PRESBYTERIAN
Health Plan, Inc.

P.O. Box 27489, Albuquerque, NM 87125-7489
www.phs.org/Medicare

Important Information Regarding Your Hospice Services
Presbyterian Senior Care (HMO)

April 29, 2021

Dear Member,

This is important information regarding your hospice services in your Presbyterian Senior Care (HMO) coverage.

We previously sent you the Evidence of Coverage (EOC) which provides information about your coverage as an enrollee in our plan. This notice is to give you an update to your EOC regarding hospice services. Please keep this information for your reference. Your EOC, and the information contained in this notice, can be found on our website at https://www.phs.org/Medicare.

Quality Improvement Organization
(paid by Medicare to check on the quality of care for people with Medicare)

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state. Each Quality Improvement Organization has a group of doctors and other health care professionals who are paid by the Federal government. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare.

For New Mexico, the Quality Improvement Organization is called KEPRO. KEPRO is an independent organization. It is not connected with our plan.

You should contact KEPRO if you think coverage for your hospice services are ending too soon.

Method	**KEPRO (New Mexico's Quality Improvement Organization) – Contact Information**
CALL	1-844-430-9504, Monday through Friday, 9 a.m. – 5 p.m.
WRITE	5201 W. Kennedy Blvd, Suite 900 Tampa, FL 33609
WEBSITE	www.keproqio.com

How to ask us to keep covering certain medical services if you think your coverage is ending too soon
When you are getting hospice care as a patient in a hospice, you have the right to keep getting your covered services for that type of care for as long as the care is needed and you are eligible

for hospice services. For more information on your covered services, including your share of the cost and any limitations to coverage that may apply, see Chapter 4 of your Evidence of Coverage.

Step 1: Make your Level 1 Appeal: contact the Quality Improvement Organization for your state and ask for a review. You must act quickly.

What is the Quality Improvement Organization?

This organization is a group of doctors and other health care experts who are paid by the Federal government. These experts are not part of our plan. They check on the quality of care received by people with Medicare and review plan decisions about when it's time to stop covering certain kinds of medical care.

How can you contact this organization?

The written notice you received tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in this notice above.)

What should you ask for?

Ask this organization for a "fast-track appeal" (to do an independent review) of whether it is medically appropriate for us to end coverage for your medical services.

Your deadline for contacting this organization.

You must contact the Quality Improvement Organization to start your appeal by noon of the day before the effective date on the Notice of Medicare Non-Coverage.

If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to file an appeal, you must make an appeal directly to us instead. For details about this other way to make your appeal, see Section 1.4 below.

Ask for help if you need it. If you have questions or need help at any time, please call Member Services (phone numbers are printed on the back cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Chapter 2 of your Evidence of Coverage).

If you ask for a Level 1 Appeal on time, the Quality Improvement Organization reviews your appeal and decides whether to change the decision made by our plan.

Here are the steps to appeal our decision:

Step 2: The Quality Improvement Organization conducts an independent review of your case.

What happens during this review?

Health professionals at the Quality Improvement Organization (we will call them "the reviewers" for short) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.

The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.

By the end of the day, the reviewers inform us of your appeal, and you will also get a written notice from us that explains in detail our reasons for ending our coverage for your hospice services.

Legal Terms
This notice of explanation is called the "**Detailed Explanation of Non-Coverage."**

<u>Step 3:</u> Within one full day after they have all the information they need, the reviewers will tell you their decision.

What happens if the reviewers say yes to your appeal?

If the reviewers say *yes* to your appeal, then **we must keep providing your covered services for as long as it is medically necessary.**

You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered services (see Chapter 4 of your Evidence of Coverage).

What happens if the reviewers say no to your appeal?

If the reviewers say *no* to your appeal, then **your coverage will end on the date we have told you.** We will stop paying our share of the costs of this care on the date listed on the notice.

If you decide to keep getting the hospice services *after* this date when your coverage ends, then **you will have to pay the full cost** of this care yourself.

<u>Step 4:</u> If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal.

This first appeal you make is "Level 1" of the appeals process. If reviewers say *no* to your Level 1 Appeal – <u>and</u> you choose to continue getting care after your coverage for the care has ended – then you can make another appeal.

Making another appeal means you are going on to "Level 2" of the appeals process.

Section 1.3	**Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time**

If the Quality Improvement Organization has turned down your appeal <u>and</u> you choose to continue getting care after your coverage for the care has ended, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal. If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your hospice services *after* the date when we said your

coverage would end.

Here are the steps for Level 2 of the appeal process:

Step 1: You contact the Quality Improvement Organization again and ask for another review.

You must ask for this review **within 60 days** after the day when the Quality Improvement Organization said *no* to your Level 1 Appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 days of receipt of your appeal request, reviewers will decide on your appeal and tell you their decision.

What happens if the review organization says yes to your appeal?

We must reimburse you for our share of the costs of hospice care you have received since the date when we said your coverage would end. **We must continue providing coverage** for the hospice care for as long as it is medically necessary.

You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the review organization says no?

It means they agree with the decision we made to your Level 1 Appeal and will not change it.

The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further.

There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers turn down your Level 2 Appeal, you can choose whether to accept that decision or to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by an Administrative Law Judge or attorney adjudicator.

Chapter 7 (Presbyterian Senior Care (HMO) Plan 1 only) or Chapter 9 (Presbyterian Senior Care (HMO) Plans 2 and 3) of the Evidence of Coverage tells more about Levels 3, 4, and 5 of the appeals process.

Section 1.4 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to us instead

As explained above in Section 1.2, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, *the first two levels of appeal are different.*

Step-by-Step: How to make a Level 1 *Alternate* Appeal

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a "fast review" or "expedited reconsideration." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Here are the steps for a Level 1 Alternate Appeal:

Legal Terms
A "fast review" (or "fast appeal") is also called an **"expedited reconsideration."**

<u>Step 1:</u> Contact us and ask for a "fast review."

For details on how to contact us, go to Chapter 2 of your Evidence of Coverage and look for the section called, *How to contact us, including how to reach customer service at the plan.*

Be sure to ask for a "fast review." This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines.

You must make your appeal request within 60 calendar days from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal.

Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.

<u>Step 2:</u> We do a "fast review" of the decision we made about when to end coverage for your services.

During this review, we take another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending the plan's coverage for services you were receiving.

We will use the "fast" deadlines rather than the standard deadlines for giving you the answer to this review.

Step 3: We give you our decision within 72 hours after you ask for a "fast review" ("fast appeal").

If we say yes to your fast appeal, it means we have agreed with you that you need services longer and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)

If we say no to your fast appeal, then your coverage will end on the date we told you and we will not pay any share of the costs after this date.

If you continued to get hospice services *after* the date when we said your coverage would end, then **you will have to pay the full cost** of this care yourself.

Step 4: If we say *no* to your fast appeal, your case will *automatically* go on to the next level of the appeals process.

To make sure we were following all the rules when we said no to your fast appeal, **we are required to send your appeal to the "Independent Review Organization."** When we do this, it means that you are *automatically* going on to Level 2 of the appeals process.

Step-by-Step: Level 2 *Alternate* Appeal Process

During the Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said no to your "fast appeal." This organization decides whether the decision we made should be changed.

Legal Terms
The formal name for the "Independent Review Organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

Step 1: We will automatically forward your case to the Independent Review Organization.

We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Chapter 6 (Presbyterian Senior Care (HMO) Plan 1 only) or Chapter 8 (Presbyterian Senior Care (HMO) Plans 2 and 3) of your Evidence of Coverage tells how to make a complaint.)

<u>Step 2:</u> The Independent Review Organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

The Independent Review Organization is an independent organization that is hired by Medicare. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.

Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.

If this organization says *yes* to your appeal, then we must reimburse you (pay you back) for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.

If this organization says *no* to your appeal, it means they agree with the decision our plan made to your first appeal and will not change it.

The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal.

<u>Step 3:</u> If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.

There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers say no to your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by an Administrative Law Judge or attorney adjudicator.

Chapter 7 (Presbyterian Senior Care (HMO) Plan 1 only) or Chapter 9 (Presbyterian Senior Care (HMO) Plans 2 and 3) of your Evidence of Coverage tells more about Levels 3, 4, and 5 of the appeals process.

You are not required to take any action in response to this document, but we recommend you keep this information for future reference. If you have any questions, please call us at:

(505) 923-6060
1-800-797-5343
(TTY 711)

info@phs.org

October 1 - March 31:
8 a.m. to 8 p.m., seven days a week
(except holidays)

April 1 - September 30:
8 a.m. to 8 p.m., Monday - Friday
(except holidays)

Sincerely,
Your Presbyterian Customer Service Center Team

Presbyterian Senior Care (HMO) is a Medicare Advantage plan with a Medicare contract. Enrollment in Presbyterian Senior Care (HMO) depends on contract renewal.

Presbyterian complies with civil rights laws and does not discriminate on the basis of protected status including but not limited to race, color, national origin, age, disability, or sexual orientation or gender expression. If you need language assistance, services are available at no cost. Call (505) 923-5420, 1-855-592-7737 (TTY: 711).

ATENCIÓN: Si usted prefiere hablar en español, están a su disposición servicios gratuitos de ayuda lingüística. Llame al (505) 923-5420, 1-855-592-7737 (TTY: 711).

Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih (505) 923-5420, 1-855-592-7737 (TTY: 711).

For more information, visit **https://www.phs.org/pages/nondiscrimination.aspx**.