

COMPLAINTS AND APPEALS

Aetna Health of California HMO has procedures for **Members** to use if they are dissatisfied with a decision that the **HMO** has made or with the operation of the **HMO**. The procedure the **Member** needs to follow will depend on the type of issue or problem the **Member** has.

- **Appeal.** An **Appeal** is a request to the **HMO** to reconsider an adverse benefit determination. The **Appeal** procedure for an adverse benefit determination has one level. An **Appeal** is a type of **Complaint**. If the **Member** is appealing a **Disputed Health Care Service**, the **Member** has the right to independent medical review in addition to the processes described in the Complaints and Appeals Section.
- **Complaint.** A **Complaint** is a written or oral expression of dissatisfaction regarding the **HMO** or the operation of the **HMO** and/or a **Provider** including quality of care concerns, and includes a grievance, dispute, and request for reconsideration or **Appeal** made by an enrollee or the enrollee’s representative.

A. Complaints.

If the **Member** is dissatisfied with the administrative services the **Member** receives from the **HMO**, or wants to complain about a **Participating Provider**, call or write Member Services within 180 calendar days of the incident. The **Member** will need to include a detailed description of the matter and include copies of any records or documents that the **Member** thinks are relevant to the matter. The **HMO** will review the information and provide the **Member** with a written response within 30 calendar days of the receipt of the **Complaint**. The response will tell the **Member** what the **Member** needs to do to seek an additional review.

B. Appeals of Adverse Benefit Determinations.

The **Member** will receive written notice of an adverse benefit determination (including **Coverage Decisions** and **Disputed Health Care Service** decisions) from the **HMO**. The notice will include the reason for the decision and it will explain what steps must be taken if the **Member** wishes to **Appeal**. The notice will also identify the **Member’s** rights to receive additional information that may be relevant to an **Appeal**. Requests for an **Appeal** must be made in writing or by phone within 180 calendar days from the date of the notice.

A **Member** may also choose to have another person (an authorized representative) make the **Appeal** on the **Member’s** behalf by providing the **HMO** with written consent. However, in case of an urgent care claim or a pre-service claim, a **Physician** may represent the **Member** in the **Appeal**.

The following chart summarizes some information about how the **Appeals** are handled for different types of claims.

<u>HMO Timeframe for Responding to an Adverse Benefit Determination Appeal</u>	
Type of Claim	HMO Response Time from Receipt of Appeal
Urgent Care Claim. A claim for medical care or treatment where delay could seriously jeopardize the life or health of the Member , the ability of the Member to regain maximum function; or subject the Member to severe pain that cannot be adequately managed without the requested care or treatment.	Within 72 hours Review provided by personnel not involved in making the adverse benefit determination.

<u>HMO Timeframe for Responding to an Adverse Benefit Determination Appeal</u>	
Type of Claim	HMO Response Time from Receipt of Appeal
Pre-Service Claim. A claim for a benefit that requires approval of the benefit in advance of obtaining medical care.	Within 30 calendar days Review provided by personnel not involved in making the adverse benefit determination.
Concurrent Care Claim Extension. A request to extend or a decision to reduce a previously approved course of treatment.	Treated like an urgent care claim or a pre-service claim depending on the circumstances
Post-Service Claim. Any claim for a benefit that is not a pre-service claim.	Within 30 calendar days Review provided by personnel not involved in making the adverse benefit determination.

[C]. **Exhaustion of Process.**

The foregoing procedures and process are mandatory and must be exhausted prior to: the establishing of any litigation or arbitration, or any administrative proceeding regarding either any alleged breach of the **Group Agreement** or **EOC** by **HMO**, or any matter within the scope of the **Complaints** and **Appeals** process.

[D]. **Record Retention.**

HMO shall retain the records of all **Complaints** and **Appeals** for a period of at least 7 years.

[E]. **Fees and Costs.**

Nothing herein shall be construed to require **HMO** to pay counsel fees or any other fees or costs incurred by a **Member** in pursuing a **Complaint** or **Appeal**.

[F.] **Review by Governmental Agencies.**

The following is a notice that the HMO is required to provide to Members that tells how to contact the HMO and the Department of Managed Health Care. A **Member** has the right to submit unresolved **Complaints** and **Appeals** to the California Department of Managed Health Care for review after either completing the complaints and appeals process described above or participating in the process for at least 30 days.

“The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your plan at 1-800-445-5299 and use the plan’s grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unsolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are



experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department has a toll-free telephone number [1-888-466-2219] and a TDD line [1-877-688-9891] for the hearing and speech impaired. The department's Internet Web site (<http://www.dmhc.ca.gov>) has complaint forms, IMR application forms and instructions online. “

INDEPENDENT MEDICAL REVIEW

Members have the right to an independent review of decisions by the **HMO** to deny, modify or delay coverage for health care service(s) based on Medical Necessity (**Disputed Health Care Services**). **Members** have the right to an independent medical review of decisions by the **HMO** to deny coverage for health care services which have been determined by the **HMO** to be excluded as **Experimental and Investigative**. Section A below describes how **Members** may request Independent Medical Review for certain Experimental and Investigative treatments related to **Life-Threatening or Seriously Debilitating Illnesses**. The Department of Managed Health Care will manage the independent medical review process, which is available to **Members** when they meet the criteria developed by the Department of Managed Health Care. **Members** are not required to pay any application or processing fees to request or receive independent medical review. Independent medical review is available in addition to **HMO Complaint** and **Appeal** procedures and any other remedies available to the **Member** by law. **Members** should be aware that the decision not to participate in the independent medical review process may cause the **Member** to forfeit any statutory right to pursue legal action against the **HMO** regarding a **Disputed Health Care Service**.

A. Independent Medical Review Procedure for Experimental and Investigative Treatment

Members have the right to request an independent medical review when coverage is denied as an **Experimental or Investigational Procedure** and the following conditions are met:

1. The **Member** has a **Life-Threatening or Seriously Debilitating Illness**; and
2. The **Member's Physician** certifies that the **Member** has a condition, described in 1. above, for which
 - a] standard therapies have not been effective in improving the condition of the **Member**, or
 - b) standard therapies would not be medically appropriate, or
 - c) there is no more beneficial standard therapy covered by the plan than the therapy proposed by the **Physician**, and
- 3) the **Member's Participating Physician** has certified in writing that the proposed procedure, device, drug or other therapy is more likely to be more beneficial to the **Member** than any available standard therapies, **or**
- 4) the **Member**, or the **Member's Physician** (who is a licensed, board-certified or board-eligible **Physician**, qualified to practice in the area of practice appropriate to treat the **Member's** condition) has provided to **HMO** a written statement which certifies that, based on two documents from **Medical and Scientific Evidence** the requested, drug, device, procedure or therapy is likely to be more beneficial to the **Member** than any available standard therapy. The **Physician** or the **Member** must identify the documents relied upon as **Medical and Scientific Evidence** as part of the written certification.

When coverage for a requested service is denied as **Experimental and Investigative**, the **HMO** must notify the **Member** in writing, within five business days of the date of the decision to deny coverage, of the **Member's** right to request independent medical review. Included in the notice will be the forms and instructions necessary to apply to the Department of Managed Health Care for independent medical review of the **HMO's** decision. The **Member** will need to demonstrate to the Department of Managed Health Care that they meet criteria (1), (2) and (3), or criteria (1), (2) and (4).



The independent medical review will be a review of the specific medical and scientific reasons cited by the **HMO** for the denial of coverage. The review will be done at no cost to the **Member**. The Department of Managed Health Care will evaluate the **Member's** request and decide whether the **Complaint** qualifies for independent medical review. The Department of Managed Health Care will notify the **Member** and the **HMO** of its decision. Within three business days of notification from the Department of Managed Health Care that the **Member's** request for independent medical review has been approved, the **HMO** must provide the independent entity performing the review with the medical records relevant to the **Member's** condition, a copy of the relevant documents used by the **HMO** in determining whether the proposed treatment is covered, and any other information submitted to the **HMO** by the **Member** or the **Member's Physician** in support of the request for coverage.

If the **Member's Provider** determines that the effectiveness of either the proposed treatment or any alternative treatment covered under this **EOC** would be materially reduced if not provided at the earliest possible date, the review shall be done within 7 business days of the date of the request and the **HMO** shall submit the above referenced documents within 24 hours of the Department of Managed Health Care's notification to the **HMO** that the **Member's Complaint** qualifies for expedited independent medical review.

B. **Independent Medical Review Procedure for Disputed Health Care Services**

As part of the **Complaint** and **Appeal** process, **Members** have the right to an independent medical review of their **Appeal**, when they believe that health care services have been improperly denied, modified, or delayed because they are not **Medically Necessary** (a **Disputed Health Care Service**), and the conditions listed below are met.

1. The **Member** has filed an **Appeal** regarding a **Disputed Health Care Service**.
2. The **Member** has participated in the **HMO Complaint** and **Appeal** process for 30 days or the **HMO** has responded to the **Member's Appeal** by upholding the **HMO's** denial of the **Disputed Health Care Service**. In cases involving an expedited complaint or appeal the **Member** is not required to participate in the **HMO Complaint** and **Appeal** process for more than three days.
3. Either, the **Member's Provider** (who may be a non-participating **Provider**, subject to the conditions noted below) must have recommended the health care service as medically necessary; or the **Member** received **Urgent Care** or **Emergency Services** that a **Provider** deemed medically necessary,
4. Or, the **Member** has been seen by a **Participating Provider** for the diagnosis or treatment of the medical condition for which the **Member** seeks independent review. Upon request by a **Member**, **HMO** will expedite access to a **Participating Provider**. Note that the **Member** may request independent medical review for the **Disputed Health Care Service** whether or not the **Participating Provider** recommends the service.

Members may request an independent medical review for services recommended or performed by a **Non-Participating Provider**, **but the HMO has no liability to pay for the services of a Non-Participating Provider unless the Member has been referred to the Non-Participating Provider according to the requirements set forth in this EOC.**

When the **HMO** receives notice from the Department of Managed Health Care approving the **Member's** request for an independent medical review, the **HMO** will submit the documents required by Health and Safety section 1374.30(n) within 3 business days.

HMO will concurrently provide a copy of these documents to the **Member** and the **Member's Provider**.



In the event of the imminent and serious threat to the health of the **Member**, the **HMO** will deliver the required documents to the Independent Medical Review Organization within 24 hours of receipt of notification of the Department of Managed Health Care's approval of the **Member's** request.

C Department of Managed Health Care and Independent Medical Review.

If the **Member** wishes to pursue independent medical review the **Member** should complete the form which the **Member** will have received from the **HMO** and send it (in the envelope provided with the form and instructions) to the Department of Managed Health Care. The Department will review the **Member's** request and determine whether the **Member** meets the criteria for independent medical review and therefore, is eligible for independent medical review. If the Department of Managed Health Care approves the **Member's** request, the **Member's Appeal** will be submitted to the Independent Medical Review Organization for review by a medical specialist, or a panel of medical specialists. The designated specialist or panel of specialists will make an independent determination of whether or not the care which is the subject of the **Appeal** is medically necessary. The **Member** will receive a copy of the independent medical review assessment of the **Appeal**. If the outcome of the independent medical review is that the care requested is medically necessary or does not qualify as **Experimental and Investigative**, the **HMO** will cover the provision of the health care services which were the subject of the **Appeal**.

For non urgent cases, the independent medical review organization must provide its determination within 30 days of receiving the **Member's** application and supporting documents. For cases which qualify for expedited review, the Independent Medical Review Organization must provide its determination within 3 business days.

Upon notification of an independent medical review decision that the health care services under review are medically necessary, **HMO** will promptly take the actions necessary to comply with the decision.