

ADMINISTRATIVE REVIEWS AND GRIEVANCES

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Overview

The Plan maintains distinct grievance and administrative review processes for members and providers, as well as access to the state's hearing system. Providers have the right to participate in these processes on behalf of patients and to challenge failure by the Plan to cover a specific service. Members, or their representatives, can call the Customer Service department to file an administrative review request or a grievance.

The toll-free number (866-231-1821) to access the Grievance system.

Definitions

An *administrative review* 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 may file an administrative review. Examples of actions that can be administratively reviewed 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 administratively reviewed. Specifically, a *grievance* is an expression of dissatisfaction with any aspect of the managed care Plan or provider's operation, provision of health care services, activities or behaviors. A member or a member's representative acting on behalf of the member and with the member's written consent.

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Possible subjects for grievances include but are not limited to the following:

- Quality of care of services provided;
- Rudeness of the provider or staff; or
- Failure to respect the member's rights.

The Plan ensures that decision-makers on grievances and administrative reviews 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 advice from providers with expertise in the field of medicine related to the request when deciding any of the following:

- An administrative review of a denial based on lack of medical necessity;
- A grievance regarding denial of expedited resolution of an administrative review;
- A grievance or administrative review involving clinical issues.

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

Submission of Member Administrative Reviews

Any party to an action appropriate for administrative review, 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 a request for an expedited or standard administrative review determination. A provider may file a statement with the member's administrative review request supporting the need for an expedited resolution. The request must be a

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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 requesting a standard or expedited administrative review.

The Plan gives members reasonable assistance in completing forms and other procedural steps for an administrative review, including, but not limited to, providing interpreter services and TTY/TDD toll-free telephone numbers with interpreter capability. To arrange interpreter services, please contact Customer Service 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 for the Plan to accept the late request. Examples of good cause include but are not limited to the following:

- 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 administrative review;
- 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 limit;
- The member had incorrect or incomplete information concerning the administrative review process;
- The member lacked capacity to understand the time frame for filing a request for reconsideration.

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Questions regarding the filing or status of an administrative review should be directed to Customer Service, which will coordinate with the 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.

A member, a member's representative or a provider acting on behalf of the member with a member's written consent may file an administrative review request verbally or in writing within 30 calendar days of the date on the Notice of Proposed Action.

If filed verbally through Customer Service, the request must then be supplemented with a written, signed administrative review request to the Plan. For verbal filings, the time frame for resolution begins on the date the verbal request was called into Customer Service. The Plan will assist the member to ensure that a written administrative review is filed immediately by converting a verbal filing into a written record. If the member follows the verbal filing with a written administrative review, this administrative review will supersede the written record.

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

An acknowledgement of receipt will be provided to the person filing the administrative review within ten business days.

The Plan must make a determination on an administrative review within the following time frames:

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

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- Retrospective Request: **45 calendar days**

Members have the right to request continuation of benefits during an administrative review. The member may be liable for the cost of any continued benefits if the Plan's action is upheld at the discretion of the Georgia Department of Community Health (DCH).

The Plan will continue the member's benefits if:

The administrative review or hearing request is filed timely, meaning on or before the later of the following:

1. Within 10 calendar days of the date on the Notice of Action; or
 2. The intended effective date of the Plan's proposed action.
- The administrative review 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 continuation of benefits.

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

- The member withdraws the administrative review;
- Ten calendar days pass from the date of the Plan's Notice of an Adverse Administrative Review Decision and the member has not requested a Hearing with continuation of benefits within the 10 calendar day time frame;

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- A Hearing or administrative review decision adverse to the member is made; or
- The authorization expires or authorized service limits are met.

This process shall also be available for dissatisfaction concerning the timeliness of services or the timeliness of grievance responses.

Request for Member Administrative Review Determinations

Request for Expedited Determination

A request for an expedited administrative review may be made verbally by calling Customer Service or in writing by mail to the Appeals department. A written administrative review is not required.

The plan has a responsibility to review all administrative reviews and expedite those that warrant quicker action. 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 on whether processing will be expedited or standard within one business day from the receipt of the request.

Administrative reviews selected for expedited processing will be determined within 72 hours from receipt of the request. The Plan will make reasonable efforts to notify the member of the disposition of their request verbally and also in writing.

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

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Denial of Expedited Request

If the Plan denies the request for the expedited determination, then the Plan will automatically transfer the request to the standard reconsideration process no later than 30 calendar days from the date the Plan received the request for expedited reconsideration. The Plan will then make its determination as expeditiously as the member's health condition requires. The plan will also make reasonable efforts to give the member prompt verbal notice of the denial, and will follow-up within two calendar days with a written notice.

Request for Standard Pre-Service Determination

A request for a standard administrative review determination may be made verbally by calling Customer Service or in writing by mail to the Appeals department. The Plan will make a determination and provide notification within 30 calendar days from receipt of the standard request.

Request for Retrospective Determination

The provider and member must complete an Appointment of Representative statement, which can be found in the **Forms** section of this handbook to file a request for a retrospective determination.

The Plan will make a determination and provide notification within 45 calendar days from receipt of the retrospective request.

14-Day Extension

The Expedited and Standard Administrative Review determination periods noted above may be extended up to 14 calendar days if the member, member's authorized representative, or a provider acting on behalf of the member with the member's written consent requests an extension or if the Plan justifies a need for additional information and documents how an extension is in the best interest of the member. If an extension is not requested by

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the member, the Plan will obtain prior approval from DCH, and if approved, will provide the member with written notice of the reason for the delay and the date by which a decision must be made.

Affirmation of Denial

If the Plan upholds the action and/or denial, then the member, the member's representative or the provider will be notified in writing of the decision, as well as any additional administrative review 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 administrative review 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 administrative review was pending and the disposition reverses a decision to deny, limit or delay services.

Member Administrative Law or DCH Hearing Rights

The member and his/her representative have the right to request an Administrative Law (Medicaid) or DCH (PeachCare for Kids) Hearing only after completing the Plan's administrative review process.

The member and his/her representative may review the case file and present evidence during the hearing.

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

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A provider can be a representative or a witness in a hearing process.

Reasonable assistance is available to members and his/her representative to request an administrative law hearing. The member or a member's authorized representative with written consent from the member, may request an Administrative Law/DCH Hearing within 30 calendar days of the date the Notice of Adverse Action is mailed by the Plan. A provider cannot request an Administrative Law Hearing on behalf of the member. The request must be sent to the following addresses:

Medicaid

WellCare of Georgia
Administrative Law Hearing Request
P.O. Box 31850
Tampa, FL 33631-3580

PeachCare for Kids

PeachCare for Kids
Attn: Resolution Coordinator
2 Peachtree Street, NW
Atlanta, GA 30303-3159

A. The Plan will continue the member's benefits if:

- The administrative review 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; or
 - The intended effective date of the Plan's proposed action.
- The administrative review involves the termination, suspension or reduction of a previously authorized course of treatment.

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- The services were ordered by an authorized provider;
- The original period covered under the original authorization has not expired; and
- The member requests continuation of benefits.

B. The Plan will continue the member's benefits while the Administrative Law Hearing is pending if:

- The Administrative Law Hearing request is filed timely meaning on or before the later for the following:
 - Within 10 calendar days of the date on the Notice of Action; or
 - The intended effective date of the Plan's proposed action.

Until one of the following occurs:

- The member withdraws the Administrative Law Hearing request;
- Ten calendar days pass after WellCare mailed the Notice of Adverse Action unless the member within the ten calendar day timeframe has requested continuation of benefits until an Administrative Law Hearing decision is reached
- An Administrative Law Hearing judge issues a hearing decision adverse to the member; or
- The time period or service limits of a previously authorized service has been 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 Administrative Law/DCH Hearing was pending and reverses a decision to deny, limit or delay services.

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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.

Submission of Provider Administrative Reviews

Providers have 30 days* from the original utilization management denial or claim denial to file a provider administrative review. Cases reviewed after that time will be denied for untimely filing. There is no second level consideration for cases denied for untimely filing. If the provider feels they have filed their case within the appropriate time frame, they may send 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 administrative review by submitting a letter stating this purpose and/or an administrative review form with supporting documentation such as medical records. In reviewing provider complaints or appeals related to denial of claims, providers may consolidate complaints or appeals of multiple claims that involve the same or similar payment or coverage issues, regardless of the number of individual patients or payment claims included in the bundled complaint or appeal. An administrative review form may be found in the **Forms** section of this handbook.

- 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.

* *Subject to change*

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The Plan has 30 business 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. In the event the provider submits additional information, the Plan will have 30 business days from the receipt of the additional information to render a decision in writing.

- 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 reviewed 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 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 federal and state requirements.

Submission of Provider Claim Reconsiderations

Claim Reconsiderations

A Provider may file a Claim Reconsideration by submitting a letter to the Plan with supporting documentation such as medical records.

- A provider can resubmit a corrected claim for reconsideration of payment within three months of the month for which the Explanation of Payment (EOP) posted.
- A provider can dispute a claim payment within three months of the month for which the EOP posted.

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Claim Reconsideration requests received after that time will be denied for untimely filing. If a provider feels they have filed their case within the appropriate time frame, they may send proof to the Plan.

For written requests, acceptable proof of timely filing will only be in the form of a registered postal receipt signed by a representative of the Plan, a similar receipt from other commercial delivery services or a fax confirmation.

- The Plan is not responsible for payment of medical records generated as a result of provider initiated claim reconsideration requests. 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.

In the event the outcome of the review of the Provider Appeal is adverse to the provider, the Plan will issue a written Notice of Adverse Action to the provider. The Notice of Adverse Action will state that providers may request an Administrative Law Hearing in accordance with OCGA § 49-4-153 or select binding arbitration by a private arbitrator who is certified by a nationally recognized association that offers training and certification in alternative dispute resolution.

If WellCare and the provider are unable to agree on an association, the rules of the American Arbitration Association shall apply. The arbitrator shall have experience and expertise in the health care field and shall be selected according to the rules of his or her certifying association. Arbitration conducted pursuant to this Code section shall be binding on the parties. The arbitrator shall conduct a hearing and issue a final ruling within 90 days of being selected, unless the care management organization and the provider mutually agree to extend this deadline. All costs of arbitration, not including attorney's fees, shall be shared equally by the parties.

To pursue the Administrative Hearing the provider must

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request one in writing with a copy of the Administrative Review determination letter to:

**WellCare Health Plans, Inc.
Administrative Law Hearing Request
PO Box 31580
Tampa, FL 33631-3580**

To schedule a hearing, the provider must make a request within 15 business days of the date of the administrative review determination letter.

Submission of Provider Administrative Review for a Termination Request

If a provider termination is initiated by the Plan, regardless of whether the termination is with cause or without cause, the Plan will notify the provider of the termination decision in writing, via certified mail, of the reason including, but not limited to, termination for business reasons.

Providers will be informed as to their right to appeal the action, 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 three 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 five business days to submit the required documentation. If not received within five 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

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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 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 is obligated to notify all appropriate regulatory agencies of provider terminations in writing. The Plan will notify members who have been seen two or more times within the past six months, are in active, ongoing treatment or are under OB care, 30 days prior to and no later than five business days after the termination effective date of a specialist, a significant ancillary provider or a hospital.

Submission of Provider Complaints

The Plan encourages providers to contact Customer Service to informally resolve any concerns or issues. Refer to the **Quick Reference Guide** for telephone numbers. In the event an issue cannot be resolved, the Plan has established a provider complaint system that permits a provider to formally dispute the Plan's policies, procedures or any aspect of the administrative functions.

Providers have 30 calendar days from the date he or she becomes aware of the issue to file a written complaint. Complaints received after that time will be denied for untimely filing. If a provider feels they have filed their case within the appropriate time frame, they may send proof. For written complaints, 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 a complaint by submitting a letter with supporting documentation such as medical records.

- The Plan is not responsible for payment of medical

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records generated as a result of a provider complaint. 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 will respond to the complaint within 45 calendar days of receipt.

Customer Service has dedicated staff that may be reached via telephone or our Web site to answer provider questions, assist providers in filing a complaint and help resolve any issues.

During the complaint process, the Plan will thoroughly investigate each provider complaint using applicable statutory, regulatory and contractual provisions, collect all pertinent facts from all parties and apply the Plan's written policies and procedures. Plan management members with the authority to implement corrective action are involved throughout the provider complaint process.

The Plan is required to submit a quarterly report to the state on all provider complaints filed and the resolution of each.

In the event a provider is not satisfied with the Plan's complaint decision, the provider may request a review at an Administrative Law Hearing. However, providers must exhaust the Plan's provider termination and/or provider complaint procedures before bringing action by way of arbitration or court action against WellCare.

Administrative Law Hearing

In the event the outcome of the review of the provider complaint is adverse to the provider, the Plan will provide a written notice of adverse action to the provider. The notice of adverse action will state that a provider has 15 business days from receipt of the notice, to file a request for an administrative law hearing with the state.

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To file a request for administrative law hearing, submit the request in writing to:

WellCare Health Plans, Inc.
Administrative Law Hearing Request
PO Box 31580
Tampa, FL 33631-3580

A request for an administrative law hearing must include the following information:

- A clear expression by the provider or authorized representative that he/she wishes to present his/her case to an administrative law judge;
- Identification of the adverse action being appealed and the issues that will be addressed at the hearing;
- A specific statement of why the provider believes the Plan's adverse action is wrong; and
- A statement of the relief sought.

Submission of Member Grievances

A member or a member's representative acting on behalf of the member, may file a grievance either verbally or in writing. 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 filing.

If the member wishes to appoint another person as their representative, he/she must complete an Appointment of Representative statement. The member and the person who will be representing the member must sign the statement. This form is available in the **Forms** section of this handbook.

The Plan will send an acknowledgement of receipt to the person filing the grievance within 10 business days. The Plan will make a determination on the grievance notification within 90 calendar days

The Plan gives members reasonable assistance in

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completing forms and other procedural steps, including but not limited to the provision of interpreter services and TTY/TDD toll-free telephone numbers with interpreter capability. Refer to the **Quick Reference Guide** for the appropriate contact information.

Members will be provided reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing.

Request for Standard Member Grievance Determination

A grievance will be investigated, a determination made and a closure letter sent to the complainant (and DCH upon request), within 90 calendar days of receipt of the standard request.

The closure letter will include:

- The date of the letter
- Member's name, address, city, state, identification number, and the grievance file number
- The substance of the Grievance
- The decision of the Grievance
- Only in the situation on where timeliness to close a grievance exceeded 90 calendar days, the letter will also provide the member's right to request an Administrative Law Hearing

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 the 10 business days, a second fax and letter is sent giving an additional five business days to respond.

Continued failure to respond may result in the provider's

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panel being closed to new patients and/or will be interpreted as the provider not in disagreement 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 may 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.