

#### Overview

The Plan maintains member and provider grievance systems that include a grievance process, an appeal process as well as access to the Medicaid fair hearing system.

An *appeal* is a request for review of some action taken by or on behalf of the Plan. For a member appeal, the member may file the appeal, or a provider, acting on behalf of the member and with the member's written consent, may file an appeal. Providers also have the ability to file an authorization or claim-related appeal. Examples of actions that can be appealed 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 that involves a Plan determination or Action; expressing dissatisfaction with any aspect of the operations, activities or behavior of WellCare, regardless of whether remedial actions can be taken. Grievances may include, but are not limited to, complaints regarding the timeliness, appropriateness, access to and/or setting of a provided item.

An enrollee, his or her appointed representative or the enrollee's physician with written consent — in the form of an Appointed Representative document (AOR) — of the member, may file a grievance on the member's behalf. For Medicaid, a grievance may be filed orally or in writing within one year of the occurrence.

- Medicaid Only: Provider Complaint System. The provider is permitted to dispute the Plan's policies, procedures or any aspect of the Plan's

administrative functions, including proposed action.

The Plan ensures that decision-makers on grievances and appeals were 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/disease or have sought advise from providers with expertise in the field of medicine related to the request when deciding 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 Member Appeals for All Products**

Any party to an action that is appropriate for an 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 through the member appeal process.

The member, member's representative or any provider acting on the member's behalf may file for an expedited, standard pre-service or retrospective appeal determination. The request can come from the physician or an office staff working on behalf of the physician.

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. A written description or summary of the Policy and Procedure is available upon request to any member, provider, or facility rendering service.

If the member request for reconsideration is submitted after 30 calendar days for Medicaid and Healthy Kids and after 60 calendar days for Medicare recipients, 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 member did not personally receive the adverse organization determination notice or 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
- 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

Questions regarding the filing or status of an appeal or grievance should be directed to the Customer Service department, which will coordinate with the Appeals and Grievance department as appropriate to provide the status of the inquiry.

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**Submission of  
Member Appeals  
for Medicaid and  
Healthy Kids**

A member, provider on behalf of a member, or a member's representative may file an appeal request either verbally or in writing within 30 days of the date of the notice of action. If the Plan does not issue a written notice of action, then the member or provider may file an appeal within one year of the action.

If filed verbally through Customer Service, the request must then be followed up with a written, signed appeal to the Plan. For verbal filings, the time frames for resolution begin on the date the verbal filing was received.

If the member wishes to use a representative, then he/she must complete an Appointment of Representative (AOR) statement. The member and the person who will be representing the member must sign the (AOR) statement. This form is located in the **Forms** section of this manual.

The Plan must make a determination from the receipt of the request on a member appeal and notify the appropriate party within the following time frames:

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

Members have the right to request continuation of benefits during an appeal or Medicaid fair hearing. The member may be liable for the cost of any continued benefits if the Plan's action is upheld.

The Plan will continue the member's benefits if the appeal is filed timely, meaning on or before the later of the following:

- Within 10 calendar days of the date on the notice of action (add five calendar days if the notice is sent via U.S. mail);
- The intended effective date of the Plan's

proposed action;

- The appeal involves the termination, suspension or reduction of a previously authorized course of treatment;
- The services were ordered by an authorized provider;
- The authorization period has not expired; and
- The member requests extension of benefits.

If the Plan continues or reinstates member benefits while the appeal is pending, the member's benefits will be continued until one of following occurs:

- The member withdraws the appeal;
- **Medicaid Only:** 10 calendar days past the date of the Plan's adverse plan decision and the member has not requested a Medicaid Fair Hearing with continuation of benefits until a Medicaid Fair Hearing decision is reached. (add five calendar days if the notice is sent via U.S. mail);
- **Medicaid Only:** A Medicaid Fair Hearing decision adverse to the member is made; or
- The authorization expires or authorized service limits are met.

### **Request for Determinations for Medicaid and Healthy Kids**

### **Request for Expedited Determination**

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

The request must state that it is a request for "an expedited process" and include reasons 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 retrospective 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. The Plan will make reasonable efforts to notify the member verbally and will also notify the member, provider on behalf of the member, or the member's representative in writing within two calendar days of the disposition of their request.

#### **Denial of Expedited Request**

If the Plan denies the request for the expedited redetermination, the Plan will automatically transfer the request no later than within 30 calendar days for Healthy Kids and 30 calendar days for Medicaid from the date the Plan received the request for expedited reconsideration to the standard reconsideration process and then make its determination as expeditiously as the member's health condition requires.

#### **Request for Standard Pre-Service Determination**

The member's representative must complete an Appointment of Representative statement, which can be found in the **Forms** section of the Provider Manual, to request a standard pre-service determination. An AOR is not needed for a provider request that is on behalf of the member.

The Plan will make a determination and provide notification within 30 calendar days for Healthy Kids and 30 calendar days for Medicaid from the date of receipt of the standard pre-service request.

#### **Request for Retrospective Determination**

The member's representative must complete an Appointment of Representative statement, which can be found in the **Forms** section of the Provider Manual, to file a request for a retrospective determination. An AOR

is not needed for a provider request that is on behalf of the member.

The Plan will make a determination and provide notification within 30 calendar days from the date of receipt of the retrospective request.

**14-Day Extension**

The Expedited, Standard Pre-Service and Retrospective Determination periods noted above may be extended by up to 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.

**Affirmation of Denial**

If the Plan upholds its initial action and/or denial, then the member, member's representative or provider will be notified in writing of the decision as well as any additional rights that are available. Please refer to the Medicaid Fair Hearing and Subscriber Assistance Program below for further rights.

**Reversal of Denial**

If the Plan overturns its initial action and/or denial, it will notify the member and provider verbally and in writing for pre-services appeals. For retrospective appeals, the member and provider will be notified in writing only.

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 appeal was pending and the decision is to reverse a decision to deny, limit or delay services.

The Plan also will pay for disputed services, in accordance with state policy and regulations, if the services were furnished while the appeal was pending and the disposition reverses a decision to deny, limit or delay services.

**Submission of Member Appeals for Medicare**

A party may request a standard reconsideration by filing a signed written request with the Plan, Social Security Administration (SSA) office or, in the case of a qualified Railroad Retirement Board (RRB) beneficiary, an RRB 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 or RRB will be forwarded to the Plan for reconsideration; however, the time frames for review do not begin until the Plan receives the request for reconsideration.

The Plan must make a determination from the receipt of the request on a member appeal and notify the appropriate party within the following time frames:

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

**Request for Expedited Determination for Medicare**

A request for an expedited determination may be made verbally by calling Customer Service or in writing to the Appeals department. The request must state that it is a request for “an expedited process” and include reasons 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. The Plan will make a determination within 72 hours from receipt of the request and will send notification within two calendar days.

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

**14-Day Extension**

The determination period of 72 hours may be extended

by up to 14 calendar days if the member requests an extension. The time frame also may be extended by up to 14 calendar days 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 taken, the member will be notified verbally and in writing and give further rights should he or she not agree.

**Denial of Expedited Request**

If the Plan denies the request for expedited determination, the Plan will automatically transfer the request no later than within 30 calendar days from the date the Plan received the request for expedited reconsideration to the standard reconsideration process and then make its determination as expeditiously as the member's health condition requires.

The Plan will notify the member verbally and in writing of the denial and transfer of the request to the standard reconsideration process.

**Affirmation of Denial**

If the Plan affirms 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 72 hours from receipt of the case to issue a final determination.
  - Once a final determination has been made, the IRE will notify the member and the Plan and give the member further appeal rights, if the IRE agrees with the Plan.

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 the denial, it will notify the member 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 provide verbal notification to the member, member representative and provider that the services are approved along with 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 for Medicare**

The provider on behalf of the member and member's representative must complete an Appointment of Representative statement, which can be found in the **Forms** section of the Provider Manual, to request a standard pre-service determination.

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

**Affirmation of Denial**

If the Plan affirms 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.
  - Once a final determination has been

made, the IRE will notify the member and the Plan and give the member further appeal rights, if the IRE agrees with the Plan.

- 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.

- For pre-service appeals, the Plan will also notify the member, member's representative, and provider on behalf of the member verbally and in writing that the services are approved along with an authorization number within 72 hours if member's condition warrants it or no later than 14 calendar days from receipt of the IRE's determination.

#### Request for Retrospective Determination for Medicare

The provider on behalf of the member and member's representative must complete an Appointment of Representative statement, which can be found in the **Forms** section of the Provider Manual, to file a request for a retrospective determination.

The Plan will make a determination and provide notification within 30 calendar days from the date of receipt of the retrospective request.

#### Affirmation of Denial

If the Plan affirms 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.
- Once a final determination has been made, the IRE will notify the member and the Plan and give the member further appeal rights, if the IRE agrees with the Plan.
- 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 paid within 30 calendar days of receipt of the IRE's determination.

#### Submission of Provider Appeals

Providers have 90 days\* from the original utilization management or claim denial to file a provider appeal. Cases appealed after that time will be denied for untimely filing. If the provider feels they have filed their case within the appropriate time frame, they may submit 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.

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\* *Subject to change*

- 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.

The Plan has 30 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 related to the appeal, 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 set forth in 42 CFR 447.45 and 447.46 and Chapter 641, F.S., whichever is more stringent.

### **Request for Expedited Grievance Determination**

An enrollee may file a grievance or his or her appointed representative or a physician acting on behalf of the enrollee and with enrollee's written consent may request an expedited grievance 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. Please refer to the **Quick Reference Guide** for appropriate contact information. A

determination on the expedited request is as follows:

- Expedited Request: 72 hours (Medicaid Only)
- Expedited Request: 24 hours (Medicare Only)

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

- Process a request for service or request to continue service under the expedited 72-hour time frame rather than the standard 14-calendar-day time frame.
- Process an appeal under the standard process rather than the expedited process.
- Invoke a 14-calendar-day extension to a request for service or on an appeal.

#### **Request for Standard Grievance Determination**

A grievance will be investigated, determination made and closure letter sent to the complainant, within:

- 90 calendar days (Medicaid Only)
- 30 calendar days (Medicare Only)

The closure letter will include the results and date of the grievance resolution, and for decisions not wholly in the member's favor, will include:

1. **Medicaid Only:** Notice of the right to request a Medicaid Fair Hearing within 30 days;
2. **Medicaid Only:** Information on how to request a Medicaid Fair hearing, including the Department of Children and Families (DCF) address for pursuing a fair hearing, which is Office of Public Assistance Appeals Hearings, 1317 Winewood Boulevard, Building 5, Room 203, Tallahassee, FL 32399-0700;
3. **Medicaid Only:** Notice of the right to continue to receive benefits pending a hearing;
4. **Medicaid Only:** Information about how to request

the continuation of benefits;

5. **Medicaid Only:** Notice that if the plan's action is upheld in a hearing, the member may be liable for the cost of any continued benefits;
6. **Medicaid Only:** Notice that if the appeal is not resolved to the satisfaction of the member, the member has one year in which to request review of the Plan's decision concerning the appeal by the Statewide Provider and Subscriber Assistance Program, as provided in section 408.7056, F.S. The notice will also explain how to initiate such a review and will include the addresses and toll-free telephone numbers of the Agency and the Subscriber Assistance Program; and
7. **Medicaid Only:** Notice of the right to request a second-level grievance to the Plan, that the time limit to file a second-level request is 30 calendar days from the date of the notice, and that he/she may present the case at 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 a response. 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 letter is sent with an additional 10 business days to respond. If a provider has not responded within the second request, a third letter is sent giving the provider five days to respond.

Continued failure to respond may result in the provider's panel being closed to new patients and/or will be interpreted 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 quality issue exists. If the nurse feels a 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**

The Expedited, Standard Pre-Service and Retrospective determination periods noted above may be extended by up to 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. An extension notification will be sent to the member informing explanation of extension.

**Medicaid  
Fair Hearing**

The following Medicaid Fair Hearing process does not apply to Florida Healthy Kids. The member has the right to request a Medicaid Fair Hearing in addition to pursuing the Plan's grievance process. If this process is chosen, the member waives his/her further rights to appeal to the Subscriber Assistance Program.

The provider, acting on behalf of the member and with the member's written consent, may also request a Medicaid Fair Hearing.

Parties to the Medicaid Fair Hearing include the Plan as well as the member and his/her representative or the representative of a deceased member's estate.

The member, the representative or provider may only request a Medicaid Fair Hearing within 30 days of the date of the notice of action and/or denial. The request must be sent to DCF at the following address:

Office of Public Assistance Appeals Hearings  
1317 Winewood Boulevard  
Building 5, Room 203  
Tallahassee, FL 32399-0700

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

1. The Medicaid Fair Hearing is filed timely, meaning on or before the latter of the following:
  - Within 10 calendar days of the date on the notice of action (add five calendar days if the notice is sent via U.S. mail).
  - The intended effective date of the Plan's proposed action.
2. The Medicaid Fair Hearing involves the termination, suspension or reduction of a previously authorized course of treatment;
3. The services were ordered by an authorized provider;
4. The authorization period has not expired; and
5. The member requests extension of benefits.

If the Plan continues or reinstates the member's benefits while the Medicaid Fair Hearing is pending, the benefits will be continued until one of following occurs:

1. The member withdraws the request for Medicaid Fair Hearing.
2. Ten days pass from the date of the plan's adverse plan decision and the member has not requested a Medicaid Fair Hearing with continuation of benefits until a Medicaid Fair Hearing decision is reached (add five days if the notice is sent via U.S. mail).
3. A Medicaid fair hearing decision adverse to the member is made.
4. The authorization expires or authorized service limits are met.

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 the Medicaid Fair Hearing officer 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 Medicaid Fair Hearing was pending and the Medicaid Fair Hearing officer reverses a decision to deny, limit, or delay services.

The Plan will not take punitive action against a provider who requests a Medicaid Fair Hearing on the member's behalf or supports a member's request.

**Subscriber Assistance Program - Agency for Health Care Administration (AHCA)**

The following Subscriber Assistance program does not apply to Florida Healthy Kids. The member may, after completing the Plan's appeal and grievance process, appeal to AHCA or the Subscriber Assistance Program. Members who have taken grievances to Medicaid fair hearing will not be considered by the Panel.

The member or provider acting on behalf of the member must make a request for Panel review within one year of receipt of the final decision letter from the Plan by contacting:

Agency for Health Care Administration  
Subscriber Assistance Program  
Building 1, MS#26  
2727 Mahan Drive  
Tallahassee, FL 32308  
Telephone: (850) 412-4502 or (888) 419-3456

**Provider Complaint System**

A provider may file a written complaint to dispute the Plan's policies, procedures or any aspect of its administrative functions, including proposed actions, no later than 45 calendar days from the date the provider becomes aware of the issue generating the complaint.

**Medicaid only**

Provider complaints may be filed in writing via mail or fax to:

WellCare Health Plans, Inc.  
Attn: Grievance Department  
PO Box 31384  
Tampa, FL 33631-3384  
Fax: (866) 388-1769

A provider complaint will be thoroughly investigated using applicable statutory, regulatory and contractual provisions, collecting all pertinent facts from all parties and applying the Plan's written policies and procedures.

The Plan will also ensure that Plan executives with the authority to implement corrective action are involved in the provider complaint process.

The Plan will reply, in writing, to all complaints. In the event the outcome of the review of the provider complaint is adverse to the provider, the Plan shall provide a written notice of adverse action to the provider.

A provider may also contact the Plan's Customer Service department where dedicated staff is available to answer questions, assist in filing a provider complaint and resolve any issues. The appropriate Customer Service department contact information can be found in the **Quick Reference Guide** of this manual.

**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, of the reason.

Providers will be informed as to their right to appeal the action and the process and timing for reconsideration of the termination decision. The appeal request must be filed within 15 days of receipt of the Plan's termination notice.

The Plan will send an acknowledgement letter to the

provider within five business days of receipt of the appeal request.

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

A panel will review the appeal request and upon determination send an outcome letter to the provider stating that the appeal 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 prior to 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 assigned to the member. The member will be notified in writing of their new PCP and given a choice to change their PCP by contacting Customer Service.

The Plan will also notify members of the termination of a participating hospital, specialist or a significant ancillary provider within the service area, who have been seen two or more times within the past six months, 30 days prior to and no later than five business days after the termination effective date.

**Provider Claim  
Dispute  
Resolution  
Program**

If a provider does not agree with the final decision of the Plan, they have the right to request a review by the Florida Provider and Managed Care Organization Claim Dispute Resolution Program for all claims with date(s) of service after Oct. 1, 2000. Currently, the contracted review agency is Maximus Center for Health Dispute

Resolution (CHDR). This telephone number can be found on the **Quick Reference Guide**.