

## Guidance Regarding Grievances, Coverage Determinations and Appeals

This is a *summary* of our grievance, coverage determination (including exceptions) and appeals processes.

Below we summarize how to ask for coverage decisions, make appeals or make a complaint, if you are having trouble getting the medical care or prescription drugs you think are covered by our plan. This includes asking us to make exceptions to the rules or extra restrictions on your coverage for prescription drugs, and asking us to keep covering hospital care and certain types of medical services if you think your coverage is ending too soon.

**For step-by-step guidance please refer to the Evidence of Coverage for your plan in the chapter titled *What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*.**

### How to make a Complaint or Grievance

The 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. Please refer to your Evidence of Coverage chapter titled *What to do if you have a problem or complaint (coverage decisions, appeals, complaints)* for step-by-step instructions.

To make a complaint, usually calling Customer Service is the first step. If there is anything else you need to do, Customer Service will let you know

If you do not wish to call, or you called and were not satisfied, you can put your complaint in writing and send it to us.

If you want to complain to us regarding any of the issues described above, you must call or send us a letter within 60 days of any notice to you from us, or within 60 days of the date on which you have knowledge or should have had knowledge of the event or subject matter of the grievance.

We look into your complaint and give you our answer. If possible, we will answer you right away. Most complaints are answered in 30 days, but we may take up to 44 days.

If we do not agree with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer.

If your complaint is about the quality of care you received, you can make your complaint to our plan or, if you prefer, you can make your complaint directly to the Quality Improvement Organization *with or without* making the complaint to our plan. Information on how to contact the Quality Improvement Organization is located in your Evidence of Coverage.

## How to ask for a Coverage Determination

Start by calling, writing, or faxing our plan to make your request for us to provide coverage for the medical care you want. You, your doctor, or your representative can do this. Our address and contact numbers are listed below.

When we give you our decision, we will use the “standard” deadlines unless we have agreed to use the “fast” deadlines. A standard decision means we will give you an answer within 14 days after we receive your request.

If your health requires it, ask us to give you a “fast decision” we will answer within 72 hours. There are requirements that must be met to qualify for a “fast decision.”

## Making an appeal about medical coverage

If we make a coverage decision and you are not satisfied with the outcome, 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 make an appeal, we review the coverage decision we have made to check to see if we were being fair and following all of the rules properly. When we have completed the review, we give you our decision.

To start an appeal you, your representative, or in some cases, your doctor must contact our plan. Make your standard appeal in writing by submitting a signed request. You may also ask for an appeal by calling us.

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.

Our plan considers your appeal, and we give you our answer. When we are using the “fast deadlines”, we must give you our answer within 72 hours after we receive your appeal. 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.

If our plan says no to your appeal for medical coverage, we are required to *automatically* send your appeal on to Level 2 in the appeals process which is to the “Independent Review Organization”. The Independent Review Organization is an outside, independent organization that is hired by Medicare. Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal. The Independent Review Organization will tell you its decision in writing and explain the reasons for it. 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. Please refer to your Evidence of Coverage in the chapter *What to do if you have a problem or complaint (coverage decisions, appeals, complaints)* for step-by-step instructions.

## Making an appeal about drug coverage

If your appeal is about drug coverage and our plan says no to your appeal, then you can choose whether to accept this decision or continue by making another appeal (Level 2 Appeal) to the Independent Review Organization.

## How to contact us for Grievances, Coverage Determinations and Appeals:

WINhealth Partners Medicare Members	
CALL	800-840-2211 Calls to this number are free. Hours of operation: for medical care questions, call Monday – Friday, 8:00 a.m. to 5:00 p.m., Mountain Time. For Part D prescription drug benefit questions, call Monday- Friday, 8:00 a.m. – 8:00 p.m. From November 15 through March 1, we are also available 8:00 a.m. to 8:00 p.m., Mountain Time, on weekends and most holidays.
TTY	800-704-6370 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
FAX For Medical Coverage Decisions, Appeals or Complaints	877-201-7302
FAX For Part D Prescription Coverage Determinations, or Complaints	970-248-5043
FAX For an appeal about your Part D Prescription Drug Coverage	970-244-7828
WRITE For Coverage decisions or complaints for Medical care or Part D Prescription Drug	WINhealth Partners Medicare Plan, c/o RMHP Customer Service P.O. Box 10600 Grand Junction, CO 81502-5600
WRITE For Appeals for Part D Prescription Drug Coverage	WINhealth Partners Medicare Plan, c/o RMHP Member Appeals P.O. Box 10600 Grand Junction, CO 81502-5600