

## **Appeals & Grievances**

### **Medicare Advantage Part D Prescription Drug Benefits**

#### **Grievance**

**Liberty Health Advantage Member Services**  
**500 Seventh Avenue, 18<sup>th</sup> Floor**  
**New York, NY 10018**  
**Toll Free Phone: 1-866-542-4269**  
**TTY : 1-800-662-1220**  
**Fax : 1-866-542-6359**

A grievance is any complaint other than one that involves a coverage determination. You would file a grievance if you have any type of problem with Liberty Health Advantage or one of our network pharmacies that does not relate to coverage for a prescription drug. For example, you would file a grievance if you have a problem with things such as waiting times when you fill a prescription, the way your network pharmacist or others behave, being able to reach someone by phone or get the information you need, or the cleanliness or condition of a network pharmacy.

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

- You feel that you are being encouraged to leave (disenroll from) Liberty Health Advantage.
- Problems with the Member Service you receive.
- Problems with how long you have to spend waiting on the phone or in the pharmacy.
- Disrespectful or rude behavior by pharmacists or other staff.
- Cleanliness or condition of pharmacy.
- If 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 difficult to understand.
- Failure to give you a decision within the required timeframe.
- Failure to forward your case to the independent review entity if we do not give you a decision within the required timeframe.
- Failure by the Plan to provide required notices.

- Failure to provide required notices that comply with CMS standards.

In certain cases, you have the right to ask for a “fast grievance,” meaning your grievance will be decided within 24 hours.

**If you have a complaint, we encourage you to first call Member Services at 1-866-542-4269. 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 a Grievance Procedure. To use the formal Grievance Procedure, you may file a grievance with Liberty Health Advantage either orally or in writing. You must file a grievance no later than 60 days after the event or incident that precipitates the grievance. Liberty Health Advantage will notify you of the decision as expeditiously as the case requires, based on your health status, but no later than 30 days after the date we receive the oral or written grievance. Liberty Health Advantage may extend the 30-day timeframe by up to 14 days if you request the extension or if Liberty Health Advantage justifies a need for additional information and documents how the delay is in your best interest. When Liberty Health Advantage extends the deadline, we must immediately notify you in writing of the reasons for the delay. Liberty Health Advantage offers an Expedited Grievance Procedure or “fast-track grievance” and will respond to expedited complaints within 24 hours. Expedited Grievances may be filed for the following complaint types:

- Complaints that involve a Liberty Health Advantage Part D refusal to grant a request for an expedited coverage determination or an expedited redetermination and you have not received the drug in dispute.

Liberty Health Advantage will inform you of the disposition of the grievance in accordance with the following procedures:

- All grievances submitted in writing will be responded to in writing.
- Grievances submitted orally will be responded to either orally or in writing, unless you request a written response.
- All grievances related to quality of care, regardless of how the grievance is filed, will be responded to in writing. The response will include a description of your right to file a written complaint with the Quality Improvement Organization. For any complaint submitted to a Quality Improvement Organization, Liberty Health Advantage will cooperate with the Quality Improvement Organization in resolving the complaint. If you file a quality of care grievance with a QIO you are not required to file the grievance within a specific time period. Therefore, quality of care grievances filed with a QIO may be filed and investigated beyond the 60-day time frame.

Liberty Health Advantage has an established process to track and maintain records on all grievances received both orally and in writing.

## **Coverage Determinations**

**Medicare Part D Appeals**  
**PO Box 407**  
**Boys Town, NE 68010**  
**1-800-546-5677**  
**TTY/TDD 1-866-706-4757**

Coverage determinations may be requested by a Liberty Health Advantage member or their authorized representative. An authorized representative may be a friend, relative or doctor. If a member would like to name an authorized representative, both the member and the authorized representative must sign and date a statement giving the representative permission to act on behalf of the member. Upon request, Liberty Health Advantage will provide a form for appointing a representative.

For requests for standard coverage determinations, Liberty Health Advantage will notify the member (and prescribing physician as appropriate) of the determination as expeditiously as possible but no later than 72 hours after receipt of the request for the coverage determination, or for an exceptions request, the physician's supporting documentation.

For requests for expedited coverage determinations, written notice of the determination will be provided by Liberty Health Advantage to the member (and the prescribing physician as appropriate) of the determination as expeditiously as possible but no later than 3 business days of the date of the request, (or for an exceptions request, no later than 3 business days after receipt of the physician's supporting documentation). If the request is granted, Liberty Health Advantage will provide notice to the member (and prescribing physician as appropriate) within 24 hours of receiving the request (or for an exceptions request in which a non-formulary drug is requested) within 24 hours of receiving the physician's supporting documentation. If the expedited request is denied, Liberty Health Advantage will make the determination within 72 hours of receipt of physician's documentation and give prompt verbal notice of the denial which explains the standard process, informs the member of the right to file an expedited grievance, informs the member of the right to resubmit the request with a physician's supporting documentation, and provides instructions about LHA's grievance process and timeframes. Expedited coverage determinations are not offered for payment requests.

## **Exceptions Process**

**Medicare Part D Appeals**  
**PO Box 407**  
**Boys Town, NE 68010**

**1-800-546-5677**  
**TTY/TDD 1-866-706-4757**

Providers may request an exception in the following instances:

- If LHA's formulary tiering structure has changed mid-year and a member is adversely affected by the change
- To request coverage of a non-formulary drug

In order for an exception request to be evaluated, the provider must provide supporting documentation that the formulary drug would not be as effective (or has been ineffective) and/or would have adverse effects. All drugs approved under the exceptions process must meet the definition of a Part D drug. In addition, a provider's submission of supporting documentation does not necessarily result in an automatic favorable determination.

## **Appeals/Re-determinations**

**Medicare Part D Appeals**  
**PO Box 407**  
**Boys Town, NE 68010**  
**1-800-546-5677**  
**TTY/TDD 1-866-706-4757**

A member who has received an adverse coverage determination may request an appeal (re-determination). For standard appeals, a member or their representative must make a written request within 60 calendar days of the notice of the coverage determination. This may be extended if the member shows good cause (this must be in writing and provide reason for untimely filing). For expedited appeals, a member or their prescribing physician make a verbal or written request for coverage. Liberty Health Advantage will promptly decide whether to expedite the request.

For a standard appeal (re-determination), if the request is granted, Liberty Health Advantage will make the determination and provide notice within 7 calendar days of receiving the request. If the request is granted in whole or in part, Liberty Health Advantage will notify the member in writing within 7 calendar days of receiving the request for appeal. If the request is for payment, payment will be effectuated within 7 calendar days of receiving the request. Note that expedited appeals are not offered for payment requests.

For an expedited appeal (re-determination), if the request is granted, Liberty Health Advantage will make the determination and give notice within 72 hours of receiving the request. If additional medical information is needed, the member and prescribing

physician will be notified immediately. If the request for an expedited appeal is denied, Liberty Health Advantage will make the determination within 7 days of the request and give prompt verbal notice of the denial. The denial will explain the standard process, inform the member of the right to file and expedited grievance, inform the member of the right to resubmit the request with the physician's supporting documentation and provide instructions about LHA's grievance process and timeframes.