How to Voice a Complaint

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

Customer Service 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 Customer Service 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 15 calendar days for a pre-service grievance and 30 calendar days for a post-service grievance. If you do not agree with the resolution, you or your authorized representative 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.

The member grievance process includes two steps. The first step is to file the grievance and the second step is to appeal the resolution.

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:

- An administrative grievance/appeal may be due to a denial of payment to the provider. An administrative grievance/appeal may be due to a lack of authorization or the provider being out of THC's network.
- 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 180 days from the date of the adverse determination letter to file a grievance/appeal
- You must give 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
- A pre-service grievance/appeal takes at most 15 days and a pre-service appeal takes at most 15 days. The whole process will be completed within 30 days of receipt. Similarly, a post-service grievance takes at most 30 days and a post-service appeal also takes at most 30 days. The whole process will be completed within 60 days. The time frame may be extended up to ten (ten) business days if you request an extension or if the Plan can show that there is need for additional information and can demonstrate that the delay is in your best interest. If the plan utilizes the extension, you will receive written notice of the reason for the delay.
- 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 knows 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 denied 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 Department of Insurance and Financial Services (DIFS)

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

EXTERNAL REVIEW DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES (DIFS):

- You or your authorized representative also have the right to ask for an external review from DIFS
- The request can be made after we tell you of the final decision
- Notification of the final decision completes our internal appeal process
- You or your representative must file the DIFS, 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 DIFS 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, DIFS 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 questions about the external review process, call our Grievance Coordinator at (313) 871-2000 or (800) 826-2862. To request an independent review write to:

Department of Insurance and Financial Services
Office of General Counsel – Appeals Section
P.O. Box 30220
Lansing, Michigan 48909-7720
Phone number: (877) 999-6442
Fax number: (517) 284-8838