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**Overview**

The Plan maintains a member grievance system that includes a grievance process, an appeal process, an External Independent Review process and access to the Medicaid Hearing system.

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 with the member's written consent may file an 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 an expression of dissatisfaction about any matter other than an action that can be appealed. Specifically, a *grievance* is any dissatisfaction expressed to the Plan regarding the availability, delivery, appropriateness or quality of health care services and matters pertaining to the contractual relationship between the member and the Plan for which the member has a reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of the dissatisfaction. A member, a member's representative or a provider acting on behalf of a member 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 or staff;

- Failure to respect the member's rights.

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 or disease or have sought advice 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.

No health care provider may be penalized by a plan for providing testimony, evidence, records or any other assistance to a member who is disputing a denial, in whole or in part, of a health care treatment, service or claim thereof.

### **Submission of Member Appeals**

Any party to an action appropriate for appeal (including a reopened and revised determination), including a member or a member's authorized representative, may request that the action be reconsidered.

The member, member's representative or provider may file for an expedited, standard pre-service or retrospective appeal determination. A provider may file a statement with the member's appeal request supporting the need for expedited resolution. The request must be a statement by the physician him/herself and not from an office staff member.

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.

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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. For interpreter services, please contact our Customer Service department for assistance.

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 30 calendar days, then good cause must be shown in order for the Plan to except the late request. Examples of good cause include but are not limited to:

- The member did not personally receive the Notice of Action, 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;
- Documentation was difficult to locate within the time limits;
- The member had incorrect or incomplete information concerning the appeal 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 should be directed to the Customer Service department, which will coordinate with Appeals department as appropriate. A member of the Customer Service or Appeals team will be in contact with the provider within two business days of the inquiry.

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A member, member's representative, or provider 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 member's representative 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 Representation** 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 must make a determination on an appeal within the following time frames:

- **Expedited Request: 72 hours**
- **Standard Pre-Service Request: 15 business days**
- **Retrospective Request: 15 business days**

Members have the right to request continuation of benefits during an appeal or Medicaid 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 or hearing request 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);

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- The intended effective date of the Plan's 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 original period covered under the original authorization has not expired; and
- The member requests extension of benefits.

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

- The member withdraws the appeal;
- Ten calendar days pass from the date of the Plan's action and the member has not requested a Medicaid Hearing with continuation of benefits until a Medicaid Hearing decision is reached. (Add five calendar days if the notice is sent via U.S. mail);
- A Medicaid Hearing or appeal decision adverse to the member is made; or
- The authorization expires or authorized service limits are met.

#### **Request for Appeal Determinations**

#### **Request for Expedited Appeal**

A request for an expedited appeal 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 reasons why the case should be

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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. The Plan will make reasonable efforts to notify the member verbally and will also notify the member in writing of the disposition of their request.

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

If the Plan denies the request for the expedited determination, the Plan will automatically transfer the request no later than within 15 business 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.

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

A request for a pre-service determination may be made verbally by calling Customer Service or in writing to the Appeals department.

The Plan will make a determination and provide notification within 15 business days from receipt of the standard pre-service request.

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

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

The Plan will make a determination and provide notification within 15 business days from 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 the 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 appeal rights.

**Reversal of Denial**

If the Plan overturns the action, it will notify the member and provider verbally and in writing.

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.

**Request for External Independent Review (EIR)**

The External Independent Review (EIR) process is available for the resolution of appeals regarding an adverse utilization determination, an adverse determination of medical necessity or a determination that a proposed service is experimental.

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The member, or provider on behalf of the member, may file a written request with the Plan for an appeal of the appeal resolution not later than 45 calendar days after the member is notified of the Plan's resolution.

The Plan will acknowledge receipt of the request for EIR review within three business days of receiving the request.

A standard external review will be resolved within 15 business days after the standard review request. An expedited review will be resolved within 72 hours of receipt of the request.

For a standard review, the member is notified within 72 hours of the EIR panel's decision. For an expedited review, the member is notified within 24 hours of the EIR panel's decision.

If at any time during the external review the member submits information to the Plan that is relevant to the Plan's resolution and was not considered previously, the following will occur:

- The Plan will reconsider its previous decision;
- The EIR organization will cease the external review process until the reconsideration is completed;
- The Plan will notify the member of its reconsideration decision within 72 hours for expedited appeals and 15 business days for standard appeals.

If the reconsideration decision remains adverse to the member, the member may request that the EIR organization resume the external review. If the member does request resumption, the Plan will notify the EIR organization and forward the additional information for review.

### **Submission of Grievances**

A member, member's representative or provider acting on behalf of the member with the written consent of the member may file a grievance either verbally or in writing

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within one year after the date of an 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 or written request.

If the member wishes to appoint another person as their representative, he/she must complete an **Appointment of Representation** 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 member's behalf or supports a member's grievance.

The Plan will send an acknowledgement letter, within 10 business days of receipt of a grievance and must make a determination on an grievance within the following time frames:

- **Expedited Request: 72 hours**
- **Standard Request: 30 calendar days**

The Plan may extend the grievance resolution time frame by up to 14 calendar days if the member, member's representative or provider on behalf of a member (with the member's written consent) requests an extension if additional information is needed and the delay is in the member's best interest.

The Plan will prompt notification to the member, member's representative or provider on behalf of the member using an approved notice (letter) regarding the plan to take up to a 14-calendar day extension on a grievance case.

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.

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See the **Rapid Reference Guide** for the TTY/TDD phone number.

Please contact Customer Service for help with interpreter services.

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**

A member, a member representative or a provider on behalf of a member 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 directly to:

Wellcare Health Plans  
Attn: Grievance Department  
P.O. Box 31384  
Tampa, Florida 33631  
Or Fax to:  
(866) 388-1769

A determination on the expedited request will be made within 72 hours of receipt of the expedited request.

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 standard 14-calendar day time frame rather than the expedited 72-hour 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.

An expedited grievance can also be filed if processing under the standard process would seriously jeopardize

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the life or health of the member or the member's ability to reach and maintain maximum function.

The Plan will respond in writing to the member within five business days after resolution of the grievance. The resolution will include a notice of the member's right to file an appeal.

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

A grievance will be investigated and determination made within 30 calendar days of receipt of the standard request.

The Plan will respond in writing to the member within 10 business days after resolution of the grievance. The resolution will include the decision reached by the Plan, the reasons, policies and procedures that are the basis of the decision and a notice of the member's right to file an appeal.

#### **Grievance Appeal**

If the member remains dissatisfied after the grievance determination, he/she may file an appeal to the Appeals and Grievance Committee. The Plan will acknowledge the appeal in writing within three business days after receipt of the appeal. The appeal of the grievance decision will be resolved as expeditiously as possible and with regard to the clinical urgency of the appeal. The appeal will be resolved not later than 45 calendar days after the appeal is filed.

#### **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 member may mail the grievance to :

Wellcare Health Plans  
P.O. Box 31384  
Tampa, Florida 33631  
Or Fax to:  
(866) 388-1769

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The provider is given 10 business days to respond and submit medical records for review. If a provider has not responded within the 10 business days, a second fax and 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 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.

### **Medicaid Hearing**

The member has the right to request a Medicaid Hearing after completing the Plan's appeal process.

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

The member, or member's representative, may only request a Medicaid Hearing within 30 days of the date of the initial action that is being reviewed. The request must be sent to state of Illinois Department of Healthcare and Family Services (HFS) at the following address:

Illinois Department of Human Services  
Bureau of Assistance Hearings  
401 S. Clinton, 6th Floor  
Chicago, Illinois 60607

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

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- The Medicaid Hearing is filed timely, meaning on or before the later of the following:
  1. Within 10 calendar days of the date on the Notice of Adverse Action (add five calendar days if the notice is sent via U.S. mail).
  2. The intended effective date of the Plan's action.
- The Medicaid Hearing 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 the member's benefits while the Medicaid Hearing is pending, the benefits will be continued until one of following occurs:

- The member withdraws the request for Medicaid Hearing;
- Ten days pass from the date of the Plan's adverse decision and the member has not requested a Medicaid Hearing with continuation of benefits until a Medicaid Hearing decision is reached (add five days if the notice is sent via U.S. mail);
- A Medicaid Hearing decision adverse to the member is made;
- 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 Hearing was pending and the Administrative Law Judge 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 Hearing was pending and the Administrative Law Judge reverses a decision to deny, limit or delay services.

### **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 30 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 10 business days to submit the required documentation. If not received within 10 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 60 calendar days prior to and no more than 10 calendar days after receipt or issuance of the termination notice. 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 a choice 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, 30 days prior to and no later than five business days after the termination effective date of a participating hospital, specialist or a significant ancillary provider within the service area.