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**Overview**

The Plan maintains distinct grievance and appeals processes for members and providers, as well as access to the Medicaid Fair Hearing system.

An *appeal* is a request for review of some action taken by or on behalf of the Plan. Member appeals may be submitted by the member or a provider, acting on behalf of the member and with the member's written consent. Providers also have the ability to file an authorization or claim-related appeal. Examples of actions that may 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; or
- 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. A member may file a grievance and a provider, acting on behalf of the member and with the member's written consent, may file the grievance. Provider grievances are also accepted.

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/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; or
- A grievance or appeal involving clinical issues.

Members and Providers may file oral complaints and/or grievances by calling 1-866-822-1340.

**Submission  
of Member Appeals**

Any party to an action appropriate for appeal (including a reopened and revised determination), including a member, a member's authorized representative or a contracted or non-contracted physician or provider to the Plan, may request that the determination be reconsidered. Providers do not have appeal rights through the member appeals process.

The member, a member's representative or a provider acting on the member's behalf may request an expedited, standard pre-service or retrospective appeal determination. The request must come from the physician, not from the physician's office staff.

The Plan will not take or threaten to take punitive action against a provider acting on behalf of or in support of a member in requesting an appeal or an expedited appeal.

The Plan gives members reasonable assistance in completing forms and other procedural steps for an appeal, including but not limited to providing interpreter services, a toll-free telephone number 1-866-822-1340 (TTY/TDD 1-877-650-0952) and interpreter capability. 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 90 calendar days from the notice of action letter, then good cause must be shown in order for the Plan to accept the late request. Examples of good cause include, but are not limited to:

- The member did not personally receive the adverse organization determination notice, 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 reconsideration process; or
- 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 as appropriate. Please refer to the **Quick Reference Guide** for contact information.

A member or a provider on behalf of the member may file an appeal request either verbally or in writing within 90 days of the date of the notice of action. If the Plan does not issue a written notice of action, then the member or provider may file an appeal within one year of the action.

If filed verbally through Customer Service, the request must be followed up with a written, signed appeal to the Plan. For verbal filings, the time frame for resolution begins on the date the verbal filing was received.

## APPEALS AND GRIEVANCES

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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: **Three business days**
- Standard Request: **45 calendar days**

Members have the right to request continuation of benefits during an appeal or Medicaid Fair 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 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);
- The intended effective date of the Plan's proposed action.

The Plan will continue the member's benefits if:

- The appeal terminates, suspends or reduces a previously authorized course of treatment;
- The service is ordered by an authorized provider;
- The authorization period has not expired; and
- The member requests extension of the benefits.

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

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

All appeals must be submitted initially to the Plan and may later be appealed to the Missouri Department of Social Services (DSS) through the Fair Hearing Process. This process shall also be available for dissatisfaction concerning the timeliness of services, timeliness of appeal responses or denials of requests to obtain services outside a rural contracting area.

### **Request for Appeal Determinations**

### **Request for Expedited Determination**

A request for an expedited determination 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 lists reasons why the case should be 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 three business days 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, then the Plan will automatically transfer the request to 45 calendar 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. The plan will make reasonable efforts to give the member prompt verbal notice of the denial, and follow up within two calendar days with a written notice.

### **Request for Standard Determination**

The provider and member must complete an Appointment of Representation statement, which can be found in the **Forms** section of this manual to request a standard pre-service determination.

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

### **14-Day Extension**

The Expedited, and Standard 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 its initial 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 that are available (Medicaid Fair Hearing).

**Reversal of Denial**

If the Plan overturns its initial action and/or denial, it will notify the member and provider 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.

**Medicaid  
Fair Hearing**

The member has the right to request a Medicaid Fair Hearing in addition to pursuing the Plan's appeals process.

The provider, acting on behalf of the member and with the member's written consent, may also request a Medicaid Fair Hearing.

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

The member, the representative or provider may only request a Medicaid Fair Hearing within 90 calendar days of the date of the notice of action and/or denial. The request must be sent to DSS at the following address:

Division of Medical Services  
Recipient Services Unit  
P.O. Box 3535  
Jefferson City MO 65102

For questions regarding Medicaid Fair Hearings, you may contact the Recipient Services Unit at 1-800-392-2161.

The state must reach its decisions within the specified time frames:

- 1) Standard resolution: within 90 calendar days of the date the member filed the appeal with the health plan if the member filed initially with the health plan (excluding the days the member took to subsequently file for a State fair hearing) or the date the member filed for direct access to a State fair hearing.
- 2) Expedited resolution (if the appeal was heard first through the health plan appeal process): within three working days from the state agency's receipt of a hearing request for a denial of a service that:
  - Meets the criteria for an expedited appeal process but was not resolved using the health plan's expedited appeal time frames, or
  - Was resolved wholly or partially adversely to the member using the health plan's expedited appeal timeframes.
- 3) Expedited resolution (if the appeal was made directly to the State Fair

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Hearing process without accessing the health plan appeal process): within three working days from the state agency's receipt of a hearing request for a denial of a service that meets the criteria for an expedited appeal process.

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

1. The Medicaid Fair Hearing 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); or
  - The intended effective date of the Plan's proposed action.
2. The Medicaid Fair Hearing involves the termination, suspension or reduction of a previously authorized course of treatment;
3. The services were ordered by a provider;
4. The authorization period has not expired; and
5. The member requests extension of benefits.

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

1. The member withdraws the request for Medicaid Fair Hearing.
2. Ten days pass from the date of the plan's adverse plan decision and the member has not requested a Medicaid Fair Hearing with continuation of benefits until a Medicaid Fair Hearing decision is reached (add five days if the notice is sent via U.S. mail);

3. A Medicaid Fair Hearing decision adverse to the member is made; or
4. 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 Fair Hearing was pending and the Medicaid Fair Hearing officer 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 Fair Hearing was pending and the Medicaid Fair Hearing officer reverses a decision to deny, limit or delay services.

The Plan will not take punitive action against a provider who requests a Medicaid Fair Hearing on the member's behalf or supports a member's request.

### **Submission of Provider Appeals**

The Provider inquiry, complaint, grievance, and appeal process comprises the following five separate processes.

#### **1. Inquiry Process**

Providers can ask questions, file inquiries and complaints, and get problems resolved through the inquiry process. The Company's services function is staffed to receive telephone calls and meet personally with providers. The Company probes the inquiries so as to validate the possibility of any inquiry actually being a complaint. The Company identifies any inquiry patterns.

#### **2. Complaint Process**

Complaints can be filed verbally or in writing within one year of the incident that resulted in a

complaint. Complaints are resolved within 10 calendar days of their filing. The provider(s) and the Company will attempt to resolve all complaints before proceeding to a grievance.

### **3. Grievance Process**

The Company provides a grievance process that providers can use to file their dissatisfaction with the complaint resolution. If a provider is dissatisfied with the complaint resolution, the provider can file a grievance in writing with the Company within 90 calendar days of the complaint resolution. The provider must deliver a written, substantiated agreement with the complaint resolution to the Company. The Company will acknowledge the receipt of grievances in writing within 10 business days after receiving a grievance. Grievances will be investigated by the Company and reviewed by the designated authority within the Company. The Company will reach decisions on grievances within 30 calendar days of the filing date. At the time of the Company's decision regarding a grievance, the Company will notify the provider in writing of their right to file an appeal with the Company.

### **4. Appeal Process**

The Company provides an appeals process through which providers can challenge a negative decision to their grievances. Providers have 90 calendar days following written notification of a grievance decision to appeal. The appeal must be filed in writing either by the provider or the provider's representative, or through the provider's instructions to the Company's representative that the provider wishes to appeal. The Company acknowledges receipt of each appeal in writing within 10 business days after receiving an appeal. Appeals will be filed directly to the Company's governing body, or the Company's delegated representative (Appeals Committee). The appeal process includes an

opportunity for providers or their representatives to present their cases in person to the appellate body. The Company will reach a final decision on an appeal and provide written notice of the appeal resolution within 60 calendar days of receipt of the appeal, with extensions possible if approved by the state agency.

**5. Expedited Review**

The Company has a procedure for expedited review of the complaint or grievance if the standard timeframe could seriously jeopardize the member's life, physical or mental health, or the member's ability to regain maximum function. The expedited review will be resolved no later than three business days or as expeditiously as the member's physical or mental health requires.

Providers have 365 days\* from the original utilization management denial or claim denial to file an appeal. Cases appealed 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 documentation which supports their case of timely filing.

A Provider may file an appeal by submitting a letter of the appeal and/or an appeal form with supporting documentation such as medical records. Appeal forms may be found in the **Forms** section of this manual.

- 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.

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\* *Subject to change*

The Plan has 60 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.

- 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 appealed 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 the federal and state requirements.

**Submission of  
Provider  
Termination  
Appeal Request**

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 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.

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### 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 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 will also notify members who have:

- Been seen two or more times within the past 12 months;
- An open OB authorization (as applicable);
- An open authorization.

The member will be notified 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.

### Submission of Grievances

A member or a provider acting on behalf of the member may file a grievance either verbally or in writing within one year of the date of the 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 filing.

If the member wishes to appoint another person as his or her representative, he or 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 an enrollee's grievance.

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

- Expedited Request: **Three business days**
- Standard Request: **Thirty calendar days**

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. 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 acting 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 or faxed directly to the Grievance department. A determination on the expedited request will be made within three business days of receipt of the expedited request.

A request for an expedited grievance determination can be made for complaints related to Plan's decisions to:

- A grievance regarding denial of expedited resolution of an appeal; or
- A grievance or appeal that involves clinical issues.

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

A grievance will be investigated, a determination made and a closure letter sent to the complainant (and DSS upon request), within 30 calendar days of the filing date.

The closure letter will include:

- The results and date of the grievance resolution;
- Notice of the right to request a second-level grievance to the Plan;
- The time limit to file a second-level request (standard is 30 calendar days from the date of the notice); and
- Information on how to present the case at the second-level Grievance Committee either in person or via teleconference.

### **14-Day Extension**

The Plan may extend the time frames for a determination on a standard grievance by up to 14 calendar days if the member requests an extension or if the Plan shows that there is need for additional information (to the satisfaction of the state, upon its request) and includes how the delay is in the member's interest.

### **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 10 business days, a second fax and letter are sent giving the provider an additional five business days to respond.

Continued failure to respond may result in closure of the provider's panel to new patients and/or will be interpreted as an agreement by the provider 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 of care 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.

**Fraud and Abuse**

The mission of the Special Investigations Unit (SIU) is to effectively pursue the prevention, investigation and prosecution of health care fraud and abuse, to recover lost funds and to comply with state regulations mandating fraud plans and reporting.

Harmony is committed to the prevention and deterrence of fraud and abuse. All Plan associates are required to undergo fraud and abuse awareness training. This training is available on desktop via training modules and the Plan is able to track the completion rate and results for reporting purposes.

**Prevention efforts include the following:**

- Corporate Member of the National Healthcare Antifraud Association (NHCAA);
- Subscribe to NHCAA publications, including the sharing of cases discovered by other insurers and government agencies;
- Compliance and Fraud Awareness training of all levels of WellCare employees;
- Facilitate Provider education by Report Card comparing him to peer providers;
- Well-trained Special Investigations Unit (SIU) with years of experience dealing in healthcare fraud and abuse;
- Senior level management support for antifraud programs;

- Systems support for data mining and ad hoc reports to discover aberrancies early and prevent going forward; and
- The SIU works with the networks, medical management, quality, provider relations and credentialing.

**Methods of detection utilized include:**

- Harmony associates must report any instance of suspected fraud or abuse to the SIU;
- Intelliclaim software installed and updated to identify potential fraud and abuse prepayment (unbundling, double billing, and other rules based edits prevent improper payments from being made);
- Instituting aggressive companywide training in fraud and abuse identification;
- Online access to SIU referral form;
- Systems provide ability to compare peer providers billing and treatment behaviors, over utilization, and underutilization, upcoding, potential services not rendered, and scope of practice issue identification;
- CRMS software pulls date from claims system to assist in the identification of outlier providers; and
- Harmony has a fraud and abuse compliance hotline known as the Trust Hotline. All calls are investigated to determine if the allegation can be substantiated. The Hotline telephone number can be found in the, **Quick Reference Guide**.

**Investigation efforts include:**

- Investigations are opened and meticulously documented. Allegations are reviewed in detail and exposure or potential losses determined;
- Cases are researched and evidence accrued to verify or negate allegations; and
- The SIU has relationships with local, regional and federal law enforcement. We participate in state Departments of Insurance task force meetings where available.

**Reporting methods utilized are:**

- The SIU follows legislated requirements for reporting fraud. We are also able to design reports specific to Missouri's needs;
- As members of the National Healthcare Antifraud Association, we receive data on providers who have potentially harmed the Plan;
- Harmony has developed a good relationship with the departments of insurance, in states where we do business. We routinely receive and report relevant data within the confines of the law;
- SIU staff regularly reports potential issues to the Credentialing and Provider Relations areas in order to resolve issues pertaining to providers; and
- The SIU maintains statistics on open and closed and referred cases. We also report on recoveries.

**Corrective actions include the following:**

- Harmony has the ability to "hold" claims when it has been determined a further review or

investigation is warranted due to fraud or abuse potential;

- Providers found to be billing fraudulently are eliminated from the network and reported to the appropriate agencies; and
- Providers who require education on billing or coding issues receive it.

Providers can assist Harmony with the detection of fraud and abuse. To report a suspected case of fraud and abuse, please refer to the **Quick Reference Guide**.

