APPEALS AND GRIEVANCES

WHAT TO DO IF YOU HAVE COMPLAINTS

Your comments are important to us. We continually work to improve the quality of care and service that you receive as a member of UPMC *for Life*. We encourage you to let us know right away if you have questions, concerns, or problems related to covered services or the care you receive while you are a member of UPMC *for Life* by calling Member Services at the following number:

UPMC *for Life* Specialty Plan (for individuals entitled to Medicare Part A and enrolled in Medicare Part B and have full Medical Assistance coverage)

If you are a current UPMC *for Life* Specialty Plan member, contact Member Services at 1-800-606-8648, from 8 a.m. to 8 p.m., seven days a week. TTY/TDD users should call 1-866-407-8762. From March 2 through November 14, you may receive a messaging system on weekends and holidays. Please leave a message and your call will be returned the next business day.

UPMC *for Life* Plans (for individuals entitled to Medicare Part A and enrolled in Medicare Part B)

If you are a current UPMC *for Life* member, contact UPMC *for Life* at 1-877-539-3080, from 8 a.m. to 8 p.m., seven days a week. TTY/TDD users should call 1-800-361-2629. From March 2 through November 14, you may receive a messaging system on weekends and holidays. Please leave a message and your call will be returned the next business day.

If at any point, you are not satisfied with the responses from UPMC *for Life* or the services that you received, you may file a complaint. If you make a complaint, we must be fair in how we handle it. You cannot be disenrolled from UPMC *for Life* or penalized in any way if you make a complaint.

WHAT ARE THE TYPES OF COMPLAINTS I CAN FILE ABOUT MY MEDICAL SERVICES?

What are the types of complaints I can file about my medical services?
You have the right to make a complaint if you have concerns or problems related to your medical coverage or care. Under the medical portion of your plan, you have the right to make “appeals” and “grievances.”

COMPLAINTS ABOUT A HOSPITAL DISCHARGE

What kind of complaint can I file if I disagree with my hospital discharge?
When you are hospitalized, you have the right to get all the hospital care covered by UPMC *for Life* that is necessary to diagnose and treat your illness or injury. The day you leave the hospital (your “discharge date”) is based on when your stay in the hospital is no longer medically necessary.

What information should I receive during my hospital stay?
When you are admitted to the hospital, someone at the hospital should give you a notice called the *Important Message from Medicare*. This notice explains:
- Your right to get all medically necessary hospital services covered.
- Your right to know about any decisions that the hospital, your doctor, or anyone else makes about your hospital stay, and who will pay for it.
- That your doctor or the hospital may arrange for services you will need after you leave the hospital.
- Your right to appeal a discharge decision.

If you think that you are being discharged too soon:
- You can talk to the hospital staff, your doctor, and UPMC *for Life* about your concerns.
- You also have the right to an appeal, that is, a review of your case by a Quality Improvement Organization (QIO). The QIO is an outside reviewer hired by Medicare to look at your case to decide whether you are ready to leave the hospital.
  - **If you want to appeal, you must contact the QIO no later than your planned discharge date and before you leave the hospital.**
    - If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copayments and deductibles).
  - If you do not appeal, but decide to stay in the hospital past your planned discharge date, you may have to pay for any services you receive after that date.

How do I get a review of my hospital discharge?
If you think you are being discharged too soon and want to have your discharge reviewed, you must act quickly to contact the QIO. The Important Message from Medicare gives the name and telephone number of your QIO and tells you what you must do.
- You must ask the QIO for a “fast review” of whether you are ready to leave the hospital. This “fast review” is also called a “fast appeal” because you are appealing the discharge date that has been set for you.

How soon do I have to ask the QIO to review my coverage?
You must be sure that you have made your request to the QIO before you are discharged from the hospital. This deadline is very important. If you meet this deadline, you are allowed to stay in the hospital past your discharge date without paying for it yourself, while you wait to get the decision from the QIO.

What information should I receive after I ask QIO to review my coverage?
You will receive a detailed notice from the hospital or UPMC *for Life* that explains the reasons they think you are ready to be discharged.

What happens during the QIO review?
When the QIO reviews your discharge, it will first look at your medical information. Then it will give an opinion about whether it is medically appropriate for you to be discharged on the date that has been set for you. The QIO will make this decision within one full working day after it has received your request and all of the medical information it needs to make a decision.

Who pays for my hospital charges during the QIO review?
If the QIO decides that your discharge date was medically appropriate, you will not be responsible for paying the hospital charges until noon of the calendar day after the QIO gives you its decision.

If the QIO agrees with you, then we will continue to cover your hospital stay for as long as medically necessary.

Do I have to pay for charges if I stay past my discharge date?
If you stay in the hospital after your UPMC *for Life* approved discharge date and do not ask for immediate QIO review, you may be financially responsible for the cost of many of the services you receive. However, you can appeal any bills for hospital care you receive, using the appeals process.

Who pays for the hospital charges during a "fast appeal"?
Whether you have to pay or not depends on the decision we make.

- If we decide, based on the clinical information received from the hospital and your doctors, that you need to stay in the hospital, we will continue to cover your hospital care for as long as medically necessary.
- If we decide that you should not have stayed in the hospital beyond your discharge date, we will not cover any hospital care you received if you stayed in the hospital after the discharge date. You will be provided with instructions for an appeal to an Independent Review Entity (IRE) with our decision.

COMPLAINTS ABOUT SKILLED NURSING FACILITIES (SNF), HOME HEALTH AGENCIES (HHA) OR COMPREHENSIVE OUTPATIENT REHABILITATION FACILITIES (CORF)

What information will I receive during my SNF stay, or while receiving CORF or HHA services?
If we decide to end our coverage for your SNF, HHA, or CORF services, you will get a written advance notice called the "Notice of Medicare Non-Coverage" (NOMNC) either from us or your provider at least 2 calendar days before your coverage ends. You (or someone you authorize) will be asked to sign and date this document to show that you received the notice. Signing the notice does not mean that you agree that coverage should end – it only means that you received the notice.

How do I get a review of my coverage by the Quality Improvement Organization?
You have the right by law to ask for an appeal of our termination of your coverage. As will be explained in the notice you get from us or your provider, you can ask the Quality Improvement Organization (the "QIO") to do an independent review of whether our terminating your coverage is medically appropriate.

How soon do I have to ask the QIO to review my coverage?
If you want to appeal the termination of your coverage, you must act quickly to contact the QIO. The written notice you got from us or your provider gives the name and telephone number of the QIO and tells you what you must do.

- If you get the notice 2 days before your coverage ends, you must be sure to make your request no later than noon of the day after you get the notice.
- If you get the notice and you have more than 2 days before your coverage ends, then you must make your request no later than noon the day before the date that your Medicare coverage ends.

What will happen during the review?
When the QIO reviews your case, the QIO will ask for your opinion about why you believe the services should continue. You do not have to prepare anything in writing, but you may do so if you wish. The QIO will also look at your medical information, talk to your doctor, and review other information that we have given to the QIO. You and the QIO will each get a copy of our explanation about why your services should not continue.

After reviewing all the information, the QIO will give an opinion about whether it is medically appropriate for your coverage to be terminated on the date that has been set for you. The QIO will make this decision within one full day after it receives the information it needs to make a decision.

What happens if the QIO decides in my favor?
If the QIO agrees with you, then we will continue to cover your SNF, HHA, or CORF services for as long as medically necessary.

What happens if the QIO denies my request?
If the QIO decides that our decision to terminate coverage was medically appropriate, you will be responsible for paying the SNF, HHA, or CORF charges after the termination date on the advance notice you got from us or your provider. Neither Original Medicare nor UPMC *for Life* will pay for these services. If you stop receiving services on or before the date given on the notice, you can avoid any financial liability. However, the QIO decision notification will explain how you can ask the QIO for a reconsideration.

What if you do not ask the QIO for a review in time?
You still have another option. If you do not ask the QIO for a "fast appeal" of your discharge or termination of coverage by the deadline, you can ask us for a "fast appeal" of your discharge or termination of coverage. If you ask us for a fast appeal of your termination and you continue getting services from the SNF, HHA, or CORF, you run the risk of having to pay for the care you receive past your termination date.

Who pays for my charges during a "fast appeal"?
Whether you have to pay or not depends on the decision we make.
- If we decide, based on the fast appeal, that you need to continue to get your services covered, then we will continue to cover your care for as long as medically necessary.
- If we decide that you should not have continued getting coverage for your care, then we will not cover any care you received if you stayed or continued to receive services after the termination date.

Do I have to pay if I stay past my discharge date or continue to receive services after the termination date? (The QIO does not decide in my favor.)
If you do not ask the QIO by noon after the day you are given written notice that we will be terminating coverage for your SNF, HHA, or CORF services, and if you stay in the SNF or continue to receive HHA or CORF after this date, you run the risk of having to pay for the SNF, HHA, or CORF care you receive on and after this date.

How do I request an exception to UPMC *for Life*'s Formulary?
You can ask us to make an exception to our coverage rules by calling Pharmacy Services at 1-800-396-4139, from 8 a.m. to 8 p.m., seven days a week. TTY/TDD users should call 1-800-361-2629. From March 2

through November 14, you may receive a messaging system on weekends and holidays. Please leave a message and your call will be returned the next business day. There are several types of exceptions that you can ask us to make.

- You can ask us to cover your drug even if it is not on our formulary.
- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, UPMC *for Life* limits the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover more.
- You can ask us to provide a higher level of coverage for your drug. For example, if your drug is usually considered a Brand drug, you can ask us to cover it as a Preferred Brand instead. This would lower the copayment amount you must pay for your drug.

Generally, UPMC *for Life* will only approve your request for an exception if the alternative drugs included on the plan's formulary or the lower-tiered drug would not be as effective in treating your condition and/or would cause you to have adverse medical effects. Once an exception request is approved, it is valid for the remainder of the plan year so long as your physician continues to prescribe the drug for you and it continues to be safe and effective for treating your condition.

What kind of complaints (appeals) can I make about UPMC *for Life* and my Part D drugs?

You have rights on what you can do if you have problems getting the prescription drugs you believe we should cover. We use the word "cover" in a general way to include such things as authorizing prescription drugs, paying for prescription drugs, or continuing to cover a Part D prescription drug that you have been getting. Problems getting a Part D prescription drug that you believe we should cover include the following situations:

- If you are not getting a prescription drug that you believe may be covered by UPMC *for Life*.
- If you have received a Part D prescription drug you believe may be covered by UPMC *for Life* while you were a member, but we have refused to pay for the drug.
- If we will not pay for a Part D prescription drug that your doctor has prescribed for you because it is not on our formulary.
- If you disagree with the amount that we require you to pay for a Part D prescription drug that your doctor has prescribed for you.
- If you are being told that coverage for a Part D prescription drug that you have been getting will be reduced or stopped.
- If there is a requirement that you try another drug before we pay for the drug your doctor prescribed, or if there is a limit on the quantity (or dose) of the drug and you disagree with the requirement or dosage limitation.

What are the steps for requesting a Part D benefit or payment from UPMC *for Life*?

If you are having a problem getting care, Part D benefits, or payment for care or a prescription drug, there are six possible steps you can take to ask for the care, benefits, or payment you want from us. At each step, your request is considered and a decision is made. If you are unhappy with the decision, you may be able to take another step if you want to continue requesting the care, benefits, or payment.

- In Steps 1 and 2, you make your request directly to us. We review it and give you our decision.
- In Steps 3 through 6, people in organizations that are not connected to us make the decisions about your request. To keep the review independent and impartial, those who review the request and make the decision in Steps 3 through 6 are part of (or in some way connected to) the Medicare program or the federal court system.

The six possible steps are summarized below. The Evidence of Coverage provides additional information about each step. You may request the most recent UPMC *for Life* or UPMC *for Life* Specialty Plan Evidence of Coverage by calling the UPMC *for Life* Member Services at the number listed on the first page.

STEP 1: The initial decision or coverage determination by UPMC *for Life*

The starting point is when we make an "initial decision" about your medical care, Part D prescription drug, or about paying for care or a drug that you have already received. When we make an "initial decision," we are giving our interpretation of how the services and benefits that are covered for members of UPMC *for Life* apply to your specific situation. You can ask for a "fast initial decision" if you have a request for medical care or Part D benefits that needs to be decided more quickly than the standard time frame.

STEP 2: Appealing the initial decision by UPMC *for Life*

If you disagree with the decision we make in Step 1, you may ask us to reconsider our decision. This is called an "appeal" or "request for redetermination." You can ask for a "fast appeal" if your request for medical care or Part D benefit needs to be decided more quickly than the standard time frame. After reviewing your appeal, we will decide whether to stay with our original decision, or change this decision and give you some or all of the care, benefit, or payment you want.

To file a standard appeal, you or your authorized representative should mail a request in writing within 60 days of the initial decision to UPMC Health Plan, Attn: Appeals and Grievances, P.O. Box 2939, Pittsburgh, PA 15230-2939.

You, any doctor, or your authorized representative can ask us to give a fast appeal (rather than a standard appeal) by calling us at the number listed on the first page. Or, you can deliver a written request to UPMC Health Plan, Attn: Appeals and Grievances, One Chatham Center, 112 Washington Place, Pittsburgh, PA 15219, or fax it to 412-454-7920. Be sure to ask for a "fast," "expedited," or "72-hour" review.

STEP 3: Review of your request by an Independent Review Organization

If we turn down part or your entire request for medical care in Step 2, we are required to send your request to an independent review organization that has a contract with the federal government and is not part of UPMC *for Life*. This organization will review your request and make a decision about whether we must give you the care or payment you want. If we turn down your request for a Part D prescription drug in Step 2, you may ask an independent review organization to review our decision. The independent review organization has a contract with the federal government and is not part of UPMC Health Plan. The independent review organization will review your request and make a decision about whether we must give you the benefit or payment you want.

STEP 4: Review by an Administrative Law Judge

If you are unhappy with the decision made by the independent review organization that reviews your case in Step 3, you may ask for an Administrative Law Judge to consider your case and make a decision. The Administrative Law Judge works for the federal government.

STEP 5: Review by a Medicare Appeals Council

If you or we are unhappy with the decision made in Step 4, either of us may be able to ask the Medicare Appeals Council (MAC) to review your case. The MAC is part of the federal department that runs the Medicare program.

STEP 6: Federal Court

If you or we are unhappy with the decision made by the MAC in Step 5, either of us may be able to take your case to a Federal Court.

COMPLAINTS (GRIEVANCES) ABOUT ANY OTHER TYPE OF PROBLEM YOU HAVE WITH UPMC *for LIFE* OR ONE OF OUR PLAN PROVIDERS

What is included in "all other types of problems"?

Here are some examples of problems that are included in this category of "all other types of problems":

- Problems with the quality of the medical care you receive, including quality of care during a hospital stay.
- If you feel that you are being encouraged to leave (disenroll from) UPMC *for Life*.
- Problems with the Member Service you receive.
- Problems with how long you have to spend waiting on the phone, in the waiting room, or in the exam room.
- Problems with getting appointments when you need them, or having to wait a long time for an appointment or to have your prescription filled.
- Disrespectful or rude behavior by pharmacists, doctors, nurses, receptionists, or other staff.
- Cleanliness or condition of pharmacies, doctor's offices, clinics, or hospitals.

If you have one of these types of problems and want to make a complaint, it is called "filing a grievance." In addition, you have the right to ask for a "fast grievance" if you disagree with our decision to not give you a "fast appeal" or if we take an extension on our initial decision or appeal.

What do I do if I have questions or concerns?

We will try to resolve any questions or concerns that you might have over the phone. If we cannot resolve your questions or concerns over the phone, we have a formal procedure to review your complaints. We call this formal procedure the UPMC *for Life* grievance procedure.

How do I file a grievance?

To use the UPMC *for Life* grievance procedure, ask a Member Services representative to document your concerns or send your grievance in writing to the Member Services Department at the following address:

UPMC Health Plan
Attn: Appeals and Grievances Coordinator
P.O. Box 2939
Pittsburgh, PA 15230-2939

When will UPMC *for Life* respond to me with a decision about my grievance?

We must notify you of our decision about your grievance as quickly as your case requires based on your health status, but no later than 30 calendar days after receiving your complaint. We may extend the time frame by up to 14 calendar days if you request the extension, or if we justify a need for additional information and the delay is in your best interest.

What happens during the grievance process?

Your complaint will be reviewed by an internal Grievance Review Committee, consisting of one or more employees of UPMC Health Plan. The Committee will investigate the details of your grievance. The committee will make a decision within 30 days of receipt of your complaint. You will receive written notification of the committee decision specifying the reasons for the decision. The Committee decision will be binding. You may authorize a representative to assist you in the grievance process.

For quality of care problems, you may also complain to the QIO.

If you are concerned about the quality of care you received, including care during a hospital stay, you can also complain to an independent organization called the QIO. You can contact Member Services to get information on how to contact the QIO. If you file a quality of care grievance, our decision letter will also include information on how to contact the QIO.

What if I want to designate someone to represent me during an appeal or grievance?

At any time during the grievance or appeal process, you may authorize a representative to assist you in the process. We must receive an authorization, in writing, from you to designate a representative. You can contact Member Services for additional information about designating a representative.