
Appeals Process

WellCare established and maintains a system for the resolution of appeals initiated by members or by providers, acting on behalf of a member and with the member's consent, with respect to the denial, termination or other limitation of covered health care services. Appeals received from a provider without a member's consent will not qualify for this process and will be processed as an administrative appeal. For further information see the Provider Payment Dispute/Administrative Appeals entry in this manual section.

An appeal may be filed when the Plan issues a notice of action to a Plan member.

A member, provider or authorized representative on behalf of the member with the member's consent, may file an appeal within 90 calendar days of the notice of action. A verbal appeal may be submitted in order to establish the appeal submission date; however, this must be followed by a written request. The Plan will assist the member, provider or authorized representative in this process.

Appeals may be verbal (followed up in writing) or written to:

WellCare Health Plans Inc.
PO Box 31368
Tampa, FL 33631-3368

Customer Service is available between the hours
of 8 a.m.-6 p.m.

For standard resolution of an appeal, the Plan will resolve the appeal and provide a written notice of disposition to the parties as expeditiously as the member's health condition requires, but no more than 15 calendar days from the day the Plan receives the appeal.

The Plan may extend the resolution time frame by up to 14 days if the member requests the extension, or the Plan shows (to the satisfaction of the Ohio

Department of Job & Family Services (ODJFS), upon its request for review) that there is need for additional information and how the delay is in the member's interest.

For any extension not requested by a member, the Plan will give the member written notice of the reason for the delay.

The Plan will include the following in the written notice of the resolution:

- The results of the appeal process and the date it was completed; and
- For appeals not resolved wholly in favor of the member: The right to request a state administrative hearing, and clear instructions about how to access this process;
 - The right to request an expedited state administrative hearing if applicable;
 - The right to request to receive benefits while the hearing is pending and how to make the request; and
 - A statement that the member may be held liable for the cost of those benefits if the hearing decision upholds the Plan's action.

Expedited Appeal Process

The Plan maintains an expedited review process for appeals. The member, his or her representative or a provider may file an expedited appeal either verbally or in writing. No additional follow-up will be required. An expedited appeal is only appropriate when the Plan determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life, health or ability to attain, maintain or regain maximum function.

The Plan ensures that punitive action is not taken against a provider who requests an expedited

resolution or who supports a member's appeal.

For expedited resolution of an appeal, the Plan will resolve the appeal and provide written notice to the affected parties as expeditiously as the member's health condition requires, but no more than three business days from the time the Plan received the appeal. The Plan will make reasonable efforts to also provide verbal notice to the member with the appeal determination.

The Plan may extend the expedited appeal resolution time frame by up to 14 days if the member requests the extension or the Plan needs additional information and demonstrates to the ODJFS that the extension of time is in the member's interest.

The Plan will notify an ODJFS Plan liaison within 24 hours regarding expedited appeals if an expedited appeal has been granted by the Plan or if an expedited appeal time frame has been requested by the member or the Plan. The Plan will provide the reason it is requesting a 14 day extension to the ODJFS Plan Liaison. The Plan will notify the ODJFS Plan Liaison within 24 hours (or sooner if possible) from the time the expedited appeal is lost.

For any extension not requested by the member, the Plan will give the member written notice of the reason for the delay. If the Plan denies a request for expedited resolution of an appeal, it will:

- Transfer the appeal to the time frame for standard resolution;
- Make reasonable efforts to give the member prompt verbal notice of the denial;
- Follow-up within two days of written notice; and
- Inform the member verbally and in writing that they may file a grievance for the denial of the expedited process.

The Plan will provide the member a reasonable opportunity to present evidence and allegations of

fact or law, in person as well as in writing. The Plan will inform the member of limited time available to present this information.

State Hearings

Members have the right to ask for a state hearing. Members are not required to exhaust WellCare's internal appeal process in order to access the state's hearing system. Providers may request a state hearing on behalf of a member with a member's consent and they may act as a witness for a member. To request a state hearing members or their representative may return the state hearing form issued by WellCare within 90 calendar days of the mailing date of the state hearing notice or contact:

Ohio Department of Job & Family Services
Bureau of State Hearings
P.O. Box 182825
Columbus, Ohio 43218-2825

Continuation of Benefits During an Appeal or State Administrative Hearing

The Plan will continue the member's benefits if:

- The member requests an extension of benefits;
- The appeal or request for state administrative hearing is filed in a timely manner, meaning on or before the later of the following:
 - Within 10 days of the Plan mailing the notice of adverse action; or
 - The intended effective date of the Plan's proposed adverse action.
- The appeal or request for state administrative hearing involves the termination, suspension, or reduction of a previously authorized course of treatment;

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- The services were ordered by an authorized provider; and
 - The original authorization period has not expired.

If the Plan continues or reinstates the member's benefits while the appeal or state administrative hearing is pending, the Plan will continue all benefits until one of following occurs:

- The member withdraws the appeal;
- The member does not request a state administrative hearing within 10 days from when the Plan mails a notice of adverse action;
- A state administrative hearing decision adverse to the member is made; or
- The authorization expires or authorization service limits are met.

If the final resolution of the state administrative hearing is adverse to the member, that is, upholds the Plan's adverse action, then the Plan may recover the cost of the services furnished to the member while the appeal is pending.

If the Plan or the state reverses a decision to deny, limit or delay services that were not furnished while the appeal was pending, the Plan will authorize or provide these disputed services promptly, and as expeditiously as the member's health condition requires.

If the Plan or the state reverses a decision to deny authorization of services and the member received the disputed services while the appeal was pending, the Plan shall pay for those services.

**Provider Payment
Dispute/Administrative
Appeals**

Although it is our intent to satisfy you as a WellCare network provider, WellCare recognizes that there may be instances where you need to file a complaint or appeal a decision. The WellCare claims payment resolution procedure is outlined below and is in compliance with the State of Ohio Department of Job & Family Services Regulations.

Verbal Inquiries

A Provider may make a verbal claim inquiry to check the status of a previously submitted claim by contacting the Provider Hotline during normal business hours.

Electronic Inquiries

WellCare has the capability to receive an ANSI X12N 276 health claim status inquiry and generate an ANSI X12N 277 health claim status response through Centene Corporation.

**Informal Claim Payment Resolution Procedure –
Adjustment Requests**

An informal claim resolution procedure precedes the formal claim resolution procedure. The informal claim resolution procedure allows providers to make complaints verbally, in written correspondence, faxes, web inquires and e-mails.

In order to resolve claims issues verbal or written requests by participating providers must be received by WellCare within 60 calendar days from receipt of WellCare's explanation of payment (EOP), and non-participating providers have 365 days from receipt of the EOP.

The informal claim resolution process can be used for the following claim issues:

- Deletions in claims payments
- Denial of claims
- Claims not paid correctly, and

- Any aspect of WellCare's claims functions, including proposed actions

WellCare will review the claim or claim-related issue for resolution and respond to the provider within 60 days of the day after the date of submission to the Plan.

WellCare will maintain a log of all informally filed provider claim complaints. The logged information will include the provider's name, date of the complaint, nature of the complaint and disposition.

To initiate the informal claim resolution procedure, a provider should contact WellCare's Provider Services Department either verbally or in writing at:

WellCare Health Plans, Inc.
Ohio Region
P.O. Box 31224
Tampa, FL 33631-3224

Formal Claim Resolution Procedure

In the event the disputed claim for informal resolution is not resolved to the provider's satisfaction within 60 days after the provider commenced the informal claim resolution procedure, the provider will have 30 days from that point to submit the matter to the formal claim resolution procedure by submitting a written explanation to include additional information outlining specific details that may justify reconsideration of the disputed claim.

WellCare's receipt of the provider's written notice initiates the formal claim resolution process. The provider must submit written notice that specifies the basis of the formal claim dispute and includes the EOP.

A panel of one or more individuals selected by WellCare will conduct the formal claim resolution procedure within 10 days of WellCare's receipt of the written formal review request. Any individual who has

been involved in any previous consideration of the dispute may not be on the WellCare panel. Panel members must be knowledgeable about the policy, legal and clinical issues involved in the matter. WellCare's medical director or another licensed physician designated by the medical director may serve as a consultant to the panel. The panel will inform the provider of the opportunity to appear in person before the panel or to communicate with the panel if the provider is unable to appear in person and question the panel in regard to issues involved in the dispute.

Within 10 days of the initial receipt of the provider's written formal review request, the panel will deliver WellCare's written determination of the dispute to the provider. The written determination will include, as applicable, a detailed explanation of the factual, legal policy and clinical basis of the panel's determination.

WellCare will maintain a log of all formally filed Provider claim disputes. The logged information will include the provider's name, date of dispute, nature of dispute and disposition. WellCare will submit annual reports to the Department of Human Services regarding the number and type of provider disputes.

Providers may access a timely payment dispute resolution process. A payment dispute is any dispute between the health care provider and WellCare for reason(s) including, but not limited to, requests for additional explanation as to services or treatment rendered by a health care provider, inappropriate or unapproved referrals initiated by the providers, billing disputes, timely filing and notification/preauthorization issues. No action is required by the member.

Administrative Appeals

An administrative appeal is a payment dispute between the health care provider and WellCare for service already provided where the provider does not agree with the results of WellCare's claim

adjudication. No action is required by the member. Administrative appeals include appeals received from a provider without member consent that are related to a medical necessity determination.

Providers will not be penalized for filing a payment dispute. Appeals must be submitted in writing to WellCare's Appeals department. The letter must detail the reason for the appeal and be accompanied by any and all supporting documentation, such as the EOB and/or medical records. The Appeals Department will receive, distribute and coordinate all administrative appeals. Appeals may be mailed to:

WellCare Health Plans Inc.
PO Box 31368
Tampa, FL 33631-3368

The provider should file an appeal, which must be received within 90 days of the paid date of the provider's EOB.

The Appeals Department will research and determine the current status of a payment dispute. If additional information is needed, a letter will be sent to the provider. If the requested information is not received within 60 calendar days, the Appeals Department will send a denial letter to the provider.

Payment disputes received with supporting clinical documentation will be retrospectively reviewed. Established clinical criteria will be applied to the payment dispute. After retrospective review, the payment dispute may be approved or forwarded to the Plan medical director for further review and resolution.

- The provider must submit a written appeal to the Appeals department with all applicable documentation supporting the provider's position regarding the adjudication of the claim. The written appeal must be received within 90 days of the provider's EOB.

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- WellCare's Appeals Department will render a written determination within 30 business days of the receipt of the appeal.
 - If additional information is requested, the provider must submit the additional information within 60 calendar days. If the information is not received within 60 calendar days, the appeal will be denied and closed because of incomplete information.

Questions regarding WellCare's provider payment dispute process should be directed to your WellCare Provider Relations representative or Customer Service

Submission of Grievances

A member, or member's representative acting on behalf of the member, with the members written consent may file a grievance either verbally or in writing within 90 calendar days of the date that the member became aware of the issue. A verbal request may be followed up with a written request, but the time frame for resolution begins the date the Plan receives the verbal filing.

If the member wishes to appoint another person as their representative, he/she must complete an Appointment of Representative statement. The member and the person who will be representing the member must sign the statement. This form is located in the **Forms** section of this manual.

The Plan will send an acknowledgement of receipt to the person filing the grievance within three business days. If the grievance is filed verbally, a verbal acknowledgement will be provided. If filed in writing, written acknowledgement will be provided.

The Plan will make a determination on the grievance within the following timeframes:

- Within two business days of receipt if the grievance is regarding access to

Medicaid-covered services

- Within 30 calendar days of receipt for non-claims related grievances
- Within 60 calendar days of receipt of claims-related grievances

The Plan gives members reasonable assistance in completing forms and other procedural steps, including but not limited to providing interpreter services and toll-free telephone numbers with TTY/TDD and interpreter capability. See the **Quick Reference Guide** for the TTY/TDD telephone number. Please contact Customer Service for help with interpreter services.

Members will be provided reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing.

Request for a Grievance Reconsideration

The Plan will provide verbal and or written notification to the member of a grievance resolution. The resolution will include the decision reached by the Plan, the reasons, policies, and procedures that are the basis of the decision and a notice of the member's right to file an appeal. However, if the Plan is unable to speak directly with the member and/or the resolution includes information that must be confirmed in writing, the resolution will be provided in writing simultaneously with the Plan's decision.

If the Managed Care Organization's (MCO) resolution to a grievance is to affirm the denial, reduction, suspension, or termination of a service or billing of a member due to the MCO's denial payment for that service, the MCO must notify the member of their rights to request a State Hearing.

Grievance Reconsideration

If the member remains dissatisfied after a grievance determination, he/she may request a reconsideration

of the grievance determination from the State Hearing. The Plan will acknowledge the reconsideration request in writing within 10 business days after receipt. The reconsideration request will be resolved as expeditiously as possible and with regard to the clinical urgency of the request but will be resolved no later than 30 calendar days after the reconsideration is filed.

The MCO, member and member's authorized representative are parties to the state hearing.

- (1) MCO's must maintain records of all grievances including resolutions for a period of six years and the records must be made available upon request to ODJFS and the MFCU.
- (2) MCOs must identify a key staff person responsible for the logging and reporting of grievances and assuring that the grievance system is in accordance with this rule.
- (3) MCOs are required to submit information at least regarding grievances activity to ODJFS.

Grievances Filed Against a Provider

Potential Quality of Care

If a member files a grievance against a provider in reference to the quality of care or service provided, the Plan will fax and mail a request to the provider for response. The provider is given 10 business days to respond and submit medical records for review. If a provider has not responded within the 10 business days, a second fax and letter is sent giving an additional five business days.

Continued failure to respond may result in the provider's panel being closed to new patients and/or will be interpreted that the provider does not disagree with the member's issue. The case is then forwarded to the Quality Improvement department for further investigation.

If the provider does respond, the case is referred to a Plan nurse who reviews the medical records to determine if a possible quality issue exists. If the nurse feels a possible quality issue does exist, the case is referred to a Plan medical director for review. If he/she determines a quality issue exists, the case is referred to the Quality Improvement department for further investigation. If no quality issue is identified, the case is entered into the Plan's database for tracking and trending purposes.

State Hearing

The Plan will notify members of their right to a State Hearing whenever the plan denies, reduces, suspends or terminates a service or upholds the denials of payment and the member is being billed due to the plan's denial of payment.

Parties to the State Hearing include the Plan, as well as the member and his/her representative or the representative of a deceased member's estate. A provider can be a representative or a witness in the hearing process.

The member, or member's representative with written consent, may only request a State Hearing within 90 days from the date on the State Hearing notice.

The request may be sent to the following address:

**Ohio Department of Job & Family Services
Bureau of State Hearings
P.O. Box 182825
Columbus, Ohio 43218-2825**

The Plan will continue the member's benefits while the State Hearing is pending if:

- The State Hearing is filed timely, meaning on or before the following:
 - Within 15 days of the mailing date on the State Hearing notice (add five calendar days if the

notice is sent via U.S. mail).

- The State Hearing involves the termination, suspension or reduction of a previously authorized course of treatment;

If the Plan continues or reinstates the member's benefits while the State Hearing is pending, the benefits will be continued until one of following occurs:

- The member withdraws the request for State Hearing;
- A State Hearing decision adverse to the member is made;
- The authorization expires or authorized service limits are met.

The Plan will authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires, if the services were not furnished while the State Hearing was pending and reverses a decision to deny, limit or delay services.

The Plan will pay for disputed services, in accordance with state policy and regulations, if the services were furnished while the State Hearing was pending and reverses a decision to deny, limit or delay services.

At the discretion of ODJFS, the member may be liable for the cost of any continued benefits if the Plan's action is upheld.

**Submission
of Provider
Termination
Reconsideration
Request**

If a provider termination is initiated by the Plan, regardless of whether the termination is for cause or not, the Plan will notify the provider of the termination decision in writing, via certified mail, of the reason.

Providers will be informed as to their right to petition the termination action and the process and timing for

reconsideration of the termination decision. The termination reconsideration request must be filed within 15 days of receipt of the Plan's termination notice.

The Plan will send an acknowledgement letter to the provider within five business days of receipt of the termination reconsideration request.

The Plan may request additional information from the provider in order to review the termination reconsideration request. If this is the case, the provider has three business days to submit the required documentation. If not received within three business days, the Plan will continue to process the termination reconsideration request.

A panel will review the termination reconsideration request and upon determination send an outcome letter to the provider stating that the termination reconsideration request has been overturned or upheld.

Termination Overturn

If the Plan overturns the termination of the provider, the Plan will ensure that there is no lapse in the period of the provider's participation with the Plan.

Termination Upheld

If the Plan upholds its termination of the provider, the Plan will notify members 45 calendar days prior to the effective date of the termination.

The notification will include the following:

- Primary Care Provider's (PCP's) name and last date the PCP is available to provide care;
- The name, location, telephone number and effective date of the member's newly assigned PCP.

Members will also be informed how to select a different PCP and the Plan telephone number they can call for further assistance.

The Plan will also notify members who have:

- Been seen two or more times within the past 12 months;
- An open OB authorization (as applicable);
- An open authorization.

These additional members will be notified 45 days prior to the termination effective date of a participating hospital, specialist or a significant ancillary provider within the service area.

Submission of Provider Claim Reconsiderations

Claim Reconsiderations

A Provider may file claim reconsideration by submitting a letter with supporting documentation such as medical records. The claim reconsideration must be submitted within 90 days of the Remittance Advice/Explanation of Benefits. Claim reconsideration requests received after that time will be denied for untimely filing. If a provider feels they have filed their case within the appropriate time frame, they may send proof.

For written requests, acceptable proof of timely filing will only be in the form of a registered postal receipt signed by a representative of the Plan, or similar receipt from other commercial delivery services or a fax confirmation.

- The Plan is not responsible for payment of medical records generated as a result of provider initiated claim reconsideration requests. Any invoices received by the Plan for such charges will be redirected to the provider.

- Cases received without the necessary documentation will be denied for lack of information.

A decision on the claim reconsideration request will be made within 60 days of receipt.