

# **AlohaCare Advantage Plus**

## **Organization and Coverage Determinations, Appeals and Grievances Processes and Other Important Information**

### **Part C Appeals**

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

An “organization determination” is our initial decision (approval or denial) about whether we will provide the medical care or service you request, or pay for a service you received. Organization determinations may be “standard” or “expedited.” You, your physician or an appointed representative may request an organization determination, standard or expedited, by contacting AlohaCare Advantage Plus verbally or in writing. Requests may be made by a family member, friend or other party, in your behalf, if the individual demonstrates legal authority to do so. As an example, a medical power of attorney will be accepted or other similar document. Another way for you to delegate this authority is by submitting a signed Appointment of Representative form to us.

#### **What is an appeal?**

If a health care service or claim is denied, or if AlohaCare Advantage Plus fails to provide you with a timely organization determination, you have the right to file an appeal in writing. If the denial could jeopardize your health status, you may request an expedited appeal by phone or fax.

The first level of medical appeal is a "reconsideration" and is conducted by the plan's health care professionals and physicians. AlohaCare must gather information and make a determination within a 30-day time period, or within 72 hours for expedited appeals. Time extensions are possible. Claim payments are decided within 60 days.

If AlohaCare upholds its initial denial, we send the appeal automatically to Medicare's independent review contractor. If the independent reviewer agrees with the health plan's denial, you have the same rights to all federal levels of appeals and judicial review as do beneficiaries in Original Medicare.

### **Part D Appeals**

#### **What is a coverage determination?**

A coverage determination is a decision (approval or denial) made by AlohaCare regarding prescription drug benefits or payments to which you believe you are entitled. This includes decisions on requests for “exceptions” which means asking AlohaCare Advantage Plus to make an exception to our coverage rules, such as:

- You can ask us to cover your drug even if it is not on the formulary
- You can ask us to waive coverage restrictions or limits on your drug
- You can ask us to provide a higher level of coverage for your drug (tiering exception)

Coverage determinations (including exceptions) may be “standard” or “expedited.” You, your appointed representative, or your prescribing physician may request a coverage determination, standard or expedited, by contacting AlohaCare Advantage Plus verbally or in writing. Requests may be made by a family member, friend or other party if the individual demonstrates legal authority, such as a medical power of attorney. Another

way to be delegated this authority is by submitting a signed Appointment of Representative form to us. When the request is for an exception to our coverage rules, your doctor must provide a statement to support the request.

### **What is an appeal?**

If a coverage determination request (including exception requests) or prescription drug claim payment is denied, or if AlohaCare Advantage Plus fails to provide you with a timely coverage determination, you have the right to file an appeal in writing. If the denial could jeopardize your health status, you may request an expedited appeal by phone or fax.

The first level of medical appeal is a "redetermination" and is conducted by the plan's health care professionals and physicians. AlohaCare must gather information and make a determination within a 30-day time period, or within 72 hours for expedited appeals. Time extensions are possible. Claim payments are decided within 60 days.

If AlohaCare upholds its initial denial, you have the right to all federal levels of appeals and judicial review as do beneficiaries in Original Medicare.

### **Grievances**

#### **What is a grievance?**

A grievance is any dispute (other than one that involves an organization or coverage determination or payment) that expresses dissatisfaction with the operations, activities or behavior of AlohaCare Advantage Plus. This could include complaints about our customer service hours, one of our network providers (including a pharmacy provider), having to wait too long for medical or prescription drug services, or quality of care. For quality of care complaints, in addition to using the grievance process, you can contact an independent review organization called a Quality Improvement Organization (QIO).

### **Other Important Information**

#### **Appointing a representative**

An appointed representative is a relative, friend, advocate, doctor or other person authorized to act on your behalf in obtaining an organization or coverage determination, or filing a grievance or appeal.

Those not authorized under state law to act for you will need to sign an Appointment of Representation form (CMS-1696) and mail it to: AlohaCare Advantage Plus Customer Service, 1357 Kapiolani Blvd., Suite 1250, Honolulu, HI 96814. You can obtain this form by calling Customer Service at the numbers below or visiting our web site at [www.AlohaCareHawaii.org](http://www.AlohaCareHawaii.org).

An attorney can also ask for a coverage determination on your behalf. For further information, you can call AlohaCare Advantage Plus Customer Service 8 a.m.–8 p.m., Monday through Friday, at the numbers below.

### **How to request an organization or coverage determination, of file an appeal or grievance**

For more information on how to request an organization or coverage determination (including exceptions), or how to file a grievance or appeal, you can call AlohaCare Advantage Plus Customer Service at the numbers below.

**Phone:** 973-6395 from Oahu

**Phone Toll-Free:** 1-866-973-6395 from the Neighbor Islands or Mainland

**TTY Toll-Free:** 1-877-447-5990

You can also contact AlohaCare Advantage Plus in writing.

**Fax:** 1-808-973-0726

**Mail:** AlohaCare Advantage Plus, Customer Service,  
1357 Kapiolani Blvd., Suite 1250  
Honolulu, HI 96814

**Status of a request: Member or appointed representative inquiries**

For questions regarding the process or status of an organization or coverage determination, appeal, or grievance request, you or your appointed representative should call AlohaCare Advantage Plus Customer Service at the following numbers:

**Phone:** 973-6395 from Oahu

**Phone Toll-Free:** 1-866-973-6395 from the Neighbor Islands or Mainland

**TTY Toll-Free:** 1-877-447-5990

**Organization or coverage determinations, appeals, and grievances data**

AlohaCare will track and maintain records about the receipt and handling of organization or coverage determinations (including exceptions), appeals grievances. We will also disclose organization and coverage determination (including exceptions), appeals and grievances data to you upon request. To obtain this data, you should call AlohaCare Advantage Plus Customer Service at 973-6395 on Oahu, or toll free at 1-866-973-6395 from the Neighbor Islands or the Mainland. TTY users should call toll free 1-877-447-5990. You can call 8 a.m.–8 p.m., Monday through Friday.

AlohaCare has contracted with the Centers for Medicare & Medicaid Services to offer AlohaCare Advantage Plus, a Medicare Advantage Plan.

**AlohaCare's contract with the Centers for Medicare and Medicaid Services (CMS)**

AlohaCare is authorized by law to refuse to renew its contract with CMS, if we choose. CMS may also refuse to renew the contract. Termination or non-renewal of our contract may result in termination of your enrollment in AlohaCare Advantage Plus. In addition, AlohaCare may reduce our service area and no longer offer services in the area where you reside.