

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

[Plans that integrate the description of Medicare and Medicaid processes must revise the sections of this chapter as needed to clearly describe the appeals and grievance processes.]

[Plans should refer to other parts of the Member Handbook using the appropriate chapter number, section, and/or page number. For example, "refer to Chapter 9, Section A, page 1." An instruction [insert reference, as applicable] appears with many cross references throughout the Member Handbook. Plans may always include additional references to other sections, chapters, and/or member materials when helpful to the reader.]

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

Introduction

This chapter has information about your rights. Read this chapter to find out what to do if: [\[Add any additional language for Medi-Cal information\]](#)

- You have a problem with or complaint about your plan.
- You need a service, item, or medication that your plan said it won't pay for.
- You disagree with a decision your plan 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 Community-Based Adult Services (CBAS) and Nursing Facility (NF) services.

This chapter is in different sections to help you easily find what you are looking for. **If you have a problem or concern, read the parts of this chapter that apply to your situation.**

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 have a problem with your care, you can call the Medicare Medi-Cal Ombuds Program at 1-855-501-3077 for help.** This chapter explains different options you have for different problems and complaints, but you can always call the Ombuds Program to help guide you through your problem. For additional resources to address your concerns and ways to contact them, refer to **Chapter 2** of your *Member Handbook*.



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>. 1

[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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A. What to do if you have a problem or concern

This chapter explains how to handle problems and concerns. The process you use depends on the type of problem you have. Use one process for **coverage decisions and appeals** and another for **making complaints**; also called grievances.

To ensure fairness and promptness, each process has a set of rules, procedures, and deadlines that we and you must follow.

A1. About the legal terms

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

For example, we say:

- “Making a complaint” instead of “filing a grievance”
- “Coverage decision” instead of “organization determination”, “benefit determination”, “at-risk determination”, or “coverage determination”
- “Fast coverage decision” instead of “expedited determination”
- “Independent Review Organization” (IRO) instead of “Independent Review Entity” (IRE)

Knowing the proper legal terms may help you communicate more clearly, so we provide those too.

B. Where to get help

B1. For more information and help

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

Help from the Health Insurance Counseling and Advocacy Program

You can call the Health Insurance Counseling and Advocacy Program (HICAP). HICAP counselors can answer your questions and help you understand what to do about 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.



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

Help from the Medicare Medi-Cal Ombuds Program

You can call the Medicare Medi-Cal Ombuds Program and speak with an advocate about your health coverage questions. They offer free legal help. The Ombuds Program is not connected with us or with any insurance company or health plan. Their phone number is 1-888-804-3536 and their website is www.healthconsumer.org.

Help and information from Medicare

For more information and help, you can contact Medicare. Here are two ways to get help from Medicare:

- Call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.
- Visit the Medicare website (www.medicare.gov).

Help and information from Medi-Cal

Help from the California Department of Health Care Services

The California Department of Health Care Services (DHCS) Medi-Cal Managed Care Ombudsman can help. They can help if you have problems joining, changing or leaving a health plan. They can also help if you moved and are having trouble getting your Medi-Cal transferred to your new county. You can call the Ombudsman Monday through Friday, between 8:00 a.m. and 5:00 p.m. at 1-888-452-8609.

Help from the California Department of Managed Health Care

Contact the California Department of Managed Health Care (DMHC) for free help. The DMHC is responsible for overseeing health plans. The DMHC helps people 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 TDD number, 1-877-688-9891. You can also visit DMHC's website at www.HealthHelp.ca.gov.

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 [\[insert plan phone number\]](#) 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 **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's internet website www.dmh.ca.gov has complaint forms, IMR application forms and instructions online.

C. Understanding Medicare and Medi-Cal complaints and appeals in our plan

You have Medicare and Medi-Cal. Information in this chapter applies to **all** of your Medicare and Medi-Cal benefits. This is sometimes called an “integrated process” because it combines, or integrates, Medicare and Medi-Cal processes.

Sometimes Medicare and Medi-Cal processes cannot be combined. In those situations, you use one process for a Medicare benefit and another process for a Medi-Cal benefit. **Section F4** explains these situations.

D. Problems with your benefits

If you have a problem or concern, read the parts of this chapter that apply to your situation. The following chart helps 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 or prescription drugs are covered or not, the way they are covered, and problems about payment for medical care or prescription drugs.	
<p>Yes.</p> <p>My problem is about benefits or coverage.</p> <p>Refer to Section E, “Coverage decisions and appeals.”</p>	<p>No.</p> <p>My problem is not about benefits or coverage.</p> <p>Refer to Section K, “How to make a complaint.”</p>

E. Coverage decisions and appeals

The process for asking for a coverage decision and making an appeal deals with problems related to your benefits and coverage. It also includes problems with payment.

E1. Coverage decisions



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

A coverage decision is a decision we make about your benefits and coverage or about the amount we pay for your medical services or drugs. For example, your plan network doctor makes a (favorable) coverage decision for you whenever you receive medical care from them (refer to Chapter 4, Section H of your *Member Handbook*).

You or your doctor can also contact us and ask for a coverage decision. You or your doctor may be unsure whether we cover a specific medical service or if we may refuse to provide medical care you think you need. **If you want to know if we will cover a medical service before you get it, you can ask us to make a coverage decision for you.**

We make a coverage decision whenever we decide what is covered for you and how much we pay. In some cases, we may decide a service or drug is not covered or is no longer covered for you by Medicare or Medi-Cal. If you disagree with this coverage decision, you can make an appeal.

E2. Appeals

If we make a coverage decision and you are not satisfied with this decision, you can “appeal” the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made.

When you appeal a decision for the first time, this is called a Level 1 Appeal. In this appeal, we review the coverage decision we made to check if we followed all rules properly. Different reviewers than those who made the original unfavorable decision handle your appeal.

In most cases, you must start your appeal at Level 1. 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 IMR Medical Review from the Department of Managed Health Care at www.dmhca.ca.gov. Refer to page <xx> for more information.

When we complete the review, we give you our decision. Under certain circumstances, explained later in this chapter [*insert reference, as applicable*], you can ask for an expedited or “fast coverage decision” or “fast appeal” of a coverage decision.

If we say **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 medical service or item or Part B drugs, the letter will tell you that we sent your case to the Independent Review Organization (IRO) for a Level 2 Appeal. If your problem is about coverage of a Medicare Part D or Medicaid service or item, the letter will tell you how to file a Level 2 Appeal yourself. Refer to **Section F4** for more information about Level 2 Appeals. If your problem is about coverage of a service or item covered by both Medicare and Medicaid, the letter will give you information regarding both types of Level 2 Appeals.

If you are not satisfied with the Level 2 Appeal decision, you may be able to go through additional levels of appeal.



E3. Help with coverage decisions and appeals

You can ask for help from any of the following:

- **Member Services** at the numbers at the bottom of the page.
- **Medicare Medi-Cal Ombuds Program at 1-855-501-3077.**
- **Health Insurance Counseling and Advocacy Program (HICAP)** at 1-800-434-0222.
- **The Help Center at the Department of Managed Health Care (DMHC)** for free help. The DMHC is responsible for overseeing health plans. The DMHC helps people 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 TDD number, 1-877-688-9891. You can also visit DMHC's website at www.HealthHelp.ca.gov.
- **Your doctor or other provider.** Your doctor or other provider can ask for a coverage decision or appeal on your behalf.
- **A friend or family member.** You can name another person to act for you as your “representative” and ask for a coverage decision or make an appeal.
- **A lawyer.** You have the right to a lawyer, but **you are not required to have a lawyer** to ask for a coverage decision or make an appeal.
 - 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.
 - Ask for a legal aid attorney from the Medicare Medi-Cal Ombuds Program at 1-888-804-3536.

Fill out the Appointment of Representative form if you want a lawyer or someone else to act as your representative. The form gives someone permission to act for you.

Call Member Services at the numbers at the bottom of the page and ask for the “Appointment of Representative” form. You can also get the form by visiting 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>.*]. **You must give us a copy of the signed form.**

E4. Which section of this chapter can help you

There are four situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We give details for each one in a separate section of this chapter. Refer to the section that applies:



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>. 8

- **Section F**, “Medical care” *[insert reference, as applicable]*
- **Section G**, “Medicare Part D prescription drugs” *[insert reference, as applicable]*
- **Section H**, “Asking us to cover a longer hospital stay” *[insert reference, as applicable]*
- **Section I**, “Asking us to continue covering certain medical services” *[insert reference, as applicable]* (This section only applies to these services: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.)

If you’re not sure which section to use, call Member Services at the numbers at the bottom of the page. *[Plans may insert additional resources and contact information (e.g., SHIP, Ombudsperson Program).]*

F. Medical care

[Plans may update the heading and terms such as “medical care” throughout to account for Medi-Cal services such as behavioral health and long-term care services as directed by the state.]

This section explains what to do if you have problems getting coverage for medical care or if you want us to pay you back for our share of the cost of your care.

This section is about your benefits for medical care and services that are described in **Chapter 4** of your *Member Handbook*. We generally refer to “medical care coverage” or “medical care” in the rest of this section. The term “medical care” includes medical services and items as well as Medicare Part B prescription drugs which are drugs administered by your doctor or health care professional. Different rules may apply to a Medicare Part B prescription drug. When they do, we explain how rules for Medicare Part B prescription drugs differ from rules for medical services and items.

F1. Using this section

This section explains what you can do in any of the following situations:

1. You think we cover medical care you need but are not getting.

What you can do: You can ask us to make a coverage decision. Refer to **Section F2**.

2. We didn’t approve the medical care your doctor or other health care provider wants to give you, and you think we should.

What you can do: You can appeal our decision. Refer to **Section F3**.



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

3. You got medical care that you think we cover, but we will not pay.

What you can do: You can appeal our decision not to pay. Refer to **Section F5**.

4. You got and paid for medical care you thought we cover, and you want us to pay you back.

What you can do: You can ask us to pay you back. Refer to **Section F5**.

5. We reduced or stopped your coverage for certain medical care, and you think our decision could harm your health.

What you can do: You can appeal our decision to reduce or stop the medical care. Refer to **Section F4**.

- If the coverage is for hospital care, home health care, skilled nursing facility care, or CORF services, special rules apply. Refer to **Section H** *[insert reference, as applicable]* or **Section I** *[insert reference, as applicable]* to find out more.
- For all other situations involving reducing or stopping your coverage for certain medical care, use this section (**Section F**) as your guide.

6. You are experiencing delays in care or you cannot find a doctor.

What you can do: You can file a complaint. Refer to **Section K2**.

F2. Asking for a coverage decision

When a coverage decision involves your medical care, it's called an **"integrated organization determination"**.

You, your doctor, or your representative can ask us for a coverage decision by:

- calling: *<phone number>*, TTY: *<phone number>*.
- faxing: *<phone number>*.
- writing: *<address>*.

Standard coverage decision

When we give you our decision, we use the "standard" deadlines unless we agree to use the "fast" deadlines. A standard coverage decision means we give you an answer about a:

- Medical service or item within 14 calendar days after we get your request. For Knox-Keene plans, within 5 business days, and no later than 14 calendar days after we get your request.



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- Medicare Part B prescription drug within 72 hours after we get your request.

Fast coverage decision

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

When you ask us to make a coverage decision about your medical care and your health requires a quick response, ask us to make a “fast coverage decision.” A fast coverage decision means we will give you an answer about a:

- Medical service or item within 72 hours after we get your request, or sooner if your medical condition requires a quicker response.
- Medicare Part B prescription drug within 24 hours after we get your request.

To get a fast coverage decision, you must meet two requirements:

- You are asking for coverage for medical care you **did not get**. You can’t ask for a fast coverage decision about payment for medical care you already got.
- Using the standard deadlines **could cause serious harm to your health** or hurt your ability to function.

We automatically give you a fast coverage decision if your doctor tells us your health requires it. If you ask without your doctor’s support, we decide if you get a fast coverage decision.

- If we decide that your health doesn’t meet the requirements for a fast coverage decision, we send you a letter that says so and we use the standard deadlines instead. The letter tells you:
 - We automatically give you a fast coverage decision if your doctor asks for it.
 - 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 making a complaint, including a fast complaint, refer to **Section K** [\[insert reference, as applicable\]](#).

If we say No to part or all of your request, we send you a letter explaining the reasons.

- If we say **No**, you have the right to make an appeal. If you think we made a mistake, making an appeal is a formal way of asking us to review our decision and change it.
- If you decide to make an appeal, you will go on to Level 1 of the appeals process (refer to **Section F3** [\[insert reference, as applicable\]](#)).



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

In limited circumstances we may dismiss your request for a coverage decision, which means we won't review the request. Examples of when a request will be dismissed include:

- if the request is incomplete,
- if someone makes the request on your behalf but isn't legally authorized to do so,
or
- if you ask for your request to be withdrawn.

If we dismiss a request for a coverage decision, we will send you a notice explaining why the request was dismissed and how to ask for a review of the dismissal. This review is called an appeal. Appeals are discussed in the next section.

F3. Making a Level 1 Appeal

To start an appeal, you, your doctor, or your representative must contact us. Call us at *<phone number> [insert additional contact information, as applicable]*.

Ask for a standard appeal or a fast appeal in writing or by calling us at *<phone number>*.

- If your doctor or other prescriber asks to continue a service or item you are already getting during your appeal, you may need to name them as your representative to act on your behalf.
- If someone other than your doctor makes the appeal for you, include an Appointment of Representative form authorizing this person to represent you. You can get the form by visiting 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>]*.
- We can accept an appeal request without the form, but we can't begin or complete our review until we get it. If we don't get the form within 44 calendar days after getting your appeal request:
 - We dismiss your request, and
 - We send you a written notice explaining your right to ask the IRO to review our decision to dismiss your 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 the deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good reasons are things like you had a serious illness or we gave you the wrong information about the deadline. Explain the reason why your appeal is late when you make your appeal.



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>. 12

- You have the right to ask us for a free copy of the information about your appeal. You and your doctor may also give us more information to support your appeal.

If your health requires it, ask for a fast appeal.

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

- If you appeal a decision we made about coverage for care that you did not get, you and/or your doctor decide if you need a fast appeal.

We automatically give you a fast appeal if your doctor tells us your health requires it. If you ask without your doctor’s support, we decide if you get a fast appeal.

- If we decide that your health doesn’t meet the requirements for a fast appeal, we send you a letter that says so and we use the standard deadlines instead. The letter tells you:
 - We automatically give you a fast appeal if your doctor asks for it.
 - How you can file a “fast complaint” about our decision to give you a standard appeal instead of a fast appeal. For more information about making a complaint, including a fast complaint, refer to **Section K** *[insert reference, as applicable]*.

If we tell you we are stopping or reducing services or items that you already get, you may be able to continue those services or items during your appeal.

- If we decide to change or stop coverage for a service or item that you get, we send you a notice before we take action.
- If you disagree with our decision, you can file a Level 1 Appeal.
- We continue covering the service or item if you ask for a Level 1 Appeal within 10 calendar days of the date on our letter or by the intended effective date of the action, whichever is later.
 - If you meet this deadline, you will get the service or item with no changes while your Level 1 appeal is pending.
 - You will also get all other services or items (that are not the subject of your appeal) with no changes.
 - If you do not appeal before these dates, then your service or item will not be continued while you wait for your appeal decision.

We consider your appeal and give you our answer.

If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- When we review your appeal, we take another careful look at all information about your request for coverage of medical care.
- We check if we followed all the rules when we said **No** to your request.
- We gather more information if we need it. We may contact you or your doctor to get more information.

There are deadlines for a fast appeal.

- When we use the fast deadlines, we must give you our answer **within 72 hours after we get your appeal, or sooner if your health requires a quicker response**. We will give you our answer sooner if your health requires it.
 - If we don't give you an answer within 72 hours, we must send your request to Level 2 of the appeals process. An IRO then reviews it. Later in this chapter *[insert reference, as applicable]*, we tell you about this organization and explain the Level 2 appeals process. *[Insert as applicable and adjust language as directed by the state: If your problem is about coverage of a Medicaid service or item, you can file a Level 2 – State Hearing with the state yourself as soon as the time is up. In <insert name of state> a State Hearing is called <insert description>. To file a State Hearing, refer to <Insert reference>, as applicable]*
- **If we say Yes to part or all of your request**, we must authorize or provide the coverage we agreed to provide within 72 hours after we get your appeal, or sooner if your health requires it.
- **If we say No to part or all of your request**, we send your appeal to the IRO for a Level 2 Appeal.

There are deadlines for a standard appeal.

- When we use the standard deadlines, we must give you our answer **within 30 calendar days** after we get your appeal for coverage for services you didn't get.
- If your request is for a Medicare Part B prescription drug you didn't get, we give you our answer **within 7 calendar days** after we get your appeal or sooner if your health requires it.
 - If we don't give you an answer by the deadline, we must send your request to Level 2 of the appeals process. An IRO then reviews it. Later in this chapter *[insert reference, as applicable]*, we tell you about this organization and explain the Level 2 appeals process. *[Insert as applicable and adjust language as directed by the state: If your problem is about coverage of a Medicaid service or item, you can file a Level 2 – State Hearing with the state]*



yourself as soon as the time is up. In *<insert name of state>* a State Hearing is called *<insert description>*. To file a State Hearing, refer to *<Insert reference>*, as applicable]

If we say Yes to part or all of your request, we must authorize or provide the coverage we agreed to provide within 30 calendar days of the date we got your appeal request, or as fast as your health condition requires and within 72 hours of the date we change our decision, or within 7 calendar days of the date we got your appeal if your request is for a Medicare Part B prescription drug.

If we say **No** to part or all of your request, **you have additional appeal rights**:

- If we say **No** to part or all of what you asked for, we send you a letter.
- If your problem is about coverage of a Medicare service or item, the letter tells you that we sent your case to the IRO for a Level 2 Appeal.
- If your problem is about coverage of a Medi-Cal service or item, the letter tells you how to file a Level 2 Appeal yourself.

F4. Making a Level 2 Appeal

If we say **No** to part or all of your Level 1 Appeal, we will send you a letter. This letter tells you if Medicare, Medi-Cal, or both programs usually cover the service or item.

- If your problem is about a service or item that **Medicare** usually covers, we 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 service or item that **Medi-Cal** usually covers, you can file a Level 2 Appeal yourself. The letter tells you how to do this. We also include more information later in this chapter *[insert reference, as applicable]*.
- If your problem is about a service or item that **both Medicare and Medi-Cal** may cover, you automatically get a Level 2 Appeal with the IRO. In addition to the automatic Level 2 Appeal, you can also ask for a State Hearing and an Independent Medical Review with the state. However, an Independent Medical Review is not available if you have already presented evidence in a State Hearing.

If you qualified for continuation of benefits when you filed your Level 1 Appeal, your benefits for the service, item, or drug under appeal may also continue during Level 2. Refer to **Section F3** *[insert reference, as applicable]* for information about continuing your benefits during Level 1 Appeals.



- If your problem is about a service usually covered only by Medicare, your benefits for that service don't continue during the Level 2 appeals process with the IRO.
- If your problem is about a service usually covered only by Medi-Cal, your benefits for that service continue if you submit a Level 2 Appeal within 10 calendar days after getting our decision letter.

When your problem is about a service or item Medicare usually covers

The IRO reviews your appeal. It's an independent organization hired by Medicare.

The formal name for the "Independent Review Organization" (IRO) is the "**Independent Review Entity**", sometimes called the "**IRE**".

- This organization isn't connected with us and isn't a government agency. Medicare chose the company to be the IRO, and Medicare oversees their work.
- We send information about your appeal (your "case file") to this organization. You have the right to a free copy of your case file.
- You have a right to give the IRO additional information to support your appeal.
- Reviewers at the IRO take a careful look at all information related to your appeal.

If you had a fast appeal at Level 1, you also have a fast appeal at Level 2.

- If you had a fast appeal to us at Level 1, you automatically get a fast appeal at Level 2. The IRO must give you an answer to your Level 2 Appeal **within 72 hours** of getting your appeal.

If you had a standard appeal at Level 1, you also have a standard appeal at Level 2.

- If you had a standard appeal to us at Level 1, you automatically get a standard appeal at Level 2.
- If your request is for a medical item or service, the IRO must give you an answer to your Level 2 Appeal **within 30 calendar days** of getting your appeal.
- If your request is for a Medicare Part B prescription drug, the IRO must give you an answer to your Level 2 Appeal **within 7 calendar days** of getting your appeal.

If the IRO gives you their answer in writing and explains the reasons.

- **If the IRO says Yes to part or all of a request for a medical item or service,** we must promptly implement the decision:



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- Authorize the medical care coverage **within 72 hours, or**
- Provide the service within **5 working days** after we get the IRO's decision for **standard requests, or**
- Provide the service **within 72 hours** from the date we get the IRO's decision for **expedited requests.**
- **If the IRO says Yes to part or all of a request for a Medicare Part B prescription drug, we must authorize or provide the Medicare Part B prescription drug under dispute:**
 - **Within 72 hours** after we get the IRO's decision for **standard requests, or**
 - **Within 24 hours** from the date we get the IRO's decision for **expedited requests.**
- **If the IRO says No to part or all of your appeal,** it means they agree that we should not approve your request (or part of your request) for coverage for medical care. This is called “upholding the decision” or “turning down your appeal.”
 - If your case meets the requirements, you choose whether you want to take your appeal further.
 - There are three additional levels in the appeals process after Level 2, for a total of five levels.
 - If your Level 2 Appeal is turned down and you meet the requirements to continue the appeals process, you must decide whether to go on to Level 3 and make a third appeal. The details about how to do this are in the written notice you get after your Level 2 Appeal.
 - An Administrative Law Judge (ALJ) or attorney adjudicator handles a Level 3 Appeal. Refer to **Section J** *[insert reference, as applicable]* for more information about Level 3, 4, and 5 Appeals.

When your problem is about a service or item Medi-Cal usually covers

[Non-COHS plans insert this statement: 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.]

[COHS plans delete the entire Independent Medical Review section below and begin with the State Hearing section]

(1) Independent Medical Review



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>. 17

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.
- Disputes whether a surgical service or procedure was cosmetic or reconstructive in nature.
- 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, or sooner, if your health requires it, 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 unless your appeal involves an imminent and serious threat to your health, including but not limited to, severe pain, potential loss of life, limb, or major bodily function.

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

In most cases, you must file an appeal with us before requesting an IMR. Refer to 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: www.dmhc.ca.gov/FileaComplaint/IndependentMedicalReviewComplaintForms.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 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
- You may also submit your Independent Medical Review Application/Complaint Form and Authorized Assistant form online: www.dmhc.ca.gov/FileaComplaint.aspx

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.

An IMR can take longer if the DMHC does not receive all of the medical records needed from you or your treating doctor. If you are using a doctor who is not in your health plan's network, it is important that you get and send us your medical records from that doctor. Your health plan is required to get copies of your medical records from doctors who are in the network.

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.

[COHS plans should change the heading below to: (1) State Hearing.]

(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 "Appeal Decision Letter" 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.
2. You can call the California Department of Social Services at 1-800-743-8525. 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.

[Plans should describe the process for Medi-Cal Level 2 Appeals, in which members must submit the Level 2 Appeal themselves.]

The State Hearings Division gives you their decision in writing and explain the reasons.

- If the State Hearings Division says **Yes** to part or all of a request for a medical item or service, we must authorize or provide the service or item **within 72 hours** after we get their decision.
- If the State Hearings Division says **No** to part or all of your appeal, it means they agree that we should not approve your request (or part of your request) for coverage for medical care. This is called “upholding the decision” or “turning down your appeal.”

If the IRO or State Hearing decision is **No** for all or part of your request, you have additional appeal rights.

If your Level 2 Appeal went to the **IRO**, you can appeal again only if the dollar value of the service or item you want meets a certain minimum amount. An ALJ or attorney adjudicator handles a Level 3 Appeal. **The letter you get from the IRO explains additional appeal rights you may have.**

The letter you get from the State Hearings Division describes the next appeal option.

Refer to **Section J** *[insert reference, as applicable]* for more information about your appeal rights after Level 2.

F5. 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].]*

[Plans insert if the state DOES allow members to be directly reimbursed for Medi-Cal benefits: 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. If you do pay the bill, you can get a refund from our plan if you followed the rules for getting services or item.]



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

For more information, refer to **Chapter 7** of your *Member Handbook*. It describes situations when you may need to ask us to pay you back or pay a bill you got from a provider. It also tells how to send us the paperwork that asks us for payment.

If you ask to be paid back, you are asking for a coverage decision. We will check if the service or item you paid for is covered and 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: you or your provider] [insert: the payment or if the plan has cost-sharing, our share of the cost]* for the service or item within 60 calendar days after we get your request. *[Insert, as applicable: Your provider will then send the 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 won't pay for the service or item and explaining why.

If you don't agree with our decision not to pay, **you can make an appeal**. Follow the appeals process described in **Section F3** *[insert reference, as applicable]*. When you follow these instructions, note:

- If you make an appeal for us to pay you back, we must give you our answer within 30 calendar days after we get your appeal.
- If you ask us to pay you back for medical care you got and paid for yourself, you can't ask for a fast appeal.

If our answer to your appeal is **No** and **Medicare** usually covers the service or item, we will send your case to the IRO. We will send you a letter if this happens.

- If the IRO 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 to you or to the health care provider within 60 calendar days.
- If the IRO says **No** to your appeal, it means they agree that we should not approve your request. This is called "upholding the decision" or "turning down your appeal." You will get a letter explaining additional appeal rights you may have. Refer to **Section J** for more information about additional levels of appeal.



If our answer to your appeal is **No** and Medi-Cal usually covers the service or item, you can file a Level 2 Appeal yourself. Refer to **Section F4** for more information. *[Plans may edit as needed and/or provide additional instructions about the process for Level 2 payment appeals.]*

G. Medicare Part D prescription drugs

Your benefits as a member of our plan include coverage for many prescription drugs. Most of these are Medicare Part D drugs. There are a few drugs that Medicare Part D doesn't cover that Medi-Cal may cover. **This section only applies to Medicare Part D drug appeals.** We'll say "drug" in the rest of this section instead of saying "Medicare Part D drug" every time. *[Insert as applicable and adjust language as directed by the state: For drugs covered only by Medi-Cal follow the process in Section E on page <insert page number>.]*

To be covered, the drug must be used for a medically accepted indication. That means the drug is approved by the Food and Drug Administration (FDA) or supported by certain medical references. Refer to **Chapter 5** of your *Member Handbook* for more information about a medically accepted indication.

G1. Medicare Part D coverage decisions and appeals

Here are examples of coverage decisions you ask us to make about your Medicare Part D drugs:

- You ask us to make an exception, including asking us to:
 - Cover a Medicare Part D drug that is not on our plan's Drug List or
 - Set aside a restriction on our coverage for a drug (such as limits on the amount you can get)
- You ask us if a drug is covered for you (such as when your drug is on our plan's Drug List but we must approve it for you before we cover it)

NOTE: If your pharmacy tells you that your prescription can't be filled as written, the pharmacy gives you a written notice explaining how to contact us to ask for a coverage decision.

An initial coverage decision about your Medicare Part D drugs is called a "**coverage determination.**"

- You ask us to pay for a drug you already bought. This is asking for a coverage decision about payment.



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>. 23

If you disagree with a coverage decision we made, you can appeal our decision. This section tells you both how to ask for coverage decisions and how to make an appeal. Use the chart below to help you.

Which of these situations are you in?

<p>You need a drug that isn't on our Drug List or need us to set aside a rule or restriction on a drug we cover.</p>	<p>You want us to cover a drug on our Drug List, and you think you meet plan rules or restrictions (such as getting approval in advance) for the drug you need.</p>	<p>You want to ask us to pay you back for a drug you already got and paid for.</p>	<p>We told you that we won't cover or pay for a drug in the way that you want.</p>
<p>You can ask us to make an exception. (This is a type of coverage decision.)</p>	<p>You can ask us for a coverage decision.</p>	<p>You can ask us to pay you back. (This is a type of coverage decision.)</p>	<p>You can make an appeal. (This means you ask us to reconsider.)</p>
<p>Start with Section G2, then refer to Sections G3 and G4 <i>[insert reference, as applicable]</i>.</p>	<p>Refer to Section G4 <i>[insert reference, as applicable]</i>.</p>	<p>Refer to Section G4 <i>[insert reference, as applicable]</i>.</p>	<p>Refer to Section G5 <i>[insert reference, as applicable]</i>.</p>

G2. Medicare Part D exceptions

If we don't cover a drug in the way you would like, you can ask us to make an "exception." If we turn down your request for an exception, you can appeal our decision.

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

Asking for coverage of a drug not on our Drug List or for removal of a restriction on a drug is sometimes called asking for a **"formulary exception."**

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

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



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>. 24

- *[Plans without cost-sharing delete]* If we agree to make an exception and cover a drug that is not on our Drug List, you pay the copay that applies *[insert as appropriate: to 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 can't get an exception to the required copay amount for the drug.

2. Removing a restriction for a covered drug

- Extra rules or restrictions apply to certain drugs on our Drug List (refer to **Chapter 5** of your *Member Handbook* for more information).
 - Extra rules and restrictions for certain drugs include:
 - *[Omit if the plan does not use generic substitution]* Being required to use the generic version of a drug instead of the brand name drug.
 - *[Omit if the plan does not use prior authorization (PA)]* Getting our approval in advance before we agree to cover the drug for you. This is sometimes called "prior authorization (PA)."
 - *[Omit if the plan does not use step therapy]* Being required to try a different drug first before we agree to cover the drug you ask for. This is sometimes called "step therapy."
 - *[Omit if the plan does not use quantity limits]* Quantity limits. For some drugs, there are restrictions on the amount of the drug you can have.
 - *[Plans with a formulary structure (e.g., no tiers) that does not allow for tiering exceptions omit this bullet.]* If we agree to an exception for you and set aside a restriction, you can ask for an exception to the copay amount you're required to pay.
3. *[Plans with no cost-sharing and plans with a formulary structure (e.g., no tiers) that does not allow for tiering exceptions, omit this section.]* **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on our Drug List is in one of *[insert number of tiers]* cost-sharing tiers. In general, the lower the cost-sharing tier number, the less your required copay amount is.

Asking to pay a lower price for a covered non-preferred drug is sometimes called asking for a **"tiering exception."**

- Our Drug List often includes more than one drug for treating a specific condition. These are called "alternative" drugs.



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- If an alternative drug for your medical condition is in a lower cost-sharing tier than the drug you take, you can ask us to cover it at the cost-sharing amount for the alternative drug. This would lower your copay amount for the drug.
 - *[Plans that have a formulary structure where all biological products are on one tier or that do not limit their tiering exceptions in this way, omit this bullet:]*
If the drug you take is a biological product, you can ask us to cover it at the cost-sharing amount for the lowest tier for biological product alternatives for your condition.
 - *[Plans that do not limit their tiering exceptions in this way, omit this bullet:]* If the drug you take is a brand name drug, you can ask us to cover it at the cost-sharing amount for the lowest tier for brand name alternatives for your condition.
 - *[Plans that do not limit their tiering exceptions in this way; omit this bullet:]* If the drug you take is a generic drug, you can ask us to cover it at the cost-sharing amount for the lowest tier for either brand or generic alternatives for your condition.
- *[If the plan designated one of its tiers as a “specialty tier” and exempts that tier from the exceptions process, include the following language: You can’t ask us to change the cost-sharing tier for any drug in [insert tier number and name of tier designated as the high-cost/unique drug tier].]*
- If we approve your tiering exception request and there is more than one lower cost-sharing tier with alternative drugs you can’t take, you usually pay the lowest amount.

G3. Important things to know about asking for an exception

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 asking for an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Our Drug List often includes more than one drug for treating a specific condition. These are called “alternative” drugs. If an alternative drug is just as effective as the drug you ask for and wouldn’t cause more side effects or other health problems, we generally do **not** approve your exception request. *[Plans with a formulary structure (e.g., no tiers) that does not allow for tiering exceptions omit the next sentence.]* If you ask us for a tiering exception, we generally do **not** approve your exception request unless all alternative drugs in the lower cost-sharing tier(s) won’t work as well for you or are likely to cause an adverse reaction or other harm.

We can say Yes or No to your request.



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>. 26

- If we say **Yes** to your exception request, 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 exception request, you can make an appeal. Refer to **Section G5** *[insert reference, as applicable]* for information on making an appeal if we say **No**.

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

G4. Asking for a coverage decision, including an exception

- Ask for the type of coverage decision you want by calling *<phone number>*, writing, or faxing us. You, your representative, or your doctor (or other prescriber) can do this. Please include your name, contact information, and information about the claim.
- You or your doctor (or other prescriber) or someone else acting on your behalf can ask for a coverage decision. You can also have a lawyer act on your behalf.
- Refer to **Section E3** *[insert reference, as applicable]* to find out how to name someone as your representative.
- You don't need to give written permission to your doctor or other prescriber to ask for a coverage decision on your behalf.
- If you want to ask us to pay you back for a drug, refer to **Chapter 7** of your *Member Handbook*.
- If you ask for an exception, give us a "supporting statement." The supporting statement includes your doctor or other prescriber's medical reasons for the exception request.
- Your doctor or other prescriber can fax or mail us the supporting statement. They can also tell us by phone and then fax or mail the statement.
- *[Plans that allow members to submit coverage determination requests electronically (e.g., through a secure member portal) may include a brief description of that process.]*

If your health requires it, ask us for a "fast coverage decision."

We use the "standard deadlines" unless we agree to use the "fast deadlines."

- A **standard coverage decision** means we give you an answer within 72 hours after we get your doctor's statement.



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>. 27

- A **fast coverage decision** means we give you an answer within 24 hours after we get your doctor's statement.

A "fast coverage decision" is called an "**expedited coverage determination.**"

You can get a fast coverage decision if:

- It's for a drug you didn't get. You can't get a fast coverage decision if you are asking us to pay you back for a drug you already bought.
- Your health or ability to function would be seriously harmed if we use the standard deadlines.

If your doctor or other prescriber tells us that your health requires a fast coverage decision, we agree and give it to you. We send you a letter that tells you.

- If you ask for a fast coverage decision without support from your doctor or other prescriber, we decide if you get a fast coverage decision.
- If we decide that your medical condition doesn't meet the requirements for a fast coverage decision, we use the standard deadlines instead.
 - We send you a letter that tells you. The letter also tells you how to make a complaint about our decision.
 - You can file a fast complaint and get a response within 24 hours. For more information making complaints, including fast complaints, refer to **Section K** *[insert reference, as applicable]*.

Deadlines for a fast coverage decision

- If we use the fast deadlines, we must give you our answer within 24 hours after we get your request. If you ask for an exception, we give you our answer within 24 hours after we get your doctor's supporting statement. We give you our answer sooner if your health requires it.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an IRO. Refer to **Section G6** *[insert reference, as applicable]* for more information about a Level 2 Appeal.
- If we say **Yes** to part or all of your request, we give you the coverage within 24 hours after we get your request or your doctor's supporting statement.
- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how you can make an appeal.



Deadlines for a standard coverage decision about a drug you didn't get

- If we use the standard deadlines, we must give you our answer within 72 hours after we get your request. If you ask for an exception, we give you our answer within 72 hours after we get your doctor's supporting statement. We give you our answer sooner if your health requires it.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an IRO.
- If we say **Yes** to part or all of your request, we give you the coverage within 72 hours after we get your request or your doctor's supporting statement for an exception.
- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how to make an appeal.

Deadlines for a standard coverage decision about a drug you already bought

- We must give you our answer within 14 calendar days after we get your request.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an IRO.
- If we say **Yes** to part or all of your request, we pay you back within 14 calendar days.
- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how to make an appeal.

G5. Making a Level 1 Appeal

An appeal to our plan about a Medicare Part D drug coverage decision is called a plan "**redetermination**".

- Start your **standard** or **fast appeal** by calling <phone number>, writing, or faxing us. You, your representative, or your doctor (or other prescriber) can do this. Please include your name, contact information, and information regarding your 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 the deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good reasons are things like you



had a serious illness or we gave you the wrong information about the deadline.
Explain the reason why your appeal is late when you make your appeal.

- You have the right to ask us for a free copy of the information about your appeal. You and your doctor may also give us more information to support your appeal.

If your health requires it, ask for a fast appeal.

A fast appeal is also called an “**expedited redetermination.**”

- If you appeal a decision we made about a drug you didn’t get, you and your doctor or other prescriber decide if you need a fast appeal.
- Requirements for a fast appeal are the same as those for a fast coverage decision. Refer to **Section G4** *[insert reference, as applicable]* for more information.

We consider your appeal and give you our answer.

- We review your appeal and take another careful look at all of the information about your coverage request.
- We check if we followed the rules when we said **No** to your request.
- We may contact you or your doctor or other prescriber to get more information.

Deadlines for a fast appeal at Level 1

- If we use the fast deadlines, we must give you our answer **within 72 hours** after we get your appeal.
 - We give you our answer sooner if your health requires it.
 - If we don’t give you an answer within 72 hours, we must send your request to Level 2 of the appeals process. Then an IRO reviews it. Refer to **Section G6** *[insert reference, as applicable]* for information about the review organization and the Level 2 appeals process.
- If we say **Yes** to part or all of your request, we must provide the coverage we agreed to provide within 72 hours after we get your appeal.
- If we say **No** to part or all of your request, we send you a letter that explains the reasons and tells you how you can make an appeal.

Deadlines for a standard appeal at Level 1



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- If we use the standard deadlines, we must give you our answer **within 7 calendar days** after we get your appeal for a drug you didn't get.
- We give you our decision sooner if you didn't get the drug and your health condition requires it. If you believe your health requires it, ask for a fast appeal.
 - If we don't give you a decision within 7 calendar days, we must send your request to Level 2 of the appeals process. Then an IRO reviews it. Refer to **Section G6** *[insert reference, as applicable]* for information about the review organization and the Level 2 appeals process.

If we say **Yes** to part or all of your request:

- We must **provide the coverage** we agreed to provide as quickly as your health requires, but **no later than 7 calendar days** after we get your appeal.
- We must **send payment to you** for a drug you bought **within 30 calendar days** after we get your appeal.

If we say **No** to part or all of your request:

- We send you a letter that explains the reasons and tells you how you can make an appeal.
- We must give you our answer about paying you back for a drug you bought **within 14 calendar days** after we get your appeal.
 - If we don't give you a decision within 14 calendar days, we must send your request to Level 2 of the appeals process. Then an IRO reviews it. Refer to **Section G6** *[insert reference, as applicable]* for information about the review organization and the Level 2 appeals process.
- If we say **Yes** to part or all of your request, we must pay you within 30 calendar days after we get your request.
- If we say **No** to part or all of your request, we send you a letter that explains the reasons and tells you how you can make an appeal.

G6. Making a Level 2 Appeal

If we say **No** to your Level 1 Appeal, you can accept our decision or make another appeal. If you decide to make another appeal, you use the Level 2 Appeal appeals process. The **IRO** reviews our decision when we said **No** to your first appeal. This organization decides if we should change our decision.



The formal name for the “Independent Review Organization” (IRO) is the **“Independent Review Entity”**, sometimes called the **“IRE”**.

To make a Level 2 Appeal, you, your representative, or your doctor or other prescriber must contact the IRO **in writing** and ask for a review of your case.

- If we say **No** to your Level 1 Appeal, the letter we send you includes **instructions about how to make a Level 2 Appeal** with the IRO. The instructions tell who can make the Level 2 Appeal, what deadlines you must follow, and how to reach the organization.
- When you make an appeal to the IRO, we send the information we have about your appeal to the organization. This information is called your “case file”. **You have the right to a free copy of your case file.**
- You have a right to give the IRO additional information to support your appeal.

The IRO reviews your Medicare Part D Level 2 Appeal and gives you an answer in writing. Refer to **Section F4** *[insert reference, as applicable]* for more information about the IRO.

Deadlines for a fast appeal at Level 2

If your health requires it, ask the IRO for a fast appeal.

- If they agree to a fast appeal, they must give you an answer **within 72 hours** after getting your appeal request.
- If they say **Yes** to part or all of your request, we must provide the approved drug coverage **within 24 hours** after getting the IRO’s decision.

Deadlines for a standard appeal at Level 2

If you have a standard appeal at Level 2, the IRO must give you an answer:

- **within 7 calendar days** after they get your appeal for a drug you didn’t get.
- **within 14 calendar days** after getting your appeal for repayment for a drug you bought.

If the IRO says **Yes** to part or all of your request:

- We must provide the approved drug coverage **within 72 hours** after we get the IRO’s decision.
- We must pay you back for a drug you bought within 30 calendar days after we get the IRO’s decision.



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- If the IRO says **No** to your appeal, it means they agree with our decision not to approve your request. This is called “upholding the decision” or “turning down your appeal”.

If the IRO says **No** to your Level 2 Appeal, you have the right to a Level 3 Appeal if the dollar value of the drug coverage you ask for meets a minimum dollar value. If the dollar value of the drug coverage you ask for is less than the required minimum, you can’t make another appeal. In that case, the Level 2 Appeal decision is final. The IRO sends you a letter that tells you the minimum dollar value needed to continue with a Level 3 Appeal.

If the dollar value of your request meets the requirement, you choose if you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2.
- If the IRO says **No** to your Level 2 Appeal and you meet the requirement to continue the appeals process, you:
 - Decide if you want to make a Level 3 Appeal.
 - Refer to the letter the IRO sent you after your Level 2 Appeal for details about how to make a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** [\[insert reference, as applicable\]](#) for information about Level 3, 4, and 5 Appeals.

H. Asking us to cover a longer hospital stay

When you’re 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. For more information about our plan’s hospital coverage, refer to **Chapter 4** of your *Member Handbook*.

During your covered hospital stay, your doctor and the hospital staff work with you to prepare for the day when you leave the hospital. They also help arrange for 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’re being asked to leave the hospital too soon or you are concerned about your care after you leave the hospital, you can ask for a longer hospital stay. This section tells you how to ask.

Notwithstanding the appeals discussed in this Section H, you may also file a complaint with and ask the DMHC for an Independent Medical Review to continue your hospital stay. Please refer



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>. 33

to Section F4 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.

H1. Learning about your Medicare rights

Within two days after you're admitted to the hospital, someone at the hospital, such as a nurse or caseworker, will give you a written notice called "An Important Message from Medicare about Your Rights." Everyone with Medicare gets a copy of this notice whenever they are admitted to a hospital.

If you don't get the notice, ask any hospital employee for it. If you need help, call Member Services at the numbers at the bottom of the page. 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 the notice** carefully and ask questions if you don't understand. The notice 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're being discharged from the hospital too soon.
- **Sign the notice** to show that you got it and understand your rights.
 - You or someone acting on your behalf can sign the notice.
 - Signing the notice **only** shows that you got the information about your rights. Signing does **not** mean you agree to a discharge date your doctor or the hospital staff may have told you.

- **Keep your copy** of the signed notice so you have the information if you need it.

If you sign the notice more than two days before the day you leave the hospital, you'll get another copy before you're discharged.

You can look at a copy of the notice in advance if you:

- Call Member Services at the numbers at the bottom of the page



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>. 34

- Call Medicare at 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- Visit www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.

H2. Making a Level 1 Appeal

If you want us to cover your inpatient hospital services for a longer time, make an appeal. The Quality Improvement Organization (QIO) reviews the Level 1 Appeal to find out if your planned discharge date is medically appropriate for you.

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

In California, the QIO is *[insert state-specific QIO name]*. Call them at *[insert QIO toll-free phone number]*. Contact information is also in the notice, “An Important Message from Medicare about Your Rights,” and in **Chapter 2**.

Call the QIO before you leave the hospital and no later than your planned discharge date.

- **If you call before you leave**, you can stay in the hospital after your planned discharge date without paying for it while you wait for the QIO’s decision about your appeal.
- **If you do not call to appeal**, and you decide to stay in the hospital after your planned discharge date, you may pay all costs for hospital care you get after your planned discharge date.
- **If you miss the deadline** for contacting the QIO about your appeal, appeal to our plan directly instead. Refer to **Section G4** *[insert reference, as applicable]* for information about making an appeal to us.
- 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 refer to Section F4 on page <xx> to learn how to file a complaint and ask the DMHC for an Independent Medical Review.

Ask for help if you need it. If you have questions or need help at any time:

- Call Member Services at the numbers at the bottom of the page.



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>. 35

- Call the Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222.

Ask for a fast review. Act quickly and contact the QIO to ask for a fast review of your hospital discharge.

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

What happens during fast review

- Reviewers at the QIO ask you or your representative why you think coverage should continue after the planned discharge date. You aren’t required to write a statement, but you may.
- Reviewers look at your medical information, talk with your doctor, and review information that the hospital and our plan gave them.
- By noon of the day after reviewers tell our plan about your appeal, you get a letter with your planned discharge date. The letter also gives reasons why your doctor, the hospital, and we think that is the right discharge date that’s medically appropriate for you.

The legal term for this written explanation is the “**Detailed Notice of Discharge.**” You can get a sample by calling Member Services at the numbers at the bottom of the page or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) You can also refer to a sample notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.

Within one full day after getting all of the information it needs, the QIO give you their answer to your appeal.

If the QIO says **Yes** to your appeal:

- We will provide your covered inpatient hospital services for as long as the services are medically necessary.

If the QIO says **No** to your appeal:

- They believe your planned discharge date is medically appropriate.
- Our coverage for your inpatient hospital services will end at noon on the day after the QIO gives you their answer to your appeal.



- You may have to pay the full cost of hospital care you get after noon on the day after the QIO gives you their answer to your appeal.
- You can make a Level 2 Appeal if the QIO turns down your Level 1 Appeal **and** you stay in the hospital after your planned discharge date.

H3. Making a Level 2 Appeal

For a Level 2 Appeal, you ask the QIO to take another look at the decision they made on your Level 1 Appeal. Call them at *[insert QIO toll-free phone number]*.

You must ask for this review **within 60 calendar days** after the day the QIO said **No** to your Level 1 Appeal. You can ask for this review **only** if you stay in the hospital after the date that your coverage for the care ended.

QIO reviewers will:

- Take another careful look at all of the information related to your appeal.
- Tell you their decision about your Level 2 Appeal within 14 calendar days of receipt of your request for a second review.

If the QIO says **Yes** to your appeal:

- We must pay you back for our share of hospital care costs since noon on the day after the date the QIO turned down your Level 1 Appeal.
- We will provide your covered inpatient hospital services for as long as the services are medically necessary.

If the QIO says **No** to your appeal:

- They agree with their decision about your Level 1 Appeal and won't change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.
- You may also file a complaint with or ask the DMHC for an Independent Medical Review to continue your hospital stay. Please refer to Section E4 on page <xx> to learn how to file a complaint with and ask the DMHC for an Independent Medical Review.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** *[insert reference, as applicable]* for information about Level 3, 4, and 5 Appeals.

H4. Making a Level 1 Alternate Appeal



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>. 37

The deadline for contacting the QIO for a Level 1 Appeal is within 60 days or no later than your planned hospital discharge date. If you miss the Level 1 Appeal deadline, you can use an “Alternate Appeal” process.

Contact Member Services at the numbers at the bottom of the page and ask us for a “fast review” of your hospital discharge date.

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

- We look at all of the information about your hospital stay.
- We check that the first decision was fair and followed the rules.
- We use fast deadlines instead of standard deadlines and give you our decision within 72 hours of when you asked for a fast review.

If we say **Yes** to your fast appeal:

- We agree that you need to be in the hospital after the discharge date.
- We will provide your covered inpatient hospital services for as long as the services are medically necessary.
- We 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 appeal:

- We agree that your planned discharge date was medically appropriate.
- Our coverage for your inpatient hospital services ends on the date we told you.
- We will not pay any share of the costs after this date.
- You may have to pay the full cost of hospital care you got after the planned discharge date if you continued to stay in the hospital.
- We send your appeal to the IRO to make sure we followed all the rules. When we do this, your case automatically goes to the Level 2 appeals process.

H5. Making a Level 2 Alternate Appeal

We send the information for your Level 2 Appeal to the IRO within 24 hours of saying **No** to your Level 1 Appeal. We do this automatically. You don’t need to do anything.

If you think we didn’t meet this deadline, or any other deadline, you can make a complaint. Refer to **Section K** *[insert reference, as applicable]* for information about making complaints.



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>. 38

The IRO does a fast review of your appeal. They take a careful look at all of the information about your hospital discharge and usually give you an answer within 72 hours.

If the IRO says **Yes** to your appeal:

- We pay you back for our share of the costs of care you got since the date when we said your coverage would end.
- We will provide your covered inpatient hospital services for as long as the services are medically necessary.

If the IRO says **No** to your appeal:

- They agree that your planned hospital discharge date was medically appropriate.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** [*insert reference, as applicable*] for information about Level 3, 4, and 5 Appeals.

You may also file a complaint with and ask the DMHC for an Independent Medical Review to continue your hospital stay. Please refer to Section F4 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.

I. Asking us to continue covering certain medical services

This section is only about three types of services you may be getting:

- home health care services
- skilled nursing care in a skilled nursing facility, **and**
- rehabilitation care as an outpatient at a Medicare-approved CORF. This usually means you're getting treatment for an illness or accident or you're recovering from a major operation.

With any of these three types of services, you have the right to get covered services for as long as the doctor says you need them.

When we decide to stop covering any of these, we must tell you **before** your services end. When your coverage for that service ends, we stop paying for it.

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



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>. 39

I1. Advance notice before your coverage ends

We send you a written notice that you'll get at least two days before we stop paying for your care. This is called the "Notice of Medicare Non-Coverage." The notice tells you the date when we will stop covering your care and how to appeal our decision.

You or your representative should sign the notice to show that you got it. Signing the notice **only** shows that you got the information. Signing does **not** mean you agree with our decision.

I2. Making a Level 1 Appeal

If you think we're ending coverage of your care too soon, you can appeal our decision. This section tells you about the Level 1 Appeal process and what to do.

- **Meet the deadlines.** The deadlines are important. Understand and follow the deadlines that apply to things you must do. Our plan must follow deadlines too. If you think we're not meeting our deadlines, you can file a complaint. Refer to **Section K** *[insert reference, as applicable]* for more information about complaints.
- **Ask for help if you need it.** If you have questions or need help at any time:
 - Call Member Services at the numbers at the bottom of the page.
 - Call the HICAP at 1-800-434-0222.
- **Contact the QIO.**
 - Refer to **Section H2** *[insert reference, as applicable]* or refer to **Chapter 2** of your *Member Handbook* for more information about the QIO and how to contact them.
 - Ask them to review your appeal and decide whether to change our plan's decision.
- **Act quickly and ask for a "fast-track appeal."** Ask the QIO if it's medically appropriate for us to end coverage of your medical services.

Your deadline for contacting this organization

- You must contact the QIO to start your appeal by noon of the day before the effective date on the "Notice of Medicare Non-Coverage" we sent you.
- If you miss the deadline for contacting the QIO, you can make your appeal directly to us instead. For details about how to do that, refer to **Section I4** *[insert reference, as applicable]*.



- 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 refer to Section F4 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 the numbers at the bottom of the page or call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or get a copy online at www.cms.gov/Medicare/Medicare-General-Information/BNI/FFS-Expedited-Determination-Notices.

What happens during a fast-track appeal

- Reviewers at the QIO ask you or your representative why you think coverage should continue. You aren’t required to write a statement, but you may.
- Reviewers look at your medical information, talk with your doctor, and review information that our plan gave them.
- Our plan also sends you a written notice that explains our reasons for ending coverage of your services. You get the notice by the end of the day the reviewers inform us of your appeal.

The legal term for the notice explanation is “**Detailed Explanation of Non-Coverage**”.

- Reviewers tell you their decision within one full day after getting all the information they need.

If the QIO says **Yes** to your appeal:

- We will provide your covered services for as long as they are medically necessary.

If the QIO says **No** to your appeal:

- Your coverage ends on the date we told you.



- We stop paying *[plans with cost-sharing should include: our share of]* the costs of this care on the date in the notice.
- You pay the full cost of this care yourself if you decide to continue the home health care, skilled nursing facility care, or CORF services after the date your coverage ends
- You decide if you want to continue these services and make a Level 2 Appeal.

I3. Making a Level 2 Appeal

For a Level 2 Appeal, you ask the QIO to take another look at the decision they made on your Level 1 Appeal. Call them at *[insert QIO toll-free phone number]*.

You must ask for this review **within 60 calendar days** after the day the QIO said **No** to your Level 1 Appeal. You can ask for this review **only** if you continue care after the date that your coverage for the care ended.

QIO reviewers will:

- Take another careful look at all of the information related to your appeal.
- Tell you their decision about your Level 2 Appeal within 14 calendar days of receipt of your request for a second review.

If the QIO says **Yes** to your appeal:

- We pay you back for *[plans with cost-sharing should include: our share of]* the costs of care you got since the date when we said your coverage would end.
- We will provide coverage for the care for as long as it is medically necessary.

If the QIO says **No** to your appeal:

- They agree with our decision to end your care and will not change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.
- You may file a complaint with and ask the DMHC for an Independent Medical Review to continue coverage of your health care services. Please refer to Section F4 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.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** *[insert reference, as applicable]* for information about Level 3, 4, and 5 Appeals.



14. Making a Level 1 Alternate Appeal

As explained in **Section I2** *[insert reference, as applicable]*, you must act quickly and contact the QIO to start your Level 1 Appeal. If you miss the deadline, you can use an “Alternate Appeal” process.

Contact Member Services at the numbers at the bottom of the page and ask us for a “fast review”.

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

- We look at all of the information about your case.
- We check that the first decision was fair and followed the rules when we set the date for ending coverage for your services.
- We use fast deadlines instead of standard deadlines and give you our decision within 72 hours of when you asked for a fast review.

If we say **Yes** to your fast appeal:

- We agree that you need services longer.
- We will provide your covered services for as long as the services are medically necessary.
- 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 appeal:
 - Our coverage for these services ends on the date we told you.
 - We will not pay any share of the costs after this date.
 - You pay the full cost of these services if you continue getting them after the date we told you our coverage would end.
 - We send your appeal to the IRO to make sure we followed all the rules. When we do this, your case automatically goes to the Level 2 appeals process.

15. Making a Level 2 Alternate Appeal

During the Level 2 Appeal:



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- We send the information for your Level 2 Appeal to the IRO within 24 hours of saying No to your Level 1 Appeal. We do this automatically. You don't need to do anything.
- If you think we didn't meet this deadline, or any other deadline, you can make a complaint. Refer to **Section K** *[insert reference, as applicable]* for information about making complaints.
- The IRO does a fast review of your appeal. They take a careful look at all of the information about your hospital discharge and usually give you an answer within 72 hours.

If the IRO says **Yes** to your appeal:

- We pay you back for our share of the costs of care you got since the date when we said your coverage would end.
- We will provide your covered inpatient hospital services for as long as the services are medically necessary.

If the IRO says **No** to your appeal:

- They agree with our decision to end your care and will not change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

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 refer to Section F4 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.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** *[insert reference, as applicable]* for information about Level 3, 4, and 5 Appeals.

J. Taking your appeal beyond Level 2

J1. 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 of your appeals were turned down, you may have the right to additional levels of appeal.

If the dollar value of the Medicare service or item you appealed does not meet a certain minimum dollar amount, you cannot appeal any further. If the dollar value is high enough, you



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>. 44

can continue the appeals process. The letter you get from the IRO for your Level 2 Appeal explains who to contact and what to do to ask for a Level 3 Appeal.

Level 3 Appeal

Level 3 of the appeals process is an ALJ hearing. The person who makes the decision is an ALJ or an attorney adjudicator who works for the federal government.

If the ALJ or attorney adjudicator says **Yes** to your appeal, we have the right to appeal a Level 3 decision that is favorable to you.

- If we decide **to appeal** the decision, we send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.
- If we decide **not to appeal** the decision, we must authorize or provide you with the service within 60 calendar days after getting the ALJ or attorney adjudicator's decision.
 - If the ALJ or attorney adjudicator says **No** to your appeal, the appeals process may not be over.
- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 Appeal.

Level 4 Appeal

The Medicare Appeals Council (Council) reviews your appeal and gives you an answer. The Council is part of the federal government.

If the Council says **Yes** to your Level 4 Appeal or denies our request to review a Level 3 Appeal decision favorable to you, we have the right to appeal to Level 5.

- If we decide **to appeal** the decision, we will tell you in writing.
- If we decide **not to appeal** the decision, we must authorize or provide you with the service within 60 calendar days after getting the Council's decision.

If the Council says **No** or denies our review request, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.



- If you decide **not to accept** this decision that turns down your appeal, you may be able to continue to the next level of the review process. The notice you get will tell you if you can go on to a Level 5 Appeal and what to do.

Level 5 Appeal

- A Federal District Court judge will review your appeal and all of the information and decide **Yes** or **No**. This is the final decision. There are no other appeal levels beyond the Federal District Court.

J2. Additional Medi-Cal appeals

You also have other appeal rights if your appeal is about services or items that Medi-Cal usually covers. The letter you get from the State Hearings Division will tell you what to do if you want to continue the appeals process.

[Plans may, at the discretion of the state, insert a clear, brief description of the procedures, timing, and instructions about what members need to do if they want to file an additional appeal in the state.]

J3. Appeal Levels 3, 4 and 5 for Medicare Part D Drug Requests

This section may be appropriate for you if you made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the value of the drug you appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. The written response you get to your Level 2 Appeal explains who to contact and what to do to ask for a Level 3 Appeal.

Level 3 Appeal

Level 3 of the appeals process is an ALJ hearing. The person who makes the decision is an ALJ or an attorney adjudicator who works for the federal government.

If the ALJ or attorney adjudicator says **Yes** to your appeal:

- The appeals process is over.
- We must authorize or provide the approved drug coverage within 72 hours (or 24 hours for an expedited appeal) or make payment no later than 30 calendar days after we get the decision.

If the ALJ or attorney adjudicator says **No** to your appeal, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.



- If you decide **not to accept** this decision that turns down your appeal, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 Appeal.

Level 4 Appeal

The Council reviews your appeal and gives you an answer. The Council is part of the federal government.

If the Council says **Yes** to your appeal:

- The appeals process is over.
- We must authorize or provide the approved drug coverage within 72 hours (or 24 hours for an expedited appeal) or make payment no later than 30 calendar days after we get the decision.

If the Council says **No** to your appeal, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you may be able to continue to the next level of the review process. The notice you get will tell you if you can go on to a Level 5 Appeal and what to do.

Level 5 Appeal

- A Federal District Court judge will review your appeal and all of the information and decide **Yes** or **No**. This is the final decision. There are no other appeal levels beyond the Federal District Court.

K. How to make a complaint

K1. What kinds of problems should be complaints

The complaint process is used for certain types of problems only, such as problems related to quality of care, waiting times, coordination of care, and customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaint	Example
Quality of your medical care	<ul style="list-style-type: none">• You are unhappy with the quality of care, such as the care you got in the hospital.



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>. 47

Complaint	Example
Respecting your privacy	<ul style="list-style-type: none"> • You think that someone did not respect your right to privacy or shared confidential information about you.
Disrespect, poor customer service, or other negative behaviors	<ul style="list-style-type: none"> • A health care provider or staff was rude or disrespectful to you. • Our staff treated you poorly. • You think you are being pushed out of our plan.
Accessibility and language assistance	<ul style="list-style-type: none"> • You cannot physically access the health care services and facilities in a doctor or provider's office. • Your doctor or provider does not provide an interpreter for the non-English language you speak (such as American Sign Language or Spanish). • Your provider does not give you other reasonable accommodations you need and ask for.
Waiting times	<ul style="list-style-type: none"> • You have trouble getting an appointment or wait too long to get it. • Doctors, pharmacists, or other health professionals, Member Services, or other plan staff keep you waiting too long.
Cleanliness	<ul style="list-style-type: none"> • You think the clinic, hospital or doctor's office is not clean.
Information you get from us	<ul style="list-style-type: none"> • You think we failed to give you a notice or letter that you should have received. • You think written information we sent you is too difficult to understand.



Complaint	Example
Timeliness related to coverage decisions or appeals	<ul style="list-style-type: none"> You think we don't meet our deadlines for making a coverage decision or answering your appeal. You think that, after getting a coverage or appeal decision in your favor, we don't meet the deadlines for approving or giving you the service or paying you back for certain medical services. You don't think we sent your case to the IRO on time.

There are different kinds of complaints. 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 not affiliated with our plan. If you need help making an internal and/or external complaint, you can call [\[insert contacts and contact information\]](#).

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

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

K2. 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 Medicare Part D drug. If the complaint is about a Medicare Part D drug, you must make it **within 60 calendar** days after you had the problem you want to complain about.

- If there is anything else you need to do, 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 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 don't make a decision within 30 calendar days because we need more information, we notify you in writing. We also provide a status update and estimated time for you to get the answer.
- If you make a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we automatically give you a "fast complaint" and respond to your complaint within 24 hours.
- If you make a complaint because we took extra time to make a coverage decision or appeal, we automatically give you a "fast complaint" and respond to your complaint within 24 hours.

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

K3. External complaints

Medicare

You can tell Medicare about your complaint or send it to Medicare. The Medicare Complaint Form is available at: www.medicare.gov/MedicareComplaintForm/home.aspx. You do not need to file a complaint with *[insert plan name]* before filing a complaint with Medicare.

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

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

Medi-Cal

You can file a complaint with the California Department of Health Care Services (DHCS) Medi-Cal Managed Care Ombudsman by calling 1-888-452-8609. TTY users can call 711. Call Monday through Friday between 8:00 a.m. and 5:00 p.m.

You can file a complaint with the California Department of Managed Health Care (DMHC). The DMHC is responsible for regulating health plans. You can call the DMHC Help Center for help with complaints about Medi-Cal services. For non-urgent matters, you may file a complaint with the DMHC if you disagree with the decision in your Level 1 appeal or if the plan has not resolved your complaint after 30 calendar days. However, you may contact the DMHC without filing a Level 1 appeal if you need help with a



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>. 50

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 (www.dmhca.ca.gov).

Office for Civil Rights (OCR)

You can make a complaint to the Department of Health and Human Services (HHS) OCR 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 OCR is 1-800-368-1019. TTY users should call 1-800-537-7697. You can visit www.hhs.gov/ocr for more information.

You may also contact the local OCR office at:

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

You may also have rights under the Americans with Disability Act (ADA) and under *[plans may insert relevant state law]*. You can contact *[insert contacts and contact information]*.

QIO

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

- You can make your complaint about the quality of care directly to the QIO.
- You can make your complaint to the QIO and to our plan. If you make a complaint to the QIO, we work with them to resolve your complaint.

The QIO 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 QIO, refer to **Section H2** *[insert reference, as applicable]* or refer to **Chapter 2** of your *Member Handbook*.

In California, the QIO is called *<state specific QIO name>*. The phone number for *<state-specific QIO name>* is *<phone number>*.

