

**MEDICARE APPEALS AND
QUALITY OF CARE GRIEVANCES
AvMed Health Plans
October 1, 2010 through September 30, 2011**

What kind of information is this?

When you ask for it, the government requires AvMed Health Plans to provide you with reports that describe **what happened** to formal complaints that AvMed Health Plans received from their Medicare members. There are two types of formal complaints: **Appeals and Grievances. Medicare members have the right to file an appeal or grievance with their Medicare health plans.** The next few pages contain information about the appeals and quality of care grievances that AvMed Health Plans received from October 1, 2010 through September 30, 2011. Each Medicare health plan will have different numbers of appeals and quality of care grievances, and these numbers can mean different things. For example, a Medicare health plan might have a small number of appeals and quality of care grievances because the plan talks with members about their concerns and agrees to find solutions. Or a Medicare health plan might have a small number of appeals and quality of care grievances because its members are not aware of their right to file an appeal or grievance.

How big is AvMed Health Plans

AvMed Health Plans has about 26,630 Medicare members.
(line 3 on the attached reports)

**Appeals Information beginning on Page 2; Quality of Care
Grievance Information on Page 6**

INFORMATION ON MEDICARE APPEALS

October 1, 2010 through September 30, 2011

What is an appeal?	<p>An appeal is a formal complaint about AvMed Health Plans' decision not to pay for, not to provide, or to stop an item or service that a Medicare member believes s/he needs.</p> <p>If a member cannot get an item or service that the member feels she/he needs, or if the health plan has denied payment of a claim for a service the member has already received, the member can appeal. For example, a member might appeal AvMed Health Plans' decision to stop physical therapy, to deny a visit to a specialist, or to deny payment of a claim.</p>
How many appeals did AvMed Health Plans receive?	<p>AvMed Health Plans received 1337 appeals from its Medicare members. 4.2 of every 1,000 Medicare members appealed AvMed Health Plans' decision not to pay for or provide, or to stop a service that they believed they needed.</p> <p>(lines 2 and 4 on the attached report)</p>
How many appeals did AvMed Health Plans review?	<p>AvMed Health Plans reviewed 1337 appeals during this time period.</p> <p>(line 5 on the attached report)</p>
What happened?	<p>From the 1337 appeals it received from its members:</p> <p>AvMed Health Plans decided to pay for, or provide all services that the member asked for 58% of the time.</p> <p>AvMed Health Plans decided not to pay for, or provide the services that the member asked for 29% of the time.</p> <p>Medicare members withdrew their request before AvMed Health Plans could decide 12% of the time.</p> <p>(lines 5 through 8 on the attached report)</p>

Expedited or "Fast" Appeals Information on Page 3

INFORMATION ON EXPEDITED OR “FAST” APPEALS
October 1, 2010 through September 30, 2011

What is a “fast” or expedited appeal?

A Medicare member can request that AvMed Health Plans review the member's appeal quickly if the member believes that his health could be seriously harmed by waiting for a decision about a service. This is called a request for an **expedited** or **“fast” appeal**. AvMed Health Plans looks at each request and decides whether a “fast” appeal is necessary. By law, AvMed Health Plans must consider an appeal as quickly as a member's health requires. If AvMed Health Plans determines that a “fast” appeal is necessary, it must notify the Medicare member as quickly as the member's health requires but no later than 72 hours.

How many “fast” appeals did AvMed receive?

AvMed Health Plans received 277 requests for “fast” appeal from its Medicare members.

(line 14 on the attached report)

What happened?

When a member requested a “fast” review, AvMed Health Plans agreed that a “fast” review was needed 96% of the time. AvMed Health Plans did not agree to a “fast” review 4% of the time. This number may include requests by members for whom the health plan may not have believed were in danger or serious harm.
(lines 14 through 15 on the attached report)

Independent Review of Appeals on Page 4

INFORMATION ON INDEPENDENT REVIEW

October 1, 2010 through September 30, 2011

What is Independent Review of an appeal?

After a member has sent an appeal to AvMed Health Plans, if the organization continues to decide that it should not pay for or provide all services that the member asked for, AvMed Health Plans must send all of the information about the appeal to an **independent review organization** that contracts with Medicare, not for AvMed Health Plans.

An independent review provides an opportunity for a new, fresh look at the appeal outside of the health plan. The independent review organization goes over all of the information from AvMed Health Plans and can consider any new information.

If the independent review organization does not agree with AvMed Health Plans' decision, AvMed Health Plans must provide or pay for the services that the Medicare member requested.

There may be several reasons why the independent review organization decides to agree with either the Medicare member or AvMed Health Plans. For example, the independent review organization may disagree with AvMed Health Plans because the independent review organization may have had more information about the appeal.

How many appeals did the independent review organization consider?
What happened?

The independent review organization considered 63 appeals from AvMed Health Plans.

(line 9 on the attached report)

The independent review organization agreed with the Medicare member's appeal 11% of the time. This means that in 7 of these cases, AvMed Health Plans ended up paying for or providing all services that these members asked for.

The independent review organization disagreed with the Medicare member's appeal 81% of the time. This means that in 51 of these cases, AvMed Health Plans ended up **not** paying for or providing all services that these members asked for.

Medicare members withdrew their request for independent review 8% of the time.

By December 22, 2011, 0% of appeals were still waiting to be reviewed by the independent review organization.

Note that these percentages may not add to 100% because sometimes the independent review organization dismisses an appeal.

(lines 10 through 13 on the attached report)

Quality of Care Grievance Information on Page 5

INFORMATION ON QUALITY OF CARE GRIEVANCES October 1, 2010 through September 30, 2011

What is a Quality of Care grievance?

A grievance is a complaint that a Medicare member makes about the way AvMed Health Plans provides care (other than complaints about requests for service or payment). A **grievance** about the **quality of care** is one kind of grievance. For example, a member can file a grievance about the quality of care when the member believes that the service the member received was not timely or correct, when the member had problems getting a service because of long waiting times or long travel distances, or when the wrong kind of doctor or hospital provided the service.

How many Quality of Care grievances did AvMed Health Plans receive?

AvMed Health Plans received 58 grievances about the quality of care. 0.18 out of every 1,000 Medicare members filed a grievance about the quality of care they received from AvMed Health Plans doctors and hospitals.

(lines 2 and 4 under “Quality of Care Grievance Data” on the attached report)

Where can I get more information?

If you are a member of AvMed Health Plans, you have the right to file an appeal or grievance.

You can contact AvMed Health Plans at 800-782-8633 to resolve a concern you may have or to get more information on how to file an appeal or grievance. TTY users should call 877-442-8633. Representatives are available to assist you 24 hours a day, 7 days a week. You may also refer to your Evidence of Coverage for a complete explanation of your rights.

You also can contact a group of independent doctors in Florida, called a Quality Improvement Organization, at 800-844-0795 for more information about quality of care grievances or to file a quality of care grievance.

Appeal Data

1. Time Period Covered: 10/01/2010 through 09/30/2011
2. Total Number of Requests for an Appeal Received by AvMed Health Plans: 1337
3. Average Number of Enrollees in AvMed Health Plans: 26,630
4. Total Number of Appeal Requests per 1,000 enrollees: 4.2
5. Of the Appeal Requests Received by AvMed Health Plans between 10/01/2010 through 09/30/2011, AvMed Health Plans completed: 1337
6. 780 or 58% of the appeals were decided fully in favor of the enrollee
7. 392 or 29% of the appeals were not decided fully in favor of the enrollee
8. 165 or 12% were withdrawn by the enrollee
9. For all appeals received by AvMed Health Plans between 10/01/2010 through 09/30/2011, 63 cases were sent to the independent review entity for review
10. 7 or 11% of AvMed Health Plans cases reviewed by the independent review entity were decided fully in favor of the enrollee
11. 51 or 81% of AvMed Health Plans cases reviewed by the independent review entity were not decided fully in favor of the enrollee
12. 5 or 8% were withdrawn by the enrollee
13. 0 or 0% are still awaiting a decision by the independent review agency
14. Between 10/01/2010 through 09/30/2011, AvMed Health Plans received 277 requests for expedited processing for appeals
15. 266 or 96% of the requests for expedited processing of the appeal were granted

Quality of Care Grievance Data

1. Time Period Covered: 10/01/2010 through 09/30/2011
2. Total Number of Quality of Care Grievances Received by AvMed Health Plans: 58
3. Average Number of Enrollees in AvMed Health Plans: 26,630
4. Total Number of Quality of Care Grievances received per 1,000 enrollees: 0.18