YOUR SATISFACTION
Grievance and Appeals Process

What do I do if I am not satisfied with my health care plan or the care that I get?

We want to be sure that all ABCS participants are satisfied with the care they receive. Please let us know right away if there is a problem or concern about care, or if you feel you are not receiving services that meet your needs. If you have a concern or complaint about services whether they are medical or non-medical in nature, that is considered a ***Grievance.*** This can be done either in writing or verbally. If you have a problem you should do the following:

1. You or your family member should discuss the grievance with a member of ABCS staff or management, or you may send a written grievance to ABCS at the following address:

Alexian Brothers Community Services
425 Cumberland Street
Chattanooga, Tennessee 37404
Attn: Chief Executive Officer
423-698-0802

If the concern is about a denial of service, then you should call or send a letter to the above address giving details about the denial. (see "ABCS' Appeal Process")

2. The ABCS staff member who receives the grievance will give it to a member of ABCS management, who will review it and see that action is taken. We will give you something in writing to show that we know about your grievance. A file is kept to document all complaints/grievances. This information will be documented and reported as part of ABCS' quality improvement plan.

3. ABCS will try to resolve the grievance within thirty (30) working days. We will notify you or your family member explaining the action taken to resolve the matter. If you or your family member is satisfied with the action taken by ABCS the grievance is settled.

4. If you are still not satisfied with the results of the grievance process you may contact the ABCS Chief Executive Officer and ask for further consideration concerning your grievance. The ABCS CEO will respond to your request within thirty (30) working days.

5. There will be no discrimination against you if you file a grievance.

6. All grievances will be treated confidentially.

7. You will continue to receive all of your services from ABCS staff or our contract providers during the grievance process.

ABCS' Appeals Process

It is the goal of ABCS to provide the services that best meet your needs. Sometimes you may ask for ABCS to pay for or provide a service that the ABCS Team does not feel is needed as part of your plan of care. If ABCS denies a service that you feel is necessary then you have the right to have that decision reconsidered by ABCS. This is called an **Internal Appeals Process.**

When a service is denied or not paid for, you will be notified both verbally and in writing by ABCS staff. This notification or letter will tell you why your request was denied and the steps you may take if you wish to appeal the decision. If what you are asking to be reconsidered is urgent because you believe that not having the service would place your life or ability to function in jeopardy, then your appeal will be responded to within 72 hours by ABCS. This fast decision process is called an *Expedited Review*. The 72 hours may be extended if you ask ABCS to extend it or if ABCS explains to TennCare that delaying the decision would be best for you. If a decision is not urgently needed then your request will be responded to within 21 days.

The following is ABCS' **Internal Appeals Process:**

1. To start the Internal Appeals Process you must sign a form that says that you want the decision of ABCS to be reconsidered.

2. For ABCS enrollees who have TennCare-Medicaid coverage, you must also agree to be willing to pay for the service in question should ABCS decide that the service will not covered.

3. If the service was already in place but was stopped or reduced, you will be able to have it continue during the appeal.

4. You will continue to receive all the other services that were in place while your request is being reviewed.

5. You will have the opportunity to present any information you think ABCS may need to evaluate your request.

6. Others not involved in the original decision will review your request. This will allow ABCS and you to feel your request is being fairly considered.

7. If ABCS decides your request was appropriate then the service will be provided as soon as possible.

8. If ABCS decides your request was NOT appropriate, you have the right to have the decision reviewed **Externally** by Medicare if you have Medicare coverage or by the Bureau of TennCare if you have Medicaid coverage. You may choose one of the external appeal processes (Medicare or TennCare) but you can **not** do both.

9. All decisions by ABCS will be given to you in writing.

10. All appeals will be treated confidentially.

External Appeals

If after the Internal Appeals Process you are still not satisfied, then you may make an External Appeal to either Medicare or TennCare-Medicaid. If you have TennCare-Medicaid coverage you can appeal directly to TennCare-Medicaid at anytime. If you have Medicare coverage only, you must complete ABCS' Internal Appeals Process first.

If you have both TennCare-Medicaid and Medicare, ABCS will help you choose which appeals process you should follow. ABCS staff will help you prepare any information that you may need to have the decision reviewed. **However, the External Appeal may only be made to one or the other, (Medicare or TennCare-Medicaid) but not to both.** The Medicare and TennCare-Medicaid external appeal processes are described below.

Medicare External Appeals Process

If you choose to appeal using **Medicare's** external appeals process, ABCS will send your appeal to Medicare's independent review organization for you. The review organization will review your appeal and then contact ABCS with their decision. The review organization will either agree with ABCS' original decision or make ABCS change our decision in your favor.

You can request a fast decision called an expedited external appeal if you believe your health would be in danger by not receiving the service you requested. You can request a standard external appeal for a service that is not urgent or for nonpayment of a service.

TennCare-Medicaid External Appeal Process

If you choose to appeal using TennCare-Medicaid's external appeals process, ABCS will assist you with that process. TennCare conducts external appeals through the state's fair hearing process. You have the right to a fair hearing any time services are denied, reduced or stopped.

For appeals about the denial of a service to **TennCare-Medicaid**, there are three ways to appeal:

1. Mail. You can mail an appeal form or letter about your request to TennCare Solutions at **P.O. Box 000593, Nashville, Tennessee 37202-0593**. To get an appeal form, call TennCare Solutions at 1-800-878-3192.

2. Fax. You can fax the appeal form or a letter to **1-888-345-5575** (toll free).

3. Call. You can call TennCare Solutions at **1-800-878-3192**. Please call during the day if possible, but you can call anytime. If you have an emergency, someone can help you day or night.

TennCare-Medicaid External Appeal Process (continued)

For appeals about involuntary disenrollment to **TennCare-Medicaid**, there are three ways to appeal:

1. Mail. You can mail an appeal form or letter about your involuntary disenrollment to TennCare Long Term Care Division at **P.O. Box 450, Nashville, Tennessee 37202-0450**.

2. Fax. You can fax the appeal form or a letter to **1-615-532-9140**.

3. Call. You can call TennCare Long Term Care Division at **1-877-224-0219.** Please call during the day if possible, but you can call anytime.