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ORGANIZATION DETERMINATIONS, GRIEVANCES AND APPEALS

MEMBER GRIEVANCE (COMPLAINT) PROCESS

Alliance CompleteCare encourages its members to let us know right away if they have questions, concerns, or problems related to covered services or the care they receive. Members are encouraged to contact their Care Advisor for assistance.

CMS defines a grievance as any complaint or dispute, other than one involving an organization determination, expressing dissatisfaction with the manner in which a Medicare health plan or delegated entity provides health care services, regardless of whether any remedial action can be taken. An enrollee may make the complaint or dispute, either orally or in writing, to a Medicare health plan, provider, or facility. An expedited grievance may also include a complaint that a Medicare health plan refused to expedite an organization determination or reconsideration, or that the plan invoked an extension to an organization determination time frame.

In addition, grievances may include complaints regarding the timeliness, appropriateness, access to, and/or setting, of a provided health service, procedure, or item. Grievance issues may also include complaints that a covered health service procedure or item during a course of treatment did not meet accepted standards for delivery of health care.

Generally, grievances should be filed directly with the Alliance through the Care Advisor Unit, but for matters related to quality of care, members also have the opportunity to file such complaints with Lumetra, California's Quality Improvement Organization.

Alliance CompleteCare and its contracted providers or delegated groups will not treat members unfairly (discriminate against them) because they initiate a complaint. Alliance CompleteCare will contact the contracting provider or delegated group to follow up on a member's grievance/complaint upon receipt of the grievance/complaint. Should a member submit a complaint, contracted providers and delegated groups are expected to instruct the member to contact Alliance CompleteCare to file their grievance/complaint. In addition, Alliance CompleteCare contracted providers and delegated groups will forward all Member complaints

and Grievances received by a contractor to the Alliance within twenty-four hours of receipt of the grievance.

Alliance CompleteCare has developed a member grievance policy and procedure, and a related process as part of the Quality Improvement Program. The basic steps are as follows:

1. Upon receipt of a verbal or written complaint, the Grievances and Appeals Coordinator sends a written acknowledgement to the member that the complaint has been received and will be reviewed within 30 calendar days. All grievances pertaining to clinical care and/or services issues are reviewed within the Quality Department.
2. In most instances, delegated groups, providers or their office managers, depending upon the specific situation, are notified either verbally or in writing about the complaint, and asked for input. On occasion, Alliance CompleteCare staff will assist in obtaining additional information from providers.
3. Upon receipt of the delegated group or provider's response, the grievance review team evaluates the information. The grievance is assigned a rating for degree of severity and for preventability of the issue of concern. The provider will be notified of the results of the review.
4. All potential quality issues (PQI) and their respective ratings are entered into our secured quality database for tracking and trending purposes. This quality of care related data becomes part of the provider's credentialing file and is reviewed periodically and for re-credentialing.

It is the responsibility of all network providers and delegated groups to participate in our quality of care review process. Providers and delegated groups are expected to respond to a request for information in a timely manner to ensure grievance review completion within the specified time frame. All communications between delegated groups, providers, and Alliance representatives concerning the review of a grievance is considered peer review privileged information and is not shared with members. Members are notified in writing when review of their grievance is complete.

Acting as an Appointed Representative

A member may have any individual, including a provider, act as his or her representative as long as the designated representative has not been disqualified or suspended from acting as a representative in proceedings before CMS, or is otherwise prohibited by law.

The member and representative must complete the Appointment of Representative Form, in order to act as a representative.

A provider that has furnished services or items to a member may represent that member on the appeal; however, the provider may not charge the member a fee for representation.

The 'Appointment of Representative' document is located in the Section 11 - Forms. Further information about acting as an appointed representative can be found on the CMS website in Chapter 14 of the CMS Medicare Managed Care Manual.
http://www.cms.hhs.gov/manuals/downloads/mc86c14.pdf

Quality Improvement Organization (QIO) Complaint Process

If a member is dissatisfied with the quality of the care he/she has received, the member may also file a complaint with Lumetra, California's Quality Improvement Organization. Lumetra is under contract with CMS to conduct medical reviews and other functions with respect to Medicare beneficiaries.

Lumetra is responsible for the quality of care review of healthcare services provided to California Medicare patients enrolled in a Medicare Advantage (MA) organization having a risk contract with CMS. This includes the Alliance CompleteCare Medicare Advantage Part D Special Needs Plan for Dual Eligibles.

Lumetra maintains a review system to ensure that services provided to Medicare beneficiaries enrolled in Medicare Advantage organizations are of adequate quality across all settings.

An enrollee who is dissatisfied with Lumetra's determination can request a reconsideration from Lumetra in accordance with § 422.626(f).

ORGANIZATIONAL DETERMINATIONS AND THE MEMBER APPEALS PROCESS

CMS defines an organizational determination as any determination made by a Medicare health plan with respect to any of the following:

- Payment for temporarily out of the area renal dialysis services, emergency services, post-stabilization care, or urgently needed services.
- Payment for any other health services furnished by a provider other than the Medicare health plan that the enrollee believes are covered under Medicare, or if not covered under Medicare, should have been furnished, arranged for, or reimbursed by the Medicare health plan.
- The Medicare health plan's refusal to provide or pay for services, in whole or in part, including the type or level of services that the enrollee believes should be furnished or arranged for by the Medicare health plan.
- Discontinuation of a service, if the enrollee believes that continuation of the services is medically necessary.
- Failure of the Medicare health plan to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the enrollee with timely notice of an adverse determination, such that a delay would adversely affect the health of the enrollee.

CMS defines an appeal as any of the procedures that deal with the review of adverse organization determinations on the health 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 CFR 422.566(b). These procedures include reconsideration by the MA (Medicare Advantage) organization, and if necessary, an independent review entity (IRE), hearings before Administrative Law Judges (ALJs), review by the Medicare Appeals Council (MAC), and judicial review

Standard Member Appeals

Appeals may be filed if a member asks Alliance CompleteCare to reconsider an Organization Determination and change a decision we have made about what services or benefits are

covered, or what the Alliance authorizes. A member may file an appeal under these circumstances:

- If the Alliance refused to cover or pay for services a member thinks we should cover.
- If the Alliance, or one of our plan providers, refuses to render a service that a member believes should be covered.
- If the Alliance, or one of our plan providers, reduces or cuts back on services or benefits that a member has been receiving.
- If a member believes that the Alliance stopped coverage of a service or benefit too soon.

Member appeal procedures include reconsideration by the Alliance and, if necessary, the Independent Review Entity hearings before Administrative Law Judges (ALJs), review by the Medicare Appeals Council (MAC), and judicial review.

Hospital Discharge Appeals

There is a special type of appeal that applies only to hospital discharges. If a member has received a Notice of Discharge and Medicare Appeal Rights, and believes that the planned discharge is too soon, the member or appointed representative may ask for a Lumetra review to determine whether the planned discharge is medically appropriate. The Notice of Discharge and Medicare Appeal Rights provides this information, as well as Lumetra's name and telephone number.

In order to request a QIO review regarding a hospital discharge, the member must contact Lumetra no later than noon of the first working day after the written notice is provided. If this deadline is met, the member is permitted to stay in the hospital past the planned discharge date without financial liability. If Lumetra reviews the case, it will review medical records and provide a decision within one full working day after it has received the request and all of the medical information necessary to make a decision. If Lumetra decides that the discharge date was medically appropriate, the member will have no financial liability until noon of the calendar day after Lumetra provides its decision. If Lumetra decides that the discharge date was too soon and that continued confinement is medically appropriate, Alliance CompleteCare will continue to cover the hospital stay for as long as it is medically necessary.

If the member does not ask Lumetra for a review by the deadline, the member may ask Alliance CompleteCare for an expedited appeal. If the member asks us for an expedited appeal of the planned discharge, and stays in the hospital past the discharge date, he or she may have financial liability for services provided beyond the discharge date. This depends on the expedited appeal decision. If the expedited appeal decision is in the member's favor, we will continue to cover the hospital care for as long as it is medically necessary. If the expedited appeal decision is that continued confinement was not medically appropriate, we will not cover any hospital care that is provided beyond the planned discharge date. The Alliance will coordinate resolution of hospital discharge appeals with delegated groups.

When the member is dually enrolled in Alliance CompleteCare and the Alliance's Medi-Cal managed care plan, services may be covered through the coordination of services and payment through the Medi-Cal eligible benefits.

Expedited Appeals

Members or their authorized representatives may make expedited reconsideration requests or expedited appeals. An expedited appeal is a review of a pre-service, time-sensitive adverse determination, on the health care services that a member believes that he/she is entitled to receive. The Alliance will coordinate resolution of expedited appeals with delegated groups.

Requests for expedited appeals can be accepted both verbally and in writing. If the request meets the necessary time-sensitive criteria, a decision is due within 72 hours of receipt of the request, unless an extension is needed. Extensions of up to 14 calendar days can be granted if it is in the best interest of the member.

Organizational Determinations, Grievances and Appeals - Pharmacy

Relative to grievances, coverage determinations, and appeals, the rights of Part D enrollees include, but are not limited to, the following:

Grievances

- The right to have grievances heard and resolved.
- The right to request quality of care grievance data from Alliance CompleteCare.
- The right to make a quality of care complaint under the Lumetra process.

Coverage Determinations

- The right to a timely coverage determination.
- The right to request an expedited coverage determination.
- The right to receive information from a network pharmacist about the enrollee's ability to obtain a detailed written notice from the Alliance regarding the enrollee's Part D benefits.
- The right to a detailed written notice of the Alliance's decision to deny a benefit in whole, or in part, which includes the enrollee's appeal rights.
- The right to receive notice when a coverage determination is forwarded to the Independent Review Entity (IRE).

Appeals

- The right to a timely or an expedited redetermination.
- The right to request and receive appeal data from the Alliance.
- The right to receive notice when an appeal is forwarded to the IRE.
- The right to reconsideration by the IRE, upon request, if the Alliance upholds the original adverse determination, in whole or in part.
- The right to request an expedited reconsideration as provided in this section.
- The right to an Administrative Law Judge (ALJ) hearing if the IRE upholds the original adverse determination, in whole or in part and the remaining amount in controversy meets the appropriate threshold requirement.
- The right to request Medicare Appeals Council (MAC) review if the ALJ hearing decision is unfavorable to the enrollee, in whole or in part.
- The right to judicial review of the hearing decision of the ALJ hearing.
- MAC review is unfavorable to the enrollee, in whole or in part, and the amount remaining in controversy meets the appropriate threshold requirement.

- The right to request and be given timely access to the enrollee's case file and a copy of that case file subject to federal and state law regarding confidentiality of patient information.

Alliance CompleteCare requires the cooperation of prescribing providers when meeting these member rights. For provider questions regarding determinations, grievances and appeals pertaining to prescription drugs, please contact Alliance CompleteCare at (877) 585-PLAN (7526).

CMS RESOURCES

You can access appeals information on the CMS website at:
http://www.cms.hhs.gov/home/medicare.asp.

Important Message from Medicare (CMS-R-193) and Form Instructions

http://www.cms.hhs.gov/BNI/12_HospitalDischargeAppealNotices.asp

The Detailed Notice of Discharge (CMS 10066) and Form Instructions

http://www.cms.hhs.gov/BNI/12_HospitalDischargeAppealNotices.asp

APPOINTMENT OF REPRESENTATIVE FORM

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB no. 0938-0950

APPOINTMENT OF REPRESENTATIVE

NAME OF BENEFICIARY	MEDICARE NUMBER

SECTION I: APPOINTMENT OF REPRESENTATIVE

To be completed by the beneficiary:

I appoint this individual: _____ to act as my representative in connection with my claim or asserted right under Title XVIII of the Social Security Act (the "Act") and related provisions of Title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my appeal, wholly in my stead. I understand that personal medical information related to my appeal may be disclosed to the representative indicated below.

SIGNATURE OF BENEFICIARY		DATE
STREET ADDRESS		PHONE NUMBER (AREA CODE)
CITY	STATE	ZIP

SECTION II: ACCEPTANCE OF APPOINTMENT

To be completed by the representative:

I, _____, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services; that I am not, as a current or former employee of the United States, disqualified from acting as the beneficiary's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a / an_____
(PROFESSIONAL STATUS OR RELATIONSHIP TO THE PARTY, E.G. ATTORNEY, RELATIVE, ETC.)

SIGNATURE		DATE
STREET ADDRESS		PHONE NUMBER (AREA CODE)
CITY	STATE	ZIP

SECTION III: WAIVER OF FEE FOR REPRESENTATION

Instructions: This form should be filled out if the representative waives a fee for such representation. (Note that providers or suppliers may not charge a fee for representation and thus, all providers or suppliers that furnished the items or services at issue **must** complete this section.)

I waive my right to charge and collect a fee for representing _____ before the Secretary of the Department of Health and Human Services.

SIGNATURE	DATE

SECTION IV: WAIVER OF PAYMENT FOR ITEMS OR SERVICES AT ISSUE

Instructions: Providers or suppliers that furnished the items or services at issue must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act. (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, and could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.)

I waive my right to collect payment from the beneficiary for furnished items or services at issue involving 1879(a)(2) of the Act.

SIGNATURE	DATE

Form CMS-1696 (07/05) EF (07/05)