Finding Your Way Through the HMO Grievance and Appeals Process:

An NRH Field Guide for People with Disabilities

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Finding Your Way through the HMO Grievance and Appeals Process:

AN NRH FIELD GUIDE FOR PEOPLE WITH DISABILITIES

June 2002

PREPARED BY

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MANAGED HEALTH CARE FOR INDIVIDUALS WITH DISABILITIES
GRANT #H133B70003-97A

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Acknowledgements

Development and distribution of Finding Your Way is supported by grant #H133B70003-97A from the National Institute on Disability and Rehabilitation Research, U.S. Department of Education.

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Designed by Flannery Studios, 301-590-0994.

Finding Your Way Through the HMO Grievance and Appeals Process: An NRH Field Guide for People with Disabilities

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We tried to make sure that this information is correct. If you follow the steps in this guide, you will have a good chance of resolving a complaint. This document does not replace legal advice. Medstar Health and its subsidiaries and affiliates are not responsible for any outcome that occurs if you follow the steps in this document.
If you are a person with a disability, and if you are enrolled in an HMO, you have the right to get the health care you need. Sometimes, you must fight for your rights. Sometimes, your doctor or clinic will not know that you have these rights. This pamphlet tells you how you can try to get your doctor or HMO to change its answer of “no” to an answer of “yes”.

Your rights and the steps you must follow to appeal decisions depend on who pays for your health insurance. This table shows where you can go for information:

<table>
<thead>
<tr>
<th>My insurance is paid by...</th>
<th>The rules are written out in...</th>
</tr>
</thead>
<tbody>
<tr>
<td>my employer</td>
<td>the Evidence of Coverage</td>
</tr>
<tr>
<td>Medicaid</td>
<td>state regulations and laws</td>
</tr>
<tr>
<td>Medicare</td>
<td>Code of Federal Regulations (CFR) and Evidence of Coverage</td>
</tr>
</tbody>
</table>

If your employer signed you up for your insurance, read your Evidence of Coverage for instructions. You can get a copy from your HMO member services at the phone number on the back of your enrollment card, or from your employee health benefits office.

If you have Medicaid, the state guarantees your rights and has rules that describe the steps for filing a complaint and grievance. You need to contact your state Medicaid office for instructions. (See “more resources” at the end of this booklet).

If you are enrolled in a Medicare HMO, you have many rights guaranteed by federal law. This field guide describes your rights as a Medicare beneficiary. If you are both a Medicare and a Medicaid beneficiary and both Medicare and Medicaid cover the specific service in question, the rules that are more favorable to you (such as shorter time frames) are the ones that apply.

We want you to know that the federal agency in charge of Medicare, the Centers for Medicare & Medicaid Services (CMS), is working hard to have all HMOs make decisions about the care for people with disabilities in the same way. The United States Congress is very interested in this topic and in how well CMS is monitoring HMOs’ compliance with the grievance and appeals process. If you go through this process and are dissatisfied, you may want to write your Senator and Representative and let them know what happened. If you don’t know who your Senator or Representative is, you can find out by calling your library.
Questions and Answers

**What are my rights under Medicare?**

As a person with a disability, you may be especially interested in these rights:

**Emergency room care.** If you think your health is in serious danger because you have severe pain, a bad injury, sudden illness, or an illness quickly getting much worse, you can get emergency care anywhere in the United States and the HMO must pay for it. You do not need to have the HMO approve your care before you go.

**Specialty care.** If you have a complex or serious medical condition, you have the right to have enough visits to a specialist to deal with your needs. Since Medicare does not define “complex” or “serious”, you must find out from your HMO if they define “complex” or “serious”. If they do not define it, you may decide to file a grievance to make them define it.

**Women’s care.** You have a right to choose a women’s health specialist from your plan’s list of doctors to meet your women’s health care needs. You have many other rights under Medicare, which you can read about on the Medicare web site at www.medicare.gov. Or, call 1-800-MEDICARE (1-800-633-4227; TTY/TDD: 1-877-486-2048) and ask for Publication No. HCFA-10112, May 2001.

**What are my rights under Medicaid?**

Your rights under Medicaid depend on the state in which you live.

But the rights are probably very much like the ones for Medicare.

A good place to look for help is the Independent Living Research Utilization / University of Houston Law Center, 1-800-949-4232.

This organization has a list of each state’s regulations that describe the requirements for HMO grievance and appeals processes. If you are a Medicaid or private sector HMO enrollee, you may want to call them.
What are my rights under my employer?

Your rights and the procedures will be in the Evidence of Coverage. 40 states have laws about your rights and procedures. You can read a state-by-state chart of these rules in a publication from Consumers Union. It is on their website at www.consumersunion.org, “A Consumer Guide to Handling Disputes with your Private or Employer Health Plan.”

Whom should I contact if I want to file an appeal?

Everyone in Medicare gets instructions on how to appeal a medical decision at the following times:

- When you first enroll in the HMO.
- Every time the HMO denies you a service (such as a referral).
- Every time the HMO denies payment for a service (such as coverage for a specific medication).
- When you are admitted to a short-term or rehabilitation hospital.
- When you are discharged from a short-term or rehabilitation hospital.

- Once a year in the fall, in the “Medicare & You Handbook” which the federal government mails to your house. You can also get a copy anytime on the internet, at www.medicare.gov/publications.
- Once a year, by your HMO. The HMO may send you a special letter, or place an article or insert in its newsletter or other health plan publication directed to Medicare enrollees.
- Anytime, when you call the government at: 1-800-MEDICARE (1-800-633-4227) TTY/TDD: 1-877-486-2048
- In the Evidence of Coverage.
Each HMO publishes a report on:

- the numbers of grievances and appeals that were submitted by Medicare members
- the numbers of grievances and appeals per 1000 Medicare members
- the percentage that were denied by the HMO
- the percentage that were further appealed to an independent reviewer, and
- the percentage of those that were approved or denied.

You can get this information from any HMO. New reports are available every 6 months. If you see that a lot of grievances and appeals have been filed with your HMO, you may want to think about changing your health plan.

Where can I find information about my HMO’s record of grievances and appeals?

You may file an appeal yourself or someone (such as a caregiver, friend, a court appointed guardian, an agent or doctor) may file it for you.

If you want someone to represent you, you need to provide your name, Medicare number, and a statement which appoints an individual as your representative. For example, you can use the words in this box.

- You must sign and date the statement.
- Your representative must also sign and date this statement unless he/she is an attorney.
- You must include this signed statement with your appeal.

Who can request an appeal?

Your letter might look like this: (Replace the information in the brackets with your own information)

Date
I [your name] appoint [name of representative] to act as my representative in requesting an appeal from [name of your HMO] and/or the Center for Medicare and Medicaid Services regarding [name of your HMO]'s (denial of services) or (denial of payment for services).

Your name
Date
Your Medicare number

You can also complete CMS form #1696, at www.medicare.gov/basics/forms, or call your local Social Security Administration office.
My physician said the HMO wouldn’t allow him or her to give me a referral for service I think I need.

You can appeal to the HMO to get a referral. Your physician or your therapist may not know that you can do this.

Call your HMO’s member services department and follow up with a letter. The appeals process starts when you make the telephone call and ask for a “fast decision”.

“Hello. I have a complex medical condition that needs to be seen by Dr. [insert the name and address of the doctor you want to see]. If that doctor does not see me, my health will get worse. My doctor, [insert your doctor's name and address], will not give me a referral. I am appealing that denial of care. I request a fast decision from [insert name of your health plan]. I believe that my health could be seriously harmed by waiting for a standard decision.”
You can appeal to the HMO to receive more services. Your physician or your therapist may not know that you can do this. Call your HMO’s member services department right away and follow up with a letter. The time frame starts when you make the telephone call and ask for a “fast decision”.

"Hello. I have a complex medical condition that needs therapy [insert how often]. If I don’t get this therapy, I will not regain my maximum function. My therapist, [insert name and address], says I have run out of visits. I am appealing that denial of care. I request a fast decision from [insert name of your health plan]. I believe that my health could be seriously harmed by waiting for a standard decision."

Date
Member Services
Your HMO
Address
City, State, Zip
Dear [HMO],
I have a complex medical condition that needs therapy [insert how often]. If I don’t get this therapy, I will not regain my maximum function. My therapist, [insert name and address], says I have run out of visits. I am appealing that denial of care. I request a fast decision from [insert name of your health plan]. I believe that my health could be seriously harmed by waiting for a standard decision.

Sincerely,
Your name
Your HMO ID number
There are different times when you may think about filing a grievance or appeal:

• Appealing your discharge from a hospital or skilled nursing facility (NODMAR = Notice of Discharge and Medicare Appeal Rights).
• When you are worried about things not related to a specific service or payment, such as quality of care (grievance).
• When you are worried that you need a service, or that the HMO wants you to pay for a service you already got (appeal).

**Organization determination** = any decision made by the HMO about:
- payment for emergency services
- payment for health services furnished by a non-HMO provider that you believe are covered by Medicare
- the HMO's refusal to provide services that you believe should be furnished by the HMO
- stopping a service

**Grievance** = any complaint or dispute NOT involving an “organization determination”, such as lack of a building-accessible doctor.

**Appeal** = any complaint or dispute that DOES involve an “organization determination”, such as stopping therapy or not providing a wheelchair.

There are different times when you may think about filing a grievance or appeal:

- Appealing your discharge from a hospital or skilled nursing facility (NODMAR = Notice of Discharge and Medicare Appeal Rights).
- When you are worried about things not related to a specific service or payment, such as quality of care (grievance).
- When you are worried that you need a service, or that the HMO wants you to pay for a service you already got (appeal).

**NODMAR = NOTICE OF DISCHARGE AND MEDICARE APPEAL RIGHTS**

When you are in a hospital or skilled nursing facility (SNF), the hospital or SNF will give you a written notice, called the NODMAR, before they send you home. The notice will include:

1. the reason why you don't need to be in a hospital or SNF anymore;
2. if you choose not to leave, the date that you (instead of Medicare) will have to start paying for your care; and
3. your appeal rights and how to contact the hospital's PRO (Peer Review Organization). PROs are a statewide company that oversees quality of care in hospitals for the US government.

You may not think that you will be ready to leave when your HMO says so. Your HMO may not know the special needs you have or the challenges your disability creates for you. Your HMO also may not know that they need to work extra hard to get the hospital doctors to talk to your usual doctors.
**MEDICARE GRIEVANCES AND APPEALS**

**Chart 1**

**NODMAR - Notice of Discharge and Medicare Appeal Rights**

The hospital or HMO gives you a notice that says you will leave the hospital on a certain date.

**IF YOU AGREE...**

You will be discharged on that date.

**IF YOU DISAGREE...**

**OR**

Do these three things:
- Ask for "Immediate PRO Review".
- Ask in writing or by telephone.
- Ask by noon of the first working day after you get the NODMAR.

(If you miss the deadline, go to "fast HMO review").

- That afternoon, the PRO tells your HMO that you have filed an appeal.
- PRO makes decision within 3 days.
- PRO will give you more information about further appeals.
- You will not have to pay for extra days if your HMO approved the hospital admission or you were admitted for urgent or emergency care.

Go to Chart 3.
Chart 1 shows your appeal rights if you think you need to stay in the hospital longer than the HMO wants to allow. PROs (peer review organizations) monitor the quality of hospital care for Medicare. We recommend that you appeal to the Peer Review Organization, not the HMO. We recommend this because:

• you will get a decision on your appeal more quickly, and
• you can stay extra days for free while the PRO reviews your case, if the HMO approved you going to the hospital or you went to the hospital for a medical emergency.

The NODMAR will include all the information you need to contact the PRO.

If you miss the 12:00 noon deadline to contact the PRO, you can request a “reconsideration” by the HMO (Chart 3a). The HMO will take up to 6 days to decide. You may have to pay for the extra days you stay in the hospital, yourself.

For more information on NODMAR, refer to 42 CFR 422.620 -.622, in the Code of Federal Regulations.

GRIEVANCES

If you have concerns or problems with your HMO which are not about payment or service requests, you have a right to file a grievance. A grievance is a type of complaint.

For example, you may think that your HMO does not contract with enough building-accessible specialists or accessible primary care physicians. Or, you may think that building-accessible physicians are located too far from your home or are open at hours when it is difficult to get assisted transportation. In these cases, you may file a grievance.

You can file a grievance about the quality of care when you believe:

• the service you got was too late or wrong
• you had problems getting a service because of long waiting times or long travel distances
• the wrong kind of doctor or hospital provided the service.

If you believe you are not getting a high quality of care, you may file a grievance either with your HMO or with the Peer Review Organization (PRO) in your State. If you file with the PRO, the grievance will follow a different set of procedures than what we describe here, and probably take longer.

Each HMO may set its own procedures and timelines for dealing with grievances. You can get a copy of your HMO’s grievance process by looking at the Evidence of Coverage. If you do not have a copy of this, ask your HMO to send you a copy or a description of the grievance procedure.

In the meantime, you may be interested in learning about the number of quality of care grievances filed against your HMO and how long it takes to get them resolved. Contact your HMO and ask them for their “Report of Medicare Grievances and Appeals”. It is updated every 6 months.

You start a grievance by sending your HMO a letter or by calling them. We recommend that you send them a letter and keep a copy of all your correspondence. If you do not get a response from the HMO in writing within 45 days or the time period specified in their grievance procedures, send them another letter and send a copy to the state agency that licenses the HMO (see appendix).
You have a complaint about quality of care. You write or call your HMO. Tell them you are "filing a grievance".

HMO reviews your request and makes a decision.

YES

Your complaint is resolved.

NO

You may also contact the Peer Review Organization in the state.

If you disagree, follow the HMO's procedures. If you are enrolled through work, ask your employer for help. If you are enrolled through Medicaid, phone your state at the number in the Appendix, and ask for help.
Chart 2 shows you the steps to follow to start a grievance with the HMO.

For more information on Grievances, refer to 42 CFR 422.564.

**INTERNAL APPEALS OR "ORGANIZATION DETERMINATION"**

If you cannot get an item or service that you feel you need, or if you want the HMO to pay a claim for a service you have already received, you can request an organization determination (decision). Federal law guarantees Medicare beneficiaries many rights under this process, including your rights to appeal the HMO’s decision. For example, you might appeal the HMO’s decision to stop physical therapy or to deny a visit to a specialist who has experience caring for people with disabilities.

Every HMO has an internal appeals process. That is, other HMO workers review the first denial. You must go through the internal appeals process before starting the external appeals process.

We will tell you about two different timeframes for internal appeals. The first is the “fast decision” and the second is the “standard decision”.

If you think that lack of medical services will endanger your life, your health, or your ability to regain maximum function, then you should follow the fast decision time frame (Chart 3a). If you do not need a fast decision about services, or if you are asking the HMO to pay for services you already received, then you must follow the standard decision timeframe (Chart 3b).

We recommend you make a workbook like the one on page 22. This will help you keep track of papers and phone calls. Later, you might need a workbook to prove you followed all the steps in the proper order and proper timeframe.

**DETAILS ON THE FAST DECISION TIMEFRAME**

The timeframe does not begin until you contact the HMO. You may write them a letter or telephone the HMO. We recommend that you telephone the HMO, and follow up with a letter. If you feel uncomfortable making this call, someone can make it for you, but you must follow these instructions.

In your phone call and follow-up letter, use these words “I want a fast decision, within 72 hours (3 days)” AND say or write that “I believe that my health could be seriously harmed by waiting for a standard decision.” Try to fax the letter to the HMO, because the clock starts as soon as they get it. The HMO’s member services department will tell you the special fax number for appeals. Remember to make entries in your workbook.

The first decision the HMO makes is whether or not they agree that your situation requires a “fast” or “expedited” review. The HMO may decide that a determination can wait because it believes you are not in danger. They will call you and tell you this as soon as they make the decision, and follow up with a letter to you within 3 days. Then your request will go through the “standard” 14-calendar day timeframe.

If your doctor calls or writes the HMO and requests a fast or expedited review because he or she believes that the standard time frame could seriously jeopardize your life or health, or your ability to regain maximum function, then the HMO must follow the fast timeframe. So, try to get your physician to call the HMO.

If you or your doctor need time to provide the HMO with additional information, or if the HMO needs to have additional diagnostic tests completed, the 3 day deadline can be extended up to 14 additional calendar days. You may want to ask for an extension if you need to get information from a non-HMO provider to the HMO.
Chart 3 — Internal Appeal

3a — FAST REVIEW (3 days)

Is the HMO refusing to provide services you think you should have?
Does the HMO want to stop a service you have been getting that you think you still need?

**YES**

- Call your HMO and ask for a "fast review".
- Call your doctor.

**Ask your doctor to call the HMO**
- Ask your doctor to support your request for a "fast review".

**HMO decides if your request needs a "fast review".**

**YES**

HMO does a "fast review" (72 hours = 3 days)

**YES**

You get your service.

**NO**

Automatically goes to "standard review" (Chart 3b). You may complain about this decision and file a grievance (Chart 2).

**NO**

You may ask for "reconsideration". Go to Chart 4.
DETAILS ON THE STANDARD TIMEFRAME

The timeframe does not begin until you contact the HMO. If you are requesting services, you may write them a letter or telephone the HMO. We recommend that you telephone the HMO, and follow-up with a letter confirming your call. If you feel uncomfortable making this call, you can ask someone to make it for you. Remember to fill out your Appeals Workbook like the one on page 23.

The HMO must tell you their decision about services as soon as possible within 14 calendar days from the time you call or write them. If you or your doctor need time to provide the HMO with additional information, or if the HMO needs to have additional diagnostic tests completed, the 14 calendar day deadline can be extended up to another 14 calendar days. You may want to ask for an extension if you need to get information from a non-HMO provider to the HMO.

The standard timeframe is longer if you are asking about payment for services or a request for services outside the HMO. You must submit a request for payment in writing. If you call, the HMO will tell you to send a letter. The HMO must make a decision within 30 days of receiving your letter, though they may take as long as 60 days in some circumstances. If they only pay part of the bill or refuse to pay anything, they will send you a notice of their decision and instructions on how to appeal.

[Enter today's date]

Dear [Name of your health plan]:

On [date #1] I requested [service or payment for service] from my doctor. On [date #2] I was notified by [person] that [name of plan] denied my request. I appealed that denial on [date #3]. On [date #4] I received notice that my appeal for [the service or payment you want] was denied.

I request an expedited reconsideration of that denial. I request that you include a physician with a lot of experience in treating people with my disability and complications. Please send me information about the physician's experience.

I also request a fast time frame because lack of this service will increase the chance that my health will get worse.

Sincerely,
[Your name]
[Your address]
[Your HMO ID number]

RECONSIDERATION BY THE HMO

If the “organization determination” results in a decision which is not in your favor (that is, the HMO denies the service you request or denies payment), you may ask that the HMO review your case again. Wait no more than 60 days to request the reconsideration. You must request the reconsideration in writing.

If you or a physician (even a physician not part of the HMO) think that lack of medical services will endanger your life, your health, or your ability to regain maximum function, then you or your physician may request a fast time frame for HMO reconsideration. You will
Chart 3 — Internal Appeal

3b — STANDARD REVIEW (14 days)

Request for Service:
Call and/or write the HMO.

Request for Payment:
Write the HMO (don't call).

HMO does the review
(14 days for service request
30 days for payment request)

YES

You get your service.
Your bill is paid.

NO

• No service
• No payment
• Partial Payment

You may ask for "reconsideration".
Go to Chart 4.
have to authorize the physician to act on your behalf. Your physician may make this request by phone or in writing. The time frame is 72 hours (3 days). Otherwise, the standard reconsideration time frame is 30 days for a service request, and 60 days for a payment request.

The people at the HMO who reconsider your case will not be the same people who made the first organization determination.

If you are asking the HMO to reconsider denial of coverage based on a lack of medical necessity (such as termination of therapy), the HMO will have a physician with expertise in a medical field appropriate for the services you want, do the reconsideration. You should try to find out if the physician has experience treating people with your disability and complications. Be sure to ask in writing for this information and to keep copies of all your letters.

The HMO will promptly notify you, in writing, of the results of their reconsideration. For fast reconsiderations, the HMO will call you at the time of the decision and follow up with a letter within 2 days of their decision.

RECONSIDERATIONS BY THE INDEPENDENT ENTITY

Medicare hires a company called the “independent entity” to review the HMO’s second decision. (At the time of this printing, the contracting company is the Center for Health Dispute Resolution). If the HMO denied your case for the second time, the HMO will automatically send your case to the independent contractor, within 24 hours of the HMO’s decision. You do not need to do anything. See Chart 5. The independent entity will look to see that you followed all of the proper procedures to get a “no” changed to a “yes”. This is why it is important to keep copies of your letters and to use the Appeals Workbook.

EXTERNAL APPEALS

If your case involves care worth at least $100, you may appeal the decision of the independent contractor, but you must do it within 60 days of their letter to you. This appeal goes to the U.S. Social Security Administration Administrative Law Judges (“ALJ”).

If the ALJ decides against you, you may ask the Department of Health and Human Services Appeals Board (DAB) to review the ALJ ruling, but you must ask within 60 days.

If the DAB decides against you, and if your claim involves $1000 or more, you may appeal one more time to the federal district court. Again, you must file within 60 days of the ruling.

For more information on organization determinations, reconsiderations, and appeals, refer to 42 CFR 422.566-612
Chart 4
RECONSIDERATION

From Chart 3a or 3b → Wait no more than 60 days!

Write HMO to request a "reconsideration of the organization determination".

Will lack of service endanger your life, health or ability to regain maximum function?

- YES
  - You or your doctor calls or writes HMO for "expedited reconsideration".
    - HMO makes prompt decision on whether your case needs "expedited reconsideration".
      - YES
        - Expedited reconsideration (72 hours = 3 days)
        - May be extended 14 days to get more information
      - NO
        - Standard reconsideration
          - (30 days for service request)
          - (60 days for payment request)
          - May be extended by 14 days for service requests.
  - NO
    - Standard reconsideration
      - Automatically goes to "standard" reconsideration. You may complain about this decision and file a grievance (Chart 2).

- NO
  - Automatic transfer to "independent contractor" within 24 hours. Go to Chart 5.

- YES
  - You get service!

You get service or your bill is paid!
Chart 5

INDEPENDENT RECONSIDERATIONS

From Chart 4
Automatic review of the second denial by the HMO.

Medicare's "Independent Entity"

If this was an "expedited reconsideration" in Chart 4, then you get a decision within 72 hours (3 days).

If this was a "standard reconsideration" in Chart 4, then you get a decision within 30 days.

DECISION

YES
You get your service.

NO
Go to Chart 6.
Chart 6

MEDICARE APPEALS

Is the amount in controversy $100 or more?

- **YES**
  - Wait no more than 60 days!
  - Appeal to ALJ
    - *(Very long time. Average is 1 year, could be 2 years.)*

- **NO**
  - END

  **YES**
  - **DECISION**
  - You get services or bill is paid!

- **NO**
  - Wait no more than 60 days!
  - Appeal to DHHS Appeals Board (DAB)

  **YES**
  - **DECISION**
  - You get services or bill is paid!

  **NO**
  - *(or DAB denies review)*
  - Is the amount in controversy $1000 or more?

- **NO**
  - END

- **YES**
  - Wait no more than 60 days!
  - Appeal to Federal District Court
Sample Appeals Workbook

This page gives you an idea of how you can keep track of important dates and documents. Keep your workbook and copies of all letters, together in a safe place.

**Service I am requesting:** [describe what you or your doctor thinks you need, such as more therapy visits or referral to a certain specialist]

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>I asked my doctor for service.</td>
<td>Doctor said “No.”</td>
</tr>
<tr>
<td>2.</td>
<td>I phoned my health plan and asked for a “fast review”. Person I spoke with: ____________________ I phoned my doctor and asked him to call my health plan and also ask for a fast review.</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td>Health plan said no.</td>
</tr>
<tr>
<td>4.</td>
<td>I wrote my health plan for an expedited reconsideration.</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td>Health plan said no.</td>
</tr>
<tr>
<td>6.</td>
<td>Health plan sends to independent contractor.</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td></td>
<td>Independent contractor says no.</td>
</tr>
<tr>
<td>8.</td>
<td>Decide if I want and can appeal to an Administrative Law Judge.</td>
<td></td>
</tr>
</tbody>
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### Resources

**Appealing Your HMO Decision? — Call These Numbers**

<table>
<thead>
<tr>
<th></th>
<th><strong>MEDICARE &amp; STATE OFFICIALS</strong></th>
<th><strong>MEDICAID</strong></th>
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+ IN-STATE CALLS ONLY
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### RESOURCES

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HELPFUL WEBSITES

MEDICARE REGULATIONS
www.medicare.gov

STATE REGULATIONS
ILRU/University of Houston Law Center
www.ilru.org/mgdcare/legalprotections

PRIVATE HEALTH PLAN RULES
www.consumersunion.org