

## COMPLAINTS, GRIEVANCES & APPEALS

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#### Medicaid Family Health Plus Child Health Plus

#### Checking Our Decisions: Utilization Review

The Plan has established utilization review teams to ensure its resources are sufficient to meet member needs. Doctors and nurses are on the Utilization Review Board. Their job is to be sure the treatment given is medically needed and right for the condition at hand. They do this by checking the member's treatment plan against medically acceptable standards. Utilization Review will occur whenever judgment about medical necessity or experimental services are made.

The provider, a member, or the member's designee can make a request or review our decision about a specific treatment plan. Our failure to make a timely decision has the same effect as a denial. Therefore, if we don't give you or the member a decision in the allowed time, you, the member, or the member's designee can ask for an appeal.

For **Medicaid/FHP** The Plan must send notice of denial on the date review timeframes expire.

We will review past care (retrospective review), care that the member is seeking (prior approvals or prospective review) and care that the member is now getting and wants to continue to get more of (concurrent review). Just call Member Services at **(800) 288-5441** and ask for Utilization Review.

The following treatments or services must be approved before the member receives them:

- All specialist visits by a participating provider require authorization from the member's Primary Care Physician (PCP);
- Surgical procedures, inpatient services, specialty services by non-participating providers;
- Some tests require prior authorization by the member's PCP and the WellCare Medical Management department;

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- Experimental or investigational health care services requested by the member.

To get approval for these treatments or services, the member must:

- Consult with his or her PCP. After assessing the member's medical needs, his or her PCP will take care of getting the necessary authorizations for medical services.
- Three business days after we get the required information, we will decide the case. We will let you, the member, and/or the member's designee know by telephone and in writing.

If the member is receiving care or treatment that should be continued, or if additional services are needed, we will review the request and make our decision within one business day following receipt of the information required. We notify the provider, the member and/or the member's designee by telephone and in writing.

When an adverse determination is rendered without provider input, the provider has the right to reconsideration. The reconsideration shall occur within one (1) business day of receipt of the request and shall be conducted by the enrollee's health care provider and the clinical peer reviewer making the initial determination.

If we do not approve the member's request for services, we will tell him or her or the member's designee how you, the PCP, can appeal. Your options for asking for an appeal from us or the State will be explained.

Adverse determinations will be made by a clinical peer reviewer. A written notice of an adverse determination (initial adverse determination) will be sent to the member and provider and will include:

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- a) the reason for the determination including the clinical rationale, if any;
- b) instructions on how to initiate internal appeals (standard and expedited appeals) and eligibility for external appeals;
- c) notice of the availability, upon request of the enrollee or the enrollee's designee of the clinical review criteria relied upon to make such determination and;
- d) the notice will also specify what, if any, additional necessary information must be provided to or obtained by the Plan in order to render a decision.

For **Medicaid/FHP** notice will also include:

- e) description of Action to be taken;
- f) statement that the Plan will not retaliate or take discriminatory action if appeal is filed;
- g) process and timeframe for filing/reviewing appeals, including enrollee right to request expedited review;
- h) enrollee right to contact DOH with the 1-800 number, regarding their complaint;
- i) Fair Hearing notice including aid to continue rights and;
- j) statement that notice is available in other languages and formats for special needs and how to access these formats.

### **Appeal of Utilization Review Decisions**

The enrollee or their designee, and for retrospective UR denials, the provider, may appeal an adverse determination on an expedited or standard appeal

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basis. The timeframe for the Plan to make an appeal determination begins upon the receipt of necessary information.

For **Medicaid/FHP**, the review timeframe begins upon first receipt of appeal, whether filed orally or in writing.

The request may be sent to the following address:

WellCare Health Plans, Inc.  
PO Box 31368  
Tampa, FL 33631-3368

or by calling 1-800-288-5441 between the hours of 8am-6pm.

For **Medicaid/FHP**, before and during the appeal review period, the enrollee or designee may see their case file. The enrollee may present evidence to support their appeal in person or in writing.

The time frame for WellCare to make an appeal determination begins upon the Plan's receipt of necessary information. The review time frame begins upon receipt of appeal, whether filed verbally or in writing.

1. Use the **expedited** appeals process when:

- continued or extended health care services, procedures or treatments are needed;
- additional services for enrollee undergoing a course of continued treatment; or
- The health care provider believes an immediate appeal is warranted.

If the Plan requires information necessary to conduct an expedited appeal, the Plan will immediately notify the enrollee and the enrollee's health care provider by

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telephone or facsimile to identify and request the necessary information followed by written notification.

We will decide on expedited appeals within two business days after we get the information we need. A clinical peer reviewer will be available to speak with the provider within one (1) business day following the notice of appeal. The Plan will make reasonable effort to provide verbal notice to enrollee and provider at the time the determination is made. If the Plan denies enrollee request for expedited, the Plan will provide notice by telephone immediately, followed by written notice in two days.

For **Medicaid/FHP**, expedited appeals will be decided as fast as the enrollee's condition requires and within two (2) business days of receipt of necessary information but no more than three (3) business days of receipt of appeal. This time may be extended for up to 14 days upon enrollee or provider request; or if the Plan demonstrates more information is needed and delay is in best interest of enrollee and so notices enrollee.

Written notice of a final adverse determination concerning an expedited Utilization Review Appeal shall be transmitted to the member within 24 hours of rendering the determination.

The Plan will make a reasonable effort to notify the member, his or her designee, and the provider where appropriate, by phone, at the time the Action Appeal determination is made.

If you, the member, or the member's designee still do not agree with what we decide, you may appeal using the **standard appeals** process or through the external appeal process.

A standard appeal may be filed by the enrollee or enrollee's designee. A provider may file a UR appeal for retrospective denial.

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- You must file an appeal (by telephone or in writing) within 60 business days of receiving our decision. Verbal appeals must be followed up by written signed appeal.
- For **Medicaid/FHP**, an enrollee will have no less than 60 business days, and no more than 90 days to file an appeal.
- Within 15 business days, we will send you a letter to let you know we have received your appeal and are working on it.
- If the Plan requires information necessary to conduct a standard internal appeal, the Plan will notify the enrollee and the enrollee's health care provider, in writing, within 15 days of receipt of the appeal, to identify and request the necessary information.
- In the event that only a portion of such necessary information is received, the Plan will request the missing information, in writing, within five (5) business days of receipt of the partial information.

After we get the information we need, we will decide your appeal within 60 days. We will tell you, the member and/or the member's designee within two business days of our decision.

For **Medicaid/FHP**, standard appeal determination will be made as fast as the enrollee's condition requires, and no later than 30 days from receipt of the appeal. This time frame may be extended for up to 14 (fourteen) days upon enrollee or provider request; or if the Plan demonstrates more information is needed and delay is in the best interest of enrollee and so notifies enrollee.

- If we deny your appeal, we will specify a reason, in writing. We will also include information on

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how you can make further appeals.

Each notice of final adverse determination will be in writing, dated, and include:

- (a) the basis and clinical rationale for the determination;
- (b) the words “final adverse determination”;
- (c) the Plans contact person and telephone number;
- (d) the enrollee coverage type;
- (e) the name and address of UR agent, contact person and telephone number;
- (f) the health service denied, including facility or provider and developer or manufacturer of service as available;
- (g) a statement that the enrollee may be eligible for external appeal and time frames for such appeal; and if the appeal was expedited, a statement that the enrollee may chose to file a standard action appeal with the plan or file an external appeal;
- (h) an attachment with a standard description of the external appeals process;
- (i) a summary of the appeal and date filed;
- (j) the date the appeal process was completed;
- (k) a description of the enrollee’s fair hearing rights if not included with initial denial;
- (l) a statement on the right of the enrollee to complain to the Department of Health at any time with the respective toll-free

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number; and

(m) a statement that the notice is available in other languages and formats for special needs members and how to access these resources.

- If we do not make a decision within the applicable time periods, it shall be deemed to be a reversal of the plan's initial adverse determination.
- Expedited and standard appeals will be conducted by a clinical peer reviewer; provided that any such appeal will be reviewed by a clinical peer reviewer other than the clinical peer reviewer who rendered the adverse determination.

### External Appeals

The enrollee, the enrollee's designee and, in connection with retrospective adverse determinations, an enrollee's health care provider has the right to request an external appeal.

An external appeal may be filed:

- (a) When the enrollee has had coverage of a health care service, which would otherwise be a covered benefit under a subscriber contract or governmental health benefit program, denied on appeal, in whole or in part, on the grounds that such health care service is not medically necessary **and**;
- (b) the health care plan has rendered a final adverse determination with respect to such health care service **or**;
- (c) both the plan and the enrollee have jointly agreed to waive any internal appeal.

In order to be eligible for an external appeal, providers

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must complete an External Appeal application and submit it to the New York State Insurance Department within 45 days upon receipt of the date of the final adverse determination from the first level of appeal with a health plan. New York external review is not available if the patient is covered under a Medicare managed care plan or a self-insured plan.

The Plan's initial denial, the notice of final adverse determination from the Plan, the fee (if required by the health plan), and the patient's signed consent must be included with the application.

The application must be sent by certified or registered mail to:

New York State Insurance Department  
PO Box 7209  
Albany, NY 12224-0209

To obtain a copy of the application, or if you have any questions, contact the Insurance Department at 1-800-400-8882 or visit their Web site at [www.ins.state.ny.us](http://www.ins.state.ny.us).

A provider will be responsible for the full cost of an appeal for a concurrent adverse determination upheld in favor of the Managed Care Organization; an Managed Care Organization is responsible for the full cost of an appeal that is overturned; and the provider and Managed Care Organization must evenly divide the cost of a concurrent adverse determination that is overturned in-part.

In addition, a provider requesting an external appeal of a concurrent adverse determination, including a provider requesting the external appeal as the member's designee, is prohibited from seeking payment, except applicable co-pays, from a member for services determined not medically necessary by the external appeal agent.

### Fair Hearings

Members enrolled in Healthy Choice, WellCare's

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Medicaid product, or Family Health Plus, may request a fair hearing from New York State:

- The member is not happy with a decision his or her local department of social services or the State Department of Health made about staying or leaving the plan.
- The member is not happy with a decision that WellCare made about medical care that he or she was receiving. The member feels the decision limits his or her Medicaid benefits or that WellCare did not make the decision in a reasonable time.
- The member is not happy about a decision WellCare made about denied medical care he or she wanted.
- The member is not happy with the decision that his or her doctor would not order services he or she wanted. The member feels the doctor's decision stops or limits his or her Medicaid benefits. The member must file a complaint and an appeal with WellCare. If WellCare agrees with the member's doctor, he or she may request a State fair hearing.

Parties to the Medicaid Fair Hearing include the Plan, as well as the member and his or her representative or the representative of a deceased member's estate. A provider can be a representative or a witness in a hearing process.

To request a Fair Hearing, members may call the Office of Administrative Hearings (OAH) at (800) 342-3334. They may also visit the Web site at <http://www.otda.state.ny.us/oah/forms.asp>.

The Plan will continue the member's benefits while the Medicaid Fair Hearing is pending if:

- The Plan has or is seeking to reduce, suspend

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or terminate a treatment or Benefit Package service currently being provided;

- The member has filed a timely request for a fair hearing with OAH; and
- There is a valid order for the treatment or service from a Participating Provider.

The Plan will provide aid continuing until the matter has been resolved to the member's satisfaction or until the administrative process is completed and there is a determination from OAH that the member is not entitled to receive the service; the member withdraws the request for aid continuing and/or the fair hearing in writing; or the treatment or service originally ordered by the provider has been completed, whichever occurs first.

The Plan will authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires, if the services were not furnished while the Medicaid Fair Hearing was pending and reverses a decision to deny, limit or delay services.

The Plan will pay for disputed services, in accordance with state policy and regulations, if the services were furnished while the Administrative Law/DCH Hearing was pending and reverses a decision to deny, limit or delay services. At the discretion of DCH, the member may be liable for the cost of continued benefits if the Plan's action is upheld.

Remember, members and providers can complain at any time to the New York State Department of Health by calling (800) 206-8125. In some cases, members can continue to receive care while they wait for a fair hearing.

### **Member Complaints and Complaint**

#### **How to File a Member Complaint**

A member or member's designee has the right to file on their behalf.

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#### Appeals

1. A member may file a complaint by telephone if:

- We have denied payment for a referral, or
- We have determined the service is not covered.

To file a complaint by telephone, the member should contact Member Services at (800) 288-5441, Monday through Friday from 8:00 a.m. through 6:00 p.m. A member may leave a message should they call during non-business hours. The Plan will return the call on the next business day.

2. A written complaint may also be filed by mail to:

**WellCare Grievance Department**  
**PO Box 31384**  
**Tampa, FL 33631-3384**  
or fax the complaint to: **1-866-388-1769**

#### Next Steps

The Plan will send an acknowledgement letter within 15 business days of receipt of a complaint. The letter will include:

- the Plan's contact on the complaint,
- how to reach this person, and
- if further information is needed.

After the Plan receives all of the information needed:

- The Plan will render a determination within 48 hours when a delay would risk the health of the member. A letter will follow in three (3) business days.
- If regarding a referral or benefits, the Plan will render decision in writing within 30 days.
- For all other complaints, the Plan will render a decision in writing within 45 days.

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The determination letter will list the reasons for the decision made by the Plan. It will also include information on how to appeal the Plan's decision along with the related forms.

A member may also file a complaint anytime by calling:

- New York State Department of Health at (800) 206-8125, or
- The local department of social services.

*or* in writing to:

NYS Department of Insurance  
One Commerce Plaza  
Albany, NY 12257

### Complaint Appeals

If the member is not satisfied with the determination on the complaint, he or she will have at least 60 business days after receiving the determination letter to file an appeal. The appeal must be submitted in writing. The member can write a letter or use the Plan's complaint form.

WellCare  
ATTN: New York Appeals Department  
P.O. Box 31368  
Tampa, FL 33631-3368

The Member Services department will provide assistance to members through our toll-free telephone number at (800) 288-5441.

The Plan will send an acknowledgement letter within 15 business days of receipt of an appeal. The letter will include:

- the Plan's contact on the appeal,
- how to reach this person, and
- if further information is needed.

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The appeal will be reviewed by:

- a clinical peer reviewer when the appeal is regarding a clinical matter. Reviewers will not be the same as those who deliberated on the initial complaint.
- health care professionals with a higher level of credentials or certification than those who completed the determination on the original complaint.

After the Plan receives all of the information needed:

- the Plan will render a determination within 2 business days when a delay would risk the health of the member.
- for all other complaints, the Plan will render a decision in writing within 30 days.

The Plan will provide reasons for its decision and the clinical rationale, if it applies. If the member is still not satisfied, he or she can file a complaint with the New York State Department of Health at (800) 206-8125 or your local department of social services. The member can also write to the New York State Department of Health,, Coming Tower, Empire State Plaza, Albany NY 12237.

### **Provider Appeals**

Providers have 90 days from the original claims denial to file an appeal. Cases appealed after that time will be denied for untimely filing.

Appeals should be submitted in writing to:

WellCare  
ATTN: New York Appeals Department  
P.O. Box 31368  
Tampa, FL 33631-3368

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Outline the reason(s) why the denial should be reversed and include specific, pertinent documentation that supports the appropriateness of the services rendered. Include all medical records that apply to the service on the claim. Be sure to include the member name, member identification number, and the date of service(s).

Once a case is received for review, a letter of acknowledgement is sent notifying the provider that the plan has received the case. A decision will be made and the provider will be notified in writing within the 60 calendar days.

#### Questions or Comments

The Plan is available to offer assistance in filing complaints, complaint appeals and action appeals. Questions on how to file an appeal or the status of an appeal should be directed to the Customer Service department at (800) 288-5441. Any questions that cannot be answered by the Customer Service staff will be redirected to the Appeals and Grievance Staff.

#### Expedited Request for Grievance

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

An expedited request may be requested for the following:

1. Complaints related to the Plan's decision to process a request for service or request to continue service under the standard 14 calendar day time frames rather than the expedited 72 hour time frame.
2. Complaints related to the Plan's decision to process an appeal under the standard 30 calendar day process rather than the expedited 72 hour time frame.

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3. Complaints related to the Plan's decision to invoke a 14 calendar day extension to a request for service or on an appeal.

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