Complaints, Grievances
And Fair Hearings

- If a Member is unhappy about something an MCO or a provider has done the Member can file a Complaint or Grievance.

- If a Member disagrees with an MCO’s decision a Member can file a Complaint or Grievance.

- A dispute or objection regarding a participating health care provider or the coverage, operations or management of an MCO.

- Examples of Complaints:
  - Member is unhappy with the care the Member is receiving.
  - The Member cannot receive a service or item the Member wants because it is not a covered service or item.
  - Member has not received services that the MCO has approved for the Member.

- A request to have an MCO or utilization review entity reconsider a decision concerning the medical necessity and appropriateness of a covered service.

- Examples of Grievances:
  - MCO denies a service a Member requested because it is not medically necessary.
  - MCO decreases a service a Member has been receiving because the amount of the service the Member has been receiving is not medically necessary.
  - MCO approves a service different from the service requested because the service requested is not medically necessary.

- Depending on the subject of the Complaint, a Complaint will either have one or two levels of MCO review.

- All Grievances have only one level of MCO review.

- Complaints and Grievances can be filed orally or in writing.
- If in writing, the Complaint or Grievance can be mailed or faxed to the MCO.

- A Complaint or Grievance can be filed by:
  - Member.
  - Member’s representative.
  - Provider.

- If filed by a representative or a provider, the Member must provide written consent for the representative or provider to be involved or act on the Member’s behalf.

- If the Complaint is the result of a decision by the MCO, the Complaint must be filed within 60 days of the date the Member receives written notice of the decision.

- If it is a Complaint as a result of the failure of the MCO to provide a service or item in a timely manner, the Complaint must be filed within 60 days from the date the services should have been provided.

- If it is a Complaint as a result of the failure of the MCO to decide a Complaint or Grievance within the time frames for deciding a Complaint or Grievance, the Complaint must be filed within 60 days of the date the Member receives written notice of the MCO’s failure to timely decide the Complaint or Grievance.

- There is no time limit for filing all other Complaints.

Who Can Decide a First Level Complaint

- First level Complaint review committee:
  - One or more MCO staff.
  - MCO staff may not have been involved in and may not work for someone involved in the issue the Complaint is about.
  - If the Complaint involves a clinical issue, the committee must include a licensed physician or licensed psychologist and the physician or psychologist must decide the Complaint.

- MCO has 30 days to decide a first level Complaint and send written notice of the decision to the Member.
- Time frame can be extended by up to 14 days if requested by the Member.

Options After a First Level Complaint Is Decided

If the Complaint is about the following the Member may request a Department of Human Services Fair Hearing, request an external Complaint review by either the Department of Health or the Insurance Department, or request both a Fair Hearing and an external review:

- MCO’s decision to deny a service or item because it is not a covered service or item;
- MCO’s decision to not pay a provider after a service or item has been delivered;
- MCO’s failure to provide a service or item in a timely manner;
- MCO’s failure to decide a Complaint or Grievance within the specified time frames; or
- MCO’s decision to deny a request to disagree with MCO’s decision that the Member has to pay a provider.

For all other Complaints, the Member may request a

second level Complaint review.

- Requests for Fair Hearings must be filed within 120 days from the date on the written notice of the MCO’s first level Complaint decision.

- Requests for external review by either the Department of Health or Insurance Department must be filed within 15 days of the date the Member receives the written notice of the MCO’s first level Complaint decision.

- Second level Complaints must be filed within 45 days from the date the Member receives the written notice of the MCO’s first level Complaint decision.

Second level Complaint review committee:

- Three or more individuals.
- At least one-third of the members may not be employees of the MCO.
- MCO staff may not have been involved in and may not work for someone involved in the issue Complaint is about.

Who Can Decide a Second Level Complaint

- At least 20% of the second level Complaint review committees in a year must include a consumer representative.
- If the Complaint involves mental health services for an adult, the consumer representative must have received or is currently receiving mental health services.
- If the Complaint involves substance abuse services for an adult, the consumer representative must have received or is currently receiving substance abuse services.

- If the Complaint involves mental health services for a child or adolescent, the consumer representative may be a parent or guardian of a child or adolescent who has received or is currently receiving mental health services or an individual who has received or is currently receiving mental health services.

- If the Complaint involves substance abuse services for a child or adolescent, the consumer representative may be a parent or guardian of a child or adolescent who has received or is currently receiving substance abuse services or an individual who has received or is currently receiving substance abuse services.

MCO has 45 days to decide a second level Complaint and send written notice of the decision to the Member.

Option After a Second Level Complaint Is Decided

- The Member may request an external review by either the Department of Health or the Insurance Department.

- Requests for external review must be filed with either the Department of Health or the Insurance Department within 15 days of the date the Member receives the written notice of the MCO’s second level Complaint decision.

- The Department of Health reviews Complaints that involve the way a provider provides care or services.

- The Insurance Department reviews Complaints that involve the MCO’s policies and procedures.

All Grievances must be filed within 60 days from the date the Member receives written notice of the MCO’s decision about the medical necessity and appropriateness of a covered service.

Grievance review committee:

- Three or more individuals.
- At least one-third of the members may not be employees of the MCO.
- MCO staff may not have been involved in and may not work for someone involved in the issue the Grievance is about.
- Must include a licensed physician or licensed psychologist and the physician or psychologist must decide the Grievance.

Who Can Decide a Grievance

- At least 20% of the Grievance review committees in a year must include a consumer representative.
- If the Grievance involves mental health services for an adult, the consumer representative must have received or is currently receiving mental health services.
- If the Grievance involves substance abuse services for an adult, the consumer representative must have received or is currently receiving substance abuse services.

Who Can Decide a Grievance

- If the Grievance involves mental health services for a child or adolescent, the consumer representative may be a parent or guardian of a child or adolescent who has received or is currently receiving mental health services or an individual who has received or is currently receiving mental health services.

- If the Grievance involves substance abuse services for a child or adolescent, the consumer representative may be a parent or guardian of a child or adolescent who has received or is currently receiving substance abuse services or an individual who has received or is currently receiving substance abuse services.

Time Frame for Deciding a Grievance

- MCO has 30 days to decide a Grievance and send written notice of the decision to the Member.

- Time frame can be extended by up to 14 days if requested by the Member.

Options After a Grievance Is Decided

- A Member may request a Department of Human Services Fair Hearing, request an external review by the Department of Health, or request both a Fair Hearing and an external review.

- Requests for Fair Hearings must be filed within 120 days from the date on the written notice of the MCO's Grievance decision.

- Requests for external review must be filed within 15 days of the date the Member receives the written notice of the MCO's

Grievance decision.

- Review by a doctor who does not work for MCO.
- A written decision will be issued within 60 days from the filing of the request for the external Grievance review.
- The external Grievance decision may be appealed to a court of

competent jurisdiction.

Expedited review is when an MCO decides a Complaint or Grievance faster than the normal time frames.

Expedited Review

- An MCO must conduct expedited review if:
  - The MCO determines that waiting the usual amount of time to receive a decision about a Complaint or Grievance could harm the Member's health.
  - The Member provides the MCO with a certification from the Member's provider that explains why waiting the usual amount of time to receive a decision about a Complaint or Grievance could harm the Member's health.

Who Can Decide an Expedited Complaint

- Review committee for an expedited Complaint:
  - Must include a licensed physician or licensed psychologist.
  - The physician or psychologist must decide the Complaint.
  - Committee members may not have been involved in and may not work for someone involved in the issue the Complaint is about.

Review committee for an expedited Grievance is the same as the review committee for a regular Grievance.

- MCO must issue a decision within either 48 hours of receiving the provider certification or 72 hours of receiving the request for expedited review, whichever is shorter.
- The Member can request that the time frame for deciding an expedited Complaint or Grievance be extended by up to 14 days.

- A Member may request a Department of Human Services Fair Hearing, request expedited external review by the Department of Health or Insurance Department, or request both a Fair Hearing and an expedited external review.
- Requests for Fair Hearings must be filed within 120 days from the date on the written notice of the MCO’s expedited Complaint or Grievance decision.
- Requests for expedited external review must be filed within 2 business days from the date the Member receives the MCO’s expedited Complaint or Grievance decision.

- Member receives an acknowledgement letter.
- Member may ask to see any information the MCO has about the issue the Complaint or Grievance is about, at no cost to the Member.
- Member can send information it has about the Complaint or Grievance to the MCO.

- Member may attend the Complaint or Grievance review.
- The MCO will tell the Member the location, date, and time of the review in advance.
- The Member can appear at the review in person or by telephone.
- If the Member does not attend the review, the review must be conducted as if the Member was present and it will not affect the decision.

- Fair Hearings are conducted by the Department of Human Services, Bureau of Hearings and Appeals.
- No direct access to a Fair Hearing.

- Member must participate in the Fair Hearing.
- Member can participate in the Fair Hearing by telephone or in person.
- MCO will participate in the Fair Hearing to explain why the MCO made the decision or explain what happened.
- Member can ask the MCO for any records, reports, and other information the MCO has about the issue, at no cost to the Member.

A Fair Hearing must be decided within 90 days of the date the Member filed for a first level Complaint or a Grievance, not including the number of days between the date on the written notice of the MCO’s first level Complaint or Grievance decision and the date the Member requested a Fair Hearing.

Expedited Fair Hearings

- No direct access to an expedited Fair Hearing.
- BHA will conduct an expedited Fair Hearing:
  - If the Member provides BHA with a signed written certification from the Member's provider explaining why waiting the usual amount of time to receive a Fair Hearing decision could harm the Member's health.
  - If the Member's provider provides testimony at the Fair Hearing which explains why using the usual time frames for deciding a Fair Hearing would harm the Member's health.
- An expedited Fair Hearing must be decided within 3 business days from the request for expedited

review.

Continuation of Services

Services that are denied must continue when:

- Member has been receiving the services.
- Member requests any level of Complaint or Grievance review or files a request for a Fair Hearing.
- The request for review or Fair Hearing is made within 10 days from the mail date on the written notice of the MCO’s decision.

- Final Managed Care Rule
  - 81 FR 27497
  - 42 CFR §§ 438.400 - .424

For additional information or questions you may have, please contact Members Services at:

- Bedford/Somerset: 1-866-773-7891
- Capital Region: 1-866-722-8646
- Franklin/Fulton: 1-866-773-7917