APPEALS PROCESS

As a Medicare Advantage and Prescription Drug Plan Organization contracted with the Centers for Medicare & Medicaid Services (CMS) to offer Medicare Advantage and Prescription Drug Plans (PDP), Aetna handles complaints and appeals in accordance with CMS requirements. Beneficiaries enrolled in Medicare Advantage or Prescription Drug Plans have the right to appeal any decision resulting in the Plan's denial of coverage for or pay for what they believe are covered benefits and services. These include but are not limited to:

1. Reimbursement for coverage of emergency or urgently needed services.
2. A denied claim for coverage of health care services that the beneficiary believes should have been reimbursed by the Plan.
3. Coverage for an item or service that has not yet been received but which the beneficiary believes should be covered.
4. Any decision to discharge from the hospital if the beneficiary believes it is too early to do so. (Please be aware: In this case, a notice will be given to the beneficiary with information about how to appeal to a Medicare Quality Improvement Organization (QIO). The beneficiary will remain in the hospital while the QIO immediately reviews the decision, and will not be held liable for charges incurred during this period regardless of the outcome of the review. Should the beneficiary miss the QIO review time period, they can also exercise their Medicare Advantage appeal rights. Please refer to the Evidence of Coverage for the QIO in your area.)
5. Reduction or terminations of coverage for what the beneficiary feels are medically necessary covered services.

Aetna Medicare Part C standard appeals and Medicare Part C expedited appeals process

Aetna has a Medicare standard appeals process and a Medicare expedited appeals process. Aetna must notify a beneficiary in writing of any decision (partial or complete) to deny a claim or service. The notice must state the reasons for the denial and the right to file an appeal. If a decision is made to proceed with the Medicare standard appeals process, the following steps will occur:

- The enrollee, his/her appointed representative, physician or another prescriber can request an appeal (redetermination). The requestor must ask for an appeal by making a written request to Aetna and must file his/her request within 60 days of the date on the written adverse coverage determination notice.
- Standard appeal decisions (favorable or unfavorable) for covered Part B Drug benefits must be provided to the enrollee in writing (and effectuated if favorable) as expeditiously as the enrollee's health condition requires but no later than 7 calendar days of receipt of the appeal request.
- Standard Part C and Part B appeal decisions (favorable or unfavorable) for a request for payment must be provided to the enrollee in writing (and effectuated if favorable) but no later than 60 calendar days of receipt of the appeal request.

- Failure to meet the time frames noted constitutes an adverse determination and Aetna must forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication time frame for the IRE to issue the appeal (redetermination) decision. This applies to both standard and expedited appeal requests.
- The enrollee can request an expedited appeal review for any of the items outlined in the coverage determinations section for which an enrollee received an adverse coverage determination. The enrollee, his/her appointed representative, physician, or another prescriber can request an expedited appeal. Members can expedite a request submitted orally or in writing to Aetna. The physician or other prescriber may provide oral or written support for an enrollee's request for an expedited appeal. **Note:** A request for payment of drugs that the enrollee has already received does not qualify for expedited appeals processing.
- Aetna will automatically process an expedited appeal on specific services or will expedite as requested if upon review it determines that applying the standard time frame for making a determination may seriously jeopardize the life or health of the enrollee or his/her ability to regain maximum function.
- A request made or supported by the enrollee's prescribing physician will expedite the request if the physician indicates that applying the standard time frame for making a determination may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.
- Aetna determines the seriousness of the enrollee's health. If not seriously jeopardized, then the request is not expedited. Aetna notifies the enrollee verbally and in writing and automatically begins processing the request under the standard reconsideration process.
- The member or member's authorized representative has the option to file an expedited grievance with Aetna if he/she disagrees with our decision to process the appeal in the standard reconsideration process. The written notice includes instructions on how to file a grievance. CSR refers to the Oral Grievance General CSR Procedures section for handling instructions.
- If we denied a request to review an appeal following the expedited reconsideration process, an enrollee has the right to resubmit his/her request for an expedited appeal with the prescribing physician's support.
- If additional medical information is required to process the request, Aetna must request it within 24 hours of receiving the expedited appeal request or within 4 days of a standard appeal request. Even if additional medical information is required, Aetna must still issue a decision within the 72-hour time frame for expedited appeals and within 30 days for standard appeals. A 14-day extension is allowed for either process if needed.
- If Aetna fails to make a redetermination within the 72-hour time frame it constitutes an adverse determination. Aetna sends the request to the Independent Review Entity (IRE) designated by CMS within 24 hours of the expiration of the adjudication time frame and the IRE issues a determination.

If Aetna decides to uphold the original adverse decision, either in whole or in part, the member is sent a letter that explains their right to file a level 2 appeal. In that letter, the member is provided with instructions on how to file their appeal by submitting their request to MAXIMUS Federal Services, Inc. for a new and impartial review. MAXIMUS is CMS's independent contractor for appeal reviews involving Medicare Advantage managed care plans.

For cases submitted for review, MAXIMUS will make a reconsidered decision and notify the beneficiary in writing of the reasons for the decision. If MAXIMUS upholds Aetna's decision, their notice will tell the beneficiary of his or her right to a hearing (level 3 appeal) before an Administrative Law Judge.

If MAXIMUS decides in the beneficiary's favor, Aetna must:

- Authorize the disputed service within 72 hours from the date we receive notice from MAXIMUS reversing the decision for an expedited appeal;
- Authorize the disputed service within 72 hours from the date we receive notice from MAXIMUS reversing the decision or render the service(s) within 14-days for a standard appeal, or
- Pay for the disputed service within thirty 30 calendar days from the date we receive notice from MAXIMUS reversing the decision.

If MAXIMUS does not rule fully in the beneficiary's favor, there are further levels of appeal:

- If the amount in dispute meets the established CMS dollar threshold, the beneficiary may request a hearing before an Administrative Law Judge (ALJ) by submitting a written request to Aetna, MAXIMUS or the Office of Medicare Hearings and Appeals (OMHA).
- The request must be sent within sixty 60 calendar days of the date of MAXIMUS' notice that the reconsidered decision was not in the beneficiary's favor. This sixty (60) day notice may be extended for good cause.
- Either the beneficiary or Aetna may request a review of an ALJ decision by the Medicare Appeals Council (MAC), which may either review the decision or decline review.
- If the amount in dispute meets the established CMS dollar threshold, either the beneficiary or Aetna may request that a decision made by the MAC, or the ALJ, if the MAC has declined review, be reviewed by a Federal district court.
- Any initial or reconsidered decision made by Aetna, MAXIMUS, the ALJ, or the MAC can be reopened by any party (a) within twelve months, (b) within four (4) years for just cause, or (c) at any time for clerical correction of an error or in cases of fraud.