

tips for problem solving

- 7 Keep records.** Save all documents, notices and bills you receive. Keep records of telephone calls, including the name, date and phone number of any health plan contacts, and what the person said.
- 8 Submit evidence.** If you appeal, be sure the health plan has full information. You can still give the plan information after you have filed the appeal. Submit medical records, doctors' statements, and any other information you think would be helpful. Seek a second opinion if necessary. Make copies of all documents you send to the health plan.
- 9 Contact resources for help.** Call the state insurance department to register a complaint and to seek help. Look for local health advocacy groups and legal services programs. If you are covered by Medicare, contact the State Health Insurance Counseling and Assistance Program (SHIP) coordinator or volunteer in your area, through your area agency on aging. If you are in a union plan, your union representative may be able to help.
- 10 Be persistent.** Know the health plan's time limit for making decisions. Call to check on the status of your appeal or grievance. Submit any new information. Don't give up. If your health plan does not make a decision in the required time limit, file an appeal at the next level of review.



11 Participate in plan hearings. In many health plans, if your appeal is turned down, you can still ask for further review. Often, you can attend and present your case to a committee that will make a decision. Get a lawyer, other advocate, family member or friend to help you prepare for the hearing and go with you to support your case. If you cannot go in person, ask whether you can participate by telephone.

12 Ask for accommodations. If you have a disability, request accommodations so you can file a complaint or appeal. For example, you may need a text telephone (TTY) if you have a hearing loss, or a large print membership book if you have a vision loss.

13 Know your rights to outside review. If your health plan denies your appeal, you may be entitled to outside review. Some states have independent review organizations. Medicare requires that the plan automatically send your case to an outside agency for review. Medicaid gives you a right to a state fair hearing — in some cases without appealing to the plan first.

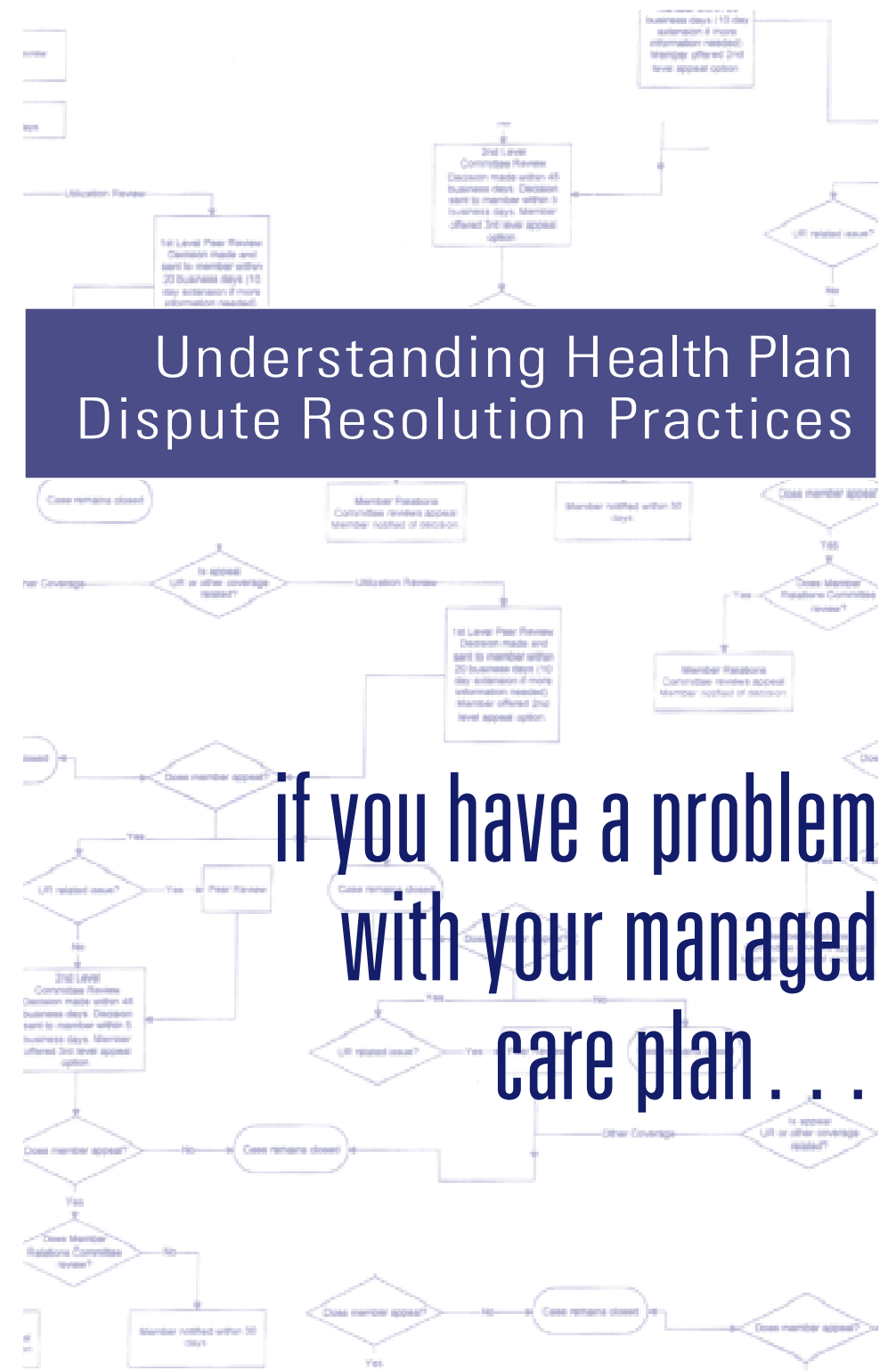


**American Bar Association
Commission on Legal Problems of The Elderly**

740 15th Street, NW, Washington, DC 20005-1022

(202) 662-8690

www.abanet.org/elderly



if you have a problem
with your managed
care plan...

what you need to know

Generally you will get the health care you need from your Health Maintenance Organization (HMO) or other managed health care plan. But sometimes you may have problems. Your plan may refuse to provide or pay for the treatment that you think you need – or may stop treatment sooner than you think is wise. You may think that doctors or hospitals are too far from where you live, that it took too long to get an appointment, or that you did not get good care.

Health plans have procedures to help solve such problems. State and federal laws require plans to have these procedures. But every plan is different. There may be different procedures for Medicare members, Medicaid members, and private or commercial members (who get plan coverage through their employer or pay for it themselves). This brochure gives you an overview of your options, but you should get specific information from your plan. You can also get help from your state insurance or health department, and from agencies in your community. You have certain rights under federal law if you are covered by **Medicare or Medicaid**.

here are the processes your health plan should provide:

Customer Service is the department set up to answer questions and to resolve problems simply and informally. You can contact Customer Service by telephone, usually a toll-free number. Some plans also have a walk-in customer service office. Customer service agents are trained to answer questions on the spot, or to get back to you quickly. If your plan has denied a service or payment, customer service agents may be able to change a plan decision.

If the customer service agent can't solve the problem quickly, you may need to file an appeal or grievance. But don't wait too long. There are time limits in which you must file.

An **appeal** is the process to request that your health plan change a decision about services or payment. (Your plan may have a different name for an appeal, such as grievance or complaint.) For example, you may appeal when:

- Your doctor or plan won't refer you to a specialist or approve a surgical procedure.
- Your plan says you no longer need nursing home care or physical therapy.
- Your plan won't pay for an emergency room visit.
- You get a bill you think you should not have to pay.

Sometimes you will receive a letter or form telling you that care is denied. Other times your doctor may tell you that the plan won't cover a treatment, or you may get no notice about a plan decision. In any case, you may appeal to the plan, and the plan should have a formal process for reconsidering its decision.

The plan should tell you how to submit new information on your case, and may let you attend a meeting about the appeal. The plan should have specific time limits for making a decision, and should notify you in writing what the decision is and why.

An **expedited appeal** is a fast track appeal involving health care you believe you need quickly. If you think your life or health will be harmed by waiting for a health plan decision, in most cases you can ask for a fast appeal, usually in 72 hours or less. Your doctor may be able to help get you a fast appeal.

A **grievance** is a complaint about the quality of service from your doctor or health plan. Grievances don't involve denials of care or payment, and filing a grievance will not get you care or payment. Different health plans have different names for this complaint process. When you file a grievance, the plan may conduct a quality investigation. While you may not find out the results, your grievance could help improve plan services in the future.

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- 1 Read membership materials.** When you join a health plan, and when you have a problem, review the section of your membership handbook or other plan documents on complaints and appeals. Know about the plan's process for resolving problems.
- 2 Call the plan's customer service number.** Look for your health plan's 1-800 number on your membership card and in your membership handbook.
- 3 Talk to your doctor.** Your doctor can be your advocate, and may be able to resolve a problem with a letter or phone call.
- 4 Get notice of the denial.** Ask for a letter explaining why the plan refuses to give you the care or payment you think you should have.
- 5 File an appeal.** If you think your health plan has unfairly denied care or if you receive bills that you think you should not pay, write a letter to the appeals coordinator or fill out an appeals form. Ask for a decision in writing. Keep a copy of your letter.
- 6 Know the time limits.** Look carefully at the time limits for filing an appeal. If you don't file your appeal within the required number of days, you may lose your right to appeal. If you are covered by Medicaid, you need to file an appeal very quickly to make sure that your care continues until the appeal is decided.

