

How to Voice a Complaint

If you have a problem or complaint, our Member Service Department can help. The department is available Monday-Friday, 8:30 a.m.-5:00 p.m. at (313) 871-2000 or (800) 826-2862.

Member Services will try to solve your issues right away. Issues that cannot be solved right away are generally resolved within twenty-four (24) hours. If we are unable to solve your issue within twenty-four (24) hours or you do not agree with the solution, we will explain your rights. You have the right to file a grievance. At your request, the Member Services representative will mail you a grievance form. If you need help writing the grievance, we can help you.

When filing a grievance, another person can act as your authorized representative. The person may be a family member, state agency representative, friend, or doctor. If you decide to use an authorized representative, you must send written consent to Total Health Care authorizing the person to act on your behalf.

Grievance

We will contact you by mail within two (2) business days to tell you that the Grievance Coordinator has received your grievance. The Grievance Coordinator will send you a resolution within thirty-five (35) calendar days. If you do not agree with the resolution, you or your authorized may file a grievance/appeal by mail, email, or fax.

You can also call (313) 871-2000 or (800) 826-2862 to file a grievance/appeal. The grievance/appeal information is included with your resolution letter.

How to Voice a Grievance/Appeal

Grievance/Appeal

A grievance/appeal is the procedure used when a grievance is not solved to your liking under the grievance process. Appeals can be due to:

- A denial of payment or
- An adverse determination (means your health care services have been reviewed and denied, reduced or terminated; or an untimely response to a request)

When filing a grievance/appeal:

- You or your authorized representative have 90 days from the date of the adverse determination letter to file a grievance/ appeal
- You must give a written consent for an authorized representative to represent you
- The consent must be sent with the grievance/appeal

At your request, we can help you file a grievance/appeal.

You have the right to:

- Have your benefits continue pending resolution of the grievance/appeal
- Authorize someone to act as your authorized representative in the grievance/appeal process
- Send additional documentation with the grievance/appeal

At your request, we can arrange a meeting with the Appeal Review Committee:

- You can discuss your grievance/appeal with the committee
- You or your authorized representative can attend the meeting in person or by telephone
- A person not involved in the first decision will review your grievance/appeal
- No one who reports to the person involved in the initial decision can review your grievance/appeal
- The person who reviews your grievance/appeal will be of a similar specialty

When the grievance/appeal is received:

- You will get a letter of receipt of the appeal in 2 business days
- Medical grievance/appeals will be done within 30 calendar days after receipt
- Administrative or denial of payment grievance/appeal will be done in 35 days after receipt
- You will be notified in writing of the final decision
- If the decision upholds the denial, an external appeal can be filed
- The final letter tells you of your external appeal rights and how to file the appeal

Expedited Grievance/Appeal

Sometimes, waiting may increase the risk of harm to your health or life. A grievance/appeal is expedited (quickly) when:

- A doctor tells us verbally or in writing that waiting 30 days will cause you to have severe pain or put your life at risk
- The doctor know about your medical condition and can support the claim

When filing an expedited grievance/appeal:

- We will not punish a doctor who asks for or supports an expedited grievance/appeal
- The grievance/appeal must be received within 10 days of the denial
- A denial request for an expedited grievance/appeal is changed to a 30-day grievance/appeal
- After filing an expedited internal grievance/appeal, you can file an appeal to request an expedited external review with the Office of Financial and Insurance Regulation (OFIR)

Decisions about an expedited grievance/appeal

- Will be made no later than 72 hours after receipt, and
- We will notify you of the decision by phone
- We will mail the decision to you within 2 business days

- You can request more time, moving the expedited grievance/appeal to a 30-day grievance/appeal

If the denial is upheld, you will get the reasons for the final denial. If you ask, you can have access to and copies of all papers related to your grievance/appeal. The notification letter will include:

- The benefit provision;
- Guideline;
- Protocol, or
- Other criteria used

External Appeal Rights

- You or your authorized representative have the right to ask for an Administrative Fair Hearing
- After you get your first denial letter, you have 90 days to ask for the hearing
- If you are getting benefits and ask for a hearing, there will be no action taken against you
- You can request a Fair Hearing at any time
- Your request for an Administrative Fair Hearing must be in writing
- An Administrative Fair Hearing request form will be sent with your denial letter
- The form must be signed by you or an authorized representative

IMPORTANT:

- An authorized representative must have your written consent to represent you
- The authorized representative can ask for a hearing for you
- The authorized representative can represent you at the Hearing
- The Hearing may be delayed, dismissed, or denied if you do not give written proof to the Department of Community Health that you approved this person to act on your behalf
- You can use a letter or court order naming this person as guardian or conservator
- Written permission is not needed if the person is your spouse or attorney

The Administrative Fair Hearing starts an appeal directly to State of Michigan Department of Community Health.

If you need help filling out the form, call Total Health Care at (800) 826-2862. If you have any question about the hearing process, call the State Office of Administrative Hearings and Rules at (877) 833-0870.

Mail the form to:

State Office of Administrative Hearing and Rules
Michigan Department of Community Health
Administrative Tribunal
P.O. Box 30763
Lansing, Michigan 48909-7695

EXTERNAL REVIEW OFFICE OF FINANCIAL AND INSURANCE REGULATION (OFIR):

- You or your authorized representative also have the right to ask for an external review from OFIR
- The request can be made after we tell you of the final decision
- Notification of the final decision completes our internal appeal process
- You and your representative must file the OFIR, Health Care-Request for External Review Form to get an external review
- A copy of the form will be sent with the final decision letter
- You can also call OFIR at (877) 999-6442 to have a form sent to you
- The form should be filed no later than 60 days after you get the final decision letter

When appropriate, OFIR gets the advice of an independent review organization. The organization is not part of Total Health Care. The organization reviews the grievance/appeal as stated in the Patients Right to Independent Review Act.

To ask question about the external review process, call our Grievance Coordinator at (313) 871-2000 or (800) 826-2862. To request an independent review write to:

Office of Financial and Insurance Regulation
Health Plan Division
P.O. Box 30220
Lansing, Michigan 48909-7720
Phone number: (877) 999-6442
Fax number: (517) 241-4168