File a Grievance

A “grievance” is a formal process for filing a complaint. If you are unhappy with your care or the service you’ve received, please let SCAN know so we can try to resolve it for you first. If we can’t, or you want to file a formal complaint, please complete the form below. You’ll find more information on the grievance process in your Evidence of Coverage, or call SCAN Member Services to file a grievance by phone.

Examples of Grievances:

- The quality of care you receive from your doctors
- Office waiting times
- The way you were treated by your doctor or office staff
- The condition of the medical offices
- The treatment you receive from SCAN representatives
- Involuntary disenrollment issues
- Any other areas, except those related to coverage or payment (see below)

To file a grievance by mail:

SCAN Health Plan
Attention: Grievance and Appeals Department
PO Box 22644
Long Beach, CA 90801-5644

Please note: If your complaint is about a decision related to coverage of care or payment of services, the grievance process does not apply. Instead, you can file an appeal.

We're happy to help today. Call Member Services:

1-800-559-3500 (TTY: 711)

Hours are 8 a.m. to 8 p.m., seven days a week from October 1 to March 31.

From April 1 to September 30, hours are 8 a.m. to 8 p.m. Monday through Friday. Messages received on holidays and outside of our business hours will be returned within one business day.

https://www.scanhealthplan.com/contact-us/file-a-grievance

Grievances, Complaints, and Beneficiary Resources

1. What is a grievance?
A grievance is a formal complaint that you file with your Medicare Advantage Plan or Part D prescription drug plan. If you are dissatisfied with your plan for any reason, you can choose to file a grievance. A grievance is not an appeal, which is a request for your plan to cover a service or item that it has denied.

Times when you may wish to file a grievance include if your plan has poor customer service or you face administrative problems. Some examples of issues that might lead you to file a grievance include:

- Your plan fails to return a coverage determination or appeal decision on time
- Your plan fails to expedite a coverage determination or appeal
- You experience poor quality of care from an in-network provider (see number 3)
- You experience poor customer service from a plan representative
- You are asked to pay an incorrect copayment amount
    - For example, if you are enrolled in the Qualified Medicare Beneficiary (QMB) program and are billed by your provider. Those in the QMB program have limited income and assets and are protected under federal law from being billed by providers for any Medicare cost-sharing.
- You are involuntarily disenrolled from your plan
- There is a change in premiums or cost-sharing
- You receive inadequate written communications from your plan
- You experience potential marketing violations or enrollment fraud (see number 7)

In some cases, you may want to file both an appeal and a grievance.

To file a grievance, send a letter to your plan's Grievance and Appeals department. Visit your plan's website or contact them by phone for the address. You can also file a grievance with your plan over the phone, but it is best to send your complaints in writing. Be sure to send your grievance to your plan within 60 days of the event that led to the grievance.

Your plan must investigate your grievance and get back to you within 30 days. If you made your grievance in writing, the plan must respond to you in writing. If you make your request over the phone, your plan may respond verbally or in writing, unless you specifically request that the response be in writing. If your request is urgent, your plan must get back to you within 24 hours. If you have not heard back from your plan within this time, you can check the status of your grievance by calling your plan or 1-800-MEDICARE. Your State Health Insurance Assistance Program (SHIP) can help you understand when and how to submit grievances.

2. When should I file a complaint about my plan with Medicare?
In some cases, if you have an issue with your Medicare Advantage or Part D prescription drug plan that has not been resolved through the grievance process, or if you want to make Medicare aware of other issues, you can file a complaint with Medicare. Medicare uses a system called the Complaint Tracking Module (CTM) to handle beneficiary concerns with Medicare health and drug plans. You might want to call Medicare to make a formal complaint in order to escalate an issue to Medicare's attention. For example, if a plan fails to respond to appeals according to Medicare's specified deadlines, preventing you from accessing medically necessary

services. To file a complaint, call 1-800-MEDICARE. Your State Health Insurance Assistance Program (SHIP) can also help you submit complaints to Medicare. Most SHIPs have access to the CTM.

The Centers for Medicare & Medicaid Services (CMS), the government agency that oversees the Medicare program, uses information from the complaint tracking module in setting Medicare Advantage and Part D star ratings each year. Star ratings measure how well Medicare Advantage and Part D plans perform. Medicare scores how well plans perform in several categories, including quality of care and customer service. Ratings range from one to five stars, with five being the highest and one being the lowest. Making a complaint to Medicare about a problem with a private plan is a way to make sure that plan is held accountable for mistakes or bad behavior.

3. What should I do if I have a concern about the quality of care I have received?
If you have a concern about the quality of care you receive from a Medicare provider, your concern can be directed to the Beneficiary and Family Centered Care-Quality Improvement Organization (BFCC-QIO) for your area. The BFCC-QIOs are made up of practicing doctors and other health care experts. Their role is to monitor and improve the care given to Medicare enrollees. BFCC-QIOs review complaints about the quality of care provided by:

- Physicians
- Inpatient hospitals
- Hospital outpatient departments
- Hospital emergency rooms
- Skilled nursing facilities (SNFs)
- Home health agencies (HHAs)
- Ambulatory surgery centers

Examples of situations about which you might wish to file a quality-of-care complaint include:

- A medication mistake
- Picking up an infection during a stay in a facility
- Receiving the wrong care or treatment
- Running into barriers to receiving care
- Receiving inadequate discharge instructions

You can file a quality-of-care complaint by calling your BFCC-QIO or submitting a written complaint. When the BFCC-QIO gets your complaint, they should call you to ask clarifying questions about your complaint and to get the contact information for your provider. A physician of matching specialty will review the medical record to determine whether the care provided met the medical standard of care, or whether the standard of care was not met. The review process can take up to a few months, and when the review is over, you and your doctor will be notified by phone and in writing. Livanta and KEPRO are currently the two BFCC-QIOs that serve the entire country. To find out which BFCC-QIO serves your state or territory and how to contact them, visit www.qioprogram.org/locate-your-bfcc-qio or call 1-800-MEDICARE.

Note that the BFCC-QIO is also involved in the appeals of beneficiaries whose care is ending and who disagree with this end of care. This appeals process is separate from quality-of-care concerns.

If you have a Medicare Advantage Plan, you can choose to make complaints about the quality of care you receive through your plan's grievance process, through the BFCC-QIO, or both. If you file a grievance with your plan (see number 1) about the quality of care you receive, the plan should inform you of your right to file a complaint with the BFCC-QIO.

Your state may have other ways for you to file a complaint against a doctor. You may be able to file a complaint through the consumer or patient protection sections within your state's office of the Attorney General. You can also consider filing a complaint through the state licensing boards that regulate providers, for example, the Board of Medicine or the Nursing Board.

4. What should I do if I have a complaint about my durable medical equipment supplier?
Durable medical equipment (DME) suppliers should have processes in place to handle complaints from Medicare beneficiaries. If you have a complaint, contact your DME supplier and tell them what your complaint is. Within five calendar days, your supplier must let you know they received your complaint and that they are investigating it. Within 14 calendar days, the supplier should send you the result of its investigation in writing.

If your supplier does not handle the complaint appropriately or does not respond in time, you can also file a complaint with Medicare via 1-800-MEDICARE.

5. What should I do if I have a complaint about my dialysis or kidney transplant center?
End-Stage Renal Disease (ESRD) Networks can handle many of the complaints that you might have about dialysis or kidney transplant care. An ESRD Network is made up of all the Medicare-approved ESRD facilities in a geographic area. Each ESRD Network has an ESRD Network Organization. The ESRD Network Organizations monitor and improve the quality of care given to people with ESRD.

Complaints you might have about your ESRD facility include:

- The facility staff does not treat you with respect
- Your dialysis shifts conflict with your work hours, and the facility will not let you change your shift
- Your facility is not providing you with medication--or helping you access a medication--that they are responsible for providing to you
- You made complaints to your facility, and they were not addressed

If you have these kinds of concerns, you can raise them to your facility by requesting a patient care meeting or following your facility's formal complaint process. You can also contact your ESRD Network office to start the Network grievance process. The ESRD Network can handle these grievances in several ways:

- **Confidential consultation:** A conversation with someone at the Network about your care.
- **Immediate advocacy:** A way for the ESRD Network to work with you and your facility to resolve an issue. Immediate advocacy must be completed in seven days.
- **Quality of care review:** A larger scale review if you feel that your concerns involve poor care to you and/or other patients. This review might include a review of medical records and can take up to 60 days.
- **Referral:** In some cases, your Network might identify another agency that can help you resolve your issue. In this case, the Network should provide you with the contact information of that organization.

To find contact information for your ESRD Network Organization, call 1-800-MEDICARE or visit www.esrdnetworks.org.

In cases when your complaint is related to claims of abuse, unsafe conditions, or poor quality of care, you may want to file a complaint with your State Survey Agency. Call 1-800-MEDICARE for the contact information of your State Survey Agency.

6. What should I do if I suspect Medicare fraud, errors, or abuse by my provider?
Medicare fraud occurs when someone knowingly deceives Medicare to receive payment when they should not, or to receive higher payment than they should. **Medicare abuse** involves billing Medicare for services that are not covered or are not correctly coded, when the provider has unknowingly and unintentionally misrepresented the facts to obtain payment. Abuse includes any practice that does not provide patients with medically necessary services or meet professionally recognized standards of care. **Medicare errors** are honest mistakes related to the billing of a health care service or product. A pattern of errors by a physician or provider could be considered a red flag or potential fraud or abuse if not corrected. Some common examples of Medicare fraud or abuse are:

- Billing for services or supplies that were not provided
- Providing unsolicited supplies to beneficiaries
- Misrepresenting a diagnosis, a beneficiary's identity, the service provided, or other facts to justify payment
- Prescribing or providing excessive or unnecessary tests and services
- Violating the participating provider agreement with Medicare by refusing to bill Medicare for covered services or items and billing the beneficiary instead
- Offering or receiving a kickback (bribe) in exchange for a beneficiary's Medicare number or for getting a service from them
- Requesting Medicare numbers at an educational presentation or in an unsolicited phone call

You can watch out for fraud by keeping a calendar or calling your local SMP for a My Health Care Tracker, to track all of your medical appointments. Then comparing it with your Medicare statements (Medicare Summary Notices (MSNs) if you have Original Medicare and Explanations of Benefits (EOBs) if you have Medicare Advantage or Part D) and bills from your providers. If something does not seem right—for example, if you see in your MSN that your provider billed Medicare for an office visit on a day when you did not see them, you should first contact your provider. Call your doctor or their billing office and let them know about the problem in case it was a billing error. If your doctor does not fix the error or if you continue to suspect fraud or abuse, you can call:

- Your **Senior Medicare Patrol (SMP):** Your SMP can help you identify Medicare fraud, errors, or abuse, and can help you report potential fraud to the correct authorities. Contact information for your SMP is on the final page of this document.

7. What should I do if a plan is engaging in inappropriate or misleading marketing?
Insurance companies selling private Medicare plans must follow certain rules when promoting their products. These rules are meant to prevent plans from presenting misleading information about a plan's costs or benefits, also known as marketing violations. Medicare plans are allowed to conduct certain activities. For instance, companies can market their plan through direct mail, email (but only to current enrollees, unless they have

opted out), radio, television, and print advertisements. Agents can visit your home if you have given them prior permission and the permission is documented. However, insurance agents cannot:

- Call you if you did not give them permission to do so
- Visit you in your home, nursing home, or other place of residence without your invitation
- Ask for your financial or personal information (like your Social Security number, Medicare number, or bank information) if they call you
- Provide gifts or prizes worth more than $15 to encourage you to enroll (gifts or prizes that are worth more than $15 must be made available to the general public, not just to people with Medicare)
- Disregard federal and state consumer protection laws for telemarketing, the National Do-Not-Call registry or do-not-call-again requests
- Market or sell their plans at educational events
- Sell you life insurance or other non-health insurance products at the same appointment unless you had requested such information be included in your appointment
- Compare their plan to another plan by name in advertising materials
- Use the term "Medicare-endorsed" or suggest that their plan is a preferred Medicare plan
- Imply that they are calling on behalf of Medicare

Additionally, you are being misled if an agent from an insurance company says that you:

- Must sign-up for a Medicare Advantage Plan (also called Part C) to get Medicare Part D drug coverage
- Will pay a higher Part B premium unless you sign up for a certain plan (some plans help pay your Part B premium or charge additional premiums, but your Part B premium will not increase based on your coverage choices)
- Must invite a plan representative to your home to get information about the plan or to enroll
- Can switch back to Original Medicare at any time if you are dissatisfied, without providing information about enrollment periods
- Will receive additional benefits that are actually Medicare-covered services
- Will receive additional benefits, such as dental or vision, that are actually covered by other insurance you have or are eligible for (such as Medicaid)
- Will lose your Medicaid benefits unless you sign up for a certain plan

If a plan representative engages in any of these behaviors, save any documented proof of this interaction. You can contact 1-800-MEDICARE and your local SMP (877-808-2468).

8. How can I get help resolving a dispute with my provider?
Immediate advocacy is an informal alternative dispute resolution process used by the BFCC-QIO to quickly resolve a verbal concern or complaint. This process starts when you, a family member, or an advocate gives the BFCC-QIO permission to address the concern or complaint. The BFCC-QIO will then contact your provider. If your provider agrees to participate in the resolution of the issue, the BFCC-QIO will work with both you and your provider to resolve the issue. If your provider declines to participate, you will be able to file a written complaint. The process is totally voluntary for both the beneficiary and the provider or practitioner. Examples of complaints that may be resolved through Immediate advocacy include (but are not limited to):

- Complaints about a lack of communication by hospital staff
- Concerns about the failure to receive a motorized scooter, wheelchair, or another piece of equipment

- Difficulty scheduling an appointment for a prescription refill

In cases when immediate advocacy is used, the issue should be resolved within no more than two business days. Livanta and KEPRO are currently the two BFCC-QIOs that serve the entire country. To find out which BFCC-QIO serves your state or territory and how to contact them, visit www.qioprogram.org/locate-your-bfcc-qio or call 1-800-MEDICARE.

9. What other resources are available to me as a Medicare beneficiary?
If you experience issues with your Medicare enrollment or with accessing services, or if you need help understanding your benefits, these resources are available:

State Health Insurance Assistance Program (SHIP): If you have questions about Medicare, call your local SHIP for assistance. Contact information for your SHIP is on the last page of this document. SHIPs can help with:

- Appealing denials of coverage by Original Medicare or your Medicare Advantage or Part D prescription drug plan
- Navigating the formal processes for submitting grievances to plans or complaints about plans
- Enrolling in Medicare Part A and B for the first time
- Medicare Advantage and Part D prescription drug plan selection and enrollment
- Eligibility screenings and enrollment in programs for people with limited incomes, like the Medicare Savings Programs, Extra Help, and State Pharmaceutical Assistance Programs
- Questions about what items and services are covered by Medicare
- Questions about coordination of benefits between Medicare and other types of insurance, like supplemental policies, Medicaid, and retiree coverage

Senior Medicare Patrol (SMP): SMPs empower and assist Medicare beneficiaries, their families, and caregivers to prevent, detect, and report health care fraud, errors, and abuse (see numbers 6 and 7). Contact information for your SMP is on the final page of this document.

The Social Security Administration: If you are enrolling in Medicare Part A and/or Part B for the first time, you need to do so through the Social Security Administration (SSA). You can reach the SSA by visiting your local office, calling the SSA helpline at 1-800-772-1213, calling your local office, or going to your Social Security account on the SSA online portal (www.ssa.gov/myaccount/). SSA can also provide information about:

- Extra Help, a federal program that helps people save money on prescription drugs
- Your Medicare Parts A and B enrollment history
- Your Part B late enrollment penalty, if you have one
- Employment programs for people receiving Medicare due to disability

1-800-MEDICARE: Medicare can provide you information about enrollment and coverage rules in general, and about your own Medicare enrollment and claims information. Call Medicare for information about:

- Your current enrollment and enrollment history in Medicare Advantage or Part D prescription drug plans

- Costs and coverage of items and services covered under Original Medicare
- Claims that have been submitted to Medicare for your care, and to get a copy of your Medicare Summary Notice (MSN)
- To make a complaint about a Medicare private plan (see number 2) or a durable medical equipment supplier (see number 5)

You can also log into or create your Medicare account to see your enrollment history, track claims, and get a copy of your MSN.

Your local department of social services (LDSS): If you need help finding out if you qualify for Medicaid or would like to apply, call your LDSS to learn about eligibility and to apply.

Long-term care ombudsman: Each state has an ombudsman to assist residents of that state with finding and affording quality long-term care. They can also sometimes help investigate and mediate disagreements between a resident and their facility. You can find your ombudsman by visiting www.ltcombudsman.org.

Health insurance Marketplace: If you are not eligible for Medicare and need to enroll in health insurance through the Marketplace, you can get more information and enroll by visiting https://www.healthcare.gov/.

SHIP case study
Richie recently had a hospital stay that was covered by his Medicare Advantage Plan. He felt that there were some problems with the quality of care that he received—he didn't think that the hospital staff checked on him often enough, and he thinks that this might have gotten in the way of his recovery. He already reported the hospital to his state's department of health, but wants to know if there are other steps he can take to hold the hospital accountable.

What should Richie do?

- Richie should call his State Health Insurance Assistance Program (SHIP) for advice about this situation.
  - If Richie does not know how to reach his SHIP, he can call 877-839-2675 or visit www.shiphelp.org.
- The SHIP counselor can tell Richie that for a complaint related to quality of care received from a Medicare Advantage provider, he can report his concern to his plan and to the BFCC-QIO.
  - If Richie wishes to file a grievance with his plan, the SHIP counselor can help Richie write a brief complaint and can direct him to call his plan to find out where to send the grievance. The plan should respond to the grievance within 30 days.
    - The SHIP counselor can also tell Richie that if his plan does not respond to this grievance in a timely fashion, he can call 1-800-MEDICARE to file a complaint.
  - If Richie wishes to file a quality-of-care complaint with the BFCC-QIO, the SHIP counselor can help Richie determine whether his BFCC-QIO is Livanta or KEPRO and can help him find information about where to call or send a written complaint to.
    - The QIO will contact Richie for more information about his complaint. He should be prepared to provide information about why he is complaining and about how the QIO can contact the hospital.

SMP case study
Josephina got a Medicare Summary Notice (MSN) showing that a doctor submitted several claims to Medicare for services she received the previous month. She is confused because she only saw the provider once, but her MSN lists three different dates of service. She is concerned that this is incorrect information or an error, and that it might affect her plan covering services that she needs in the future.

What should Josephina do?

- Josephina can call her Senior Medicare Patrol (SMP) for advice about what to do next.
  - If Esther doesn't know how to reach her SMP, she can call 877-808-2468 or visit www.smpresource.org.
- The SMP will tell Josephina that she should contact her provider to let them know about the errors that she found on her MSN and to ask them to clarify and/or correct it.
- If Josephina's provider is unresponsive or unwilling to correct the errors, Josephina may want to report this as potential Medicare fraud or abuse. The SMP can help Esther report it to the proper sources.
- The SMP can remind Josephina to continue keeping track of her health care appointments and checking her Medicare statements and medical bills against a calendar or her My Health Care Tracker of her appointments. If Josephina suspects fraud, errors, or abuse on the part of her providers, she can call the SMP again.

Local SHIP Contact Information	Local SMP Contact Information
SHIP toll-free: **SHIP email:** **SHIP website:** **To find a SHIP in another state:** Call 877-839-2675 or visit www.shiphelp.org.	**SMP toll-free:** **SMP email:** **SMP website:** **To find an SMP in another state:** Call 877-808-2468 or visit www.smpresource.org.