# SECTION IX: Provider & Member Appeals

## OVERVIEW

CMS utilizes specific terminology in the appeals process. An initial decision made by the health plan regarding a service for the Part C benefit is identified as an organization determination. Appeals of an organization determination are identified as reconsiderations. An Initial decision made by the health plan regarding a prescription drug benefit, Part D, is identified as a coverage determination. Appeals of a coverage determination are identified as redeterminations.

All coverage and organization determinations may be appealed to ONECare.

Providers dissatisfied with an organization determination (Part C) are encouraged to first contact the Claims Customer Service Department at 602.778.8345 or 877.778.1855, options 5,4.

Providers dissatisfied with a coverage determination (Part D) are encouraged to first contact the Pharmacy Department at 602.778.8345 or 877.778.1855, options 5,5

Medicare does not permit Managed Care plans to offer appeal rights to contracted providers. Contracted providers who are unable to find satisfaction by speaking to the Claims or Pharmacy Department are encouraged to notify their assigned Provider Network Representative of the matter. A contracted provider may file an appeal of a pre-service organization determination on an enrollee's behalf, if the provider has an established relationship with the enrollee. A provider may not charge a fee for representing an enrollee in the appeal process. A contracted provider must seek resolution of a post-service (i.e. claim) issue with their assigned Provider Network Representative.

Contact the Provider Network Operations Department:

Attn: PNO
ONECare Health Plan, Arizona
2355 E. Camelback Rd., Ste 300
Phoenix, AZ 85016

PNO Department: 602.778.8345
or 877.778.1855 (options 5,7)
Fax: 602.778.1875
Email: PNOAZ@care1st.com

Medicare requires Managed Care plans offer appeal rights to non-contracted providers. Non-contracted providers may file an appeal of both a pre-service organization determination for an established patient, and a post-service (i.e. claim) determination when the provider agrees to indemnify the enrollee regardless of the result of the appeal.

Contact the Claim Dispute & Appeals Department:
Attn: ONECare Appeals
ONECare
2355 E. Camelback Rd, Suite 300
Phoenix AZ 85016

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ONECare is required to comply with CMS's Chapter 13 - Medicare Managed Care Beneficiary Grievances, Organization Determinations, and Appeals Manual **and** Chapter 18 - Part D Enrollee Grievances, Coverage Determinations, and Appeals Manual.

Appeals should be filed within sixty (60) calendar days from the date of the initial determination being appealed. All appeals must be in writing and state with specificity the action being appealed and what resolution is being requested. The provider should provide documentation supporting the request. A provider should never wait longer than the required time frames to file an appeal; however, **providers are encouraged to exhaust all other available means of resolving an issue before filing an appeal.**

Decisions will be issued in writing within the time frame allowed for the kind of appeal requested as specified in the CMS Managed Care Manuals Chapters 13 & 18. If the appeal resolution is not in the provider's favor, the rights and obligations to challenge the plan determination will be provided in the resolution letter, as appropriate with the kind of determination being appealed.