



## **Grievance:**

Any complaint or dispute, other than one involving an organization determination, expressing dissatisfaction with the manner in which a Medicare health plan/Part D sponsor or 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. An expedited grievance may also include a complaint that Health Plus refused to expedite an organization determination or reconsideration, or invoked an extension to an organization determination or reconsideration time frame.

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.

Grievances filed orally, may be responded to orally unless the enrollee requests a written response or the grievance concerns a quality of care issue. Grievances filed in writing must be responded to in writing.

Grievances can be initiated by phone or mail by contacting Health Plus Elite at (800) 300-8181 or PO Box 200-288, Brooklyn NY 11220-0288.

## **Grievance Categories:**

The following list contains examples of issues that would be handled as standard grievances. The list includes, but is not limited to the following:

- Complaints regarding provider service: office staff or physician behavior, adequacy of facilities.
- Complaints regarding plan customer service.
- Involuntary disenrollment from the plan.
- If a member is dissatisfied with the amount of a particular co-payment.
- Members who feel that they were misled by a sales counselor during the enrollment process.
- Member disagrees with Health Plus decision to process his/her medical service request for a service or to continue a service under the standard 14 calendar day time frame rather than the expedited/72-hour time frame.
- Member disagrees with Health Plus decision to process his/her appeal request under the standard 30-day time frame rather than the expedited/72 hour time frame.

- For prescription drug matters, the member complaint involves a refusal to grant his/her request for an expedited coverage determination (24 hour time frame) or an expedited redetermination (24 hour time frame), and the member has not yet purchased or received the drug that is in dispute.
- Complaints about an excluded drug not being covered (by Medicare) or not being included in the Health Plus formulary.
- Member disagrees with the decision to extend a medical service (standard or expedited) appeal time frame by 14 days.
- Access and availability of care: travel time, appointment wait time, wait at the point of service and communication barriers.

### Standard Grievances

If a grievance was not able to be resolved verbally at the time of receipt (via phone call or walk-in visit), a written acknowledgement of the receipt of the member's issue (except in cases of imminent health risk) will be sent within 3 business days.

Prompt, appropriate action, including a full investigation of the grievance, will occur as expeditiously as the case requires, based on the member's health status, so that the case may be brought to conclusion no later than 30 days from receipt of the oral or written request. This time frame may be extended by up to 14 days based on a member's request or if Health Plus needs additional time for investigation. Health Plus must justify why the extra time is needed and how it is in the best interest of the member. The member will be immediately notified in writing of an extension.

After the investigation is complete, a determination must be made and sent in writing to the member no later than 30, or 44 days if there is an extension; after the receipt of the grievance.

### Expedited Grievances

Health Plus will respond within 24 hours to a member's expedited grievance whenever Health Plus extends the time frame to make an organization determination or reconsideration or refuses to grant a request for an expedited organization determination or reconsideration (includes organizational determinations for prescription drugs when the member has not received the drug in dispute). Expedited grievance determinations if warranted are made within 72 hours.

### Quality Grievance Categories:

**Access/Availability:** Pertains to the member's expression of the amount, type and frequency of service they received that may or has adversely impacted their health status.

**Adequacy/Competency:** Pertains to the members expression of the providers lack of ability to perform a service or that they are being treated or not treated by the appropriate provider for their condition and the result of this allegation may or has adversely impacted upon their health status.

**Appropriateness:** Pertains to the member's expression of the amount, type and frequency of service they received may or has impacted adversely on their health status.

**Sentinel:** Pertains to an unexpected occurrence involving death or serious physical or psychological injury. Serious injury includes the loss of limb or function or any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.

### **Appeals:**

Once the Medicare Plan has made an official claim determination, members, providers, and suppliers have the right to appeal coverage and payment decisions. There are five levels of appeals processes involving Medicare Part A and Part B. These include:

**First Level of Appeal:** Redetermination by a Medicare carrier, fiscal intermediary (FI), or Medicare Administrative Contractor (MAC).

**Second Level of Appeal:** Reconsideration by a Qualified Independent Contractor (QIC).

**Third Level of Appeal:** Hearing by an Administrative Law Judge (ALJ) in the Office of Medicare Hearings and Appeals.

**Fourth Level of Appeal:** Review by the Medicare Appeals Council.

**Fifth Level of Appeal:** Judicial Review in Federal District Court.

### **Appeal Categories:**

**Standard Review (30 days):** Standard appeal decisions must be made no later than 30 days after an appeal is submitted. Extensions can be granted up to 14 days if an extension is requested by the member, or if the plan needs additional information and the extension benefits the enrollee.

**Expedited Review (72 hours):** Fast appeal decisions must be made no later than 72 hours after receipt of the appeal. Extensions can be granted up to 14 days if an extension is requested by the member, or if the plan needs additional information and the extension benefits the enrollee.

*If a doctor asks for a fast appeal for an enrollee, or supports the enrollee in asking for a fast appeal; and the doctor indicates that waiting 30 days could jeopardize the enrollee's health, the plan will automatically give you a fast appeal.*

*If the enrollee asks for a fast appeal without medical support from a doctor, the plan will decide if the enrollee's health requires a fast appeal. If the plan decides not to give a fast appeal, the enrollee's appeal will be decided within 30 days.*

**Reconsiderations:** An enrollee's first step in the appeal process after an adverse organizational determination had been made. A Medicare health plan or independent review entity may re-evaluate an adverse organizational determination, the findings upon which it was based, and any other evidence submitted or obtained.

*The MA plan must have an expedited reconsideration process when an adverse reconsideration determination could seriously jeopardize the life or health of the member or the member's ability to regain maximum function. Reconsideration determinations must be processed within the 72 Hour CMS required timeframe.*

*The MA plan must designate someone other than the person involved in making the initial organization determination when reviewing reconsideration. If the original denial was based on a lack of medical necessity, then the reconsideration must be performed by a physician with expertise in the field of medicine that is appropriate for the services at issue.*

*If the MA plan requires medical information from a non-contracted provider to make a decision, the plan must request the necessary information from the non-contracted provider within 24 hours of the initial request for an expedited organization determination.*

## **How do I request an exception to the Health Plus Formulary?**

You can ask Health Plus to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make.

- You can ask us to cover your drug even if it is not on our formulary.
- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, Health Plus limits the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover more.
- You can ask us to provide a higher level of coverage for your drug. If your drug is contained in our non-preferred tier, you can ask to cover it at the cost sharing amount that applies to drugs in the preferred tier instead. This would lower the amount you must pay for your drug. Please note, if we grant your request to cover a drug that is not on our formulary, you may not ask us to provide a higher level of coverage for the drug.

Generally, Health Plus will only approve your request for an exception if the alternative drugs included on the plan's formulary, the lower-tiered drug or additional utilization restrictions would not be as effective in treating your condition and/or would cause you to have adverse medical effects. You should contact us to ask us for an initial coverage decision for a formulary, tiering or utilization restriction exception. **When you are requesting a formulary, tiering or utilization restriction exception**

**you should submit a statement from your physician supporting your request.**

Generally, we must make our decision within 72 hours of getting your prescribing physician's supporting statement. You can request an expedited (fast) exception if you or your doctor believe that your health could be seriously harmed by waiting up to 72 hours for a decision. If your request to expedite is granted, we must give you a decision no later than 24 hours after we get your prescribing physician's supporting statement.