Chapter 9: What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

What's in this chapter?

This chapter has information about your rights to ask for a coverage decision, an appeal or make a complaint. Read this chapter to find out what to do if for example:

- You have a problem with or complaint about your plan.
- You need a service, item, or medication that your plan has said it will not pay for.
- You disagree with a decision that your plan has made about your care.
- You think your covered services are ending too soon.

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. This chapter is broken into different sections to help you easily find what you are looking for.

If you are facing a problem with your health or long-term services and supports

You should receive the health care, drugs, and nursing facility and home and community based waiver services (also called long-term services and supports) that your doctor and other providers determine are necessary for your care as a part of your care plan. However, sometimes you may run into a problem getting services, or you may be unhappy with how services were provided or how you were treated. This chapter will explain the different options you have for dealing with problems and complaints about our plan, our plan's providers, getting services, and payment of services.

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Section 1: Introduction

Section 1.1: What to do if you have a problem

This chapter will tell you what to do if you have a problem with your plan or with your services or payment. These processes have been approved by Medicare and Medicaid. Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

Section 1.2: What about the legal terms?

There are difficult legal terms for some of the rules and deadlines in this chapter. Many of these terms can be hard to understand, so we have used simpler words in place of certain legal terms. We use abbreviations as little as possible.

For example, we will say:

- “Making a complaint” rather than “filing a grievance”
- “Coverage decision” rather than “organization determination” or “coverage determination”
- “Fast coverage decision” rather than “expedited determination”

Knowing the proper legal terms may help you communicate more clearly, so we provide those too.

Section 2: Where to call for help

Section 2.1: Where to get more information and help

Sometimes it can be confusing to start or follow through the process for dealing with a problem. This can be especially true if you do not feel well or have limited energy. Other times, you may not have the knowledge you need to take the next step. You can contact any of the following resources for help.

Getting help from CareSource MyCare Ohio's Member Services

Member Services can help you with any problems or complaints you may have getting health care, drugs, and long-term services and supports. We want to help with problems such as: understanding what services are covered; how to get services; finding a provider; being asked to pay for a service; asking for a coverage decision or appeal; or making a complaint (also called a grievance). To contact us you can:

- Call Member Services at **1-855-475-3163** (TTY: 1-800-750-0750), Monday – Friday, 8 a.m. – 8 p.m. The call is free.
- Visit our website at **CareSource.com/MyCare** to send a question, complaint, or appeal.
- Fill out the appeal/complaint form on page 170 of this chapter or call Member Services and ask us to mail you a form.
- Write a letter telling us about your question, problem, complaint, or appeal. Be sure to include your first and last name, the number from the front of your CareSource MyCare Ohio member ID card, and your address and telephone number so we can contact you, if needed. You should also send any information that helps explain your problem.

Mail the form or your letter to: CareSource
Attn: Member Appeals
P.O. Box 1947
Dayton, OH 45401

Getting help from the Ohio Department of Medicaid

If you need help, you can always call the Ohio Medicaid Hotline. The hotline can answer your questions and direct you to staff that will help you understand what to do to handle your problem. The hotline is not connected with us or with any insurance company or health plan. You can call the Ohio Medicaid Hotline at 1-800-324-8680 (TTY: 1-800-292-3572), Monday through Friday from 7 a.m. to 8 p.m. and Saturday from 8 a.m. to 5 p.m. The call is free. You can also visit the Ohio Department of Medicaid website at http://www.medicaid.ohio.gov.

Getting help from the MyCare Ohio Ombudsman

You can also get help from the MyCare Ohio Ombudsman. The MyCare Ohio Ombudsman helps you resolve issues that you might have with our plan. They can help you file a complaint or an appeal with our plan. The MyCare Ohio Ombudsman is an independent advocate and is not connected with us or with any insurance company or health plan. You can call the MyCare Ohio Ombudsman at 1-800-282-1206 (TTY Ohio Relay Service: 1-800-750-0750), Monday through Friday from 8 a.m. to 5 p.m. You can also submit an online complaint at: http://aging.ohio.gov/contact. The services are free.

Getting help from Medicare

You can call Medicare directly for help with problems. Here are two ways to get help from Medicare:

- Call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY: 1-877-486-2048. The call is free.
- Visit the Medicare website (http://www.medicare.gov).

Getting help from other resources

You may also want to talk to the following people about your problem and ask for their help.

- You can talk to your doctor or other provider. Your doctor or other provider can ask for a coverage decision. If you disagree with the coverage decision, the doctor or primary care practitioner that requested the service can submit a Level 1 appeal on your behalf.
  - » If you want your doctor or other provider to act on your behalf for an appeal of services covered by Medicaid only or for a Medicaid State Hearing, you must name him or her as your representative in writing.
- You can talk to a friend or family member. A friend or family member can ask for a coverage decision, an appeal, or submit a complaint on your behalf if you name them as your “representative.”
  - » If you want someone to be your representative, call Member Services and ask for the “Appointment of Representative” form. You can also get the form on the Medicare website at http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf or on our website at **CareSource.com/MyCare**. The form will give the person permission to act for you. You must give us a copy of the signed form.
  - » We will also accept a letter or other appropriate form to authorize your representative.
- You can talk to a lawyer. You may call your own lawyer, or get the name of a lawyer from the local bar association or other referral service. If you want information on free legal help, you can contact your local legal aid office or call Ohio Legal Services toll free at 1-866-529-6446 (1-866-LAW-OHIO). If you want a lawyer to represent you, you

will need to fill out the Appointment of Representative form. Please note, **you do not need a lawyer** to ask for a coverage decision or to make an appeal or complaint.

Section 3: Problems with your Benefits

Section 3.1: Should you use the process for coverage decisions and appeals? Or do you want to make a complaint?

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The chart below will help you find the right section of this chapter for problems or complaints.

Is your problem or concern about your benefits or coverage? (This includes problems about whether particular medical care, prescription drugs, or long-term services and supports are covered or not, the way in which they are covered, and problems related to the plan's denial of payment for items and services.)	
Yes. My problem is about benefits or coverage. Go to the next section of this chapter, **Section 4, "Coverage decisions and appeals."**	**No.** My problem is <u>not</u> about benefits or coverage. Skip ahead to **Section 10** at the end of this chapter: **"How to make a complaint."**

Section 4: Coverage decisions and appeals

Section 4.1: Overview of coverage decisions and appeals

The process for asking for coverage decisions and making appeals deals with problems related to your benefits and coverage. It also includes problems with payment denials.

What is a coverage decision?

A *coverage decision* is an initial decision we make about your benefits and coverage or about the amount we will pay for your medical services, items, or drugs. We are making a coverage decision whenever we decide what is covered for you and how much we pay.

If you or your doctor are not sure if a service, item, or drug is covered by Medicare or Medicaid, either of you can ask for a coverage decision before the doctor gives the service, item, or drug.

What is an appeal?

An *appeal* is a formal way of asking us to review our decision and change it if you think we made a mistake. For example, we might decide that a service, item, or drug that you want is not medically necessary, not a covered benefit, or is no longer covered by Medicare or Medicaid. If you or your doctor disagree with our decision, you can appeal.

How can I get help with coverage decisions and appeals?

If you need help, you can contact any of the resources that are listed in Section 2.1, *Where to get more information and help*.

Section 4.2: Which section of this chapter will help you?

There are four different types of situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We separate this chapter into different sections to help to help you find the rules you need to follow. You only need to read the section that applies to your problem:

- **Section 5** gives you information if you have problems getting medical care, dental or vision services, behavioral health, long-term services and supports, items, and prescription drugs (but not Part D drugs). This includes if you are being told that coverage for care you have been getting will be reduced, suspended, or stopped and you disagree with our decision. For example, use this section if:
    - You are not getting medical care you want, and you believe that this care is covered by our plan.
    - We did not approve services, items, or drugs that your doctor wants to give you, and you believe that this care should be covered.
        - **NOTE:** Only use Section 5 for problems with drugs **not** covered by Part D. Drugs in the *List of Covered Drugs* with a * (non-Part D drugs) are not covered by Part D. See Section 6 for Part D drug appeals.
    - You received medical care or services that you think should be covered, but we are not paying for this care.
    - You got and paid for medical services or items you thought were covered, and you want to ask us to pay for the services so your payment can be refunded.
    - You are being told that coverage for care you have been getting will be reduced or stopped, and you disagree with our decision.

- **NOTE: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services**, you need to read a separate section of this chapter because special rules apply to these types of care. See Sections 7 and 8.

- **Section 6** gives you information if you have problems about Part D drugs. For example, use this section if:
  - You want to ask us to make an exception to cover a Part D drug that is not on the plan's *List of Covered Drugs* (Drug List).
  - You want to ask us to waive limits on the amount of the drug you can get.
  - You want to ask us to cover a drug that requires prior approval.
  - We did not approve your request or exception, and you or your doctor or other prescriber thinks we should have.
  - You want to ask us to pay for a prescription drug you already bought so your payment can be refunded. (This is asking for a coverage decision about payment.)
- **Section 7** gives you information on how to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon. Use this section if:
  - You are in the hospital and think the doctor asked you to leave the hospital too soon.
- **Section 8** gives you information if you think your home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

If you're not sure which section you should be using, please call Member Services at **1-855-475-3163** (TTY: 1-800-750-0750), Monday – Friday, 8 a.m. – 8 p.m.

Section 5: Problems about services, items, and drugs (not Part D drugs)

Section 5.1: When to use this section

This section is about what to do if you have problems with your benefits for your medical care, dental or vision services, behavioral health, items, and long-term services and supports. You can also use this section for problems with drugs that are not covered by Part D. Drugs in the List of Covered Drugs with a * (non-Part D drugs) are not covered by Part D. Use Section 6 for Part D drug appeals.

This section tells what you can do if you are in any of the following situations:

1. **You think the plan covers a benefit that you need but are not getting.**

   What you can do: You can ask the plan to make a coverage decision. Go to Section 5.2 (page 131) for information on asking for a coverage decision.

2. **You want the plan to cover a benefit that requires plan approval (also called prior authorization) before you receive the service.**

   What you can do: You can ask the plan to make a coverage decision. Go to Section 5.2 (page 131) for information on asking for a coverage decision.

   NOTE: See the *Benefits Chart* in Chapter 4, Section D, for a general list of covered services as well as information on what services require prior authorization from CareSource MyCare Ohio. See the *List of Covered Drugs* to see if any drugs **not** covered by Part D require prior authorization. You can also view the lists of benefits and drugs that require prior authorization at **CareSource.com/MyCare**.

3. **The plan did not approve care your doctor wants to give you, and you think it should have.**

   What you can do: You can appeal the plan's decision to not approve the care. Go to Section 5.3 (page 133) for information on making an appeal.

4. **The plan did not approve your request to receive waiver services from a specific network non-agency or participant-directed provider.**

   What you can do: You can appeal the plan's decision to not approve the request. Go to section 5.3 (page 133) for information on making an appeal.

5. **You received services or items that you think the plan covers, but the plan will not pay.**

What you can do: You can appeal the plan's decision not to pay. Go to Section 5.3 (page 133) for information on making an appeal.

6. **You got and paid for medical services or items you thought were covered, and you want the plan to work with the provider to refund your payment.**

   What you can do: You can ask the plan to work with the provider to refund your payment. Go to Section 5.6 (page 141) for information on asking for payment.

7. **Your coverage for a certain service or item is being reduced, suspended, or stopped, and you disagree with our decision.**

   What you can do: You can appeal the plan's decision to reduce, suspend, or stop the service or item. Go to Section 5.3 (page 133) for information on making an appeal.

   NOTE: If we tell you that services or items you were approved to receive will be reduced, suspended, or stopped before you receive all of the services or items that were approved, you may be able to continue to receive the services and items during the appeal. Read *Will my benefits continue during Level 1 appeals* in Section 5.3.

   NOTE: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, special rules apply. Read Sections 7 or 8 to find out more.

8. **The plan did not make a coverage decision within the timeframes we should have.**

   What you can do: You can file a complaint or an appeal. Go to Section 10 (page 164) for information on making a complaint. Go to Section 5.3 (page 133) for information on making a Level 1 Appeal.

9. **The plan did not make an appeal decision within the timeframes we should have.**

   What you can do: You can file a complaint. Go to Section 10 (page 164) for information on making a complaint. Also, if your problem is about coverage of a Medicaid service or item, you can ask for a State Hearing if you have not done so already. Go to Section 5.4 (page 137) for information on requesting a State Hearing. Note that if your problem is about coverage for a Medicare service or item, we will automatically forward your appeal to Level 2 if we do not give you an answer within the required timeframe.

Section 5.2: Asking for a coverage decision

How to ask for a coverage decision to get a service, item, or Medicaid drug (go to Section 6 for Medicare Part D drugs)

To ask for a coverage decision, call, write, or fax us, or ask your authorized representative or doctor to ask us for a decision.

- You can call us at: **1-855-475-3163**, TTY: 1-800-750-0750.
- You can fax us at: 1-855-489-3403
- You can to write us at: CareSource, Attn: Member Appeals
  P.O. Box 1947
  Dayton, OH 45401

➔ Remember, you must complete the Appointment of Representative form to appoint someone as your authorized representative. We will also accept a letter or other appropriate form to authorize your representative. For more information, see Section 2, page 124.

How long does it take to get a coverage decision?

We will make a standard coverage decision on Medicaid drugs within 72 hours after your request was received.

We will make a standard coverage decision on all other services and items within 14 calendar days after your request was received. If we don't give you our decision within 14 calendar days, you can appeal.

➔ You or your provider can ask for more time, or we may need more time to make a decision. If we need more time, we will send you a letter telling you that we need to take up to 14 more calendar days. The letter will explain why more time is needed.

Can I get a coverage decision faster?

Yes. If you need a response faster because of your health, you should ask us to make a "fast coverage decision." If we approve the request, we will notify you of our decision **within 24 hours for Medicaid drugs and within 72 hours for all other services and items**.

➔ Except for fast coverage decisions for Medicaid drugs, you or your provider can ask for more time or we may need more time to make a decision. If we need more time, we will send you a letter telling you that we need to take up to 14 more calendar days. The letter will explain why more time is needed.

> ***The legal term** for "fast coverage decision" is **"expedited determination."***

Asking for a fast coverage decision:

- If you request a fast coverage decision, start by calling or faxing our plan to ask us to cover the care you want.
- You can call us at **1-855-475-3163** or fax us at 1-855-489-3403. For the details on how to contact us, go to Chapter 2, Section A, *How to contact CareSource MyCare Ohio Member Services*.
- You can also have your doctor or your authorized representative call us.

Here are the rules for asking for a fast coverage decision:

You must meet the following two requirements to get a fast coverage decision:

- You can get a fast coverage decision *only* if you are asking for coverage for medical care or an item *you have not yet received*. (You cannot get a fast coverage decision if your request is about refunding your payment for medical care or an item you have already received.)
- You can get a fast coverage decision *only* if the standard deadlines could *cause serious harm to your health or hurt your ability to function.* The standard deadlines are 72 hours for Medicaid drugs and 14 calendar days for all other services and items.
    - ➔ **If your doctor says that you need a fast coverage decision, we will automatically give you one.**
    - ➔ If you ask for a fast coverage decision without your doctor's support, we will decide if you get a fast coverage decision.
        - If we decide that your health does not meet the requirements for a fast coverage decision, we will send you a letter. We will also use the standard deadlines instead to make our decision.
        - This letter will tell you that if your doctor asks for the fast coverage decision, we will automatically give a fast coverage decision.
        - The letter will also tell how you can file a "fast complaint" about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)

If the coverage decision is *Yes*, when will I get the service or item?

For standard coverage decisions, CareSource MyCare Ohio will authorize the coverage within 72 hours for Medicaid drugs and 14 calendar days for all other services and items. For

fast coverage decisions, CareSource MyCare Ohio will authorize the coverage within 24 hours for Medicaid drugs and 72 hours for all other services and items. If we extended the time needed to make our coverage decision, we will authorize the coverage by the end of that extended period.

If the coverage decision is *No*, how will I find out?

If the answer is *No*, we will send you a letter telling you our reasons for saying *No*.

- If we say no, you have the right to ask us to reconsider – and change – this decision by making an appeal. Making an appeal means asking us to review our decision to deny coverage.
- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (see Section 5.3 below).
- You also have the right to ask for a State Hearing if the coverage decision was for a service or item that could be covered by Medicaid (see Section 5.4).

Section 5.3: Level 1 Appeal for services, items, and drugs (not Part D drugs)

What is an Appeal?

An *appeal* is a formal way of asking CareSource MyCare Ohio to review our coverage decision and change it if you think we made a mistake. If you, your authorized representative, or your doctor or primary care practitioner that requested the service disagrees with our decision, you can appeal. You can also appeal our failure to make a coverage decision within the timeframes we should have. CareSource MyCare Ohio will send you a notice in writing whenever we take an action or fail to take an action that you can appeal.

➔ If you want your doctor or other provider to act on your behalf for an appeal of services covered by Medicaid only, you must name him or her as your representative in writing. See below or Section 2.1 for more information.

What is a Level 1 Appeal?

A Level 1 Appeal is the first appeal to our plan. We will review your coverage decision to see if it is correct. The reviewer will be someone who did not make the original coverage decision. When we complete the review, we will give you our decision in writing.

➔ **Please note:** You do not have to first appeal to the plan for services or items that are covered primarily by Medicaid or by both Medicare and Medicaid. You can appeal to the plan, the Bureau of State Hearings, or both. CareSource MyCare Ohio will send you a notice of your right to appeal to the Bureau of State Hearings when the services or items are primarily covered by Medicaid or by both Medicare and Medicaid. Read below for

information on filing an appeal with the plan, and go to Section 5.4 (page 137) for information on filing an appeal with the Bureau of State Hearings.

How do I make a Level 1 Appeal?

- To start your appeal, you, your authorized representative, or your doctor or primary care practitioner that requested the service must contact us. You can call us at **1-855-475-3163** (TTY: 1-800-750-0750) or write to us at the following address:

  CareSource
  Attn: Member Appeals
  P.O. Box 1947
  Dayton, OH 45401

  If you decide to write to us, you can draft your own letter or you can use the appeal/complaint form on page 170. Be sure to include your first and last name, the number from the front of your CareSource MyCare Ohio member ID card, and your address and telephone number so we can contact you, if needed. You should also include any information that helps explain your problem.

- For additional details on how to reach us for appeals, see Chapter 2, page 14.

- You can ask us for a "standard appeal" or a "fast appeal."

> ***The legal term** for "fast appeal" is **"expedited reconsideration."***

Can someone else make the appeal for me?

Yes. Your doctor or primary care practitioner that requested the service can make the appeal for you. Also, someone else can make the appeal for you, but first you must complete an Appointment of Representative form. The form gives the other person permission to act for you.

To get an Appointment of Representative form, call Member Services and ask for one, or visit the Medicare website at https://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf or our website at **CareSource.com/MyCare**. We will also accept a letter or other appropriate form to authorize your representative.

➔ If the appeal comes from someone besides you, your doctor, or the primary care practitioner that requested the service, we must receive your written authorization before we can review the appeal. For services covered by Medicaid only, if you want your

doctor, other provider, or anyone else to act on your behalf we must receive your written authorization.

How much time do I have to make an appeal?

You must ask for an appeal within 90 calendar days after the date on the letter we sent to tell you our decision.

If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of a good reason are: you had a serious illness, or we gave you the wrong information about the deadline for requesting an appeal.

➔ If you are appealing because we told you that medical care you have been getting will be reduced, suspended, or stopped before you receive all the services that were approved, read *Will my benefits continue during Level 1 appeals* below for additional information.

Can I get a copy of my case file?

Yes. Ask us for a copy.

Can my doctor give you more information about my appeal?

Yes, you and your doctor may give us more information to support your appeal.

How will the plan make the appeal decision?

We take a careful look at all of the information about your request for coverage of medical care. Then, we check to see if we were following all the rules when we said *No* to your request. The reviewer will be someone who did not make the original decision.

If we need more information, we may ask you or your doctor for it.

When will I hear about a "standard" appeal decision?

We must give you our answer within 15 calendar days after we get your appeal. We will give you our decision sooner if your health condition requires us to.

- However, if you or your provider asks for more time, or if we need to gather more information, we may take up to 14 more calendar days. If we take extra days to make the decision, we will write you to explain why more time is needed.
- If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours (see Section 10).
- If we do not give you an answer within 15 calendar days or by the end of the extra days (if we took them), you can file a complaint (see Section 10). Also, if your problem is about coverage of a Medicaid service or item, you can ask for a State Hearing if you haven't done so already (see Section 5.4). If your problem is about coverage of a

Medicare service or item, we will automatically send your case to Level 2 of the appeals process (see Section 5.5). You will be notified when this happens.

- **If our answer is *Yes*** to part or all of what you asked for, we must approve the service within 15 calendar days after we get your appeal.

- **If our answer is *No*** to part or all of what you asked for, we will send you a letter. If your problem is about coverage of a Medicare service or item, the letter will tell you that we sent your case to the Independent Review Entity for a Level 2 Appeal (see Section 5.5). If your problem is about coverage of a Medicaid service or item, the letter will remind you that you can also request a State Hearing (see Section 5.4).

What happens if I ask for a fast appeal?

If you ask for a fast appeal, we will give you your answer within 72 hours after we get all information needed to decide your appeal. We will give you our answer sooner if your health requires us to do so.

- However, if you or your provider asks for more time, or if we need to gather more information, we may take up to 14 more calendar days. If we take extra days to make the decision, we will write you to explain why more time is needed.
- If we do not give you an answer within 72 hours or by the end of the extra days (if we took them), you can file a complaint (see Section 10). Also, if your problem is about coverage of a Medicaid service or item, you can ask for a State Hearing if you haven't done so already (see Section 5.4). If your problem is about coverage of a Medicare service or item, we will automatically send your case to Level 2 of the appeals process (see Section 5.5). You will be notified when this happens.

- **If our answer is *Yes*** to part or all of what you asked for, we must authorize the coverage within 72 hours after we get your appeal.

- **If our answer is *No*** to part or all of what you asked for, we will send you a letter. If your problem is about coverage of a Medicare service or item, the letter will tell you that we sent your case to the Independent Review Entity for a Level 2 Appeal (see Section 5.5). If your problem is about coverage of a Medicaid service or item, the letter will remind you that you can also request a State Hearing (see Section 5.4).

Will my benefits continue during Level 1 appeals?

If we previously approved coverage for a service but then decided to change or stop the service before the authorization period expired, we will send you a notice at least 15 days in advance of taking the action. You, your authorized representative, or your doctor or primary care practitioner that requested the service must ask for an appeal on or before the later of the following to continue the service during the appeal:

- Within 15 calendar days of the mailing date of the notice or

- The intended effective date of the action.

If your benefits are continued, you can keep getting the service until one of the following happens: 1) you withdraw the appeal; 2) 15 calendar days pass after we notify you that we said "no" to your appeal; or 3) the authorization expires or you receive all of the services that were previously approved.

➔ **Note:** Sometimes your benefits may continue even if CareSource MyCare Ohio says "no" to your appeal. If the service is covered by Medicaid and you also asked for a State Hearing, you may be able to continue your benefits until the Bureau of State Hearings makes a decision (see Section 5.4, page 137). If the service is covered by both Medicare and Medicaid, your benefits will continue during the Level 2 appeal process (see Section 5.5, page 139).

Section 5.4: State Hearings for services primarily covered by Medicaid or both Medicare and Medicaid

You should read this section if you disagree with our coverage decision on a service or item that is primarily covered by Medicaid or both Medicare and Medicaid. You can request a State Hearing in addition to or instead of appealing to CareSource MyCare Ohio.

What is a State Hearing?

A ***State Hearing*** is a meeting with you or your authorized representative, CareSource MyCare Ohio, and a hearing officer from the Bureau of State Hearings within the Ohio Department of Job and Family Services (ODJFS). You will explain why you think CareSource MyCare Ohio did not make the right decision and we will explain why we made our decision. The hearing officer will listen and then decide who is right based on the information given and the rules.

CareSource MyCare Ohio will send you a notice in writing of your right to request a State Hearing. If you are on the MyCare Ohio Waiver, you may have other State Hearing rights. Please refer to your Home & Community-Based Services Waiver Member Handbook regarding waiver eligibility and services.

How do I ask for a State Hearing?

To request a State Hearing, you or your authorized representative must contact the Bureau of State Hearings within 90 calendar days of receiving the notice of your State Hearing rights. The 90 calendar days begins on the day after the mailing date on the notice. If you miss the 90 calendar day deadline and have a good reason for missing it, the Bureau of State Hearings may give you more time to request a hearing. **Remember, you do not have to ask for a Level 1 Appeal before you can ask for a State Hearing.**

- If you want someone to act on your behalf, including your doctor, you must give the Bureau of State Hearings an authorized representative notice saying that you want that person to act on your behalf.

You can sign and return the State Hearing form to the address or fax number listed on the form, call the Bureau of State Hearings at 1-866-635-3748, or submit your request by e-mail to bsh@jfs.ohio.gov.

Can I get legal help for my State Hearing?

Yes. See Section 2.1, *Where to get more information and help*, for information on free legal help. Please remember, you do not need a lawyer to ask for a State Hearing.

How long does it take to get a State Hearing decision?

State Hearing decisions are usually given no later than 70 calendar days after the request is received. However, if the Bureau of State Hearings agrees that this timeframe could cause serious harm to your health or hurt your ability to function, the decision will be given as quickly as needed but no later than three working days after the request is received.

How will I find out about the decision?

The Bureau of State Hearings will send you a written hearing decision in the mail.

- **If the hearing decision is *Yes* (sustained)** to all or part of what you asked for, the decision will clearly explain what CareSource MyCare Ohio must do to address the issue. If you do not understand the decision or have a question about getting the service or payment being made, contact Member Services for assistance.

- **If the hearing decision is *No* (overruled)** to part or all of what you asked for, it means the Bureau of State Hearings agreed with CareSource MyCare Ohio. The State Hearing decision will explain the Bureau of State Hearings' reasons for saying "no" and will tell you that you have the right to request an Administrative Appeal. The Bureau of State Hearings must receive your request for an Administrative Appeal within 15 calendar days of the date the hearing decision was issued. See Section 9.2 for more information.

Will my benefits continue during my State Hearing?

If we previously approved coverage for a service but then decided to change or stop the service before the authorization period expired, we will send you a notice at least 15 days in advance of taking the action. You or your authorized representative must request a State Hearing before the later of the following to continue the service during the State Hearing:

- Within 15 calendar days of the mailing date of the notice or
- The intended effective date of the action.

If your benefits are continued, you can keep getting the service until one of the following happens: 1) you withdraw the State Hearing request; 2) the Bureau of State Hearings decides “no” on your appeal; or 3) the authorization expires or you receive all of the services that were previously approved.

➔ **Note:** Sometimes your benefits may continue even if the Bureau of State Hearings says “no” to your appeal. If you also asked for an appeal with CareSource MyCare Ohio, you may be able to continue your benefits until the plan makes its decision (see Section 5.3, page 133). If the service is covered by both Medicare and Medicaid, your benefits will also continue during the Medicare Level 2 appeal process (see Section 5.5, page 139).

Section 5.5: Level 2 Appeal for services, items, and drugs (not Part D drugs)

If the plan says *No* at Level 1, what happens next?

If we say “no” to part or all of your Level 1 Appeal, we will send you a letter. This letter will tell you if the service or item is primarily covered by Medicare and/or Medicaid.

- If your problem is about a **Medicare** service or item, you will automatically get a Level 2 Appeal with the Independent Review Entity (IRE) as soon as the Level 1 Appeal is complete.
- If your problem is about a **Medicaid** service or item, the letter will remind you that you may ask for a State Hearing if you have not done so already. Remember, you can request a State Hearing in addition to or instead of appealing to CareSource MyCare Ohio. See Section 5.4 for information on State Hearings.
- If your problem is about a service or item that could be primarily **covered by both Medicare and Medicaid**, you will automatically get a Level 2 Appeal with the IRE. The letter will remind you that you may also ask for a State Hearing if you have not done so already. See Section 5.4 for information on State Hearings.

What is a Level 2 Appeal?

A Level 2 Appeal is the second appeal regarding a service or item that is covered by Medicare or both Medicare and Medicaid. The Level 2 Appeal is reviewed by an independent organization that is not connected to the plan.

What will happen at the Level 2 Appeal?

An Independent Review Entity will do a careful review of the Level 1 decision, and decide whether it should be changed.

- You do not need to request the Level 2 Appeal. We will automatically send any denials (in whole or in part) to the Independent Review Entity. You will be notified when this happens.
- The Independent Review Entity is hired by Medicare and is not connected with this plan.
- You may ask for a copy of your file.

➔ The Independent Review Entity must give you an answer to your Level 2 Appeal within 30 calendar days of when it gets your appeal. This rule applies if you sent your appeal before getting medical services or items.

» However, if the Independent Review Entity needs to gather more information that may benefit you, it can take up to 14 more calendar days. If the IRE needs extra days to make a decision, it will tell you by letter.

➔ If you had "fast appeal" at Level 1, you will automatically have a fast appeal at Level 2. The review organization must give you an answer within 72 hours of when it gets your appeal.

» However, if the Independent Review Entity needs to gather more information that may benefit you, it can take up to 14 more calendar days. If the IRE needs extra days to make a decision, it will tell you by letter.

Will my benefits continue during Level 2 appeals?

If we previously approved coverage for a service but then decided to change or stop the service before the authorization period expired, you can ask to continue your benefits during Medicare Level 2 appeals in some cases.

- If your problem is about a service primarily covered by **Medicare only**, your benefits for that service will **not** continue during the Level 2 appeal process with the IRE.
- If your problem is about a service primarily covered by **both Medicare and Medicaid**, your benefits for that service will continue during the Level 2 appeal process with the IRE.

If your benefits are continued, you can keep getting the service until one of the following happens: 1) you withdraw the appeal; 2) the IRE decides "no" on your Level 2 Appeal; or 3) the authorization expires or you receive all of the services that were previously approved.

➔ **Note:** If your problem is about a service primarily covered by both Medicare and Medicaid, sometimes your benefits may continue even if the IRE says "no" to your Medicare Level 2 Appeal. If you also asked for a Medicaid State Hearing, you may be

able to continue your benefits until the Bureau of State Hearings makes its decision (see Section 5.4, page 137).

How will I find out about the decision?

The Independent Review Entity will send you a letter explaining its decision.

- **If the Independent Review Entity says *Yes*** to part or all of what you asked for, we must authorize the medical care coverage within 72 hours or give you the service or item within 14 calendar days from the date we receive the IRE's decision.
- **If the Independent Review Entity says *No*** to part or all of what you asked for, it means they agree with the Level 1 decision. This is called "upholding the decision." It is also called "turning down your appeal."

I appealed to both the Independent Review Entity and the Bureau of State Hearings for services covered by both Medicare and Medicaid. What if they have different decisions?

If either the Independent Review Entity or the Bureau of State Hearings decides "yes" for all or part of what you asked for, we will give you the approved service or item that is closest to what you asked for in your appeal.

If the decision is *No* for all or part of what I asked for, can I make another appeal?

You can appeal again only if the dollar value of the service or item you want meets a certain minimum amount. The letter you get from the IRE will explain additional appeal rights you may have.

See Section 9 of this chapter for more information on additional levels of appeal.

Section 5.6: Payment problems

We do not allow CareSource MyCare Ohio providers to bill you for covered services. This is true even if we pay the provider less than the provider charges for a covered service.

If in the rare situation that you had to pay for your medical care and you want to ask us for payment, start by reading Chapter 7 of this booklet: *Asking us to pay a bill you have gotten for covered services or drugs*. Chapter 7 describes the situations in which you may need to ask us to assist you with payment you made to a provider or to pay a bill you have received from a provider. It also tells how to send us the paperwork that asks us for payment. Chapter 7 also gives information to help you avoid payment problems in the future.

If you pay or receive a bill for services or items you think we should cover, contact Member Services (see Section 2.1, page 124). CareSource MyCare Ohio will contact the doctor or

provider to discuss the service. It is possible that we will pay the provider so they can refund your payment or the provider will agree to stop billing you for the service.

Section 6: Part D drugs

Section 6.1: What to do if you have problems getting a Part D drug or you want your payment refunded for a Part D drug

Your benefits as a member of our plan include coverage for many prescription drugs. Most of these drugs are "Part D drugs." There are a few drugs that Medicare Part D does not cover but that Medicaid may cover. **This section only applies to Part D drug appeals.**

- The *List of Covered Drugs (Drug List)*, includes some drugs with a * (non-Part D drugs). These drugs are **not** Part D drugs. Appeals or coverage decisions about drugs with the * symbol follow the process in **Section 5.**

Can I ask for a coverage decision or make an appeal about Part D prescription drugs?

Yes. Here are examples of coverage decisions you can ask us to make about your Part D drugs:

- You ask us to make an exception such as:
  - » Asking us to cover a Part D drug that is not on the plan's *List of Covered Drugs* (Drug List)
  - » Asking us to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get)
- You ask us if a drug is covered for you (for example, when your drug is on the plan's Drug List but we require you to get approval from us before we will cover it for you).
  - » *Please note:* If your pharmacy tells you that your prescription cannot be filled, you will get a notice explaining how to contact us to ask for a coverage decision.
- You ask us to pay for a prescription drug you already bought. This is asking for a coverage decision about payment. Remember, you should not have to pay for any medically-necessary services covered by Medicare and Medicaid. If you are being asked to pay for the full cost of a drug, call Member Services for assistance.

> ***The legal term** for a coverage decision about your Part D drugs is **"coverage determination."***

If you disagree with a coverage decision we have made, you can appeal our decision. This section tells you both how to ask for coverage decisions and how to request an appeal.

Use the chart below to help you determine which part has information for your situation:

Which of these situations are you in?			
Do you need a drug that isn't on our Drug List or need us to waive a rule or restriction on a drug we cover? You can ask us to make an exception. (This is a type of coverage decision.) Start with **Section 6.2** of this chapter. Also see Sections 6.3 and 6.4.	Do you want us to cover a drug on our Drug List and you believe you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need? You can ask us for a coverage decision. Skip ahead to **Section 6.4** of this chapter.	Do you want to get your money back for a drug you have already received and paid for? You can ask to have your money refunded. (This is a type of coverage decision.) Skip ahead to **Section 6.4** of this chapter.	Have we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for? You can make an appeal. (This means you are asking us to reconsider.) Skip ahead to **Section 6.5** of this chapter.

Section 6.2: What is an exception?

An *exception* is permission to get coverage for a drug that is not normally on our List of Covered Drugs, or to use the drug without certain rules and limitations. If a drug is not on our List of Covered Drugs, or is not covered in the way you would like, you can ask us to make an "exception."

When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception.

Here are examples of exceptions that you or your doctor or another prescriber can ask us to make:

1. Covering a Part D drug that is not on our *List of Covered Drugs* (Drug List).
2. Removing a restriction on our coverage. There are extra rules or restrictions that apply to certain drugs on our Drug List (for more information, go to Chapter 5, Section C, *Limits on coverage for some drugs*).
   - The extra rules and restrictions on coverage for certain drugs include:
     - » Being required to use the generic version of a drug instead of the brand name drug.
     - » Getting plan approval before we will agree to cover the drug for you. (This is sometimes called "prior authorization.")
     - » Being required to try a different drug first before we will agree to cover the drug you are asking for. (This is sometimes called "step therapy.")
     - » Quantity limits. For some drugs, the plan limits the amount of the drug you can have.

> ***The legal term*** *for asking for removal of a restriction on coverage for a drug is sometimes called asking for a* ***"formulary exception."***

Section 6.3: Important things to know about asking for exceptions

Your doctor or other prescriber must tell us the medical reasons

Your doctor or other prescriber must give us a statement explaining the medical reasons for requesting an exception. Our decision about the exception will be faster if you include this information from your doctor or other prescriber when you ask for the exception.

Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called "alternative" drugs. If an alternative drug would be just as effective as the drug you are asking for, and would not cause more side effects or other health problems, we will generally *not* approve your request for an exception.

We will say* Yes *or* No *to your request for an exception

- If we say *Yes* to your request for an exception, the exception usually lasts until the end of the calendar year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.

- If we say *No* to your request for an exception, you can ask for a review of our decision by making an appeal. Section 6.5, *Level 1 Appeal for Part D drugs*, tells how to make an appeal if we say *No*.

The next section tells you how to ask for a coverage decision, including an exception.

Section 6.4: How to ask for a coverage decision about a Part D drug or reimbursement for a Part D Drug, including an exception

What to do

- Ask for the type of coverage decision you want. Call, write, or fax us to make your request. You, your representative, or your doctor (or other prescriber) can do this. You can call us at **1-855-475-3163**.
- You or your doctor (or other prescriber) or someone else who is acting on your behalf can ask for a coverage decision. You can also have a lawyer act on your behalf.

  Read Section 2, *Where to call for help*, to find out how to give permission to someone else to act as your representative.

  ➔ You do not need to give your doctor or other prescriber written permission to ask us for a coverage decision on your behalf.
- If you paid for a drug that you think should be covered, read Chapter 7, *Asking us to pay a bill you have gotten for covered services or drugs*, of this handbook. Chapter 7 tells how to call Member Services or send us the paperwork that asks us to cover the drug.

***At a glance:* How to ask for a coverage decision about a Part D drug or payment**

Call, write, or fax us to ask, or ask your representative or doctor or other prescriber to ask. We will give you an answer on a standard coverage decision within 72 hours. We will give you an answer on reimbursing you for a Part D drug you already paid for within 14 calendar days.

- If you are asking for an exception, include the supporting statement from the doctor or other prescriber.
- You or your doctor or other prescriber may ask for a fast decision. (Fast decisions usually come within 24 hours.)

➔ Read this chapter to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

- If you are requesting an exception, provide the “supporting statement.” Your doctor or other prescriber must give us the medical reasons for the drug exception. We call this the “supporting statement.”

Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone, and then fax or mail a statement.

If your health requires it, ask us to give you a "fast coverage decision"

We will use the "standard deadlines" unless we have agreed to use the "fast deadlines."

- A standard coverage decision means we will give you an answer within 72 hours after we get your doctor's statement.
- A fast coverage decision means we will give you an answer within 24 hours.
  - » You can get a fast coverage decision *only* if you are asking for a *drug you have not yet received*. (You cannot get a fast coverage decision if you are asking us to pay you back for a drug you have already bought.)
  - » You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function.*
  - » If your doctor or other prescriber tells us that your health requires a "fast coverage decision," we will automatically agree to give you a fast coverage decision, and the letter will tell you that.

    If you ask for a fast coverage decision on your own (without your doctor's or other prescriber's support), we will decide whether you get a fast coverage decision.

    If we decide to give you a standard decision, we will send you a letter telling you that. The letter will tell you how to make a complaint about our decision to give you a standard decision. You can file a "fast complaint" and get a decision within 24 hours.
  - » If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).

> ***The legal term*** *for "fast coverage decision" is* ***"expedited coverage determination."***

Deadlines for a "fast coverage decision"

- If we are using the fast deadlines, we must give you our answer within 24 hours. This means within 24 hours after we get your request. Or, if you are asking for an exception, 24 hours after we get your doctor's or prescriber's statement supporting your request. We will give you our answer sooner if your health requires us to.
- If we do not meet this deadline, we will send your request to Level 2 of the appeals process. At Level 2, an outside independent organization will review your request and our decision.

- **If our answer is *Yes*** to part or all of what you asked for, we must give you the coverage within 24 hours after we get your request or your doctor's or prescriber's statement supporting your request.

- **If our answer is *No*** to part or all of what you asked for, we will send you a letter that explains why we said *No*. The letter will also explain how you can appeal our decision.

Deadlines for a "standard coverage decision" about a drug you have not yet received

- If we are using the standard deadlines, we must give you our answer within 72 hours after we get your request or, if you are asking for an exception, after we get your doctor's or prescriber's supporting statement. We will give you our answer sooner if your health requires it.
- If we do not meet this deadline, we will send your request on to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review the decision.

- **If our answer is *Yes*** to part or all of what you asked for, we must approve or give the coverage within 72 hours after we get your request or, if you are asking for an exception, your doctor's or prescriber's supporting statement.

- **If our answer is *No*** to part or all of what you asked for, we will send you a letter that explains why we said *No*. The letter will also explain how you can appeal our decision.

Deadlines for a "standard coverage decision" about payment for a drug you have already bought

- We must give you our answer within 14 calendar days after we get your request.
- If we do not meet this deadline, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review the decision.

- **If our answer is *Yes*** to part or all of what you asked for, we will make payment to the pharmacy within 14 calendar days. The pharmacy will refund your money.

- **If our answer is *No*** to part or all of what you asked for, we will send you a letter that explains why we said *No*. This statement will also explain how you can appeal our decision.

Section 6.5: Level 1 Appeal for Part D drugs

- To start your appeal, you, your doctor or other prescriber, or your representative must contact us.
- If you are asking for a standard appeal, you can make your appeal by sending a request in writing. You may also ask for an appeal by calling us at **1-855-475-3163**.
- If you want a fast appeal, you may make your appeal in writing or you may call us.
- Make your appeal request within 60 calendar days from the date on the notice we sent to tell you our decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make you appeal. For example, good reasons for missing the deadline would be if you have a serious illness that kept you from contacting us or if we gave you incorrect or incomplete information about the deadline for requesting an appeal.

***At a glance:* How to make a Level 1 Appeal**

You, your doctor or prescriber, or your representative may put your request in writing and mail or fax it to us. You may also ask for an appeal by calling us.

- Ask within 60 calendar days of the decision you are appealing. If you miss the deadline for a good reason, you may still appeal.
- You, your doctor or prescriber, or your representative can call us to ask for a fast appeal.

➔ Read this chapter to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

The legal term *for an appeal to the plan about a Part D drug coverage decision is plan* ***"redetermination."***

- You can ask for a copy of the information in your appeal and add more information.
- You have the right to ask us for a copy of the information about your appeal.
  - » If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

If your health requires it, ask for a "fast appeal"

- If you are appealing a decision our plan made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a "fast appeal."

- The requirements for getting a "fast appeal" are the same as those for getting a "fast coverage decision" in Section 6.4, *How to ask for a coverage decision about a Part D drug or reimbursement for a Part D Drug, including an exception*, of this chapter.

> ***The legal term** for "fast appeal" is **"expedited reconsideration."***

Our plan will review your appeal and give you our decision

- We take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said *No* to your request. We may contact you or your doctor or other prescriber to get more information.

Deadlines for a "fast appeal"

- If we are using the fast deadlines, we will give you our answer within 72 hours after we get your appeal, or sooner if your health requires it.
- If we do not give you an answer within 72 hours, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review our decision.

➔ **If our answer is *Yes*** to part or all of what you asked for, we must give the coverage within 72 hours after we get your appeal.

➔ **If our answer is *No*** to part or all of what you asked for, we will send you a letter that explains why we said *No*.

Deadlines for a "standard appeal"

- If we are using the standard deadlines, we must give you our answer within 7 calendar days after we get your appeal, or sooner if your health requires it. If you think your health requires it, you should ask for a "fast appeal."
- If we do not give you a decision within 7 calendar days, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review our decision.

➔ **If our answer is *Yes*** to part or all of what you asked for:

  » If we approve a request for coverage, we must give you the coverage as quickly as your health requires, but no later than 7 calendar days after we get your appeal.

  » If we approve a request to cover a drug you already paid for, we will pay the pharmacy within 30 calendar days after we get your appeal request. The pharmacy will refund your money.

➔ **If our answer is *No*** to part or all of what you asked for, we will send you a letter that explains why we said *No* and tells how to appeal our decision.

Section 6.6: Level 2 Appeal for Part D drugs

If we say *No* to your appeal, you then choose whether to accept this decision or continue by making another appeal. If you decide to go on to a Level 2 Appeal, the Independent Review Entity will review our decision.

- If you want the Independent Review Entity to review your case, your appeal request must be in writing. The letter we send about our decision in the Level 1 Appeal will explain how to request the Level 2 Appeal.
- When you make an appeal to the Independent Review Entity, we will send them your case file. You have the right to ask us for a copy of your case file.
- You have a right to give the Independent Review Entity other information to support your appeal.
- The Independent Review Entity is an independent organization that is hired by Medicare. It is not connected with this plan and it is not a government agency.

***At a glance:* How to make a Level 2 Appeal**

If you want the Independent Review Organization to review your case, your appeal request must be in writing.

- Ask within 60 calendar days of the decision you are appealing. If you miss the deadline for a good reason, you may still appeal.
- You, your doctor or other prescriber, or your representative can request the Level 2 Appeal.

➔ Read this chapter to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

- Reviewers at the Independent Review Entity will take a careful look at all of the information related to your appeal. The organization will send you a letter explaining its decision.

Deadlines for "fast appeal" at Level 2

- If your health requires it, ask the Independent Review Entity for a "fast appeal."
- If the review organization agrees to give you a "fast appeal," it must give you an answer to your Level 2 Appeal within 72 hours after getting your appeal request.
- If the Independent Review Entity says *Yes* to part or all of what you asked for, we must authorize or give you the drug coverage within 24 hours after we get the decision.

Deadlines for "standard appeal" at Level 2

- If you have a standard appeal at Level 2, the Independent Review Entity must give you an answer to your Level 2 Appeal within 7 calendar days after it gets your appeal.
  - » If the Independent Review Entity says *Yes* to part or all of what you asked for, we must authorize or give you the drug coverage within 72 hours after we get the decision.
  - » If the Independent Review Entity approves a request to cover a drug you already paid for, we will pay the pharmacy within 30 calendar days after we get the decision. The pharmacy will refund your money.

What if the Independent Review Entity says No to your Level 2 Appeal?

No means the Independent Review Entity agrees with our decision not to approve your request. This is called "upholding the decision." It is also called "turning down your appeal."

If the dollar value of the drug coverage you want meets a certain minimum amount, you can make another appeal at Level 3. The letter you get from the Independent Review Entity will tell you the dollar amount needed to continue with the appeals process. The Level 3 Appeal is handled by an administrative law judge.

Section 7: Asking us to cover a longer hospital stay

When you are admitted to a hospital, you have the right to get all hospital services that we cover that are necessary to diagnose and treat your illness or injury.

During your hospital stay, your doctor and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will also help arrange for any care you may need after you leave.

- The day you leave the hospital is called your "discharge date." Our plan's coverage of your hospital stay ends on this date.
- Your doctor or the hospital staff will tell you what your discharge date is.

If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay. This section tells you how to ask.

Section 7.1: Learning about your Medicare rights

Within two days after you are admitted to the hospital, a caseworker or nurse will give you a notice called *An Important Message from Medicare about Your Rights.* If you do not get this notice, ask any hospital employee for it. If you need help, please call Member Services (phone numbers are printed on the back cover of this booklet). You can also call 1-800-

MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Read this notice carefully and ask questions if you don't understand. The *Important Message* tells you about your rights as a hospital patient, including:

- Your right to get Medicare-covered services during and after your hospital stay. You have the right to know what these services are, who will pay for them, and where you can get them.
- Your right to be a part of any decisions about the length of your hospital stay.
- Your right to know where to report any concerns you have about the quality of your hospital care.
- Your right to appeal if you think you are being discharged from the hospital too soon.

You should sign the Medicare notice to show that you got it and understand your rights. Signing the notice does ***not*** mean you agree to the discharge date told to you by your doctor or hospital staff.

Keep your copy of the signed notice so you will have the information in it if you need it.

- To look at a copy of this notice in advance, you can call Member Services at **1-855-475-3163**. You can also call 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. The call is free.

  You can also see the notice online at https://www.cms.gov/BNI/12_HospitalDischargeAppealNotices.asp.

➔ If you need help, please call Member Services at **1-855-475-3163**. You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. The call is free.

Section 7.2: Level 1 Appeal to change your hospital discharge date

If you want us to cover your inpatient hospital services for a longer time, you must request an appeal. A Quality Improvement Organization will do the Level 1 Appeal review to see if your planned discharge date is medically appropriate for you.

To make an appeal to change your discharge date, call KePRO (Ohio's Quality Improvement Organization) at: **1-800-589-7337**.

Call right away!

Call the Quality Improvement Organization ***before*** you leave the hospital and no later than your planned discharge date. *An Important Message from Medicare about Your Rights* contains information on how to reach the Quality Improvement Organization.

- If you call before you leave, you are allowed to stay in the hospital *after* your planned discharge date *without paying for it* while you wait to get the decision on your appeal from the Quality Improvement Organization.
- If you do *not call* to appeal, and you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you get after your planned discharge date.

***At a glance:* How to make a Level 1 Appeal to change your discharge date**

Call the Quality Improvement Organization in your state at 1-800-589-7337 and ask for a "fast review."

Call before you leave the hospital and before your planned discharge date.

➔ If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our plan instead. For details, see Section 7.4, *What happens if I miss an appeal deadline?*

We want to make sure you understand what you need to do and what the deadlines are.

- **Ask for help if you need it**. If you have questions or need help at any time, please call Member Services at **1-855-475-3163**.

What is a Quality Improvement Organization?

It is a group of doctors and other health care professionals who are paid by the federal government. These experts are not part of our plan. They are paid by Medicare to check on and help improve the quality of care for people with Medicare.

Ask for a "fast review"

You must ask the Quality Improvement Organization for a **"fast review"** of your discharge. Asking for a "fast review" means you are asking for the organization to use the fast deadlines for an appeal instead of using the standard deadlines.

The legal** term for "fast review" is **"immediate review."

What happens during the review?

- The reviewers at the Quality Improvement Organization will ask you or your representative why you think coverage should continue after the planned discharge date. You don't have to prepare anything in writing, but you may do so if you wish.

- The reviewers will look at your medical record, talk with your doctor, and review all of the information related to your hospital stay.
- By noon of the day after the reviewers tell us about your appeal, you will get a letter that gives your planned discharge date. The letter explains the reasons why your doctor, the hospital, and we think it is right for you to be discharged on that date.

> ***The legal term*** *for this written explanation is called the* ***"Detailed Notice of Discharge."*** *You can get a sample by calling Member Services at 1-855-475-3163. You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or you can see a sample notice online at http://www.cms.hhs.gov/BNI/*

What if the answer is *Yes*?

- If the review organization says *Yes* to your appeal, we must keep covering your hospital services for as long as they are medically necessary.

What if the answer is *No*?

- If the review organization says *No* to your appeal, they are saying that your planned discharge date is medically appropriate. If this happens, our coverage for your inpatient hospital services will end at noon on the day *after* the Quality Improvement Organization gives you its answer.
- If the review organization says *No* and you decide to stay in the hospital, then you may have to pay the full cost of hospital care you get after noon on the day after the Quality Improvement Organization gives you its answer.
- If the Quality Improvement Organization turns down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal.

Section 7.3: Level 2 Appeal to change your hospital discharge date

If the Quality Improvement Organization has turned down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. You will need to contact the Quality Improvement Organization again and ask for another review.

Ask for the Level 2 review **within 60 calendar days** after the day when the Quality Improvement Organization said *No* to your Level 1 Appeal. You can ask for this review only if you stayed in the hospital after the date that your coverage for the care ended.

You can reach KePRO (Ohio's Quality Improvement Organization) at: **1-800-589-7337**.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.
- Within 14 calendar days, the Quality Improvement Organization reviewers will make a decision.

> ***At a glance:*** **How to make a Level 2 Appeal to change your discharge date**
>
> Call the Quality Improvement Organization in your state and ask for another review.

What happens if the answer is *Yes*?

- We must pay you back for our share of the costs of hospital care you have received since noon on the day after the date of your first appeal decision. We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary.
- You must continue to pay your share of the costs and coverage limitations may apply.

What happens if the answer is *No*?

It means the Quality Review Organization agrees with the Level 1 decision and will not change it. The letter you get will tell you what you can do if you wish to continue with the appeal process.

If the Quality Review Organization turns down your Level 2 Appeal, you may have to pay the full cost for your stay after your planned discharge date.

Section 7.4: What happens if I miss an appeal deadline?

If you miss appeal deadlines, there is another way to make Level 1 and Level 2 Appeals, called Alternate Appeals. But the *first two levels of appeal are different.*

Level 1 Alternate Appeal to change your hospital discharge date

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a “fast review.” A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

- During this review, we take a look at all of the information about your hospital stay. We check to see if the decision about when you should leave the hospital was fair and followed all the rules.
- We will use the fast deadlines rather than the standard deadlines for giving you the

> ***At a glance:*** **How to make a Level 1 Alternate Appeal**
>
> Call our Member Services number and ask for a “fast review” of your hospital discharge date.
>
> We will give you our decision within 72 hours.

answer to this review. We will give you our decision within 72 hours after you ask for a "fast review."

- **If we say *Yes* to your fast review,** it means we agree that you still need to be in the hospital after the discharge date. We will keep covering hospital services for as long as it is medically necessary.

  It also means that we agree to pay you back for our share of the costs of care you have received since the date when we said your coverage would end.

- **If we say *No* to your fast review,** we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends on the day we said coverage would end.

  » If you stayed in the hospital *after* your planned discharge date, then **you may have to pay the full cost** of hospital care you got after the planned discharge date.

➔ To make sure we were following all the rules when we said *No* to your fast appeal, we will send your appeal to the "Independent Review Entity." When we do this, it means that your case is *automatically* going to Level 2 of the appeals process.

> ***The legal term** for "fast review" or "fast appeal" is **"expedited appeal."***

Level 2 Alternate Appeal to change your hospital discharge date

We will send the information for your Level 2 Appeal to the Independent Review Entity within 24 hours of when we give you our Level 1 decision. If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 10 of this chapter, *How to make a complaint*, tells how to make a complaint.

During the Level 2 Appeal, the **Independent Review Entity** reviews the decision we made when we said *No* to your "fast review." This organization decides whether the decision we made should be changed.

> ***At a glance:* How to make a Level 2 Alternate Appeal**
>
> You do not have to do anything. The plan will automatically send your appeal to the Independent Review Entity.

- The Independent Review Entity does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.
- The Independent Review Entity is an independent organization that is hired by Medicare. This organization is not connected with our plan and it is not a government agency.

- Reviewers at the Independent Review Entity will take a careful look at all of the information related to your appeal of your hospital discharge.
- If the Independent Review Entity says *Yes* to your appeal, then we must pay you back for our share of the costs of hospital care you have received since the date of your planned discharge. We must also continue the plan's coverage of your hospital services for as long as it is medically necessary.
- If this organization says *No* to your appeal, it means they agree with us that your planned hospital discharge date was medically appropriate.

The letter you get from the Independent Review Entity will tell you what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by a judge.

Section 8: What to do if you think your Medicare home health care, skilled nursing care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon

This section is about the following types of care *only when they are covered by Medicare*:

- Home health care services.
- Skilled nursing care in a skilled nursing facility.
- Rehabilitation care you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major operation.

  ➔ With any of these three types of care, you have the right to keep getting covered services for as long as the doctor says you need it.

  ➔ When we decide to stop covering any of these, we must tell you before your services end. When your coverage for that care ends, *we will stop paying for your care.*

If you think we are ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask for an appeal.

Section 8.1: We will tell you in advance when your coverage will be ending

The agency or facility that is providing your care will give you a notice at least two days before we stop paying for your care.

- The written notice tells you the date when we will stop covering your care.
- The written notice also tells you how to appeal this decision.

You or your representative should sign the written notice to show that you got it. Signing it does not mean you agree with the plan that it is time to stop getting the care.

When your coverage ends, we will stop paying.

Section 8.2: Level 1 Appeal to continue your care

If you think we are ending the coverage of your care too soon, you can appeal our decision. This section tells you how to ask for an appeal.

Before you start, understand what you need to do and what the deadlines are.

- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section 10 of this chapter tells you how to file a complaint.)
- **Ask for help if you need it**. If you have questions or need help at any time, please call Member Services at **1-855-475-3163**.

During a Level 1 Appeal, The Quality Improvement Organization will review your appeal and decide whether to change the decision we made. You can find out how to call them by reading the *Notice of Medicare Non-Coverage.*

What is a Quality Improvement Organization?

It is a group of doctors and other health care professionals who are paid by the federal government. These experts are not part of our plan. They are paid by Medicare to check on and help improve the quality of care for people with Medicare.

At a glance: **How to make a Level 1 Appeal to ask the plan to continue your care**

Call the Quality Improvement Organization in your state and ask for another review.

Call before you leave the agency or facility that is providing your care and before your planned discharge date.

What should you ask for?

Ask them for an independent review of whether it is medically appropriate for us to end coverage for your services.

What is your deadline for contacting this organization?

- You must contact the Quality Improvement Organization *no later than noon of the day after you got the written notice telling you when we will stop covering your care.*
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to us instead. For details about this other way to make your appeal, see Section 8.4, *What if you miss the deadline for making your Level 1 Appeal?*

> ***The legal term*** *for the written notice is* ***"Notice of Medicare Non-Coverage."*** *To get a sample copy, call Member Services at 1-855-475-3163 (TTY: 1-800-750-0750), Monday – Friday, 8 a.m. – 8 p.m., or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or see a copy online at http://www.cms.hhs.gov/BNI/*

What happens during the Quality Improvement Organization's review?

- The reviewers at the Quality Improvement Organization will ask you or your representative why you think coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- When you ask for an appeal, the plan must write a letter explaining why your services should end.
- The reviewers will also look at your medical records, talk with your doctor, and review information that our plan has given to them.
- **Within one full day after reviewers have all the information they need, they will tell you their decision.** You will get a letter explaining the decision.

> ***The legal term*** *for the letter explaining why your services should end is* ***"Detailed Explanation of Non-Coverage."***

What happens if the reviewers say *Yes*?

- If the reviewers say *Yes* to your appeal, then we must keep providing your covered services for as long as they are medically necessary.

What happens if the reviewers say *No*?

- If the reviewers say *No* to your appeal, then your coverage will end on the date we told you. We will stop paying our share of the costs of this care.
- If you decide to keep getting the home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date your coverage ends, then you will have to pay the full cost of this care yourself.

Section 8.3: Level 2 Appeal to continue your care

If the Quality Improvement Organization said *No* to the appeal **and** you choose to continue getting care after your coverage for the care has ended, you can make a Level 2 Appeal.

You can ask the Quality Improvement Organization to take another look at the decision they made at Level 1. If they say they agree with the Level 1 decision, you may have to pay the full cost for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end. The Quality Improvement Organization will review your appeal and decide whether to change the decision we made. You can find out how to call them by reading the *Notice of Medicare Non-Coverage.*

Ask for the Level 2 review **within 60 calendar days** after the day when the Quality Improvement Organization said *No* to your Level 1 Appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.
- The Quality Improvement Organization will make its decision within 14 calendar days.

***At a glance:* How to make a Level 2 Appeal to require that the plan cover your care for longer**

Call the Quality Improvement Organization in your state and ask for another review.

Call before you leave the agency or facility that is providing your care and before your planned discharge date.

What happens if the review organization says *Yes*?

- We must pay you back for our share of the costs of care you have received since the date when we said your coverage would end. We must continue providing coverage for the care for as long as it is medically necessary.

What happens if the review organization says *No*?

- It means they agree with the decision they made on the Level 1 Appeal and will not change it.
- The letter you get will tell you what to do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

Section 8.4: What if you miss the deadline for making your Level 1 Appeal?

If you miss appeal deadlines, there is another way to make Level 1 and Level 2 Appeals, called Alternate Appeals. But the *first two levels of appeal are different.*

Level 1 Alternate Appeal to continue your care for longer

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a “fast review.” A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

- During this review, we take a look at all of the information about your hospital stay. We check to see if the decision about when your services should end was fair and followed all the rules.

- We will use the fast deadlines rather than the standard deadlines for giving you the answer to this review. We will give you our decision within 72 hours after you ask for a "fast review."
- **If we say *Yes*** to your fast review, it means we agree that we will keep covering your services for as long as it is medically necessary.

  It also means that we agree to pay you back for our share of the costs of care you have received since the date when we said your coverage would end.
  If we say *No* to your fast review, we are saying that stopping your services was medically appropriate. Our coverage ends as of the day we said coverage would end.

  » If you continue getting services after the day we said they would stop, **you may have to pay the full cost** of the services.

***At a glance:* How to make a Level 1 Alternate Appeal**

Call our Member Services number and ask for a "fast review."

We will give you our decision within 72 hours.

➔ To make sure we were following all the rules when we said *No* to your fast appeal, we will send your appeal to the "Independent Review Entity." When we do this, it means that your case is *automatically* going to Level 2 of the appeals process.

The legal term** for "fast review" or "fast appeal" is **"expedited appeal."

Level 2 Alternate Appeal to continue your care for longer

We will send the information for your Level 2 Appeal to the Independent Review Entity within 24 hours of when we give you our Level 1 decision. If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 10 of this chapter, *How to make a complaint*, tells how to make a complaint.

During the Level 2 Appeal, the **Independent Review Entity** reviews the decision we made when we said *No* to your "fast review." This organization decides whether the decision we made should be changed.

- The Independent Review Entity does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.
- The Independent Review Entity is an independent organization that is hired by Medicare. This organization is not connected with our plan, and it is not a government agency.

- Reviewers at the Independent Review Entity will take a careful look at all of the information related to your appeal.
- **If this organization says *Yes*** to your appeal, then we must pay you back for our share of the costs of care. We must also continue the plan's coverage of your services for as long as it is medically necessary.
- **If this organization says *No*** to your appeal, it means they agree with us that stopping coverage of services was medically appropriate.

> ***At a glance:* How to make a Level 2 Appeal to require that the plan continue your care**
>
> You do not have to do anything. The plan will automatically send your appeal to the Independent Review Organization.

The letter you get from the Independent Review Entity will tell you what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by a judge.

> ***The formal name** for "Independent Review Organization" is **"Independent Review Entity."** It is sometimes called the **"IRE."***

Section 9: Taking your appeal beyond Level 2

Section 9.1: Next steps for Medicare services and items

If you made a Level 1 Appeal and a Level 2 Appeal for Medicare services or items, and both your appeals have been turned down, you may have the right to additional levels of appeal. The letter you get from the Independent Review Entity will tell you what to do if you wish to continue the appeals process.

Level 3 of the appeals process is an Administrative Law Judge (ALJ) hearing. If you want an ALJ to review your case, the item or medical service you are requesting will have to meet a minimum dollar amount. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, you can ask an ALJ to hear your appeal.

If you do not agree with the ALJ's decision, you can go to the Medicare Appeals Council. After that, you may have the right to ask a federal court to look at your appeal.

If you need assistance at any stage of the appeals process, you can contact the MyCare Ohio Ombudsman. The phone number is 1-800-282-1206.

Section 9.2: Next steps for Medicaid services and items

If you had a State Hearing for services covered by Medicaid and your State Hearing decision was overruled (not in your favor), you also have the right to additional appeals. The State Hearing decision notice will explain how to request an Administrative Appeal by submitting your request to the Bureau of State Hearings. The Bureau of State Hearings must get your request within 15 calendar days of the date the hearing decision was issued. If you disagree with the Administrative Appeal decision, you have the right to appeal to the court of common pleas in the county where you live.

If you have any questions or need assistance with State Hearings or Administrative Appeals, you can contact the Bureau of State Hearings at 1-866-635-3748.

Section 10: How to make a complaint

What kinds of problems should be complaints?

The complaint process is used for certain types of problems *only,* such as problems related to quality of care, waiting times, receiving a bill, and customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaints about quality

- You are unhappy with the quality of care, such as the care you got in the hospital.

Complaints about privacy

- You think that someone did not respect your right to privacy, or shared information about you that is *confidential.*

Complaints about poor customer service

- A health care provider or staff was rude or disrespectful to you.
- CareSource MyCare Ohio staff treated you poorly.
- You think you are being pushed out of the plan.

Complaints about physical accessibility

- You cannot physically access the health care services and facilities in a doctor or provider's office.

Complaints about waiting times

- You are having trouble getting an appointment, or waiting too long to get it.
- You have been kept waiting too long by doctors, pharmacists, or other health professionals or by Member Services or other plan staff.

Complaints about cleanliness

- You think the clinic, hospital or doctor's office is not clean.

Complaints about language access

- Your doctor or provider does not provide you with an interpreter during your appointment.

Complaints about receiving a bill

- Your doctor or provider is sending you a bill.

Complaints about communications from us

***At a glance:* How to make a complaint**

Call Member Services or send us a letter telling us about your complaint.

➔ If your complaint is about *quality of care*, you have more choices. You can:

1. Make your complaint to the Quality Improvement Organization,
2. Make your complaint to Member Services and to the Quality Improvement Organization, or
3. Make your complaint to Medicare.

- You think we failed to give you a notice or letter that you should have received.
- You think the written information we sent you is too difficult to understand.

Complaints about the timeliness of our actions related to coverage decisions or appeals

- You believe that we are not meeting our deadlines for making a coverage decision or answering your appeal.
- You believe that, after getting a coverage or appeal decision in your favor, we are not meeting the deadlines for approving or giving you the service or paying the provider for certain medical services so they can refund your money.
- You believe we did not forward your case to the Independent Review Entity on time.

> ***The legal term*** *for a "complaint" is a* ***"grievance."***
>
> ***The legal term*** *for "making a complaint" is* ***"filing a grievance."***

Section 10.1: Details and deadlines

- Call Member Services at **1-855-475-3163** (TTY: 1-800-750-0750), Monday – Friday, 8 a.m. – 8 p.m. The complaint must be made within 90 calendar days after you had the problem you want to complain about.
- If there is anything else you need to do, Member Services will tell you.
- You can also write your complaint and send it to us. If you put your complaint in writing, we will respond to your complaint in writing. You can also use the form on page 170 to submit the complaint.
- Specifically, if you would like to file a complaint, you can do so in any of the following ways:
    - Call Member Services at **1-855-475-3163** (TTY: 1-800-750-0750 or 711), Monday through Friday, 8 a.m. to 8 p.m., or
    - Fill out the Member Grievance/Appeal form available online or on page 170, or
    - Call Member Services to request they mail you a Grievance/Appeal form, or
    - Write a letter telling us what you are unhappy about.

- Be sure to put your first and last name, the number from the front of your CareSource MyCare Ohio member ID card, and your address and telephone number in the letter so that we can contact you, if needed. You should also send any information that helps explain your problem.

  Mail the form or your letter to:
  CareSource
  Attn: Member Appeals
  P.O. Box 1947
  Dayton, OH 45401-1947

- If your grievance is about getting a bill for care you or a family member received, please call the telephone number on the bill to make sure they have your CareSource MyCare Ohio ID number, or to give them the primary insurance for the family member who received the care. If they tell you they have this information, please ask them why you are receiving a bill.

  After you have done this, please contact our Member Services Department and provide us with the following information contained on your bill:

  - The date you or your family member received services
  - The amount of the bill
  - The provider's name
  - The telephone number
  - The account number
  - Tell us why the provider's office told you they were billing you

- If you are not happy with our answer to your grievance, please contact our Member Services Department and we will be happy to discuss it with you.

- You also have the right at any time to file a complaint by contacting the:

  - Ohio Department of Medicaid
    Bureau of Managed Care
    P.O. Box 182709
    Columbus, Ohio 43218-2709
    1-800-324-8680

- If you are making a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we will automatically give you a "fast complaint" and respond to your complaint within 24 hours.

> ***The legal term** for "fast complaint" is **"expedited grievance."***

If possible, we will answer you right away. If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.

- Complaints about access to care are answered in 2 business days. All other complaints are answered in 30 calendar days. If we need more information and the delay is in your best interest, or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. We will tell you in writing why we need more time.
- **If we do not agree** with some or all of your complaint we will tell you and give you our reasons. We will respond whether we agree with the complaint or not.

Section 10.2: You can file complaints with the Office of Civil Rights

If you have a complaint about disability access or about language assistance, you can file a complaint with the Office of Civil Rights at the Department of Health and Human Services. You can call 312-886-2359 (TTY: 312-353-5693) or send your complaint to:

Office of Civil Rights
United States Department of Health and Human Services
233 N. Michigan Ave., Suite 240
Chicago, Illinois 60601

You may also have rights under the Americans with Disability Act and under Ohio Revised Code 4112.02. You can contact Member Services at **1-855-475-3163** (TTY: 1-800-750-0750), Monday – Friday 8 a.m. – 8 p.m., or the Ohio Medicaid Hotline at 1-800-324-8680 (TTY: 1-800-292-3572) for assistance.

Section 10.3: You can make complaints about quality of care to the Quality Improvement Organization

When your complaint is about *quality of care*, you also have two choices:

- If you prefer, you can make your complaint about the quality of care directly to the Quality Improvement Organization (*without* making the complaint to us).
- Or you can make your complaint to us *and also* to the Quality Improvement Organization. If you make a complaint to this organization, we will work with them to resolve your complaint.

The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients.

The phone number for the Quality Improvement Organization is 1-800-589-7337.

Section 10.4: You can tell Medicare about your complaint

You can also send your complaint to Medicare. The Medicare Complaint Form is available at: https://www.medicare.gov/MedicareComplaintForm/home.aspx

Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the plan is not addressing your problem, please call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048. The call is free.

Section 10.5: You can tell Medicaid about your complaint

You can call the Ohio Medicaid Hotline at 1-800-324-8680 or TTY 1-800-292-3572. The call is free. You can also e-mail your complaint to bmhc@medicaid.ohio.gov.

Member Grievance/Appeal Form Ohio

Member Name _____

Member ID# _____

Member Address _____

_____

Member Telephone _____

If the grievance/appeal concerns a provider(s), please supply the following information, if known.

Name of Provider(s) _____

Address _____

Telephone _____

Please write a description of the grievance/appeal with as much detail as possible. Attach extra pages, if needed.

_____ _____

(Member Signature) (Date Filed)

OFFICE USE ONLY
Date Received: _____
Received By: _____
Grievance Level 1 2
Hearing Date: _____

Action taken to resolve grievance/appeal:

_____ _____

(Signature Plan Rep) (Resolution Date)

Request for Redetermination of Medicare Prescription Drug Denial

Because CareSource® MyCare Ohio (Medicare-Medicaid Plan) denied your request for coverage of (or payment for) a prescription drug, you have the right to ask us for a redetermination (appeal) of our decision. You have 60 days from the date of our Notice of Denial of Medicare Prescription Drug Coverage to ask us for a redetermination. This form may be sent to us by mail or fax:

Address:
CVS Caremark
MC 109
P.O. Box 52000
Phoenix, AZ 85072-2000

Fax Number:
1-855-633-7673

You may also ask us for an appeal through our website at CareSource.com/MyCare.

Expedited appeal requests can be made by phone at 1-855-475-3163.

Who May Make a Request: Your prescriber may ask us for an appeal on your behalf. If you want another individual (such as a family member or friend) to request an appeal for you, that individual must be your representative. Contact us to learn how to name a representative.

Enrollee's Information

Enrollee's Name _____ Date of Birth _____

Enrollee's Address _____

City _____ State _____ Zip Code _____

Phone _____

Enrollee's Plan ID Number _____

Complete the following section ONLY if the person making this request is not the enrollee:

Requestor's Name _____

Requestor's Relationship to Enrollee

_____

Address

_____

City _____ State _____ Zip Code_____

Phone _____

Representation documentation for appeal requests made by someone other than enrollee or the enrollee's prescriber:

Attach documentation showing the authority to represent the enrollee (a completed Authorization of Representation Form CMS-1696 or a written equivalent) if it was not submitted at the coverage determination level. For more information on appointing a representative, contact your plan or 1-800-Medicare.

Prescription drug you are requesting:

Name of drug: _____ Strength/quantity/dose: _____

Have you purchased the drug pending appeal? ☐ Yes ☐ No

If "Yes":

Date purchased: _____ Amount paid: $ _____ (attach copy of receipt)

Name and telephone number of pharmacy:

_____

Prescriber's Information

Name

_____

Address

_____

City _____ State _____ Zip Code_____ Office Phone _____ Fax _____

Office Contact Person

_____

Important Note: Expedited Decisions

If you or your prescriber believe that waiting 7 days for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescriber indicates that waiting 7 days could seriously harm your health, we will automatically give you a decision within 72 hours. If you do not obtain your prescriber's support for an expedited appeal, we will decide if your case requires a fast decision. You cannot request an expedited appeal if you are asking us to pay you back for a drug you already received.

☐ **CHECK THIS BOX IF YOU BELIEVE YOU NEED A DECISION WITHIN 72 HOURS**

If you have a supporting statement from your prescriber, attach it to this request.

Please explain your reasons for appealing. Attach additional pages, if necessary. Attach any additional information you believe may help your case, such as a statement from your prescriber and relevant medical records. You may want to refer to the explanation we provided in the Notice of Denial of Medicare Prescription Drug Coverage.

_____

_____

_____

Signature of person requesting the appeal (enrollee, or the enrollee's prescriber or representative):

_____ Date: _____

CareSource MyCare Ohio (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and Ohio Medicaid to provide benefits of both programs to enrollees.

Limitations, copays, and restrictions may apply. For more information call CareSource MyCare Ohio Member Services or read the Member Handbook.

Benefits, Lists of Covered Drugs, pharmacy and provider networks and/or copayments may change from time to time throughout the year and on January 1 of each year.

H8452_OHMMC226 File and Use 4/22/2014

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