

Complaints & Appeals

In the unlikely event you feel compelled to file either a complaint or an appeal, learn how this process works.

Your Medicare Appeal Rights

You have the right to appeal any decision about your Medicare services. This is true whether you are in the Original Medicare Plan or a Medicare Preferred Provider Organization plan. If Medicare does not pay for an item or service you have been given, or if you are not given an item or service you think you should receive, you can file an appeal.

Appeal Rights Under the Original Medicare Plan

If you receive your medical benefits under the Original Medicare Plan, you can file an appeal if you think Medicare should have paid for, or did not pay enough for, an item or service you received. If you file an appeal, ask your doctor or provider for any information related to the bill that might help your case. Your appeal rights are on the back of the Explanation of Medicare Benefits or Medicare Summary Notice that is mailed to you from a company that handles bills for Medicare. The notice also tells you why your bill was not paid and what appeal steps you can take.

Appeal Rights Under Medicare Preferred Provider Organization Plan

If you are in a Medicare Preferred Provider Organization plan, you can file an appeal if your plan will not pay for, does not allow, or stops a service that you think should be covered or provided. If you think your health could be seriously harmed by waiting for a decision about a service, ask the plan for a fast decision. The plan must answer you within 72 hours. [Read how to file a MedicareBlue PPO appeal.](#)

After you file an appeal, the plan will review its decision. Then, if your plan does not decide in your favor, the appeal is reviewed by an independent organization that works for Medicare, not for the plan. See your plan's membership materials or contact your plan for details about your Medicare appeal rights.

If you have concerns or problems with your plan which are not about payment or service requests, you have a right to file a complaint. For example, if you believe your plan's hours of operation should be different, you can file a complaint.

You are Protected When You Are in the Hospital

This is true whether you are in the Original Medicare Plan or a Medicare Preferred Provider Organization plan. If you are admitted to a Medicare participating hospital, you should receive a copy of An Important Message from Medicare. It explains your rights as a hospital patient. If you don't receive one, ask for it. It explains:

- You have the right to get all of the hospital care that you need, and any follow-up care after you leave the hospital.
- What to do if you think the hospital is making you leave too soon.

If you have questions about this, call **1-800-MEDICARE**, or TTY/TDD users should call 1-877-486-2048, 24 hours a day, 7 days a week.

Total Number of Complaints, Appeals, and Exceptions

If you would like to inquire as to the total number of complaints, appeals, and exceptions received by this Plan, call:

Toll Free 1-888-457-3009 TTY/TDD users should call 1-888-457-3005 Monday-Friday, 8:00 a.m. to 6:00 p.m. Central and Mountain Time

Complaints & Appeals — How to File a MedicareBlue PPO Appeal

Federal law guarantees your right to file an appeal or grievance if you have concerns or problems with your medical care or prescription drug services. If you make a complaint, you cannot be disenrolled from your plan or penalized in any way. There are three categories of complaints.

Category 1: Coverage or Payment of Services or Prescription Drugs

You can file an “appeal” if you have a complaint that has to do with our payment or provision of services or prescription drugs. For example, you may appeal our decision:

- Not to authorize or pay for all or part of a treatment, service or drug you think is covered
- To reduce or stop a covered treatment, service or drug you had been receiving
- Not to provide a prescription drug because it is not on our formulary
- To require that you try another drug before we pay for the prescription drug your doctor prescribed, or to limit the quantity (or dose) of the drug

To file an appeal concerning any of the above, or similar decisions, follow these steps:

Step 1 — To Appeal the Initial Decision:

If you disagree with a decision we make, you must file a written appeal within 60 days of the decision. Send your appeal to:

Appeals Department
2901 Kinwest Parkway, Building B
Irving, TX 75063-5815

Or you can fax your written appeal to 1-800-706-5236.

Questions about your appeal? Call 1-888-832-0075.

You can ask for an “expedited appeal” if your request needs to be decided more quickly than the standard time frame (7 days for covered drug benefits). You will receive a written decision. If your request for an expedited appeal is granted, the decision on your appeal will be issued within 72 hours.

Step 2 — To Have an Independent Review Organization Review Your Request:

If your appeal in Step 1 is denied in whole or in part with respect to *medical services or payment for medical services*, we **must** automatically send it to an Independent Review Organization (IRO) for reconsideration. You will be notified of the decision. If your appeal is denied in whole or in part with respect to *prescription drug benefits*, you may appeal by filing a written “request for review by the IRO” within 60 days after receiving the denial. The IRO is not related to the plan and has a contract with the federal government.

Step 3 — Ask to have an Administrative Law Judge Review Your Request:

If you are unhappy with the decision made in Step 2, you may file a written request to have an Administrative Law Judge (ALJ) consider your request within 60 days after the decision in Step 2, so long as the dollar value of your contested claim meets the minimum amount determined by CMS. The ALJ works for the federal government.

Step 4 — Ask a Medicare Appeals Council to Review Your Request:

If you still are unhappy with the decision made in Step 3, you may file a written request within 60 days of that decision asking a Medicare Appeals Council (MAC) to consider your request. The plan can appeal to the MAC, too. The MAC is part of the federal department that runs the Medicare program.

Note: extensions of the timeframes described above may be available in some cases.

Step 5 — Take Your Case to a Federal Court:

If you or the plan is unhappy with the MAC’s decision in Step 4, either party may file an action in federal court within 60 days after the decision in Step 4, so long as the dollar value of your contested claim meets the minimum amount determined by CMS.

Note: Extensions of the timeframes described above can be made in some cases.

Category 2: Discharge From a Hospital, Skilled Nursing Facility, Home Health Agency, or Comprehensive Outpatient Rehabilitation Facility

When you are hospitalized, or are a patient in a skilled nursing facility (SNF), home health agency (HHA), or comprehensive outpatient rehabilitation facility (CORF), you have the right to all medically necessary benefits covered by the Plan. This summary describes your appeal and grievance rights.

Step 1 — Request Written Notice of Discharge & Medicare Appeal Rights:

If you believe you are being discharged too soon from the hospital or an SFT, HHA or CORF, you may ask the plan to give you a “Notice of Discharge & Medicare Appeal Rights.” This notice will tell you:

- Why you are being discharged
- The date the plan will stop covering your hospital or SNF/HHA/CORF stay
- The name and telephone number of the Quality Improvement Organization (QIO) for your state

The QIO is a group of doctors and other health care experts paid by the federal government to help improve the care given to Medicare patients. Each State has its own QIO.

Step 2 — Ask Your QIO to Review Your Request:

You have the right to appeal the plan’s termination of coverage for your hospital or SNF/HHA/CORF stay. Your deadline for appealing depends on when you receive the “Notice of Discharge & Medicare Appeal Rights” described above. If you receive the notice more than 2 days before your hospital or SNF/HHA/CORF stay ends, you must file your written appeal no later than noon of the day before the stay ends. If you get the notice 2 days or less before your coverage ends, you must file your written appeal no later than noon of the first working day after you receive the notice. *This deadline is very important.* If you file your appeal by the deadline, you may stay in the hospital, SNF, HHA or CORF past your scheduled discharge date without paying for it yourself, while you wait for QIO to review your appeal. If you miss the deadline, you do not have this right, but still may request an “expedited appeal” of any bills for hospital or SNF/HHA/CORF care using the steps described above for Category 1 complaints.

Requests and denials:

If the QIO agrees with you, the plan will continue to cover your hospital, SNF, HHA or CORF services for as long as medically necessary. But if the QIO decides that the decision to terminate coverage was medically appropriate, you will be responsible for paying the hospital, SNF, HHA or CORF charges from the coverage termination date.

Category 3: Any Other Problem With Your Plan or a Provider

If you have any other problem concerning your plan or a provider, such as the quality or timeliness of your care, we encourage you to first call MedicareBlue PPO Customer Service:

Toll Free 1-888-457-3009

TTY/TDD users should call 1-888-457-3005

Monday-Friday, 8:00 a.m. to 6:00 p.m. Central and Mountain Time

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, you may file a “grievance” within 60 days after the event or incident giving rise to the grievance. You will be notified of the decision on your grievance as quickly as your case requires based on your health status, but no later than 30 calendar days after the grievance is received. This period may be extended by up to 14 calendar days if you request it, or if the delay is in your best interest. You can also ask for an “expedited grievance,” and receive a response within 24 hours, if the plan determines that your request needs to be decided more quickly than the standard time frames. Send your written grievance to:

MedicareBlue PPO
Customer Service
P.O. Box 13652
Philadelphia, PA 19101-3652

Or you can fax your written grievance to 1-888-289-3008.

If you are concerned about the quality of care you received, including care during a hospital stay, you may also contact your QIO.