

Heart of America Health Plan

Member Complaint Procedure and Appeals Process

This is a *summary* of Heart of America Health Plan's Member Complaint Procedure (Filing a Grievance) and Appeals Process for Coverage Determinations.

Below we summarize how to make a complaint, make an appeal or make an appeal regarding a coverage decision if you are having trouble getting the medical services you feel we should provide. This includes asking us to make exceptions to the rules and asking us to continue covering hospital care and certain types of medical services if you think your coverage is ending too soon.

For step-by-step instructions, please refer to the 2012 Evidence of Coverage chapter titled *What to do if you have a problem or complaint (coverage decision, appeals, complaints)*.

How to make a Complaint or File a Grievance

The complaint process is used for certain types of problems only. This includes problems relating to quality of care, waiting times, physician behavior, customer service, involuntary disenrollment or other concerns that are not about benefits or coverage. Please refer to your Evidence of Coverage chapter titled *What to do if you have a problem or complaint (coverage decisions, appeals, complaints)* for step-by-step instructions.

To make a complaint, usually calling Customer Service is the first step. If there is anything else you need to do, Customer Service will let you know.

If you do not wish to call, or you called and were not satisfied when you called, you can put your complaint in writing (complaint form on page 5) and either fax it to us or mail it to us.

If you want to complain to us regarding any of the issues described above, you must call or send a letter within **60 days** after you had the problem you want to complain about.

We look into your complaint and give you our answer. If possible, we will answer you right away. Most complaints are answered within 30 days. If we need more information and the delay is in your best interest, we may take up to 14 more calendar days (44 calendar days total) to answer your complaint.

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If we do not agree with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer.

If your complaint is about the **quality of care** you received, you can make your complaint to us or you can make your complaint directly to the Quality Improvement Organization.

How to Ask for a Coverage Decision

A coverage decision is any decision we make about your benefits and coverage, or about the amount we will pay for your medical services.

If you want to know if we will cover a medical service **before** you receive it, you can ask us to make a coverage decision for you. You can call, write, or fax a request for us to provide coverage for the medical care you want. You, your doctor, or your representative can do this. When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. A "standard decision" means we will give you an answer within 14 days after we receive your request. If your health requires it, ask us to give you a "fast decision", and we will answer it within 72 hours. There are requirements that must be met to qualify for a fast decision. For example, you can get a fast decision only if you are asking for coverage for medical care you have not yet received.

A request for an "exception" is also a type of coverage decision. When you ask for an exception, your doctor will need to explain the medical reasons why you need the exception approved. We will then consider your request.

Making an Appeal about a Coverage Decision

If we make a coverage decision and you are not satisfied with this decision, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made. When you make an appeal, we review the coverage decision we have made to check to see if we were following all of the rules properly. When we have completed the review, we give you our decision.

To start an appeal you, your doctor, or your representative must contact us. Make your standard appeal in writing by submitting a signed request (Appeal form on page 6). You may also ask for an appeal by calling us. Contact information can be found in the chart on page 4.

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You must make your appeal request within 60 calendar days from the date on the written notice we sent to you with our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. If your health requires a quick response, you must call and ask for a “Fast Appeal”.

We consider your appeal, and we give you our answer. When we are using the “Fast deadlines”, we must give you our answer within 72 hours after we receive your appeal. If our answer is yes to part or all of what you requested, we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal. When we are using the “standard deadlines”, we must give you our answer within 30 days after we receive your appeal. If our answer is yes to part or all of what you requested, we must authorize or provide the coverage we have agreed to provide within 30 days.

If our plan says no to your appeal for medical coverage, we are required to automatically send your appeal to the “Independent Review Organization”. The Independent Review Organization is an independent organization that is chosen by Medicare. Reviewers at the Independent Review Organization will take a careful look at all the information related to your appeal. The Independent Review Organization will tell you its decision in writing and explain the reason for it. If your appeal is turned down and your case meets the requirements, you choose whether you want to take your appeal further. There are three additional levels in the appeals process. Please refer to your Evidence of Coverage in the chapter (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) for step-by-step instructions.

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How to contact Heart of America Health Plan for Complaints (file a Grievance), Coverage Decisions, and Appeals regarding Coverage Decisions

<p>CALL</p>	<p>701-776-5848 or 1-800-525-5661 (calls to this number are free)</p> <p>Hours are 8:00 a.m. to 5:00 p.m., Monday through Friday</p>
<p>TTY</p> <p>This number requires special telephone equipment and is only for people who have hearing or speaking difficulties</p>	<p>1-800-366-6888</p>
<p>FAX</p> <p>Complaints (File a Grievance) regarding Medical care</p> <p>Coverage Decisions (Pre-authorization) for Medical care</p> <p>Appeals regarding Coverage Decisions for Medical care</p>	<p>701-776-5848</p>
<p>WRITE</p> <p>Complaints (File a Grievance) regarding Medical care</p> <p>Coverage Decisions (Pre-authorization) for Medical care</p> <p>Appeals regarding Coverage Decisions for Medical care</p>	<p>Heart of America Health Plan 800 So. Main Avenue Rugby, ND 58368</p> <p>Email: hoahp@gondtc.com</p>
<p>CALL OR WRITE</p> <p>To Complain to Quality Improvement Organization about the quality of care you received</p>	<p>701-852-4231, Fax 701-838-6009</p> <p>Write: North Dakota Health Care Review 800-31st Avenue SW Minot, ND 58701</p> <p>Website: www.ndhcri.org</p>

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MEMBER COMPLAINT REPORT

MEMBER'S NAME: _____

POLICY NUMBER: _____

DATE OF INCIDENT : _____ DATE OF REPORT: _____

DESCRIPTION OF INCIDENT: _____

REQUESTED REMEDY:

SIGNATURE: _____ DATE: _____

I REQUEST A HEARING ACCORDING TO PROCEDURES IN THE HAHP COMPLAINT PROCEDURE. ____ (YES) ____ (NO)

THE HEARING WILL BE SCHEDULED WITHIN 30 DAYS OF RECEIPT OF ALL NECESSARY INFORMATION.

COMPLETE IN DUPLICATE, RETAIN ONE COPY, AND SEND ONE COPY TO:

HEART OF AMERICA HEALTH PLAN
810 S MAIN AVENUE
RUGBY, ND 58368

TELEPHONE #: (701)-776-5848 OR 1-(800) 525-5661
FAX 701-776-5425

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MEDICARE APPEALS REPORT

COMPLAINANT'S NAME: _____

POLICY NUMBER: _____

DATE OF INCIDENT : _____ DATE OF REPORT: _____

DESCRIPTION OF INCIDENT: _____

REQUESTED REMEDY:

SIGNATURE: _____ DATE: _____

APPEALS WILL BE FILED WITHIN 60 DAYS OF RECEIPT OF ALL INFORMATION NECESSARY TO COMPLETE THE APPEAL. EXPEDITED APPEALS (EMERGENCY SITUATIONS) SHALL BE COMPLETED WITHIN 48 HOURS OF RECEIPT OF ALL INFORMATION NECESSARY TO COMPLETE THE APPEAL.

COMPLETE IN DUPLICATE, RETAIN ONE COPY, AND SEND ONE COPY TO:

HEART OF AMERICA HEALTH PLAN
810 S MAIN AVENUE
RUGBY, ND 58368

TELEPHONE #: (701)-776-5848 OR 1-(800) 525-5661
FAX 701-776-5425

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