MEDICARE APPEALS AND QUALITY OF CARE GRIEVANCES
AvMed
April 1, 2018 through March 31, 2019

What kind of information is this?	When you ask for it, the government requires AvMed to provide you with reports that describe **what happened** to formal complaints that AvMed 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 received from 04/01/2018 through 03/31/2019. 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	AvMed has about 28,046 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
April 1, 2018 through March 31, 2019

What is an appeal?	An appeal is a formal complaint about AvMed's decision not to pay for, not to provide, or to stop an item or service that a Medicare member believes s/he needs. 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's decision to stop physical therapy, to deny a visit to a specialist, or to deny payment of a claim.
How many appeals did AvMed receive?	AvMed received 286 appeals from its Medicare members. 10.2 of every 1,000 Medicare members appealed AvMed's decision not to pay for or provide, or to stop a service that they believed they needed. (lines 2 and 4 on the attached report)
How many appeals did AvMed review?	AvMed reviewed 286 appeals during this time period. (line 5 on the attached report)
What happened?	From the 286 appeals it received from its members: AvMed decided to pay for, or provide all services that the member asked for 56.3% of the time. AvMed decided **not** to pay for, or provide the services that the member asked for 31.5% of the time. Medicare members withdrew their request before AvMed could decide 12.2% of the time. (lines 5 through 8 on the attached report)

Expedited or "Fast" Appeals Information on Page 3

INFORMATION ON EXPEDITED OR "FAST" APPEALS
April 1, 2018 through March 31, 2019

What is a "fast" or expedited appeal?	A Medicare member can request that AvMed 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 looks at each request and decides whether a "fast" appeal is necessary. By law, AvMed must consider an appeal as quickly as a member's health requires. If AvMed 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 received 96 requests for "fast" appeal from its Medicare members. (line 14 on the attached report)
What happened?	When a member requested a "fast" review, AvMed agreed that a "fast" review was needed 100% of the time. AvMed did not agree to a "fast" review 0% 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
April 1, 2018 through March 31, 2019

What is Independent Review of an appeal?

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

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 and can consider any new information.

If the independent review organization does not agree with AvMed's decision, AvMed 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. For example, the independent review organization may disagree with AvMed because the independent review organization may have had more information about the appeal.

How many appeals did the independent review organization consider?

The independent review organization considered 80 appeals from AvMed.
(line 9 on the attached report)

What happened?

The independent review organization agreed with the Medicare member's appeal 10% of the time. This means that in 8 of these cases, AvMed ended up paying for or providing all services that these members asked for.

The independent review organization disagreed with the Medicare member's appeal 90% of the time. This means that in 72 of these cases, AvMed ended up **not** paying for or providing all services that these members asked for.

Medicare members withdrew their request for independent review 0% of the time.

By July 22, 2019, 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
April 1, 2018 through March 31, 2019

What is a Quality of Care grievance?	A grievance is a complaint that a Medicare member makes about the way AvMed 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 receive?	AvMed received 64 grievances about the quality of care. 2.28 out of every 1,000 Medicare members filed a grievance about the quality of care they received from AvMed 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, you have the right to file an appeal or grievance. You can contact AvMed 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: 04/01/2018 through 03/31/2019

2. Total Number of Requests for an Appeal Received by AvMed: 286

3. Average Number of Enrollees in AvMed: 28,046

4. Total Number of Appeal Requests per 1,000 enrollees: 10.20

5. Of the Appeal Requests Received by AvMed between 04/01/2018 through 03/31/2019, AvMed completed: 286

6. 161 or 56.3% of the appeals were decided fully in favor of the enrollee

7. 90 or 31.5% of the appeals were not decided fully in favor of the enrollee

8. 35 or 12.2% were withdrawn by the enrollee

9. For all appeals received by AvMed between 04/01/2018 through 03/31/2019, 80 cases were sent to the independent review entity for review

10. 8 or 10% of AvMed cases reviewed by the independent review entity were decided fully in favor of the enrollee

11. 72 or 90% of AvMed cases reviewed by the independent review entity were not decided fully in favor of the enrollee

12. 0 or 0% were withdrawn by the enrollee

13. 0 or 0% are still awaiting a decision by the independent review agency

14. Between 04/01/2018 through 03/31/2019, AvMed received 96 requests for expedited processing for appeals

15. 96 or 100% of the requests for expedited processing of the appeal were granted

Quality of Care Grievance Data

1. Time Period Covered: 04/01/2018 through 03/31/2019

2. Total Number of Quality of Care Grievances Received by AvMed: 64

3. Average Number of Enrollees in AvMed: 28,046

4. Total Number of Quality of Care Grievances received per 1,000 enrollees: 2.28