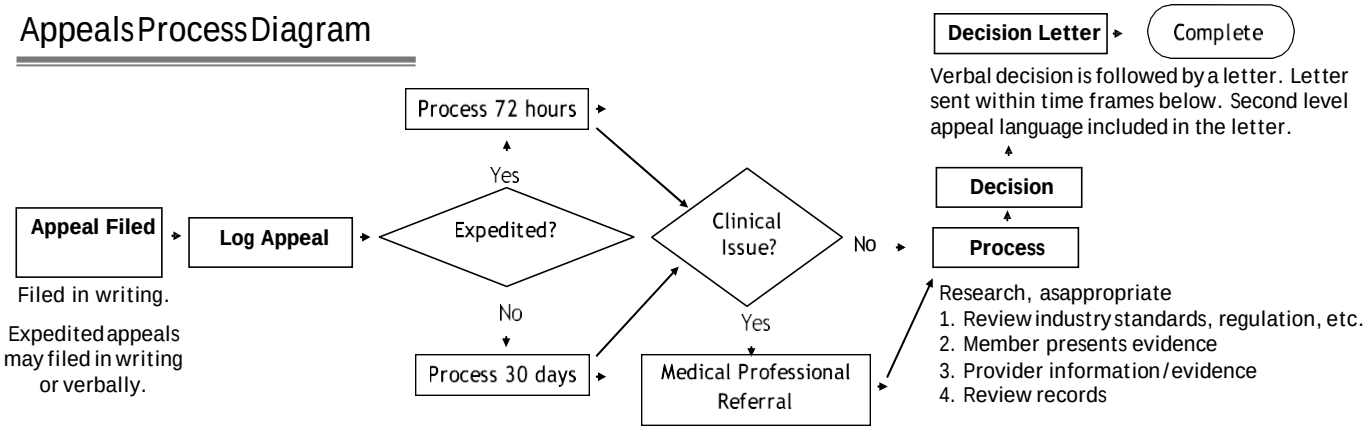
Appeal Process

Definition

Appeal: Any of the procedures that deal with the review of adverse organization determinations on the health care services an enrollee believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the enrollee), or on any amounts the enrollee must pay for a service as defined in 42 CFR 422.566(b). These procedures include reconsideration by the Medicare health plan and, if necessary, an independent review entity, hearings before Administrative Law Judges (ALJs), review by the Medicare Appeals Council (MAC), and judicial review.

Process

Golden State Medicare Health Plan will provide the member or party with a reasonable opportunity to present evidence and allegations of fact or law, related to the issue in dispute. In the case of an expedited reconsideration, the opportunity to present evidence is limited by the short timeframe for making a decision.



Time Frames

The member's health condition is considered, but a determination will be made no later than 30 calendar days after the date of receipt of the request for a standard reconsideration and 72 hours for an expedited determination. The Plan may extend the timeframe by up to 14 calendar days if the member requests the extension or if the organization justifies a need for additional information and how the delay is in the interest of the member.

Appeals must be filed within 60 days of the date of the notice of the organization determination reconsideration. Extensions may be granted under atypical circumstances and must be in writing.

The Plan does not delegate appeals.

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How to contact us when you are making an appeal about your medical care

Appeals for Medical Care	
CALL	(562) 799-0319 Calls to this number are not toll free, unless dialed locally. Hours of operation are 8 a.m. to 8 p.m. Monday through Friday and daily during the enrollment and disenrollment periods. (877) 541-4111 Calls to this number are free. Hours of operation are 8 a.m. to 8 p.m. Monday through Friday and daily during the enrollment and disenrollment periods.
TTY	(877) 551-4111 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours of operation are 8 a.m. to 8 p.m. Monday through Friday and daily during the enrollmentand disenrollment periods.
FAX	(562) 799-0507
WRITE	Golden State Medicare Health Plan c/o Member Services PO BOX 10729 Newport Beach, CA 92658
MEDICARE WEBSITE	You can submit a complaint about Golden State Medicare Health Plan directly to Medicare. To submit an online complaint to Medicare, go to https://www.medicare.gov/MedicareComplaintForm/home.aspx.

For more information on making an appeal about your medical care, see Chapter 9 in the Evidence of Coverage.

The reconsideration process consists of a review of an adverse organization determination, the evidence and findings upon which it was based, and any other evidence the parties submit. Requests for reconsideration must be in writing (expedited appeals may be filed verbally) and must be filed by a member, legal representative or provider who was a party to the organization determination.

A member or party must file a request for reconsideration no later than 60 days from the date of the notice of the organization determination.

If the 60-day period in which to file a request for reconsideration expires, a party to the organization determination may file a request for reconsideration with the Plan. The request for reconsideration and to extend the timeframe must:

- Be in writing
- State why the request for reconsideration was not filed on time

Time Frames

Except in the case of an extension of the filing time frame, a party must file the request for

reconsideration within 60 calendar days from the date of the notice of the organization determination.

When a party has made a request for reconsideration, the Plan will notify the member of its determination as expeditiously as possible. The member's health condition is considered, but a determination will be made no later than 30 calendar days after the date of receipt of the request for a standard pre-service reconsideration and 60 days for a payment reconsideration. The Plan may extend the timeframe by up to 14 calendar days if the member requests the extension or if the organization justifies a need for additional information and how the delay is in the interest of the member (for example, the receipt of additional medical evidence from noncontract providers may change a decision to deny). The member will be notified in writing of the reasons for the delay, and inform the member of the right to file an expedited grievance if he or she disagrees with the decision to grant an extension.

When the Plan approves a request for expedited reconsideration, the Plan will complete its reconsideration and give the member (and the physician involved, as appropriate) notice of its decision as expeditiously as the member's health condition requires but no later than 72 hours after receiving the request.

When the Plan makes a reconsidered determination that affirms, in whole or in part, its adverse organization determination, it must prepare a written explanation and send the file to the independent entity contracted by CMS as expeditiously as the member's health condition requires, but no later than 30 calendar days from the date it receives the request for a standard reconsideration (or no later than the expiration of an extension).

Denial of a reconsideration based on a lack of medical necessity (or any substantively equivalent term used to describe the concept of medical necessity), must be made by a physician with expertise in the field of medicine that is appropriate for the services at issue. The physician making the reconsidered determination need not, in all cases, be of the same specialty or subspecialty as the treating physician.

If the Plan approves the request for an expedited reconsideration, then it must complete the expedited reconsideration and give the member (and the physician involved, as appropriate) notice of its reconsideration as expeditiously as the member’s health condition requires, but no later than 72 hours after receiving the request. While the Plan may notify the enrollee orally or in writing, the enrollee must be notified within the 72 hour time frame. Mailing the notice within 72 hours in and of itself is insufficient. The member must receive the notice within 72 hours. If the Plan first notifies the member orally of a completely favorable expedited reconsideration, it must mail written confirmation to the enrollee within 3 calendar days. When the reconsideration is adverse the Plan must mail written confirmation within 3 calendar days after providing oral notification, if applicable.

Withdrawing a Request

The party who files a request for reconsideration may withdraw it by filing a written request for withdrawal with the Health Plan.

Reconsidered Determination by the Independent Review Entity (IRE)
When the Plan affirms the adverse organization determination (in whole or in part) it will submit a written explanation with the complete case file to the independent review entity contracted by CMS within the time frames appropriate for standard and expedited cases. The Plan will submit a hard copy case file to the independent review entity by mail at its designated address at Maximus.

The Plan will notify the member that it has forwarded the case to the independent entity for review. The notice will advise the member of his/her right to submit additional evidence that may be pertinent to the member's case and to direct such submissions directly to the independent review entity. The contact information of the independent review entity will be provided.

When the independent entity makes the reconsidered determination, it is responsible for mailing a notice of its reconsidered determination to the parties.
The notice must:

- State the specific reasons for the entity's decisions in understandable language
- Describe the member's rights and procedures to follow to obtain an ALJ hearing (when the reconsidered determination is adverse the amount in controversy is $100 or more)

If, on reconsideration of a request for payment, the Plan's determination is reversed in whole or in part by the independent outside entity, the Plan will pay for the service no later than 60 calendar days from the date it receives notice reversing the organization determination for standard requests.

Right to a Hearing
If the amount remaining in controversy after reconsideration meets the threshold requirement established annually by the CMS Secretary, any party to the reconsideration who is dissatisfied with the reconsidered determination has a right to a hearing before an ALJ. The amount remaining in controversy can include any combination of Part A and Part B services.

A party must file a written request for a hearing with the entity specified in the IRE's reconsideration notice and must file a request for a hearing within 60 days of the date of the notice of a reconsidered determination.

Medicare Appeals Council (MAC) Review
Any party to the hearing, including the Plan, who is dissatisfied with the ALJ hearing decision, may request that the MAC review the ALJ's decision or dismissal.

When the Plan files an appeal with the Medicare Appeals Council, the Plan will wait for the outcome of the review before it pays for, authorizes, or provides the service under dispute.

Fast-track Appeals
Members have a right to a fast-track appeal of the decision to terminate provider services. Members who desire a fast-track appeal must submit a request for an appeal to an IRE under contract with CMS, in writing or by telephone, by noon of the first day after the day of delivery of the termination notice. If, due to an emergency, the IRE is closed and unable to accept the member's request for a fast-track appeal, the member must file a request by noon of the next day that the IRE is open for business.

When a member fails to make a timely request to an IRE, he or she may request an expedited reconsideration by the MA organization. If, after delivery of the termination notice, a member chooses to leave a provider or discontinue receipt of covered services on or before the proposed termination date, the member may not later assert fast-track IRE appeal rights under this section relative to the services or expect the services to resume, even if the member requests an appeal before the discontinuation date in the termination notice.

Coverage of provider services continues until the date and time designated on the termination notice, unless the member appeals and the IRE reverses the Plan's (or delegates) decision.

The Plan (or delegate) will provide a detailed explanation why services are either no longer reasonable, or necessary, or are no longer covered. Any applicable policy, contract provision, or rationale upon which the termination decision was based will be provided, in addition to medical records.

The IRE must issue a reconsidered determination as expeditiously as the member's health.

If the IRE reaffirms its decision, in whole or in part, the member may appeal the IRE's reconsidered determination to an ALJ, the MAC or a federal court.

If on reconsideration the IRE determines that coverage of provider services should terminate on a given date, the member is liable for the costs of continued services after that date unless the IRE's decision is reversed on appeal. If the IRE's decision is reversed on appeal, the member will be reimbursed for the costs of any covered services for which the member paid.

Judicial Review
Any party, including the Plan, (upon notifying the other parties) may request judicial review when the amount in controversy meets the threshold requirement established annually by the CMS Secretary and if it is the final decision of CMS. In order to request judicial review, a party must file a civil action in a district court of the United States in accordance with section 205(g) of the Act.