

Grievance and Coverage Determination Procedures

In a Medicare health plan, there are many "legal" terms and actions that must be used; Medicare has many laws (regulations) to protect Medicare members. To make it easier to understand, we've tried to explain the process in simple terms.

GEMCare Health Plan ("GHP") is responsible for keeping track of grievance and appeals cases that Members ask us to handle. We must report this information to Medicare and to members if they request the information.

GHP is also responsible for how quickly we must review a case. Time frames are one important part of the process. A time frame is the amount of time we are allowed to make a decision; time frames are also based on how quickly a member's medical condition needs a decision.

There will be times where GHP may need to request member records so a case can be decided correctly. Please know that all information, decisions and actions taken during our review are private and protected and, by law, cannot be given to an outside party.

This document has basic information regarding Pharmacy Grievances, Redeterminations and Coverage Determinations; you should also reference your yearly Evidence of Coverage for more detailed information.

GRIEVANCES (Complaints)

A grievance is basically a complaint. There are different types of grievances:

- General grievances:
 - The pharmacist was rude
 - I called and called and no one picked up the phone and it was really annoying
- Co-payment grievances:
 - I don't like the amount of the co-payments the plan has set
- Benefit design grievances:
 - I know I have to pay a certain amount for this drug, but I think what they're asking for this particular drug is too high and should be placed in the lower category.
- Quality of care grievances:
 - My pharmacist gave me the wrong prescription
 - The pharmacist gives different information about how to take the drug than my provider did.
- Excluded drug grievances:
 - I don't think that this particular drug should be excluded from coverage!

There are also different time frames for:

- Standard: GHP must make a decision as quickly as the member's health requires, but no later than 30 days after receiving the request. GHP can extend the time by 14 days if it is in the best interest of the member. Members will receive a letter giving the result of the complaint or of an extension.
- Expedited: This is a grievance that has to be decided quicker (within 24 hours of receiving the grievance) than a general grievance. GHP can extend the time by 14 days if it is in the best interest of the member. Members will receive a telephone call first and then a letter giving the result of the complaint or of an extension.
- An expedited "fast" grievance review is valid only in the following two situations:
 - If GHP feels it's necessary to extend the timeframe required for additional information to make a decision for a prescription, and

- If GHP (or its delegates) refuse to do a “fast” decision for prescription drugs

[Note: The member (or their appointed representative) are responsible for submitting the grievance within 60 days of the event – there are special circumstances where for “good cause” (illness, new information) a member may be able to submit after those 60 days.]

Some grievances can't be fixed; some can be fixed:

- Let's say a member submits a complaint about a pharmacy being closed on a Sunday. After speaking with the pharmacy, we find that they were planning to extend hours to include Sundays. The complaint was reported, researched, investigated, and resolved. GHP “fixed” this complaint.
- Let's say a member submits a complaint about there never being handicapped parking available at the pharmacy; after speaking with the pharmacy, we find that there are legally enough handicapped spaces in the parking lot and that no additional handicapped parking will be added. Though GHP couldn't “fix” the complaint, we did report and research the situation. But, we did “resolve” the case because we “worked” it to the best of our ability.

To Submit A Grievance (Complaint):

Telephone Call:

661-716-8800

877-697-2464

TDD/TTY 888-833-9312 for the hearing-impaired

Fax:

661-716-4812

Email:

PartDcoverage@gemcarehealthplan.com

By mail:

GEMCare Health Plan
 Appeals & Grievance Department
 4550 California Avenue, Ste. 100
 Bakersfield, CA 93309

Federal Express:

GEMCare Health Plan
 Appeals & Grievance Department
 4550 California Avenue, Ste. 100
 Bakersfield, CA 93309

PART D COVERAGE DETERMINATION

A coverage determination request is one where an initial decision needs to be made about a Part D drug. This could include a formulary exception (the requested drug is not on the “formulary” or the list of approved drugs for the plan) or a tiering exception (the requested drug is on the formulary, at a higher co-payment than a member believes it should be). The coverage determination request can be made by the member; the member's appointed representative or a member's provider.

There are different types of coverage determinations:

- Payment determination:
 - Decision about whether a Part D drug will be paid for or provided. This could be based on whether or not the drug is in the formulary or not, and if not was it medically necessary; if the drug was purchased at an out-of-network pharmacy or perhaps it was an excluded drug.
 - Failure to provide a coverage determination in a timely matter when the member's health could be affected.
 - Tiering (drugs placed in different co-payment levels) exceptions, when a member believes a drug should be in a different tier.
 - Cost-sharing amounts – the amount members pay for a drug
 - Formulary exception; when a member thinks a drug should be included on the formulary list, but it's not.
 - When a pre-authorization or utilization management (how a member uses the plan their given) requirement has not been satisfied by the member.

There are also different time frames for:

- Standard appeal: The member and provider will be informed of a decision within 72 hours (3 days) of receipt of the request or as expeditiously as the health condition requires (within a period of time that doesn't put a member's life into serious jeopardy or the ability to regain maximum function). If a decision could not be made within those 72 hours, an appeal will automatically be sent within 24 hours to an Independent Review Entity for their review and determination.
- Expedited: The member and provider feel that the health condition requires an expedited review, because waiting longer would put the life into serious jeopardy or the ability to regain maximum function would be affected, member and provider will be informed of a decision within 24 hours (1 day) of receipt of the original request. If a decision could not be made within those 24 hours, an appeal will automatically be sent within 24 hours to an Independent Review Entity for their review and determination.

REDETERMINATION PROCESS (Request to re-review a decision)

Re-determination:

A re-determination/appeal request is one where a coverage determination was denied (either in full or in part) but a member is asking that the decision be re-reviewed. A re-determination request needs to be requested by the member within 60 calendar days from the denial notice, unless there is a good reason that the request was not sent within those 60 days. A re-determination request can be made by a member, the member's appointed representative or if the case is "expedited," the provider; the provider can request a re-determination for a standard case, but only if they act as an appointed representative.

Re-determinations are based upon coverage determination denials (in full or in part) (see coverage determination examples above).

As with all cases, there are different time frames for review and decision:

- Standard: GHP must make a decision as quickly as a member's health requires, but no later than 7 calendar days after receiving the request. Members will receive written notification of the result of the complaint. If a decision could not be made within those 7 days, an appeal will automatically be sent within 24 hours to an Independent Review Entity for their review and determination.
- Expedited: This is a re-determination that has to be decided quickly, within 72 hours of receiving the request. This is used when a standard appeal could seriously put a member's life or health in danger, or the ability to regain the greatest function. A provider is the most suitable person to decide if a "fast" rather than a standard review is appropriate. If a decision could not be made within those 72 hours, an appeal will automatically be sent within 24 hours to an Independent Review Entity for their review and determination.

To Submit A Coverage Determination or Re-determination:

Telephone Call:

661-716-8800
 877-697-2464
 TDD/TTY 888-833-9312 for the hearing-impaired

By mail:

GEMCare Health Plan
 Appeals & Grievance Department
 4550 California Avenue, Ste. 100
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Email:

PartDcoverage@gemcarehealthplan.com

INDEPENDENT REVIEW (Reconsideration)

If the appeal was denied, in full or in part, members have the right to an independent review. The independent review entity (IRE) also called the independent review organization, contracts with the federal government and is not part of Health Plan. GHP *automatically* submits an appeal to the IRE for review if a case cannot be decided within the timeline specified by CMS; a member, the appointed representative or provider will be notified. However, if GHP made its decision in a timely manner, it is the member (or the appointed representative) who must request an IRE reconsideration.

There are different levels of appeals if one or more of the IRE's denies the case either full or in part, GHP (and the member) will be notified. The member (of the appointed representative) may continue the appeal by asking for other review(s) and based on the decisions, can continue appealing up to a federal court judge.

If denied where case can be submitted:	Time Frame	Dollar Amount needed for case to be "heard"	GHP Time Frame to Fulfill the if Case Decision
MAXIMUS Federal Services - IRE	Standard : 7 days Expedited 72 hours		GHP has to fulfill the decision from receipt of notice of the decision. Drug Benefit Standard: as quickly as member's health requires, but must approve/provide no later than 72 hrs Expedited: as quickly as member's health requires, but must approve/provide no later than 24 hrs Drug Payment: Approve no later than 72 hrs; payment within 30 days.
Administrative Law Judge (ALJ)	ALJ will make a decision as soon as possible. There is no specific decision time frame.	[\$130] for [2010]	GHP has to fulfill the decision from receipt of notice of the decision. Drug Benefit Standard: as quickly as member's health requires, but must approve/provide no later than 72 hrs Expedited: as quickly as

			<p>member's health requires, but must approve/provide no later than 24 hrs</p> <p>Drug Payment: Approve no later than 72 hrs; payment within 30 days.</p>
Medicare Appeals Council (MAC)	MAC will make a decision as soon as possible. There is no specific decision time frame.		<p>GHP has to fulfill the decision from receipt of notice of the decision. Drug Benefit Standard: as quickly as member's health requires, but must approve/provide no later than 72 hrs</p> <p>Expedited: as quickly as member's health requires, but must approve/provide no later than 24 hrs</p> <p>Drug Payment: Approve no later than 72 hrs; payment within 30 days.</p>
United States District Court (Federal Court Judge)	The Federal judiciary is in control of the timing of any decision.	[\$1260] for [2010]	<p>GHP has to fulfill the decision from receipt of notice of the decision. Drug Benefit Standard: as quickly as member's health requires, but must approve/provide no later than 72 hrs</p> <p>Expedited: as quickly as member's health requires, but must approve/provide no later than 24 hrs</p> <p>Drug Payment: Approve no later than 72 hrs; payment within 30 days.</p>

The judge's decision is final. Neither a member nor the Health Plan may take the appeal any further.