Appealing a coverage decision made by your Medical Assistance plan

A Guide to Grievances, Complaints, and Fair Hearings in Pennsylvania's Medical Assistance Program.

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Consumers who have had health care services denied, reduced, or stopped by their Medical Assistance (MA) heath plan should appeal if they disagree with those decisions. This brochure explains the appeals processes available to Medical Assistance consumers.

The appeal process available to a consumer depends on whether the individual receives MA through a Managed Care Organization (MCO) or through the Fee for Service (FFS) system.

The Fee For Service (FFS) Appeal System

Individuals receiving MA through the FFS system (ACCESS Card) who have been denied medical care or services can appeal the decision by asking for a Department of Public Welfare (DPW) Fair Hearing. This is how the process works:

- When a notice of decision is received, the consumer must request a Fair Hearing within 30 days from the date of the decision by writing to the address listed on the denial. State in the letter if you want a hearing in person or by phone.

- The hearing is conducted either in person or by phone. In person hearings take place in Philadelphia, Erie, Pittsburgh, Harrisburg, Reading, or Wilkes-Barre. For the telephone hearing, the consumer will be called at their home number. For individuals who do not have a phone, go to your County Assistance Office for the phone hearing.

- An Administrative Law Judge will hold the Fair Hearing. An attorney, advocate or friend can represent the consumer at the hearing. Witnesses are also permitted. Before the hearing, the consumer should ask DPW for copies of all information it may have that relates to the consumer's case.

- The Administrative Law Judge has 90 days from the date the consumer requested a Fair Hearing to hold the hearing and send out a decision. If the decision is unfavorable, the consumer may file for Reconsideration to the Secretary of DPW and/or appeal the case to Commonwealth Court.

How to continue getting services during the appeals process

If an individual has been receiving the services that are being reduced, changed or terminated and wishes to continue receiving the services, the individual should file a request for a Fair Hearing which is postmarked or hand-delivered within 10 days of the date on the decision being appealed. The services will be continued until a hearing de-

cision is made.

Appealing a Managed Care Organization (MCO) Decision

Individuals receiving MA through an MCO who are unhappy with the care they have received or are denied services have several appeal options:

- The consumer can request a complaint or grievance within the MCO

and/or

- The consumer can request a DPW Fair Hearing

What is a Complaint?

A Complaint is a dispute or objection about a participating provider, or about the coverage, operations or management of the plan. Appeals to the MCO about any of the following matters will be considered a Complaint:

- The health plan denies payment for a service a consumer received because the MCO claims a non-MA provider gave the service without its approval.
- The health plan denies a service or payment for a service because it has decided the service is not a covered benefit under the individual's plan.
- The health plan did not meet the required timeframes for providing the consumer with a service.
- The health plan failed to decide a complaint or grievance a consumer filed within the required timeframes.

How does the Complaint Process Work?

(For Physical Health MCOs and Behavioral Health MCOs)

There are two levels within the MCO's Complaint process - the First Level Complaint and the Second Level Complaint. At each Complaint Level, the consumer may bring someone to represent him/her or to help present the member's case. In the alternative, a consumer can request the health plan to provide one of their staff to act as an advocate for the member and help with the appeal. A consumer can also ask for copies of all documents the MCO may have that relate to the Complaint, and he/she can submit to the MCO additional information or documentation that supports the Complaint.

First Level Complaint

If a consumer is not satisfied with the care or treatment given by the MCO or the providers, or a consumer disagrees with a decision the MCO made for reasons other than the medical needs of the consumer, he/she can file a First Level Complaint. If the Complaint involves one of the four matters listed above, it must be filed within 45 days of the incident or the date the notice was received. If the Complaint is about other issues, it can be filed at any time.

Complaints can be made orally or in writing. In either case, the consumer will receive a written confirmation (a Complaint Acknowledgement letter) from the MCO that the Complaint was received.

A consumer can choose to participate in his/her First Level Complaint in person, by phone or by videoconference, if available. If the consumer wants to participate, he/she must tell the MCO within five business days of the date of the Complaint Acknowledgement letter.

A committee of one or more people within the MCO, who were not involved in the initial decision, reviews the First Level Complaint. A summary of the issues presented to the committee and the decisions made must be prepared and made part of the record.

The First Level Complaint will be decided within 30 days of the date the Complaint request was received. If additional time is needed to submit information to the MCO, a consumer can request up to a 14-day extension. Once the First Level Complaint review is completed, the consumer will receive a written decision from the MCO that must include: the decision; all reasons for the decision; any authority in policy, guidelines, etc. for the decision; and information on how to appeal if the consumer is not satisfied with the decision.

Urgent Matters

If waiting 30 days for a First Level Complaint decision would harm a consumer's health, he/she should contact his/her MCO and request that his/her Complaint be decided faster. The consumer's doctor will need to submit a statement within three business days of the request stating that waiting 30 days for a Complaint decision would jeopardize the consumer's life, health, or ability to attain, maintain or regain maximum function. Once the statement is received, the MCO must issue an Expedited Complaint decision within 48 hours of receiving the doctor's statement, or within three business days of the request, whichever is shorter.

Second Level Complaint

If a consumer is not satisfied with the decision from the First Level Complaint, he/she may file a Second Level Complaint orally or in writing within 45 days of receiving the First Level decision.

A committee hears the Second Level Complaint. This committee must include at least one person who is a member of the MCO. The consumer will be given an opportunity to appear before the Committee and must be given at least 15 days advance written notice of the meeting of the Committee. The Second Level Complaint must be heard and resolved within 30 days (if the dispute is with a Behavioral Health MCO) and within 45 days (if the dispute is with a Physical Health MCO).

External Review for Complaints

If a consumer is not satisfied with the Second Level Complaint decision, he/she can file for an External Review of the decision outside the MCO. The External Review must be requested within 15 days of the date the consumer received the Second Level Complaint Decision. The appeal goes to the Department of Health (for quality of care or services issues) or the Department of Insurance (for coverage or other insurance issues).

The Department of Health (or the Insurance Department) will get the consumer's file from the MCO to review. The consumer can also send them any additional information. Once a decision is made, a copy will be sent to the consumer. The letter will tell the consumer the reasons for the decision and what the consumer can do if he/she disagrees with the decision.

How to continue getting services during the complaint process

If the Complaint involves disputing a decision to discontinue, change, or reduce services already being received on the basis that the service is not a covered benefit, a consumer can continue to receive the services pending the outcome of the Complaint as long as the Complaint is postmarked or hand-delivered within 10 days of the date on the MCO's notice.

Grievance Process (Physical Health and Behavioral Health Plans)

A "grievance" is a consumer's request to have an MCO reconsider a decision solely concerning the medical necessity and appropriateness of the health care service. There are two levels within the MCO's Grievance process - a First Level Grievance and a Second Level Grievance.

First Level Grievance

If a consumer disagrees with the MCO's decision to deny, reduce or terminate the consumer's services, he/she can request a First Level Grievance orally or in writing. The Grievance request must be made within 45 days of the date the MCO's notice was received.

Grievances can be made orally or in writing. In either case, the consumer will receive a written confirmation (a Grievance Acknowledgement letter) from the MCO that the Grievance was received.

A consumer can choose to participate in his/her First Level Grievance in person, by phone or by videoconference, if available. If the consumer wants to participate, he/she must tell the MCO within five business days of the date of the Grievance Acknowledgement letter.

A committee of one or more people within the MCO who were not involved in the initial decision reviews the First Level Grievance. At least one person on the committee must be a doctor of the same or a similar specialty as the prescribing doctor. A summary of the issues presented to the committee and the decisions made must be prepared and made part of the record.

A First Level Grievance must be decided within 30 days of the date of the date the MCO receives the Grievance request. The consumer will receive a written decision within five business days after the First Level Grievance review is completed that must include: the decision; all reasons for the decision; any authority for the decision in policy, guidelines, etc.; and information on how to appeal if the consumer is not satisfied with the decision.

Second Level Grievance

If a consumer is not satisfied with the First Level Grievance decision, he/she may file a Second Level Grievance orally or in writing within 45 days of receiving the First Level decision.

A committee within the MCO conducts the Second Level Grievance review. The committee must include: at least one doctor of the same or a similar specialty to the prescribing doctor; and at least one consumer member of the MCO. The consumer will be given an opportunity to appear before the committee and must be given at least 15 days advance written notice of the meeting with the committee. The Second Level Grievance must be heard and resolved within 30 days (if the dispute is with a Behavioral Health MCO) and within 45 days (if the dispute is with a Physical Health MCO).

External Review for Grievances

If a consumer is not satisfied with the Second Level Grievance decision, he/she can file for an External Review of the decision outside the MCO. The consumer must send a letter to the MCO within 15 days of the date of receiving the Second Level Grievance decision. The letter is forwarded to the Department of Health who will assign an organization outside of the MCO (called a Certified Review Entity or CRE) to review the MCO's decision. The MCO will send the CRE a copy of the consumer's grievance file to review. The consumer can also send the CRE any additional information that may support their appeal. The CRE will issue a decision within 60 days of the date the External Grievance was filed. Once a decision is made, a copy will be sent to the consumer. The letter will tell the consumer the reasons for the decision and what the consumer can do if he/she disagrees with the decision.

Urgent Matters

If a consumer's doctor believes that waiting the usual time for a Grievance decision would harm his/her health, the consumer can contact the MCO and request that the Grievance be decided quickly. The consumer's doctor will need to submit a statement within three business days of the request stating that waiting 30 days for a Grievance decision would jeopardize the consumer's life, health or ability to attain, maintain or regain maximum function. Once the statement is received, the MCO must issue an Expedited Grievance decision within 48 hours of receiving the doctor's statement or within three business days of your request, whichever is shorter. If the decision is not satisfactory, a consumer can seek an Expedited Grievance outside of the MCO.

How to continue getting services during the grievance process

If the Grievance involves disputing a reduction, change, or termination to services already being received, a consumer can continue to receive the services pending the outcome of the Grievance as long as the Grievance is postmarked or hand-delivered within 10 days of the date on the MCO's notice.

Department of Pubic Welfare Fair Hearings

In all Grievance matters and in most Complaints, a consumer can file a DPW Fair Hearing request **instead of, or in addition to,** filing a Grievance or a Complaint. A consumer can ask for a Fair Hearing at the same time he/she files a Complaint or Grievance or can ask for a Fair Hearing after the MCO decides the First or Second Level Complaint or Grievance. A consumer must file for a Fair Hearing in writing within 30 days of the date of the decision from the consumer is appealing.

How to continue getting services during a Fair Hearing

If the Fair Hearing involves disputing a reduction, change, or termination to services already being received, a consumer can continue to receive the services pending the outcome of the Fair Hearing as long as the Fair Hearing request is postmarked or hand-delivered within 10 days of the date on the decision being appealed.

Expedited Fair Hearings

If a consumer's doctor believes that waiting for the usual timeframe for a Fair Hearing decision would harm his/her health, the consumer can request that the Fair Hearing be decided more quickly. The consumer's doctor will need to certify that waiting 90 days for a decision would jeopardize the consumer's life, health, or ability to attain, maintain or regain maximum function. The Fair Hearing will be held by telephone. As with expedited complaints and grievances, DPW must give a decision within 48 hours of when the harm statement is received from the provider, **or** within three business days of the date the request for an expedited process was received, whichever is **shorter.**

Questions? Call the Pennsylvania Health Law Project at 1-800-274-3258.