COMMUNITY HEALTH PLAN of Washington™ | MEDICARE ADVANTAGE

The power of community

Appeals and Grievances

Community Health Plan of Washington Medicare Advantage Dual Complete Plan (HMO D-SNP)
Community Health Plan of Washington Medicare Advantage Dual Select Plan (HMO D-SNP)

As a Community Health Plan of Washington (CHPW) Medicare Advantage Dual Plan (HMO D-SNP) enrollee, you have the right to voice a complaint if you have a problem or concern about your health care or health care coverage. The Federal Medicare program has rules about what you need to do to make a complaint and what CHPW is required to do when we receive a complaint. If you make a complaint, we are impartial in how we manage it. You cannot be disenrolled from your CHPW Medicare Advantage Dual Plan or penalized in any way if you make a complaint.

This document is designed to help you understand:

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

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

What are appeals and grievances?

You have the right to make a complaint if you have concerns or problems related to your coverage or care. Complaints can fall into two categories. "*appeals*" and "grievances".

Appeals

An "*appeal"* is a type of complaint you make when you want CHPW to reconsider a decision we have made about what benefits or prescription drugs are covered under your plan or what we will pay.
For example, you might *appeal* if you think:

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

Grievances

A "*grievance"* is a type of complaint you make if you have a problem with your health care provider or the service CHPW provided to you.

For example, you might file a *grievance* if you have a concern about things such as:

- The quality of your care.
- Waiting times for appointments or in the waiting room.
- Your provider's behavior.
- The ability to reach someone by phone or get the information you need.
- The cleanliness or condition of your provider's office or the courtesy of the service we provide you.

What is the appeal process?

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

There are two types of *appeals*: ***standard*** and ***fast*** (also called ***expedited***).

- Standard *appeal*, also called a "reconsideration," is a formal request for your health care plan to review its denial of a service or item that you believe should be covered or paid for.
- Fast (expedited) *appeal* is filed if you or your doctor feels that a delay in receiving a standard *appeal* decision by waiting more than 72 hours (3 calendar days) could seriously jeopardize your health, life, or ability to regain maximum function.

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

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

How do I file an appeal?

Both standard and fast (expedited*) appeals* can be filed verbally by calling

Community Health Plan of Washington Customer Service
1-800-942-0247 (TTY: 711), 8:00 a.m. to 8:00 p.m., 7 days a week.

Or you can send your *appeal* in writing to:

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

You can also fax your *appeal* to:
Standard *appeal* **1-206-652-7010**
Fast (expedited) *appeal* **1-206-652-7011**

You can deliver your *fast (expedited) appeal* in person to:

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

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

Who may file an appeal?

Only the member, their authorized representative, treating provider, or Primary Care Provider (PCP) can file a Part C *appeal*. For Part D *appeals*, the member, their authorized representative, or the prescribing physician may *appeal*. You can designate someone to represent you, such as a relative, friend, advocate, attorney, or doctor, and all communication will be sent to them.

To appoint a representative, you must complete an Appointment of Representative (AOR) form. The form is available at www.CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at www.medicare.chpw.org/member-center/member-resources/medicare-plan-documents/. This form gives that person permission to act on your behalf. It must be signed by you and by the person you want to act on your behalf. You must give us a copy of the signed form. Alternatively, you may submit a written statement containing the same information indicated on the form.

How long does an appeal decision take?

Standard appeals are processed within 30 calendar days from the date we receive your request for a *standard appeal*. This may be extended to 44 calendar days if additional information is needed. You will receive notice of our decision in writing along with any supporting explanation. If your *appeal* is for payment of a service you have already received, you will receive a written decision within 60 days. Decisions on *standard* Part D prescription drug *coverage redetermination appeals* are made within 7 calendar days.

Fast (*expedited) appeals* are processed within 72 hours of the receipt of the *appeal*. If we determine that the *appeal* should be *standard* instead, we will promptly call you with that decision and follow up with a written notice within 2 calendar days. Decisions on *fast* (*expedited)* Part D Prescription drug *coverage redetermination appeals* are made within 72 hours.

How does the decision process work?

There are **5 levels** of *appeal*. Each of these levels has steps that you and CHPW must follow.

In each of the **5 levels** of *appeal*, if you disagree with the decision made at any level, you can generally move on to the next level. At each step, you will receive a decision letter that includes instructions on how to proceed to the next level of *appeal.*

Step 1: Organization Determinations

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

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

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

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

Step 2: Review by an Independent Review Entity (IRE)
The independent review entity is an independent organization hired by Medicare. It is not connected with CHPW and isn't a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

If we say no to part or all of your **Part B or C Level 1 *appeal,*** we'll automatically send your *appeal* to the independent review organization for a **Level 2 *appeal.***

If we say no to your **Part D Level 1 *appeal***, you decide if you want to continue with the *appeal*s process and make *another appeal*, which means your *appeal* goes on to the Level 2 Independent Review Entity (IRE)of the *appeal*s process. We will send you a written notice that includes how to make a Level 2 *appeal*, the deadlines you must follow, and how to reach the independent review organization.

If you disagree with the IRE's decision in the **Level 2 *appeal***, you have 60 days from the date of the IRE's decision to ask for a **Level 3 *appeal***, which is a decision by the Office of Medicare Hearings and *Appeal*s (OMHA). The *appeal* request must be made in writing and filed within 60 calendar days from the date of receipt of the IRE's reconsideration decision notice. A written request may be made using the form "OMHA-100." Forms needed for **Level 3 *appeal***: https://www.hhs.gov/about/agencies/omha/filing-an-*appeal*/forms/index.html

Step 3: Administrative Law Judge or an Attorney Adjudicator
If you disagree with the outcome of your **Level 2 *appeal*** made by the Independent Review Entity (IRE), you may ask for an Administrative Law Judge (ALJ) to consider your case and make a ruling. The ALJ is employed by the Federal Government. At **Level 3** of the *appeal* process, your *appeal* will be reviewed by an OMHA adjudicator, and you may have a hearing before an Administrative Law Judge (ALJ). An Administrative Law Judge or an attorney adjudicator will review your *appeal* and give you an answer. If you don't want to accept the decision, 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***. The dollar value of your contested benefit must be at least $190 to be considered in **Step 4**.

Step 4: Review by the Medicare *Appeal*s Council (MAC)
If the ALJ's decision is unfavorable, or you do not want to accept the decision made at the **Level 3 *appeal***, the decision will contain information needed to file a request for review by the Medicare *Appeal*s Council (MAC).

The **Level 4 *appeal*** request must be made in writing and filed with the *Appeal*s Council within 60 calendar days after receipt of the ALJ's or attorney adjudicator's decision using ***Appeal* Form DAB-101**, which is available at hhs.gov/about/agencies/dab/different-*appeal*s-at-dab/*appeal*s-to-council/forms/index.html.

If you don't want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your *appeal*, the notice you get will tell you whether the rules allow you to go to a **Level 5 *appeal*** and how to continue with a **Level 5 *appeal***.

Step 5: Judicial Review in Federal District Court
If you, or we, do not agree with the decision made by the Medicare *Appeal*s Council (Council) **Level 4** decision and the amount in controversy is at least $1,900, a civil action may be filed with the local Federal District Court. The notice of decision from the Council will give information about filing a civil action. Please note that your request must be filed with the Federal District Court within 60 days of receiving the Medicare *Appeal*s Council decision.

This is the last level of *appeals* – **Level 5**.

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

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

Step 1: Call Community Health Plan of Washington (or have someone authorized in writing by you call us) immediately at **1-800-942-0247 (TTY: 711)** to receive a Notice of Discharge & Medicare *Appeal* Rights. This notice will tell you:

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

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

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

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

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

- If we review your medical information and decide that you need to stay in the hospital, we will continue to cover your hospital care for as long as is medically necessary.
- If we turn down part or all of your Part C *appeal*, we will send your request to an IRE. This organization will review your request and make a decision about whether we must give you the care or payment you want.

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

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

If you are a patient in a skilled nursing facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF), you have the right to keep getting your services for that type of care for as long as the care is needed to diagnose and treat your illness or injury. The day we end your SNF, HHA, or CORF coverage is based on when your stay is no longer medically necessary. This part explains what to do if you believe that your coverage is ending too soon. You will receive written notice from us or your provider at least 2 calendar days before your coverage ends. If you believe we are ending your care coverage too soon, this section explains what to do next.

- If you receive a notice and have more than two calendar days before your coverage for Skilled Nursing Facility (SNF), Comprehensive Outpatient Rehabilitation Facility (CORF), or Home Health Agency (HHA) services ends, you must submit your request by noon the day before your coverage ends. We will notify you in writing at least 2 calendar days before any termination of coverage. You or someone you authorize will be asked to sign and date this document to show that you received the notice, which does not indicate agreement with the coverage ending
- You have the right to *appeal* our decision to terminate your coverage. In the notice from us or your provider, we will explain how to request an independent review from the Quality Improvement Organization (QIO). The QIO will review your medical information, interview you, and consult with your provider. After reviewing all the information, the QIO will give an opinion about whether it is medically appropriate for your coverage to be terminated on the date that has been set for you. The QIO will make this decision within one full day of receiving the information needed to make a decision.
- If the QIO agrees with you, then we will continue to cover your SNF stay, or CORF or HHA services, for as long as medically necessary.
- If the QIO determines that our decision to terminate your coverage is medically appropriate, you will be responsible for paying charges from the Skilled Nursing Facility, Home Health Agency, or Comprehensive Outpatient Rehabilitation Facility after the termination date listed in your advance notice. If your request for continued coverage is denied and you receive services after the termination date, you will be responsible for those charges.

If you do not meet the QIO request deadline, you may ask the QIO for a *fast (expedited) appeal* of your coverage termination date for your SNF, HHA, or CORF services. The QIO will review your request and make a decision about whether we must give you the care or payment you requested.

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

If you do not ask the QIO by noon after the day you are given written notice that we will be terminating coverage for your SNF, HHA, or CORF services, and if you stay in the SNF, HHA, or CORF after this date, you run the risk of having to pay for the SNF, HHA, or CORF care you receive on and after this date. However, you can *appeal* any bills for SNF, HHA, or CORF care you receive using **Step 1 Level 1** of the *appeal*s process described in the Evidence of Coverage.

Filing a grievance

A *grievance* must be filed within **60 calendar days** after the event or incident that precipitates the *grievance*. *Grievances* are complaints that you may have about types of problems other than coverage, such as:

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

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

How do I file a grievance?

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

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

Grievances can be submitted verbally by calling:

Community Health Plan of Washington Customer Service
1-800-942-0247 (TTY: 711), 8:00 a.m. to 8:00 p.m., 7 days a week.

Or you can file a *grievance* in writing to:

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

Grievances filed in writing and all quality of care *grievances* are responded to in writing. Decisions on *expedited grievance* submittals are made within 24 hours of the receipt of the request. Decisions on Part D prescription drug *standard grievance* requests are made within 30 days. Decisions on Part D prescription drug *expedited grievance* requests are made within 24 hours.

You can also fax your *grievance* to **1-206-652-7010**

You can deliver your *grievance* in person to:

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

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

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

You can also tell Medicare about your complaint: You can submit a complaint about CHPW Medicare Advantage Dual Plans directly to Medicare.

To submit a complaint to Medicare, go to www.Medicare.gov/my/medicare-complaint. You can also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users call 1-877-486-2048. This toll-free help line is available 24 hours a day, 7 days a week.

Who may file a grievance?

You can submit a *grievance* yourself or designate a representative to submit the *grievance* for you. Your provider, however, may not file a *grievance* on your behalf. If you choose to designate someone else to represent you, all communication will be sent to that person. To appoint a representative, you must complete the Appointment of Representative form, which is not necessary if you file a grievance on your own. (The form is also available at www.CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at www.medicare.chpw.org/member-center/member-resources/medicare-plan-documents/. This form gives that person permission to act on your behalf. It must be signed by you and by the person you want to act on your behalf. You must give us a copy of the signed form. Alternatively, you may submit a written statement containing the same information indicated on the form.

How long does a grievance decision take?

Standard grievance requests are typically decided upon within 30 calendar days from the date we receive your request but may be extended up to 44 days if additional information is needed. *Grievances* filed verbally are responded to verbally. For expedited *grievance*s, notification must be delivered no later than 24 hours from receipt. When written notification is required for expedited *grievance*s, CHPW will provide verbal notification of its decision and must deliver written confirmation of its decision within 3 calendar days of the verbal notification.

How does the grievance decision process work?

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

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

Confidentiality

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

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

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

To request a coverage determination or exception to Part D **Prescription Drugs,** please contact Express Scripts:

Express Scripts
Attn: Medicare Reviews
P.O. Box 66571
St. Louis, MO 63166-6571
Call 1-844-605-8168, option 0. Hours of operation are 24 hours a day, 7 days a week
TTY 1-800-899-2114
Fax 1-877-251-5896
Website www.express-scripts.com

Step 1: You can ask us to make an exception to our coverage rules by calling Express Scripts at 1-844-605-8168 (TTY: 1-800-899-2114), 24 hours a day, 7 days a week. There are several types of coverage exceptions you can ask us to make:

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

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

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

Step 2: If we do not approve a coverage exception request, you can *appeal* the decision as outlined in the *appeal*s process. You have the right to ask us to reconsider our decision regarding the coverage exception you requested. You can also find the *appeal*s process in your Evidence of Coverage (EOC).

Problems with your Medicaid Benefits

If you have a problem or complaint regarding your Washington State Apple Health (Medicaid) benefits, you can contact the Washington State Health Care Authority (HCA).

To contact the Health Care Authority (Washington's Medicaid program):

Health Care Authority HCA
Call 1-800-562-3022 Monday through Friday, 7:00 a.m. to 4:30 p.m.
TTY 711 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.
Mail P.O. Box 45531
Olympia, WA 98504-5505
Website hca.wa.gov

The Office of the Insurance Commissioner, Washington State helps people enrolled in Washington State Apple Health (Medicaid) with service or billing problems. They can help you file a *grievance* or *appeal* with our plan.

To the Office of the Insurance Commissioner, Washington State:

Office of the Insurance Commissioner
Call 1-800-562-6900, Monday through Friday, 8:00 a.m. to 5:00 p.m.
TTY 360-586-0241 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.
Fax 360-664-2782
Mail P.O. Box 40255
Olympia, WA 98504-0257
Website https://www.insurance.wa.gov/

How can you Prevent Healthcare Fraud?

The National Health Care Anti-Fraud Association (HCAFA) estimates that the financial losses from health care fraud are about $100 million per day. CHPW is committed to doing all we can to prevent, detect, and correct health care fraud.

What is Health Care Fraud, Waste and Abuse (FWA)?

- **Fraud** occurs when someone knowingly and willfully submits a false claim that results in inappropriate payment.
- **Waste** is the overuse of services or other practices that, directly or indirectly, result in unnecessary medical costs.
- **Abuse** is an action that may result in unnecessary medical costs. When a person or entity unknowingly or purposely misrepresents fact to obtain payment, this is abuse.

Protecting Yourself from FWA

- Give your Community Health Plan of Washington ID card or ID number only to a health care provider, clinic, or hospital.
- Give your ID only when you are getting care.
- Never let anyone borrow your Community Health Plan of Washington ID card.
- Never sign a blank insurance form.
- Always be ready to show picture ID when checking in for a medical appointment.
- Be careful about giving out your Social Security number

How to Report Fraud to CHPW

CHPW offers many mechanisms for reporting suspected FWA:
You can visit our website medicare.chpw.org and complete the **Potential Fraud Report Form.**

- Email report to the compliance.incident@chpw.org mailbox
- Fax report to 206-652-7017; Attention Compliance Officer
- Mail report to:

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

Anonymous Reporting to CHPW

CHPW has partnered with **NAVEX**, an independent third-party vendor, to offer a confidential anonymous reporting of suspected noncompliance by members, providers, and employees to include FWA, Health Insurance Portability and Accountability Act (HIPAA privacy rules) incidents, without the fear of retaliation. To make an anonymous report, call **1-800-826-6762 (available 24 hrs.)** or make a report online by visiting http://chpw.ethicspoint.com/. When you make a report, Navex forwards the report to the VP Compliance Officer and Chief Legal and Human Resources Officer for investigation.

Report Fraud to Medicare or the HHS Office of Inspector General

Medicare by phone or by mail:

- **Phone** 1-800-MEDICARE (1-800-633-4227) / TTY: 877-486-2048
- **Mail** Medicare Beneficiary Contact Center
  PO Box 39
  Lawrence, KS 66044

HHS Office of Inspector General by phone, mail or online:

- **Phone** 1-800-HHS-TIPS (1-800-447-8477)/ TTY: 1-800-377-4950
- **Mail** HHS Tips
  PO Box 23489
  Washington, DC 20026-3489
- **Online** oig.hhs.gov/fraud/report-fraud/index.asp

State Health Insurance Assistance Program (SHIP)
Each state has a government program with trained counselors. The program isn't connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you're having. They can also answer questions, give you more information, and offer guidance on what to do. The services of SHIP counselors are free.

Call Statewide Health Insurance Benefits Advisors (SHIBA) at 1-800-562-6900 TTY 1-360-586-0241, 8 a.m. to 5 p.m., Monday through Friday.

Get help with your rights & protections
If you feel your rights have been violated, you can contact these offices and programs for help:

- The Medicare Beneficiary Ombudsman
- Your State Health Insurance Assistance Program (SHIP)
- The Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO)
- Your State Survey Agency

Definitions Related to Appeals:

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

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

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

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

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

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

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

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

Definitions Related to Grievances:

Adverse Organization Determination - Adverse organization determinations are those determinations on the health care services an enrollee believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the enrollee), or on any amounts the enrollee must pay for a service. These procedures include a reconsideration process by the MA organization and if necessary, an IRE, hearings before ALJs, review by the DAB, and judicial review.

These would be appealed through the reconsideration process, not the *grievance* process.

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

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

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

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

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

Quality Improvement Organization (QIO) 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 enhance the quality of care they deliver. They also engage with patients and families to promote understanding of quality health 190care and help them choose the best providers.

Quality of Care Issue - A quality of care issue may be filed through the MA organization's *grievance* process and/or a QIO. A QIO must determine whether the quality of services (including both inpatient and outpatient services) provided by a MA organization meets professionally recognized standards of health care, including whether appropriate health care services have not been provided or have been provided in inappropriate settings. *Grievances* regarding potential quality of care issues will be processed according to the Quality of Care Complaint Policy and Procedure for CHPW.

Community Health Plan of Washington is an HMO plan with a Medicare contract and a contract with the Washington State Medicaid program. Enrollment in Community Health Plan of Washington depends on contract renewal. Community Health Plan of Washington complies with applicable federal, state, and local civil rights laws. Community Health Plan of Washington does not discriminate, exclude, or treat people differently on the basis of race, color, national origin, age, sex, sexual orientation, gender (including gender identity or expression), veteran or military status, or the presence of any sensory, mental or physical disability or the use of a service animal. If you need an accommodation, or require documents in another format or language, please call 1-800-942-0247 (TTY: 711) 8 a.m. to 8 p.m., 7 days a week. ATENCIÓN: Si habla español y necesita una adaptación, o necesita documentos en otro formato o idioma, llame al 1-800-942-0247 (TTY:711).ВНИМАНИЕ: Если вы владеете русским языком и нуждаетесь в жилье, или вам нужны документы в другом формате или на другом языке, пожалуйста, позвоните по телефону 1-800-942-0247 (TTY:711)