

## **Part C Grievance, Coverage/Organization Determination and Appeals Process (Health)**

### **GRIEVANCE (Complaint)**

A grievance is a type of **complaint** you make about us or one of our network providers or pharmacies. This type of complaint does not involve coverage or payment disputes. The grievance / complaint process is used for certain types of problems only. This includes problems related to quality of care, waiting times, and the customer service you receive. Here are examples of the kinds of problems handled by the complaint process:

#### **Quality of your medical care**

- Are you unhappy with the quality of the care you have received (including care in the hospital)?

#### **Respecting your privacy**

- Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?

#### **Disrespect, poor customer service, or other negative behaviors**

- Has someone been rude or disrespectful to you?
- Are you unhappy with how our Member Services team has dealt with you?
- Do you feel you are being encouraged to leave our plan?

#### **Waiting times**

- Are you having trouble getting an appointment, or waiting too long to get it?
- Have you been kept waiting too long by doctors, pharmacists, or other health care professionals? Or by Member Services or other staff at our plan?
  - Examples include waiting too long on the phone, in the waiting room, when getting a prescription, or in the exam room.

#### **Cleanliness**

- Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?

#### **Information you get from our plan**

- Do you believe we have not given you a notice that we are required to give?
- Do you think written information we have given you is hard to understand?

#### **Timeliness**

If you have already asked for a coverage decision or made an appeal, and you think that our plan is not responding quickly enough, you can also make a complaint about our slowness. Here are examples:

- If you have asked us to give you a "fast coverage decision" or a "fast appeal," and we have said we will not, you can make a complaint.
- If you believe our plan is not meeting the deadlines for giving you a coverage determination or an answer to an appeal you have made, you can make a complaint.

## **Part C Grievance, Coverage/Organization Determination and Appeals Process (Health), continued**

- When a coverage decision we made is reviewed and our plan is told that we must cover or reimburse you for certain medical services or drugs, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint.
- When our plan does not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint

### **Making a Complaint**

#### **Contact us promptly - either by phone or in writing;**

- **Usually calling Member Services is the first step** - If there is anything else you need to do, Member Services will let you know. Call 1-833-866-6559. TTY: 1-800-955-8770. Hours are 8:00 a.m. - 8:00 p.m. local time, seven days a week, from October 1 - March 31, except for Thanksgiving Day and Christmas Day. However, from April 1- September 30, our hours are 8:00 a.m. - 8:00 p.m. local time, five days a week. You will have to leave a message on Saturdays, Sundays and Federal holidays. We will return your call within one business day.
- **If you do not wish to call (or you called and were unsatisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.
- Member Services has established a process for reviewing member grievances / complaints. The purpose of this process is to facilitate the review of your dissatisfaction.

The grievance / complaint process also permits you or your authorized representative to request a “fast” complaint or an “urgent” complaint.

#### **Standard Complaints and Grievances:**

You or someone you have authorized to act on your behalf may contact our Member Services by phone, fax, or e-mail (the phone numbers are listed on the cover). The e-mail address is [memberservices@fhcp.com](mailto:memberservices@fhcp.com).

You must submit all grievances within 60 calendar days after the event or incident leading to your complaint.

## **Part C Grievance, Coverage/Organization Determination and Appeals Process (Health), continued**

Once we receive your complaint we will work with the appropriate administrative personnel and departments to review your concerns. We will complete this review process within 30 days from receipt of your complaint. We may extend this time by an additional 14 days if we require additional information. If additional time is necessary we will notify you of the need and the reason for the additional time within the first 30 days. This notification will include information regarding your right to file a “Fast” Grievance if you disagree without request for additional time. At the end of our investigation you will be notified, verbally of the outcome by one of our Member Services Representatives.

If your complaint was received by Member Services in writing (this is also called a Grievance), or, if your Complaint is regarding quality of care, then you will receive both a verbal and written notification of the outcome of our investigation.

If you need assistance in preparing a written complaint (this is also called a grievance), a Member Services Representative will work with you and will forward a copy of the written document when completed, for your signature, along with a stamped self-addressed envelope for returning the signed document to us.

If you or your authorized representative has a complaint regarding a Quality issue you, your authorized representative or a physician you have authorized to act on your behalf may contact the state’s Quality Improvement Organization (QIO) in Florida the quality improvement organization is listed below:

KEPRO  
5201 West Kennedy Blvd  
Suite 900  
Tampa, FL 33609-0795  
Phone: 1-844-455-8708  
TTY Users: TRS Relay 711

## Part C Grievance, Coverage/Organization Determination and Appeals Process (Health), continued

### **“FAST” Complaint**

If you are making a complaint regarding our decision to extend the timeframe by 14 days of a complaint regarding medical care or services, or an appeal regarding a request for medical care or services that we have initially denied, you can request a “Fast” Complaint or “Fast” Grievance.

You can also request a “Fast” Complaint or “Fast” Grievance if we have decided to deny your request for a “Fast” or “Expedited” initial determination or Appeal.

When we receive your verbal or written request for a “Fast” Complaint we will review your concerns and respond to you both verbally and in writing within 24 hours.

### **“Urgent” Complaint**

If you are concerned about the quality of care you are receiving or have received, or if you have a complaint such as a delay in access to a service and believe that it is medically necessary that we resolve your complaint as fast as possible, you can request an “Urgent” review.

Your request for an “Urgent” Complaint may be made by phone, in writing, by fax or by e-mail to our Member Services. Once our Member Services receives your request for an “Urgent” Complaint we will review your concerns with the appropriate Administration, Departments and/or Medical Review Panel. We will notify you both verbally and in writing of the results of our review within 72 hours. We may extend this time by an additional 14 days if we require additional information. If additional time is necessary we will notify you of the need and the reason for the additional time within the first 72 hours.

- **Whether you call or write, you should contact Member Services right away.** The complaint must be made within 60 calendar days after you had the problem you want to complain about.
- **If you are making a complaint because we denied your request for a “fast coverage decision” or a “fast appeal,” we will automatically give you a “fast complaint.”** If you have a “fast complaint,” it means we will give you an answer within 24 hours.

## **Part C Grievance, Coverage/Organization Determination and Appeals Process (Health), continued**

### **Problems/Concerns About Part C Medical Benefits and Coverage**

We encourage you to let us know right away if you have questions, concerns, or problems related to:

- Requests for Part C medical care or services or payments
- If you think you are asked to leave the hospital too soon.
- If you think your skilled nursing facility (SNF), home health (HHA) or comprehensive out patient rehabilitation facility (CORF) services are ending too soon.

To file your complaint or for additional information, please contact our Member Services Department at 1-833-866-6559 (TTY: 1-800-955-8770). Hours are 8:00 a.m. - 8:00 p.m. local time, seven days a week from October 1 - March 31, except for Thanksgiving Day and Christmas Day. However, from April 1- September 30, our hours are 8:00 a.m. - 8:00 p.m. local time, five days a week. You will have to leave a message on Saturdays, Sundays and Federal holidays. We will return your call within one business day.

The complaint will be handled as a [grievance \(complaint\)](#), [coverage decisions](#), or an [appeal](#) depending on the subject of the complaint

## Part C Grievance, Coverage/Organization Determination and Appeals Process (Health), continued

### How To Appeal A Coverage Decision

#### LEVEL 1 APPEAL

How to ask for a review of a medical care coverage decision OR payment for medical care coverage decision made by our plan.

**You contact us and make your appeal.** If your health requires a quick response, you must ask for a “fast appeal.”

#### ***What to do***

- **To start an appeal you, your doctor, or your representative, must contact us.** For details on how to reach us for any purpose related to your appeal, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are making an appeal about your medical care and/or Part D prescription drugs.*
- **If you are asking for a standard appeal, make your standard appeal in writing by submitting a request.**
  - If you have someone appealing our decision for you other than your doctor, your appeal must include an Appointment of Representative form authorizing this person to represent you. To get the form, call Member Services (phone numbers are printed on the back cover of this booklet) and ask for the “Appointment of Representative” form. It is also available on Medicare’s website at <https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf> or on our website at [www.fhcpmedicare.com](http://www.fhcpmedicare.com). While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form within 44 calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the Independent Review Organization to review our decision to dismiss your appeal.
- Make your "Standard" appeal request in writing, by submitting a signed request to:

FHCP Medicare  
Attn: Member Services  
1340 Ridgewood Avenue  
Holly Hill, FL 32117  
Fax#: 386-676-7149

If your health requires a quick response, you can request a "Fast" appeal. You may make your request by phone or in writing. To make your request by phone, call 1-833-866-6559 (TTY: 1-800-955-8770).

## Part C Grievance, Coverage/Organization Determination and Appeals Process (Health), continued

- You must make your appeal request within 60 calendar days from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.

Our plan considers your appeal and we give you our answer:

Deadlines for a "fast" appeal

- We must give you our answer within 72 hours after we receive your appeal. We will give you our answer sooner if your health requires us to do so.
  - However, if you ask for more time, or if we need to gather more information that may benefit you, we **can take up to 14 more calendar days**. If we decide to take extra days to make the decision, we will tell you in writing.
  - If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell you about this organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will automatically send your appeal to the Independent Review Organization for a Level 2 Appeal.

## Part C Grievance, Coverage/Organization Determination and Appeals Process (Health), continued

Deadlines for a "Standard" appeal (MEDICAL CARE COVERAGE DECISIONS)

We must give you our answer within 30 calendar days after we receive your appeal. If your appeal is about coverage for services you have not yet received. We will give you our decision sooner if your health condition requires us to.

- However, if you ask for more time, or if we need to gather more information that may benefit you, **we can take up to 14 more calendar days**. If we decide to take extra days to make the decision, we will tell you in writing.
- If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours.
- If we do not give you an answer by the deadline above (or by the end of the extended time period if we took extra days), we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 30 calendar days after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will automatically send your appeal to the Independent Review Organization for a Level 2 Appeal

**If our plan says no to part or all of your appeal, your case will *automatically* be sent on to the next level of the appeals process.**

- To make sure we were following all the rules when we said no to your appeal, **we are required to send your appeal to the "Independent Review Organization."** When we do this, it means that your appeal is going on to the next level of the appeals process, which is Level 2.

### **LEVEL 2 APPEAL:**

If our plan says no to your Level 1 Appeal, your case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews our decision for your first appeal. This organization decides whether the decision we made should be changed.

- The Independent Review Organization is an independent organization that is hired by Medicare. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- We will send the information about your appeal to this organization. This information is called your "case file." **You have the right to ask us for a copy of your case file.** We are allowed to charge you a fee for copying and sending this information to you.

## Part C Grievance, Coverage/Organization Determination and Appeals Process (Health), continued

- You have a right to give the Independent Review Organization additional information to support your appeal.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.

### ***If you had a “fast appeal” at Level 1, you will also have a “fast appeal” at Level 2***

- If you had a fast appeal to our plan at Level 1, you will automatically receive a fast appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal **within 72 hours** of when it receives your appeal.
- However, if the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**.

### ***If you had a “standard appeal” at Level 1, you will also have a “standard appeal” at Level 2***

- If you had a standard appeal to our plan at Level 1, you will automatically receive a standard appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal **within 30 calendar days** of when it receives your appeal.
- However, if the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**.

### **Step 2: The Independent Review Organization gives you their answer.**

The Independent Review Organization will tell you its decision in writing and explain the reasons for it.

- **If the review organization says yes to part or all of what you requested**, we must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we receive the decision from the review organization for standard requests or within 72 hours from the date the plan receives the decision from the review organization for expedited requests.
- **If this organization says no to part or all of your appeal**, it means they agree with us that your request (or part of your request) for coverage for medical care should not be approved. (This is called “upholding the decision.” It is also called “turning down your appeal.”)
  - If the Independent Review Organization “upholds the decision” you have the right to a Level 3 Appeal. However, to make another appeal at Level 3, the dollar value of the medical care coverage you are requesting must meet a certain minimum. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal, which means that the decision at Level 2 is final. The written notice you get from the Independent Review Organization will tell you how to find out the dollar amount to continue the appeals process.

## **Part C Grievance, Coverage/Organization Determination and Appeals Process (Health), continued**

**Step 3: 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 of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. The details on how to do this are in the written notice you got after your Level 2 Appeal.
- The Level 3 Appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

**What if you are asking us to pay you for our share of a bill you have received for medical care?**

### **LEVELS 3, 4 AND 5 OF THE APPEAL PROCESS:**

If you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down and the dollar value of the item of medical service you have appealed meets certain minimum values, you may be able to go on to additional levels of appeal. If the dollar value is high enough, the written response you received to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way.

For additional information please refer to the "What to do if you have a problem or complaint (coverage decisions, appeals, complaints)" section of your 2019 Evidence of Coverage.