Liberty Health Advantage (HMO)

Summary of Grievance and Appeal Process for Medicare Advantage Benefits

Member Grievances/Complaints

A grievance is a complaint for certain types of problems with Liberty Health Advantage HMO (LHA) or one of our plan providers. Grievances include problems related to the quality of care you received during a hospital stay, waiting time for appointments or in waiting rooms, hold time on the phones of your doctor's office, behavior of your doctor or their staff during an appointment, or lack of cleanliness or the condition of the doctor's office.

You or your representative may file a grievance on your behalf. If your representative is filing the grievance, both you as the member and your authorized representative must sign and date a statement giving the representative permission to act on behalf of you, the member.

Filing a Grievance/Making a Complaint

A grievance may be filed either orally by contacting our Member Services department or in writing to:

Liberty Health Advantage HMO
Attention: Grievances and Appeals
1 Huntington Quadrangle, Suite 3N01
Melville, New York 11747
Toll Free Phone: 1-866-542-4269
TTY/TDD: 1-800-662-1220
Fax: 1-866-542-6359

You must file a grievance within sixty (60) calendar days after the event or incident that precipitates the grievance.

Grievances will be resolved as expeditiously as the case requires based on your health status, but no later than thirty (30) days from the date after LHA receives the oral or written grievance. LHA may extend the thirty (30) day timeframe by up to fourteen (14) days, if you request such an extension or LHA justifies a need for additional information and documents how the delay is in your best interests. When LHA extends the deadline, we will notify you immediately in writing of the reasons for the delay.

If you file a grievance because we denied your request for a "fast" response to a coverage decision or appeal, we will automatically give you a "fast" grievance, meaning we will give you an answer within twenty-four (24) hours.

If you are concerned about the quality of care you received, you may also file a grievance with an independent Quality Improvement Organization called a QIO. You may contact the QIO at IPRO-Island Peer Review Organization, 1979 Marcus Avenue, Lake Success, NY 11042-1002.

Member Appeals

An appeal is a type of complaint you make to request a reconsideration of a decision (determination) that was made regarding a service, or the amount of payment LHA paid or will pay for a service or the amount you must pay for a service. You or your representative may file an appeal on your behalf. If your representative is filing the appeal, both you as the member and your authorized representative must sign and date a statement giving the representative permission to act on behalf of you, the member. Your doctor may file a standard appeal, upon notification to you, without being appointed as your representative.

Filing an Appeal

An appeal may be filed either orally by contacting our Member Services department or in writing to:

Liberty Health Advantage HMO
Attention: Grievance and Appeal
1 Huntington Quadrangle, Suite 3N01
Melville, New York 11747
Toll Free Phone: 1-866-542-4269
TTY/TDD: 1-800-662-1220
Fax: 1-866-542-6359

You may file an appeal within sixty (60) calendar days of the date of notice of the initial organization determination.

You may file an appeal for any of the following reasons:

LHA refuses to cover or pay for services you think your health plan should cover.

LHA or one of our contracted medical providers refuses to provide a service you think should be covered.

LHA or one of our contracted medical providers reduces or cuts back on services you have been receiving.

If you think LHA is stopping your coverage too soon.

NOTE: The sixty (60) day limit for filing an appeal may be extended for good cause. Include in your written request for appeal the reason why you could not file within the sixty (60) day timeframe.

Standard Appeal Process

Liberty Health Advantage will consider your appeal and notify you in writing of our decision using the following time frames:

For a decision about payment for care you have already received: After we receive your appeal we have sixty (60) calendar days to reach a decision. If we do not decide within sixty (60) calendar days, you can file an appeal with an independent review organization for review.

For a standard decision about medical care: After we receive your appeal, we have up to thirty (30) calendar days to make a decision, but will make a decision as expeditiously as your health requires. However, if you request it, or if we find that some information is missing which can help you, we can take up to fourteen (14) more calendar days to make our decision. If we do not decide within thirty (30) calendar days of receipt of your appeal (or by the end of the extended time period) you can file an appeal with an independent review organization.

If we decide fully in your favor on a request for medical care, we must provide or authorize the requested care within thirty (30) calendar days of the date we receive your appeal. If we decide fully in your favor on a request for payment, we must make the requested payment within sixty (60) calendar days of the date we receive your appeal.

If we decide to uphold our original adverse determination either in whole or in part, we are required to send your request to an independent review organization. We must send the independent review organization the file within thirty (30) calendar days of a request for services and within sixty (60) calendar days for a request for payment.

The independent review organization will review your request and make a decision about whether we must give you the care or payment you requested. You will be notified in writing of the reasons for their decision. If the independent review organization upholds our decision, their notice will inform you of your right to a hearing before an Administrative Law Judge (ALJ).

If the independent review organization decides in your favor, we must:

Authorize the medical service within seventy-two (72) hours or provide the service, as expeditiously as your health requires, but no later than fourteen (14) calendar days from the date we receive notice from the independent review organization reversing the decision.

Pay for the service within thirty (30) calendar days from the date we receive notice from the independent review organization reversing the decision.

If the independent review organization does not rule fully in your favor, there are further levels of appeal:

If the dollar value of the item or medical services you have appealed meets certain minimum levels, you may request a hearing before an Administrative Law Judge (ALJ). If the dollar value is high enough, the response from the independent review organization will explain who to contact and what to do to request a hearing before an ALJ.

If you or we are unhappy with the decision made by the ALJ, either of us may be able to ask the Medicare Appeals Council to review the case.

If you or we are unhappy with the decision made by the Medicare Appeals Council, the notice you get will tell you whether the rules allow you to take your appeal to a Federal Court.

Fast Appeal/Expedited Appeals

You may file a request for a "fast appeal" for the denial of medical care if you or your doctor believes that waiting for a standard decision could jeopardize your health or your ability to function. Fast appeals only apply to requests for medical care.

For a fast appeal about medical care, after we receive your appeal we have up to seventy-two (72) hours to make a decision, but will make a decision as expeditiously as your health requires. However, if you request it, or if we find that some information is missing, which can help you; we can take up to fourteen (14) more calendar days to make our decision. If we do not decide within thirty (30) calendar days of receipt of your "fast appeal" (or by the end of the extended time period) your appeal will automatically go to an independent review organization.

For more information on the Appeals process, please refer to Chapter 9 of your Evidence of Coverage or call our Member Services department at 1-866-542-4269 (TTY/TDD: 1-800-662-1220), 8AM to 8PM.