

Gateway Health Plan *Medicare Assured*[®] Provider Manual 2010

Chapter VIII Appeals and Grievances

Introduction

Gateway Health Plan *Medicare Assured*[®] HMO encourages its members to let us know right away if they have questions, concerns, or problems related to covered services or the care that they receive. Members are encouraged to contact Member Services for assistance.

This section provides an outline of rules for making complaints in different types of situations. Federal law guarantees a member's right to make complaints regarding concerns or problems with any part of their medical care as a plan member. The Medicare program has set forth requirements for the filing and processing of member complaints. If a member or authorized representative files a complaint, we are required to follow certain processes when we receive it. We must be fair in how we handle it, and we are not permitted to disenroll or penalize a member in any way for making a complaint.

What are Appeals and Grievances?

Members have the right to make a complaint if he or she has concerns or problems related to coverage or care. "Appeals" and "grievances" are the two different types of complaints that can be made.

An "**appeal**" can be filed if a member asks Gateway Health Plan *Medicare Assured*[®] HMO to reconsider and change a decision we have made about what services or benefits are covered or what we will pay for a service or benefit. A member may file an appeal under these circumstances:

- If we refuse to cover or pay for services a member thinks we should cover
- If we or one of our plan providers refuses to render a service that a member believes should be covered
- If we or one of our plan providers reduces or cuts back on services or benefits that a member has been receiving, or
- If a member believes that we are stopping coverage of a service or benefit too soon

A "**grievance**" is the type of complaint that can be made if a member has any other type of problem with Gateway Health Plan *Medicare Assured*[®] HMO or one of our plan providers. For example, grievances may be filed if a member is experiencing a problem regarding the following situations:

- The quality of care by a plan provider
- Waiting times for appointments or in the waiting room
- Provider behavior
- Being able to reach someone by phone or get the information needed, or
- The cleanliness or condition of a provider's facilities

Generally, grievances should be filed directly with Gateway Health Plan[®], but for matters related to quality of care, members also have the opportunity to file such complaints with a Quality Improvement

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Organization (QIO). THE QIO in Pennsylvania is Quality Insights of Pennsylvania. QIO reviews are discussed on pages 61 and 69.

Acting as an Appointed Representative

Gateway Health Plan *Medicare Assured*[®] HMO will accept appeals made by the member and/or his or her authorized representative or the prescribing physician or other prescriber or a non-participating provider involved in the member's care. A member may have any individual (relative, friend, advocate, attorney, congressional staff member, member of advocacy group, or suppliers, etc.) act as his or her representative, as long as the designated representative has not been disqualified or suspended from acting as a representative in proceedings before CMS or is otherwise prohibited by law.

In order to act as a representative, the member and representative must complete the Appointment of Representative Form, which can be found in the *Forms and Reference Material Section* of this manual, or an equivalent document.

A representative must sign the appointment within thirty (30) calendar days of the member's signature. The appointment remains valid for a period of one year from either the date signed by the party making the appointment or the date the appointment is accepted by the representative, whichever is later. The appointment is valid for any subsequent levels of appeal on the claim or service in question unless the member specifically withdraws the representative's authority.

If the requestor is the member's legal guardian or otherwise authorized under State law, no appointment is necessary. Gateway Health Plan[®] will require submission of appropriate documentation, such as a durable power of attorney.

The prescribing physician or other prescriber or a non-participating provider who is involved in the member's care (upon providing notice to the member) may request an appeal on the member's behalf without having been appointed as the member's representative.

A provider that has furnished services or items to a member may represent that member on the appeal; however, the provider may not charge the member a fee for representation. Further, the provider appointed must acknowledge in a signed, dated statement that the member will not be held financially responsible for payment for the services under review. Providers who do not have a contract with Gateway Health Plan *Medicare Assured*[®] HMO must sign a "Waiver of Liability" statement, which can be found in the *Forms and Reference Material Section* of this manual, that the provider will not require the member to pay for the medical service under review, regardless of the outcome of the appeal.

Appeals Regarding Hospital Discharge

There is a special type of appeal that applies only to hospital discharges. If a member feels that the Gateway Health Plan[®] coverage of a hospital stay is ending too soon, the member or his or her authorized representative can appeal directly and immediately to the Quality Improvement Organization (QIO). Quality Improvement Organizations are assigned regionally by the Centers for Medicare and Medicaid Services (CMS). The QIO for the state of Pennsylvania is Quality Insights of Pennsylvania. The QIOs are groups of health professionals that are paid to handle this type of appeal from Medicare patients. When such an appeal is filed on time, the stay may be covered during the appeal review. One must act very quickly to make this type of appeal, and it will be decided quickly.

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If a member believes that the planned discharge is too soon, the member or his or her authorized representative may ask for a QIO review to determine whether the planned discharge is medically appropriate. The Important Message from Medicare document given to the member within two days of admission and copied to the member within two days of discharge provides the appeal information as well as the QIO name and telephone number.

In order to request a QIO review regarding a hospital discharge, the member or his or her authorized representative must contact the QIO no later than noon of the first working day after the written notice is provided. If this deadline is met, the member is permitted to stay in the hospital past the planned discharge date without financial liability. If the QIO reviews the case, it will review medical records and provide a decision within one full working day after it has received the request and all of the medical information necessary to make a decision. If the QIO decides that the discharge date was medically appropriate, the member will have no financial liability until noon of the calendar day after the QIO provides its decision. If the QIO decides that the discharge date was too soon and that continued confinement is medically appropriate, we will continue to cover the hospital stay for as long as it is medically necessary.

If the member or his or her authorized representative does not ask the QIO for a review by the deadline, the member or authorized representative may ask Gateway Health Plan *Medicare Assured*[®] HMO for an expedited appeal. If the member or authorized representative asks us for an expedited appeal of the planned discharge and stays in the hospital past the discharge date, he or she may have financial liability for services provided beyond the discharge date. This depends on the expedited appeal decision. If the expedited appeal decision is in the member's favor, we will continue to cover the hospital care for as long as it is medically necessary. If the expedited appeal decision is that continued confinement was not medically appropriate, we will not cover any hospital care that is provided beyond the planned discharge date, unless an IRE review overturns our decision.

Skilled Nursing Facility (SNF), Home Health (HHA) or Comprehensive Outpatient Rehabilitation Facility (CORF) Services

There is another special type of appeal that applies only when coverage will end for SNF, HHA or CORF services. If a member feels that coverage for these services is ending too soon, he or she can appeal directly and immediately to the QIO. As with hospital services, these services may be covered during the appeal review if filed on time.

If Gateway Health Plan *Medicare Assured*[®] HMO decides to end our coverage for such a stay, the member is provided with a written Notice of Medicare Non-Coverage (NOMNC) at least two (2) calendar days before coverage ends. The member or authorized representative will be asked to sign and date this document. Signing the document does not mean that the member agrees to the decision, only that the notice was provided. After the NOMNC is completed, the provider must fax it to Gateway Health Plan *Medicare Assured*[®] HMO at 1-800-685-5231 and retain a copy in the provider's records.

Quality Improvement Organization (QIO) Review

For these types of services, members have the right by law to ask for an appeal of a termination of coverage. As will be explained in the notice referenced above, the member or his or her authorized

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representative can ask the QIO to do an independent review of whether terminating coverage is medically appropriate.

The notice will provide the name and phone number of the appropriate QIO agency. If the member receives the termination notice two days before coverage is scheduled to end, the member must contact the QIO no later than noon of the day the notice is received. If the notice is received more than two (2) days prior to the scheduled end in coverage, the QIO must be contacted no later than noon of the day before the scheduled termination of coverage.

If the QIO reviews the case, the QIO will ask for the member's opinion about why the services should continue. The response is not required in writing. The QIO will also look at medical information, talk to the doctor, and review other information that Gateway provides to the QIO. Gateway will provide both the member and the QIO a copy of the explanation for termination of coverage of these services.

After reviewing all the information, the QIO will decide whether it is medically appropriate for 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 necessary to make a decision. If the QIO decides in favor of the member, Gateway will continue to cover the stay for as long as medically necessary. If the QIO decides that our decision to terminate coverage was medically appropriate, the member will be responsible for paying the SNF, HHA or CORF charges after the termination date that appears on the advance notice. Neither Original Medicare nor Gateway will pay for these services. If the member agrees to discontinue receiving services on or before the date given on the notice, there will be no financial liability.

If the member or his or her authorized representative does not ask the QIO for a review in a timely manner, the member or authorized representative may request an expedited appeal. It is important to note that if the member or authorized representative requests an expedited appeal regarding termination and services continue to be provided, the member may have financial liability if services are provided beyond the termination date.

If Gateway staff decides upon expedited appeal review that services are medically necessary to continue, we will continue to cover the care for as long as medically necessary. If the decision is not in the member's favor, we will not cover any of the care that was provided beyond the termination date, and the member may be financially responsible.

Appeals for Coverage of Other *MEDICAL SERVICES*

There are several steps that members may use to request care or payment from Gateway. If we deny all or part of a request for coverage of services or payment for services, a member may ask for us to reconsider our decision. This is called an appeal or request for reconsideration. A member or his or authorized representative may call Member Services for assistance in filing an appeal. All appeals must be filed within sixty (60) calendar days of any Gateway initial denial notice. Additional time may be granted for good cause.

At each step, qualified personnel evaluate the request and a decision is made. If the decision is not in the member's favor, there are subsequent appeal options that are available.

After Gateway has issued an organization determination, a member or authorized representative may file an appeal. The first step of the appeal process is referred to as a request for reconsideration. If the member's medical condition warrants it, an expedited appeal may be requested. Gateway staff will make every effort to gather all the information needed in order to make a decision about the appeal. Qualified individuals who were not involved in making the initial coverage determination will review the appeal.

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Members also have the right to obtain and provide additional information as part of the appeal. Additional information in support of the member's appeal may be provided in writing or in person at the following address:

**Gateway Health Plan *Medicare Assured*[®] HMO
Attention: Medicare Complaints Administrator
US Steel Tower, Floor 41
600 Grant Street
Pittsburgh, PA 15219-2704**

Information may also be provided as follows:

**Fax: 412-255-4503
Telephone: 1-800-685-5209**

Members also have the right to ask us for a copy of the information that pertains to their appeal. Members may reach the Medicare Complaints Administrator as indicated above in order to make such a request.

For a decision about payment for care already received, the appeal must be finalized by Gateway within sixty (60) days, which includes payment for the services or forwarding the appeal to the Independent Review Entity (IRE) for review. For a standard review about medical care not yet provided, Gateway must finalize the appeal within thirty (30) days or sooner if the member's health condition warrants. For expedited appeals regarding medical care, Gateway has up to seventy-two (72) hours to make a decision, but will make it sooner if the member's life, health, or ability to regain maximum function requires it. If we do not issue a decision within seventy-two (72) hours or by the end of the extended time period, the appeal will be automatically forwarded to the IRE for review.

If the member requests an extension, or if we find that some information is needed that would be beneficial to the member in this review, an extension of up to fourteen (14) calendar days may be granted. The fourteen (14) day extension is also an option with expedited appeal. If we do not issue a decision within thirty (30) calendar days (or by the end of the extended time period), the appeal is automatically forwarded to the Independent Review Entity (IRE) for review. The IRE has a contract with CMS and is not part of Gateway.

Upon completion of the reconsideration, the member and parties to the appeal will be notified of either the approval of the service or payment or that the appeal has been forwarded to the IRE.

IRE Review

Gateway will notify the member and provider in writing when an appeal has been forwarded to the IRE for review. The member may request a copy of the file that is provided to the IRE for review. The IRE will review the request and make a decision about whether Gateway must provide the care or payment for the care in question. For appeals regarding payment of services already received, the IRE has up to sixty (60) calendar days to issue a decision. For standard appeals regarding medical care not yet provided, the IRE has up to thirty (30) calendar days to issue a decision. For expedited appeals regarding medical care, the IRE has up to seventy-two (72) hours to make a decision. These timeframes can be extended by up to fourteen (14) calendar days if more information is needed and the extension is in the member's best interest.

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The IRE will issue its decision in writing to both the member (or authorized representative) and the plan. If the decision is not in the member's favor, the member may have the opportunity to pursue coverage of the services through the review of an Administrative Law Judge.

Administrative Law Judge Review

If the IRE decision is not in the member's favor, and if the dollar value of the contested benefit meets minimum requirements the member or his or her authorized representative may ask for an Administrative Law Judge (ALJ) to review the case. The ALJ also works for the federal government. The IRE decision letter will instruct the member how to request an ALJ review.

During an ALJ review, the member may present evidence, review the record, and be represented by an attorney. The ALJ will not review the appeal if the dollar value of the medical care is less than the minimum requirement, and there are no further avenues for appeal. The ALJ will hear the case, weigh all of the evidence and make a decision as soon as possible.

The ALJ will notify all parties of the decision. The party against which the decision is made has the opportunity to request a review by the Medicare Appeals Council/Departmental Appeal Board. The decision issued by the ALJ will inform the member how to request such a review.

Medicare Appeals Council

The party against whom the ALJ decision is made has the right to request the review by the Medicare Appeals Council (MAC). This Council is part of the federal department that runs the Medicare program. The MAC does not review every case it receives. When it receives a case, the MAC decides whether to conduct the review. If they decide not to review the case, either party may request a review by a Federal Court Judge; however, the Federal Court Judge will only review cases when the amount in controversy meets the minimum requirement.

Federal Court

The party against whom the Medicare Appeals Council decision is made has the right to file the case with Federal Court if the dollar value of the services meets the minimum requirements. If the dollar value of the service in question is less, the Federal Court Judge will not review it and there is no further right of appeal.

Appeals for Coverage of Part D *DRUGS*

Gateway Health Plan *Medicare Assured*[®] *HMO* encourages its members to contact us through Member Services with any questions concerns or problems related to prescription drug coverage. As with medical services, Gateway also has processes in place to address various types of complaints that members may have regarding their prescription drug benefits.

Prescribing physicians or other prescribers who feels that an enrollee's life or health is in serious jeopardy may have immediate access to the Part D appeal process by calling 1-800-213-7083. Prescribers may also use this number to address process or status questions regarding the Part D appeal process.

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An “appeal” is any part of the procedures that deal with the review of an unfavorable coverage determination. A member or his or her authorized representative may file an appeal if he or she wants Gateway to reconsider and change a decision we have made about what Part D prescription drug benefits are covered or what we will pay for a prescription drug.

It is important to note that if Gateway approves a member’s exception request for a non-formulary drug, the member may not request an exception to the co-payment that applies to that drug.

Problems getting a Part D prescription drug that may be addressed by an appeal are as follows:

- If the member is not able to get a prescription drug that may be covered
- If a member has received a Part D prescription drug that may be covered but we have refused to pay for the drug.
- If we will not pay for a Part D prescription drug that has been prescribed because it is not on the formulary.
- If a member disagrees with the copayment amount.
- If coverage of a drug is being reduced or stopped.
- If there is a requirement to try other drugs before the prescribed drug is covered
- If there is a limit on the quantity or dose of the drug.

There are several steps that members may use to request care or payment from Gateway. At each step, qualified personnel evaluate the request and a decision is made. If the decision is not in the member’s favor, there are subsequent appeal options available.

After Gateway has issued an organization determination, a member or authorized representative or prescribing physician or other prescribers may file an appeal, also commonly referred to as a request for re-determination. All appeals must be filed within sixty (60) calendar days from the date of the coverage determination. If the member’s life, health, or ability to regain maximum function is in jeopardy, an expedited appeal may be requested. Gateway staff will make every effort to gather all the information needed in order to make a decision about the appeal. Qualified individuals who were not involved in making the coverage determination will review each request. Members have the right to obtain and provide additional information as part of the appeal. Additional information in support of the member’s appeal may be provided in writing or in person at the following address:

**Gateway Health Plan *Medicare Assured*[®] HMO
Attention: Medicare Complaints Administrator
US Steel Tower, Floor 41
600 Grant Street
Pittsburgh, PA 15219-2704**

Information may also be provided by fax at 412-255-4503 or by telephone at 1-800-685-5209. Members also have the right to ask us for a copy of the information that pertains to their appeal. Members may reach the Member Complaints Administrator as indicated above in order to make such a request.

Upon completion of the re-determination, the member and parties to the appeal will be notified of the decision. For a standard decision about a Part D drug, which includes any request for reimbursement for a Part D drug that has already been provided, Gateway has up to seven (7) calendar days to issue a decision and authorize or pay for the drug in question. If the member’s health condition requires it, the decision will be issued sooner. If Gateway does not issue a decision within seven (7) calendar days, the request will automatically be forwarded to the Independent Review Entity (IRE) for review.

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For an expedited appeal regarding Part D drugs that have not been provided, Gateway has up to seventy-two (72) hours to issue a decision and authorize the requested medication. If the member's health condition requires it, the decision will be issued sooner. If an expedited appeal was requested and Gateway does not comply with the seventy-two (72) hour timeframe, the case will automatically be forwarded to the IRE for review.

If the re-determination does not result in the approval of the drug under review, the member may ask for review by IRE. It is important to note that IRE review of Part D drug denials is not automatic as it is for medical services. The IRE has a contract with the federal government and is not part of Gateway.

Independent Review Entity (IRE)

The member or his or her authorized representative must submit a request to the IRE in writing within sixty (60) calendar days of the appeal decision notice. An expedited IRE is also available if the member's condition requires it. The IRE's name and address will be included in this notice. If a member requests review by IRE, the IRE will review the request and make a decision about whether Gateway Health Plan *Medicare Assured*[®] HMO must cover or pay for the medication. For an expedited IRE review, the IRE must issue a decision within seventy-two (72) hours. For a standard IRE review, the IRE has up to seven (7) calendar days to issue the decision.

The IRE will issue its decision in writing, explaining the reasons for the decision. If the decision is in the member's favor and the member has already paid for the medication, Gateway will reimburse the member within thirty (30) calendar days of the IRE's decision. We will also send the IRE confirmation that we have honored their decision. If the decision is in the member's favor and the member has not yet received the drug, Gateway will authorize the medication within seventy-two (72) hours of receiving the decision notice. Confirmation will be sent to the IRE in this situation as well. If an expedited IRE review was conducted, Gateway will authorize the medication within twenty-four (24) hours of receiving the IRE's decision notice.

If the member is not satisfied with the result of the IRE review, he or she may request the review by an Administrative Law Judge.

Administrative Law Judge (ALJ) Review

If the decision is not in the member's favor, the member or his or her authorized representative may request the review by an ALJ. In order to request a review by an ALJ, the value of the drug in question must meet minimum requirements. To calculate the amount in controversy, the dollar value of the drug will be projected based on the number of refills prescribed for the requested drug during the plan year. This projected value includes co-payments, all expenses incurred after the member's expenses exceed the initial coverage limit and any expenses paid by other entities. Claims may also be combined to meet the dollar value requirement if the claims involve the delivery of Part D drugs to the member, if all claims have been reviewed by the IRE, each of the combined requests are filed in writing within the sixty (60) day filing limit, and the hearing request identifies all of the claims to be heard by the ALJ.

The request must be made in writing within sixty (60) calendar days of the date of the IRE decision. The member may request an extension of the deadline for good cause. During the ALJ review, the member or appointed representative may present evidence, review the record, and be represented by counsel.

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The ALJ will hear the member's case, weigh all of the evidence submitted, and issue a decision as soon as possible. The ALJ will issue a decision in writing to all parties.

If the decision is in the member's favor and the member has already received and paid for the drug in question, Gateway will reimburse the member within thirty (30) calendar days from the date we receive the ALJ decision. If the decision is in the member's favor and the member has not yet received the drug in question, Gateway will authorize the medication within seventy-two (72) hours of the date we receive the ALJ decision. In cases where an expedited ALJ review was requested, Gateway will authorize the medication within twenty-four (24) hours of receiving the ALJ notice.

If the ALJ rules against the member, the ALJ notice will provide instructions on how to request a review by the Medicare Appeals Council.

Medicare Appeals Council

If the decision of the ALJ is not in the member's favor, Medicare Appeals Council (MAC) review may be requested. The MAC is part of the federal department that runs the Medicare program. There is no minimum dollar value for the MAC to conduct a review. The MAC does not review every case it receives. When it gets a case, it decides whether to review the case. If the MAC decides not to review the case, a written notice will be issued, and this notice will advise the member if any further action can be taken with respect to the request for review. The notice will instruct the member how to request a review by a Federal Court Judge.

If the MAC reviews the case, it will inform all parties of its decision in writing. If the decision is in the member's favor and the member has already received and paid for the drug in question, Gateway will reimburse the member within thirty (30) calendar days of receiving the MAC notice. If the decision is in the member's favor, but the member has not yet received the drug in question, Gateway will authorize the drug within seventy-two (72) hours of receiving the MAC notice. If an expedited MAC review was requested and the decision is in the member's favor, Gateway will authorize the drug within twenty-four (24) hours of receiving the MAC notice.

If the MAC reviews the case and the decision is not in the member's favor, the member may request a judicial review, but only if the dollar value of the medication meets minimum requirements.

Federal Court

If the member is not satisfied with the decision made by the MAC, in order to request judicial review of the case, the member must file civil action in a United States District Court. The MAC letter will explain how to do this. The dollar value of the drug in question must meet the minimum requirement to go to a Federal Court. The federal judiciary is in control of the timing of any decision.

If the Judge decides in the member's favor, Gateway is obligated to authorize or pay for services under the same time constraints as outlined above. If the Judge issues a decision that is not in the member's favor, the decision is final and there is no further right of appeal.

Amount in Controversy, Federal Minimum Requirements for Filing

<u>Appeal Level</u>	<u>Calendar Year 2007</u>	<u>Calendar Year 2008</u>	<u>Calendar Year 2009</u>	<u>Calendar Year 2010</u>
ALJ Hearing	\$110	\$120	\$120	\$130

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Judicial Review	\$1,130	\$1,180	\$1,220	\$1,260
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Member Grievances

A grievance is different from an appeal in that it usually does not involve coverage or payment for benefits. Concerns about failure to pay for a certain drug or service should be addressed through the appeals processes.

The member grievance process may be used to address other problems related to coverage, such as:

- Problems with waiting on the phone or in the pharmacy.
- Disrespectful or rude behavior by pharmacists or other staff.
- The cleanliness or condition of a network pharmacy.
- If a member disagrees with our decision not to expedite a request for coverage determination.
- If Gateway does not provide a decision within the required timeframe.
- If Gateway does not forward a case to an IRE if we do not comply with required timeframes for reconsideration.
- If Gateway does not provide the member with required notices.

Members also have the opportunity to file expedited grievances under certain conditions. See page (68).

Members are encouraged to contact our Member Services first in order to be provided with immediate assistance. Our staff will try to resolve any complaint over the telephone. If a written response is requested, one will be provided. If our Member Services staff is not able to resolve the telephone complaint, we will provide a written response to the member. Gateway employs a formal, multi-disciplinary process to review member grievances. Members may file a grievance by calling our Member Services Department or by writing to the following address:

Gateway Health Plan *Medicare Assured*[®] HMO
Attention: Medicare Complaints Administrator
US Steel Tower, Floor 41
600 Grant Street
Pittsburgh, PA 15219-2704

If the member would like to have someone else file a grievance for him or her, an Appointment of Representative Form must be completed, which can be found in the *Forms and Reference Material Section* of this manual. Grievances must be filed within 60 days of the date of the incident. Upon receipt of any grievance, Gateway will send the member a confirmation letter. The confirmation letter will ask the member to sign and return a form confirming that the complaint has been filed

First Level Grievance

The member or his or her authorized representative will have the opportunity to submit any information, documentation or evidence regarding the grievance. The First Level Grievance Committee will review all of this information in making their decision. The Committee will send a written response as quickly as the case requires based on the member's health status, but no later than thirty (30) calendar days after receiving the grievance. We may extend the timeframe by up to fourteen (14) calendar days if you

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request the extension or if we justify a need for additional information and the delay is in your best interest.

Second Level Grievance

If the member is not satisfied with the decision of the First Level Grievance Committee, he or she may ask for a Second Level Grievance Review. A Second Level Grievance review can be requested in the same manner as outlined above, within forty-five (45) calendar days of the date of receiving the First Level Grievance decision letter.

Once Gateway receives such a request, a Second Level Grievance Committee Hearing will be scheduled. The member is given at least fifteen (15) days notice for this hearing. The member may participate in this hearing in person or by telephone. Participation in this hearing is not required. The Second Level Grievance Committee will investigate the grievance and send the member a decision letter as quickly as the case requires based on the member's health status, but no later than thirty (30) calendar days after receiving your grievance.

Expedited Grievances

Gateway Health Plan *Medicare Assured*[®] HMO also has a process in place when it may be necessary to expedite the review of a grievance because the member's life, health, or ability to regain maximum function is in jeopardy. Members may file expedited grievances in the following circumstances:

- When we have extended the timeframe to make an Organization Determination.
- When we have extended the timeframe to resolve a standard request for Reconsideration.
- When we have refused to grant a Member's request for an expedited Organization Determination.
- When Gateway has refused to grant a Member's request for an expedited Reconsideration (Appeal).

The circumstances outlined above are the **only** times that an expedited grievance review is available.

When an expedited grievance is filed, an Expedited Grievance Hearing is immediately scheduled to occur within twenty-four (24) hours of receiving the request. As with Second Level Grievances, the member or appointed representative may participate in this hearing, but participation is not required. All affected parties will be notified of the decision by telephone within twenty-four (24) hours of filing the Expedited Grievance, and a letter explaining the decision will follow within three (3) days.

Quality Improvement Organization Review

Complaints concerning the quality of care received under Medicare may be investigated and acted upon by Gateway under the internal grievance process or by an independent organization called the Quality Improvement Organization (QIO) or by both. For example, if member believes that his or her pharmacist provided the incorrect dosage of a prescription or was prescribed a medication in error, the enrollee may file a complaint with the QIO in addition to or instead of a complaint filed under the plan sponsor's grievance process. For any complaint filed with the QIO, Gateway must cooperate with the QIO in resolving the complaint.

How to File a Quality of Care Complaint with the QIO

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QIOs are assigned regionally by CMS. For members who reside in Pennsylvania, quality of care complaints filed with the QIO must be made in writing to the following address:

**Quality Insights of Pennsylvania
2601 Market Place Street
Suite 320
Harrisburg, PA 17110**

There is no filing limit for quality of care grievances

Provider Appeals

Any provider may file a formal provider appeal to request the review of any post-service denial. This process is intended to afford providers with the opportunity to address issues regarding payment only. Appeals for services that have not yet been provided must follow the Member Reconsideration or Re-determination processes. The formal Provider Appeal Process must be initiated by the provider through a written request for an appeal. The written request for an appeal, along with all supporting documentation, must be received by Gateway within ninety (90) calendar days of the date of the denial notice. All written appeals must be sent to:

**Gateway Health Plan[®], Inc.
Medicare Complaints Administrator
US Steel Building, 41st Floor
600 Grant Street
Pittsburgh, PA 15219-2704**

First Level Appeal (The Informal Dispute Resolution Process)

The Gateway Provider Appeal Committee will resolve all First Level Appeals as soon as possible after receipt of all necessary information, but no less than thirty (30) calendar days from the date received. The Appeal Committee will be comprised of two (2) or more Gateway staff members who were not involved in the initial review. The First Level Appeal Committee will inform the provider of its decision in a written decision notice.

Second Level Appeal (The Informal Dispute Resolution Process)

If the provider is not in agreement with the first level appeal decision, the provider may request a Second Level Appeal. The provider must submit a written request for a Second Level Appeal to Gateway within thirty (30) calendar days of the date of the First Level Appeal decision letter. The Appeal Committee will be comprised of two (2) or more staff members who were not involved in any previous level of review. The provider will have the opportunity to participate in person or by telephone conference call in the second level appeal review. The provider must notify the Complaints Administrator in writing of the intent to participate. The Complaints Administrator will provide written notice of the hearing date at least fifteen (15) days in advance.

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All Second Level Appeals will be resolved within forty-five (45) days from the date received. The Second Level Appeal Committee will inform the provider of its decision in a written decision notice. The decision of the Second Level Appeal Committee is final and binding.