



## GRIEVANCES, INITIAL DETERMINATIONS and APPEALS

### What is a grievance?

A grievance is a type of complaint that you make about us or one of our network providers including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

Grievances may include but are not limited to:

- Problems with the service you receive from Member Services or a sales representative
- You feel you are being encouraged to leave (disenroll from) MAHP (Cost)
- You believe our notices and other written materials are hard to understand
- Problems with the quality of the medical care or services you receive, including quality of care during a hospital stay
- Problems with how long you have to wait on the phone, in the waiting or exam room, or waiting too long to get an appointment
- Rude behavior by doctors, nurses, receptionists, other staff or sales representatives
- Cleanliness or condition of doctors' offices, clinics or hospitals
- You disagree with our decision not to give you a "fast" decision or a "fast" appeal, or we do not give you a decision within the required time.

### Filing a grievance

You may file the grievance or name someone to help you file it. The person you name may be your legal representative or someone you authorize, in writing, to act for you for this particular situation. If you call with your complaint, we will try to resolve your grievance over the telephone or, if you wish, you may submit a grievance in writing. Contact MAHP at the phone number or address listed at the end of this document for more information about how to file a grievance.

Grievances must be submitted within 60 days of the event or incident. Decisions will be made as

quickly as the case requires based on your health status, but no later than 30 days after receiving your complaint. The timeframe for responding to you may be extended for up to 14 days if you request the extension or if more information is needed and the delay is in your best interest. If your grievance is denied, our written decision will explain why we denied it and tell you about any dispute resolution options you may have.

### What is an initial determination?

An initial determination is the starting point for dealing with request about covering medical care or services you need, or paying for medical care you already received. Initial decisions about medical care or services are called "organization determinations". With this decision, we explain whether we will provide the medical care or services you are requesting or pay for the medical care or services you already received.

The following are examples of request for initial determinations:

- You are not getting the medical care or services you want, and you believe that this care is covered by MAHP (Cost)
- 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 MAHP (Cost)
- You are being told that a medical treatment or service you have been getting will be reduced or stopped, and you believe that this could harm your health
- You have received medical care or services that you believe should be covered by MAHP (Cost), but we have refused to pay for this care

### Requesting an initial determination

As a member, you, your prescribing physician or someone you name may request an initial determination. The person you name would be your

“appointed representative.” You may name a relative, friend, advocate, doctor or anyone 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 who is not already authorized under state law, then you and that person must sign and date a statement that gives the person you name legal permission to be your appointed representative. If you are requesting medical care or services, the request for an initial determination must be sent to us at the address or fax number listed at the end of this document.

Generally, standard initial determinations about medical care or services you have not yet received are made within 14 days. Most decisions about payments for services already received are made within 30 days, but can take up to 60 days from the receipt of your request. “Fast” initial determination decisions about medical care or services you have not yet received are made within 72 hours if waiting longer will affect your health. You have the right to appeal any unfavorable decision about an initial determination using our appeals process (see below).

### Appealing decisions

If we deny your grievance or your request for an initial determination, in whole or in part, we will send you a written explanation of the reason why. This letter will also tell you about any dispute resolution options you may have. There are five levels of appeal.

- ▶ **Appeal level 1** – This is a request for plan reconsideration. Within 60 days of the denial, you or your representative may ask us to review our initial determination, even if only part of the decision is not what you requested.
- ▶ **Appeal level 2** – If your request for plan reconsideration is not resolved in your favor, you or your representative may request a second level appeal. Second level appeals are reviewed by an outside Independent Review Entity (IRE) that has a contract with the Centers for Medicare & Medicaid Services (CMS).

CMS is the government agency that runs Medicare. The IRE has no connection to MAHP (Cost).

- ▶ **Appeal level 3** – If the IRE does not rule completely in your favor, you or your

representative may ask for a review by an Administrative Law Judge (ALJ) if the dollar value of the medical care or service you asked for meets the minimum requirement provided in the IRE’s decision. This request must be made in writing within 60 days of the IRE’s decision. The ALJ will make a decision as soon as possible.

- ▶ **Appeal level 4** – If the ALJ does not rule completely in your favor, you or your representative may ask for a review by the Medicare Appeals Council (MAC). If the MAC reviews the request, it will make a decision as soon as possible. If the MAC does not review your request, or it is denied and the amount disputed in the case meets the minimum requirements specified in the MAC’s decision, it may be appealed to the next level.
- ▶ **Appeal level 5** – You or your representative have the right to continue your appeal by asking a federal court judge to review your case if the amount involved meets the minimum specified in the Medicare Appeals Council’s decision and:
  - The decision is not completely favorable to you, or
  - The decision tells you the MAC decided not to review your appeals request

This decision is final and there are no appeals after this level.

For more information about how to file an appeal, please see your MAHP (Cost) Evidence of Coverage.

### Write or call MAHP (Cost)

You can write or call MAHP (Cost) to file a grievance or request an initial determination at:

Medical Associates Health Plans  
1605 Associates Drive, Suite 101  
Dubuque, IA 52002

(563) 556-8070 locally or 1-800-747-8900 toll free  
TTY only, call 1-800-735-2943, Fax (563) 556-5134

Office hours: Monday through Friday, 8:00 a.m. to 5:00 p.m.