COMPLAINTS AND APPEALS

Aetna Health of California HMO has procedures for Members to use if they are dissatisfied with a decision that the HMO has made or with the operation of the HMO. The procedure the Member needs to follow will depend on the type of issue or problem the Member has.

- **Appeal.** An Appeal is a request to the HMO to reconsider an adverse benefit determination. The Appeal procedure for an adverse benefit determination has one level. An Appeal is a type of Complaint. If the Member is appealing a Disputed Health Care Service, the Member has the right to independent medical review in addition to the processes described in the Complaints and Appeals Section.

- **Complaint.** A Complaint is a written or oral expression of dissatisfaction regarding the HMO or the operation of the HMO and/or a Provider including quality of care concerns, and includes a grievance, dispute, and request for reconsideration or Appeal made by an enrollee or the enrollee’s representative.

A. **Complaints.**

If the Member is dissatisfied with the administrative services the Member receives from the HMO, or wants to complain about a Participating Provider, call or write Member Services within 180 calendar days of the incident. The Member will need to include a detailed description of the matter and include copies of any records or documents that the Member thinks are relevant to the matter. The HMO will review the information and provide the Member with a written response within 30 calendar days of the receipt of the Complaint. The response will tell the Member what the Member needs to do to seek an additional review.

B. **Appeals of Adverse Benefit Determinations.**

The Member will receive written notice of an adverse benefit determination (including Coverage Decisions and Disputed Health Care Service decisions) from the HMO. The notice will include the reason for the decision and it will explain what steps must be taken if the Member wishes to Appeal. The notice will also identify the Member’s rights to receive additional information that may be relevant to an Appeal. Requests for an Appeal must be made in writing or by phone within 180 calendar days from the date of the notice.

A Member may also choose to have another person (an authorized representative) make the Appeal on the Member’s behalf by providing the HMO with written consent. However, in case of an urgent care claim or a pre-service claim, a Physician may represent the Member in the Appeal.

The following chart summarizes some information about how the Appeals are handled for different types of claims.

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<tr>
<th>HMO Timeframe for Responding to an Adverse Benefit Determination Appeal</th>
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<tr>
<td><strong>Type of Claim</strong></td>
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<td>Urgent Care Claim. A claim for medical care or treatment where delay could seriously jeopardize the life or health of the Member, the ability of the Member to regain maximum function; or subject the Member to severe pain that cannot be adequately managed without the requested care or treatment.</td>
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<tr>
<td>Review provided by personnel not involved in making the adverse benefit determination.</td>
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<td>Type of Claim</td>
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| **Pre-Service Claim.** A claim for a benefit that requires approval of the benefit in advance of obtaining medical care. | Within 30 calendar days
|                                    | Review provided by personnel not involved in making the adverse benefit determination. |
| **Concurrent Care Claim Extension.** A request to extend or a decision to reduce a previously approved course of treatment. | Treated like an urgent care claim or a pre-service claim depending on the circumstances |
| **Post-Service Claim.** Any claim for a benefit that is not a pre-service claim. | Within 30 calendar days
|                                    | Review provided by personnel not involved in making the adverse benefit determination. |

[C]. **Exhaustion of Process.**

The foregoing procedures and process are mandatory and must be exhausted prior to: the establishing of any litigation or arbitration, or any administrative proceeding regarding either any alleged breach of the **Group Agreement** or **EOC** by HMO, or any matter within the scope of the **Complaints** and **Appeals** process.

[D]. **Record Retention.**

HMO shall retain the records of all **Complaints** and **Appeals** for a period of at least 7 years.

[E]. **Fees and Costs.**

Nothing herein shall be construed to require HMO to pay counsel fees or any other fees or costs incurred by a **Member** in pursuing a **Complaint** or **Appeal**.

[F]. **Review by Governmental Agencies.**

The following is a notice that the HMO is required to provide to Members that tells how to contact the HMO and the Department of Managed Health Care. A **Member** has the right to submit unresolved **Complaints** and **Appeals** to the California Department of Managed Health Care for review after either completing the complaints and appeals process described above or participating in the process for at least 30 days.

“The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your plan at 1-800-445-5299 and use the plan’s grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unsolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are...
Members have the right to an independent review of decisions by the HMO to deny, modify or delay coverage for health care service(s) based on Medical Necessity (Disputed Health Care Services). Members have the right to an independent medical review of decisions by the HMO to deny coverage for health care services which have been determined by the HMO to be excluded as Experimental and Investigative. Section A below describes how Members may request Independent Medical Review for certain Experimental and Investigative treatments related to Life-Threatening or Seriously Debilitating Illnesses. The Department of Managed Health Care will manage the independent medical review process, which is available to Members when they meet the criteria developed by the Department of Managed Health Care. Members are not required to pay any application or processing fees to request or receive independent medical review. Independent medical review is available in addition to HMO Complaint and Appeal procedures and any other remedies available to the Member by law. Members should be aware that the decision not to participate in the independent medical review process may cause the Member to forfeit any statutory right to pursue legal action against the HMO regarding a Disputed Health Care Service.

A. Independent Medical Review Procedure for Experimental and Investigative Treatment

Members have the right to request an independent medical review when coverage is denied as an Experimental or Investigative Procedure and the following conditions are met:

1. The Member has a Life-Threatening or Seriously Debilitating Illness; and

2. The Member’s Physician certifies that the Member has a condition, described in 1. above, for which

   a] standard therapies have not been effective in improving the condition of the Member, or

   b) standard therapies would not be medically appropriate, or

   c) there is no more beneficial standard therapy covered by the plan than the therapy proposed by the Physician, and

3) the Member’s Participating Physician has certified in writing that the proposed procedure, device, drug or other therapy is more likely to be more beneficial to the Member than any available standard therapies, or

4) the Member, or the Member’s Physician (who is a licensed, board-certified or board-eligible Physician, qualified to practice in the area of practice appropriate to treat the Member’s condition) has provided to HMO a written statement which certifies that, based on two documents from Medical and Scientific Evidence the requested, drug, device, procedure or therapy is likely to be more beneficial to the Member than any available standard therapy. The Physician or the Member must identify the documents relied upon as Medical and Scientific Evidence as part of the written certification.

When coverage for a requested service is denied as Experimental and Investigative, the HMO must notify the Member in writing, within five business days of the date of the decision to deny coverage, of the Member’s right to request independent medical review. Included in the notice will be the forms and instructions necessary to apply to the Department of Managed Health Care for independent medical review of the HMO’s decision. The Member will need to demonstrate to the Department of Managed Health Care that they meet criteria (1), (2) and (3), or criteria (1), (2) and (4).
The independent medical review will be a review of the specific medical and scientific reasons cited by the HMO for the denial of coverage. The review will be done at no cost to the Member. The Department of Managed Health Care will evaluate the Member’s request and decide whether the Complaint qualifies for independent medical review. The Department of Managed Health Care will notify the Member and the HMO of its decision. Within three business days of notification from the Department of Managed Health Care that the Member’s request for independent medical review has been approved, the HMO must provide the independent entity performing the review with the medical records relevant to the Member’s condition, a copy of the relevant documents used by the HMO in determining whether the proposed treatment is covered, and any other information submitted to the HMO by the Member or the Member’s Physician in support of the request for coverage.

If the Member’s Provider determines that the effectiveness of either the proposed treatment or any alternative treatment covered under this EOC would be materially reduced if not provided at the earliest possible date, the review shall be done within 7 business days of the date of the request and the HMO shall submit the above referenced documents within 24 hours of the Department of Managed Health Care’s notification to the HMO that the Member’s Complaint qualifies for expedited independent medical review.

B. Independent Medical Review Procedure for Disputed Health Care Services

As part of the Complaint and Appeal process, Members have the right to an independent medical review of their Appeal, when they believe that health care services have been improperly denied, modified, or delayed because they are not Medically Necessary (a Disputed Health Care Service), and the conditions listed below are met.

1. The Member has filed an Appeal regarding a Disputed Health Care Service.

2. The Member has participated in the HMO Complaint and Appeal process for 30 days or the HMO has responded to the Member’s Appeal by upholding the HMO’s denial of the Disputed Health Care Service. In cases involving an expedited complaint or appeal the Member is not required to participate in the HMO Complaint and Appeal process for more than three days.

3. Either, the Member’s Provider (who may be a non-participating Provider, subject to the conditions noted below) must have recommended the health care service as medically necessary; or the Member received Urgent Care or Emergency Services that a Provider deemed medically necessary;

4. Or, the Member has been seen by a Participating Provider for the diagnosis or treatment of the medical condition for which the Member seeks independent review. Upon request by a Member, HMO will expedite access to a Participating Provider. Note that the Member may request independent medical review for the Disputed Health Care Service whether or not the Participating Provider recommends the service.

Members may request an independent medical review for services recommended or performed by a Non-Participating Provider, but the HMO has no liability to pay for the services of a Non-Participating Provider unless the Member has been referred to the Non-Participating Provider according to the requirements set forth in this EOC.

When the HMO receives notice from the Department of Managed Health Care approving the Member’s request for an independent medical review, the HMO will submit the documents required by Health and Safety section 1374.30(n) within 3 business days.

HMO will concurrently provide a copy of these documents to the Member and the Member’s Provider.
In the event of the imminent and serious threat to the health of the Member, the HMO will deliver the required documents to the Independent Medical Review Organization within 24 hours of receipt of notification of the Department of Managed Health Care’s approval of the Member’s request.

C Department of Managed Health Care and Independent Medical Review.

If the Member wishes to pursue independent medical review the Member should complete the form which the Member will have received from the HMO and send it (in the envelope provided with the form and instructions) to the Department of Managed Health Care. The Department will review the Member’s request and determine whether the Member meets the criteria for independent medical review and therefore, is eligible for independent medical review. If the Department of Managed Health Care approves the Member’s request, the Member’s Appeal will be submitted to the Independent Medical Review Organization for review by a medical specialist, or a panel of medical specialists. The designated specialist or panel of specialists will make an independent determination of whether or not the care which is the subject of the Appeal is medically necessary. The Member will receive a copy of the independent medical review assessment of the Appeal. If the outcome of the independent medical review is that the care requested is medically necessary or does not qualify as Experimental and Investigative, the HMO will cover the provision of the health care services which were the subject of the Appeal.

For non urgent cases, the independent medical review organization must provide its determination within 30 days of receiving the Member’s application and supporting documents. For cases which qualify for expedited review, the Independent Medical Review Organization must provide its determination within 3 business days.

Upon notification of an independent medical review decision that the health care services under review are medically necessary, HMO will promptly take the actions necessary to comply with the decision.