

Grievance and Appeal 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.

GRIEVANCES (Complaints)

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

- General grievances:
 - My doctor’s staff was rude
 - I called and called and no one picked up the phone and I was really upset
 - The doctor spoke to me in a tone I didn’t appreciate
- Quality of care grievances (*these are handled by the Appeals and Grievance Department, with GHP’s Quality Management team*):
 - I called and called and no one picked up the phone when I was calling the nurses line during a medical emergency
 - I went to my doctor and they didn’t have the equipment necessary to do the proper testing on my heart condition
 - When the nurse took my blood, she really hurt me, I don’t think she has training

There are also different time frames for:

- Standard: A decision must be made as quickly as the member’s health requires, but no later than 30 calendar 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 “fast”: This is a grievance that has to be decided quicker (within 24 hours of receiving the grievance) than a standard 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 felt it was necessary to lengthen the timeframe required to get more information to make a decision for medical care, and
 - If GHP (or it’s delegates) refuse to do a “fast” decision in making a decision for medical care

[Note: Members are responsible for submitting a grievance within 60 days of the complaint – there are special cases (illness, new information) where case may be able to pass those 60 days and still submit a grievance.]

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

- Let's say a member submits a complaint about a provider not having evening appointments; GHP speaks to the provider and now the provider's office is open in the evening two times a week. The complaint was reported, researched, investigated, and resolved. GHP "fixed" this complaint.
- Let's say a member submits a complaint about no parking in front of the provider's office; GHP speaks to the provider, but as much as they would like, the provider cannot fix the parking situation. 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:

661-716-4810

Email:

AppealGrievance@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

MEDICAL SERVICES CLAIM OR APPEAL (Request to re-review a decision)

Medical services are services that apply to Part A (inpatient services) and Part B (outpatient services/part B drugs) coverage. Information for appealing pharmacy/non-part B drugs is in a separate document, because those cases are handled differently.

Whenever a medical service is requested, or a claim is submitted, a decision needs to be made whether to approve or deny the original request or submission. That "first look" at the request is called an initial decision or organizational determination. A member (or appointed representative), provider, or other individual that would have an interest in the case) can file an appeal if they feel all or part of a request was denied for the wrong reason.

There are different types of appeals:

- Payment appeal:
 - A provider submitted a bill to GHP to pay for medical services already received. The claim was not approved, but the member/provider feels that the claim should be paid. Or:
 - The claim was paid, but the member feels they were charged too much for the service;
- Pre-Service medical appeal:
 - Provider requests approval for a medical procedure or treatment, but it was denied. The provider feels it should have been approved; the member or provider submits an appeal to re-review the denial.

There are also different time frames:

- Standard payment appeal: A decision must be made no later than 60 calendar days after receiving the request. Members will receive a letter giving the result of the review.
- Standard pre-service medical appeal: A decision must be made as quickly as the health requires, but no later than 30 calendar days after receiving the request. The member and provider will

receive a letter giving the result of the review. GHP can extend the decision by up to 14 calendar days, if more information is needed and it will benefit the member in the end. Members will be sent a letter telling of the extension and also be told they can file an expedited grievance. The member and provider will also receive a letter giving them the result of the review.

- Expedited “fast”: This is an appeal that has to be decided quickly (within 72 hours) because a standard appeal could seriously put the member’s life or health in danger, or their ability to regain the greatest function. The Member’s provider is the most suitable person to decide if a “fast” rather than a standard review is needed. GHP can extend the decision by up to 14 calendar days, if more information is needed and it will benefit the member in the end. The member and provider will be sent a letter telling of the extension and that they can file an expedited grievance. . The member and provider will also receive a phone call telling them of the decision and a letter will also be sent giving them the result of the review. Please note if a service was already received and only a payment is being appealed, a “fast” review cannot be given.

[Note: Members are responsible for submitting the appeal within 60 days of the denial – there are special circumstances where a member may be able to submit passed those 60 days.]

To Submit a Medical Services Appeal:

Telephone Call:

661-716-8800

877-697-2464

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

[The Member Services Representative can assist you in filling out a form for submitting.]

Fax:

661-716-4810

By mail:

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

Federal Express:

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AppealGrievance@gemcarehealthplan.com

INDEPENDENT REVIEW

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 further review after a full or partial denial. In the letter a member receives giving information about the original denial will also explain that the case was forwarded to the IRE.

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 (CHDR) - IRE	Standard Payment: 60 calendar days Standard Medical		GHP has to fulfill the decision from receipt of notice of the decision.

	<p>Service: 30 calendar days, plus 14 calendar day extension if in enrollee's interest, or sooner if warranted by enrollee's medical condition</p> <p>Expedited 72 hours, plus 14 calendar day extension if in enrollee's interest, or sooner if warranted by enrollee's medical condition</p>		<p>Payment: 30 days</p> <p>Service: as quickly as member's health requires, but must approve no later than 72 hours or provide care as quickly as health requires, but no later than 14 calendar days after receiving the decision.</p> <p>Expedited: as quickly as your health requires, but no later than 72 hours after receiving the request for appeal</p>
Administrative Law Judge (ALJ)	ALJ will make a decision as soon as possible. There is no specific decision time frame.	\$110 for 2006	<p>GHP has to fulfill the decision from receipt of notice of the decision.</p> <p>Payment: 60 days</p> <p>Service: 30 days</p>
Medicare Appeals Council (MAC)	MAC will make a decision as soon as possible. There is no specific decision time frame.		GHP has to fulfill the decision within 60 days from receipt of notice of the decision. GHP can appeal this decision to a Federal Court.
United States District Court (Federal Court Judge)	The Federal judiciary is in control of the timing of any decision.	\$1090 for 2006	GHP has to fulfill the decision within 60 days from receipt of notice of the decision made by the Federal Court.

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