COMMUNITY HEALTH PLAN of Washington™ | MEDICARE ADVANTAGE
The power of community

Community Health Plan of Washington is an HMO plan with a Medicare contract. Enrollment in Community Health Plan of Washington depends on contract renewal.

Appeals and Grievances

Community Health Plan of Washington Medicare Advantage Plan 2 (HMO)
Community Health Plan of Washington Medicare Advantage Plan 4 (HMO)
Community Health Plan of Washington Medicare Advantage Freedom Plan (HMO)

As a Community Health Plan of Washington (CHPW) Medicare Advantage enrollee, you have the right to voice a complaint if you have a problem or concern about your health care or health care coverage.

The Federal Medicare program has rules about what you need to do to make a complaint and what CHPW is required to do when we receive a complaint.

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

This booklet is designed to help you understand:

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

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

What are appeals and grievances?

Complaints can fall into two categories:

- *Appeals* and
- *Grievances*

Appeals

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

- We do not approve payment for care you believe should be covered.
- We have not paid for a particular medical procedure or other service you think should be covered.
- We will not authorize payment for medical treatment or a Part D prescription drug your provider or other medical provider states is medically necessary, and you believe this treatment is covered by your plan.
- If you are being told that coverage for a treatment or service or a Part D Drug you have been getting will be reduced or stopped, and you feel this could harm your health.
- If you have received care or a Part D prescription drug that you believe was covered by your plan while you were an enrollee, but we have refused to pay for this care.
- If we will not pay for a Part D prescription drug prescribed by your provider because it is not in our formulary.
- If you disagree with the amount that we require you to pay for a Part D prescription drug.
- If there is a requirement that you try another drug before we pay for the drug your provider prescribed, or if there is a quantity or dose limit that you disagree with.

Grievances

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

- The quality of your care.
- Waiting times for appointments or in the waiting room.

- Your provider's behavior.
- The ability to reach someone by phone or get the information you need.
- The cleanliness or condition of your provider's office; or the courtesy of the service we provide you.

Filing an appeal

Appeals must be submitted within 65 calendar days from the notice of denial date.

This section explains how to file an *appeal* if you have complaints about your denial of medical coverage or Part D prescription drug benefits under CHPW Medicare Advantage, including:

- What the process involves.
- How long it takes for an *appeal* decision.
- What happens if an *appeal* is denied.
- Complaints specific to hospital discharge, skilled nursing facility, home health and comprehensive outpatient rehabilitation facility services coverage.

How do I file an appeal?

There are two kinds of *appeal*: *standard* and *fast* (also called *expedited*).

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

Community Health Plan of Washington
Attn: Medicare Advantage Appeals
1111 3rd Ave, Suite 400
Seattle, WA 98101

You can also fax your request to: 1-206-652-7010.

A *fast appeal* can be submitted in writing to the address above, or verbally by calling **1-800-942-0247 (TTY: 711), 8:00 a.m. to 8:00 p.m., 7 days a week**. You should file an *expedited appeal* if your health or ability to function could be seriously harmed by waiting more than 72 hours (3 calendar days) for a decision.

You can also fax your request to: 1-206-652-7011 or deliver it in person to:

Community Health Plan of Washington
1111 3rd Ave, Suite 400
Seattle, WA 98101

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

Who may file an appeal?

Only the member, their authorized representative, treating provider, or Primary Care Provider (PCP) may file a Part C *appeal*.

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

How long does an appeal decision take?

Standard appeals are processed within:
30 calendar days from the date we receive your request for a standard appeal. This may be extended to 44 calendar days if additional information is needed. You will receive notice of our decision in writing along with any supporting explanation. If your appeal is for payment of a service, you have already received, you will receive a written decision within 60 days.

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

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

Decisions on *fast* or *expedited* Part D Prescription drug *coverage redetermination appeals* are made within 72 hours.

How does the decision process work?

Step 1:
In both kinds of *appeals*, the review is coordinated by a CHPW Grievance Coordinator. Every decision in the appeals process is made by someone other than the person who made the original coverage decision. You or your provider can request to examine your case file before and during the *appeal* process.

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

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

Appeal decisions related to medical necessity are made by a provider with expertise in the appropriate field of medicine.

Step 2:
If we turn down part or all of your Part C *appeal*, we send your request to an Independent Review Entity (IRE) that has a contract with the Federal Government and is not part of CHPW. This organization will review your request and make a decision about whether we must give you the care or payment you want. You have the option of requesting an independent review if we turn down part or all of your Part D appeal.

Step 3:
If you are unhappy with the decision made by the independent review organization, you may ask for an Administrative Law Judge (ALJ) to consider your case and make a decision. The ALJ works for the Federal Government.

Step 4:
If you, or we, disagree with the decision made by the ALJ, either of us may ask the Departmental Appeals Board (DAB) to review your case. The Board is part of the federal department that runs the Medicare program.

Step 5:
If you, or we, do not agree with the decision made by the DAB, and the amount in controversy is $1,460 or more, either of us may request a Judicial Review through a civil action in a United States district court.

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

If you are hospitalized for any reason, you will be discharged from the hospital when your stay there is considered no longer medically necessary. At that time, your coverage for the hospitalization typically ends. If you think you are being discharged too soon, you have the right to ask for a review of your discharge date:

Step 1:
Call us (or have someone authorized in writing by you call us) immediately to receive a Notice of Discharge & Medicare Appeal Rights. This notice will tell you:

- Why you are being discharged.
- The date that we will stop covering your hospital stay.
- What you can do if you think you are being discharged too soon.
- Who to contact for help, including the name and number of the Quality Improvement Organization (QIO), which can review whether your discharge is medically appropriate.

Step 2a:
Contact the QIO no later than noon on the first business day after you are given written notice that you are being discharged from the hospital. This deadline is very important, as meeting it allows you to stay in the hospital past your discharge date without having to pay for it yourself, while you wait to get a decision from the QIO.

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

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

Step 2b:
If you do not meet the QIO request time deadline, you can ask us for a "*fast appeal*" of your discharge. Please note that if you ask us for a *fast appeal* of your discharge and you stay in the hospital past your discharge date, you may have to pay for the hospital care you receive past that date. Whether you must pay or not depends on our decision:

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

Step 3:
You can *appeal* any bills for hospital care you receive as outlined earlier in the *appeal*s process.

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

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

- You must act quickly and make your request to the QIO no later than noon of the day after you receive our written notice.
- If you get the notice and have more than 2 calendar days before your plan coverage for the SNF stay, or CORF or HHA services end, you must make your request no later than noon the day before the date that your Medicare coverage ends.
- The QIO will interview you, look at your medical information, talk to your provider and review information provided by us. The QIO will make their decision within one full day after it receives the necessary information.
- If the QIO agrees with you, then we will continue to cover your SNF stay, or CORF or HHA services, for as long as medically necessary.
- If the QIO denies your request and you continue to receive SNF care, or CORF or HHA services after the termination date stated in the original written notice you received from us, you will be responsible for paying any charges past the coverage termination date.

Step 1:
If you do not meet the QIO request time deadline, you may ask the QIO for a fast appeal of your coverage termination date for your SNF stay or CORF or HHA services. The QIO is an independent review organization that has a contract with the Federal Government and is not part of CHPW. This organization will review your request and make a decision about whether we must give you the care or payment you want.

- If they review your medical information and decide that you need to continue to have these services covered, we will continue to cover them for as long as is medically necessary.
- Please note that if you ask for a fast appeal and you continue with your SNF stay, or CORF or HHA services, you may have to pay for the charges you receive past the termination date. Whether you must pay or not depends on the QIO's decision.

Filing a grievance

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

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

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

How do I file a grievance?

We will try to resolve any grievance you might have over the phone. You may also file a grievance in writing. Any grievance filed in writing and any quality of care grievance will be responded to in writing.

There are two kinds of grievance requests, standard and expedited (rush), you can file with us. You may request an *expedited grievance only* if: CHPW extends the time frame to make an organization determination or reconsideration or if we refuse to grant a request for an expedited organization determination or reconsideration.

Grievances can be submitted verbally by calling **1-800-942-0247 (TTY: 711), 8:00 a.m. to 8:00 p.m., 7 days a week,** or by writing to:

Community Health Plan of Washington
Attn: CHPW Medicare Advantage
Grievance Coordinator
1111 3rd Ave, Suite 400
Seattle, WA 98101

Grievances filed in writing and all quality of care grievances are responded to in writing.

Decisions on expedited grievance submittals are made within 24 hours of the receipt of the request.

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

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

You can also fax your *grievance* to 1-206-652-7010 or deliver in person to:

Community Health Plan of Washington
1111 3rd Ave, Suite 400
Seattle, WA 98101

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

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

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Who may file a grievance?

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

How long does a grievance decision take?

Standard grievance requests are typically decided upon within 30 calendar days from the date we receive your request but may be extended up to 44 days if additional information is needed. Grievances filed verbally are responded to verbally.

How does the grievance decision process work?

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

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

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

Confidentiality

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

Pharmacy coverage determination and request for an exception to covered prescription drugs.

A coverage determination is the first step you take in requesting a ruling on a Part D prescription drug benefit. When we make a coverage determination, we are making a decision whether or not to pay for a Part D drug and what your share of the cost is. You have the right to ask us for an exception if you believe you need a drug that is not on our list of covered drugs (formulary) or believe you should get a drug at a lower cost to you. If you request an exception, your physician must provide a statement to support your request.

To request a coverage determination or exception to Part D please call Express Scripts at 1-844-605-8168.

Step 1:
You can ask us to make an exception to our coverage rules by calling CHPW Pharmacy Services at 1-800- 417-8164 (TTY: 711), from 8:00 a.m. to 8:00 p.m., 7 days a week. There are several types of coverage exceptions you can ask us to make:

- You can ask us to cover your drug even if it is not in our formulary.
- You can ask us to waive coverage restrictions or limits on your drug. For example, if your drug has a quantity limit, you can request that we waive the limit and cover a larger quantity.
- You can ask us to provide a higher level of coverage for your drug. For example, if your drug is considered a non-preferred brand drug, you can request it be covered as a preferred brand drug instead. This would lower the cost share amount you must pay for your drug.

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

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

Step 2:
If we do not approve a coverage exception request, you can appeal the decision as outlined earlier in the appeals process.

Definitions Related To Appeals:

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

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

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

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

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

Independent Review Entity (IRE) - An independent entity contracted by the Centers for Medicare & Medicaid Services (CMS) to review Medicare Advantage organizations' denial of coverage determinations. Currently, this organization is MAXIMUS Federal Services, Inc.

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

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

Definitions Related To Grievances:

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

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

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

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

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

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

Quality Improvement Organization (QIO) - Organizations comprised of practicing providers and other health care experts under contract to the Federal Government to monitor and improve the care given to Medicare enrollees. They review complaints raised by enrollees about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Medicare managed care CHPW plans, and ambulatory surgical centers. A QIO also reviews continued stay denials in acute inpatient hospital facilities.

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

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

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How Can I Help Stop Health Care Fraud?
Health care fraud takes money from health care programs and leaves less money for medical care. Here are ways you can help stop fraud:

- Report the loss or theft of your health plan card.
- Only give your health plan card or number to a health care provider, a clinic, or a hospital when you are getting care, and be careful giving out your Social Security number.
- Never let anyone borrow or use your health plan card.
- Keep records of your medical visits, including dates, receipts, statements, and your notes.
- Check your Explanation of Benefits (EOB) carefully. Let us know if you see a charge for a service, you did not have or receive a bill from a provider you didn't see.
- Shred your medical bills and records when you dispose of them.
- Report potential fraud.

How to Report Fraud to Community Health Plan of Washington
You can report fraud by visiting our website medicare.chpw.org and completing a **Report Potential Fraud** form. You can send your report to us:

- By email at compliance.incident@chpw.org
- By fax at 206-652-7017 to the attention of the Compliance Officer
- By mail in an envelope clearly marked "Confidential" to:

Compliance Officer
Community Health Plan of Washington
1111 3rd Ave, Suite 400
Seattle WA, 98101

If you wish to report **anonymously**, you can send your report from a proxy fax number or email address. You may also contact our Customer Service team to complete a Report Potential Fraud Form anonymously over the phone at **1-800-942-0247 (TTY: 711), 8:00 a.m. to 8:00 p.m., 7 days a week.**

We strongly encourage you to complete a Report Potential Fraud Form to ensure that enough details are provided for our investigation. If you don't have access to the internet, you can make a report without a form, but please be sure to include details.

Report Fraud to Medicare or the HHS Office of Inspector General
You can report fraud to Medicare by phone or by mail:

Phone: 1-800-Medicare/ TTY: 877-486-2048

Mail:
Medicare Beneficiary Contact Center PO Box 39
Lawrence KS, 66044

You can report fraud to the HHS Office of Inspector General by phone, mail or online:

Phone: 1-800-HHS-TIPS (1-800-447-8477)/
TTY: 1-800-377-4950

Mail:
HHS Tips Hotline PO Box 23489
Washington, DC 20026-3489

Online: oig.hhs.gov/fraud/report-fraud/index.asp

This information is available for free in other languages and alternate formats. Please call our customer service number. Prospective members call 1-800-944-1247 (TTY: 711) and current members call 1-800-942-0247 (TTY: 711), 8:00 a.m. to 8:00 p.m., 7 days a week.