VII. COMPLAINTS, GRIEVANCES AND APPEALS

A. MCO Enrollee Services and Hotline Information

MedStar Family Choice wants you to get the healthcare you need in the best way possible. We want to know what you think about the services we provide. So, please call Member Services toll-free at 888-404-3549 if you think we are not meeting your needs or if you have any questions about your benefits or the care you are getting. We also will be calling you from time to time to ask you if you are happy with your care.

We have a Consumer Advisory Board made up of members and MedStar Family Choice employees. They meet six times a year to talk about the care our members are getting and to make suggestions on how to improve the services we provide. You may be asked to serve on this board. We hope that you will help us take care of your health.

B. MedStar Family Choice Internal Grievance Procedures

Internal Grievance Procedure

If you have a question or grievance about your healthcare, such as not being able to get an appointment, the way in which you were treated or having to travel too far to get healthcare services, call Member Services toll-free at 888-404-3549 Monday through Friday between 8:30 a.m. and 5 p.m.
See page 15 for information about interpreter services and TTY/TDD services) The member service representative will:

1. Take your grievance
2. Answer any questions
3. Tell you when he/she will have an answer for you (within 24 hours for emergency issues, five days for urgent issues and 30 days for routine issues)
4. Forward your grievance to the appropriate person, who will:
   a. Investigate your grievance
   b. Decide what steps will be taken
   c. Respond to your grievance

Second Level Grievance Review Procedure (Grievance Appeal)

If you are not happy with the answer you get from MedStar Family Choice and the grievance is regarding access, a provider of services or payment of services, you may be allowed to file a grievance appeal. Call Member Services Toll-free at 888-404-3549. A member service representative who is different from the member service representative that initially took your grievance will:

1. Take your grievance
2. Answer any questions
3. Tell you when he/she will have an answer for you (within 24 hours for emergent, five days for urgent and 30 days for routine issues)
4. Forward your grievance to the appropriate person, who will:
   a. Investigate your grievance
   b. Decide what steps will be taken
   c. Respond to your grievance

If you are still not satisfied with the outcome, you may at anytime during the grievance process contact the HealthChoice Enrollee Help Line at 800-284-4510 Monday through Friday between 7:30 a.m. and 5:30 p.m.

C. Medical Coverage Appeals

MedStar Family Choice approves or denies services based upon whether or not the service is medically needed and a covered benefit. We do not financially reward our providers, staff or anyone contracted with MedStar Family Choice for denying services. In addition, we do not financially reward anyone involved in the decision process in such a way that would encourage them to deny services.

When you do not agree with our decision to deny, stop or reduce a service that has been requested by your provider, you or your provider can ask us to review our decision again. This is called an appeal. You may appeal MedStar Family Choice's decision to cover a service once you receive a denial (adverse determination) letter from us. You have 90 days after receiving a denial to appeal our decision. The letter provides the details of why the medical services were denied. It also gives instructions on the appeals process. At any time during the appeal process you may contact the State's Enrollee Help Line at 800-284-4510. They can provide you with information on how to request a hearing.

Medical appeals are either urgent or nonurgent. Appeals are considered to be urgent if your life is in jeopardy, if there could be a loss in the ability to regain maximum functioning or if your doctor believes the care is urgent or could cause you severe pain. Nonurgent appeals are divided into pre-service and post-service appeals.

The appeal, verbal or written, must include the specific reason for reconsidering the denial. You may file the appeal on your own. We have a simple form you can use to file your appeal. Just call 410-933-2200 or 800-905-1722 to get one. We will mail or fax the appeal form to you and provide assistance if you need help completing it. Other people can also help you file an appeal, like a family member or a lawyer. With written permission from you, you may have your provider or an authorized representative file the appeal on your behalf. All requests for appeals can be submitted verbally or in writing to the MedStar Family Choice Denial and Appeal Division. Written appeals must be sent to the following address:

MedStar Family Choice
8094 Sandpiper Circle, Suite O
Baltimore, MD 21236
Attn: Denial and Appeal Division

We will send you a letter letting you know that we have received your appeal within 5 business days. If you prefer to verbally request an appeal, please call 410-933-2200 or 1-800-905-1722 Monday through Friday between 8:30 am and 5 p.m..

When you file an appeal, be sure to let us know any new information that you have that will help us make our decision. While your appeal is being reviewed, you can still send or deliver any additional information that you think will help us make our decision.

When reviewing your appeal we will:

- Use doctors who know about the type of illness you have
- Not use the same people who denied your request for a service
- Make a decision about your appeal within 24 hours for urgent appeals, 20 days for nonurgent first level appeals and 10 days for second level appeals

Urgent Appeals

Urgent first level appeals must be requested within 90 days of receiving the denial (adverse determination) letter from MedStar Family Choice. Urgent appeals may not be requested for services that have already been received. In addition to the specific reason for the appeal, you, your authorized representative or your provider are given the chance to provide any additional documentation that you want considered during the appeal process. Within 24 hours of receiving a request for an urgent appeal review, MedStar Family Choice will contact you, your authorized representative and your provider on the telephone. We will send you (and your authorized representative, if applicable) the outcome of the appeal within 24 hours of the decision. MedStar Family Choice determines whether or not your appeal is considered to be urgent.

If you are not satisfied with the outcome, you, your authorized representative or your provider may appeal a second time to MedStar Family Choice. The second level of appeal is the final level of appeal within MedStar Family Choice. MedStar Family Choice's President or designee will make the decision on this level of appeal. The request for a second-level appeal of an urgent appeal must be made within 60 calendar days from the date you received your first level appeal determination letter. Once again you will be given the chance to provide any additional information that you want considered during the appeal process. Within 48 hours of receiving a second level appeal request for an urgent review, MedStar Family Choice will contact your provider on the telephone and send you (and your authorized representative, if applicable) the outcome of the appeal.

If you are still not satisfied with the outcome of your appeal, you may contact the HealthChoice Enrollee Help Line at 800-284-4510 Monday through Friday between 7:30 a.m. and 5:30 p.m. In addition, you may contact the Enrollee Action Line at any time through the appeal process.

Nonurgent Appeals

Nonurgent first level appeals must be requested within 90 days of receiving the denial (adverse determination) letter from MedStar Family Choice. In addition to the specific reason for the appeal, you, your authorized representative or your provider are given the chance to provide any additional documentation that you want considered during the appeal process.

There are two types of nonurgent appeals:

- If you are appealing a service that has not yet occurred MedStar Family Choice will notify you, your authorized representative and your provider of our decision within 20 calendar days of receiving your appeal request.
- If the service has already occurred, and the appeal is to determine whether or not the service was a covered benefit, MedStar Family Choice will notify you, your authorized representative and your provider of our decision within 30 calendar days from receiving your appeal request.

The response time for either type of nonurgent appeals may be extended by no more than 14 days if you ask for more time to submit information or we need to get additional information from other sources.

If you are not satisfied with the outcome, you, your authorized representative or your provider may appeal a second time to MedStar Family Choice. The second level of appeal is the final level of appeal to MedStar Family Choice. MedStar Family Choice's President or designee will make the decision on this level of appeal. The request for a second-level appeal of a nonurgent appeal must be made within 60 calendar days from the date you received your first-level appeal denial (determination) letter. Once again you will be given the chance to provide any additional information that you want considered during the appeal process.

- For appeals of services that have not yet occurred: Within 10 days of receiving the appeal, MedStar Family Choice will contact your provider on the telephone and send you (and your authorized representative, if applicable) the outcome of the appeal.
- For appeals of services that have already occurred: Within 30 days of receiving the appeal, MedStar Family Choice will contact your provider on the telephone and send you (and your authorized representative, if applicable) the outcome of the appeal.

If you are still not satisfied with the outcome of your appeal, you may contact the HealthChoice Enrollee Help Line at 800-284-4510 Monday through Friday between 7:30 a.m. and 5:30 p.m. In addition, you may contact the Enrollee Help Line at any time through the appeal process.

If your appeal is about a service that was already authorized and you were already receiving, you may be able to keep getting the service while we review your appeal. Contact us at 410-933-2200 or 800-905-1722 Monday through Friday between 8:30 a.m. and 5 p.m. if you would like to keep getting services while your appeal is reviewed. If you do not win your appeal, you may have to pay for the services that you received while the appeal was being reviewed.

D. The State's Complaint Process

Getting Help From the HealthChoice Enrollee Help Line

If you have a question or complaint about your healthcare and we have not solved the issue to your satisfaction, you can ask for help from the State's HealthChoice Enrollee Help Line. To reach the HealthChoice Enrollee Help Line, call 800-284-4510 Monday through Friday between 7:30 a.m. and 5:30 p.m. (or you can leave a recorded message at any other time).

When you call the Help Line, you can ask your question or explain your problem to one of the Help Line staff, who will:

- Answer your questions;
- Work with us to discuss what you need; or
- Send your complaint to the Complaint Resolution Unit nurses who may:
  - Ask us to provide information about your case within five days;
  - Work with your provider and us to assist you in getting what you need;
  - Help you to get more community services, if needed; or
  - Help you to appeal denials and send you the fair hearing process in writing. (See Section VII. E.)

E. The State's Appeal Process

Asking the State to Review Our Decision

When you do not agree with our decision to deny, stop or reduce a service, you can ask the state to review the decision. This is called an appeal.

You can contact the Enrollee Help Line at 800-284-4510 and tell the representative that you would like to appeal our decision. Your appeal will be sent to a nurse in the Complaint Resolution Unit.

The Complaint Resolution Unit will attempt to resolve your issue with us in 10 business days. If it cannot be resolved in 10 business days, you will be sent a notice that gives you a choice to request a fair hearing or wait until the Complaint Resolution Unit has finished its review.

When the Complaint Resolution Unit is finished working on your appeal, you will be notified of their findings.

- If the State thinks we should provide the requested service, it can order us to give you the service; or,

- If the State thinks that we do not have to give you the service, you will be told that the State agrees with us.

If you do not agree with the state's decision, which you will receive in writing, you will again be given the opportunity to request a state fair hearing.

Types of State Decisions You Can Appeal

You have the right to appeal three types of decisions made by the State. When the State:

- Agrees with us that we should not cover a requested service;
- Agrees with us that a service you are currently receiving should be stopped or reduced; or,
- Denies your request to enroll in the Rare and Expensive Case Management (REM) Program.

Continuing Services During the Appeal

If your appeal is about a service that was already authorized and you were already receiving, you may be able to keep getting the service while the State reviews your appeal. Contact the Enrollee Help Line at 800-284-4510 if you would like to keep getting services while your appeal is reviewed. If you do not win your appeal, you may have to pay for the services that you received while the appeal was being reviewed.

Fair Hearings

To appeal one of the State's decisions, you must request that the State file a notice of appeal with the Office of Administrative Hearings on your behalf. This will be your appeal against the State. We usually will not be involved in the appeal, but our providers and staff members may appear as witnesses for the State at the appeal hearing.

The Office of Administrative Hearings will set a date for the hearing based on the type of decision being appealed.

- If the appeal is about us reducing or not giving you a service because both the State and MedStar Family Choice thinks you do not have a medical need for the service, the Office of Administrative Hearings will set a hearing date within 20 days of the day you file your appeal with the Office of Administrative Hearings. The Office of Administrative Hearings will make its decision on the case within 30 days of the date of the hearing.
- For all other appeals, the Office of Administrative Hearings will set a hearing date within 30 days of the day you file your appeal with the Office of Administrative Hearings. The Office of Administrative Hearings will make its decision on the case within 30 days of the date of the hearing.

You can ask for an expedited appeal. If the State thinks your hearing should be held more quickly due to the seriousness of your health condition, a hearing will be held and a decision will be made within 3 days.

The Board of Review

If the Office of Administrative Hearings decides against you, you may appeal to the state's Board of Review. You will get the information on how to appeal to the Board of Review with the decision from the Office of Administrative Hearings.

Judicial Appeal

If the Board of Review decides against you, you may appeal to the Circuit Court.