Denied a Service By Your Managed Care Plan? Appeal!

As a member of a Medicaid managed care plan, you have new appeal rights that you didn't have before in ACCESS Plus.

If your managed care plan denies, reduces or stops your services or treatment, or if you are unhappy with the care you have received, you can appeal. You can file a complaint or grievance within the plan and/or request a Fair Hearing.

For complaints and grievances, there are two levels of review done by your managed care plan; then you can appeal further by asking for a review by an outside group. Individuals can request a Fair Hearing at any stage of the appeal process.

Complaint

A complaint is a dispute or objection about a participating provider, or about the coverage, operations, or management of the plan. Examples of complaints include:

- You can't find a specialist in the Plan's network who can meet your needs
- Your health plan denies a service saying it's not a covered benefit under Medicaid

Grievance

A grievance is a request to reconsider a plan's decision that a service or treatment is not medically necessary. It's a grievance if you appeal:

- Your health plan's refusal to pay for a medication because the Plan believes another similar medication would meet your needs
- Your health plan's denial of home health aide services for your child as not medically necessary.

Important things to know when filing complaints or grievances:

- ✓ Timeframes are important – you can file a first or second level appeal within 45 days of receiving the decision. If you are appealing a reduction or a stopping of services that you have been receiving, you want to file your appeal within 10 days of the date on the notice to continue to get the services during the appeal process.
- ✓ Complaints and grievances can be made by phone or in writing. If filing by phone, you should make a note of the day the appeal was filed and the name of the plan representative who took the appeal. If the appeal is in writing, try to send it some way that there's proof that it was delivered (i.e., certified mail or delivery confirmation) and keep a copy for your records. The plan will send a written confirmation from the plan that the complaint/grievance was received.
- ✓ You can participate in any level of a complaint or grievance in person or by phone. You have to let the health plan know that you want to participate. You can always bring someone to

represent you or help present your case. Individuals can also request help from a member advocate within the health plan.

- ✓ You can ask for a copy of all documents the plan used in making its decision
- ✓ You can submit additional information or documentation to help support your complaint or grievance
- ✓ First level appeals are heard by a committee of one or more people who were not involved in the initial decision. In grievances, the committee must include a doctor. All first level appeals should be decided within 30 days of the plan's receipt of your appeal. Once a decision is made, you will receive a written decision that gives information about further appeal options
- ✓ Second level appeals are heard by a committee that must include at least one member of the managed care plan. If it's a grievance, the committee must also include at least one doctor. All second level decisions should be made within 30 days of receiving your appeal. You will be sent a written decision that gives information about further appeal options.

External Review

Individuals who are not satisfied with a second level complaint or grievance decision can request a review by someone outside the plan. You must request this within 15 days of receiving the second level decision (if you are currently receiving services, file your request within 10 days to keep getting the services during the appeal process). For complaints, the requests are handled by either the Department of Health or the Department of Insurance. All grievance reviews are sent to the Department of Health who then assigns someone outside the plan to review the decision.

The plan sends the file to the External Reviewer. You can also send them any additional information. Grievances will be decided within 60 days and a written decision will be sent. There is no timeframe for a complaint decision.

Fair Hearings

In all grievance matters and in some complaints, you can request a Fair Hearing instead of, or in addition to, requesting a grievance or complaint. You can file a Fair Hearing at the same time you request a complaint or grievance or after the first or second level decisions. You must request a Fair Hearing in writing within 30 days of the date of the decision you're appealing (10 days to get continued benefits). Fair Hearings are handled by the Department of Public Welfare, and they must be decided within 90 days of receiving your request.

Expedited Appeals

At any level of appeal, if your doctor believes that your health would be harmed by waiting the usual timeframes for a decision, you can request a quicker decision. Your doctor will need to certify that you will be harmed by waiting. Once that is received, an appeal is conducted and a decision made within 48-72 hours.

Call the Pennsylvania Health Law Project at 1-800-274-3258 for more information about the appeal processes available or for advice and/or representation in a Grievance or Fair Hearing.