

## APPEALS AND GRIEVANCES

If you do not agree with the decision made by The Health Plan, or are not happy with any services received, **you, your representative or the legal representative of a deceased enrollee's estate, or your doctor (with your written consent) can get in touch with The Health Plan's Customer Service Representative by calling 1-888-613-8385 or (740) 695-7904 or writing it down and send it to The Health Plan's Customer Service Department at 52160 National Road East, St. Clairsville, OH 43950. The Health Plan's Customer Service Representative can help you with your appeal.**

You can call or write the Customer Service Representative about many different kinds of appeals, such as:

Claims regarding the scope of coverage for health care services.

Denials, reductions, cancellations, or non-renewals of enrollee coverage.

The kinds of health care services you receive.

Not being allowed to get certain health care services.

Not being able to get services in a timely manner.

The way your doctor or The Health Plan's staff treat you.

Notice of your rights as a patient.

The Health Plan has an appeal process to help make sure that your appeals are handled quickly. The Customer Service Representative can explain the appeal process to you and will let you know what The Health Plan is doing to respond to your appeal. If you do request an appeal and if the appeal remains denied, you may have to pay for the services if care was already rendered.

**Appeal Process:** (Started by the Member or their Doctor with Member's signed consent).

If you are not happy with our decision relating to a denial of a service, a reduction in service, termination of a previously authorized service, or failure to provide service timely, then you, your representative or the legal representative of a deceased enrollee's estate, or your doctor (with your written consent) may file an appeal with The Health Plan's Customer Service Department by phone or in writing. Your information will be recorded and reviewed. (Please note: No action will be taken against a provider who files an appeal on behalf of an enrollee.)

The Health Plan's Grievance Committee will look at your appeal. If your appeal is about medical service, a doctor will be involved in this review process. If you want, you can meet with the Appeals Committee to review the situation.

**Your appeal will be answered within the following time frames:**

You will receive a written response from the Grievance Committee within 15 calendar days (if the service has not been done yet), or 30 calendar days (if the service was already done). This timeframe may be extended up to 14 days if you ask for it to or if The Health Plan shows that additional information is needed and the delay could help you in the appeal. If The Health Plan asks for the delay, we will notify you of this delay, in writing, and the reason for it. **However, you will receive an answer from us within 45 days from receipt of your request.**

If a delay of our answer might seriously endanger your life or health, you or your doctor can request a quick review and we will call you and mail you a written notice of our decision within 72 hours. If your request for a quick appeal is approved, any additional information you or your doctor want us to look at will need to be turned into The Health Plan shortly after your request so we can complete the review within the 72 hours. If we don't approve your request for a quick appeal, we will process your appeal within the 15 or 30 day timeframe listed above.

If you are not happy with the decision of the Grievance Committee, you may request a State Fair Hearing.

### **State Fair Hearings Process**

If you are not happy with The Health Plan's Appeal decision, you, your representative or the legal representative of a deceased enrollee's estate, or your doctor (with your written consent) can request a State Fair Hearing if it is within 90 days of the notice of the Appeal decision from The Health Plan. You can only request a State Fair Hearing if it relates to a denial of a service, a reduction in service, termination of a previously authorized service, or failure to provide service timely. Please contact your local Department of Health & Human Resources office to get the form you will need to fill out.

If a State Fair Hearing is requested, the State will hear your case and give you a decision in writing within 90 days of the date you filed the appeal. If you are still not happy with the decision, you can take your case to Circuit Court. If you want to proceed in taking your case to circuit court, you must file within 120 days of your notice of the State Fair Hearing decision.

**Note: At the conclusion of The Health Plan's appeals process, the enrollee has the right to appeal to the West Virginia Insurance Commissioner within 30 days.**

### **Appeal After 90 Days**

If you did not request a State Fair Hearing within the 90 days, you may still be able to appeal The Health Plan's original decision that you did not agree with. You can also use this process even if the decision is not related to a denial of service, a reduction in service, termination of a previously authorized service, or failure to provide service timely. You must have gone through The Health Plan's internal appeal process and it must be within 1 year of the date of the original decision that you did not agree with.

You can file an appeal to the Bureau for Medical Services (BMS). Send your request for an appeal to:

Bureau for Medical Services  
Office of Medicaid Managed Care  
350 Capitol Street, Room 251  
Charleston, WV 25301-3708

BMS will only review appeals related to a denial of a service, a reduction in service, termination of a previously authorized service, or failure to provide service timely. The BMS decision will be sent to you in writing.

If you are not happy with the Bureau for Medical Services decision, you can appeal to the Insurance Commissioner by sending your appeal to:

The Office of the Insurance Commissioner  
P.O. Box 50540  
Charleston, WV 25305-0540

If you are not satisfied with the decision of the Office of the Insurance Commissioner, you may appeal to Circuit Court. Your appeal must be filed within 30 days after the Insurance Commissioner's order has been mailed. Please contact your local Department of Health & Human Resources office to get the form you will need to fill out.