Chapter 12
Complaints, Grievances and Appeals

Purpose: This chapter provides guidelines for understanding the complaint, grievance and appeal procedures used at Health Partners Plans.

Topics: Important topics from this chapter include:

- Provider Disputes/Appeals
- Provider Initiated Member Grievances and Appeals
- Medicaid Member Complaint & Grievance Process
- CHIP Member Complaint & Grievance Process
- Medicare Member Grievance & Appeal Process

Overview

Health Partners Plans provides several types of appeals to providers who are dissatisfied with our decisions. Depending on the nature of the issue, providers may be able to choose between more than one available appeal avenue. This chapter of the Provider Manual describes appeal options. Appeal options include:

- Appeals of Inpatient Utilization Review
- Provider Quality of Care Sanctions and Appeals (see Provider Quality of Care Sanctions and Appeals on page 8.9)
- Health Partners Plans Provider Dispute and Appeal Process. This process may not be used to appeal decisions that regard medical necessity, or provider sanctions.
- Provider-Initiated Member Grievances (Act 68)
- With the member's consent, a provider may appeal (grieve) a Health Partners Plans decision on behalf of the member. A provider who pursues this appeal process may not additionally use the informal dispute resolution process described in Section V to appeal the same matter.

Provider Dispute & Appeal Process (Medicaid Only)

This Provider Dispute & Appeal Process is available only for the Health Partners (Medicaid) plan, and may not be used for any issues concerning medical necessity decisions, nor for provider sanctions (see Provider Quality of Care Sanctions and Appeals on page 8.9). This process allows for informal and formal processes for settlement of Provider Disputes and ensures equitability for all providers. Provider Appeal decisions are reported to the appropriate internal business areas. Provider terminations are reported to the Department of Human Services.

A Provider Dispute is a written communication to Health Partners Plans from a Medicaid provider expressing dissatisfaction with a decision (other than a medical necessity decision or a provider sanction) that directly impacts the provider. The three matters that providers may bring through Health Partners Plans' Provider Dispute & Appeal process are as follows:

- Provider credentialing denial by the plan;
- Provider termination action by the plan; and
- Provider claim denials (for reasons other than medical necessity).

Providers are encouraged to follow the Claim Reconsideration process for quick resolution to billing and payment errors (see the Claim Reconsiderations on page 11.26). Providers may, however, access the Dispute & Appeal Process for initial claim denials. If a provider chooses to use the Dispute & Appeal Process for initial claim denials, the Dispute & Appeal Process filing deadlines apply, and the Claim Reconsideration process is no longer available as a resolution process. Further, any initial claim denials presented through the Claim Reconsideration process that result in continued provider dissatisfaction may be presented through the Dispute & Appeal Process. The Dispute & Appeal Process filing deadlines apply. The Provider Dispute & Appeal Process provides for the settlement of applicable issues as follows:

Disputes

Providers have the right to file a dispute regarding provider credentialing denial, provider termination, and claim denials (including denied payment for services already rendered). Providers have thirty (30) calendar days from the date of the written notice (credentialing denial, termination or claim denial) from Health Partners Plans to file a dispute. All disputes must be in writing and mailed to:

Health Partners Plans
Attn: Complaints, Grievances & Appeals Unit
901 Market Street, Suite 500
Philadelphia, PA 19107

A provider representative (e.g., co-worker, friend, the provider's attorney, etc.) can assist the provider in filing a dispute. If a provider representative files a dispute on behalf of a provider, the provider must provide Health Partners Plans with written authorization stating that said provider representative may act on the provider's behalf. The provider is given ten (10) calendar days to provide the proper authorization for said provider representation. The dispute process begins the date upon which the written authorization from the provider is received by Health Partners Plans' Complaints, Grievances & Appeals (CG&A) Unit.

1st Level Dispute Process (Informal)

The initial dispute is a 1st Level Dispute. After Health Partners Plans' Complaints, Grievances & Appeals Unit receives the request for the dispute process by the provider or the provider representative, Health Partners Plans will initiate the 1st Level Dispute panel. The panel will consist of at least one person who has the authority, training and expertise to address and resolve provider dispute issues. The 1st Level Dispute panel has thirty (30) calendar days from the date

of receipt of the 1st Level Dispute request to investigate and render a decision. The Complaints, Grievances & Appeals Unit has five (5) business days from the date of the 1st Level Dispute panel's resolution to forward the decision notification letter to the provider.

If the provider is dissatisfied with the decision, the provider may appeal the dispute to Health Partners Plans' 2nd Level Dispute (Internal Appeal) process.

2nd Level Dispute Process (Internal Appeal/Formal)

Following resolution of his/her 1st Level Dispute, a provider has the right to file a 2nd Level Dispute (Appeal). The 2nd Level Dispute (Appeal) by the provider is due within thirty (30) calendar days of the date of the 1st Level Dispute decision notification letter. All 2nd Level Disputes (Appeals) must be in writing and mailed to:

Health Partners Plans
Attn: Complaints, Grievances & Appeals Unit
901 Market Street, Suite 500
Philadelphia, PA 19107

The Complaints, Grievances & Appeals Unit will appoint a 2nd Level Dispute review committee that shall:

- include healthcare providers/peers not employed by Health Partners Plans, comprising at least one-fourth (1/4) of the membership of the committee;
- include committee members who have the authority, training and expertise to address and resolve Provider Disputes (Appeals);
- have access to data necessary to assist committee members in making decisions; and
- document meetings and decisions of the committee.

Prior to the 2nd Level Dispute (Appeal) hearing, Health Partners Plans will send a letter to the provider informing him/her of his/her right to appear before the 2nd Level Dispute (Appeal) panel. The provider's authorized representative (if applicable) also has the right to be present at the 2nd Level Dispute (Appeal) hearing. The provider must give the name of the provider representative to Health Partners Plans at least two (2) business days prior to the 2nd Level Dispute (Appeal) hearing. Additionally, the same rules apply for appointing a provider representative as described above in this "Disputes" section.

The 2nd Level Dispute (Appeal) panel has thirty (30) calendar days from the date of receipt of the 2nd Level Dispute (Appeal) request to hold a hearing and render a decision. The CG&A Unit has five (5) business days from the date of the 2nd Level Dispute (Appeal) panel's resolution to forward the decision notification letter to the provider. The decision of the 2nd Level Dispute (Appeal) Committee is final and binding.

Provider Dispute & Appeal Process for Suspensions / Terminations/Non-Renewal of Physician Contract (Medicaid & Medicare)

In-network providers that participate with the Health Partners Plans for both Medicaid and Medicare lines of business or MEDICARE ONLY and are suspended, terminated or denied re-credentialing have the following appeal rights:

First Level Provider Appeal

- An appeal must be filed in writing by the provider or the provider's representative (with written permission of the provider) in order for the Complaints, Grievances and Appeals Unit to process the request as a written appeal.
- The provider may submit any material related to the appeal to Health Partners Plans within ten (10) calendar days of Health Partners Plans receipt of the appeal. Health Partners Plans will send the provider an acknowledgment letter within five (5) business days of receiving the Appeal.
- Health Partners Plans has thirty (30) calendar days from the date the Appeal was received, to investigate, hold a Provider Appeal hearing and render a decision in the case.
- The majority of the Provider Appeal hearing panel members will consist of peers of the affected physician.
- Health Partners Plans has five (5) business days after the Provider Appeal hearing panel makes the decision to forward a decision notification letter to the provider.
- If the decision is upheld, the provider has no further Medicare appeal rights and the decision is final and binding.
- The provider can file and 2nd level appeal for the Medicaid line of business only. Please refer to the Medicaid 2nd Level Dispute Process (Internal Appeal/Formal) on page 12.4 for further details.

Provider-Initiated Member Grievances & Appeals

This information pertains to Health Partners (Medicaid) and KidzPartners (CHIP) members. With the written permission of the member, providers have the right to appeal on behalf of the member. While a provider may request the member's written consent prior to treatment, he or she may not (as a condition of treatment) require that the member sign a document authorizing the provider to file a grievance.

Applicable regulations provide specific requirements and time frames that must be adhered to. When the member gives the provider permission to file a grievance or appeal, the provider must assure timely compliance with the requirements, since he or she has assumed the member's grievance and appeal rights. The member, however, may rescind consent at any time.

When the provider initiates a member grievance or appeal, he or she may not bill the member for the services that are the subject of the grievance until an external grievance review has been completed, or unless the member has rescinded the consent. Health Partners (Medicaid) members may never be billed or balance billed for covered services.

In situations where the provider is prohibited from billing the member, or if the provider chooses to never bill the member for the services being grieved, he or she may drop the grievance. The provider must notify the member or the member's legal representative in order to do so.

A member may ask another person to serve as his/her representative in the appeal process. This person is then termed the "member's representative." If the representative is a healthcare provider, the provider must have the member's written consent to file/pursue a grievance or appeal. This consent must be obtained prior to the onset of the grievance process, and documentation of member consent must be submitted with the request. Either the member or the member's legal representative may provide this consent.

The written consent giving a provider authority to file/pursue a grievance or appeal as the member's representative must contain each of the following:

- The member's name, address, date of birth, and plan identification number
- When the member is a minor or legally incompetent: the name, address and relationship to the member of the person signing the consent on behalf of the member
- The name, address and identification number of the healthcare provider who is obtaining consent from the member
- The name and address of the plan that will receive the grievance or appeal

- A description of the specific service(s) (whether coverage was provided or denied) that the consent will apply to
- The signature and date of signature of the member, or (if a minor or legally incompetent) the member's legal representative; and the signature and date of signature of a witness

The written consent must also include the following statements:

- The member or member's legal representative may not file a grievance or appeal about the service(s) listed in the consent form unless the member or member's legal representative rescinds the consent in writing. The member or member's legal representative has the right to rescind this consent at any time during the grievance or appeal process.
- If the provider fails to file the grievance or appeal, or does not continue to pursue the grievance or appeal through the second-level review process, the consent of the member or member's legal representative will be rescinded automatically.

The member (or the member's legal representative, if the member is a minor or legally incompetent) has read (or has been read) this consent document, and has had it explained to his/her satisfaction. The member or member's legal representative understands the information in the member's consent form.

A member may rescind his/her consent at any time throughout the grievance and appeal process. If the member rescinds consent, he/she may continue the grievance from the point at which consent was rescinded. A member may not file a separate grievance or appeal on the same matter. If a member files a grievance or appeal, he/she may, at any time during the grievance or appeal process, choose to give consent to a healthcare provider to continue the grievance or appeal on behalf of the member. A member's legal representative may similarly exercise these member rights.

Please note that, if a provider uses the following process, he or she may not also use the informal dispute resolution process described under Appeals of Inpatient Utilization Review Decisions to appeal the same matter.

Under Pennsylvania Code Title 28, chapter 9- 9.706 (c) (g), (c), once a healthcare provider assumes responsibility for filing a grievance, the healthcare provider may not bill the enrollee or the enrollee's legal representative for services provided that are the subject of the grievance until the external grievance review has been completed or the enrollee or the enrollee's legal representative rescinds consent for the healthcare provider to pursue the grievance. If the healthcare provider chooses never to bill the enrollee or the enrollee's legal representative for the services provided that are the subject of the grievance, the healthcare provider may drop the grievance with notice to the enrollee and the enrollee's legal representative in accordance with subsection (g).

Subsection (g) reads as follows:

> (g) The provider, having obtained consent from the enrollee or the enrollee's legal representative to file a grievance, shall have 10 days from receipt of the standard written UR denial and any decision letter from a first, second or external review upholding the plan's decision to notify the enrollee or the enrollee's legal representative of its intention not to pursue a grievance.

Grievances (Act 68) (Medicaid and CHIP only)

When Health Partners Plans denies, decreases, or approves a service or item different than the service or item requested because it is not medically necessary, a written grievance may be filed by the member, member's legal representative, or healthcare provider or other member's representative (with the appropriate written consent of the member) to request that Health Partners Plans reconsider its decision. Specifically, a decision may be grieved that:

- Denies or provides limited authorization for a requested service, including its type or level.
- Reduces, suspends or terminates a service that was previously authorized.
- Denies the requested service and approves an alternative.
- Denies payment, fully or in part, for a service, based on lack of medical necessity.

Provider-Initiated Member Grievances

The member, or member's representative, or provider (with member's written consent) must file the grievance within 60 days from the date of receipt of notification about the decision. In order to initiate a grievance on behalf of a member, the provider must submit the member's written consent with the request for a grievance. This member consent must be obtained prior to the onset of the grievance process.

A provider appealing with consent of the member should send the written grievance to:

> **Health Partners Plans**
> Attn: Complaints, Grievances & Appeals Unit
> 901 Market Street, Suite 500
> Philadelphia, PA 19107

When a grievance is received, Health Partners Plans issues a written confirmation to the member, the member's representative (if designated), and the provider (if the provider has filed

the grievance with member consent). The letter will provide additional information about the grievance review process, including:

- Classification of the matter as a grievance versus a complaint. The member, member's representative, or provider may question this classification by contacting the Pennsylvania Department of Health.
- The right of the member to appoint a representative to act on his/her behalf at any time during the internal grievance process.
- The ability of the member, member's representative, or provider that filed the grievance (with member consent) to review information related to the grievance upon request. They may also submit additional information to Health Partners Plans for consideration.
- The right of the member or member's representative to request that a Health Partner Plans staff member (who has not participated in the utilization management decision) help prepare the first-level grievance, at no charge.
- Notice that the member, member's representative, and provider will be given 10 days written, advance notice of the scheduled review, and that they have the right to attend and participate.

Health Partners Plans will consider the member's access to transportation, as well as any disabilities or language barriers, and will make reasonable accommodation to permit the member, member's representative, and the provider to participate, in person, by conference call, or by videoconference. When the member, member's representative, or the provider cannot attend the review in person, Health Partners Plans will provide the opportunity to communicate with the committee by other appropriate means, such as telephone and videoconference.

A committee made up of three (3) or more individuals whose members have not been involved in any prior decision and are not the subordinates of an individual involved in any prior decision regarding the grievance will provide the grievance review. A licensed physician or an approved licensed psychologist (practicing in the same or similar specialty that would typically consult on the healthcare services in question) will be a committee member. Other appropriate providers may participate in the review but the licensed physician must decide the grievance. At least one third of the grievance review committee may not be employees of Health Partners Plans or a related subsidiary or affiliate.

Health Partners Plans will provide the member, member's representative, or provider that filed a grievance with member consent access to all information about the matter being decided. Health Partners Plans will allow for written information or other additional material to be introduced in

support of the grievance. The member, member's representative, or provider may directly voice the remedy or corrective action which they are asking of Health Partners Plans.

Grievance review attendance is limited to these people:

- Review committee members who are not employees of Health Partners Plans
- Appropriate plan representatives
- The member or the member's representative(s), including legal representation and/or any attendant necessary for the member's participation in and understanding of the proceedings
- The provider who grieved the matter with the member's consent
- Any pertinent witnesses

All persons attending this meeting will need to identify themselves and their role in the grievance process for the member and any representatives for the member that are present. The committee will base the review decision on the materials and testimony presented during the review meeting only. Committee members may not discuss the case prior to the review meeting. Committee members must attend the review meeting in person, or participate actively by telephone or videoconference (and have an opportunity to review any information introduced at the review meeting prior to voting), or they may not vote. An attorney may represent the committee's interests at the review meeting, but may not argue the plan's position or represent its staff. A summary of the meeting's proceedings will be produced from an electronic recording. This summary will become part of the grievance record, and will be included in the information the plan sends if there is a request for an external grievance review.

Health Partners Plans will reach a decision and notify the member, member's representative, and provider within 30 days from receiving a grievance. A 14-day extension may be requested by the member, member's representative, or the provider who filed the grievance with written consent of the member. This notice will include the basis for the decision, and will explain how to request a Fair Hearing from the Department of Human Services (DHS), an external review of the decision by the Department of Health (DOH), or both a request for a Fair Hearing and a request for an external review of the decision. The notice will specifically include:

- A statement of the matter reviewed by the committee.
- The specific reasons for the committee's decision.
- Corresponding provisions that were the basis for the decision, and how to obtain copies of any documents used.

- The scientific or clinical judgment behind the decision.
- Information on how to file a Fair Hearing from the Department of Human Services (DHS), an external review of the decision by the Department of Health (DOH), or both a request for a Fair Hearing and a request for an external review of the decision.

The member may ask for an external review of the decision by the Department of Health (DOH) within fifteen (15) days from receipt of the decision. The member may file a request for a DHS Fair Hearing within one hundred twenty (120) days from the mail date on the written notice of decision.

Expedited Grievances

If the member's life, health or ability to regain maximum function would be jeopardized by delay caused by the standard review process, an Expedited Grievance may be filed. The member, member's representative, or provider (with written consent of the member) may file this request by calling Health Partners Plans.

To obtain an expedited review, Health Partners Plans must be provided with written certification from the member's physician that the member's life, health, or ability to regain maximum function would be jeopardized by delay. This certification must include the physician's clinical rationale and facts that support his/her opinion. The certification must include the provider's signature. If the provider certification is not included with the request for an expedited review, Health Partners Plans must inform the member that the provider must submit a certification as to reasons why the expedited review is needed and why the grievance cannot be processed within the standard thirty (30) day time frame.

The expedited grievance will be put into writing. A committee of three or more people, including a licensed doctor and a Health Partners Plans member, will review the grievance. The licensed doctor will decide the expedited grievance with help from the other representation on the committee. No one on the committee will have prior involvement with the grievance. The expedited grievance process will follow the process described above under Provider-Initiated Member Grievances (Act 68 Process), with these exceptions:

- A 48-hour time frame of receiving the provider certification or seventy-two (72) hour timeframe of receiving the Member's request for an expedited review applies, whichever is shorter.

- If the member cannot attend the hearing in person due to the short time frame, the hearing may be held by telephone or videoconference. In this case, all information presented will be read into the record.
- If the member cannot be provided with a copy of the report of the same or similar specialist prior to the expedited hearing, Health Partners Plans may read the report into the record at the hearing, and provide a copy of the report to the member at that time.
- To allow Health Partners Plans to conform to the time requirements of this section, it is the responsibility of the member, member's representative, or provider to provide information to the plan in an expedited manner.

Health Partners Plans will conduct an expedited internal review and issue a decision within either forty-eight (48) hours of receiving the Provider certification or seventy-two (72) hours of receiving the Member's request for an expedited review, whichever is shorter, unless the time frame for deciding the expedited Grievance has been extended by up to fourteen (14) days at the request of the Member. The decision notice to the member, member's representative or provider will state the basis for the decision and include any clinical rationale. It will also give the procedure for requesting an expedited external review and, if applicable, a DHS Fair Hearing. (Fair Hearings are not available in the CHIP program.) The member, member's representative or provider (with written consent of the member) has two business days from receipt of the expedited grievance decision to request an expedited external review. The member may file a request for a DHS Fair Hearing within one hundred twenty (120) days from the mail date on the written notice of Health Partners Plans' expedited Grievance decision.

If an expedited external review is requested, Health Partners Plans will submit a request to the Pennsylvania Department of Health by fax and telephone within 24 hours of receiving a request from the member, member's representative or provider with member's written consent. The Department of Health will assign a certified review entity (CRE) to the case within one business day of receiving the expedited review request. The CRE will make a decision within two business days following its receipt of the case file.

When the expedited external grievance is requested by a provider, both Health Partners Plans and the provider must establish escrow accounts in the amount of half the expected cost of the review. If the CRE's decision is then against the provider in full, the provider shall pay all fees and costs associated with the external grievance. If the CRE's decision is against the plan, in full or in part, Health Partners Plans will pay the fees and costs associated with the external grievance review, regardless of who initiated it.

External Grievances

A member, member's representative or provider with written consent of the member may request an external review following denial of a second-level grievance. Act 68 provides for the following external grievance process standards:

Within fifteen (15) days of receiving the grievance review decision, the member, member's representative or provider who filed the grievance may file a request with Health Partners Plans for an external review. If this request is filed by a provider, he or she must provide the name of the member and a copy of the member's written consent for the provider to file the external grievance.

Within five (5) business days of receiving the request, Health Partners Plans will notify the Pennsylvania Department of Health (DOH), the member and the provider that an external grievance review request has been filed. Health Partners Plans' notification to DOH shall be by phone and fax, and include a request for DOH to assign a certified review entity (CRE). DOH is responsible for notifying the provider or member about the assigned CRE, including its name, address and phone number, within two (2) business days. When the external grievance is requested by a provider, both Health Partners Plans and the provider must establish escrow accounts in the amount of half the expected cost of the review.

Within fifteen (15) days of the request for external review, Health Partners Plans will submit the case file to the designated CRE. The plan will also send the provider or member a list of all the documents sent to the CRE. Within sixty (60) days of filing the request for an external grievance review, the CRE will review the case and issue a written decision. The CRE will send its decision to the member, member's representative, provider, plan, and DOH.

Following the CRE's decision, Health Partners Plans will authorize the healthcare service(s) and pay the claim(s) found by the CRE to be medically necessary and appropriate. Despite authorization(s)/payment(s), Health Partners Plans (or the member, member's representative or provider with written consent of the member) may still appeal the CRE's decision to a court of competent jurisdiction. If the CRE's decision is against the provider in full, the provider shall pay all fees and costs associated with the external grievance. If the CRE's decision is against the plan, in full or in part, Health Partners Plans will pay the fees and costs associated with the external grievance review, regardless of who initiated it.

Sanctions and Appeals

In certain situations, a provider may be subject to review and sanctions by Health Partners Plans' Quality Management Committee. The provider has certain appeal rights concerning these Quality Management Committee decisions. For more information, see the Provider Quality of Care Sanctions and Appeals section on page 8.9.

Provider Complaint Procedure

A credentialed provider may initiate a complaint against Health Partners Plans (for issues other than denial of credentialing, claims payment, or provider termination) by contacting the Provider Services Helpline at **1-888-991-9023** (see the Contact Information section starting on page 1.13). All provider complaints requiring follow-up action will be documented on a Provider Issue form. Each complaint must be addressed within seven (7) business days.

Binding Arbitration Hearing

The dispute will be referred to arbitration before a panel comprised of three (3) individuals. Both the provider and Health Partners Plans will select one panel representative each, within 10 working days of receipt of the request for arbitration. The two panel representatives will then select a third panel representative to create the three-person arbitration board. If the two representatives cannot agree on the third representative within 14 days of the request for selection, the third panelist shall be drawn by lot from two candidates (one selected by the provider and one selected by Health Partners Plans).

Upon selection of the third arbitrator, the arbitration board must issue its decision as expeditiously as possible in accordance with the procedures of the American Arbitration Association for handling such matters. Matters concerning level of care/placement decisions shall be reviewed and decided by the panel immediately. The arbitration proceeding will be conducted according to the prevailing rules of the American Arbitration Association. The decision of the arbitration board shall be binding and subject to review by DOH.

The entire cost of the arbitration proceeding shall be borne by the losing party.

Note: Health Partners Plans will not exclude a provider from its provider network because the provider advocated on behalf of a member in a utilization management appeal or another dispute with Health Partners Plans over appropriate medical care. Additionally, Health Partners Plans cannot terminate a contract or employment with a healthcare provider for filing a grievance on a member's behalf.

Medicaid Member Complaints, Grievances, and Fair Hearings Process

This information pertains to Health Partners Plans (Medicaid) members ONLY.

If a provider or Health Partners Plans does something that you are unhappy about or do not agree with, you can tell Health Partners Plans or the Department of Human Services what you are unhappy about or that you disagree with what the provider or Health Partners Plans has done. This section describes what you can do and what will happen.

Complaints

What is a Complaint?

A Complaint is when you tell Health Partners Plans you are unhappy with Health Partners Plans or your provider or do not agree with a decision by Health Partners Plans.

Some things you may complain about:

- You are unhappy with the care you are getting.
- You cannot get the service or item you want because it is not a covered service or item.
- You have not gotten services that Health Partners Plans has approved.
- You were denied a request to disagree with a decision that you have to pay your provider.

First Level Complaint

What Should I Do if I Have a Complaint?

To file a first level Complaint:

- Call Health Partners Plans' Member Relations at **1-800-553-0784** (**TTY 1-877-454-8477**) and tell Health Partners Plans your Complaint, or
- Write down your Complaint and send it to Health Partners Plans by mail or fax, or
- If you received a notice from Health Partners Plans telling you Health Partners Plans' decision and the notice included a Complaint/Grievance Request Form, fill out the form and send it to Health Partners Plans by mail or fax.

Health Partners Plans
Complaints, Grievances & Appeals Unit
901 Market Street, Suite 500
Philadelphia, PA 19107
215-991-4105 (fax)

Your provider can file a Complaint for you if you give the provider your consent in writing to do so.

When Should I File a First Level Complaint?

Some Complaints have a time limit on filing. You must file a Complaint within **60 days of getting a notice** telling you that

- Health Partners Plans has decided that you cannot get a service or item you want because it is not a covered service or item.
- Health Partners Plans will not pay a provider for a service or item you got.
- Health Partners Plans did not tell you its decision about a Complaint or Grievance you told Health Partners Plans about within 30 days from when Health Partners Plans got your Complaint or Grievance.
- Health Partners Plans has denied your request to disagree with Health Partners Plans' decision that you have to pay your provider.

You must file a Complaint **within 60 days of the date you should have gotten a service or item** if you did not get a service or item. The time by which you should have received a service or item is listed below:

New member appointment for your first examination…	We will make an appointment for you…
members with HIV/AIDS	with PCP or specialist no later than 7 days after you become a member in Health Partners Plans unless you are already being treated by a PCP or specialist.
members who receive Supplemental Security Income (SSI)	with PCP or specialist no later than 45 days after you become a member in Health Partners Plans, unless you are already being treated by a PCP or specialist.
members under the age of 21	with PCP for an EPSDT screen no later than 45 days after you become a member in Health Partners Plans, unless you are already being treated by a PCP or specialist.
all other members	with PCP no later than 3 weeks after you become a member of Health Partners Plans.

Members who are pregnant:	We will make an appointment for you . . .
pregnant women in their first trimester	with OB/GYN provider within 10 business days of Health Partners Plans learning you are pregnant.
pregnant women in their second trimester	with OB/GYN provider within 5 business days of Health Partners Plans learning you are pregnant.
pregnant women in their third trimester	with OB/GYN provider within 4 business days of Health Partners Plans learning you are pregnant.
pregnant women with high-risk pregnancies	with OB/GYN provider within 24 hours of Health Partners Plans learning you are pregnant.

Appointment with…	An appointment must be scheduled…
PCP	
urgent medical condition	within 24 hours.
routine appointment	within 10 business days.
health assessment/general physical examination	within 3 weeks.
Specialists (when referred by PCP)	
urgent medical condition	within 24 hours of referral.
routine appointment with one of the following specialists: ▪ Otolaryngology ▪ Dermatology ▪ Pediatric Endocrinology ▪ Pediatric General Surgery ▪ Pediatric Infectious Disease ▪ Pediatric Neurology	within 15 business days of referral

- Pediatric Pulmonology
- Pediatric Rheumatology
- Dentist
- Orthopedic Surgery
- Pediatric Allergy & Immunology
- Pediatric Gastroenterology
- Pediatric Hematology
- Pediatric Nephrology
- Pediatric Oncology
- Pediatric Rehab Medicine
- Pediatric Urology
- Pediatric Dentistry

routine appointment with all other specialists	within 10 business days of referral

You may file **all other Complaints at any time.**

What happens after I file a First Level complaint?

After you file your Complaint, you will get a letter from Health Partners Plans telling you that Health Partners Plans has received your Complaint, and about the First Level Complaint review process.

You may ask Health Partners Plans to see any information Health Partners Plans has about the issue you filed your Complaint about at no cost to you. You may also send information that you have about your Complaint to Health Partners Plans.

You may attend the Complaint review if you want to attend it. Health Partners Plans will tell you the location, date, and time of the Complaint review at least 10 days before the day of the Complaint review. You may appear at the Complaint review in person, by phone, or by videoconference. If you decide that you do not want to attend the Complaint review, it will not affect the decision.

A committee of 1 or more Health Partners Plans staff who were not involved in and do not work for someone who was involved in the issue you filed your Complaint about will meet to make a decision about your Complaint. If the Complaint is about a clinical issue, a licensed doctor will be on the committee. Health Partners Plans will mail you a notice within 30 days from the date you filed your

First Level Complaint to tell you the decision on your First Level Complaint. The notice will also tell you what you can do if you do not like the decision.

If you need more information about help during the Complaint process, see page 12.28.

What to do to continue getting services:

If you have been getting the services or items that are being reduced, changed or denied and you file a Complaint verbally, or that is faxed, postmarked, or hand-delivered within **10 days of the date on the notice** telling you that the services or items you have been receiving are not covered services or items for you, the services or items will continue until a decision is made.

What if I Do Not Like Health Partners Plans' Decision?

You may ask for an external Complaint review, a Fair Hearing, or an external Complaint review and a Fair Hearing if the Complaint is about one of the following:

- Health Partners Plans' decision that you cannot get a service or item you want because it is not a covered service or item.
- Health Partners Plans' decision to not pay a provider for a service or item you got.
- Health Partners Plans' failure to decide a Complaint or Grievance you told Health Partners Plans about within 30 days from when Health Partners Plans got your Complaint or Grievance.
- You not getting a service or item within the time by which you should have received it
- Health Partners Plans' decision to deny your request to disagree with Health Partners Plans' decision that you have to pay your provider.

You must ask for an external Complaint review within 15 days of the date you got the First Level Complaint decision notice.

You must ask for a Fair Hearing within 120 days from the mail date on the notice telling you the Complaint decision.

For all other Complaints, you may file a Second Level Complaint within 45 days of the date you got the Complaint decision notice.

For information about Fair Hearings, see page 12.30.
For information about external Complaint review, see page 12.21.
If you need more information about help during the Complaint process, see page 12.15.

Second Level Complaint

What Should I Do if I Want to File a Second Level Complaint?

To file a Second Level Complaint:

- Call Health Partners Plans' Member Relations at **1-800-553-0784** (**TTY 1-877-454-8477**) and tell Health Partners Plans your Second Level Complaint, or
- Write down your Second Level Complaint and send it to Health Partners Plans by mail or fax, or
- Fill out the Complaint Request Form included in your Complaint decision notice and send it to Health Partners Plans by mail or fax.

Health Partners Plans
Complaints, Grievances & Appeals Unit
901 Market Street, Suite 500
Philadelphia, PA 19107
215-991-4105 (fax)

What happens after I file a Second Level Complaint?

After you file your Second Level Complaint, you will get a letter from Health Partners Plans telling you that Health Partners Plans has received your Complaint, and about the Second Level Complaint review process.

You may ask Health Partners Plans to see any information Health Partners Plans has about the issue you filed your Complaint about at no cost to you. You may also send information that you have about your Complaint to Health Partners Plans.

You may attend the Complaint review if you want to attend it. Health Partners Plans will tell you the location, date, and time of the Complaint review at least **15 days before the Complaint review**. You may appear at the Complaint review in person, by phone, or by videoconference. If you decide that you do not want to attend the Complaint review, it will not affect the decision.

A committee of 3 or more people, including at least 1 person who does not work for Health Partners Plans, will meet to decide your Second Level Complaint. The Health Partners Plans staff on the committee will not have been involved in and will not have worked for someone who was involved in the issue you filed your Complaint about. If the Complaint is about a clinical issue, a licensed doctor will be on the committee. Health Partners Plans will mail you a notice within **45 days from the date your Second Level Complaint was received to tell you the decision on your Second Level Complaint**. The letter will also tell you what you can do if you do not like the decision.

If you need more information about help during the Complaint process, see page 12.28.

What if I Do Not Like Health Partners Plans' Decision on My Second Level Complaint?

You may ask for an external review by either the Department of Health or the Insurance Department.

You must ask for an external review **within 15 days of the date you got the Second Level Complaint decision notice.**

External Complaint Review

How Do I Ask for an External Complaint Review?

You must send your request for external review of your Complaint in writing to either:

Pennsylvania Department of Health
Bureau of Managed Care
Health and Welfare Building, Room 912
625 Forster Street
Harrisburg, PA 17120-0701

Telephone Number: **1-888-466-2787**

or

Pennsylvania Insurance Department
Bureau of Consumer Services
Room 1209, Strawberry Square
Harrisburg, Pennsylvania 17120

Telephone Number: **1-877-881-6388**

If you ask, the Department of Health will help you put your Complaint in writing.

The Department of Health handles Complaints that involve the way a provider gives care or services. The Insurance Department reviews Complaints that involve Health Partners Plans' policies and procedures. If you send your request for external review to the wrong Department, it will be sent to the correct Department.

What Happens After I Ask for an External Complaint Review?

The Department of Health or the Insurance Department will get your file from Health Partners Plans. You may also send them any other information that may help with the external review of your Complaint.

You may be represented by an attorney or another person such as your representative during the external review.

A decision letter will be sent to you after the decision is made. This letter will tell you all the reason(s) for the decision and what you can do if you do not like the decision.

What to do to continue getting services:

If you have been getting the services or items that are being reduced, changed or denied and your request for an external Complaint review is postmarked or hand-delivered within 10 days of the date on the notice telling you Health Partners Plans' First Level Complaint decision that you cannot get services or items you have been receiving because they are not covered services or items for you, the services or items will continue until a decision is made.

GRIEVANCES

What is a grievance?

When Health Partners Plans denies, decreases, or approves a service or item different than the service or item you requested because it is not medically necessary, you will get a notice telling you Health Partners Plans' decision.

A Grievance is when you tell Health Partners Plans you disagree with Health Partners Plans' decision.

What Should I Do if I Have a Grievance?

To file a Grievance:

- Call Health Partners Plans at **1-800-553-0784** (**TTY 1-877-454-8477**) and tell Health Partners Plans your Grievance, or

- Write down your Grievance and send it to Health Partners Plans by mail or fax, or
- Fill out the Complaint/Grievance Request Form included in the denial notice you got from Health Partners Plans and send it to Health Partners Plans by mail or fax.

Health Partners Plans
Complaints, Grievances & Appeals Unit
901 Market Street, Suite 500
Philadelphia, PA 19107
215-991-4105 (fax)

Your provider can file a Grievance for you if you give the provider your consent in writing to do so. If your provider files a Grievance for you, you cannot file a separate Grievance on your own.

When Should I File a Grievance?

You must file a Grievance within **60 days from the date you get the notice** telling you about the denial, decrease, or approval of a different service or item for you.

What Happens After I File a Grievance?

After you file your Grievance, you will get a letter from Health Partners Plans telling you that Health Partners Plans has received your Grievance, and about the Grievance review process.

You may ask Health Partners Plans to see any information that Health Partners Plans used to make the decision you filed your Grievance about at no cost to you. You may also send information that you have about your Grievance to Health Partners Plans.

You may attend the Grievance review if you want to attend it. Health Partners Plans will tell you the location, date, and time of the Grievance review at least **10 days before the day of the Grievance review.** You may appear at the Grievance review in person, by phone, or by videoconference. If you decide that you do not want to attend the Grievance review, it will not affect the decision.

A committee of 3 or more people, including a licensed doctor, will meet to decide your Grievance. The Health Partners Plans staff on the committee will not have been involved in and will not have worked for someone who was involved in the issue you filed your Grievance about. Health Partners Plans will mail you a notice within **30 days from the date your Grievance was received to tell you the decision on your Grievance**. The notice will also tell you what you can do if you do not like the decision.

If you need more information about help during the Grievance process, see page 12.28.

What to do to continue getting services:

If you have been getting services or items that are being reduced, changed, or denied and you file a Grievance verbally, or that is faxed, postmarked, or hand-delivered within 10 days of the date on the notice telling you that the services or items you have been receiving are being reduced, changed, or denied, the services or items will continue until a decision is made.

What if I Do Not Like Health Partners Plans' Decision?

You may ask for an external Grievance review or a Fair Hearing or you may ask for both an external Grievance review and a Fair Hearing. An external Grievance review is a review by a doctor who does not work for Health Partners Plans.

You must ask for an external Grievance review within **15 days of the date you got the Grievance decision notice**.

- You must ask for a Fair Hearing from the Department of Human Services **within 120 days from the date on the notice** telling you the Grievance decision.

For information about Fair Hearings, see page 12.30.
For information about external Grievance review, see page 12.24.
If you need more information about help during the Grievance process, see page 12.28.

External Grievance Review

How Do I Ask for External Grievance Review?

To ask for an external Grievance review:

- Call Health Partners Plans' Member Relations at **1-800-553-0784** (**TTY 1-877-454-8477)** and tell Health Partners Plans your Grievance, or
- Write down your Grievance and send it to Health Partners Plans by mail to:

Health Partners Plans
Complaints, Grievances & Appeals Unit
901 Market Street, Suite 500
Philadelphia, PA 19107

Health Partners Plans will send your request for external Grievance review to the Department of Health.

What Happens After I Ask for an External Grievance Review?

The Department of Health will notify you of the external Grievance reviewer's name, address and phone number. You will also be given information about the external Grievance review process.

Health Partners Plans will send your Grievance file to the reviewer. You may provide additional information that may help with the external review of your Grievance to the reviewer **within 15 days of filing the request for an external Grievance review**.

You will receive a decision letter within 60 days of the date you asked for an external Grievance review. This letter will tell you all the reason(s) for the decision and what you can do if you do not like the decision.

What to do to continue getting services:

If you have been getting the services or items that are being reduced, changed, or denied and you ask for an external Grievance review verbally or in a letter that is postmarked or hand-delivered within 10 days of the date on the notice telling you Health Partners Plans' Grievance decision, the services or items will continue until a decision is made.

Expedited Complaints and Grievances

What Can I Do if My Health Is at Immediate Risk?

If your doctor or dentist believes that waiting **30** days to get a decision about your First Level Complaint or Grievance, **or 45** days to get a decision about your Second Level Complaint, could harm your health, you or your doctor or dentist may ask that your Complaint or Grievance be decided more quickly. For your Complaint or Grievance to be decided more quickly:

- You must ask Health Partners Plans for an early decision by calling Health Partners Plans at **1-800-553-0784** (**TTY 1-877-454-8477**), faxing a letter or the Complaint/Grievance Request Form to **215-991-4105**, or sending an email to quickCGA@hpplans.com.

- Your doctor or dentist should fax a signed letter to **215-991-4105** within 72 hours of your request for an early decision that explains why Health Partners Plans taking 30 days to tell you a decision about your First Level Complaint or Grievance, or 45 days to tell you a decision about your Second Level Complaint, could harm your health.

If Health Partners Plans does not receive a letter from your doctor or dentist and the information provided does not show that taking the usual amount of time to decide your Complaint or Grievance could harm your health, Health Partners Plans will decide your Complaint or Grievance in the usual time frame of **30** days from when Health Partners Plans first got your First Level Complaint or Grievance, or **45** days from when Health Partners Plans got your Second Level Complaint.

Expedited Complaint and Expedited External Complaint

Your expedited Complaint will be reviewed by a committee that includes a licensed doctor. Members of the committee will not have been involved in and will not have worked for someone who was involved in the issue you filed your Complaint about.

You may attend the expedited Complaint review if you want to attend it. You can attend the Complaint review in person, but may have to appear by phone or by videoconference because Health Partners Plans has a short amount of time to decide an expedited Complaint. If you decide that you do not want to attend the Complaint review, it will not affect the decision.

Health Partners Plans will tell you the decision about your Complaint within **48 hours of when Health Partners Plans gets your doctor's or dentist's letter** explaining why the usual time frame for deciding your Complaint will harm your health or **within 72 hours from when Health Partners Plans gets your request for an early decision**, whichever is sooner, unless you ask Health Partners Plans to take more time to decide your Complaint. You can ask Health Partners Plans to take up to 14 more days to decide your Complaint. You will also get a notice telling you the reason(s) for the decision and how to ask for expedited external Complaint review, if you do not like the decision.

If you did not like the expedited Complaint decision, you may ask for an expedited external Complaint review from the Department of Health within **2 business days from the date you get the expedited Complaint decision notice**. To ask for expedited external review of a Complaint:

- Call Health Partners Plans at **1-800-553-0784** and tell Health Partners Plans your Complaint,

Health Partners Plans
Complaints, Grievances & Appeals Unit
901 Market Street, Suite 500
Philadelphia, PA 19107

Or

- Send an email to Health Partners Plans at quickCGA@hpplans.com or
- Write down your Complaint and send it to Health Partners Plans by mail or fax:

Health Partners Plans
Complaints, Grievances & Appeals Unit
901 Market Street, Suite 500
Philadelphia, PA 19107
215-991-4105 (fax)

Expedited Grievance and Expedited External Grievance

A committee of 3 or more people, including a licensed doctor, will meet to decide your Grievance. The Health Partners Plans staff on the committee will not have been involved in and will not have worked for someone who was involved in the issue you filed your Grievance about.

You may attend the expedited Grievance review if you want to attend it. You can attend the Grievance review in person, but may have to appear by phone or by videoconference because Health Partners Plans has a short amount of time to decide the expedited Grievance. If you decide that you do not want to attend the Grievance review, it will not affect our decision.

Health Partners Plans will tell you the decision about your Grievance within 48 hours of when Health Partners Plans gets your doctor's or dentist's letter explaining why the usual time frame for deciding your Grievance will harm your health or within 72 hours from when Health Partners Plans gets your request for an early decision, whichever is sooner, unless you ask Health Partners Plans to take more time to decide your Grievance. You can ask Health Partners Plans to take up to 14 more days to decide your Grievance. You will also get a notice telling you the reason(s) for the decision and what to do if you do not like the decision.

If you do not like the expedited Grievance decision, you may ask for an expedited external Grievance review or an expedited Fair Hearing by the Department of Human Services or both an expedited external Grievance review and an expedited Fair Hearing.

You must ask for expedited external Grievance review by the Department of Health within **2 business days from the date you get the expedited Grievance decision notic**e. To ask for expedited external review of a Grievance:

- Call Health Partners Plans at **1-800-553-0784** and tell Health Partners Plans your Grievance, or
- Send an email to Health Partners Plans at quickCGA@hpplans.com, or
- Write down your Grievance and send it to Health Partners Plans by mail or fax:

Health Partners Plans
Complaints, Grievances & Appeals Unit
901 Market Street, Suite 500
Philadelphia, PA 19107
215-991-4105 (fax)

Health Partners Plans will send your request to the Department of Health within 24 hours after receiving it.

You must ask for a Fair Hearing within **120 days from the date on the notice** telling you the expedited Grievance decision.

What Kind of Help Can I Have with the Complaint and Grievance Processes?

If you need help filing your Complaint or Grievance, a staff member of Health Partners Plans will help you. This person can also represent you during the Complaint or Grievance process. You do not have to pay for the help of a staff member. This staff member will not have been involved in any decision about your Complaint or Grievance.

You may also have a family member, friend, lawyer or other person help you file your Complaint or Grievance. This person can also help you if you decide you want to appear at the Complaint or Grievance review.

At any time during the Complaint or Grievance process, you can have someone you know represent you or act for you. If you decide to have someone represent or act for you, tell Health Partners Plans, in writing, the name of that person and how Health Partners Plans can reach him or her.

You or the person you choose to represent you may ask Health Partners Plans to see any information Health Partners Plans has about the issue you filed your Complaint or Grievance about at no cost to you.

You may call Health Partners Plans' toll-free telephone number at **1-800-553-0784 (TTY 1-877-454-8477)** if you need help or have questions about Complaints and Grievances, you can contact your local legal aid office at **215-981-3700** (Philadelphia County); **1-877-429-5994** (Bucks, Chester, Delaware and Montgomery counties) or call the Pennsylvania Health Law Project at **1-800-274-3258**.

Persons Whose Primary Language Is Not English

If you ask for language services, Health Partners Plans will provide the services at no cost to you.

Persons with Disabilities

Health Partners Plans will provide persons with disabilities with the following help in presenting Complaints or Grievances at no cost, if needed. This help includes:

- Providing sign language interpreters;
- Providing information submitted by Health Partners Plans at the Complaint or Grievance review in an alternative format. The alternative format version will be given to you before the review; and
- Providing someone to help copy and present information.

DEPARTMENT OF HUMAN SERVICES FAIR HEARINGS

In some cases you can ask the Department of Human Services to hold a hearing because you are unhappy about or do not agree with something Health Partners Plans did or did not do. These hearings are called "Fair Hearings." You can ask for a Fair Hearing after Health Partners Plans decides your First Level Complaint or decides your Grievance.

What Can I Request a Fair Hearing About and By When Do I Have to Ask for a Fair Hearing?

Your request for a Fair Hearing must be postmarked within **120 days from the date on the notice** telling you Health Partners Plans' decision on your First Level Complaint or Grievance about the following:

- The denial of a service or item you want because it is not a covered service or item.

- The denial of payment to a provider for a service or item you got and the provider can bill you for the service or item.
- Health Partners Plans' failure to decide a First Level Complaint or Grievance you told Health Partners Plans about within **30 days from when Health Partners Plans got your Complaint or Grievance**.
- The denial of your request to disagree with Health Partners Plans' decision that you have to pay your provider.
- The denial of a service or item, decrease of a service or item, or approval of a service or item different from the service or item you requested because it was not medically necessary.
- You're not getting a service or item within the time by which you should have received a service or item.

You can also request a Fair Hearing within 120 days from the date on the notice telling you that Health Partners Plans failed to decide a First Level Complaint or Grievance you told Health Partners Plans about within **30 days from when Health Partners Plans got your Complaint or Grievance**.

How Do I Ask for a Fair Hearing?

Your request for a Fair Hearing must be in writing. You can either fill out and sign the Fair Hearing Request Form included in the Complaint or the Grievance decision notice or write and sign a letter.

If you write a letter, it needs to include the following information:

- Your (the member's) name and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have the Fair Hearing in person or by telephone;
- The reason(s) you are asking for a Fair Hearing; and
- A copy of any letter you received about the issue you are asking for a Fair Hearing about.

You must send your request for a Fair Hearing to the following address:

Department of Human Services
Office of Medical Assistance Programs – HealthChoices Program
Complaint, Grievance and Fair hearings
PO Box 2675
Harrisburg, PA 17105-2675

What Happens After I Ask for a Fair Hearing?

You will get a letter from the Department of Human Services' Bureau of Hearings and Appeals telling you where the hearing will be held and the date and time for the hearing. You will receive this letter at least 10 days before the date of the hearing.

You may come to where the Fair Hearing will be held or be included by phone. A family member, friend, lawyer or other person may help you during the Fair Hearing. You **MUST** participate in the Fair Hearing.

Health Partners Plans will also go to your Fair Hearing to explain why Health Partners Plans made the decision or explain what happened.

You may ask Health Partners Plans to give you any records, reports and other information about the issue you requested your Fair Hearing about at no cost to you.

When Will the Fair Hearing Be Decided?

The Fair Hearing will be decided within 90 days from when you filed your Complaint or Grievance with Health Partners Plans, not including the number of days between the date on the written notice of the Health Partners Plans' First Level Complaint decision or Grievance decision and the date you asked for a Fair Hearing.

If you requested a Fair Hearing because Health Partners Plans did not tell you its decision about a Complaint or Grievance you told Health Partners Plans about within **30 days from when Health Partners Plans got your Complaint or Grievance**, your Fair Hearing will be decided within 90 days from when you filed your Complaint or Grievance with Health Partners Plans, not including the number of days between the date on the notice telling you that Health Partners Plans failed to timely decide your Complaint or Grievance and the date you asked for a Fair Hearing.

The Department of Human Services will send you the decision in writing and tell you what to do if you do not like the decision.

If your Fair Hearing is not decided within 90 days from the date the Department of Human Services receives your request, you may be able to get your services until your Fair Hearing is decided. You can call the Department of Human Services at **1-800-798-2339** to ask for your services.

What to do to continue getting services:

If you have been getting the services or items that are being reduced, changed or denied and you ask for a Fair Hearing and your request is postmarked or hand-delivered within 10 days of the date on the notice telling you Health Partners Plans' First Level Complaint or Grievance decision, the services or items will continue until a decision is made.

Expedited Fair Hearing

What Can I Do if My Health Is at Immediate Risk?

If your doctor or dentist believes that waiting the usual time frame for deciding a Fair Hearing could harm your health, you may ask that the Fair Hearing take place more quickly. This is called an expedited Fair Hearing. You can ask for an early decision by calling the Department at **1-800-798-2339** or by faxing a letter or the Fair Hearing Request Form to **717-772-6328**. Your doctor or dentist must fax a signed letter to **717-772-6328** explaining why taking the usual amount of time to decide your Fair Hearing could harm your health. If your doctor or dentist does not send a letter, your doctor or dentist must testify at the Fair Hearing to explain why taking the usual amount of time to decide your Fair Hearing could harm your health.

The Bureau of Hearings and Appeals will schedule a telephone hearing and will tell you its decision within 3 business days after you asked for a Fair Hearing.

If your doctor does not send a written statement and does not testify at the Fair Hearing, the Fair Hearing decision will not be expedited. Another hearing will be scheduled and the Fair Hearing will be decided using the usual time frame for deciding a Fair Hearing.

You may call **Health Partners Plans**' toll-free telephone number at **1-800-553-0784 (TTY 1-877-454-8477)** if you need help or have questions about Fair Hearings, you can contact your local legal aid office at **215-981-3700** (Philadelphia County); **1-877-429-5994** (Bucks, Chester, Delaware and Montgomery counties) or call the Pennsylvania Health Law Project at **1-800-274-3258**.

Legal Aid Contact List

- **Community Legal Services Philadelphia County**
  3638 N. Broad Street
  Philadelphia, PA 19140

  Phone: **215-227-2400**

- **Philadelphia Legal Assistance**
  42 S. 15th Street, Suite 500
  Philadelphia, PA 19102

  Phone: **215-981-3800**

- **Legal Aid of Southeastern Pennsylvania, Bucks County Divisions**
  1290 Veterans Highway
  P.O. Box 809
  Bristol, PA 19007

  Phone: **215-781-1111**

  or

  100 Union Street
  Doylestown, PA 18901

  Phone: **215-340-1818**

- **Legal Aid of Southeastern Pennsylvania, Montgomery County Divisions**
  625 Swede Street
  Norristown, PA 19401

  Phone: **610-275-5400**

  or

  248 King Street
  Pottstown, PA 19464

  Phone: **610-326-8280**

- **Legal Aid of Southeastern Pennsylvania, Delaware County Division**
  410 Welsh Street
  Chester, PA 19013

  Phone: **610-874-8421**

- **Legal Aid of Southeastern Pennsylvania, Chester County Division**
  14 East Biddle Street
  West Chester, PA 19380

  Phone: **610-436-4510**

Toll-free Advice & Referral Hotline for Bucks, Chester, Delaware & Montgomery Counties is **1-877-429-5994**.

KidzPartners Member Complaint & Grievance Process

This information pertains to KidzPartners members ONLY.

Complaints

What is a complaint?

A complaint is when you tell us you are unhappy with KidzPartners or your provider or do not agree with a decision by KidzPartners. Some things you may complain about include:

- You are unhappy with the care you are getting.
- You cannot get the service or item you want because it is not a covered service or item.
- You have not gotten services that KidzPartners has approved.

As a member, you also have the right to question the classification of an appeal as a complaint.

First Level Complaint

What should I do if I have a complaint?

To file a complaint, you can:

- Call KidzPartners at **1-888-888-1211** or **215-967-4540 (TTY 1-877-454-8477)** and tell us your complaint.
- Write down your complaint and send it to us at:

  Health Partners Plans
  Attn: Complaints, Grievances & Appeals Unit
  901 Market Street, Suite 500
  Philadelphia, PA 19107

- Have your provider or designated representative file a complaint for you if you give your provider or representative your consent in writing to do so.
- This is called a first level complaint.

When do I file a first level complaint?

You must file a complaint within 60 days of getting a letter telling you that:

- KidzPartners has decided that you cannot get a service or item you want because it is not a covered service or item.
- KidzPartners will not pay for a service or item you got.
- KidzPartners did not decide a complaint or grievance (that you told us about before) within 30 days.
- KidzPartners denied your request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other financial liabilities.

You must also file a complaint within 60 days of the date you should have gotten a service or item if you did not get a service or item. The time by which you should have received a service or item is listed on the chart on page 8 [of the member handbook]. You may file all other complaints at any time.

What happens after I file a first level complaint?

After you file your complaint, you will get a letter from KidzPartners telling you that we have received your complaint, and about the first level complaint review process.

You may contact the Department of Health or the Insurance Department if you disagree with KidzPartners' classification of your request for an internal review.

You may ask KidzPartners to see any information we have about your complaint. You may also send KidzPartners any information that may help with your complaint.

You may attend the complaint review if you want to. Health Partners Plans will tell you the location, date, and time of the Complaint review at least seven days before the complaint review. You may come to our offices at 901 Market Street, Suite 500 in Philadelphia or be included by phone or by videoconference. If you decide that you do not want to attend the complaint review, it will not affect the decision.

A committee of one or more Health Partners Plans staff who has not been involved in the issue you filed your complaint about will review your complaint and make a decision. Your complaint will be decided no later than 30 days after we receive your complaint. A letter will

be mailed to you within 5 business days after the decision is made. This letter will tell you all the reasons for the decision and what you can do if you don't like the decision.

Second Level Complaint

What if I don't like KidzPartners' decision?

If you do not agree with our first level complaint decision, you may file a second level complaint with KidzPartners *unless* your complaint is about one of the following:

- KidzPartners has decided that you cannot get a service or item you want because it is not a covered service or item.
- KidzPartners failed to provide a service or item in a timely manner.
- KidzPartners will not pay for a service or item you got.
- KidzPartners did not decide a complaint or grievance (that you told us about before) within 30 days.
- KidzPartners denied your request to dispute a financial liability, including cost sharing (copayments, premiums, deductibles and coinsurance) and other financial liabilities.
- KidzPartners has decided that you cannot get a service you wanted because you are over your benefit limit but you believe you are not over the benefit limit.

If your complaint is about one of the above issues, and you do not agree with our first level complaint decision, you may file a request for an External Complaint Review (see below *External Complaint Review*).

When should I file a second level complaint?

You must file your second level complaint within 45 days of the date you receive the first level complaint decision letter. Use the same address or phone number you used to file your first level complaint.

What happens after I file a second level complaint?

You will receive a letter from KidzPartners telling you that we have received your complaint and telling you about the second level complaint review process. You may ask KidzPartners to see any information we have about your complaint. You may also send KidzPartners any information that may help with your complaint. You may attend the complaint review if you

want to. Health Partners Plans will tell you the location, date, and time of the complaint review at least 15 days before the complaint review. You may come to our offices at 901 Market Street, Suite 500 in Philadelphia or be included by phone or by videoconference. If you decide that you do not want to attend the complaint review, it will not affect our decision.

A committee made up of three or more people who have not been involved in the issue you filed your complaint about, including at least one Health Partners Plans member, will review your complaint and make a decision. Your complaint will be decided no later than 45 days after we receive your complaint.

A letter will be mailed to you within 5 business days after the decision is made. This letter will tell you all the reasons for the decision and what you can do if you don't like the decision.

External Complaint Review

What can I do if I still don't like KidzPartners' decision?

If you do not agree with KidzPartners' second level complaint decision (or first level complaint decision if it pertains to one of the above issues that is not afforded a second level complaint review), you may ask for an external review by either the Department of Health or the Insurance Department. You must ask for an external review within 15 days of the date you received the second level complaint decision letter (or first level complaint decision letter if it pertains to one of the above issues that is not afforded a second level complaint review).

You must send your request for external review in writing to either:

Pennsylvania Department of Health
Bureau of Managed Care
Attention: Complaint Appeals
Health & Welfare Bldg., Rm. 912
625 Forster Street
Harrisburg, PA 17120

Telephone Number: **1-888-466-2787**

OR

Pennsylvania Insurance Department
Bureau of Consumer Services
1321 Strawberry Square
Harrisburg, PA 17120

Telephone Number: **1-877-881-6388**

If you send your request for external review to the wrong department, it will be sent to the correct department.

The Department of Health or the Insurance Department will get your file from KidzPartners. You may also send them any other information that may help with the external review of your complaint.

You may be represented by an attorney or another person during the external review.

A letter will be sent to you after the decision is made. This letter will tell you all the reasons for the decision and what you can do if you don't like the decision.

Grievances

What is a grievance?

When KidzPartners denies, reduces or stops a service or item or approves a service or item different than the service or item you requested because it is not medically necessary. A grievance is when you tell us you disagree with KidzPartners' decision. As a member, you also have the right to question the classification of an appeal as a grievance.

Grievance

What should I do if I have a grievance?

To file a grievance, you can:

Call KidzPartners at **1-888-888-1211** or **215-967-4540 (TTY 1-877-454-8477)** and tell us your grievance.

OR

Write down your grievance and send it to us at:

Health Partners Plans
Attn: Complaints, Grievances & Appeals Unit
901 Market Street, Suite 500
Philadelphia, PA 19107

OR

Have your provider or designated representative file a grievance for you, if you give your provider or representative your consent in writing to do so.

Note: *If your provider files a grievance for you, you cannot file a separate grievance concerning the same issue on your own.*

When should I file a grievance?

You have 60 days from the date you receive the letter (notice) that tells you that KidzPartners denied, reduced or stopped a service or item or approved a different service or item, to file your grievance.

What happens after I file a grievance?

After you file your grievance, you will get a letter from KidzPartners telling you that we have received your grievance and telling you about the first level grievance review process.

You may contact the Department of Health or the Insurance Department if you disagree with KidzPartners' classification of your request for an internal review.

You may ask KidzPartners to see any information we have about your grievance. You may also send KidzPartners any information that may help with your grievance. You may attend the grievance review if you want to. Health Partners Plans will tell you the location, date, and time of the grievance review at least 15 days before the grievance review. You may come to our offices at 901 Market Street, Suite 500 in Philadelphia or be included by phone or by videoconference. If you decide that you do not want to attend the grievance review, it will not affect our decision.

A committee made up of three or more individuals who have not been involved in the issue you filed your grievance about, including a licensed doctor and a community member, will review your grievance and make a decision. Your grievance will be decided no later than 30 days after we received your grievance. A letter will be mailed to you within 5 business days after the decision is made. This letter will tell you all the reasons for the decision and what you can do if you don't like the decision.

External Grievance Review

What can I do if I don't like KidzPartners' decision?

If you do not agree with KidzPartners' grievance decision, you may ask for an external grievance review. You must call or send a letter to KidzPartners asking for an external grievance review within 15 days of the date you receive the grievance decision letter. Use the same address and phone number you used to file your grievance. We will then send your request to the Department of Health.

The Department of Health will notify you of the external grievance reviewer's name, address and phone number. You will also be given information about the external review process. KidzPartners will send your grievance file to the reviewer. You may send the reviewer any additional information that may help with the external review of your grievance within 15 days of filing the request for an external grievance review. You will receive a letter within 60 days of the date you asked for an external grievance review. This letter will tell you all the reasons for the decision and what you can do if you don't like the decision.

Expedited Complaints and Grievances

What can I do if my health is at immediate risk?

If your doctor or dentist believes that the usual time frames for deciding your complaint or grievance will harm your health, you or your doctor or dentist can call KidzPartners at **1-888-888-1211** or **215-967-4540 (TTY 1-877-454-8477)** and ask that your complaint or grievance be decided more quickly. This is called an expedited complaint or an expedited grievance. You will need to have a letter from your doctor or dentist faxed to **215-991-4105** explaining how the usual time frame for deciding your complaint or grievance will harm your health.

If your doctor or dentist does not fax KidzPartners this letter within 48 hours of your request for expedited (faster) review, your complaint or grievance will be decided within the usual time frames.

Expedited Complaint

The expedited complaint will be decided by a licensed doctor or dentist, who has not been involved in the issue you filed your complaint about. KidzPartners will call you within two days of when we receive your request for an expedited (faster) complaint review to tell you our decision. We will also send you a letter within two days telling you all the reasons for the decision and what to do if you don't like the decision.

Expedited Grievance and Expedited External Grievance

A committee of three or more people, including a licensed doctor and a community member, will review your grievance. The licensed doctor will decide your expedited grievance with help from the other people on the committee. No one on the committee will have been involved in the issue you filed your grievance about.

KidzPartners will call you within 48 hours of when we receive your request for an expedited (faster) grievance to tell you our decision. We will also send you a letter within two days telling you all of the reasons for the decision and what you can do if you don't like the decision.

If you want to ask for an expedited external grievance review by the Department of Health, you must call KidzPartners at **1-888-888-1211** or **215-967-4540 (TTY 1-877-454-8477)** within two business days from the date you get the expedited grievance decision letter. KidzPartners will send your request to the Department of Health within 24 hours after receiving it.

What kind of help can I have with the complaint and grievance processes?

You may call KidzPartners' toll-free telephone number at **1-888-888-1211** or **215-967-4540 (TTY 1-877-454-8477)** if you need help or have questions about complaints and grievances.

If you need help filing your complaint or grievance, a staff member of Health Partners Plans will help you. This person can also represent you during the complaint or grievance process. You do not have to pay for the help of a staff member. This staff member will not have been involved in any decision about your complaint or grievance.

At any time during the complaint or grievance process, you can have someone you know (which may include your provider) represent you or act on your behalf. If you decide to have someone represent or act for you, tell KidzPartners, in writing, the name of that person and how we can reach him or her.

This person can also help you if you decide you want to appear at the complaint or grievance review. For legal assistance you can contact your local legal aid office (see the Legal Aid Contact List section below for the office closest to you) or the Pennsylvania Health Law Project at **1-800-274-3258**.

Persons Who Speak a Language Other Than English

If you ask for language interpreter services, KidzPartners will provide the services at no cost to you. Please contact the Member Relations department at **1-888-888-1211** or **215-967-4540 (TTY 1-877-454-8477)** for more information.

Persons with Disabilities

If needed, KidzPartners will help persons with disabilities in presenting complaints or grievances at no cost. This help includes:

- Providing sign language interpreters;
- Giving you information that KidzPartners plans to submit at the complaint or grievance review in an alternative format, before the review; and
- Providing someone to help copy and present information.

Legal Aid Contact List

- **Community Legal Services Philadelphia County**
  3638 N. Broad Street
  Philadelphia, PA 19140
  Phone: **215-227-2400**

- **Philadelphia Legal Assistance**
  42 S. 15th Street, Suite 500
  Philadelphia, PA 19102
  Phone: **215-981-3800**

- **Legal Aid of Southeastern Pennsylvania, Bucks County Divisions**
  1290 Veterans Highway
  P.O. Box 809
  Bristol, PA 19007
  Phone: **215-781-1111**
  or
  100 Union Street
  Doylestown, PA 18901
  Phone: **215-340-1818**

- **Legal Aid of Southeastern Pennsylvania, Montgomery County Divisions**
  625 Swede Street
  Norristown, PA 19401
  Phone: **610-275-5400**
  or
  248 King Street
  Pottstown, PA 19464
  Phone: **610-326-8280**

- **Legal Aid of Southeastern Pennsylvania, Delaware County Division**
  410 Welsh Street
  Chester, PA 19013
  Phone: **610-874-8421**

- **Legal Aid of Southeastern Pennsylvania, Chester County Division**
  14 East Biddle Street
  West Chester, PA 19380
  Phone: **610-436-4510**

Toll Free Advice & Referral Hotline for Bucks, Chester, Delaware & Montgomery Counties is **1-877-429-5994**. The hotline is available Monday through Thursday from 9:00 a.m. - 1:00 p.m.

Health Partners Medicare Member Grievance & Appeal Process

This information pertains to Health Partners Medicare members ONLY.

Grievances

A Grievance means any complaint or dispute other than the one involving an organization determination, expressing dissatisfaction with any aspect of Health Partners Medicare providers' operations, activities, or behavior, regardless of whether remedial action is requested.

Members have **(60) calendar days** from the date of the incident or the date the member receives written notice of a decision to file a grievance. Grievance requests must be filed orally or in writing with Health Partners Medicare. A grievance can be filed on behalf of a member by a provider or other representative. The member's written authorization must be included with the grievance request.

For quality of care issues, a member may file a grievance with Health Partners Medicare, or file a written complaint with CMS's contracted Quality Improvement Organization (QIO). If a quality of care complaint is filed with QIO, Health Partners Medicare will work with the QIO to resolve the complaint.

Standard Grievance

Health Partners Medicare will respond to a member's grievance within (30) calendar days. We may extend the 30-day review period by up to 14 days if requested by the member, or if we justify the need for additional information. If Health Partners Medicare extends the 30-day review period, the member and the representative involved will be notified in writing of the reason for delay. A grievance decision notice will be issued no later than the expiration of the extension.

Expedited Grievance

Health Partners Medicare must respond to a member's grievance within 24 hours in the following instances:

- The grievance involves Health Partners Medicare's decision to invoke an extension to the time frame required for an organization determination in response to a service request or reconsideration (appeal).

- The grievance involves Health Partners Medicare's refusal to grant the member's request for an expedited organization determination in response to a service request or expedited reconsideration (appeal).

Reconsideration (Appeal) Process

Providers must adhere to the Medicare appeals and expedited appeals procedures, including gathering/forwarding information on appeals as necessary and as described in the Code of Federal Regulations (42 CFR 422 Subpart M).

Reconsideration (Appeal) Request

A reconsideration consists of a review of an adverse Health Partners Medicare determination notice. If the request is not filed in 60 calendar days, the member (or the members' authorized representative) may request that the reconsideration time frame be extended. The request for the reconsideration and extension of the time frame must be written, and must state why the request was not filed in a timely manner.

In order for Health Partners Plans to process a standard reconsideration (appeal) request for **service** or **payment** from a contracted plan provider on behalf of a member, Health Partner Plans must obtain an Appointment of Representation from the member, authorizing the medical provider to represent the member during the appeal process.

Note: Non-contracted providers may appeal on behalf of a member by obtaining an Appointment of Representation form. When acting as a representative of the member, a non-contracted provider is prohibited from participating as an independent party (appellant) to the appeal.

Standard Reconsideration (Appeal) of Service Determination

Health Partners Medicare will issue a written determination for a service reconsideration request as expeditiously as the member's health condition requires, but no later than 30 calendar days from the date we received the request for a standard reconsideration.

We may extend the 30-day time frame by 14 days. If Health Partners Medicare extends the time frame, we will notify the member in writing of the reasons for delay and inform the member of his/her grievance rights if the member disagrees with our decision to extend the time frame.

When Health Partners Medicare makes a reconsideration determination that upholds the initial denial, in whole or in part, we will prepare a written explanation and send the case file to

MAXIMUS as expeditiously as the member's health condition requires but no later than 30 days from receipt of the reconsideration request, subject to an additional 14-day extension.

MAXIMUS Federal Services/Part C
Medicare Managed Care Reconsideration Project
3750 Monroe Ave. Ste. 702
Pittsford, New York 14534-1302
Phone: **1-585-348-3300**

Standard Reconsideration (Appeal) of Payment Determination

Health Partners Medicare will issue a written determination for payment reconsideration requests no later than 60 days from the date we received the request for a standard reconsideration.

When Health Partners Medicare makes a reconsideration determination that upholds the initial denial, in whole or in part, we will prepare a written explanation and send the case/file to MAXIMUS within 60 days of receipt of the reconsideration request.

Expediting Certain Reconsiderations

A member or a physician (contracted or not contracted) may request that Health Partners Medicare expedite a reconsideration of a determination that involves our refusal to provide or pay for services that the member believes should be furnished or arranged for if the member believes that the continuation of services is medically necessary.

The expedited reconsideration (appeal) time frames will be applied in the following circumstances:

- A member requests reconsideration (appeal) because he/she missed the deadline to request QIO review of a non-coverage of an inpatient hospital care decision following his/her receipt of Notice of Medicare Non-Coverage (NOMNC).
- A member requests reconsideration (appeal) because he/she missed the deadline to file a Fast Track appeal request with the QIO following his/her receipt of a 2-day advance termination notice from a Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF) provider.

Contracted and non-contracted physicians may initiate an expedited reconsideration without appointment of representation or Waiver of Liability documents.

Plan's Refusal to Expedite a Reconsideration Request

If Health Partners Medicare denies a member's request for expedited reconsideration, we will give the member prompt oral notice and subsequently deliver, within 3 days, a notice to the member explaining that the request will automatically be transferred to the 30-day time frame for standard reconsiderations. The notice will also inform the member of the right to file a grievance if he/she disagrees with the decision not to expedite as well as the member's right to resubmit a request for an expedited reconsideration with any physician's support.

Plan's Decision to Expedite a Reconsideration Request

Those requests made or supported by a physician will be accepted as expedited if the physician indicates that applying the standard 30-day time frame for conducting reconsideration could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Health Partners Medicare will complete the reconsideration and give the member (and physician involved, as appropriate), notice of the decision as expeditiously as the member's health condition requires, but no later than 72 hours after receiving the request. We may extend the 72-hour deadline by up to 14 days. If Health Partners Medicare extends the time frame, we will notify the member in writing of the reason for the delay and inform the member of his/her grievance rights if the member disagrees with our decision to extend the time frame.

If Health Partners Medicare first notifies the member (and physician involved as appropriate) orally of a completely favorable expedited reconsideration, we will issue a written confirmation within 3 days. If our expedited reconsideration determination upholds the initial determination (denial), in whole or in part, we will submit a written explanation and the case file will go to MAXIMUS as expeditiously as the member's health condition requires, but no later than 24 hours from our determination. Health Partners Medicare will concurrently notify the member (and the physician involved, as appropriate) that the case file has been submitted to MAXIMUS.

Medicare Part D Grievance and Redetermination (Appeal) Process

Appeal Process

Appeals must be requested within 60 calendar days after the date of determination. Health Partners Medicare can give the member more time if there is a good reason for missing the deadline. Members/providers have the right to ask Health Partners Medicare for an exception if they believe a drug that is not on the formulary should be covered or if the drug should be

covered at a lower cost sharing amount. They can also ask for an exception to utilization management tools, such as a dose restriction or step therapy requirement. The physician must provide a statement to support the exception request.

Requesting an Appeal

Members or their appointed representative may request an appeal. A relative, friend, advocate, attorney, doctor, or someone else can act for the member. Others may already be authorized under State law to act on behalf of the member.

Health Partners Medicare can be reached at **1-800-901-8000**, 24 hours a day, 7 days a week. If members have a hearing or speech impairment, please call us at **TTY 1-877-454-8477**.

Problem Resolution – Part D

The following is communicated to all Health Partners Medicare members.

There are two kinds of appeals you can request:

- **Expedited (72 Hours) –** You can request an expedited (fast) appeal if you or your doctor believe that your health could be seriously harmed by waiting up to 7 days for a decision. If your request to expedite is granted, we must give you a decision no later than 72 hours after we get your appeal.
  - **If the doctor who prescribes the** drug(s) asks for an expedited appeal for you, or supports you in asking for one, and the doctor indicates waiting for 7 days could seriously harm your health, **we will automatically expedite the appeal.**
  - If you ask for an appeal without support from a doctor, we will decide if your health requires an expedited appeal. If we do not give you an expedited appeal, we will decide your appeal within 7 days.
  - Your appeal will not be expedited if you've already received the drug you are appealing.
- **Standard 7 Days –** You can request a standard appeal. We must give you a decision no later than 7 days after we get your request.

What do I include with my appeal request?

You should include your name, address, Member ID number, the reason for your appeal, and any evidence you wish to attach. If your appeal relates to a decision by us to deny a drug that is not on our formulary, your prescribing physician must indicate that all the drugs on any tier

of our formulary would either harm your health or not be as effective to treat your condition as the requested off-formulary drug.

How do I request an appeal?

For an Expedited Appeal: You or your appointed representative should contact us by telephone or fax us at:

Phone: 1-866-901-8000 (TTY 1-877-454-8477)
Fax: 215-991-4105

For a Standard Appeal: You or your appointed representative should mail or deliver your written appeal request to:

Health Partners Medicare
Suite 500
901 Market Street
Philadelphia, PA 19107

What Happens Next?

If you appeal, we will review your case and give you a decision. If any of the prescription drugs you requested are still denied, you can request an independent review of your case by a reviewer outside of your Medicare Drug Plan. If you disagree with the decision, you will be notified of your appeal rights.

Contact Information:

If you need information or help, call us at: **1-866-901-8000 (TTY 1-877-454-8477)**. Other Resources to help you:

Medicare Rights Center
Toll Free: **1-888-HMO-9050**

Elder Care Locater
Toll Free: **1-800-677-1116**
1-800-MEDICARE (1-800-633-4227)
TYY: 1-877-486-2048

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