

SECTION 7 - MEMBER APPEALS

Member Appeals Process

Members are informed verbally and in writing about grievance and appeal rights and have the right to appeal any adverse decision regarding service provisions or payment of claims. Written instructions are included in the Evidence of Coverage (EOC) booklet that is given to Members upon enrollment into the Program.

PHP encourages Members to call right away if there are any questions, concerns or problems related to covered services or care. Please call PHP Customer Service at 1-715-838-2900 Voice/TTY or 1-800-842-1814 if there are questions. PHP will participate and comply with determinations that may be issued relative to Members in the appeals process and as required by the State of Wisconsin Department of Health and Family Services (DHFS) and/or CMS.

Whenever PHP denies payment for a service, or a Plan Provider denies a referral for a service the Member believes is a covered benefit, Providers must supply Members with his or her Medicare appeal rights. To submit an appeal in writing, use the PHP Member Request for Appeal or Grievance Form attached as Appendix 1. The form must be signed and dated by the Provider and Member, with a copy of the form filed in the Member's medical record. In the event that a Member files an appeal, PHP will contact the Provider's office to determine the date of the denial in question.

Members are also informed and entitled to their rights to express concerns about quality of care or any other issues. The Medicare appeals and grievance processes are separate and distinct. Each process has procedures and time frames that must be adhered to.

Standard Medicare Appeals Process

Members, their representatives or providers acting on behalf of the Member, have the right to request a reconsideration of an organization determination through the Standard Medicare Appeals Process or Expedited Appeals Process. Requests for either of these options must be in writing.

A Plan Provider may file an appeal on behalf of a Member for a denied claim. A Non-Plan Provider may file an appeal of a denied claim if he or she completes a waiver of liability statement that states the Provider will not bill the Member, regardless of the outcome of the appeal.

- PHP must make reconsideration decisions *regarding coverage issues* within the standard time limit of thirty (30) calendar days or as expeditiously as the Member's health status requires.
- PHP must make reconsideration decisions *for claims payment determinations* within the standard time limit of sixty (60) calendar days.
- If PHP upholds its organization determination, in whole or in part, PHP is required to send the case to CMS's contractor, Maximus Center for Health Dispute Resolution

(CHDR) for review and determination within thirty (30) calendar days from the date that PHP received the request for coverage issues and sixty (60) calendar days for claims payment issues.

- If Maximus CHDR overturns PHP's decision, PHP has seventy-two (72) hours to authorize the requested coverage or thirty (30) calendar days to issue claim payment.
- If CHDR maintains PHP's decision to deny coverage or payment on the claim, PHP will take no further action.

A Member may appeal further through either an Administrative Law judge or Federal District court, depending on the dollar amount involved.

Expedited Medicare Appeals Process

Requests for an appeal must be filed in writing or orally and within sixty (60) calendar days of the date that PHP originally denied the Member's request for a service. However, if the Member believes that his or her health, life or ability to regain optimal function could be seriously jeopardized by waiting for a decision through the standard appeal process, the Member may request an expedited reconsideration. PHP must make its expedited reconsideration determination within seventy-two (72) hours or as expeditiously as the Member's health condition requires.

An extension of up to fourteen (14) calendar days may be granted if the Member requests an extension or if PHP needs additional information and the extension benefits the Member. If PHP determines that the Member's request does not meet criteria for the expedited appeals process, PHP must make its reconsideration determination within the standard time frames above. The Member has the right to file an urgent grievance if an expedited reconsideration determination is not given. If the Member's Primary Care Physician (PCP) requests that PHP make an expedited reconsideration determination, PHP must grant the request.

The expedited appeal period begins either when the Member makes the request or when PHP receives medical information necessary to make the decision from a physician or provider not affiliated with PHP.

Standard Medicaid Appeals Process

For Members who are only eligible for non-Medicare benefits, their representatives or providers acting on behalf of the Member, can file an appeal in writing to PHP, to the Department of Health and Family Services (DHFS), and/or to the Division of Hearings and Appeals (DHA). A Plan Provider may file an appeal on behalf of a Member for a denied claim. A Non-Plan Provider may file an appeal of a denied claim if he or she completes a waiver of liability statement that states the Provider will not bill the Member, regardless of the outcome of the appeal.

Appeals to the State of Wisconsin Department of Health and Family Services should be submitted through the Managed Care Ombudsman. The appeal must be submitted in writing within forty-five (45) days to:

State of Wisconsin Department of Health and Family Services
Managed Care Ombudsman
P.O. Box 6470
Madison, WI 53716-0470
Toll Free Number: 1-800-760-0001

To request a hearing before the Division of Hearings and Appeals, the request must be submitted in writing within forty-five (45) days of the prior decision to:

State Division of Hearing and Appeals
Department of Administration
Division of Hearings and Appeals
P.O. Box 7875
Madison, WI 53707-7875
Phone: 1-608-266-3096
Fax: 1-608-264-9885

When an appeal is submitted to PHP a response will be sent to the Member with a decision on the appeal no later than thirty (30) days from receipt of the appeal request. If PHP feels a reduction in the amount or frequency of an approved service is warranted, the Member will receive written notice at least ten (10) days in advance of the date on which services are to be reduced or terminated. No notification is required if the reduction is ordered by the member's physician.

The Member has up to sixty (60) days from the date of the written notice to request an appeal. If the Member does not request an expedited appeal, PHP will respond as quickly as the Member's health requires, but no later than thirty (30) days from the day the appeal was received. If the Member submits the request for an appeal within 10 calendar days of receiving the written notice or prior to the date that the reduction is to begin, PHP will continue to provide the service until completion of the appeal process. If PHP's decision to terminate or reduce the services is upheld through the appeals process, the Member is financially responsible for any services that were continued because of the appeal process.

An appeal for payment must be submitted in written form. PHP is not required to process oral requests for an appeal for payment. If PHP denies payment for a service, the Member can request an appeal, but it must be no later than forty-five (45) days after Member notification of payment denial. If PHP agrees to pay for the service, payment will be made no more than sixty (60) days after the appeal was requested. There is no expedited process for denial of payment.

Expedited Medicaid Appeals Process

If the Member, authorized representative, or physician feels that the Member's health could be seriously harmed by waiting too long for a decision, they may ask for an expedited appeal. If any physician asks for an expedited appeal for a Member, or supports the Member in asking for one, and the physician indicates that waiting for thirty (30) days could seriously harm the Member's health, PHP will automatically grant an expedited appeal.

PHP will decide on an expedited appeal no later than seventy-two (72) hours after it receives the appeal. This may be extended up to fourteen (14) days if the Member requests it or if PHP needs additional information and the extension benefits the Member.

If the Member asks for an expedited appeal without support from a physician, PHP can decide if the Member's health requires an expedited appeal; the standard timeframe of thirty (30) days then applies.

Member Grievance Process

"Grievance" refers to any dissatisfaction communicated orally or in writing to PHP in regard to any aspect of health plan operation. It does not include misunderstandings or misinformation that is resolved promptly. PHP's grievance policies, procedures and processes meet the requirement of CMS. Federal law guarantees Members' rights to make complaints if there are concerns or problems with any part of the medical care. If a complaint is made, PHP must be fair in how it is handled with the Member not being disenrolled from PHP or penalized in any way.

If a Member has a grievance or concern other than one involving an organizational determination, the Member may file a grievance with PHP's Grievance and Appeals Coordinator. To submit a grievance in writing, use the Member Request for Appeal or Grievance Form attached as Appendix 1. Members must file a grievance no later than sixty (60) calendar days after the event or incident that precipitates the grievance. PHP acknowledges the receipt of a written grievance within fifteen (15) business days and has thirty (30) calendar days to resolve the grievance and provide the Member with a written response. The written response contains the nature of the grievance, the issues involved, the decision and the specific reasons for the decision.

PHP may extend the thirty (30) day time frame by fourteen (14) calendar days if:

- More information is needed
- It is in the best interest of the Member
- The Member requests the extension

PHP will notify Members of any extensions issued if a decision is made to extend the grievance. Members are also informed of their right to submit a grievance for investigation to the State Quality Improvement Organization (QIO), instead of pursuing the case through the PHP grievance process. PHP will track and maintain records on all grievances, including the date of

receipt, final disposition of the grievance and the date the member was notified of the disposition.

Organization Determinations

An organization determination is any determination made by PHP with respect to any of the following:

- Payment for temporarily out of the area renal dialysis services, emergency services, post-stabilization care, or urgently needed services
- Payment for any other health services furnished by a provider where the Member believes services are covered under Medicare, or if not covered by Medicare, should have been furnished, arranged for, or reimbursed by PHP
- PHP's refusal to provide or pay for services in whole or in part, including the type or level of services that the Member believes should be furnished or arranged for by PHP
- Discontinuation of a service if the Member believes that continuation of the services is medically necessary
- Failure of PHP to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the Member with timely notice of an adverse determination, such that a delay would adversely affect the health of the Member

It is the policy of PHP to make organization coverage determinations that will ensure that Member's requests for items and services are responded to in a timely manner. PHP must make decisions regarding organization coverage determinations within the standard time limit of fourteen (14) calendar days or as expeditiously as the Member's health condition demands. An extension of up to fourteen (14) calendar days may apply if the Member requests the extension, or if PHP requires additional information and feels that it would be in the best interest of the Member.

Who can request an organization determination?

- The Member or authorized representative
- Any Provider that furnishes, or intends to furnish services to the Member
- The legal representative of a deceased Member's estate

Any decision to deny a service authorization request, or to authorize a service in an amount, duration or scope that is less than requested, will be made by a health care professional who has appropriate clinical expertise in treating the Member's condition or disease.

Expedited Organization Determinations

Who can request an expedited determination?

- A Member or authorized representative
- A physician

If the Member believes that his or her life, health or ability to regain optimal function could be jeopardized by waiting for a decision within the standard time limit, the Member may request a decision within seventy-two (72) hours or as expeditiously as the Member’s health condition requires. Expedited organization determinations are available only for coverage decisions, reductions and discontinuance of services. The Member has a right to file a grievance if an expedited determination is not granted. If the Member’s primary care provider requests that PHP make an expedited determination, PHP must grant the request. If the expedited determination is negative, the Member must be informed of the right to reconsideration.

Member Claim Information Inquiries

PHP is the first point of contact for all questions from Members regarding claim status and eligibility.

PARTNERSHIP HEALTH PLAN CONTACTS

Main Office Address Community Health Partnership, Inc.
2240 EastRidge Center
Eau Claire, WI 54701

Website..... www.communityhealthpartnership.com

Fax(715) 838-2910

Customer Service (715) 838-2900 or (800) 842-1814

Karla Crawford, Claims Specialist(715) 858-7036
Emailkcrawford@chpmail.net

Priscilla Koxlien, Claims Specialist.....(715) 838-2916
Emailpkoxlien@chpmail.net