The IRE is an independent organization that is hired by Medicare. This organization is not connected with our 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.
* **If the IRE 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 IRE 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 IRE 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, which is handled by a judge.

You may also file a complaint with and ask the DMHC for an Independent Medical Review to continue coverage of your health care services. Please go to Section 5.4 on page <xx> to learn how to ask the DMHC for an Independent Medical Review. You can file a complaint with and ask for an Independent Medical Review in addition to or instead of a Level 3 Appeal.

# Section 9: Taking your appeal beyond Level 2

## Section 9.1: Next steps for Medicare services and items

If you made a Level 1 Appeal and a Level 2 Appeal for Medicare services or items, 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 item or medical service 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 Cal MediConnect Ombuds Program at 1-855-501-3077.

## Section 9.2: Next steps for Medi-Cal services and items

You also have more appeal rights if your appeal is about services or items that might be covered by Medi-Cal. If you do not agree with the State Hearing decision and you want another judge to review it, you may ask for a rehearing and/or seek judicial review.

To ask for a rehearing, mail a written request (a letter) to:

The Rehearing Unit   
744 P Street, MS 19-37   
Sacramento, CA 95814

This letter must be sent within 30 days after you get your decision. This deadline can be extended up to 180 days if you have a good reason for being late.

In your rehearing request, state the date you got your decision and why a rehearing should be granted. If you want to present additional evidence, describe the additional evidence and explain why it was not introduced before and how it would change the decision. You may contact legal services for assistance.

To ask for judicial review, you must file a petition in Superior Court (under Code of Civil Procedure Section 1094.5) within one year after receiving your decision. File your petition in the Superior Court for the county named in your decision. You may file this petition without asking for a rehearing. No filing fees are required. You may be entitled to reasonable attorney’s fees and costs if the Court issues a final decision in your favor.

If a rehearing was heard and you do not agree with the decision from the rehearing, you may seek judicial review but you cannot request another rehearing.

# Section 10: How to make a complaint

### What kinds of problems should be complaints?

The complaint 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 complaint process.

### Complaints about quality

At a glance*:* How to make a complaint

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

To make an internal complaint, call Member Services or send us a letter.

There are different organizations that handle external complaints. 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.

### Complaints about privacy

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

### Complaints 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.

### Complaints about accessibility

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

### Complaints 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 doctors, pharmacists, or other health professionals or by Member Services or other plan staff.

### Complaints about cleanliness

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

### Complaints about language access

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

### Complaints 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.

### Complaints 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 medical services.
* You believe we did not forward your case to the Independent Review Entity on time.

The legal term for a “complaint” is a “grievance.”

The legal term for “making a complaint” is “filing a grievance.”

### Are there different types of complaints?

**Yes**. You can make an internal complaint and/or an external complaint. An internal complaint is filed with and reviewed by our plan. An external complaint is filed with and reviewed by an organization that is not affiliated with our plan. If you need help making an internal and/or external complaint, you can call the Cal MediConnect Ombuds Program at 1-855-501-3077.

## Section 10.1: Internal complaints

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

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

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

If possible, we will answer you right away. If you call us with a complaint, 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.

* We answer most complaints within 30 calendar days. If we do not make a decision within 30 calendar days because we need more information, we will notify you in writing. We will also provide a status update and estimated time for you to get the answer.
* If you are making a complaint because we denied your request for a “fast coverage decision” or a “fast appeal,” we will automatically give you a “fast complaint” and respond to your complaint within 24 hours.
* If you are making a complaint because we took extra time to make a coverage decision, we will automatically give you a “fast complaint” and respond to your complaint within 24 hours.

**If we do not agree** with some or all of your complaint, we will tell you and give you our reasons. We will respond whether we agree with the complaint or not.

## Section 10.2: External complaints

### You can tell Medicare about your complaint

You can send your 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 users can call 1-877-486-2048. The call is free.

### You can tell Medi-Cal about your complaint

The Cal MediConnect Ombuds Program also helps solve problems from a neutral standpoint to make sure that our members get all the covered services that we must provide. The Cal MediConnect Ombuds Program is not connected with us or with any insurance company or health plan.

The phone number for the Cal MediConnect Ombuds Program is 1-855-501-3077. The services are free.

### You can tell the California Department of Managed Health Care about your complaint

The California Department of Managed Health Care (DMHC) is responsible for regulating health plans. You can call the DMHC Help Center for help with complaints about Medi-Cal services. You may contact the DMHC if you need help with a complaint involving an urgent issue or one that involves an immediate and serious threat to your health, if you are in severe pain, if you disagree with our plan’s decision about your complaint, or if our plan has not resolved your complaint after 30 calendar days.

Here are two ways to get help from the Help Center:

* Call 1-888- 466-2219. Individuals who are deaf, hard of hearing, or speech-impaired can use the toll free TTY number, 1-877-688-9891. The call is free.
* Visit the Department of Managed Health Care’s website (<http://www.hmohelp.ca.gov>).

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

You can make a complaint to the Department of Health and Human Services’ Office for Civil Rights if you think you have not been treated fairly. For example, you can make a complaint 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 <https://www.hhs.gov/ocr/index.html> for more information.

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

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

You may also have rights under the Americans with Disability Act and under [plans may insert relevant state law.] You can contact the Cal MediConnect Ombuds Program for assistance. The phone number is 1-855-501-3077.

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

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

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

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 California, the Quality Improvement Organization is called <state-specific QIO name>. The phone number for <state-specific QIO name> is <phone number>.