Grievances & Appeals
Information on Grievances, Initial Determinations, Exceptions and Appeals

Grievances

What is a Grievance?

A grievance is any complaint, or dispute, expressing dissatisfaction with the manner in which our organization or delegated entity provides health care services, regardless of whether you request remedial action be taken. A grievance may also include a complaint regarding a refusal to expedite an organization determination or reconsideration or refusal to expedite a coverage determination or redetermination. In addition, grievances may include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided health service, procedure, or item.

Grievances do not involve problems related to approving or paying for Part C medical care or services (See Appeal).

You could file a grievance if you have a complaint regarding us, a provider of care, or one of our network pharmacies. For example, you could file a grievance if you have a complaint about things such as wait times in doctor's offices or when you fill a prescription, the way your network physician/pharmacist or others behave, the service you receive, and difficulty getting or understanding the information you need or request.

Filing a Grievance with Our Plan

If you have a grievance, we encourage you to call our MVP Medicare Customer Care Center immediately. We will make every attempt to resolve your complaint over the phone. If you ask for a written response, file a written grievance, or your complaint is related to your quality of care, we will respond in writing to you as quickly as your case requires based on your health status, but no later than thirty (30) calendar days after we receive your grievance. You are not required to submit your grievance in writing. You may file your grievance by phone, by mail or in person.
When a delay would significantly increase any risk to your health, you have the right to ask for a "fast" or "expedited" grievance. This means we will respond to your grievance within twenty-four (24) hours of receipt of your request. If we cannot respond to your grievance within that twenty-four (24) hour time frame because necessary information is needed, we will notify you verbally and in writing (before the 24 hours) of the reason for the delay. All notifications involving the decision will include information about the basis of our decision and describe any additional rights you may have. All grievances involving clinical decisions will be made by qualified clinical personnel.

Your grievance must be submitted within sixty (60) calendar days of the event or incident. We must address your grievance as quickly as your case requires based on your health status, but no later than thirty (30) calendar days after receiving your complaint. We may extend the time frame by up to fourteen (14) days if you ask for the extension, or if we can justify a need for additional information and the delay is in your best interest. If we deny your grievance in whole or in part, our written decision will explain why we denied it, and will tell you about any dispute resolution options you may have.

Complaints about Quality of Care
Complaints concerning the quality of care received under Medicare may be made in verbal or written format to us under the grievance process, or to an independent organization called the Quality Improvement Organization (QIO), or to both. For example, if you believe you were given the wrong treatment or you believe your pharmacist provided the incorrect dose of a prescription, you may file a complaint with the QIO in addition to or instead of a complaint filed under our grievance process. For any complaint filed with the QIO, we must cooperate with the QIO in resolving the complaint.

How do I File a Grievance?

To file a standard grievance you may:
Call us at [**1-800-665-7924,** Monday – Friday from 8 am to 8 pm Eastern Time . From October 1 – February 14, representatives are available seven days a week from 8 am – 8 pm
For TTY/TDD: **1-800-662-1220**]

Send it to us by fax: [**1-585-327-5724**]

Send it to us in writing:

MVP Health Care
Attn: Member Appeals Department
PO Box 2207
625 State Street
Schenectady, NY 12301

Register your grievance in person:
Please call the MVP Medicare Customer Care Center for information on filing your grievance in person.

Complaints and Appeals about your Part C Medical Care and Service(s)

Initial Determinations
The initial determination we make is the starting point for dealing with requests you may have about covering a Part C medical care or service you need, or paying for a Part C medical care or service you already received. Initial decisions about Part C medical care or services are called "**organization determinations**." With this decision, we explain whether we will provide the Part C medical care or service you are requesting, or pay for the Part C medical care or service you already received.

Asking for a "standard" or "fast" initial determination
A decision about whether we will give you, or pay for, the Part C medical care or service you are requesting may be a "standard" decision that is made within the standard time frame, or it can be an “expedited” decision that is made more quickly.

To ask for a standard or expedited decision for Part C medical care or service you, your representative, your doctor, or the physician providing your treatment may call, fax or write us.

Standard Initial Determination

To request a standard organization determination for Part C medical care or services you have not yet received, we will make a decision as expeditiously as your health condition requires, but no later than fourteen (14) calendar days 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 and we can justify how the delay is in your best interest. If we take additional days, we will notify you in writing.

If the request involves a decision about payment for Part C medical care or services you already received, we have up to thirty (30) calendar days to make a decision after we receive your request. However, if we need more information we have up to sixty (60) days from the date of your request to make a decision.

Fast (or "Expedited") Initial Determination
You may ask for a fast decision if it is believed that waiting for a standard decision could seriously harm your health or your ability to function.

If your request for a fast organization determination is about Part C medical care or services you have not yet received, we have seventy-two (72) hours to make a decision after we receive your request. However we can take up to fourteen (14) more days if you ask for additional time, or we need more information and we can justify it is in your best interest.

What happens if we decide against you?
If we decide against you, we will send you written notice explaining why we denied your request and provide you with your appeal rights **(See Appeal Level 1)**.

Appeals

What is an Appeal?
An appeal is any of the procedures that deal with the review of adverse coverage determinations or organization determinations on the health care services you believe you are entitled to receive. An appeal to us about Part C medical care or service is called an "**organization reconsideration**."

Filing an Appeal with our Plan:

Appeal Level 1:
If you do not agree with our decision to deny your coverage or organization determination in whole or in part, you may ask us to review our denial decision. You must file your appeal request within sixty (60) calendar days from the date on the written notice of denial. We may give you more time if you have a good reason for missing the deadline. When we receive your request for a “redetermination” or “reconsideration” it is reviewed by professionals within our organization, who were not involved in making the original initial determination. This process ensures that we give your request a thorough review, independent of the original review.

You have the right to request a **standard appeal** or a fast appeal of a "redetermination" or "reconsideration". A fast appeal is also called an **"expedited" appeal**.

To request a standard or expedited decision for Part C medical care or services you believe you are entitled to, you, your representative, your physician, or the physician providing your treatment may call, fax or write to us.

Standard Appeal:

If your appeal is about Part C medical care or services you have not yet received, we will make a decision no later than thirty (30) calendar days of receiving the appeal request, but we 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 fourteen (14) more days to make our decision. If your appeal is regarding payment denials for medical care and services you already received, our decision will be made within sixty (60) calendar days of receiving your appeal request.

Expedited Appeal:
An expedited appeal may be filed if it is determined that waiting the standard time frame may seriously jeopardize your life or health or your ability to regain maximum function.

If your appeal is about Part C medical care or services you have not yet received, we will make a decision no later than seventy-two (72) hours of receiving the appeal request, but we 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 fourteen (14) more days to make our decision.

Where to file an Appeal with our Plan:

For a Standard Appeal (Level 1)
Mail your request to:
MVP Health Care
Attn: Member Appeals Department
PO Box 2207
625 State Street
Schenectady, NY 12301

Send it to us by fax: [**1-585-327-5724**]

For an Expedited Appeal (Level 1), mail your appeal to the address above, or call us at [**1-800-665-7924**, Monday – Friday from 8 am to 8 pm Eastern Time. From October 1 – February 14, representatives are available seven days a week from 8 am – 8 pm.]

[For TTY/TDD: **1-800-662-1220**]

Appeal Level 2: Review by an Independent Review Entity (IRE)
If we did not rule completely in your favor at Appeal Level 1 for Part C medical care or services, your appeal is automatically sent to an outside, Independent Review Entity (IRE) that has a contract with the Centers for Medicare & Medicaid Services (CMS) (the government agency that runs the Medicare program). The IRE has no connection to us. You have the right to ask us for a copy of your case file that we send to this entity.

Appeal Level 3: Hearing with an Administrative Law Judge (ALJ)
If the IRE does not rule completely in your favor, you may request a review by an Administrative Law Judge (ALJ) if the dollar value of the Part C medical care or service you asked for meets the minimum requirement of {$140}. Your written request must be filed with an ALJ within sixty (60) calendar days of the date you were notified of the decision made by the IRE (Appeal Level 2). The decision you receive from the IRE will tell you how to file this appeal, including who may file it.

Appeal Level 4: Review by the Medicare Appeals Council (MAC)
If the ALJ does not rule completely in your favor, you may ask for a review by the Medicare Appeals Council (MAC). You must make the request in writing within sixty (60) calendar days of the date you were notified of the decision made by the ALJ (Appeal Level 3). The MAC may give you more time if you have a good reason for missing the deadline. The decision you receive from the ALJ will tell you how to file this appeal, including who may file it.

Appeal Level 5: Review by a Federal Court
If the MAC does not rule completely in your favor or the MAC decided not to review your appeal request, you have the right to continue your appeal by asking a Federal Court Judge to review your case. To receive a review by a Federal Court Judge, the amount involved must meet the minimum requirement of {$1400}. You must make the request in writing within sixty (60) calendar days from the date of the notice of the MAC's decision. The letter you get from the MAC will tell you how to request this review, including who may file the appeal.

Who may file a Grievance Initial Determination or Appeal?
You, your physician, the physician providing your treatment (Part C), or someone you name may file a grievance, initial determination or appeal. The person you name would be your "representative." You may name a relative, friend, lawyer, advocate, doctor, or anyone else to act for you. Other persons may already be authorized by the Court or in accordance with State law to act for you. If you want someone to act for you who is not already authorized by the Court or under State law, then you and that person must sign and date a statement that gives the person legal permission to be your representative. The representative statement must include your name and Medicare number. You may use Form CMS-1696, Appointment of Representative. You may also use an equivalent notice which satisfies the requirements in Form CMS-1696.

You have the right to have a lawyer act for you. You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will provide you free legal services if you qualify. You may want to call the Medicare Rights Center at **1-800-333-4114** or the Medicare Eldercare locator at **1-800-677-1116**.

Unless otherwise stated, your appointed representative will have all of your rights and responsibilities during the grievance or appeals process.

Where to Learn More
You may request the aggregate number of our grievances, appeals, and exceptions by contacting the MVP Medicare Customer Care Center at the numbers provided above.

To find more detailed information on the grievance and appeals process, refer to your Evidence of Coverage (EOC) [Chapter 9 (if you have drug coverage) - What to do if you have a problem or complaint (coverage decisions, appeals, complaints) or Chapter 7 (if you do not have drug coverage) - What to do if you have a problem or complaint (coverage decisions, appeals, complaints).]

MVP Health Plan, Inc. is an HMO-POS/PPO/MSA organization with a Medicare contract. Enrollment in MVP Health Plan, Inc. depends on contract renewal. Submit feedback about your Medicare plan at www.medicare.gov/MedicareComplaintForm/home.aspx.