

APPEALS AND GRIEVANCES

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Overview

The Plan maintains a member complaint system that includes grievance and appeals processes for Medicare Advantage members.

An *appeal* is a request for review of an action taken by or on behalf of the Plan. A member, a member's representative, or a provider acting on behalf of the member and with the member's written consent, may file an appeal.

Example of actions include but are not limited to the following:

- Denial or limited authorization of a requested service, including the type or level of service;
- The reduction, suspension or termination of a previously authorized service;
- The denial, in whole or in part, of payment for a service;
- The failure to provide services in a timely manner, as defined by the state.

A *grievance* is any complaint or dispute other than one involving an organization determination expressing dissatisfaction with the manner in which a Medicare health plan or delegated entity provides health care services regardless of whether any remedial action can be taken. A member or a member's representative, acting on behalf of the member and with the member's written consent, may file a grievance.

Possible subjects for grievances include but are not limited to the following:

- Quality of care of services provided
- Rudeness of the provider
- Failure to respect the member's rights

The Plan ensures that decision-makers on grievances

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and appeals are not involved in previous levels of review or decision-making. These decision-makers are health care professionals with clinical expertise in treating the member's condition or disease or have sought advice from providers with expertise in the field of medicine related to the request when making decisions on any of the following:

- An appeal of a denial based on lack of medical necessity
- A grievance regarding denial of expedited resolution of an appeal
- A grievance or appeal involving clinical issues

Submission of Provider Appeals

Providers have 90 days¹ from the original utilization management denial or claim denial to file a provider appeal. Cases appealed after that time will be denied for untimely filing. There is no second level consideration for cases denied for untimely filing. If the provider feels they have filed their case within the appropriate time frame, they may send proof. Acceptable proof of timely filing will only be in the form of a registered postal receipt signed by a representative of the Plan, or similar receipt from other commercial delivery services.

A provider may file an appeal by submitting a letter of appeal and/or an Appeal form with supporting documentation such as medical records. Appeal forms may be found in the **Forms** section of this manual.

- The Plan is not responsible for payment of medical records generated as a result of a provider inquiry. Any invoices received by the Plan for such charges will be redirected to the provider.
- Cases received without the necessary documentation will be denied for lack of information.

¹ *Subject to change*

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The Plan has 60 days to review the case for medical necessity and conformity to Plan guidelines. During this time, the Plan may request additional information from the provider in order to complete a review of the case.

- It is the responsibility of the provider to provide the requested documentation within 60 days of the denial to re-open the case. Records and documents received after that time frame will not be reviewed and the case will remain closed.

If it is determined that the provider has complied with Plan protocols and that the appealed services were medically necessary, the denial will be overturned. The provider will be notified of this decision in writing.

The provider may file a claim for payment, if they have not already done so. If a claim has been previously submitted and denied, it will be adjusted for payment after the decision to overturn the denial has been made. The plan will ensure that claims are processed and comply with the federal and state requirements.

Non-Contracted Provider Appeals

A non-contracted provider, on his or her own behalf, is permitted to file a standard appeal for a denied claim only if the provider completes a waiver of beneficiary liability statement, which provides that the provider will not bill the enrollee regardless of the outcome of the appeal. Physicians and suppliers who have executed a waiver of beneficiary liability are not required to complete the CMS-1696 unless a copy is requested by WellCare. However, the time frame for acting on a reconsideration request commences when the properly executed waiver of liability form is received.

Submission of Member Appeals

Any party to an action appropriate for appeal (including a reopened and revised determination), including a member, a member's authorized representative or a contracted or non-contracted physician or provider to the Plan, may request that the determination be reconsidered. Providers do not have appeal rights

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through the member appeals process.

The member, member's representative or provider (with member's written consent) may file a request for an expedited, standard, pre-service or retrospective appeal determination.

An expedited request must come from the provider him/herself, not from the office staff, in order to be automatically processed as expedited.

The Plan will not take, or threaten to take, any punitive action against any provider acting on behalf or in support of a member in requesting an appeal or an expedited appeal.

The Plan gives members reasonable assistance in completing forms and other procedural steps for an appeal, including but not limited to providing interpreter services and toll-free telephone numbers with TTY/TDD and interpreter capability. Members are provided reasonable opportunity to present evidence and allegations of fact or law in person, as well as in writing.

If the request for reconsideration is submitted after 60 calendar days, then good cause must be shown in order for the Plan to accept the late request.

Examples of good cause include but are not limited to the following:

- The member did not personally receive the adverse organization determination notice or he/she received it late;
- The member was seriously ill, which prevented a timely appeal;
- There was a death or serious illness in the member's immediate family;
- An accident caused important records to be destroyed;

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- Documentation was difficult to locate within the time limits;
- The member had incorrect or incomplete information concerning the reconsideration process;
- The member lacked capacity to understand the time frame for filing a request for reconsideration.

Any questions regarding the filing of an appeal or the status of an appeal should be directed to the Customer Service. A member of the Customer Service or Appeals teams will be in contact with the provider within two business days of the inquiry.

A party may request a standard reconsideration by filing a signed written request with the Plan or SSA office.

Except in the case of an extension of the filing time frame, a party must file the request for reconsideration within 60 calendar days from the date of the notice of the action or denial. Requests made at an office of the SSA will be forwarded to the Plan for reconsideration; however, the time frame for review does not begin until the Plan receives the request for reconsideration.

The Plan must make a determination on a request for appeal and notify the appropriate party within the following time frames:

- Expedited Request: **72 hours**
- Standard Pre-Service Request: **30 calendar days**
- Retrospective Request: **60 calendar days**

Request for Expedited Determination

A request for an expedited determination may be made verbally by calling Customer Service or in writing by mail to the Appeals department.

The request must state it is a request for “an expedited

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or fast process” case and the reason why the case should be expedited. In order to meet criteria for expedited review, it must be shown that applying the standard procedure could seriously jeopardize the member’s life, health or ability to regain maximum function.

A request for payment of a service already provided to a member is not eligible to be reviewed as an expedited reconsideration.

The Plan will make a determination within 72 hours from receipt of the request.

14-Day Extension

The determination period of 72 hours may be extended up to 14 calendar days if the member requests an extension or if the Plan justifies a need for additional information and documents how an extension is in the best interest of the member. If an extension is taken, the member will be notified in writing and given further rights should he/she not agree.

Denial of Expedited Request

If the Plan denies the request for the expedited determination, then the Plan will automatically transfer the request to the standard reconsideration process no later than 30 calendar days from the date the Plan received the request for expedited reconsideration. The Plan will then make its determination as expeditiously as the member’s health condition requires. The plan will also make reasonable efforts to give the member prompt oral notice of the denial, and will follow up within two calendar days with a written notice.

Affirmation of Denial

If the Plan upholds its initial action and/or denial (in whole or in part), it will:

- Submit a written explanation for a final determination with the complete case file to the

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independent review entity (IRE) contracted by CMS

- The IRE has 72 hours from receipt of the case to issue a final determination
- If the IRE agrees with the Plan, they will notify the member and the Plan and give the member further appeal rights
- Notify the member of the decision to affirm the denial and that the case has been forwarded to the IRE.

Reversal of Denial

If the Plan overturns its initial action and/or denial, the member will be notified verbally within 72 hours of receipt and in writing within three business days of the verbal notification.

If the IRE overturns the denial, the IRE notifies the member or representative in writing of the decision.

- The Plan will also verbally notify the member, member's representative and provider that the services are approved and provide an authorization number within 72 hours of receipt of the IRE's determination, or sooner, if the member's health warrants it.

Request for Standard Pre-Service Determination

If the provider is filing a standard pre-service appeal on a member's behalf, the provider and member must complete an Appointment of Representative statement, which can be found in the **Forms** Section of this manual.

The Plan will make a determination and provide notification within 30 calendar days of receipt of the standard pre-service request.

Affirmation of Denial

If the Plan upholds its initial action and/or denial (in whole or in part), it will:

- Submit a written explanation for a final determination with the complete case file to the independent review entity (IRE) contracted by CMS.
 - The IRE must issue a final determination as expeditiously as the member's health or condition requires, but no more than 30 calendar days from receipt of the case
 - If the IRE agrees with the Plan, the IRE will notify the member and the Plan and give the member further appeal rights
- Notify the member of the decision to affirm the denial and that the case has been forwarded to the IRE

Reversal of Denial

If the Plan overturns its initial action and/or denial, it will notify the member verbally and in writing within 30 calendar days of receipt of the determination request.

If the IRE overturns the denial, the IRE notifies the member or representative in writing of the decision.

- The Plan will also notify the member, member's representative and provider verbally and in writing that the services are approved and provide an authorization number within 72 hours, if the member's condition warrants it, or no more than 14 calendar days from receipt of the IRE's determination.

Request for Retrospective Determination

If the provider is filing a request for retrospective appeal on the member's behalf, the provider and member must complete an Appointment of Representative statement, which can be found in the **Forms** section of this manual.

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The Plan will make a determination and provide notification within 60 calendar days of receipt of the retrospective request.

Affirmation of Denial

If the Plan upholds its initial action and/or denial (in whole or in part), it will:

- Submit a written explanation for a final determination with the complete case file to the independent review entity (IRE) contracted by CMS
 - The IRE has 60 calendar days from receipt of the case to issue a final determination
 - If the IRE agrees with the Plan, the IRE will notify the member and the Plan and give the member further appeal rights
- Notify the member of the decision to affirm the denial and that the case has been forwarded to the IRE

Reversal of Denial

If the Plan overturns its initial action and/or denial, the member is notified verbally and in writing within 60 calendar days of receipt of the determination request.

If the IRE overturns the denial, the member is notified verbally and in writing and the claim is paid within 30 calendar days of receipt of the IRE's determination.

Submission of Grievances

A member or provider acting on behalf the member and with the member's written consent may file a grievance either verbally or in writing within 60 calendar days after the date of the occurrence that initiated the grievance. A verbal request may be followed up with a written request, but the time frame for resolution begins the date the plan receives the verbal filing.

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If the member wishes to appoint another person as their representative, he/she must complete an Appointment of Representative statement. The member and the person who will be representing the member must sign the statement. This form is located in the **Forms** section of this manual.

The Plan will ensure that punitive action is not taken against a provider who files a grievance on a beneficiary's behalf or supports a member's grievance.

The Plan will make a determination on a grievance within the following time frames:

- Expedited Request: **24 hours**
- Standard Request: **30 calendar days**

The Plan gives members reasonable assistance in completing forms and other procedural steps, including but not limited to providing interpreter services and toll-free numbers with TTY/TDD and interpreter capability. Members will be provided reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing.

Request for Expedited Grievance Determination

The member, member's representative or a provider may file a request for an expedited grievance determination verbally or in writing. A verbal request can be filed by calling Customer Service. A written request can be mailed or faxed directly to the Grievance Department at:

WellCare Health Plans
Grievance Department
P.O. Box 31384
Tampa, FL 33631-3384
Or
Fax: 1-866-388-1769

A determination on the expedited request will be made within 24 hours of receipt of the expedited request.

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A request for an expedited grievance determination can be made for complaints related to the Plan's decisions as follows:

- Extends the timeframe to make an organization determination or reconsiderations.
- Refuses to grant a request for an expedited organization or reconsideration.

Request for Standard Grievance Determination

A grievance will be investigated as expeditiously as the member's case requires, based on the member's health status, but no later than 30 calendar days from the date the oral or written request is received unless extended as permitted under 42 CFR 422.564(e)(2). The determination will be made and a closure letter will be sent to the member within this time frame as well. The closure letter will include the results and date of the grievance resolution.

A letter with decisions not wholly in the member's favor will include:

- Notice of the right to request a second-level grievance to the Plan;
 - The time limit to file a second-level request is 30 calendar days from the date of the notice; and
 - The member may present the case to the second-level Grievance Committee either in person or via teleconference.

Grievances Filed Against a Provider

If a member files a grievance against a provider in reference to the quality of care or service provided, the Plan will fax and mail a request to the provider for response.

Provider Responsibility

The provider is given 10 business days to respond and submit medical records for review. If a provider has not responded within 10 business days, a second fax and certified letter is sent giving an additional five business days.

Continued failure to respond may result in the provider's panel being closed to new patients and/or will be interpreted as an indication that the provider does not disagree with the member's issue. The case is then forwarded to the Quality Improvement department for further investigation.

If the provider does respond, the case is referred to a Plan nurse who reviews the medical records to determine if a possible quality issue exists. If the nurse feels a possible quality issue does exist, the case is referred to a Plan medical director for review. If he/she determines a quality issue exists, the case is referred to the Quality Improvement department for further investigation. If no quality issue is identified, the case is entered into the Plan's database for tracking and trending purposes.

14-Day Extension

Each of the appeal or grievance determination periods noted above may be extended by as many as 14 calendar days, if the member requests an extension or if the Plan justifies a need for additional information and documents how the extension is in the interest of the member. If an extension is not requested by the member, the Plan will provide the member with written notice of the reason for the delay.

Submission of Provider Termination Appeal Request

If a provider termination is initiated by the Plan, regardless of whether the termination is for cause or not, the Plan will notify the provider of the termination decision in writing, via certified mail.

Providers will be informed as to their rights to petition the termination action, the process and timing for

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reconsideration of the termination decision. The reconsideration request must be filed within 30 days of receipt of the Plan's termination notice. The Plan will send the provider an acknowledgement letter within five business days of receipt of the appeal request.

The Plan may request additional information from the provider in order to review the termination reconsideration request. If this is the case, the provider has 10 business days to submit the required documentation. If documentation is not received within 10 business days, the Plan will continue to process the termination reconsideration request.

A panel reviews the termination reconsideration request and upon determination will send an outcome letter to the provider stating that the termination reconsideration has been overturned or upheld.

Termination Overturn

If the Plan overturns the termination of the provider, the Plan will ensure that there is no lapse in the period of the provider's participation with the Plan.

Termination Upheld

If the Plan upholds its termination of the provider, the Plan will notify members 30 days before and no later than five business days after the termination effective date of their assigned PCP. Members will be requested to select a new PCP within 30 days. If the member does not respond, a new PCP will be selected for the member. The member will be notified in writing of their new PCP and given an opportunity to change their PCP by contacting Customer Service. The Plan will also notify members, who have been seen two or more times within the past 12 months, of the termination effective date of a participating hospital, specialist or a significant ancillary provider within the service area, 30 days before and no later than five business days after the termination.



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