Appeals and grievances

Do you have a request for coverage or concerns about the care you received?

When you enroll in a HealthPartners UnityPoint Health plan, you expect the best. And that's what we're committed to providing you. If you want us to review your request for coverage, or if you have concerns about the quality or timeliness of your care, we want to know.

If you make a complaint, we'll be fair in how we handle it. You won't be disenrolled in your plan or penalized in any way.

A **coverage decision** is a decision we make about your benefits, coverage or the amount we will pay for your medical services or medicine. (You may also hear this referred to as an **organization determination**.) If you disagree with a coverage decision, you can appeal our decision.

What's the difference between an appeal and a grievance?

- An **appeal** is the process used to ask us to review information and change our decision. You can ask for an appeal if you want us to change a coverage decision we already made.
- A **grievance** is any complaint other than one that involves a coverage decision. Grievances may include concerns about the quality or timeliness of the care you received or premium issues.

How it all comes together:

Our first decision about the medical care you want is called a **coverage decision**. If you disagree with the decision we make, you can **appeal** the decision. This is also called requesting a reconsideration. If you're unhappy with the manner in which you receive health care services, you can file a **grievance**.

Can someone else file an appeal or grievance for me?

Yes. A representative can file an appeal or grievance on your behalf. You can appoint anyone to act as your representative. Your representative could be a relative, friend, advocate, attorney, physician or someone else you trust.

Read more about appointing a representative (PDF). Fill out this form (PDF)* from the Centers for Medicare and Medicaid Services site and send it to us.

How do I make a request?

In the following sections, you'll be able to find instructions for requesting coverage, filing an appeal or filing a grievance:

- How to request a coverage decision
- How to file an appeal
- How to file a grievance
- How to file a complaint with CMS using Medicare's Complaint form*

Curious about the total number of grievances, appeals and exceptions we've received?
Contact Member Services for the numbers.

***This link will take you away from our Medicare website**

How to request a coverage decision

A **coverage decision** is a decision we make about your benefits, coverage or the amount we'll pay for your medical services or medicine. This decision is also called an **organization determination** when it is about a medical decision. It is called a **coverage determination** when it relates to a prescription drug request.

Requesting coverage for medical care

Step 1:

Send us your request. You, your doctor or your representative can do this. You can send your request in whatever way is easiest for you – phone, TTY, fax, or mail.

By phone:	**By fax:**	**By mail:**
• Toll free: **888-360-0544** • **TTY:** Toll free: **800-443-0156**	**952-883-7333**	**HealthPartners** **Member Services** MS 21103R P.O. Box 9463 Minneapolis, MN 55440-9463

Step 2:

We'll review your request and give you an answer. We provide most responses within 14 days of getting the request. If it's in your best interest, we may take more time to review your request. However, we'll let you know if we need more time.

- **If we say yes to your request**, we'll approve the agreed-upon coverage within 14 days of getting your request. If we need more time to make our decision, you'll have coverage by the end of our extended period.
- **If we say no to your request**, we'll send you a written statement that explains our decision. We'll also include your appeal rights.

If you need a fast response and waiting for the standard review time will seriously jeopardize your life or health, we'll respond within 72 hours.

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Requesting coverage for prescription drugs (Part D)

Step 1:
You, your doctor or your representative can request coverage for your medicine. You can make your request by phone, in writing or by fax. You can complete the form, or ask your doctor to fill out the form. Send the completed form to us:

By fax: 888-883-5434

By mail:
HealthPartners
Pharmacy Administration Department
MS 22205A
P.O. Box 1309
Minneapolis, MN 55440-1309

You can also complete the form online:

1. Log on to your myHealthPartners account
2. In the My plan tab, click "Find a form"
3. Scroll down to "Medicare Part D Coverage Determination/Redetermination" to begin

Step 2:
We'll review your request and give you an answer.

If you requested a decision about a drug you haven't received or if you're requesting an exception, we'll give you an answer within 72 hours. If you requested a coverage decision about a payment for a drug you already bought, we'll give an answer within 14 calendar days.

If you need a fast response and waiting for the standard review time will seriously jeopardize your life or health, we'll respond within 24 hours.

Request for Medicare Prescription Drug Coverage Determination (PDF)

Questions?

If you have questions, or if you would like someone to talk you through the process, we're here to help. Contact us:

By phone:

- 8 a.m. to 8 p.m., seven days a week **Toll Free:** 800-492-7259, **TTY:** 711

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HealthPartners
UnityPoint Health

How to file an appeal

An **appeal** is the process of asking us to review information and change our decision. If we said no to your original request, you can ask us to look at it again. Contact our Member Services team for help.
Your appeal will be reviewed by someone who wasn't involved in the coverage decision. This helps make sure your request is reviewed with a fresh perspective.

Five appeal levels
Level 1: You must make your appeal within 60 calendar days of our original decision.
Initiate your standard appeal in writing:
By fax: 952-853-8742

- **By mail:**
  HealthPartners
  Member Rights & Benefits
  MS 21103R
  P.O. Box 9463
  Minneapolis, MN 55440-9463

Please call Member Services if you need help with your appeal:

- Toll free: **888-360-0544**
- **TTY:** Toll free: **800-443-0156**

How long will it take to receive a response to my appeal?

For a medical appeal:
If you haven't received care yet, you'll get a written response to your appeal within 30 days. If you need a fast response and waiting the standard review time will seriously jeopardize your life or health, we will respond within 72 hours.

If you've already received the care you're asking for, you'll get a response within 60 days.

Level 2: If we deny your appeal, your case is automatically sent to an independent review organization. That organization is not part of HealthPartners.

For a prescription drug appeal:
If you haven't received the drugs you're asking for yet, you'll get a written response within 7 days. If you need a fast response and waiting the standard review time will seriously jeopardize your life or health, we will respond within 72 hours.

Request a redetermination for Medicare Prescription Drug Denial(PDF)

Level 2: If we deny your appeal, you can request a reconsideration from an independent review organization. That organization is not part of HealthPartners or HealthPartners UnityPoint Health.

Note: Level 3 – Level 5 apply to both medical and prescription drug appeals
Level 3: If the independent review organization doesn't rule in your favor, you can ask for a review by an Administrative Law Judge (also called an ALJ). This request must happen within 60 days after the decision

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by the independent review organization. In order for an ALJ to review your appeal, the coverage must be greater than a specified amount. If it is not, you can't appeal any further.

Level 4: If you're not satisfied with the ALJ's decision, you can ask to have your case reviewed by the Medicare Appeals Council. You must file your request within 60 calendar days of the date of receipt of the written ALJ hearing decision or dismissal. The Medicare Appeals Council will decide whether to review your case. They don't review every case. The Medicare Appeals Council will give you a written notice letting you know what action they took. They'll also tell you how to request a review by a Federal Court Judge.

Level 5: If the contested amount is above a specified dollar amount and the Medicare Appeals Council denied your request for review you can request a judicial review. To request a judicial review, you need to file a civil action in a US district court. The letter you receive from the Medicare Appeals Council (in level 4) will tell you how to request this review.

If you have questions about your appeal, please contact Member Services.

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How to file a grievance

A **grievance** is a complaint other than one that involves a coverage decision. A grievance may include a concern about the quality or timeliness of the care you received. You have 60 days (from the date of care) to file a grievance. You can call us or send your complaint in writing. We'll make every effort to resolve your complaint. We resolve the majority of oral complaints the same day they are received. If not resolved, complete the form and send it back to us, and we'll review your complaint again. If you would like help, we can help you fill out the form. Then, we would send it to you for your signature.

Filling out the grievance form

Mail your grievance to:

HealthPartners
Member Rights & Benefits
MS 21103R
P.O. Box 9463
Minneapolis, MN 55440-9463

Fax it to us at **952-853-8742**.

Our Member Rights & Benefits team will review your complaint. Within 30 days of receiving your complaint form, we'll send you our decision.

If it is in your best interest, we may take an additional 14 days to notify you of the decision. We will let you know if an extension is necessary.

If you disagree with our decision, you can review your grievance before the Medicare Grievance Review Committee. You can send your concerns in writing, in person or over the phone. If you share your concerns in writing, we'll respond within 30 days. If you share your concerns in person or by phone, we'll answer you within 45 days.

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