



315 SW Fifth Avenue, Suite 900
Portland, Oregon 97204
503-416-4100 or 800-224-4840
800-735-2900 (TTY/TDD)
Daily 8 am — 8 pm
www.careoregonadvantage.org

Appeals and Grievances

Federal law guarantees your right to make complaints if you have concerns or problems with any part of your care as a CareOregon Advantage member. **If you make a complaint, you cannot be disenrolled or penalized in any way.**

An **appeal** is a type of complaint you make when you want us to reconsider and change a decision we have made about what services are covered for you or what we will pay for a service.

The following are examples of situations when you might make an appeal:

- If you are not getting the care you want, and you believe that this care is covered by CareOregon Advantage
- If we will not authorize the medical treatment your doctor or other medical provider wants to give you and you believe that this treatment is covered by CareOregon Advantage
- If you are told that coverage for a treatment or service you have been getting will be reduced or stopped and you feel that this could harm your health
- If you have received care that you believe was covered by CareOregon Advantage while you were a member, but we have refused to pay for this care

How to Appeal

If you are having a problem getting care or payment for care, there are six possible steps you can take to ask for the care 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 or payment.

Please note that the rules that apply to appeals of drug coverage are different from the rules that apply to your health benefits.

1. The **first step** is when CareOregon Advantage makes an organization determination, or “initial decision,” about your medical care or about paying for care you have already received. When we make an organization determination, we are giving our interpretation of how the benefits and services that are covered for CareOregon Advantage apply to your specific situation. You can ask for a “fast” organization determination if you have a request for medical care that needs to be decided more quickly than the standard time frame of 14 days.
2. The **second step** is called a request for reconsideration and is done through CareOregon Advantage. You have 60 days to request an appeal from the date on your denial letter. We will request your medical records from your doctor. You may also present evidence in person or in writing and we will take that evidence into account when making a decision. CareOregon Advantage has 30 days to make a determination and 72 hours to make a determination if your health is in jeopardy.
3. If CareOregon Advantage does not change its decision in whole or part, we must send your case to Maximus Center for Health Dispute Resolution, an Independent Review Entity, which has a contract with the federal government and is not part of CareOregon Advantage. This is the **third step**. We will send you a letter notifying you of this. If Maximus Center for Health Dispute Resolution overturns CareOregon Advantage’s denial, we must authorize or provide service or payment. You can ask for a “fast appeal” if your request is for medical care and your health is in jeopardy.
4. If you are unhappy with the decision made by Maximus Center for Health Dispute Resolution, you may ask for an Administrative Law Judge (ALJ) to consider your case and make a decision. The dollar value of your contested benefit must be at least \$110. The ALJ reviews your request and decides if we must give you the care or payment you want. This is the **fourth step**.
5. If you or CareOregon Advantage is unhappy with the ALJ hearing decision, either of us may ask the Medicare Appeals Council to review your case. This Council is part of the federal department that runs the Medicare program. This is the **fifth step**.
6. If you are unhappy with the decision made by the Medicare Appeals Council in step five, and the amount involved is \$1,090 or more, you may be able to take your case to a federal court. This is the **sixth step**.

Appeals if you think you are being discharged too soon

When you are hospitalized, you have the right to get all the hospital care covered by CareOregon Advantage 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.

If you think our coverage of your hospital stay is ending too soon, you can appeal directly and immediately to the Acumentra Health. Acumentra Health is a quality improvement organization. This is a group of doctors and other health professionals that is paid to handle this type of appeal from Medicare patients. You must ask Acumentra Health for a “**fast review**” to determine if you are ready to leave the hospital. Acumentra Health makes 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.

If you think your coverage for Skilled Nursing Facility (SNF), Home Health Agency (HHA) or Comprehensive Outpatient Rehabilitation Facility (CORF) services is ending too soon, you can appeal and your stay may be covered during this time period that Acumentra Health uses to make its determination.

A **grievance** is a type of complaint that does not include payment or coverage disputes. A grievance is a complaint you make about CareOregon Advantage or one of our plan providers. We encourage you to let us know right away if you have questions or concerns.

The following concerns are examples of grievances (complaints):

- The quality of your care
- Waiting times for appointments or in the provider’s waiting room
- The way your doctors or others behave
- Inability to reach someone by phone or get the information you need
- The cleanliness or condition of the doctor’s office

How to file a grievance

We encourage you to first call **CareOregon Advantage Customer Service at 503-416-4100 or toll free at 1-800-224-4840 or TTY/TTD at 1-800-735-2900**. Our fax is 503-416-8118.

You may also mail your grievance to Appeals and Grievances, CareOregon Advantage, 315 SW Fifth, Suite 900, Portland, Oregon 97204.

We will try to resolve any complaint that you might have over the phone. If you request a written response to your phone complaint, we will respond in writing to you. If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. You can also complain to Acumentra Health.

Pharmacy Complaints

An **appeal (pharmacy)** is a type of complaint you or your authorized representative makes when you have problems getting the prescription drugs you believe CareOregon Advantage should provide. A pharmacy complaint may be handled as an appeal, coverage determination or grievance. Problems getting a Part D prescription drug that you believe we should provide include the following situations:

- If you are not able to get a prescription drug that you believe may be covered by CareOregon Advantage
- If you have received a Part D prescription drug you believe may be covered by CareOregon Advantage while you were a member, but we have refused to pay for the drug
- If we will not provide or 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 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

Coverage Determination

Whenever you ask for a Part D prescription drug benefit, the first step is called requesting a coverage determination. When we make a coverage determination, we are making a decision whether or not to provide or pay for a Part D drug and what your share of the cost is for the drug.

Coverage determinations include **exceptions requests**. You have the right to ask us for an “exception” if you believe you need a drug that is not on our list of covered drugs (formulary) or believe you should get a drug at a lower co-payment. If you request an exception, your physician must provide a statement to support your request.

You must contact CareOregon Advantage if you would like to request a coverage determination (including an exception). You cannot request an appeal if we have not issued a coverage determination.

How to Appeal a Denied Pharmacy Benefit

1. The first step is when CareOregon Advantage makes an “initial decision” about your Part D prescription drug or about paying for a Part D drug that you have already received. You can ask for a “fast initial decision” if you have a request for benefits that needs to be decided more quickly than the standard time frame.
2. If you disagree with our “initial decision,” you may ask us to reconsider. After reviewing your appeal, we decide if we will stay with our original decision or change this decision and give you the drug that you believe we should provide.
3. If we turn down your request, you may ask the Independent Review Entity (IRE) to review our decision. The IRE will decide if we must give you the drug that you believe we should provide.
4. If you are unhappy with the decision made by the IRE, you may ask for an Administrative Law Judge (ALJ) to consider your case and make a decision. The dollar value of your contested benefit must be at least \$110. The ALJ reviews your request and decides if we must give you the drug that you believe we should provide.
5. If you are unhappy with the decision made by the ALJ, you may be able to ask the Medicare Appeals Council to review your case.
6. If you are unhappy with the decision made by the Medicare Appeals Council in step five, and the amount involved is \$1,090 or more, you may be able to take your case to a federal court.

Pharmacy Grievance

You would file a grievance if you have any type of problem with CareOregon Advantage or one of our network pharmacies that does not relate to coverage for a prescription drug. For example, you would file a grievance if you have a problem with things such as:

- Waiting times when you fill a prescription
- The way your network pharmacist or others behave
- Being able to reach someone by phone or get the information you need
- The cleanliness or condition of a network pharmacy

We encourage you to let us know right away if you have questions, concerns or problems related to your prescription drug coverage.

- Contact CareOregon Advantage Customer Service at 503-416-4100 or toll free at 1-800-224-4840 or TTY/TTD at 1-800-735-2900. Our fax is 503-416-8118.
- Our mailing address is Appeals and Grievances, CareOregon Advantage, 315 SW Fifth, Suite 900, Portland, Oregon 97204.

