

Appeals and Grievances

This is a guide to appeals and grievances. This guide includes information about what appeals and grievances are, when you might want to file one and how to request it, if you need one. For more details about this subject, please refer to the Senior Dimensions Evidence of Coverage.

There are two types of grievances and appeals, standard and expedited. Expedited grievances and appeals are handled more quickly than standard ones. Typically, expedited review is considered in situations where waiting for a standard review could seriously jeopardize your life, health or your ability to regain maximum function.

GRIEVANCES

What is a grievance?

A grievance is a complaint expressing dissatisfaction with a situation that does not involve the coverage or payment for a medical service or prescription.

Examples of situations that might cause you to file a grievance/complaint are:

- You feel that you are being encouraged to leave (disenroll from) Senior Dimensions;
- You feel that you are spending too much time waiting on the phone with Member Services, the doctor's office or the pharmacy, or, waiting in the doctor's office or pharmacy;
- You feel physicians, pharmacists or their staff were rude or disrespectful;
- You feel the doctor's office or pharmacy were not clean or were in poor condition;
- You disagree with our decision not to expedite your request for an expedited coverage determination or redetermination;
- You believe our notices and other written materials are hard to understand;
- The plan did not give you a decision within the required timeframe;
- The plan did not forward your case to the independent review entity if the plan does not give you a decision within the required timeframe;
- The plan did not provide required notices; or
- The plan did not provide required notices that comply with CMS standards.

How soon must I file a grievance/complaint?

A grievance must be filed within 60 calendar days of the incident or issue causing the complaint.

How do I file a grievance/complaint?

Senior Dimensions encourages you to call our Member Services Department when you have a grievance/complaint. This way, we can address your concern more quickly and we feel that speaking with you directly can help us to better understand your issue.

You can reach a Member Services representative at: 702-242-7301 or 1-800-650-6232 (TTY/TDD 702-242-9214 or 1-800-349-3538 for the hearing impaired.)

Senior Dimensions hours of operation are:

From November 15, 2008 through March 1, 2009- 7 days/week from 8am to 8pm

From March 2, 2009 through December 31, 2009- Monday through Friday from 8am to 8pm

You can fax your grievance to: 702-242-7655

If you prefer, you can write to Senior Dimensions and formally submit your grievance/complaint. Direct your written grievance/complaint to:

Senior Dimensions/Government Programs

Grievance Request

P. O. Box 15645

Las Vegas, NV 89114-5645

Please include your name, address, telephone number, Senior Dimensions identification number and the reason for your grievance/complaint in your letter. Please include any information or documents that may support your request. If you send us a written grievance/complaint, we will send you an acknowledgement letter to let you know we received it. We will reply to your written grievance/complaint within 30 calendar days. Verbal grievances/complaints will not be responded to in writing unless specifically requested.

If you have any questions about how to submit a grievance/complaint, please call Member Services for help.

APPEALS

What is an appeal?

An appeal is a request to reconsider a decision that was not in your favor (in whole or in part). The appeal process relates to the reconsideration of decisions regarding coverage or payment of a medical service or drug. There are several steps in the appeals process and it is a little different depending upon whether you have a drug coverage issue or a medical service coverage issue. Below are explanations of the steps you must take for each type of service (drug or medical).

Examples of situations where you might want to consider filing an appeal:

- You were denied coverage or payment for a medical service or drug that you believe should be covered or paid by Senior Dimensions.
- You were advised that a drug is not covered and/or is not on the plan's list of covered drugs, also called a "formulary", but you feel it should be covered.
- Senior Dimensions will not authorize a medical treatment (where applicable) that your doctor or other medical provider has requested and you believe that this treatment should be covered by the plan.
- You disagree with the amount you are required to pay for a medical service or a drug.
- You have been advised that coverage for a medical service or drug you have been receiving will be reduced or stopped.

- You have been advised and disagree with the Plan's requirement that you must try another drug before we pay for the drug that your doctor has prescribed, or, there is a limit on the quantity or dose of the drug prescribed.

The Appeals Process as it relates to Part D Prescription Drugs

Senior Dimensions is a Medicare Advantage plan with Medicare Part D prescription drug coverage. If you go to the drug store and the pharmacist tells you that your drug is not covered by Senior Dimensions, the first step in the appeals process for drugs is to request an exception.

STEP 1

Exceptions

What is an Exception?

An exception request is a type of initial decision request for Part D drugs (and is sometimes also called a coverage determination request). It can include when you:

- Ask for a Part D drug that is not on your plan's list of covered drugs (also called a "formulary"), this is a request for a "formulary exception."
- Ask for an exception to our plan's utilization management procedures. Utilization management procedures include step therapy, which is when we ask you to use another drug first, before you are provided the prescription your doctor prescribed, and/or, restrictions that we may have regarding the quantity or dosage prescribed. These are also considered to be requests for "formulary exceptions."
- Ask for a non-preferred Part D drug at the preferred cost level, this is a request for a "tiering exception."

How do I request an exception?

To ask for an exception, you, your doctor, or your appointed representative should call, fax or submit the request in writing. Please note that a physician's supporting statement and/or medical records must be included with the request. Submit exception requests to:

Phone: **866-789-1522 (TTY/TDD 866-789-1530 for the hearing impaired)**

Senior Dimensions hours of operation are:

From November 15, 2008 through March 1, 2009- 7 days/week from 8am to 8pm

From March 2, 2009 through December 31, 2009- Monday through Friday from 8am to 8pm

Fax: 702-341-7566 or 877-219-1612

Write To:

Senior Dimensions

Exception Request

Pharmacy Services Department

P.O. Box 15645

Las Vegas, NV 89114-5645

(Coverage Determination forms are available on the Senior Dimensions web site at www.seniordimensions.com for you and/or your provider's convenience.)

The plan must respond in writing to the request within 24 hours if it is an expedited exception and in 72 hours if it is a standard exception.

STEP 2

Appeal (of the denial of the exception for a drug)

How do I request an appeal?

If Senior Dimensions does not approve your exception request, we will notify you. You, your provider or your appointed representative can ask for a redetermination. A redetermination is an appeal. It is a request for the plan to reconsider its prior decision. The appeal is reviewed by different professionals than those that made the first decision.

You must ask for an appeal within 60 calendar days of the date of the denial notice you received from us. To submit an appeal:

Phone: 702-242-7301 or 1-800-650-6232 (TTY/TDD 702-242-9214 or 1-800-349-3538 for the hearing impaired)

Senior Dimensions hours of operation are:

From November 15, 2008 through March 1, 2009- 7 days/week from 8am to 8pm

From March 2, 2009 through December 31, 2009- Monday through Friday from 8am to 8pm

Fax: 702-242-7655

Write To:

Senior Dimensions Government Programs

Appeal Request

P.O. Box 15645

Las Vegas, NV 89114-5645

Include your name, address, Senior Dimensions identification number and the reason for the appeal in your letter. Please include any notes or documents that may support your request. We will review your appeal and inform you of our decision.

The plan must respond in writing to the request within 72 hours if it is an expedited appeal and in 7 calendar days if it is a standard appeal.

STEP 3

Independent review of the appeal (if the appeal request is denied)

What is an IRE?

An Independent Review Entity, or IRE, is hired by the Centers for Medicare and Medicaid Services (CMS), to make independent reviews of cases in certain situations. The contractor that performs this review for CMS/Medicare is Maximus Federal Services. This contractor has no affiliation with Senior Dimensions.

How do I request an IRE review?

If Senior Dimensions does not approve the appeal of the denial of the exception request, we will notify you. If you disagree with our decision you, your provider or your appointed representative can ask for review by IRE.

You must ask for a review within 60 calendar days of the date of the denial notice you received from us.

You must submit your request in writing. You will be provided the IRE's address in the drug denial notice.

The IRE must respond to the request within 72 hours if it is an expedited appeal and in 7 calendar days if it is a standard appeal.

ADDITIONAL STEPS

Subsequent appeal rights (if the IRE upholds the denial)

If the IRE does not approve your request, you may appeal to an Administrative Law Judge, and subsequent to that, you can appeal to the Medicare Appeals Council, and, finally, to federal court. You will be provided detailed instructions regarding how to take these appeal steps if/when your drug is denied at those levels. In every case, you must submit your request within 60 calendar days of receiving the reviewer's denial. Each of these reviewers will make their decisions as soon as possible, but do not have prescribed timeframes in which they must make a decision.

Every time you receive a denial, at any step in the process, you will receive guidance regarding what next steps you can take if you do not agree with the decision. If you do not understand the notice or need help with the next step, you can always call Member Services for assistance.

The Appeals Process as it relates to Medical Services

By the term "medical services" Senior Dimensions means services provided under Medicare Part A (inpatient types of services) or Part B (outpatient types of services that can include, but are not limited to, services such as: doctor visits, laboratory services, x-rays, physical therapy and Part B covered drugs). The steps to take in the appeals process for medical services are very similar to the steps you take for Part D prescription drug services. But there are some differences which are explained below.

What is an initial decision?

If you or your doctor want you to have a particular medical service that requires Senior Dimensions approval before you receive it (called "prior authorization"), you or your doctor would submit a request for an initial decision. An initial decision is also sometimes called an organization determination or a coverage determination.

Who can ask for an initial decision?

- You, the member, can request one.
- Your doctor can request one.
- Someone authorized under state law to act on your behalf can ask for one.
- An attorney can ask for one on your behalf
- A friend, relative, advocate or someone else you appoint can ask for one on your behalf. In order for someone to act as your appointed representative, you will need to provide a statement that authorizes them to do so. The statement should include your name, your Medicare number, your member identification number and a statement that appoints the person as your authorized representative to ask for an appeal. Both you and your authorized representative must sign and date the form. (The Evidence of Coverage has example language for an authorization.)

How do I request an initial decision?

To ask for an initial decision, you, your doctor, or your appointed representative should call, fax or submit the request in writing. Submit initial decision requests to:

Phone: 702-242-7301 or 1-800-650-6232 (TTY/TDD 702-242-9214 or 1-800-349-3538 for the hearing impaired)

Senior Dimensions hours of operation are:

From November 15, 2008 through March 1, 2009- 7 days/week from 8am to 8pm

From March 2, 2009 through December 31, 2009- Monday through Friday from 8am to 8pm

Fax: 702-240-6281

Write To:

Senior Dimensions

Initial Decision Request

Government Programs

P.O. Box 15645

Las Vegas, NV 89114-5645

The plan must respond in writing to the request within 72 hours if it is an expedited initial decision and in 14 calendar days if it is a standard request.

STEP 2

Appeal (of the denial of the initial decision)

How do I request an appeal?

If Senior Dimensions does not approve your initial decision request, we will notify you. You, your provider or your appointed representative can ask for a redetermination. A redetermination is an appeal. It is a request for the plan to reconsider its prior decision. The appeal is reviewed by different professionals than those that made the first decision. (If your doctor is not contracted with Senior Dimensions they will need to complete a "Waiver of Payment" statement that says, if the service has been provided, they will not bill you if the coverage decision is not in your favor.)

If you receive an Explanation of Benefits from the Plan indicating that some or all of a claim for medical services was not approved, you can appeal the denial of payment. (Payment appeals cannot be expedited.)

You must ask for an appeal within 60 calendar days of the date of the denial notice you received from us. To submit an appeal:

Phone: 702-242-7301 or 1-800-650-6232 (TTY/TDD 702-242-9214 or 1-800-349-3538 for the hearing impaired).

Senior Dimensions hours of operation are:

From November 15, 2008 through March 1, 2009- 7 days/week from 8am to 8pm

From March 2, 2009 through December 31, 2009- Monday through Friday from 8am to 8pm

Fax: 702-242-7655

Write To:

Senior Dimensions Government Programs

Appeal Request

P.O. Box 15645

Las Vegas, NV 89114-5645

Include your name, address, Senior Dimensions identification number and the reason for the appeal in your letter. Please include any notes or documents that may support your request. We will review your appeal and inform you of our decision.

The plan must respond in writing to the request within 72 hours if it is an expedited appeal (expedited requests are accepted under certain criteria), 30 calendar days if it is a standard appeal (request for coverage), and 60 calendar days for post service (claim payment) appeals.

STEP 3

Independent review of the appeal (if the appeal request is denied)

What is an IRE?

An Independent Review Entity, or IRE, is hired by the Centers for Medicare and Medicaid Services (CMS), to make independent reviews of cases in certain situations. The contractor that performs this

review for CMS/Medicare is Maximus Federal Services. This contractor has no affiliation with Senior Dimensions.

How do I request an IRE review?

If Senior Dimensions does not approve the appeal of the denial of the initial decision request, we will notify you. We will also *automatically forward the upheld denial to the IRE* for review.

The IRE must respond in writing to the request within 72 hours if it is an expedited appeal, 30 calendar days if it is a standard appeal, and 60 calendar days for claim payment appeals.

ADDITIONAL STEPS Subsequent appeal rights (if the IRE upholds the denial)

If the IRE does not approve your request you may appeal to an Administrative Law Judge, and subsequent to that, you can appeal to the Medicare Appeals Council, and, finally, to federal court. You will be provided detailed instructions regarding how to take these appeal steps if/when your medical service is denied at those levels. In every case, you must submit your request within 60 calendar days of receiving the reviewer's denial. Each of these reviewers will make their decisions as soon as possible, but do not have prescribed timeframes in which they must make a decision.

Every time you receive a denial, at any step in the process, you will receive guidance regarding what next steps you can take if you do not agree with the decision. If you do not understand the notice or need help with the next step, you can always call Member Services for assistance.