Group Health Cooperative of South Central Wisconsin

Policy and Procedure

Title: Appeal/Grievance Process – Member Appeals Committee
Responsible Party: Member Services Manager
Div/Dept/Serv Area: Member Services
Number: MS.MS.001 **Date of Issue:** 6/1993
Formerly A2a.015 (7/08)/MS.001 (4/12) NCQA UM 8 A
BadgerCare Plus Grievance and Appeal Requirements
Formerly INS.MS.001

PURPOSE:

The purpose of this policy is:

1. To document the role of the Member Appeals Committee in the grievance process of Group Health Cooperative of South Central Wisconsin (GHC-SCW).

2. To document the policies and procedures for thorough, appropriate and timely registering and resolution of member appeals for Commercial, Exchange, FEHBP, ETF, and BadgerCare Plus Members.

DEFINITIONS:

1. **Adverse Determination** means an adverse benefit determination [as defined in 29 CFR 2560.503-1], as well as any rescission of coverage, as described in § 147.128 (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time).

2. **Appeal** means a request for GHC-SCW to review an Adverse Determination.

3. **Grievance:** means an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the members rights regardless of whether remedial action is requested. Grievance includes a members right to dispute an extension of time proposed by GHC-SCW to make an authorization decision. The member or authorized representative may file a grievance either orally or in writing.

4. **Post-Service Appeal** means a request to change an Adverse Determination for care or services that have already been received by the member.

5. **Pre-Service Appeal** is a request to change an Adverse Determination for care or service that GHC-SCW must approve, in whole or in part, in advance of the member obtaining care or services.

POLICY:

1. The Member Appeals Committee is the adjudicating body for GHC-SCW's appeal and/or grievance process.

    a. The voting members of the Committee include: two physicians, the GHC-SCW Insurance Operations Manager, GHC-SCW Chief Compliance Officer and the GHC-SCW Chief Strategy and Business Development Officer.

    b. The Committee shall also include non-voting members. Non-voting members may include but are not limited to the following positions at GHC-SCW: Associate Medical Director; Manager of Care Management; Manager of Member Services; Community Services Coordinator; and Chief Equity and Engagement Officer. Non-voting members shall act as consultants to voting members of the Committee.

c. GHC-SCW's BadgerCare Plus Coordinators shall attend the Committee for all Appeals/Grievances involving Medicaid members to ensure all Appeals/Grievances are adjudicated in accordance with Medicaid rules.

d. The Committee is chaired by the Member Appeals Representative.

2. The Member Appeals Committee review process is the only formal review level under the U.S. Department of Labor Benefit Claims Procedure Regulation (29 CFR 2560.503-1). The following applies to Member Appeals Committee members:

   a. Committee members who are medical professionals are free to exercise independent medical judgment and medical decision-making,

   b. Appointment of a new person to review a pre-service appeal who was not involved in the initial determination and who is not the subordinate of any person involved in the initial determination

   c. Reprisals, retaliation, recrimination or other adverse actions taken against Committee members for exercising independent medical judgment and medical decision-making during the member appeals process is prohibited at GHC-SCW.

3. GHC-SCW continues coverage under their insurance policy during the appeal process (This applies to covered services only). GHC-SCW does not allow for rescission of coverage.

4. GHC-SCW provides notifications of appeal rights to members in a culturally and linguistically appropriate manner. Notification rights are offered in a language other than English, if requested by the members.

5. GHC-SCW provides members any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to: auxiliary aids and services upon request such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

6. GHC-SCW notifies members of further appeal rights.

7. Bypassing internal appeal review: With a members permission, the organization may refer an appeal directly to an independent review organization (IRO) without conducting an internal review.

8. A GHC-SCW member or authorized representative on behalf of the member may file a written expression of dissatisfaction with the administration, claims practices or provision of services (this includes a member chosen representative including an attorney). The member has the right to appear before the Committee and present the appeal in person. GHC-SCW will consider any written expression of dissatisfaction as an appeal with the potential to go to Committee if the matter is not resolved to the members satisfaction. The Member Services Manager will maintain oversight of the grievance process and the Member Appeals Committee.

PROCEDURE:

Non-BadgerCare Plus LOB

1. Appeal/Grievance must be written unless a member is unable to submit a written appeal form. If the member is unable to submit a written appeal, they may submit the appeal orally.

   a. The appeal/grievance should include all information that is pertinent to reconsideration.

   b. Appeals/grievances will be accepted without time limitation in compliance with Section Ins. 18.03.

c. GHC-SCW allows a practitioner or other authorized representative to act on behalf of the member for the member appeals process; this includes anyone a member chooses, including an attorney. To protect the members confidentiality, GHC-SCW must receive written notification from the member appointing the representative. GHC-SCW will then direct all information to the member and their representative regarding the appeal. GHC-SCW notifies members of their right to have a representative act on their behalf at all levels of appeal when it notifies them of a denial decision.

2. GHC-SCW will document the substance of the appeal and any actions taken in the Member Services database.

   a. The database will contain information of the investigation of the substance of the appeal, including any aspect of clinical care involved, and document its findings. A review of the appeal must be conducted that does not give deference to the denial decision.

   b. The database will log the date of notification to the member of the disposition of their appeal and resolution of the case.

3. Receipt of the members appeal/grievance must be acknowledged within **five (5) business days of receipt**. The letter will also notify the member of the Member Appeals Committee meeting and provide information regarding the appeals process and the member's appeal rights, including:

   a. The opportunity for the member to submit written comments, documents, records, and other information relating to the appeal/claim for benefits;

   b. A full investigation of the substance of the appeal, including any aspects of clinical care involved must be conducted, taking into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

   c. Upon request and free of charge, reasonable access to (and copies of) all documents, records, and other information relevant to the claimant's claim for benefits.

   d. The right to request interpreter services.

4. The member must be notified in writing of the meeting at least **seven (7) calendar days** prior to the scheduled meeting date.

   a. The letter must include the date, time, and location of the meeting at which the appeal will be heard.

   b. The letter must also advise the member of their right to present their appeal in person.

5. GHC-SCW will provide the member free of charge any new or additional evidence considered, relied upon, or generated by GHC-SCW in connection with the appeal. The member will receive this with adequate time for review before the appeal is heard. Information cannot be added, changed, or deleted without adequate notice to the member. This information is included with the 5-day letter and at no cost to the member.

6. Information presented to the Committee and member may include but is not limited to the following:

   a. Confidential Appeal Information Form. This includes a brief chronology of events in date order.

   b. Appeal Outline Guide

c. Members Appeal Communication

d. Care Management Approval/Denial Letter when appropriate.

e. Information sent by the member

f. Letters of support from Providers

g. Medical Records- Include all records related to the case. This may include Primary or Specialty Care OV, PT, UC, ER, etc. Position in packets with the oldest notes first working to the current notes at the end.

h. Care Management Notes - Non MD Reviewer Note Type and Member Communication Note Type. (Member Communication is a new note type established 9-1-10).

i. Adjudication Review of claim(s) when appropriate

j. Supporting Documentation including but not limited to TAC, P&P, Millimum criteria, Certificate Language, CRM notes.

7. The member may bring a representative to the meeting.

   a. If the member is not able to attend the meeting, he or she will be provided the opportunity to communicate with the Committee by conference call or other appropriate technology.

   b. GHC-SCW allows a practitioner or other representative to be present with the member during the Member Appeals Meeting. To protect the members confidentiality, GHC-SCW must receive written notification from the member appointing the representative. GHC-SCW will then direct all information to the member and their representative regarding the appeal.

8. The Medical Director reviews appeals involving clinical issues.

   a. The Medical Director will consult with an actively practicing practitioner in the same or similar specialty that typically treats medical conditions and/or performs procedures appropriate to the case. This individual will be independent of any of the MCO's prior decisions regarding the case. This practitioner will exercise independence in decision-making and will not be the subordinate of a person involved in an initial denial or prior review.

   b. **Person or people deciding the appeal.**

      1) The organization must appoint a person not involved in the prior adverse decision to review the appeal. The appointed person must be neither the individual who made the Adverse Determination that is the subject of the appeal nor a subordinate of (i.e., directly supervised by) such individual, although the practitioner who made the initial Adverse Determination may review the case and overturn the previous decision.

      2) As with initial UM denial decisions, a physician or other appropriate clinical peer must evaluate medical necessity decisions for adverse appeal decisions.
      3) Practitioners consulted under these circumstances are afforded the same independent judgment and decision-making autonomy as Committee members.

   c. **Same-or-similar-specialist review**

      1) For appeals involving clinical issues, including appeals about whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate, a health care practitioner who

has appropriate training and experience in the field of medicine involved in the case must review the appeal. NCQA refers to this practitioner as a **same-or-similar specialist**.

2) The *same specialty* refers to a practitioner with similar credentials and licensure as those who typically treat the condition or health problem in question in the appeal. A *similar specialty* refers to a practitioner who has experience treating the same problems as those in question in the appeal, in addition to experience treating similar complications of those problems.

3) Depending on the type of case, a same-or-similar specialist may be a physician, behavioral healthcare practitioner, chiropractor, dentist, physical therapist or other type of practitioner, as appropriate.

4) Member Services will submit medical necessity appeals requiring specialty reviews to the Medical Director at the time the appeal letter is received.

1. An appeal/grievance must be resolved within **thirty (30) calendar days** of receipt.

   a. **Post-Service Appeal:** If the appeal/grievance relates to a **Post-Service** Appeal and the appeal/grievance cannot be resolved within thirty (30) calendar days, an extension of an additional thirty (30) calendar days must be requested. A post-service appeal is a request to change an Adverse Determination for care of services that have already been received by the member. All post-service appeals/grievances will be resolved within sixty (60) calendar days from the date of receipt of the proposal.

   b. **Pre-Service Appeal:** A members request for an appeal of a denial for service excluded from the organization's benefits package is a preservice appeal if the member has not received the requested services. In this case, the member may not receive coverage for the requested care or service unless the organization approves it. If the appeal/grievance relates to a **Pre-Service** Appeal, the appeal/grievance must be resolved within thirty (30) calendar days of receipt. A thirty (30) day extension is not permitted for pre-service claims unless granted by the member verbally or in writing. A pre-service appeal is a request to change an Adverse Determination for care or service that the organization must approve, in whole or in part, in advance of the member obtaining care or services.

2. The Member Appeals Representative will prepare the agenda including all materials pertinent to each appeal.

   a. The Member Appeals Representative will copy and distribute all materials to each Committee member and the grievant prior to the scheduled meeting.

   b. One copy of all materials will be kept in the Member Appeals Committee binder in the Member Services Department files.

3. The Member Appeals Representative will chair the meeting and maintain minutes.

   a. Minutes will be copied and distributed to Committee members by the Member Appeals Representative.

   b. One copy of the minutes will be kept in the Member Appeals Committee binder in the Member Services Department files.

4. The Member Appeals Representative responds to each grievance in writing within 30 days from the members written appeal with the Committee's decision regarding their appeal. The notice must include the title of each reviewer for a benefit appeal or the title, qualifications and specialty (e.g., MD, DO, PhD) of each reviewer for a medical necessity appeal. It must also specifically state that these individuals participated in the appeal review. Participant names do not need to be included in the written notification to members, but must be provided to members upon request.

a. If the appeal/grievance relates to a post-service appeal that has had an extension, the member must be notified in writing of the Committee's decision no later than sixty (60) calendar days from receipt of the members written grievance. If the appeal/grievance relates to a pre-service appeal, the member must be notified within thirty (30) calendar days of receipt unless the member has granted a 30-day extension. If the denial decision is upheld, the member is informed of further appeal rights if any. The denial letter will explain the reason for the denial, definitions when appropriate, criteria on which the decision was based and any discussion related to the decision. Administrative Rights are included in denial letters to members covered by Employee Trust Fund (ETF). It is the Member Services internal department goal to send written notification to members within five (5) business days of the meeting date.

b. Although there are allowable extensions for initial UM decisions, there are only two acceptable provisions for extending the appeal timeframe to obtain additional information.

   1) The member voluntarily agrees to extend the appeal time frame

   2) Federal program regulations allow the organization to request additional information from the member. If the appeal does not qualify for an extension, the organization must make the appeal decision within the allotted timeframe based on the information it has.

13. An **expedited appeal** is a request to change an Adverse Determination for urgent care. A member or practitioner may request that an appeal/grievance be expedited. Expedited appeals do not require a written grievance. The Medical Director will use urgent care criteria in determining the approval for an expedited appeal. Urgent care is defined as any request for medical care or treatment with respect to which the application of the time period for making non-urgent care determinations:

    a. Could seriously jeopardize the life or health of the member or the members ability to regain maximum function, based on a prudent layperson's judgment; or
    b. In the opinion of a practitioner with knowledge of the members medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request; or

    An expedited review will be granted to all requests concerning admissions, continued stay, or other health care services for a member who has received emergency services but has not been discharged from a facility.

14. Processing Expedited Appeals

    a. An expedited appeal/grievance will be resolved as expeditiously as the medical condition requires, but no later than 1BD, not to exceed 24 hours from the date the grievance is received.

    b. Expedited appeal requests received outside of normal business hours will be routed to Medical Answering for immediate handling.

    c. The Member Appeals Representative will coordinate the resolution of an approved expedited appeal with the Member Appeals Committee.

    d. The Member Appeals Representative will notify the member and/or practitioner of the Committee's decision within twenty-four (24) hours using the most expeditious method available (e.g., telephone, fax, etc.). Written notification will be sent to the member and practitioner no later than three (3) calendar days after the initial oral notification.

e. A copy of the appeal must be included in the Member Appeals Committee binder in the Member Services Department files. The Member Appeals Representative will maintain a record of all appeals by completing an entry into the Member Services database. Each entry will include a dated summary of each appeal. The response and resolution will be noted. The information contained in the log will be presented in the Member Services' Quarterly Report and the Annual Report.

15. Trends will be analyzed to help determine improvements in benefits, services, or policies of GHC-SCW.

16. Annual reports are prepared for the GHC-SCW Board of Directors and other GHC-SCW Quality Committees.

17. ERISA Notification Requirements: Notification when Decision is not in favor of the member. A denial notice must include:

    a. The specific reason for upholding the denial, in an easy to understand language; and

    b. Reference to the specific plan provisions, guideline, protocol, or other similar criterion upon which the upheld denial is based; and

       A notification statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimants claim for benefits.

    c. A statement outlining the claimants right to sue under section 502 (a) of the Employee Retirement Income Security Act of 1974 (ERISA) following an adverse benefit determination on review; and

    d. A statement making any internal rule, guideline, protocol, et al relied upon in making an Adverse Determination available free of charge to the claimant upon request; and

    e. A statement making an explanation of the scientific or clinical judgment for any determination based on medical necessity or experimental treatment exclusions or limits available free of charge to the claimant upon request; and

    f. A statement making a list of medical and vocational experts consulted during the review process available free of charge to the claimant upon request.

ETF/WPEG External Review Requirement

1. If we receive a member request for an external review, the health plan must notify ETF's Ombudsperson Services within 5 calendar days.

2. When the health plan receives the external review determination, it must notify ETF's Ombudsperson Services within 14 calendar days, this includes providing the Department with a redacted copy of the Independent Review Organizations (IRO) decision to the Ombudsperson Service at: **ETFSMBOmbudsperson@etf.wi.gov.**

BadgerCare Plus

Grievance:

- GHC-SCW utilizes the letter templates as mandated in the HMO and PHIP Member Grievances and Appeals Guide. GHC-SCW may alter the templates for readability, and all readability corrections are approved and communicated to the WI-Department of Health Services.

1. A member may file a grievance with the Health Plan at any time.

    a. The member may file a grievance either orally or in writing. The member may file a grievance with either the Department or with GHC-SCW.

    b. The grievance should include all information that is pertinent to reconsideration.

    c. GHC-SCW will not take any punitive action against a member who files a grievance with GHC-SCW.

2. GHC-SCW will document the substance of the grievance and any actions taken in the Member Services database.

    a. The database contains the following:

    b. The name of the BadgerCare Plus member for whom the grievance was filed:

    c. Information of the investigation of the substance of the grievance, including any aspect of clinical care involved, and document its findings. A review of the grievance must be conducted that does not give deference to the denial decision.

    d. The date the grievance was received,

    e. The date the grievance was reviewed in the Member Appeals Committee

    f. The date of notification to the member of the disposition of their grievance and resolution of the case.

3. For a standard resolution of a grievance, GHC-SCW must send a written acknowledgement of receipt of the grievance to the member within 10 business days of receipt of the grievance (oral or written) and a final written decision resolving the grievance within 30 calendar days of receiving the grievance (oral or written).

4. Grievances submitted by Individuals Purporting to be an Authorized Representative: If a grievance is submitted by an individual purporting to be the members authorized representative and GHC-SCW does not have the documented consent of the member for the individual to act as the members representative on file, then GHC-SCW must do the following:

    a. Upon receipt of the grievance request, attempt to follow-up with the member to confirm the members desire for the grievance to proceed.

    b. If contact is made with the member and the member confirms, either verbally or in writing, that they desire the grievance to proceed, inform the member of the need to provide written consent for an individual to act as the members authorized representative in the grievance and that, in the absence of such documented consent, the grievance will be processed as a request from the member.

    c. Initiate the grievance resolution process as of the date the member confirms that they wish to proceed with the grievance.

    d. Send the written acknowledgement letter to the member (and, if the members documented consent is obtained prior to the acknowledgment letter being sent out, to the members authorized representative) within the timeframes described under a – c. GHC-SCW's receipt of the members grievance with respect to these timeframes is the date of the members confirmation that they wish to proceed with the grievance.

e. Complete the grievance resolution process and issue a written resolution decision within the timeframes described under a - c. GHC-SCW's receipt of the members grievance with respect to these timeframes in the date of the members confirmation that they wish to proceed with the grievance.

f. If GHC-SCW does not receive documented consent from the member for the purported authorized representative to act as the members representative prior to the grievance resolution decision deadline, sent the written decision resolving the grievance to the member.

g. If GHC-SCW receives documented consent from the member for the purported authorized representative to act as the members representative prior to the grievance resolution decision deadline, send the written decision resolving the grievance to the representative and the member.

h. If contact is made with the member and the member does not wish to proceed with the grievance, dismiss the grievance and send a written notice to that effect to the member.

i. If no contact is made with the member within 30 calendar days of the receipt of the grievance from the purported representative, dismiss the grievance and send a written notice to that effect to the member.

Appeal:

- The below procedure describes the only level of appeal for GHC-SCW BadgerCare Plus members.
- GHC-SCW utilized the letter templates as mandated in the HMO and PHIP Member Grievance and Appeals Guide. GHC-SCW may alter the templates for readability, and all readability corrections are approved and communicated to the WI-Department of Health Services.
- GHC-SCW must issue a separate written notice of appeal resolution for each adverse benefit determination appealed by a member. For example, if two adverse benefit determinations are made by GHC-SCW at the same time, GHC-SCW must send out two separate adverse benefit determinations to the member. If the member appeals both adverse benefit determinations, GHC-SCW must issue two separate notices of appeal resolution.

1. Appeals must be written unless a BadgerCare Plus Member is unable to submit a written appeal form. If the member is unable to submit a written appeal, they may submit the appeal orally. Oral appeals are treated as appeals in order to establish the earliest possible filing date. However, these oral inquiries must be subsequently confirmed in writing, unless the member or the provider requests expedited resolution.

   a. A BadgerCare Plus member has 60 calendar days from the date on the adverse benefit determination notice to file a request for an appeal to GHC-SCW.

   b. The appeal should include all information that is pertinent to reconsideration.

   c. GHC-SCW allows a practitioner or other authorized representative to act on behalf of the member for the member appeals process; this includes anyone a member chooses, including an attorney. To protect the members confidentiality, GHC-SCW must receive written notification from the member appointing the representative. GHC-SCW will then direct all information to the member and their representative regarding the appeal. GHC-SCW notifies members of their right to have a representative act on their behalf at all levels of appeal when it notifies them of a denial decision.

   d. GHC-SCW will not impart any punitive action against a member who appeals GHC-SCW's decision.

e. Members seeking to appeal an adverse benefit determination orally are treated as written appeals in order to establish the earliest possible filing date. These oral inquiries must be subsequently confirmed in writing, unless the member or the provider requests expedited resolution.

2. An appeal for a GHC-SCW BadgerCare Plus member, the member has 60 days from the date of the adverse determination notice to file a request for an appeal to GHC-SCW. The 60-day appeal window for members who request their adverse decision notice in an alternate format begins only after the alternate format has been provided.

   a. Standard Resolution of Appeals: For standard resolution of an appeal, GHC-SCW must provide an initial response within 10 business days and a final response within 30 calendar days of receiving the appeal.

   b. Expedited Resolution of Appeal: For expedited resolution of an appeal, GHC-SCW must make reasonable effort to provide oral notice and issue a written disposition of an expedited hearing decision within 72 hours of receiving the verbal or written request for an expedited resolution.

      1) An **expedited appeal** is a request to change an Adverse Determination for urgent care. A member or practitioner may request that an appeal/grievance be expedited. Expedited appeals do not require a written grievance. The Medical Director will use urgent care criteria in determining the approval for an expedited appeal. Urgent care is defined as any request for medical care or treatment with respect to which the application of the time period for making non-urgent care determinations:

         a) Could seriously jeopardize the life or health of the member or the members ability to regain maximum function, based on a prudent layperson's judgment; or

         b) In the opinion of a practitioner with knowledge of the members medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request; or

         c) An expedited review will be granted to all requests concerning admissions, continued stay, or other health care services for a member who has received emergency services but has not been discharged from a facility.

      2) Processing Expedited Appeals

         a) An expedited appeal/grievance will be resolved as expeditiously as the medical condition requires, but no later than 1BD, not to exceed 24 hours from the date the grievance is received.

         b) Expedited appeal requests received outside of normal business hours will be routed to Medical Answering for immediate handling.

         c) GHC-SCW does not deny requests for expedited appeals, and processes all requests for expedited appeals according to the expedited appeal timeframe. However, GHC-SCW may:

            (1) Transfer the appeal to the timeframe for standard resolution and must send the "CRM - MAC - Notice of Denial of Request for Expedited Appeal Decision" if taking the time for a standard resolution does not seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

         d) The Member Appeals Representative will coordinate the resolution of an approved expedited appeal with the Member Appeals Committee.

e) The Member Appeals Representative will notify the member and/or practitioner of the Committee's decision within twenty-four (24) hours using the most expeditious method available (e.g., telephone, fax, etc.). Written notification will be sent to the member and practitioner no later than three (3) calendar days after the initial oral notification.

f) A copy of the appeal must be included in the Member Appeals Committee binder in the Member Services Department files. The Member Appeals Representative will maintain a record of all appeals by completing an entry into the Member Services database. Each entry will include a dated summary of each appeal. The response and resolution will be noted. The information contained in the log will be presented in the Member Services' Quarterly Report and the Annual Report.

g) Punitive action will not be taken against anyone who requests an expedited resolution of an appeal or supports a members appeal.

3. GHC-SCW will document the substance of the appeal and any actions taken in the Member Services database.

a. The database contains the following:
   1) The name of the BadgerCare Plus member for whom the appeal was filed:
   2) Information of the investigation of the substance of the appeal, including any aspect of clinical care involved, and document its findings. A review of the appeal must be conducted that does not give deference to the denial decision.
   3) The date the appeal was received,
   4) The date the appeal was reviewed in the Member Appeals Committee
   5) The date of notification to the member of the disposition of their appeal and resolution of the case.

4. Receipt of the members appeal/grievance must be acknowledged within **five (5) business days of receipt**. The letter will also notify the member of the Member Appeals Committee meeting and provide information regarding the appeals process and the members appeal rights, including:

   a. The opportunity for the member to submit written comments, documents, records, and other information relating to the appeal/claim for benefits

   b. A full investigation of the substance of the appeal, including any aspects of clinical care involved must be conducted, taking into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

   c. Upon request and free of charge, reasonable access to (and copies of) all documents, records, and other information relevant to the claimant's claim for benefits.

   d. The right to any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes and is not limited to: auxiliary aids and services upon request such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

   e. Include, as parties to the appeal, the member and his or her representative, or the legal representative of a deceased members estate.

5. The Member Appeals Representative will prepare the agenda including all materials pertinent to each appeal.

   a) Member Appeals Representative will copy and distribute all materials to each Committee member and the grievant prior to the scheduled meeting.

b) One copy of all materials will be kept in the Member Appeals Committee binder in the Member Services Department files.

6. GHC-SCW will provide the member free of charge any new or additional evidence considered, relied upon, or generated by GHC-SCW in connection with the appeal. The member will receive this with adequate time for review before the appeal is heard. Information cannot be added, changed, or deleted without adequate notice to the member. This information is included with the 5-day letter and at no cost to the member.

7. The member may bring a representative to the meeting.

    a. If the member is not able to attend the meeting, he or she will be provided the opportunity to communicate with the Committee by conference call or other appropriate technology.

    b. GHC-SCW allows a practitioner or other representative to be present with the Member during the Member Appeals Meeting. To protect the Members confidentiality, GHC-SCW must receive written notification from the member appointing the representative. GHC-SCW will then direct all information to the member and their representative regarding the appeal.

8. The Member Appeals Representative will chair the meeting and maintain minutes.

    a. Minutes will be copied and distributed to Committee members by the Member Appeals Representative.

    b. One copy of the minutes will be kept in the Member Appeals Committee binder in the Member Services Department files.

9. Information presented to the Committee and member may include but is not limited to the following:

    a. Confidential Appeal Information Form. This includes a brief chronology of events in date order.

    b. Appeal Outline Guide

    c. Members Appeal Communication

    d. Care Management Approval/Denial Letter when appropriate.

    e. Information sent by the member

    f. Letters of support from Providers

    g. Medical Records- Include all records related to the case. This may include Primary or Specialty Care OV, PT, UC, ER, etc. Position in packets with the oldest notes first working to the current notes at the end.

    h. Care Management Notes - Non MD Reviewer Note Type and Member Communication Note Type. (Member Communication is a new note type established 9-1-10).

    i. Adjudication Review of claim(s) when appropriate

    j. Supporting Documentation including but not limited to TAC, P&P, Millimum criteria, Certificate Language, CRM notes.

10. GHC-SCW may extend the thirty (30) calendar day timeframe by up to fourteen (14) calendar days if any of the following occur. The total timeline for GHC-SCW to finalize a formal grievance or appeal may not exceed 45 days from the date of the receipt for a GHC-SCW BadgerCare Plus member.

    a. The member requests an extension,

    b. GHC-SCW shows that there is need for additional information and how the delay is in the enrollee's interest. Documentation regarding this determination must be available to the Department upon request.

        1) If GHC-SCW extends the timeframes not at the request of the member, GHC-SCW must complete the following:

            a) Make reasonable efforts to give the member prompt oral notice of the delay.
            b) Within 2 calendar days give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision.
            c) Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.

11. The Medical Director reviews appeals involving clinical issues.

    a. The Medical Director will consult with an actively practicing practitioner in the same or similar specialty that typically treats medical conditions and/or performs procedures appropriate to the case. This individual will be independent of any of the MCO's prior decisions regarding the case. This practitioner will exercise independence in decision-making and will not be the subordinate of a person involved in an initial denial or prior review.

    b. **Person or people deciding the appeal.**

        1) The organization must appoint a person not involved in the prior adverse decision to review the appeal. The appointed person must be neither the individual who made the Adverse Determination that is the subject of the appeal nor a subordinate of (i.e., directly supervised by) such individual, although the practitioner who made the initial Adverse Determination may review the case and overturn the previous decision.

        2) As with initial UM denial decisions, a physician or other appropriate clinical peer must evaluate medical necessity decisions for adverse appeal decisions.

        3) Practitioners consulted under these circumstances are afforded the same independent judgment and decision-making autonomy as Committee members.

    c. **Same-or-similar-specialist review**

        1) For appeals involving clinical issues, including appeals about whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate, a health care practitioner who has appropriate training and experience in the field of medicine involved in the case must review the appeal. NCQA refers to this practitioner as a **same-or-similar specialist**.

        2) The *same specialty* refers to a practitioner with similar credentials and licensure as those who typically treat the condition or health problem in question in the appeal. A *similar specialty* refers to a practitioner who has experience treating the same problems as those in question in the appeal, in addition to experience treating similar complications of those problems.

3) Depending on the type of case, a same-or-similar specialist may be a physician, behavioral healthcare practitioner, chiropractor, dentist, physical therapist or other type of practitioner, as appropriate.

4) Member Services will submit medical necessity appeals requiring specialty reviews to the Medical Director at the time the appeal letter is received.

12. The Member Appeals Representative responds to each appeal in writing within 30 days from the members written appeal with the Committee's decision regarding their appeal. The notice must include the title of each reviewer for a benefit appeal or the title, qualifications and specialty (e.g., MD, DO, PhD) of each reviewer for a medical necessity appeal. It must also specifically state that these individuals participated in the appeal review. Participant names do not need to be included in the written notification to members, but must be provided to members upon request.

    1) If GHC-SCW fails to adhere to the notice and timing requirements in this section, the member is deemed to have exhausted the Health Plan's appeals process and the member may initiate a State fair hearing. GHC-SCW shall send the BadgerCare Plus Adverse Determination Template option "Tell you about a failure to provide services in a timely manner" template letter and include information regarding how to request a State Fair Hearing.

13. If an adverse determination is upheld by the Member Appeals Committee, the member shall be notified of their right to appeal rights with the Department of Health Services/Department of Hearings and the member must request a State fair hearing no later than 90 calendar days from the date of the GHC-SCW's notice of resolution.

    a. Upon request for information regarding a State fair hearing, the Health Plan must provide all relevant materials to appropriate party (the Department, the state's fiscal agent, or DHA) within 5 business days, or sooner if possible. This includes:

        1) The Health Plan denial letter.
        2) All pertinent medical or dental records.
        3) Any other pertinent documentation, as determined by the Department.

    b. If the adverse determination was for a concurrent service authorization, which terminated, suspended, or reduced services, the BadgerCare Plus Member has the right to continue the service through State Fair Hearing Process.

        1) At the members request, GHC-SCW continues or reinstates the enrollee's benefits while the appeal or state fair hearing is pending, the benefits must be continued until one of following occurs:
            a) The enrollee withdraws the appeal or request for state fair hearing.
            b) The enrollee fails to request a state fair hearing and continuation of benefits within 10 calendar days after the MCO, PIHP, or PAHP sends the notice of an adverse resolution to the enrollee's appeal under §438.408(d)(2).
            c) A State fair hearing office issues a hearing decision adverse to the enrollee.

14. In the event that the Department of Health Services/Department of Hearings overturns GHC-SCW appeal decision GHC-SCW must authorize or provide the disputed services promptly and as expeditiously as the members health condition requires but no later than 72 hours from the date it receives notice reversing the determination. Additionally, if the member received the services during the duration of the appeal, and the State Fair Hearing reverses GHC-SCW's decision, GHC-SCW must authorize and pay for the services.

15. Trends are analyzed to help determine improvements in benefits, services, or policies of GHC-SCW.

16. In the event a State Fair Hearing overturns a GHC-SCW adverse determination, education and policy improvements are made to appropriately adjudicate BadgerCare Plus benefit determinations.

17. The Government Programs Contract Administrator generates the quarterly Member Grievance and Appeal Reporting Form for the Department of Health Services.

18. Annual reports are prepared for the GHC-SCW Board of Directors and other GHC-SCW Quality Committees.

19. ERISA Notification Requirements: Notification when Decision is not in favor of the Member. A denial notice must include:

    a. The specific reason for upholding the denial, in an easy to understand language; and

    b. Reference to the specific plan provisions, guideline, protocol, or other similar criterion upon which the upheld denial is based; and
    A notification statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimants claim for benefits.

    c. A statement outlining the claimants right to sue under section 502 (a) of the Employee Retirement Income Security Act of 1974 (ERISA) following an adverse benefit determination on review,

    d. A statement making any internal rule, guideline, protocol, et al relied upon in making an Adverse Determination available free of charge to the claimant upon request; and

    e. A statement making an explanation of the scientific or clinical judgment for any determination based on medical necessity or experimental treatment exclusions or limits available free of charge to the claimant upon request; and

    f. A statement making a list of medical and vocational experts consulted during the review process available free of charge to the claimant upon request.