



Notice of Action Statement

Complaints and Grievances

- You can file a complaint, also called a grievance, at any time.
- If you are unhappy with something that happened to you when you received health care services, you can file a complaint or grievance. Examples of why you might file a complaint or grievance include:
 - You feel you were not treated with respect
 - You are not satisfied with the health care you got
 - It took too long to get an appointment
 - You do not agree with a decision that we made
- To file a complaint or grievance you should call The Health Plan at 1.888.613.8385 (TTY:711)
- To file a complaint or grievance in writing, you may fax it to The Health Plan at 1.888.450.6025 or mail it to 1110 Main Street, Wheeling, WV 26003
- You will need to send us a letter that has:
 - Your name
 - Your mailing address
 - The reason why you are filing the complaint and what you want The Health Plan to do
 - Your doctor or authorized representative can also file a complaint or grievance for you

We will let you know when we receive your complaint or grievance. You can file a complaint or grievance at any time after the event about which you are unhappy. The Health Plan will conduct a full investigation after we receive your complaint or grievance. We will usually give you a decision within 30 calendar days and no later than 90 calendar days, but may ask for extra time to give an answer.

The Health Plan will provide translation services, as needed, at no cost to you.

Appeals

If you believe your benefits were unfairly denied, reduced, delayed or stopped, you have the right to file an appeal with The Health Plan. You also have the right to appeal any adverse decision.

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- To file an appeal, you can call The Health Plan at 1.888.613.8385.
- To file an appeal in writing, you will need to fax it to The Health Plan at 1.888.450.6025 or mail it to 1110 Main Street Wheeling, WV 26003.
- You will need to send us a letter that has:
 - Your name
 - Your provider's name
 - The date of service
 - Your mailing address
 - The reason why we should change our decision
 - A copy of any information that you think supports your appeal, such as written comments, additional documents, records or information related to your appeal
 - Your doctor or authorized representative can also file an appeal for you

If you call and give your appeal over the phone, The Health Plan will acknowledge your appeal in a letter and send you the letter to sign. Be sure to read the letter carefully. You must sign the letter and return it to The Health Plan to have an appeal.

You must file an appeal within 60 calendar days from the date on the notice of action from The Health Plan.

We will let you know when we have received your appeal and you can get copies of documents, records, and information about the appeal for free. Information may include medical necessity criteria, and any processes, strategies, or evidence-based standards used in setting coverage limits. A committee will look at your appeal. None of the people on the Appeal Committee will have been involved in our initial decision to not authorize or pay for the health services you are appealing. If your appeal involves a medical issue, the committee will also talk to a health care professional who has the appropriate training and experience in the field of medicine necessary for making the decision on the medical issue. We have provided the titles and qualifications of individuals who may participate in your appeal decision review.

- Medical Director – board-certified practitioners certified in psychiatry and neurology, behavioral health, obstetrics/gynecology, general surgeon with current state licensures
- Nurse Navigators – registered nurses with current state licensures

The Health Plan must process and provide notice to you regarding your appeal within 30 calendar days.

If The Health Plan needs more information for the appeal, or if you want to provide more information, you or The Health Plan can ask for 14 more calendar days to finish the appeal. If The Health Plan decides to extend the review time to finish the appeal, you will be notified in writing within two (2) calendar days that you have the right to file a grievance if you disagree with the extension.

Fast Appeals



If your appeal is about our decision to not approve or pay for some or all of your health care services, and you need an appeal decision fast because you have not gotten the health care services and you might be badly hurt if you had to wait for a normal appeal decision, like the one described above, you can ask for a fast appeal by calling The Health Plan at 1.888.613.8385. A fast appeal must be written within 60 calendar days. If we allow a fast appeal, we will schedule a meeting with the Committee no later than 48 hours after we get your appeal. We will call you 24 hours after we get your appeal to let you know the date, time, and place of the meeting. We will make a decision on your appeal no later than 72 hours after we get your appeal. If The Health Plan determines that an appeal is not a fast appeal, The Health Plan will provide your fast appeal request to the State so that they can determine a timeframe for resolution. You will get a written notice explaining the next steps in the process.

To file a fast appeal you will need to provide us with:

- Your name
- Your provider's name
- The date of service
- Your mailing address
- The reason why we should change our decision
- A copy of any information that you think supports your appeal, such as written comments, additional documents, records or information related to your appeal

You can file a fast appeal by either calling us, or mailing or faxing the information to:

The Health Plan
1110 Main Street
Wheeling, WV 26003

Phone Number 1.888.613.8385
FAX – 1.888.450.6025

If we decide your appeal is not a fast appeal, we will handle your appeal like the normal appeals described in the section above. You have the right to file a grievance if you are unhappy with the decision to deny the fast appeal.

State Fair Hearing Process

If you are not happy with The Health Plan's appeal decision, and your appeal is about our decision to deny, reduce, change or terminate payment for your health care services, you can request a State Fair Hearing. 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. You will get a notice mailed to you within 13 calendar days before any action is taken. You must request a State Fair Hearing within 120 calendar days from the notice of appeal resolution from The Health Plan. You may also request a State Fair Hearing if The Health Plan does not meet the timeframe for making a decision on your appeal.

Send your request for State Fair Hearing to:

Bureau for Medical Services
Office of Medicaid Managed Care

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350 Capitol Street, Room 251
Charleston, WV 25301-3708

The Bureau for Medical Services 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 West Virginia Insurance Commissioner by sending your appeal to:

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

The Health Plan will continue your benefits during the time of an appeal process or State Fair Hearing when:

- You or your provider file an appeal on a timely basis;
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
- The services were ordered by an authorized provider;
- The original period covered by the original authorization has not expired and;
- You request an extension of benefits within thirteen (13) days of the MCO determination.

To request an extension of benefits, call member service at 1.888.613.8385. The Health Plan will pay for the services in question when the final result of the appeal is to overturn the original decision. The Health Plan will pay for some or all of the services as determined by the final appeal decision. If the final result of your appeal is to uphold the original decision to deny, reduce, change or end payment for your services, The Health Plan may take back the money that was paid for the services while the appeal was in process, and you will be responsible for paying for the services.

Keeping Your Grievance and Appeals

The Health Plan will keep copies of your grievance and appeals documents, records and information about the grievance and appeal for your review for 10 years.

Additional Services

If you need help with receiving these materials in other languages, formats or a larger font size, please call Customer Service at 1.888.613.8385 (TTY 711). The customer service representative will send you new materials based on what you need. THP can also provide materials in braille. There is no cost to you for any of these services.

