



## How to file a grievance

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### What is a Grievance?

A grievance is different from a request for an organization determination, a request for a coverage determination, or a request for an appeal because grievances do not involve problems related to coverage or payment for care or Part D benefits, problems about being discharged from the hospital too soon, and problems about coverage for Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF) services ending too soon.

For problems about coverage or payment for care, problems about being discharged from the hospital too soon, and problems about coverage for SNF, HHA, or CORF services ending too soon, please follow the rules outlined in *Information on how to make a complaint about Part C medical services and benefits* below.

**If you have a problem about our failure to cover or pay for a Part D prescription drug, you must follow the rules outlined in *Part D Appeals, Grievances and Coverage Determinations*.**

### What types of problems might lead to you filing a grievance?

- 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) New West Medicare.
- Problems with the Customer Service you receive.
- Problems with how long you have to spend waiting on the phone, in the waiting room, in a network pharmacy, or in the exam room.
- Problems with getting appointments when you need them, or having to wait a long time for an appointment.
- Disrespectful or rude behavior by doctors, nurses, receptionists, network pharmacists, or other staff.
- Cleanliness or condition of doctor's offices, clinics, network pharmacies, or hospitals.
- If you disagree with our decision not to expedite your request for an expedited coverage determination, organization determination, redetermination, or reconsideration.
- You believe our notices and other written materials are difficult to understand.
- Failure to give you a decision within the required timeframe.
- Failure to forward your case to the independent review entity (IRE) if we do not give you a decision within the required timeframe.
- Failure by New West Medicare to provide required notices.
- Failure to provide required notices that comply with CMS standards.

If you have one of these types of problems and want to make a complaint, it is called “filing a grievance.” In certain cases, you have the right to ask for a “fast grievance,” meaning your grievance will be decided within 24 hours.

## **Filing a grievance with New West Health Services**

**If you have a complaint, we encourage you to first call Customer Service at 1-888-873-8049. TTY users, please call 1-888-290-3658. Our business hours are:**

- March 2, 2007 until November 14, 2007, 8:00 a.m. until 8:00 p.m. Monday– Friday.
- November 15, 2007 until March 1, 2008, 8:00 a.m. until 8:00 p.m. seven days per week.
- Alternative technologies may be used for weekends, holidays and evenings.

**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. We call this the formal grievance procedure.** To use the formal grievance procedure the member submits their written grievance to the Appeals & Grievance Department. Upon receiving the grievance, we will send a written acknowledgment letter within five business days to advise you that the complaint has been received and that New West Medicare will address your concerns. You will receive a final written response within 30 days (24 hours if an expedited grievance) of receiving the grievance. In some instances we may require additional time to address your concern. If additional time is needed, we will keep you informed of how your grievance is being handled. Whether you use the formal (written) or informal (telephone) grievance procedure, New West Medicare tracks all appeals and grievances in order to report data to CMS and to our members, upon request. 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 days after receiving your complaint. We may extend the timeframe by up to 14 days if you request the extension, or if we justify a need for additional information and the delay is in your best interest.

## **For quality of care problems, you may also complain to the [Mountain Pacific Quality Health Foundation](#)**

Complaints concerning the quality of care received under Medicare, including care during a hospital stay, may be acted upon by New West Medicare under the grievance process, by an independent organization called the Mountain Pacific Quality Health Foundation, or by both. For any complaint filed with the Mountain Pacific Quality Health Foundation, New West Medicare must cooperate with the Mountain Pacific Quality Health Foundation in resolving the complaint.

### **How to file a quality of care complaint with the Mountain Pacific Quality Health Foundation**

Quality of care complaints filed with the Mountain Pacific Quality Health Foundation must be made in writing. An enrollee who files a quality of care grievance with the Mountain Pacific Quality Health Foundation is not required to file the grievance within a specific time period. You can contact Mountain Pacific Quality Health Foundation at:

**Mountain Pacific Quality Health Foundation**

3404 Cooney Dr  
Helena, MT 59602  
1-800-497-8232

## **Information on how to make a complaint about Part C medical services and benefits**

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### **Introduction**

This section gives the rules for making complaints about Part C services and payments in different types of situations. Federal law guarantees your right to make complaints if you have concerns or problems with any part of your medical care as a plan member. If you make a complaint, we must be fair in how we handle it. You cannot be disenrolled from New West Medicare or penalized in any way if you make a complaint.

Please refer to Original Medicare in Section 8 of your 2007 *Medicare and You Handbook* for additional guidance on your appeal rights under Original Medicare. If you do not have a *Medicare and You Handbook*, please call 1-800 Medicare to get a copy.

### **How to make complaints in different situations**

This section tells you how to complain about services or payment in each of the following situations:

- **Part 1. Complaints about what benefit or service we will provide you or what we will pay for (cover).**
- **Part 2. Complaints if you think you are being discharged from the hospital too soon.**
- **Part 3. Complaints if you think your coverage for skilled nursing facility (SNF), home health (HHA) or comprehensive outpatient rehabilitation facility (CORF) services is ending too soon.**

If you want to make a complaint about any type of problem other than those that are listed above, a **grievance** is the type of complaint you would make.

## **PART 1. COMPLAINTS ABOUT WHAT BENEFIT OR SERVICE NEW WEST HEALTH SERVICES WILL PROVIDE YOU OR WHAT NEW WEST HEALTH SERVICES WILL PAY FOR (COVER)**

### **What are “complaints about your services or payment for your care?”**

If you are not getting the care you want, and you believe that this care is covered by New West Medicare.

- 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 New West Medicare.

- If you are being told that a treatment or service you have been getting will be reduced or stopped, and you believe that this could harm your health.
- If you have received care that you believe should be covered by New West Medicare, but we have refused to pay for this care because we say it is not covered.

### **What is an organization determination?**

An organization determination is our initial decision about whether we will provide the medical care or service you request, or pay for a service you have already received. If our initial decision is to deny your request, you can **appeal** the decision by going on to Appeal Level 1 (see below). You may also appeal if we fail to make a timely initial decision on your request.

**When we make an “initial decision,” we are giving our interpretation of how the benefits and services that are covered for members of New West Medicare apply to your specific situation.** Your Evidence of Coverage and any amendments you may receive describe the benefits and services covered by New West Medicare, including any limitations that may apply to these services. Your Evidence of Coverage also lists exclusions (services that are “not covered” by New West Medicare).

### **Who may ask for an “initial decision” about your medical care or payment?**

Depending on the situation, your doctor or other medical provider may ask us whether we will authorize the treatment. Otherwise, you can ask us for an initial decision yourself, or you can name (appoint) someone to do it for you. This person you name would be your *appointed representative*. You can name a relative, friend, advocate, doctor, or someone else to act for you. Some other persons may already be authorized under state law to act for you. If you want someone to act for you, then you and the person you want to act for you must sign and date an *Appointment of Representative* statement (available on this website) that gives this person legal permission to act as your representative. This statement must be sent to us at New West Health Services, PO Box 668, Kalispell, MT 59903. You can call us at 1-888-873-8049 (TTY 1-888-290-3658) to learn how to name your representative.

You also have the right to have an attorney ask for an initial decision on your behalf. You can contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. You may want to contact The Medicare Rights Center at 1-800-HMO-9050.

### **Do you have a request for medical care that needs to be decided more quickly than the standard time frame?**

A decision about whether we will cover medical care can be a “standard decision” that is made within the standard time frame (typically within 14 days), or it can be a “fast decision” that is made more quickly (typically within 72 hours). A fast decision is sometimes called an “expedited organization determination.”

You can ask for a fast decision **only** if you or any doctor believe that waiting for a standard decision could seriously harm your health or your ability to function.

**Asking for a standard decision**

To ask for a standard decision about medical care or payment for care, you or your authorized representative should mail or deliver a request in writing to the following address: New West Health Services, Attn: Appeals and Grievances, 103 Neill Avenue, Helena, MT 59601.

**Asking for a fast decision**

You, any doctor, or your representative can ask us to give a “fast” decision (rather than a “standard” decision) about medical care by calling us at 1-888-873-8049 (TTY 1-888-290-3658). Or, you can deliver a written request to New West Health Services, 130 Neill Avenue, Helena, MT 59601 or fax it to 1-406-457-2299. Be sure to ask for a “fast” or “72-hour” review.

If **any** doctor asks for a fast decision for you, or supports you in asking for one, and the doctor indicates that waiting for a standard decision could seriously harm your health or your ability to function, we will give you a fast decision.

If you ask for a fast decision without support from a doctor, we will decide if your health requires a fast decision. If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter informing you that if you get a doctor’s support for a “fast” decision, we will automatically give you a fast decision. The letter will also tell you how to file a “grievance” if you disagree with our decision to deny your request for a fast review. It will also tell you about your right to ask for a “fast grievance.” If we deny your request for a fast decision, we will give you a standard decision.

**What happens next when you request an initial decision?**

**1. For a decision about payment for care you already received.**

We have 30 days to make a decision after we have received your request. However, if we need more information, we can take up to 30 more days. You will be told in writing when we make a decision. If we do not approve your request for payment, we must tell you why, and tell you how you can appeal this decision. If you have not received an answer from us within 60 days of your request, you can **appeal** this decision. (An appeal is also called a “reconsideration.”)

**2. For a standard initial decision about medical care.**

We have 14 days to make a decision after we have received your request. However, we can take up to 14 more days if you request the additional time, or if we need more time to gather information (such as medical records) that may benefit you. If we take additional days, we will notify you in writing. If you believe that we should not take additional days, you can make a specific type of complaint called a “fast grievance”. If we do not approve your request, we must explain why in writing, and tell you of your right to appeal our decision. If you have not received an answer from us within 14 days of your request (or by the end of any extended time period), you have the right to appeal.

**3. For a fast initial decision about medical care.**

If you receive a “fast” decision, we will give you our decision about your medical care within 72 hours after you or your doctor ask for it – sooner if your health requires. However, we can take up to 14 more days to make this decision if we find that some information is missing which may

benefit you, or if you need more time to prepare for this review. If you believe that we should not take any additional days, you can file a fast grievance.

We will tell you our decision by phone as soon as we make the decision. If we deny any part of your request, we will send you a letter that explains the decision within 3 days of contacting you by phone. If we do not tell you about our decision within 72 hours (or by the end of any extended time period), you have the right to appeal. If we deny your request for a fast decision, you may file a fast grievance.

**Appeal Level 1: If we deny any part of your request for coverage or payment of a service, you may ask us to reconsider our decision. This is called an “appeal” or a “request for reconsideration.”**

Please call us at 1-888-873-8049 (TTY 1-888-290-3658) if you need help in filing your appeal. We give the request to different people than those who were involved in making the initial decision. This helps ensure that we will give your request a fresh look.

If your appeal concerns a decision we made about authorizing medical care, then you and/or your doctor will first need to decide whether you need a “fast” appeal. The procedures for deciding on a “standard” or a “fast” *appeal* are the same as those described for a “standard” or “fast” *initial decision*.

**Getting information to support your appeal**

We must gather all the information we need to make a decision about your appeal. If we need your assistance in gathering this information, we will contact you. You have the right to obtain and include additional information as part of your appeal. For example, you may already have documents related to the issue, or you may want to get the doctor’s records or the doctor’s opinion to help support your request. You may need to give the doctor a written request to get information.

You can give us your additional information in any of the following ways:

- In writing, to New West Health Services, Attn: Appeals and Grievances, 130 Neill Ave, Helena, MT 59601.
- By fax, at 406-457-2299.
- By telephone – if it is a “fast appeal” – at 1-888-500-3355 (TTY 1-888-290-3658)
- In person, at New West Health Services, 130 Neill Ave, Helena MT 59601.

You also have the right to ask us for a copy of information regarding your appeal. You can call or write us at 1-888-500-3355 (TTY 1-888-290-3658), New West Health Services, 130 Neill Ave, Helena, MT 59601.

**How do you file your appeal of the initial decision?**

The rules about who may file an appeal are the same as the rules about who may ask for an initial decision. Follow the instructions under “Who may ask for an ‘initial decision’ about medical care or payment?” However, providers who do not have a contract with New West

Medicare must sign a “waiver of payment” statement that says that they will not ask you to pay for the medical service under review, regardless of the outcome of the appeal.

### **How soon must you file your appeal?**

You need to file your appeal within 60 days after we notify you of the initial decision. We can give you more time if you have a good reason for missing the deadline. To file your appeal you can call us at the telephone number on the cover of this booklet or send the appeal to us in writing at New West Health Services, 130 Neill Ave, Helena, MT 59601.

### **What if you want a “fast” appeal?**

The rules about asking for a “fast” appeal are the same as the rules about asking for a “fast” initial decision.

### **How soon must we decide on your appeal?**

#### **1. For a decision about payment for care you already received .**

After we receive your appeal, we have 60 days to make a decision. If we do not decide within 60 days, your appeal *automatically* goes to Appeal Level 2.

#### **2. For a standard decision about medical care.**

After we receive your appeal, we have up to 30 days to make a decision, but will make it sooner if your health condition requires. However, if you request it, or if we find that some information is missing which can help you, we can take up to 14 more days to make our decision. If we do not tell you our decision within 30 days (or by the end of the extended time period), your request will *automatically* go to Appeal Level 2.

#### **3. For a fast decision about medical care.**

After we receive your appeal, we have up to 72 hours to make a decision, but will make it sooner if your health requires. However, if you request it, or if we find that some information is missing which can help you, we can take up to 14 more days to make our decision. If we do not tell you our decision within 72 hours (or by the end of the extended time period), your request will *automatically* go to Appeal Level 2.

### **What happens next if we decide completely in your favor?**

#### **1. For a decision about payment for care you already received.**

We must pay within 60 calendar days of the day we received your request for us to reconsider our initial decision.

#### **2. For a standard decision about medical care.**

We must authorize or provide you with the care you have asked for no later than 30 days after we received your appeal. If we extend the time needed to decide your appeal, we will authorize or provide your medical care when we make our decision.

#### **3. For a fast decision about medical care.**

We must authorize or provide you with the care you have asked for within 72 hours of receiving your appeal – or sooner, if your health would be affected by waiting this long. If we extended the time needed to decide your appeal, we will authorize or provide your

medical care at the time we make our decision.

### **What happens next if we deny your appeal?**

If we deny any part of your appeal, your appeal *automatically* goes on to Appeal Level 2 where an independent review organization will review your case. This organization contracts with the federal government and is not part of New West Medicare. We will tell you in writing that your appeal has been sent to this organization for review. How quickly we must forward your appeal to the organization depends on the type of appeal:

#### **1. For a decision about payment for care you already received.**

We must send all the information about your appeal to the independent review organization within 60 days from the date we received your Level 1 appeal.

#### **2. For a standard decision about medical care.**

We must send all of the information about your appeal to the independent review organization as quickly as your health requires, but no later than 30 days after we received your Level 1 appeal.

#### **3. For a fast decision about medical care.**

We must send all of the information about your appeal to the independent review organization within 24 hours of our decision.

### **Appeal Level 2: If we deny any part of your Level 1 appeal, your appeal will automatically be reviewed by a government-contracted independent review organization**

At the second level of appeal, your case is given a new review by an outside, independent review organization that has a contract with CMS (Centers for Medicare & Medicaid Services), the government agency that runs the Medicare program. This organization has no connection to us. We will tell you when we have sent your appeal to this organization. You have the right to get a copy from us of your case file that we sent to this organization.

### **How soon must the independent review organization decide?**

- 1. For an appeal about payment for care**, the independent review organization has up to 60 days to make a decision.
- 2. For a standard appeal about medical care**, the independent review organization has up to 30 days to make a decision. However, it can take up to 14 more days if more information is needed and the extension will benefit you.
- 3. For a fast appeal about medical care**, the independent review organization has up to 72 hours to make a decision. However, it can take up to 14 more days if more information is needed and the extension will benefit you.

**If the independent review organization decides completely in your favor:**

The independent review organization will tell you in writing about its decision and the reasons for it.

1. **For an appeal about payment for care**, we must pay within 30 days after receiving the decision.
2. **For a standard appeal about medical care**, we must *authorize* the care you have asked for within 72 hours after receiving notice of the decision, or *provide* the care no later than 14 days after receiving the decision.
3. **For a fast appeal about medical care**, we must authorize or provide you with the care you have asked for within 72 hours of receiving the decision.

**Appeal Level 3: If the organization that reviews your case in Appeal Level 2 does not rule completely in your favor, you may ask for a review by an Administrative Law Judge**

You must make a request for review by an Administrative Law Judge (ALJ) in writing within 60 days after the date you were notified of the decision made at Appeal Level 2. The deadline may be extended for good cause. You must send your written request to the ALJ Field Office that is listed in the decision you receive from the independent review organization. The Administrative Law Judge will not review the appeal if the dollar value of the medical care does not meet the minimum requirement provided in the independent review organization's decision. If the dollar value is less than the minimum requirement, you may not appeal any further. During this review, you may present evidence, review the record, and be represented by counsel.

**How soon does the Judge make a decision?**

The Administrative Law Judge will hear your case, weigh all of the evidence up to this point, and make a decision as soon as possible.

**If the Judge decides in your favor**

We must pay for, authorize, or provide the service you have asked for within 60 days from the date we receive notice of the decision. We have the right to appeal this decision by asking for a review by the Medicare Appeals Council (Appeal Level 4).

**If the Judge rules against you**

You have the right to appeal this decision by asking for a review by the Medicare Appeals Council (Appeal Level 4). The letter you get from the Administrative Law Judge will tell you how to request this review.

## **Appeal Level 4: Your case may be reviewed by the Medicare Appeals Council**

### **This Council will first decide whether to review your case**

The Medicare Appeals Council does not review every case it receives. If they decide not to review your case, then either you or New West Health Services may request a review by a Federal Court Judge (Appeal Level 5). The Medicare Appeals Council will issue a written notice advising you of any action taken with respect to your request for review. The notice will tell you how to request a review by a Federal Court Judge.

### **How soon will the Council make a decision?**

If the Medicare Appeals Council reviews your case, they will make their decision as soon as possible.

### **If the Council decides in your favor**

We must pay for, authorize, or provide the medical service you have asked for within 60 days from the date we receive notice of the decision. However, we have the right to appeal this decision by asking a Federal Court Judge to review the case (Appeal Level 5), so long as the dollar value of the contested benefit meets the minimum requirement provided in the Medicare Appeals Council's decision. If the dollar value is less than the minimum requirement, the Council's decision is final.

### **If the Council decides against you**

If the amount involved meets the minimum requirement provided in the Medicare Appeals Council's decision, you or we have the right to continue your appeal by asking a Federal Court Judge to review the case (Appeal Level 5). If the value is less than the minimum requirement, the Council's decision is final and you may not take the appeal any further.

## **Appeal Level 5: Your case may go to a Federal Court**

In order to request judicial review of your case, you must file a civil action in a United States District Court. The letter you get from the Medicare Appeals Council in Appeal Level 4 will tell you how to request this review. The Federal Court Judge will first decide whether to review your case. If the contested amount meets the minimum requirement provided in the Medicare Appeals Council's decision, you or we may ask a Federal Court Judge to review the case.

### **How soon will the judge make a decision?**

The Federal judiciary controls the timing of any decision. The judge's decision is final and you may not take the appeal any further.

## **PART 2. Complaints (appeals) if you think you are being discharged from the hospital too soon**

When you are hospitalized, you have the right to get all the hospital care covered by New West Medicare 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. This section explains what to do if you believe that you are being discharged too soon.

### **Information you should receive during your 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.

### **Review of your hospital discharge by the Mountain Pacific Quality Health Foundation**

If you think that you are being discharged too soon, ask us to give you a notice called the *Notice of Discharge & Medicare Appeal Rights*. This notice will tell you:

- Why you are being discharged;
- The date that we will stop covering your hospital stay (stop paying our share of your hospital costs);
- What you can do if you think you are being discharged too soon;
- Who to contact for help.

You (or your representative) may 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 you are ready to leave the hospital – it only means that you received the notice. If you do not get the notice after you have said that you think you are being discharged too soon, ask for it immediately.

You have the right by law to ask for a review of your discharge date. As explained in the *Notice of Discharge & Medicare Appeal Rights*, if you act quickly, you can ask an outside agency called the Quality Improvement Organization to review whether your discharge is medically appropriate.

### **What is the “Quality Improvement Organization”?**

“QIO” stands for **Quality Improvement Organization**. The QIO is a group of doctors and other health care experts paid by the federal government to check on and help improve the care given to Medicare patients. They are not part of New West Medicare or your hospital. There is one QIO in each state. QIOs have different names, depending on which state they are in. In Montana, the QIO is called Mountain Pacific Quality Health Foundation. The doctors and other health experts in the Mountain Pacific Quality Health Foundation review certain types of complaints made by Medicare patients. These include complaints about quality of care and complaints from Medicare patients who think the coverage for their hospital stay is ending too soon.

### **Getting a QIO review of your hospital discharge**

If you want to have your discharge reviewed, you must quickly contact the Mountain Pacific Quality Health Foundation. The *Notice of Discharge & Medicare Appeal Rights* gives the name

and telephone number of your QIO and tells you what you must do.

- You must ask the Mountain Pacific Quality Health Foundation for a **“fast review”** of whether you are ready to leave the hospital. This “fast review” is also called an “immediate review.”
- You must be sure that you have made your request to the Mountain Pacific Quality Health Foundation **no later than noon** on the first working day after you are given written notice that you are being 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 Mountain Pacific Quality Health Foundation (see below).

If the Mountain Pacific Quality Health Foundation 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 Mountain Pacific Quality Health Foundation 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.

### **What happens if the QIO decides in your favor?**

If the Mountain Pacific Quality Health Foundation agrees with you, we will continue to cover your hospital stay for as long as it is medically necessary.

### **What happens if the QIO denies your request?**

If the Mountain Pacific Quality Health Foundation decides that your discharge date was medically appropriate, you will not be responsible for paying the hospital charges until noon of the day after the Mountain Pacific Quality Health Foundation gives you its decision.

## **What if you do not ask the QIO for a review by the deadline?**

### **You still have another option: asking New West Medicare for a “fast appeal” of your discharge**

If you do not ask the Mountain Pacific Quality Health Foundation for a fast review of your discharge by the deadline, you can ask us for a “fast appeal” of your discharge. How to ask us for a fast appeal is covered in Part 1 of this section.

If you ask us for a fast appeal of your discharge and you stay in the hospital past your discharge date, you may have to pay for the hospital care you receive past your discharge date. 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 stay in the hospital, we will continue to cover your hospital care for as long as it is 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 after the discharge date (unless the independent review organization overturns our decision).

### **PART 3. COMPLAINTS (APPEALS) IF YOU THINK YOUR COVERAGE FOR SNF, HOME HEALTH OR COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY SERVICES IS ENDING TOO SOON**

When you are a patient in a Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF), you have the right to get all the SNF, HHA or CORF care covered by New West Medicare that is necessary to diagnose and treat your illness or injury. The day we end your SNF, HHA or CORF coverage is based on when your stay is no longer medically necessary. This part explains what to do if you believe that your coverage is ending too soon.

#### **Information you will receive during your SNF, HHA or CORF stay**

If we decide to end our coverage for your SNF, HHA, or CORF services, you will get written notice either from us or your provider at least 2 calendar days before your coverage ends. You (or your representative) 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 to get a review of your coverage by the Mountain Pacific Quality Health Foundation**

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 **Mountain Pacific Quality Health Foundation** (the “QIO”) to do an independent review of whether it is medically appropriate to terminate your coverage.

#### **How soon do you have to ask the Mountain Pacific Quality Health Foundation to review your coverage?**

If you want to appeal the termination of your coverage, you must quickly contact the Mountain Pacific. The written notice you got from us or your provider gives the name and telephone number of your QIO and tells you what you must do.

- If you get the notice 2 days before your coverage ends, you must 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, you must make your request **no later than noon** of the day before the date that your Medicare coverage ends.

#### **What will happen during the review?**

The Mountain Pacific Quality Health Foundation 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 Mountain Pacific Quality Health Foundation will also look at your medical information, talk to your doctor, and review other information that we have given to the Mountain Pacific Quality Health Foundation. You and the Mountain Pacific Quality Health Foundation will each get a copy of our explanation about why we believe that your services should end.

After reviewing all the information, the Mountain Pacific Quality Health Foundation will decide whether it is medically appropriate to terminate your coverage on the date that has been set for you. The Mountain Pacific Quality Health Foundation will make this decision within one full day after it receives the information it needs to make a decision.

**What happens if the Mountain Pacific Quality Health Foundation decides in your favor?**

If the Mountain Pacific Quality Health Foundation 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 your request?**

If the Mountain Pacific Quality Health Foundation 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 New West Medicare 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.

**What if you do not ask the Mountain Pacific Quality Health Foundation for a review by the deadline?**

You still have another option: asking New West Medicare for a “fast appeal” of your discharge.

If you do not ask the Mountain Pacific Quality Health Foundation for a fast appeal of your coverage termination by the deadline, you can ask us for a fast appeal. How to ask us for a fast appeal is covered in Part 1 of this section. If you ask us for a fast appeal of your termination and you continue getting services from the SNF, HHA, or CORF, you may have to pay for the care you receive past your termination date. 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, we will continue to cover your care for as long as medically necessary;
- If we decide that you should not have continued getting your services covered, we will not cover any care you received after the termination date.