

you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

**Level 4 Appeal** The **Medicare Appeals Council** will review your appeal and give you an answer. The Medicare Appeals Council works for the Federal government.

- **If the answer is yes, the appeals process is over.** What you asked for in the appeal has been approved.
- **If the answer is no, the appeals process *may* or *may not* be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you might be able to continue to the next level of the review process. It depends on your situation. If the Medicare Appeals Council says no to your appeal or denies your request to review the appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

**Level 5 Appeal** A judge at the **Federal District Court** will review your appeal. This is the last stage of the appeals process.

- This is the last step of the administrative appeals process.

## MAKING COMPLAINTS

### SECTION 7 How to make a complaint about quality of care, waiting times, customer service, or other concerns



If your problem is about decisions related to benefits, coverage, or payment, then this section is *not for you*. Instead, you need to use the process for coverage decisions and appeals. Go to Section 4 of this chapter.

**Section 7.1 What kinds of problems are handled by the complaint process?**

This section explains how to use the process for making complaints. The complaint process is used for certain types of problems *only*. This includes problems related to quality of care, waiting times, and the customer service you receive. Here are examples of the kinds of problems handled by the complaint process.

**If you have any of these  
kinds of problems,  
you can make a complaint**

**Quality of your medical care**

- Are you unhappy with the quality of the care you have received?

**Respecting your privacy**

- Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?

**Disrespect, poor customer service, or other negative behaviors**

- Has someone been rude or disrespectful to you?
- Are you unhappy with how our Member Services has dealt with you?
- Do you feel you are being encouraged to leave our plan?

**Waiting times**

- Have you been kept waiting too long by pharmacists? Or by Member Services or other staff at our plan?
- Examples include waiting too long on the phone or when getting a prescription.

**Cleanliness**

- Are you unhappy with the cleanliness or condition of a pharmacy?

**Information you get from our plan**

- Do you believe we have not given you a notice that we are required to give?
- Do you think written information we have given you is hard to understand?

*The next page has more examples of  
possible reasons for making a complaint*

### **Possible complaints (continued)**

#### **These types of complaints are all related to the *timeliness* of our actions related to coverage decisions and appeals**

The process of asking for a coverage decision and making appeals is explained in sections 4-6 of this chapter. If you are asking for a decision or making an appeal, you use that process, not the complaint process.

However, if you have already asked for a coverage decision or made an appeal, and you think that our plan is not responding quickly enough, you can also make a complaint about our slowness. Here are examples:

- If you have asked us to give you a fast response for a coverage decision or appeal, and we have said we will not, you can make a complaint.
- If you believe our plan is not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint.
- When a coverage decision we made is reviewed and our plan is told that we must cover or reimburse you for certain drugs, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint.
- When our plan does not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint.

**Section 7.2      The formal name for “making a complaint” is “filing a grievance”**

**Legal Terms**

- What this section calls a “**complaint**” is also called a “**grievance.**”
- Another term for “**making a complaint**” is “**filing a grievance.**”
- Another way to say “**using the process for complaints**” is “**using the process for filing a grievance.**”

**Section 7.3      Step-by-step: Making a complaint**

**Step 1: Contact us promptly – either by phone or in writing.**

- **Usually, calling Customer Service is the first step.** If there is anything else you need to do, Customer Service will let you know. If you have questions or need more information, you can always call Customer Service at 1-888-786-7509 (TTY only, call 1-800-433-6313) and calls to these numbers are free. Hours are from 7 am to 8 pm Pacific time seven days a week, from November 15 to March 1, 2010. (After March 1, 2010, your call will be handled by our automated phone system Saturdays, Sundays and holidays.)
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you do this, it means that we will use our *formal procedure* for answering grievances. Here’s how it works:
  - You, the member, your authorized representative, your legal representative or any other provider or someone determined to have an appealable interest in the proceeding may file a grievance. You must file a grievance within 60 calendar days from the date of the event or incident that caused you to file the grievance. If you miss the deadline, you may still file a grievance and request an extension of the time frame. Your request must be in writing and include the reason you did not file the grievance on time.
  - You can **mail** your grievance to ODS Health Plan, Inc., **Attn: Grievance Unit-PERS ODS Advantage Rx (PDP)**, P.O. Box 40384, Portland OR, 97240-4038, or **fax** your grievance to 503-243-5105 Attn: Grievance Unit-PERS ODS Advantage Rx (PDP). You may also file your grievance **in person** at ODS Health Plan, Inc., 601 S.W. Second Ave., Suite 700, Portland OR 97204.
  - If you **call** Customer Service at 1-888-786-7509, and TTY at 1-800-433-6313, from 7 am to 8 pm Pacific time, Monday through Friday, they will record the grievance and repeat back to you the grievance as written, to confirm the

accuracy. The grievance will be noted with the time and the date. If you mail, fax or deliver your grievance, the received date and time will be noted on your letter.

- The PERS ODS Advantage Appeal and Grievance Department will then send an acknowledgement letter to you within 7 calendar days of the receipt of your letter or telephone call. You may be asked to provide additional information, which will be requested in the letter, before ODS Health Plan, Inc. can make a decision. We have 30 calendar days starting from the date the grievance was received to make a decision. Sometimes ODS Health Plan, Inc. may need more time to make a decision regarding quality of care. If ODS Health Plan, Inc. needs more time, you will receive a letter requesting the extra time and telling you why ODS Health Plan, Inc. needs more time to make a decision. When ODS Health Plan, Inc. has made a decision you will receive a letter explaining our decision. The letter will also explain what you can do if you don't agree with ODS Health Plan, Inc.'s decision and your right to file a quality of care grievance with Acumentra Health (QIO) in Oregon.
  - The grievance must be submitted within 60 days of the event or incident. We must address your grievance as quickly as your case requires based on your health status, but no later than 30 days after receiving your complaint. We may extend the time frame by up to 14 days if you ask for the extension, or if we justify a need for additional information and the delay is in your best interest. If we deny your grievance in whole or in part, our written decision will explain why we denied it, and will tell you about any dispute resolution options you may have.
  - You may file a "fast" grievance if ODS Health Plan, Inc. turns down your request or extends the time frame for a "fast" coverage determination or a "fast" organization determination and you have not yet received the drug or service, or denies your request or extends the time frame for a "fast" redetermination or a "fast" appeal and you have not yet received the drug or service. You must file the "fast" grievance within 48 hours from the date you received the decision that ODS Health Plan, Inc. would not process your "fast" coverage determination, "fast" organization determination, "fast" redetermination or "fast" appeal. Indicate clearly on your request you would like a **"FAST GRIEVANCE REQUEST"**. You may file a "fast" grievance by **phone, fax, or in person as listed above**. ODS Health Plan, Inc. will respond to your "fast" grievance in writing within 24 hours of receipt of your "fast" grievance.
- **Whether you call or write, you should contact Customer Service right away.** The complaint must be made within 60 days after you had the problem you want to complain about.
  - **If you are making a complaint because we denied your request for a "fast response" to a coverage decision or appeal, we will automatically give you a "fast" complaint.** If you have a "fast" complaint, it means we will give you **an answer within 24 hours**.

<b>Legal Terms</b>	What this section calls a <b>"fast complaint"</b> is also called a <b>"fast grievance."</b>
--------------------	---

**Step 2: We look into your complaint and give you our answer.**

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.
- **Most complaints are answered in 30 days, but we may take up to 44 days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more days (44 days total) to answer your complaint.
- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

<b>Section 7.4</b>	<b>You can also make complaints about quality of care to the Quality Improvement Organization</b>
--------------------	---

You can make your complaint about the quality of care you received to our plan by using the step-by-step process outlined above.

When your complaint is about *quality of care*, you also have two extra options:

- **You can make your complaint to the Quality Improvement Organization.** If you prefer, you can make your complaint about the quality of care you received directly to this organization (*without* making the complaint to our plan). To find the name, address, and phone number of the Quality Improvement Organization in your state, look in Chapter 2, Section 4, of this booklet. If you make a complaint to this organization, we will work together with them to resolve your complaint.
- **Or you can make your complaint to both at the same time.** If you wish, you can make your complaint about quality of care to our plan and also to the Quality Improvement Organization.