



INFORMATION FOR PARTICIPANTS ABOUT THE APPEALS PROCESS

When On Lok PACE decides not to cover or pay for a service you want, you may take action to change our decision. The action you take—whether verbally or in writing—is called an “**appeal**.” You have the right to appeal any decision we have made to deny, reduce, or stop what you believe are covered services or to pay for services that you believe we are required to pay.

You will receive written information of the appeals process when you enroll, at least annually after that, and any time that the Interdisciplinary Team denies a request for services or for payment of services.

Standard and Expedited Appeals Processes: There are two types of appeals processes: standard and expedited. Both of these processes are described below.

If you request a **standard appeal**, your appeal must be filed within one-hundred-and eighty (180) calendar days of when your request for service or payment of service was denied, reduced, or stopped. This is the date that appears on the Notice of Action for Service or Payment Request. (The 180-day limit may be extended for good cause.) We will respond to your appeal as quickly as your health requires, but no later than thirty (30) calendar days after we receive your appeal.

If you believe that your life, health, or ability to get well or stay well is in danger without the service you want, you or any treating physician may ask for an **expedited appeal**. We will automatically decide on your appeal as quickly as your health requires, but no later than seventy-two (72) hours after we receive your request for an expedited appeal. We may extend this time frame up to fourteen (14) calendar days if you ask for the extension or if we justify to the California Department of Health Care Services the need for more information and how the delay benefits you.

Note: If you have Medi-Cal and the reason for your appeal is that On Lok PACE decided to reduce or stop service(s) you were receiving, you may choose to request to continue receiving the disputed service(s) until the appeals process is completed. If our initial decision to reduce or stop services is upheld, you may be financially responsible for the payment of disputed service(s) provided during the appeals process.

The information below describes the appeals process for you or your representative to follow should you or your representative wish to file an appeal:

1. If On Lok PACE denies a service or payment for a service that you or your representative has requested or reduces or stops a service you were already receiving, you may appeal the decision. A written notification will be provided to you and/or your representative that will explain the reason for the denial of your service request or request for payment, and you will also receive verbal notification.

2. You can make your appeal either verbally, in person or by telephone, or in writing with your PACE center's staff. The staff person will make sure that you are provided with written information on the appeals process, and that your appeal is documented appropriately. You will need to provide complete information of your appeal so the appropriate staff person can help to resolve your appeal in a timely and efficient manner. If more information is needed, you will be contacted by our Health Plan Services Department who will assist you in obtaining the missing information.
3. If you wish to make your appeal by telephone, you may contact our Health Plan Services Department at **415-292-8895**, or our toll-free telephone number at **1-888-995-6565**, Monday through Friday from 8:30 a.m. to 5:00 p.m., to request an appeal form and/or to receive assistance in filing an appeal. For the hearing impaired (TTY), please call **711**.
4. If you wish to submit your appeal in writing, please ask a staff person for an appeal form. Please send your written appeal to:

On Lok PACE
Health Plan Services Department
1333 Bush Street
San Francisco, CA 94109

5. You will be sent a written acknowledgement of receipt of your appeal within five (5) business days for a **standard** appeal. For an **expedited** appeal, we will notify you or your representative within one (1) business day by telephone or in person that the request for an expedited appeal has been received.
6. The reconsideration of On Lok PACE's decision will be made by a person(s) not involved in the initial decision-making process in consultation with the Interdisciplinary Team and who does not have a stake in the outcome of your appeal. You and anyone helping with your appeal may present or submit relevant facts and/or evidence for review, in person as well as in writing.
7. Once On Lok PACE completes the review of your appeal, you and your representative will be notified in writing of the decision on your appeal. As necessary and depending on the outcome of the decision, On Lok PACE will inform you and your representative of other appeal rights you may have if the decision is not in your favor. Please refer to the information described below:

The Decision on Your Appeal:

If we decide fully in your favor, we are required to provide or arrange for services as quickly as your health condition requires. **If we decide fully in your favor** on a request for **payment**, we are required to make the requested payment within sixty (60) calendar days after receiving your request for an appeal.

If we do not decide fully in your favor, we will provide you with written notification that will include the specific reason(s) for the denial, why the service would not improve or maintain your overall health, your right to appeal the decision, and a description of your external appeal rights through either the Medicare or Medi-Cal program (**see Additional Appeal Rights**,

below). We also are required to notify the federal Centers for Medicare and Medicaid Services and the California Department of Health Care Services.

Additional Appeal Rights under Medi-Cal and Medicare

If On Lok PACE makes a decision that is not fully in your favor, you have additional appeal rights called external appeal rights. An external appeal involves a new and impartial review of your appeal request through either the Medicare or Medi-Cal program. If you are enrolled in both **Medicare and Medi-Cal**, you may choose which appeals process you wish to use. If you are not sure which program you are enrolled in, ask us. We can explain how the processes differ, and whether one would be more appropriate. The external appeal may only be made to one or the other (Medicare or Medi-Cal), but not both. We also will send your appeal on to the appropriate external program for review if you would like.

The Medicare and Medi-Cal external appeals processes are described below.

Medi-Cal External Appeals Process

The **Medi-Cal program** conducts their next level of appeal through the state hearing process.

If you are enrolled in both **Medicare and Medi-Cal OR Medi-Cal only** and choose to appeal our decision using Medi-Cal's external appeals process, we will send your appeal to the California Department of Social Services. At any time during the appeals process, you may request a state hearing through:

California Department of Social Services
State Hearings Division
P.O. Box 944243, Mail Station 19-37
Sacramento, CA 94244-2430
Telephone: 1-800-952-5253
Fax: 916-229-4410
TTY: 1-800-952-8349

If you choose to request a state hearing, you must ask for it within ninety (90) calendar days from the date of the decision by the third-party reviewer.

If the decision is not in your favor of your appeal, there are further levels of appeal, and we will assist you in pursuing your appeal.

Medicare External Appeals Process

The **Medicare program** contracts with an "Independent Review Entity" (IRE) to provide external review on appeals involving PACE programs. This review entity is completely independent of On Lok PACE.

If you are **enrolled in both Medicare and Medi-Cal OR Medicare only** and choose to appeal our decision using Medicare's external appeals process, we will send your appeal to the IRE to impartially review your appeal. A written request for reconsideration must be filed with the IRE within sixty (60) calendar days from the date of the decision by the impartial reviewer of

the internal appeal. The IRE will contact us with the results of their review. The IRE will either maintain our original decision or change our decision and rule in your favor.

For more information regarding the appeals process or to request forms, please contact our Health Plan Services Department at **415-292-8895**, or our toll-free telephone number at **1-888-995-6565**, Monday through Friday from 8:30 a.m. to 5:00 p.m., to request an appeal form and/or to receive assistance in filing an appeal. For the hearing impaired (TTY), please call **711**.

California Department of Managed Health Care Independent Medical Review (IMR) Process

The California Department of Managed Health Care operates an Independent Medical Review (IMR) process for those health care service plan enrollees who are NOT enrolled in Medicare (one is “enrolled in Medicare” if one is enrolled in both Medicare and Medi-Cal or is enrolled in Medicare only). If you are eligible for an IMR, On Lok PACE will provide you with a separate written description of your rights under this program.

“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 health plan at **415-292-8895** or **1-888-996-6565 (TTY: 711)** and use your health 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 unresolved 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 experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (**1-888-466-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department’s internet website **<http://www.dmhc.ca.gov>** has complaint forms, IMR application forms and instructions online.”