Notice of Action Statement

If you do not like a decision made by The Health Plan or are not happy with any services received, or are unhappy about any other part of The Health Plan or your provider (without getting in trouble), you can get in touch with The Health Plan by calling at 1.888.613.8385 (TTY: 711) or write it down and send it to 1110 Main Street, Wheeling, WV 26003-2704.

The Health Plan can help you with completing any forms, translation (reading) services, and auxiliary aids and services at no cost to you.

Grievances

Medicaid members may file a grievance regarding any aspect of service delivery provided or paid for by the MCO at any time. If you do not agree with a decision made by The Health Plan, or are not happy with any services received, or are unhappy about any other part of The Health Plan or your provider, you (without getting in trouble) can get in touch with The Health Plan by calling Customer Service at 1.888.613.8385 (TTY: 711), or writing it down and sending it to The Health Plan 1110 Main Street, Wheeling, WV 26003. The Health Plan will provide translation services as needed at no cost to you.

Informal Grievances

Informal grievances are when you call The Health Plan to tell us you are not happy with any matter related to The Health Plan such as our decision to not pay a bill or okay it for you, or you are unhappy with any part of your benefits, services, The Health Plan or its list of providers. If you call the Member Service Department at 1.888.613.8385 (TTY: 711) they will take all of the information you give them and look into the problem. They will try to get you an answer in 30 calendar days. This timeframe may be extended up to 14 days if you ask for it or if The Health Plan shows that more information is needed, and the delay could help you in the grievance. If they are not able to answer your question in 30 calendar days they will call you or write you back and let you know.

Formal Grievances

If you are not happy with our answer to your informal grievance, you or someone with your okay (including a provider) can file a formal grievance. You may also skip the informal grievance process and file a formal grievance right away. To file, or to ask for help with filing a grievance or appeal, contact us at The Health Plan.

Appeals

If your formal grievance is because we told you no to any part of your request for a service, it is called an "Appeal." You or your representative or someone acting on behalf of a deceased member can file an appeal. To file an appeal, 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 helps your appeal, such as written comments, additional paperwork or information related to your appeal

You must file a grievance or appeal in sixty (60) calendar days from the date on the notice of action from The Health Plan.

You should send your written grievance or appeal to:

The Health Plan
1110 Main Street
Wheeling, WV 26003-2704
Fax: 1.888.450.6025

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 approve or pay for the health services you are appealing. If your appeal involves a medical problem, the committee will also talk to a medical person who has the right training and experience in the field of medicine necessary for making the decision on the medical problem. If your appeal is an administrative appeal (one not based on a medical problem), the Appeal Committee will consist of The Health Plan senior management. You can come to the Appeal Committee meeting and talk to the Appeal Committee. You have the right to have someone speak for you during the appeal process. You may also request a copy of the benefit provision, guidelines, protocol, or criteria on which the appeal decision was based. You are entitled to receive, upon request, reasonable access to or a copy of all the relevant documents ruled upon to make the appeal decision free of charge.

If your appeal is for a service that you have not received yet, you will get the decision in 30 days after we get your appeal.

If The Health Plan needs more information for the appeal, or if you want to give us more information, you or The Health Plan can ask for 14 more calendar days to finish the appeal. If The Health Plan tells you they will extend the review time to finish the appeal,

you will be told in writing in (2) two calendar days that you have the right to file a grievance if you do not like the longer time.

For your information, we have provided the titles and qualification of individuals participating in your appeal decision review:

- Medical Director – Board-certified practitioners (Radiology, Behavioral Health, Obstetrics/Gynecology, General Surgeon) with current state licensures
- Nurse Navigators- Registered nurses with current state licensures

Fast Appeals

If your appeal is about our decision to not approve or pay for some or all of your services and you need an appeal decision fast because you have not gotten the 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. 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. You will get a letter explaining the next steps. The Health Plan will report your request for a fast appeal to the State so they can determine a timeline for a decision.

If we tell you your appeal is not a fast appeal, we will handle your appeal like the normal appeals described in the section above.

State Fair Hearing Process

If you are not happy with The Health Plan's appeal decision and your appeal is about our decision to not accept, lower, change or stop payment of your bill, you can ask a State Fair Hearing if it is in 120 days of the notice of The Health Plan's appeal decision. You can only ask for a State Fair Hearing if it relates to a denial of a service, a lowering of service, stopping of a previously approved service, or not to give you service timely. You will get a notice mailed to you in ten (10) days before any action is taken.

If you ask for a State Fair Hearing, the State will hear your case and give you a decision in writing in 90 days of the date you asked for a State Fair Hearing. If are still not happy with the decision, you can take your case to Circuit Court. If you want to take your case to Circuit Court, you must file in 30 days after your notice of the State Fair Hearing decision. You can file an appeal to the Bureau for Medical Services (BMS).

Send your letter asking for a State Fair Hearing to:

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

The BMS decision will be sent to you in writing.

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 stopping, holding, or lowering of a previously approved course of treatment;
- The services were ordered by an approved provider;
- The first period covered by the first approved has not expired; and
- You ask for a longer time to keep their benefits.

To ask for longer time to keep your benefits, call Customer Service at 1.888.613.8385 (TTY: 711).

The Health Plan will pay for the services in question when the final result of the appeal to change the first decision. The Health Plan will pay for some or all of the services as they were given to you by the final appeal decision. If the final result of your appeal is to keep the first decision to not accept, lower, change or end payment of your bill, The Health Plan may take back the money that was paid for the services while the appeal was getting talked about, and you will have to pay for the services.

Appeals after 120 Days

If you did not ask for a State Fair Hearing in the 120 days, you may still be able to appeal The Health Plan's appeal decision that you are unhappy with. You can also use these steps if the decision is related to a complaint rather than an appeal. You must have gone through The Health Plan's grievance process and it must be in one year of the date of the first decision or issue that you did not like with or were not happy with.

Keeping Your Grievance and Appeals

The Health Plan will keep copies of your grievance and appeals paperwork and information about the grievance and appeal for your review for ten (10) years.