

Grievance & Appeals Information for Medicare Advantage Plans

without Prescription Drug Benefits

How to File a Grievance

What Is a Grievance?

A grievance is any complaint, other than one that involves a request for an organization determination, or an appeal as described starting on the third page of this document, because grievances do not involve problems related to approving or paying for care, problems about having to leave the hospital too soon, and problems about having Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF) services ending too soon.

If we will not give you the services you want, you believe that you are being released from the hospital or SNF too soon, or your HHA or CORF services are ending too soon, you must follow the rules outlined starting on the third page of this document.

What Types of Problems Might Lead to Your Filing a Grievance?

- Problems with the quality of the medical care you receive, including quality of care during a hospital stay.
- If you feel that you are being encouraged to leave (disenroll from) the Plan.
- Problems with the service you receive from Customer Service.
- Problems with how long you have to wait on the phone, in the waiting room, or in the exam room.
- Problems getting appointments when you need them, or waiting too long for them.
- Rude behavior by doctors, nurses, receptionists, or other staff.
- Cleanliness or condition of doctor's offices, clinics, or hospitals.
- If you disagree with our decision not to give you a "fast" decision or a "fast" appeal. *We discuss these fast decisions and appeals in more detail starting on the third page of this document.*
- You believe our notices and other written materials are hard to understand.
- We don't give you a decision within the required time frame (on time).
- We don't forward your case to the independent review entity if we do not give you a decision on time.
- We don't give you required notices.

If you have one of these types of problems and want to make a complaint, it is called "filing a grievance." In

certain cases, you have the right to ask for a "fast grievance," meaning we will answer your grievance within 24 hours. *We discuss fast grievances in more detail starting on the third page of this document.*

Filing a Grievance With Our Plan

If you have a complaint, please call the phone number for Part C Grievances in Section 1 of your Evidence of Coverage and on this website. We will try to resolve your complaint over the phone. If you ask for a written response, we will respond in writing to you. If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. We call this the Grievance Procedure.

Expedited grievances can be filed concerning decisions to not conduct expedited organization determinations or reconsiderations, or to take an extension on initial decisions or appeals. The Plan must respond to your expedited grievance within 24 hours.

We must address your grievance as quickly as your case requires based on your health status, but no later than 30 days after receiving your complaint. We may extend the time frame by up to 14 days if you ask for the extension, or if we justify a need for additional information and the delay is in your best interest.

For Quality of Care Problems, You May Also Complain to the QIO

You may complain about the quality of care received under Medicare, including care during a hospital stay. You may complain to us using the grievance process, to an independent review organization called the Quality Improvement Organization (QIO), or both. If you file with the QIO, we must help the QIO resolve the complaint. *See Section 1 of your Evidence of Coverage for more information about the QIO.*

How to File a Quality of Care Complaint With the QIO

You must write to the QIO to file a quality of care complaint. You may file your complaint with the QIO at any time. *See Section 1 of your Evidence of Coverage for more information about how to file a quality of care complaint with the QIO.*

What to Do If You Have Complaints About Your Part C Medical Services and Benefits

Introduction

This section gives the rules for making complaints about Part C services and payments in different types of situations. Federal law guarantees your right to make complaints if you have concerns or problems with your medical care as a plan member.

If you make a complaint, we must be fair in how we handle it. You cannot be disenrolled or penalized in any way if you make a complaint.

Please refer to Original Medicare in your 2008 *Medicare & You* handbook for additional guidance on your appeal rights under Original Medicare. If you do not have a *Medicare & You* handbook, please call 1-800-MEDICARE (1-800-633-4227) to get a copy. TTY users should call 1-877-486-2048.

How to Make Complaints in Different Situations

This section tells you how to make a complaint about services or payment disputes in each of the following situations:

Part 1. Complaints about what benefit or service we will approve or what we will pay for.

Part 2. Complaints if you think you are asked to leave the hospital too soon.

Part 3. Complaints if you think your skilled nursing facility (SNF), home health agency (HHA) or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon.

If you want to make a complaint about any situation not listed above, you may file a grievance. *For more information about grievances, see the previous section of this document.*

Part 1. Complaints About What Benefit or Service the Plan Will Approve or What the Plan Will Pay for

What Are “Complaints About Your Services or Payment for Your Care?”

- If you are not getting the care you want, and you believe that this care is covered by the Plan.
- If we will not approve the medical treatment your doctor or other medical provider wants to give you, and you believe that this treatment is covered by the Plan.
- If you are being told that a treatment or service you have been getting will be reduced or stopped, and you believe that this could harm your health.
- If you have received care that you believe should be covered by the Plan, but we have refused to pay for this care because we say it is not medically necessary or is not a plan benefit.

What Is an Organization Determination?

An organization determination is our initial decision about whether we will provide the medical care or service you request, or pay for a service you have received. If our initial decision is to deny your request, you may appeal the decision by going to Appeal Level 1 (see below). You may also appeal if we fail to make a timely initial decision on your request.

When we make an “organization determination,” we are giving our interpretation of how the benefits and services that are covered for members of the Plan apply to your specific situation. Your Evidence of Coverage and any amendments you may receive describe the benefits and services covered by the Plan, including any limits on these services. Your Evidence of Coverage also lists services that are “not covered” by the Plan.

Who May Ask for an “Organization Determination” About Your Medical Care or Payment?

Your doctor or other medical provider may ask us whether we will approve the treatment. You may also ask us for an initial decision, or you can name (appoint) someone to do it for you. This person you name would be your representative.

You can name a relative, friend, advocate, doctor, or someone else to act for you. Other persons may already be authorized under state law to act for you.

If you want someone to act for you, then you and the person you want to act for you must sign and date a statement that gives this person legal permission to be your representative.

This statement must be sent to us at the address listed under Part C Organization Determinations in Section 1 of your Evidence of Coverage. Please call us at the phone number shown under Part C Organization Determinations for more information. You also have the right to have a lawyer act for you.

You can get your own lawyer, or find a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. *You may want to call the SHIP in your state at the phone numbers shown in Section 1 of your Evidence of Coverage.*

Do You Have a Request for Medical Care That Needs to Be Decided More Quickly Than the Standard Time Frame?

A decision about whether we will pay for or approve medical care can be a “standard decision” that is made within the standard time frame (typically within 14 days), or it can be a “fast decision” that is made more quickly (typically within 72 hours).

A fast decision is also called an “expedited organization determination.” You may ask for a fast decision only if you or any doctor believe that waiting for a standard decision could seriously harm your health or your ability to function.

Asking for a Standard Decision

To ask for a standard decision about providing medical care or payment for care, you or your representative

should mail or deliver a request in writing to the address listed under Part C Organization Determinations in Section 1 of your Evidence of Coverage.

Asking for a Fast Decision

You, any doctor, or your representative can ask us to give a “fast” decision (rather than a “standard” decision) about medical care by calling us. Or you may send or fax us a written request to the fax number or address listed under Part C Organization Determinations in Section 1 of your Evidence of Coverage.

For review requests made outside of regular weekday business hours, please call our Customer Service number shown in Section 1 of your Evidence of Coverage. You, your doctor, or your appointed representative will be instructed on how to leave a message. Be sure to ask for a “fast” or “72-hour” review.

If any doctor asks for a fast decision for you, or supports you in asking for one, and the doctor indicates that waiting for a standard decision could seriously harm your health or your ability to function, we will give you a fast decision.

If you ask for a fast decision without support from a doctor, we will decide if your health requires a fast decision. If we decide that you don’t need a fast decision, we will send you a letter informing you that if you get a doctor’s support for a “fast” decision, we will automatically give you a fast decision.

The letter will also tell you how to file a “grievance” if you disagree with our decision to deny your request for a fast review. It will also tell you about your right to ask for a “fast grievance.” If we deny your request for a fast decision, we will give you a standard decision. *For more information about grievances, see the previous section of this document.*

What Happens Next When You Request an Initial Decision?

1. For a decision about payment for care you already received:

We have 30 days to make a decision after we receive your request. However, if we need more information, we can take up to 30 more days. You will be told in writing if we extend the time frame for making a decision. If we do not approve your request for payment, we must tell you why, and tell you how you can appeal this decision. If you have not received an answer from us within 60 days

of your request, you can appeal this decision. (An appeal is also called a “reconsideration.”)

2. For a *standard* decision about medical care:

We have 14 days to make a decision after we receive your request. However, we can take up to 14 more days if you ask for additional time, or if we need more information (such as medical records) that may benefit you. If we take additional days, we will notify you in writing.

If you believe that we should not take additional days, you can make a specific type of complaint called a “fast grievance”. If we do not approve your request, we must explain why in writing, and tell you of your right to appeal our decision. If you have not received an answer from us within 14 days of your request (or by the end of any extended time period), you have the right to appeal.

3. For a *fast* decision about medical care:

If you receive a “fast” decision, we will give you our decision about your requested medical care within 72 hours after you or your doctor ask for it – sooner if your health requires. However, we can take up to 14 more days if we find that some information is missing that may benefit you, or if you need more time to prepare for this review. If you believe that we should not take any extra days, you can file a fast grievance.

We will call you as soon as we make the decision. If we deny any part of your request, we will send you a letter that explains the decision within 3 days of calling you. If we do not tell you about our decision within 72 hours (or by the end of any extended time period), this is the same as denying your request and you have the right to appeal. If we deny your request for a fast decision, you may file a fast grievance.

Appeal Level 1: If We Deny Any Part of Your Request For a Service or Payment of a Service, You May Ask us to Reconsider Our Decision. This Is Called an “Appeal” or a “Request for Reconsideration.”

Please call us if you need help in filing your appeal. We give the request to different people than those who made the organization determination. This helps ensure that we will give your request a fresh look.

If your appeal concerns a decision we made about a service you asked for, then you and/or your doctor will first need to decide whether you need a “fast” appeal. The procedures for deciding on a “standard” or a “fast” appeal are the same as those described for a “standard” or “fast” initial decision.

Getting Information to Support Your Appeal

If we need your help in gathering this information, we will contact you. You have the right to obtain and include additional information as part of your appeal. For example, you may already have documents related to the issue, or you may want to get your doctor’s records or your doctor’s opinion to support your request. You may need to give your doctor a written request to get information.

You can give us additional information to support your appeal by calling, faxing, or writing to the numbers or address listed under Part C Appeals in Section 1 of your Evidence of Coverage and on this website. You can also deliver additional information in person to the address listed under Part C Appeals in Section 1 of your Evidence of Coverage.

You also have the right to ask us for a copy of the information we have regarding your appeal. You may call or write us at the numbers or address listed under Part C Appeals in Section 1 of your Evidence of Coverage and on this website. We are allowed to charge a fee for copying and sending this information to you.

How Do You File Your Appeal of the Organization Determination?

The rules about who may file an appeal are the same as the rules about who may ask for an organization determination. Follow the instructions under “Who May Ask for an ‘Organization Determination’ About Medical Care or Payment?” However, providers who do not have a contract with the Plan must sign a “waiver of payment” statement that says that they will not ask you to pay for the medical service under review, regardless of the outcome of the appeal.

How Soon Must You File your Appeal?

You must file your appeal within 60 days after we notify you of our decision. We can give you more time if you have a good reason for missing the deadline. To file your appeal, you may call or write us at the phone number or address listed under Part C Appeals

in Section 1 of your Evidence of Coverage and on this website.

What If You Want a “Fast” Appeal?

The rules about asking for a “fast” appeal are the same as the rules about asking for a “fast” decision.

How Soon Must We Decide on Your Appeal?

1. For a decision about payment for care you already received:

After we receive your appeal, we have 60 days to decide. If we do not decide within 60 days, your appeal automatically goes to Appeal Level 2.

2. For a *standard* decision about medical care:

After we receive your appeal, we have 30 days to decide, but will decide sooner if your health condition requires. However, if you ask for more time, or if we find that helpful information is missing, we can take up to 14 more days to make our decision. If we do not tell you our decision within 30 days (or by the end of the extended time period), your request will automatically go to Appeal Level 2.

3. For a *fast* decision about medical care:

After we receive your appeal, we have 72 hours to decide, but will decide sooner if your health requires. However, if you ask for more time, or if we find that helpful information is missing, we can take up to 14 more days to make our decision. If we do not decide within 72 hours (or by the end of the extended time period), your request will automatically go to Appeal Level 2.

What Happens Next If We Rule Completely in Your Favor?

1. For a decision about payment for care you already received:

We must pay within 60 days of the day we received your appeal.

2. For a *standard* decision about medical care:

We must authorize or provide your requested care within 30 days of receiving your appeal. If we extended the time needed to decide your appeal, we will authorize or provide your medical care immediately.

3. For a *fast* decision about medical care:

We must authorize or provide your requested care

within 72 hours of receiving your appeal – or sooner, if your health requires it. If we extended the time needed to decide your appeal, we will authorize or provide your medical care immediately.

Appeal Level 2: If on Your Level 1 Appeal, We Do Not Rule Completely in Your Favor, Your Appeal Will Automatically Be Reviewed by an Independent Review Entity

If we do not rule completely in your favor, your appeal is automatically sent to Appeal Level 2 where an independent review entity that has a contract with CMS (Centers for Medicare & Medicaid Services), the government agency that runs the Medicare program, and is not part of the Plan, will review your appeal.

We will tell you in writing that your appeal has been sent to this organization for review. How quickly we must forward your appeal depends on the type of appeal:

1. For a decision about payment for care you already received:

We must forward your appeal to the independent review entity within 60 days of the date we received your Level 1 appeal.

2. For a *standard* decision about medical care:

We must forward your appeal to the independent review entity as quickly as your health requires, but no later than 30 days after we received your Level 1 appeal.

3. For a *fast* decision about medical care:

We must forward your appeal to the independent review entity within 24 hours of our decision.

We will send the independent review entity a copy of your case file. You also have the right to get a copy of your case file from us by calling or writing us at the phone number or address listed under Part C Appeals in Section 1 of your Evidence of Coverage. We are allowed to charge you a fee for copying and sending this information to you.

How Soon Must the Independent Review Entity Decide?

1. For an appeal about payment for care:

The independent review entity has 60 days to make a decision.

2. For a *standard* appeal about medical care:

The independent review entity has 30 days to

make a decision. However, it can take up to 14 more days if more information is needed and the extension will benefit you.

3. For a fast appeal about medical care:

The independent review entity has 72 hours to make a decision. However, it can take up to 14 more days if more information is needed and the extension will benefit you.

If the Independent Review Entity Decides Completely in Your Favor

The independent review entity will tell you in writing about its decision.

1. For an appeal about payment for care:

We must pay within 30 days after receiving the decision.

2. For a *standard* appeal about medical care:

We must authorize the care you requested within 72 hours after receiving the decision, or provide the care no later than 14 days after receiving the decision.

We must authorize or provide the care no later than 14 days after receiving the decision. If it is not appropriate to provide the service within 14 calendar days, (e.g., because of your medical condition or you are outside of the service area), we must authorize the services within 72 hours from the date we receive notice that the independent review entity reversed the determination.

3. For a *fast* appeal about medical care:

We must authorize or provide the care you requested within 72 hours after receiving the decision.

Appeal Level 3: If the Entity That Reviews Your Case in Appeal Level 2 Does Not Rule Completely in Your Favor, You May Ask for a Review by an Administrative Law Judge

You must ask for a review by an Administrative Law Judge in writing within 60 days after the date you were notified of the decision made at Appeal Level 2. They may extend the deadline for good cause. You must send your written request to the ALJ Field Office that is listed in the decision you received from the independent review organization.

The Administrative Law Judge will not review the appeal if the dollar value of the medical care does

not meet the minimum requirement included in the independent review organization's decision. If the dollar value is less than the minimum requirement, you may not appeal any further. During this review, you may present evidence, review the record, and be represented by a lawyer.

How Soon Will the Judge Make a Decision?

The Administrative Law Judge will hear your case, weigh all of the evidence up to this point, and decide as soon as possible.

If the Judge Decides in Your Favor

We must pay for, authorize, or provide the service you have asked for within 60 days of the date we receive notice of the decision. However, we have the right to appeal this decision by asking for a review by the Medicare Appeals Council (Appeal Level 4).

Appeal Level 4: If the Judge Does Not Rule Completely in Your Favor, You May Ask for a Review by the Medicare Appeals Council

The Medicare Appeals Council does not review every case it receives. If they decide not to review your case, then either you or we may ask for a review by a Federal Court Judge (Appeal Level 5).

The Medicare Appeals Council will send a notice informing you of any action it has taken on your request. The notice will tell you how to request a review by a Federal Court Judge.

How Soon Will the Council Make a Decision?

If the Medicare Appeals Council reviews your case, they will decide as soon as possible.

If the Council Decides in Your Favor

We must pay for, authorize, or provide the medical care you requested within 60 days of the date we receive the decision. However, we have the right to ask a Federal Court Judge to review the case (Appeal Level 5), as long as the dollar value of the care you asked for meets the minimum requirement.

Appeal Level 5: If the Medicare Appeals Council Does Not Rule Completely in Your Favor, You May Ask for a Review by a Federal Court

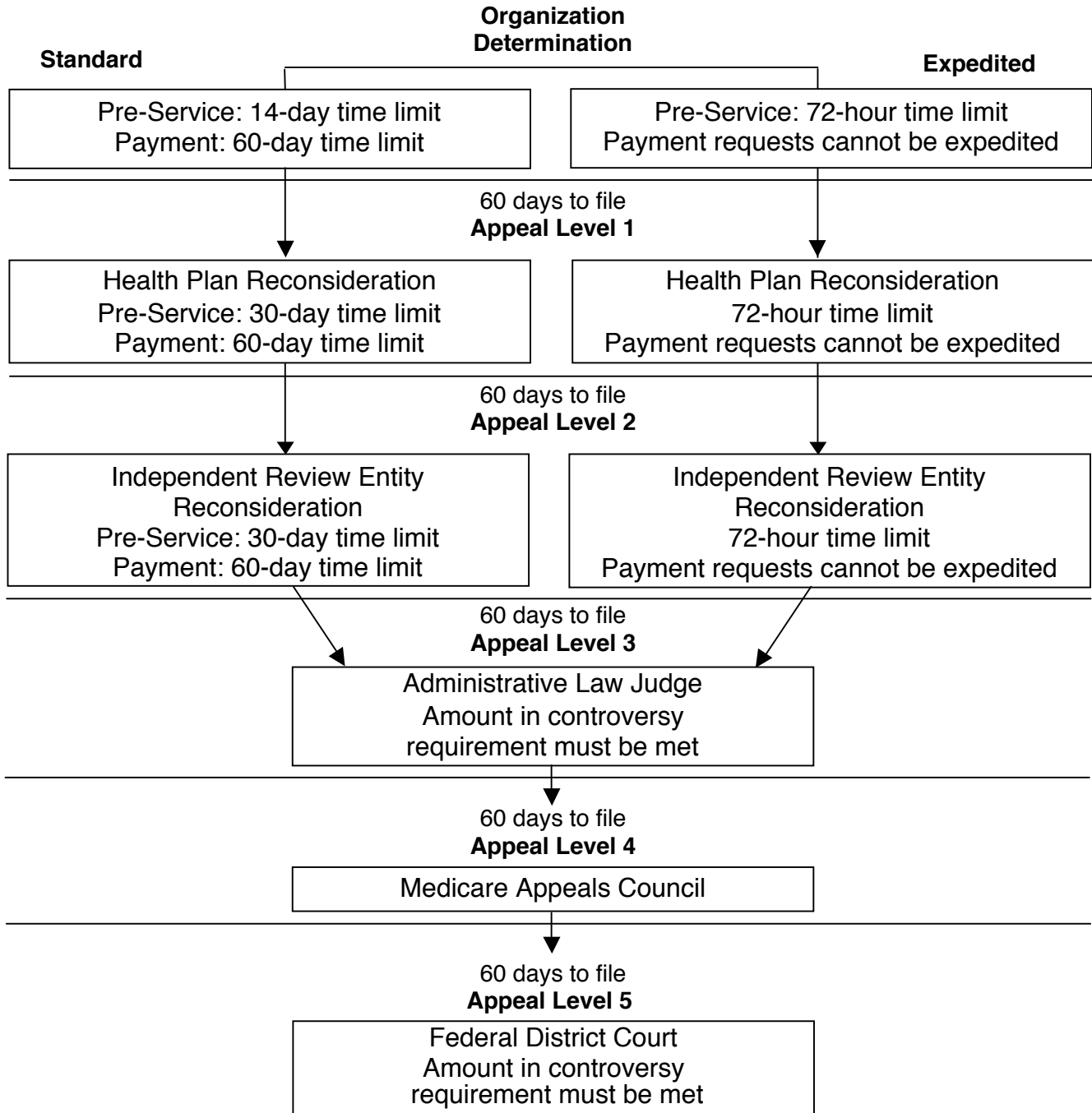
You may file an appeal in Federal court if you receive a decision from the Medicare Appeals Council (MAC) that is not completely favorable to you or the MAC decided not to review your case.

The letter you get from the MAC will tell you how to ask for this review. The Federal Court Judge will first decide whether to review your case. Your appeal will not be reviewed by a Federal court if the dollar value of the care you asked for does not meet the minimum requirement included in the MAC's decision.

How Soon Will the Judge Make a Decision?

The Federal judiciary controls the timing of any decision. The Judge's decision is final.

Complaint process for what benefit or service the Plan will approve or what the Plan will pay for:



Part 2. Complaints (Appeals) If You Think You Are Being Discharged from the Hospital Too Soon

When you are admitted to the hospital, you have the right to get all the hospital care covered by the Plan that is necessary to diagnose and treat your illness or injury. The day you leave the hospital (your discharge date) is based on when your stay in the hospital is no longer medically necessary. This part explains what to do if you believe that you are being discharged too soon.

Information You Should Receive During Your Hospital Stay

Within two days of admission as an inpatient, someone at the hospital must give you a notice called the *Important Message from Medicare* (call our Plan Customer Service phone number listed in Section 1 of your Evidence of Coverage or 1-800-MEDICARE (1-800-633-4227) to get a sample notice or see it online at <http://www.cms.hhs.gov/BNI/>). This notice explains:

- Your right to get all medically necessary hospital services paid for by the Plan (except for any applicable copayments or deductibles).
- Your right to be involved in any decisions that the hospital, your doctor, or anyone else makes about your hospital services and who will pay for them.
- Your right to get services you need after you leave the hospital.
- Your right to appeal a discharge decision and have your hospital services paid for by us during the appeal (except for any applicable copayments or deductibles).

You (or your representative) will be asked to sign the *Important Message from Medicare* to show that you received and understood this notice. Signing the notice does not mean that you agree that the coverage for your services should end – only that you received and understand the notice. If the hospital gives you the *Important Message from Medicare* more than 2 days before your discharge day, it must give you a copy of your signed *Important Message from Medicare* before you are scheduled to be discharged.

Review of Your Hospital Discharge by the Quality Improvement Organization

You have the right to request a review of your discharge. You may ask a Quality Improvement Organization to review whether you are being discharged too soon.

What Is the “Quality Improvement Organization”?

“QIO” stands for Quality Improvement Organization. The QIO is a group of doctors and other health care experts paid by the federal government to check on and help improve the care given to Medicare patients. They are not part of the Plan or the hospital.

There is one QIO in each state. QIOs have different names, depending on which state they are in. The doctors and other health experts in the QIO review certain types of complaints made by Medicare patients. These include complaints from Medicare patients who think their hospital stay is ending too soon.

Getting QIO Review of Your Hospital Discharge

You must quickly contact the QIO. The *Important Message from Medicare* gives the name and telephone number of the QIO and tells you what you must do.

- You must ask the QIO for a “fast review” of your discharge. This “fast review” is also called an “immediate review.”
- You must request a review from the QIO no later than the day you are scheduled to be discharged from the hospital. If you meet this deadline, you may stay in the hospital after your discharge date without paying for it while you wait to get the decision from the QIO.
- The QIO will look at your medical information provided to the QIO by us and the hospital.
- During this process, you will get a notice giving our reasons why we believe that your discharge date is medically appropriate.
- The QIO will decide, within one day after receiving the medical information it needs, whether it is medically appropriate for you to be discharged on the date that has been set for you.

What Happens If the QIO Decides in Your Favor?

We will continue to cover your hospital stay for as long as it is medically necessary (except for any applicable copayments or deductibles).

What Happens If the QIO Agrees With the Discharge?

You will not be responsible for paying the hospital charges until noon of the day after the QIO gives you its decision. However, you could be financially liable for any inpatient hospital services provided after noon of the day after the QIO gives you its decision. You may leave the hospital on or before that time and avoid any possible financial liability.

If you remain in the hospital, you may still ask the QIO to review its first decision if you make the request within 60 days of receiving the QIO's first denial of your request. However, you could be financially liable for any inpatient hospital services provided after noon of the day after the QIO gave you its first decision.

What Happens If You Appeal the QIO Decision?

The QIO has 14 days to decide whether to uphold its original decision or agree that you should continue to receive inpatient care. If the QIO agrees that your care should continue, we must pay for or reimburse you for any care you have received since the discharge date on the *Important Message from Medicare*, and provide you with inpatient care as long as it is medically necessary (except for any applicable copayments or deductibles).

If the QIO upholds its original decision, you may be able to appeal its decision to the Administrative Law Judge. *Please see Appeal Level 3 in Part 1 of this section for guidance on the Administrative Law Judge (ALJ) appeal.*

If the ALJ upholds the decision, you may also be able to ask for a review by the Medicare Appeals Council (MAC) or a Federal court. If any of these decision makers (Administrative Law Judge, Medicare Appeals Council, Federal court) agree that your stay should continue, we must pay for or reimburse you for any care you have received since the discharge date, and provide you with inpatient care as long as it is medically necessary (except for any applicable copayments or deductibles).

What If You Do Not Ask the QIO for a Review by the Deadline?

If you do not ask the QIO for a fast review of your discharge by the deadline, you may ask us for a "fast appeal" of your discharge, which is discussed in Part 1 of this section.

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 your discharge date. Whether you have to pay or not depends on the decision we make.

- If we decide, based on the fast appeal, that you need to stay in the hospital, we will continue to cover your hospital care for as long as it is medically necessary (except for any applicable copayments or deductibles).
- If we decide that you should not have stayed in the hospital beyond your discharge date, we will not cover any hospital care you received after the discharge date.

If we uphold our original decision, we will forward our decision and case file to the independent review entity within 24 hours. *Please see Appeal Level 2 in Part 1 of this section for guidance on the Independent Review Entity (IRE) appeal.*

If the IRE upholds our decision, you may also be able to ask for a review by an ALJ, MAC, or a Federal court. If any of these decision makers (Independent Review Entity, Administrative Law Judge, Medicare Appeals Council, Federal court) agree that your stay should continue, we must pay for or reimburse you for any care you have received since the discharge date on the notice you got from your provider, and provide you with any services you asked for as long as they are medically necessary (except for any applicable copayments or deductibles).

Part 3. Complaints (Appeals) If You Think Coverage for Your Skilled Nursing Facility, Home Health Agency, or Comprehensive Outpatient Rehabilitation Facility Services Is Ending Too Soon

When 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 get all the SNF, HHA or CORF care covered by the Plan that is necessary to diagnose and treat your illness or injury.

The day we end coverage for your SNF, HHA or CORF services is based on when these services are no longer medically necessary. This part explains what to do if you believe that coverage for your services is ending too soon.

Information You Will Receive During Your SNF, HHA or CORF Stay

Your provider will give you written notice called the *Notice of Medicare Non-Coverage* at least 2 days before coverage for your services ends (call the Plan Customer Service phone number in Section 1 of your Evidence of Coverage or 1-800-MEDICARE (1-800-633-4227) to get a sample notice or see it online at <http://www.cms.hhs.gov/BNI/>).

You (or your representative) will be asked to sign and date this notice to show that you received it. Signing the notice does not mean that you agree that coverage for your services should end – only that you received and understood the notice.

Getting QIO Review of Our Decision to End Coverage

You have the right to appeal our decision to end coverage for your services. As explained in the notice you get from your provider, you may ask the Quality Improvement Organization (the QIO) to do an independent review of whether it is medically appropriate to end coverage for your services.

How Soon Do You Have to Ask for QIO Review?

You must quickly contact the QIO. The written notice you got from your provider gives the name and telephone number of your QIO and tells you what you must do.

- If you get the notice 2 days before your coverage ends, you must contact the QIO no later than noon of the day after you get the notice.
- If you get the notice more than 2 days before your coverage ends, you must make your request no

later than noon of the day before the date that your Medicare coverage ends.

What Will Happen During the QIO's Review?

The QIO will ask why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish. The QIO will also look at your medical information, talk to your doctor, and review information that we have given to the QIO.

During this process, you will get a notice called the *Detailed Explanation of Non-Coverage* giving the reasons why we believe coverage for your services should end (call the Plan Customer Service phone number in Section 1 of your Evidence of Coverage or 1-800-MEDICARE (1-800-633-4227) to get a sample notice or see it online at <http://www.cms.hhs.gov/BNI/>).

The QIO will make a decision within one full day after it receives all the information it needs.

What Happens If the QIO Decides in Your Favor?

We will continue to cover your SNF, HHA or CORF services for as long as they are medically necessary (except for any applicable copayments or deductibles).

What Happens If the QIO Agrees That Your Coverage Should End?

You will not be responsible for paying for any SNF, HHA, or CORF services provided before the termination date on the notice you get from your provider. You may stop getting services on or before the date given on the notice and avoid any possible financial liability. If you continue receiving services, you may still ask the QIO to review its first decision if you make the request within 60 days of receiving the QIO's first denial of your request.

What Happens If You Appeal the QIO Decision?

The QIO has 14 days to decide whether to uphold its original decision or agree that you should continue to receive services. If the QIO agrees that your services should continue, we must pay for or reimburse you for any care you have received since the termination date on the notice you got from your provider, and

provide you with any services you asked for as long as they are medically necessary (except for any applicable copayments or deductibles).

If the QIO upholds its original decision, you may be able to appeal its decision to the Administrative Law Judge (ALJ). *Please see Appeal Level 3 in Part 1 of this section for guidance on the ALJ appeal.*

If the ALJ upholds our decision, you may also be able to ask for a review by the Medicare Appeals Council or a Federal court. If either the Medicare Appeals Council or Federal court agrees that your stay should continue, we must pay for or reimburse you for any care you have received since the termination date on the notice you got from your provider, and provide you with any services you asked for as long as they are medically necessary (except for any applicable copayments or deductibles).