APPENDIX H
Complaint, Grievance and Fair Hearing Processes

A. General Requirements

1. The BH-MCO must have written policies and procedures for registering, responding to, and resolving Complaints and Grievances (at all levels) as they relate to the MA population.

2. All Complaint, Grievance, and Fair Hearing policies and procedures developed by a BH-MCO must be approved in writing by the Department prior to their implementation.

3. The Complaint and Grievance processes must be fair, easy to understand, easy to follow, easily accessible and respectful of the Member's rights.

4. The BH-MCO policies and procedures regarding Member Complaints and Grievances must be provided to Members in written form:

   a. Upon enrollment into the BH-MCO,
   b. Upon Member request, and
   c. At least 30 Days before a Department-approved change becomes effective.

5. The BH-MCO must require Network Providers to display information about how to file a Complaint or a Grievance and the Complaint and Grievance process at all Network Provider offices.

6. The BH-MCO may not charge Members a fee for filing a Complaint or Grievance.

7. The BH-MCO must require Network Providers to display a notification that Members will not incur a fee for filing Complaints or Grievances at any level of the process at all Network Provider offices.

8. The BH-MCO must operate a toll-free telephone service for Members to use to file Complaints and Grievances and to follow up on Complaints and Grievances filed by Members. The phone service must be operated 24 hours a day, 7 Days a week by appropriately trained staff. Voice mail or recorded messages are not allowed. The BH-MCO must provide Members with the number of the toll-free telephone service.

9. All BH-MCO staff that interact with Members must receive training on Complaints and Grievances that includes how to record a Complaint or

Grievance and how to provide the information staff receive to designated Complaint and Grievance staff for processing.

10. All County and BH-MCO staff involved in the Complaint and Grievance processes and all review committee members must receive training in the areas related to their responsibility at least annually or more frequently, if needed.

11. All County and BH-MCO staff involved in the Complaint and Grievance processes and all review committee members must have the necessary orientation, knowledge, and experience to make a determination about assigned issues and must analyze information and resolve disputed issues in a fair and nondiscriminatory manner.

12. All review committee proceedings shall be conducted in a manner that is informal and impartial to avoid intimidating the Member or the Member's representative.

13. The BH-MCO must identify a lead person responsible for overall coordination of the Complaint and Grievance processes, including the provision of information and instructions to Members.

14. The BH-MCO must maintain an accurate log of all Complaints and Grievances, which includes, at a minimum:

    a. Identifying information about the Member
    b. A description of the reason for the Complaint or Grievance
    c. The date the Complaint or Grievance was received
    d. The date of the review or review meeting (if applicable)
    e. The decision
    f. The date of the decision
    g. If the second level Complaint review committee or the Grievance review committee included a consumer representative

    The BH-MCO must provide the log to the Department or CMS upon request.

15. The BH-MCO must retain all Complaint and Grievance records, which must include a copy of any document reviewed by the Complaint or Grievance review committee and the Complaint or Grievance log, for 10 years from the date the Complaint or Grievance was filed.

16. The BH-MCO must allow the Member or the Member's representative if the Member has provided the BH-MCO with written authorization that indicates that the representative may be involved and/or act on the Member's behalf access to all relevant documents pertaining to the subject of the Member's Complaint or Grievance, including any new or additional evidence considered, relied upon, or generated for the Complaint or Grievance review and, if an Investigator was assigned, any information obtained as part of the investigation. The BH-MCO may not charge Members or their representatives for copies of the documentation.

17. The BH-MCO must ensure that there is a link between the Complaint and Grievance processes and the Quality Management and Utilization Management programs.

18. The BH-MCO may not use the time frames or procedures of the Complaint or Grievance process to avoid the medical decision process or to discourage or prevent a Member from receiving medically necessary care in a timely manner.

19. The BH-MCO must accept Complaints and Grievances from Members who have disabilities which are in alternative formats including: TTD/TTY for telephone inquiries and Complaints and Grievances from Members who are deaf or hearing impaired; Braille; recording; or computer disk; and other commonly accepted alternative forms of communication. The BH-MCO must make its employees who receive telephone Complaints and Grievances aware of the speech limitation of some Members who have disabilities so they treat these Members with patience, understanding, and respect.

20. The BH-MCO must provide Members who have disabilities assistance with preparing and presenting their case at Complaint or Grievance reviews at no cost to the Member. This includes, but is not limited to:

    a. Providing qualified sign language interpreters for Members who are deaf or hearing impaired;

    b. Providing information submitted on behalf of the BH-MCO at the Complaint or Grievance review in an alternative format accessible to the Member filing the Complaint or Grievance. The alternative format version must be supplied to the Member before the review and at the review, so the Member can discuss and/or refute the content during the review; and

    c. Providing personal assistance to Members with other physical limitations with copying and presenting documents and other evidence.

21. The BH-MCO must provide language interpreter services when requested by a Member at no cost to the Member.

22. The BH-MCO must offer Members the assistance of a BH-MCO staff member throughout the Complaint and Grievance processes at no cost to the Member. The BH-MCO staff member cannot have been involved in and cannot be a subordinate of anyone who was involved in any previous level of review or decision-making on the issue that is the subject of the Complaint or Grievance.

23. The BH-MCO must require that anyone who participates in making the decision on a Complaint or Grievance was not involved in and is not a subordinate of anyone who was involved in any previous level of review or decision-making on the issue that is the subject of the Complaint or Grievance.

24. Upon receipt of a Complaint or Grievance, the BH-MCO must offer to provide Members with names and contact information of advocacy organizations available to assist Members.

25. If the decision on a Member's Complaint or Grievance indicates that a corrective plan of action or follow-up is needed to address quality of care concerns, the BH-MCO must implement the corrective plan of action or follow-up and document the actions taken in the Complaint or Grievance record or include in the record where documentation of the corrective action or follow-up can be found.

26. If a Member continued to receives services at the previously authorized level because the Member filed a Complaint, Grievance, or Fair Hearing to dispute a decision to discontinue, reduce, or change a service that the Member has been receiving within one Day from the mail date on the written notice of decision if acute inpatient services were being discontinued, reduced, or changed or within 10 Days from the mail date on the written notice of decision if any other services were being discontinued, reduced, or changed, the BH-MCO must pay for the services pending resolution of the Complaint, Grievance, or Fair Hearing, unless the Member subsequently withdraws the Complaint, Grievance or Fair Hearing.

27. The BH-MCO must notify the Member when the BH-MCO fails to decide a first level Complaint or Grievance within the time frames specified in this Appendix, using the Notice for Failure of the BH-MCO to Meet Complaint or Grievance Time Frames template. The BH-MCO must mail this notice to the Member one Day following the date the decision was to be made.

28. The BH-MCO must notify the Member when it denies payment after a service(s) has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program, using the Notice for Payment Denial Because the Service Was Provided Without Authorization by a Provider Not Enrolled in the Pennsylvania Medical Assistance Program template. The BH-MCO must mail this notice to the Member on the day that the decision is made to deny payment.

29. The BH-MCO must notify the Member when it denies payment after a service(s) has been delivered because the service(s) provided is not a covered service(s) for the Member, using the Notice for Payment Denial Because the Service Was Not a Covered Service for the Member template. The BH-MCO must mail this notice to the Member on the day that the decision is made to deny payment.

30. The BH-MCO must notify the Member when it denies payment after a service(s) has been delivered because the BH-MCO determined that the emergency room service(s) was not medically necessary, using the Notice for Denial of Payment After a Service(s) Has Been Delivered Because the Emergency Room Service(s) Was Not Medically Necessary template. The BH-MCO must mail this notice to the Member on the day the decision is made to deny payment.

31. The BH-MCO must notify the Member when it denies the Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities, using the Notice for Denial of Request to Dispute Financial Liability template. The BH-MCO must mail this notice to the Member on the day the decision is made to deny the request to dispute a financial liability.

32. The BH-MCO must include the Non-Discrimination Notice and Language Assistance Services templates when sending a letter or notice to a Member and a Member's representative if the Member has provided the BH-MCO with written authorization that indicates that the representative may be involved and/or take action on the Member's behalf.

33. The BH-MCO must use the templates supplied by the Department, which are available in DocuShare. The BH-MCO may not modify the templates. The BH-MCO must also follow the instruction in the templates for including detailed, specific information related to the Complaint or Grievance.

B. Complaint Requirements

1. Definition**:** A Complaint is a dispute or objection regarding a Network Provider or the coverage, operations, or management of a BH-MCO, which has not been resolved by the BH-MCO and has been filed with the BH-MCO or with the Pennsylvania Insurance Department's (PID) Bureau of Managed Care (BMC), including, but not limited to:

    a. a denial because the requested service is not a covered service;

    b. the failure of the BH-MCO to meet the required time frames for providing a service;

    c. the failure of the BH-MCO to decide a Complaint or Grievance within the specified time frames;

    d. a denial of payment by the BH-MCO after a service(s) has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program;

    e. a denial of payment by the BH-MCO after a service(s) has been delivered because the service(s) is not a covered service(s) for the Member;

    f. a denial of a Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities; or

    g. a member's dissatisfaction with the BH-MCO or a Provider.

Note: Complaints do not include requests to reconsider a decision concerning the medical necessity and appropriateness of a covered health care service.

2. First Level Complaint Process

    a. A BH-MCO must permit a Member to designate a representative, which may include the Member's Provider, if the Member provides the BH-MCO with written authorization that indicates that the representative may be involved and/or act on the Member's behalf. Failure to provide written authorization that the representative may be involved and/or act on the Member's behalf may not delay the Complaint process.

    A Member or Member's representative (if designated) may file a

Complaint either orally or in writing.

b. If the Complaint disputes one of the following, the Member or Member's representative (if designated) must file a Complaint within 60 Days from the date of the incident complained of or the date the Member receives written notice of a decision:

   i. a denial because the requested service is not a covered service;

   ii. the failure of the BH-MCO to meet the required time frames for providing a service;

   iii. the failure of the BH-MCO to decide a Complaint or Grievance within the specified time frames;

   iv. a denial of payment after a service(s) has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program;

   v. a denial of payment after a service(s) has been delivered because the service(s) is not a covered service(s) for the Member; or

   vi. a denial of a Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities.

   For all other Complaints, there is no time limit for filing a Complaint.

c. A Member who files a Complaint to dispute a decision to discontinue, reduce, or change a service that the Member has been receiving on the basis that the service is not a covered service must continue to receive the disputed service at the previously authorized level pending resolution of the Complaint, if the Complaint is filed orally, hand delivered, faxed, or post-marked within one Day from the mail date on the written notice of decision if acute inpatient services are being discontinued, reduced, or changed or within 10 Days from the mail date on the written notice of decision if any other services are being discontinued, reduced, or changed.

d. The BH-MCO must send the Member and Member's representative (if designated), an acknowledgment letter, using the appropriate acknowledgment letter template upon receipt of the Complaint, which can be no later than 5 business days after receipt of the

Complaint.

If the Complaint disputes one of the following:

i. a denial because the requested service is not a covered service;

ii. the failure of the BH-MCO to meet the required time frames for providing a service;

iii. the failure of the BH-MCO to decide a Complaint or Grievance within the specified time frames;

iv. a denial of payment after a service(s) has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program;

v. a denial of payment after a service(s) has been delivered because the service(s) is not a covered service(s) for the Member; or

vi. a denial of a Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities

the BH-MCO must use the Complaint Acknowledgement Letter template.

For all other Complaints, the BH-MCO must use the First Level Complaint Acknowledgement Letter template.

f. Upon receipt of the Complaint, the BH-MCO must assign an Investigator who was not involved in and is not the subordinate of anyone who was involved in any previous review or decision-making on the issue that is the subject of the Complaint and who will not benefit financially from the resolution of the Complaint. The Investigator is responsible for obtaining from the Member and any other individuals involved with the Complaint all relevant documents pertaining to the subject of the Complaint. The Investigator must treat the Member and any other individuals involved with the Complaint equally and with respect. The Investigator must provide to the first level Complaint review committee at least 2 Days prior to the Complaint review all information obtained as part of the investigation. The Investigator must attend the Complaint review and present the information obtained as part of the investigation to

the first level Complaint review committee. The Investigator cannot be involved in the Complaint review committee's decision.

g. The Complaint review for Complaints **not involving a clinical issue** must be performed by a Complaint review committee, which must include one or more employees of the BH-MCO who were not involved and are the not subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Complaint.

h. The Complaint review for Complaints **involving a clinical issue** must be performed by a Complaint review committee, which must include one or more employees of the BH-MCO who were not involved in and are not the subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Complaint. At least one individual on the committee must meet the qualifications described in Appendix AA, section C.3 for an individual that can deny a request for services based on medical necessity and this individual must decide the Complaint. Other appropriate individuals may participate in the review.

i. The BH-MCO must afford the Member a reasonable opportunity to present testimony and evidence and make legal and factual arguments, in person as well as in writing. The BH-MCO must allow the Member or anyone the Member chooses to present the Member's position to the Complaint review committee.

j. The Member must be provided the opportunity to appear before the Complaint review committee. The BH-MCO must be flexible when scheduling the Complaint review to facilitate the Member's attendance. The Complaint review must be conducted at a time and place that is convenient for the Member. If the Member cannot appear in person at the Complaint review, the BH-MCO must provide an opportunity for the Member to communicate with the Complaint review committee by telephone or videoconference.

k. The Complaint review committee may ask individuals who attend the Complaint review in person, by telephone, or by videoconference questions related to the subject of the Complaint.

l. The Member may elect not to attend the Complaint review meeting, but the meeting must be conducted with the same protocols as if the Member was present.

m. If the Member's Provider did not file the Complaint, the Member's

Provider may participate in the Complaint review only if the Member consents to the Provider being present at the Complaint review. The BH-MCO must document the Member's consent in the Complaint record.

n. County or BH-MCO staff may attend the Complaint review for training purposes if the Member consents to the staff person attending the Complaint review. The BH-MCO must document the Member's consent in the Complaint record.

o. The BH-MCO must maintain as part of the Complaint record a sign-in sheet that includes the date and time of the review meeting; who was present at the review meeting and why the individual was present at the review meeting; if the individual attended the review meeting in person, by phone, or by videoconference; the affiliation and job title of anyone present at the review meeting other than the Member; and documentation that all individuals present at the review meeting other than the Member have acknowledged that they will keep the information discussed during the review meeting confidential. All individuals that are present at the review meeting in person must sign the sign-in sheet.

p. The decision of the Complaint review committee must take into account all comments, documents, records, and other information submitted by the Member or the Member's representative (if designated) without regard to whether such information was submitted or considered previously. The decision of the Complaint review committee must be based solely on the information presented at the review.

q. The Complaint review committee must complete its review of the Complaint as expeditiously as the Member's health condition requires.

r. The Complaint review committee must prepare a summary of the issues presented and decisions made, which must be maintained as part of the Complaint record.

s. The BH-MCO must send a written notice of the Complaint decision to the Member, Member's representative (if designated), service Provider, and prescribing Provider (if applicable), within 30 Days from the date the BH-MCO received the Complaint, unless the time frame for deciding the Complaint has been extended by up to 14 Days at the request of the Member. The BH-MCO must document a Member's request for an extension in the Complaint record.

t. If the Complaint disputes the following the BH-MCO must use the Complaint Decision Notice template to send written notice of the Complaint decision:

i. a denial because the requested service is not a covered service;

ii. the failure of the BH-MCO to meet the required time frames for providing a service;

iii. the failure of the BH-MCO to decide a Complaint or Grievance within the specified time frames;

iv. a denial of payment after a service(s) has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program;

v. a denial of payment after a service(s) has been delivered because the service(s) is not a covered service(s) for the Member; or

vi. a denial of a Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities.

For all other Complaints, the BH-MCO must use the first level Complaint Decision Notice template to send written notice of the Complaint decision.

u. If the Complaint disputes one of the following, the Member may file a request for a Fair Hearing, a request for an external review, or both a request for a Fair Hearing and a request for an external review:

i. a denial because the requested service is not a covered service;

ii. the failure of the BH-MCO to meet the required time frames for providing a service;

iii. the failure of the BH-MCO to decide a Complaint or Grievance within the specified time frames;

iv. a denial of payment by the BH-MCO after a service(s) has been delivered because the service(s) was provided without

authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program;

v. a denial of payment by the BH-MCO after a service(s) has been delivered because the service(s) is not a covered service(s) for the Member; or

vi. a denial of a Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities.

The Member or Member's representative may file a request for a Fair Hearing within 120 Days from the mail date on the written notice of the BH-MCO's first level Complaint decision

The Member or Member's representative, which may include the Member's Provider, with proof of the Member's written authorization for the representative to be involved and/or act on the Member's behalf, may file a request for an external review in writing with PID's BMC within 15 Days from the date the Member receives written notice of the BH-MCO's first level Complaint decision.

For all other Complaints, the Member or Member's representative, which may include the Member's Provider, with proof of the Member's written authorization for the representative to be involved and/or act on the Member's behalf, may file a second level Complaint either in writing, by fax, or orally within 45 Days from the date the Member receives written notice of the BH-MCO's first level Complaint decision.

3. Second Level Complaint Process

a. A BH-MCO must permit a Member to designate a representative, which may include the Member's Provider, if the Member provides the BH-MCO with written authorization that indicates that the representative may be involved and/or act on the Member's behalf. Failure to provide written authorization that the representative may be involved and/or act on the Member's behalf may not delay the Complaint process.

b. A second level Complaint must be filed within 45 Days from the date the Member receives written notice of the BH-MCO's first level Complaint decision.

c. The BH-MCO must send the Member and Member's representative (if designated) an acknowledgment letter using the Second Level

Complaint Acknowledgment Letter template upon receipt of the second level Complaint, which can be no later than 5 business days after receipt of the second level Complaint.

d. The second level Complaint review for Complaints not involving a clinical issue must be performed by a Complaint review committee made up of 3 or more individuals who were not involved in and are not subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Complaint.

e. The second level Complaint review for Complaints involving a clinical issue must be conducted by a second level Complaint review committee made of up of three (3) or more individuals who were not involved in and or not the subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Complaint. The second level Complaint review committee must include at least one individual who meets the qualifications described in Appendix AA, section C.3 for an individual that can deny a request for services based on medical necessity and this individual must decide the Complaint. Other appropriate individuals may participate in the review.

f. At least one-third of the second level Complaint review committee may not be an employee of the BH-MCO or a related subsidiary or Affiliate.

g. At least 20% of the second level Complaint review committees in a year must include a consumer representative on the review committee.

h. If the Complaint involves mental health services for an adult, the consumer representative must have received or is currently receiving mental health services. If the Complaint involves substance abuse services, the consumer representative must have received or is currently receiving substance abuse services.

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

or an individual who has received or is currently receiving substance abuse services.

j. The BH-MCO must provide to the second level Complaint review committee at least 2 Days prior to the second level Complaint review meeting the first level Complaint record, which must include a copy of any document reviewed by the first level Complaint review committee.

k. A committee member who does not personally attend the second level Complaint review meeting may not be part of the decision-making process unless that person actively participates in the review by telephone or videoconference and has the opportunity to review all information presented at the meeting.

l. The second level Complaint review committee may not discuss the Complaint prior to the review meeting.

m. The BH-MCO must afford the Member a reasonable opportunity to present testimony and evidence and make legal and factual arguments, in person as well as in writing. The BH-MCO must allow the Member or anyone the Member chooses to present the Member's position to the second level Complaint review committee.

n. The Member must be provided the opportunity to appear before the second level Complaint review committee. The BH-MCO must be flexible when scheduling the second level Complaint review to facilitate the Member's attendance. The second level Complaint review must be conducted at a time and place that is convenient for the Member. If the Member cannot appear in person at the second level Complaint review, the BH-MCO must provide an opportunity for the Member to communicate with the second level Complaint review committee by telephone or videoconference.

o. The BH-MCO must give the Member at least 10 Days advance written notice of the second level Complaint review date. The BH-MCO must document in the Complaint record the date that it notified the Member of the review date.

p. The Member may elect not to attend the second level Complaint review meeting, but the meeting must be conducted with the same protocols as if the Member was present.

q. A facilitator must attend the second level Complaint review meeting to ensure that the review meeting is conducted in accordance with the requirements set forth in this Appendix. The facilitator may not

contribute to the discussion of the second level Complaint review committee or be involved in the decision of the second level Complaint review committee.

r. A BH-MCO staff member that is prepared to provide information on the BH-MCO's position on the issue the Complaint is about must attend the second level Complaint review meeting. The BH-MCO staff member may not be present during the discussion of the decision and may not be involved in the decision of the second level Complaint review.

s. If the Member's Provider did not file the Complaint, the Member's Provider may participate in the Complaint review only if the Member consents to the Provider being present at the Complaint review. The BH-MCO must document the Member's consent in the Complaint record.

t. The second level Complaint review committee may ask individuals who attend the Complaint review meeting in person, by telephone, or by videoconferences question related to the subject of the Complaint.

u. County or BH-MCO staff may attend the Complaint review for training purposes if the Member consents to the staff person attending the Complaint review. The BH-MCO must document the Member's consent in the Complaint record.

v. The BH-MCO must maintain as part of the Complaint record a sign-in sheet that includes the date and time of the review meeting; who was present at the review meeting and why the individual was present at the review meeting; if the individual attended the review meeting in person, by phone, or by videoconference; the affiliation and job title of anyone present at the review meeting other than the Member; and documentation that all individuals present at the review meeting other than the Member have acknowledged that they will keep the information discussed during the review meeting confidential. All individuals that are present at the review meeting in person must sign the sign-in sheet.

w. The decision of the second level Complaint review committee must take into account all comments, documents, records, and other information submitted by the Member or the Member's representative (if designated) without regard to whether such information was submitted or considered previously. The decision of the second level Complaint review committee must be based solely on the information presented at the review.

x. The second level Complaint review committee must complete its review of the Complaint as expeditiously as the Member's health condition requires.

y. The testimony taken by the second level Complaint review committee (including the Member's comments) must be either recorded and a summary prepared or transcribed verbatim and a summary prepared and maintained as part of the Complaint record.

z. The BH-MCO must send a written notice of the second level Complaint decision to the Member, Member's representative (if designated), service Provider, and prescribing Provider (if applicable), using the Second Level Complaint Decision Notice template, within 45 Days from the date the BH-MCO received the second level Complaint.

aa. The Member or Member's representative, which may include the Member's Provider, with proof of the Member's written authorization for the representative to be involved and/or act on the Member's behalf, may file in writing a request for an external review of the second level Complaint decision with PID's BMC within 15 Days from the date the Member receives the written notice of the BH-MCO's second level Complaint decision.

4. External Complaint Process

a. If a Member files a request directly with PID's BMC for an external review of a Complaint decision that disputes a decision to discontinue, reduce, or change a service that the Member has been receiving on the basis that the service is not a covered service, the Member must continue to receive the disputed service at the previously authorized level pending resolution of the external review, if the request for external review is filed orally, hand delivered, or post-marked within one Day from the mail date on the written notice of the BH-MCO's Complaint decision if acute inpatient services are being discontinued, reduced, or changed or within 10 Days from the mail date on the written notice of the BH-MCO's Complaint decision if any other services are being discontinued, reduced, or changed.

b. Upon the request of PID's BMC, the BH-MCO must transmit all records from the BH-MCO's Complaint review to PID's BMC within 30 Days from the request in the manner prescribed by PID's BMC. The Member, the Provider, or the BH-MCO may submit additional materials related to the Complaint.

5. Expedited Complaint Process

   a. The BH-MCO must conduct an expedited review of a Complaint if the BH-MCO determines that the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Complaint process or if a Member or a Member's representative (if designated) provides the BH-MCO with written certification from the Member's Provider that the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Complaint process. The certification must include the Provider's signature.

   b. A request for an expedited review of a Complaint may be filed either in writing or orally.

   c. Upon receipt of an oral or written request for expedited review, the BH-MCO must inform the Member of the right to present testimony and evidence and make legal and factual arguments, in person as well as in writing and of the limited time available to do so.

   d. If the Provider certification is not included with the request for an expedited review and the BH-MCO cannot determine based on the information provided that the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Complaint process, the BH-MCO must inform the Member that the Provider must submit a certification as to the reason why the expedited review is needed. The BH-MCO must make a reasonable effort to obtain the certification from the Provider. If the Provider certification is not received within 72 hours from the Member's request for an expedited review, the BH-MCO must decide the Complaint within the standard time frames as set forth in this Appendix, unless the time frame for deciding the Complaint has been extended by up to 14 Days at the request of the Member. If the BH-MCO decides that expedited consideration within the initial or extended time frame is not warranted, the BH-MCO must make a reasonable effort to give the Member prompt oral notice that the Complaint is to be decided within the standard time frame and send a written notice within 2 business days of the decision to deny expedited review, using the Notice of Failure to Receive Provider Certification for an Expedited Complaint template .

   e. A Member who files a request for expedited review of a Complaint to dispute a decision to discontinue, reduce, or change a service that the Member has been receiving on the basis that the service is not a

covered service must continue to receive the disputed service at the previously authorized level pending resolution of the Complaint, if the request for expedited review is filed orally, hand delivered, or post-marked within one Day from the mail date on the written notice of the BH-MCO's decision if acute inpatient services are being discontinued, reduced, or changed or within 10 Days from the mail date on the written notice of the BH-MCO's decision if any other services are being discontinued, reduced, or changed.

f. Expedited review of a Complaint must be conducted by a Complaint review committee that includes at least one individual who meets the qualifications described in Appendix AA, Section C.3 for an individual that can deny a request for services based on medical necessity. Other appropriate individuals may participate in the review, but an individual who meets the qualifications described in Appendix AA, Section C.3 for an individual that can deny a request for services based on medical necessity must decide the Complaint.

g. The members of the expedited Complaint review committee may not have been involved in and may not be the subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Complaint.

h. The Complaint review committee must prepare a summary of the issues presented and decisions made, which must be maintained as part of the expedited Complaint record.

i. The BH-MCO must issue the decision resulting from the expedited review in person or by phone to the Member, Member's representative (if designated), service Provider, and prescribing Provider (if applicable) within either 48 hours of receiving the Provider's certification or 72 hours of receiving the Member's request for an expedited review, whichever is shorter, unless the time frame for deciding the expedited Complaint has been extended by up to 14 Days at the request of the Member. The BH-MCO must document a Member's request for an extension in the Complaint record. In addition, the BH-MCO must mail written notice of the decision to the Member, Member's representative (if designated), service Provider, and prescribing Provider (if applicable), within 2 business days of the decision using the Expedited Complaint Decision Notice template.

j. The Member or the Member's representative, which may include the Member's Provider, with proof of the Member's written authorization for the representative to be involved and/or act on the

Member's behalf, may file a request for an expedited external Complaint review with the BH-MCO within 2 business days from the date the Member receives the BH-MCO's expedited Complaint decision. A Member who files a request for an expedited external Complaint review that disputes a decision to discontinue, reduce, or change a service that the Member has been receiving must continue to receive the disputed service at the previously authorized level pending resolution of the expedited external Complaint review if the request for expedited external Complaint review is filed orally, hand delivered, faxed, or post-marked within one business day from the mail date on the written notice of the BH-MCO's decision if acute inpatient services are being discontinued, reduced, or changed or within 2 business days from the mail date on the written notice of the BH-MCO's decision if any other services are being discontinued, reduced, or changed.

k. A request for an expedited external Complaint review may be filed either in writing or orally.

l. The BH-MCO must follow PID's BMC guidelines relating to submission of requests for expedited external Complaint reviews.

m. The Member or the Member's representative may file a request for a Fair Hearing within 120 Days from the mail date on the written notice of the BH-MCO's expedited Complaint decision.

n. The BH-MCO may not take punitive action against a Provider who requests expedited resolution of a Complaint or supports a Member's request for expedited review of a Complaint.

C. Grievance Requirements

1. Definition: A Grievance is a request to have a BH-MCO or utilization review entity reconsider a decision concerning the medical necessity and appropriateness of a covered service.

   A Grievance may be filed regarding a BH-MCO's decision to:

   a. deny, in whole or in part, payment for a service;

   b. deny or issue a limited authorization of a requested service, including a determination based on the type or level of a service;

   c. reduce, suspend, or terminate a previously authorized service; and

   d. deny the requested service but approve an alternative service.

2. Grievance Process

   a. A BH-MCO must permit a Member to designate a representative, which may include the Member's Provider, if the Member provides the BH-MCO with written authorization that indicates that the representative may be involved and/or act on the Member's behalf. Failure to provide written authorization that the representative may be involved and/or act on the Member's behalf may not delay the Grievance process.

   b. A Member or Member's representative (if designated) may file a Grievance either orally or in writing.

   c. The Member or Member's representative (if designated) must file a Grievance within 60 Days from the date the Member receives written notice of decision.

   d. A Member who files a Grievance to dispute a decision to discontinue, reduce, or change a service that the Member has been receiving must continue to receive the disputed service at the previously authorized level pending resolution of the Grievance, if the Grievance is filed orally, hand delivered, faxed, or post-marked within one Day from the mail date on the written notice of decision if acute inpatient services are being discontinued, reduced, or changed or within 10 Days from the mail date on the written notice of decision if any other services are being discontinued, reduced or changed.

   e. The BH-MCO must send the Member and Member's representative (if designated) an acknowledgment letter using the Grievance Acknowledgment Letter template upon receipt of the Grievance, which can be no later than 3 business days after receipt of the Grievance.

   f. In order for the Provider to represent the Member in the conduct of a Grievance, the Provider must obtain the written consent of the Member and submit the written consent with the Grievance. A Provider may obtain the Member's written permission at the time of treatment. The BH-MCO must assure that a Provider does NOT require a Member to sign a document authorizing the Provider to file a Grievance as a condition of treatment. The written consent must include:

      i. The name and address of the Member, the Member's date of birth, and identification number,

ii. If the Member is a minor, or is legally incompetent, the name, address, and relationship to the Member of the person who signed the consent,

iii. The name, address, and plan identification number of the Provider to whom the Member is providing consent,

iv. The name and address of the BH-MCO to which the Grievance will be submitted,

v. An explanation of the specific service which was provided or denied to the Member to which the consent will apply,

vi. The following statement: "The Member or the Member's representative may not submit a Grievance concerning the services listed in this consent form unless the Member or the Member's representative rescinds consent in writing. The Member or Member's representative has the right to rescind consent at any time during the Grievance process.",

vii. The following statement: "The consent of the Member or the Member's representative shall be automatically rescinded if the Provider fails to file a Grievance or fails to continue to prosecute the Grievance through the review process.",

viii. The following statement: "The Member or the Member's representative, if the Member is a minor or is legally incompetent, has read, or has been read, this consent form, and has had it explained to his/her satisfaction. The Member or the Member's representative understands the information in the Member's consent form."; and

ix. The dated signature of the Member, or the Member's representative, and the dated signature of a witness.

g. The Grievance review must be performed by a Grievance review committee made up of 3 or more individuals who were not involved in and are not subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Grievance.

h. The Grievance review committee must include at least one individual who meets the qualifications described in Appendix AA, Section C.3 for an individual that can deny a request for services based on medical necessity. Other appropriate individuals may participate in

the review, but an individual who meets the qualifications described in Appendix AA, Section C.3 for an individual that can deny a request for services based on medical necessity must decide the Grievance.

i. At least one-third of the Grievance review committee may not be an employee of the BH-MCO or a related subsidiary or Affiliate.

j. At least 20% of all Grievance review committees in a year must include a consumer representative on the review committee.

k. At least 2 Days prior to the Grievance review meeting the BH-MCO must provide to the Grievance review committee a copy of all documents reviewed to determine the medical necessity and appropriateness of the requested services.

l. If the Grievance involves mental health services for an adult, the consumer representative must have received or is currently receiving mental health services. If the Grievance involves substance abuse services, the consumer representative must have received or is currently receiving substance abuse services.

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

n. A committee member who does not personally attend the Grievance review meeting may not be part of the decision-making process unless that person actively participates in the review by telephone or videoconference and has the opportunity to review all information presented at the meeting.

o. The Grievance review committee may not discuss the Grievance prior to the review meeting.

p. The BH-MCO must afford the Member a reasonable opportunity to present testimony and evidence and make legal and factual arguments, in person as well as in writing. The BH-MCO must allow the Member or anyone the Member chooses to present the

Member's position to the Grievance review committee.

q. The Member must be provided the opportunity to appear before the Grievance review committee. The BH-MCO must be flexible when scheduling the Grievance review to facilitate the Member's attendance. The Grievance review must be conducted at a time and place that is convenient for the Member. If the Member cannot appear in person at the Grievance review, the BH-MCO must provide an opportunity for the Member to communicate with the Grievance review committee by telephone or videoconference.

r. The BH-MCO must give the Member at least 10 Days advance written notice of the Grievance review date. The BH-MCO must document in the Grievance record the date that it notified the Member of the review date.

s. The Member may elect not to attend the Grievance review meeting, but the meeting must be conducted with the same protocols as if the Member was present.

t. A facilitator must attend the Grievance review meeting to ensure that the review meeting is conducted in accordance with the requirements set forth in this Appendix. The facilitator may not contribute to the discussion of the Grievance review committee or be involved in the decision of the Grievance review committee.

u. A BH-MCO staff member that is be prepared to provide information on the BH-MCO's decision about the medical necessity and appropriateness of the requested services must attend the Grievance review meeting. The BH-MCO staff member may not be present during the discussion of the decision and may not be involved in the decision of the Grievance.

v. If the Member's Provider did not file the Grievance, the Member's Provider may participate in the Grievance review only if the Member consents to the Provider being present at the Grievance review. The BH-MCO must document the Member's consent in the Grievance record.

w. The Grievance review committee may ask individuals who attend the Grievance review in person, by telephone, or by videoconference questions related to the subject of the Grievance.

x. County or BH-MCO staff may attend the Grievance review for training purposes if the Member consents to the staff person attending the Grievance review. The BH-MCO must document the

Member's consent in the Grievance record.

y. The BH-MCO must maintain as part of the Grievance record a sign-in sheet that includes the date and time of the review meeting; who was present at the review meeting and why the individual was present at the review meeting; if the individual attended the review meeting in person, by phone, or by videoconference; the affiliation and job title of anyone present at the review meeting other than the Member; and documentation that all individuals present at the review meeting other than the Member have acknowledged that they will keep the information discussed during the review meeting confidential. All individuals that are present at the review meeting in person must sign the sign-in sheet.

z. The decision of the Grievance review committee must take into account all comments, documents, records, and other information submitted by the Member or Member's representative (if designated) without regard to whether such information was submitted or considered in the initial determination of the issue. The decision of the Grievance review committee must be based solely on the information presented at the review.

aa. The Grievance review committee must complete its review of the Grievance as expeditiously as the Member's health condition requires.

bb. The testimony taken by the Grievance review committee (including the Member's comments) must be either recorded and a summary prepared or transcribed verbatim and a summary prepared and maintained as part of the Grievance record.

cc. The BH-MCO must send a written notice of the Grievance decision , to the Member, Member's representative (if designated), service Provider, and prescribing Provider (if applicable), within 30 Days from the date the BH-MCO received the Grievance, unless the time frame for deciding the Grievance has been extended by up to 14 Days at the request of the Member. The BH-MCO must document a Member's request for an extension in the Grievance record.

dd. The BH-MCO must use the appropriate Grievance Decision Notice template to send written notice of the Grievance decision:

i. Overturned: The review committee determined that the evidence presented supports the reversal or alteration of a prior decision concerning the medical necessity and

appropriateness of the health care service.

ii. Partially Overturned: The review committee determined that the evidence presented supports the partial reversal or alteration of a prior decision concerning the medical necessity and appropriateness of the health care service.

iii. Upheld: The review committee determined that the evidence presented does not support the reversal or alteration of a prior decision concerning the medical necessity and appropriateness of the health care service.

ee. The Member may file a request for a Fair Hearing, a request for an external review, or both a request for a Fair Hearing and a request for external review.

The Member or Member's representative may file a request for a Fair Hearing within 120 Days from the mail date on the written notice of the BH-MCO's Grievance decision.

The Member or Member's representative, which may include the Member's Provider, with proof of the Member's written authorization for the representative to be involved and/or act on the Member's behalf, may file a request with the BH-MCO for an external review of a Grievance decision by a certified review entity (CRE) appointed by PID's BMC. The request must be filed in writing or orally within 15 Days from the date the Member receives the written notice of the BH-MCO's Grievance decision.

3. External Grievance Process

a. The BH-MCO must process all requests for external Grievance review. The BH-MCO must follow the protocols established by PID's BMC to meet all time frames and requirements necessary for coordinating the request and notification of the decision to the Member, Member's representative, if the Member has designated one in writing, service Provider, and prescribing Provider.

b. A Member who files a request for external Grievance review that disputes a decision to discontinue, reduce, or change a service that the Member has been receiving must continue to receive the disputed service at the previously authorized level pending resolution of the external Grievance review, if the request for external Grievance review is filed orally, hand delivered, or post-marked within one Day from the mail date on the written notice of the BH-MCO's Grievance decision if acute inpatient services are

being discontinued, reduced, or changed or within 10 Days from the mail date on the written notice of the BH-MCO's Grievance decision if any other services are being discontinued, reduced, or changed.

c. Within 5 business days of receipt of the request for an external Grievance review, the BH-MCO must notify the Member, the Member's representative (if designated), the Provider, if the Provider filed the request for the external Grievance review, and PID's BMC that the request for an external Grievance review has been filed.

d. The external Grievance review must be conducted by a CRE not affiliated with the BH-MCO.

e. Within 2 business days from receipt of the request for an external Grievance review, PID's BMC will randomly assign a CRE to conduct the review. The BH-MCO and assigned CRE will be notified of this assignment.

f. Within two (2) business days of receipt of notice of the assignment of the CRE, the BH-MCO must notify the Member using the template provided by PID's BMC of the name and contact information of the assigned CRE.

g. If PID's BMC fails to select a CRE within 2 business days from receipt of a request for an external Grievance review, the BH-MCO may designate a CRE to conduct a review from the list of CREs approved by PID's BMC. The BH-MCO may not select a CRE that has a current contract or is negotiating a contract with the BH-MCO or its Affiliates or is otherwise affiliated with the BH-MCO or its Affiliates.

h. The BH-MCO must forward all documentation regarding the Grievance decision, including all supporting information, a summary of applicable issues, and the basis and clinical rationale for the Grievance decision, to the CRE conducting the external Grievance review. The BH-MCO must transmit this information within 15 Days from receipt of the Member's request for an external Grievance review.

i. The BH-MCO must inform the Member that within 15 Days from receipt of the request for an external Grievance review by the BH-MCO, the Member, the Member's representative (if designated), or the Member's Provider may supply additional information to the CRE conducting the external Grievance review for consideration.

The BH-MCO must document in the Grievance record the date the Member was informed that the Member could supply additional information to the CRE conducting the external Grievance review for consideration. The BH-MCO must also inform the Member that the Member must provide the BH-MCO at the same time with copies of the additional information submitted so that the BH-MCO has an opportunity to consider the additional information.

j. Within 60 Days from the filing of the request for the external Grievance review, the CRE conducting the external Grievance review must issue a written decision to the BH-MCO, the Member, the Member's representative, PID's BMC, and the Provider (if the Provider filed the Grievance with the Member's consent) that includes the basis and clinical rationale for the decision. The standard of review must be whether the service was medically necessary and appropriate under the terms of the BH-MCO contract.

k. The external Grievance decision may be appealed by the Member, the Member's representative, or the Provider to a court of competent jurisdiction within 60 Days from the date the Member receives notice of the external Grievance decision.

4. Expedited Grievance Process

a. The BH-MCO must conduct an expedited review of a Grievance if the BH-MCO determines that the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Grievance process or if a Member or a Member's representative (if designated) provides the BH-MCO with written certification from the Member's Provider that the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Grievance process. The certification must include the Provider's signature.

b. A request for an expedited review of a Grievance may be filed either in writing via mail or fax or be filed orally.

c. The expedited review process is bound by the same rules and procedures as the Grievance review process with the exception of time frames, which are modified as specified in this section.

d. Upon receipt of an oral or written request for expedited review, the BH-MCO must inform the Member of the right to present testimony and evidence and make legal and factual arguments, in person as well as in writing and of the limited time available to do so.

e. If the Provider certification is not included with the request for an expedited review and the BH-MCO cannot determine based on the information provided that the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Grievance process, the BH-MCO must inform the Member that the Provider must submit a certification as to the reasons why the expedited review is needed. The BH-MCO must make a reasonable effort to obtain the certification from the Provider. If the Provider certification is not received within 72 hours from the Member's request for an expedited review, the BH-MCO must decide the Grievance within the standard time frames as set forth in this Appendix, unless the time frame for deciding the Grievance has been extended by up to 14 Days at the request of the Member. If the BH-MCO decides that expedited consideration within the initial or extended time frame is not warranted, the BH-MCO must make a reasonable effort to give the Member prompt oral notice that the Grievance is to be decided within the standard time frame and send a written notice within 2 business days of the decision to deny expedited review, using the Notice of Failure to Receive Provider Certification for an Expedited Grievance template.

f. A Member who files a request for expedited review of a Grievance to dispute a decision to discontinue, reduce, or change a service that the Member has been receiving must continue to receive the disputed service at the previously authorized level pending resolution of the Grievance, if the request for expedited review is filed orally, hand delivered, faxed, or post-marked within one Day from the mail date on the written notice of the BH-MCO's decision if acute inpatient services are being discontinued, reduced, or changed or within 10 Days from the mail date on the written notice of the BH-MCO's decision if any other services are being discontinued, reduced, or changed.

g. Expedited review of a Grievance must be performed by a Grievance review committee made up of 3 or more individuals who were not involved in and are not subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Grievance.

h. The Grievance review committee must include at least one individual who meets the qualifications described in Appendix AA, Section C.3 for an individual that can deny a request for services based on medical necessity. Other appropriate individuals may participate in the review, but the individual who meets the

qualifications described in Appendix AA, Section C.3 for an individual that can deny a request for services based on medical necessity must decide the Grievance.

i. At least one-third of the Grievance review committee may not be an employee of the BH-MCO or a related subsidiary or Affiliate.

j. The Grievance review committee must prepare a summary of the issues presented and decisions made, which must be maintained as part of the Grievance record.

k. The BH-MCO must issue the decision resulting from the expedited review in person or by phone to the Member, Member's representative (if designated), service Provider, and prescribing Provider (if applicable), within either 48 hours of receiving the Provider's certification or 72 hours of receiving the Member's request for an expedited review, whichever is shorter, unless the time frame for decided the expedited Grievance has been extended by up to 14 Days at the request of the Member. The BH-MCO must document a Member's request for an extension in the Grievance record.

l. The BH-MCO must send written notice of the Grievance decision to the Member, Member's representative (if designated), service Provider, and prescribing Provider (if applicable), within 2 business days of the decision using the appropriate Expedited Grievance Decision Notice template:

    i. Overturned: The review committee determined that the evidence presented supports the reversal or alteration of a prior decision concerning the medical necessity and appropriateness of the health care service.

    ii. Partially Overturned: The review committee determined that the evidence presented supports the partial reversal or alteration of a prior decision concerning the medical necessity and appropriateness of the health care service.

    iii. Upheld: The review committee determined that the evidence presented does not support the reversal or alteration of a prior decision concerning the medical necessity and appropriateness of the health care service.

m. The Member or the Member's representative, which may include the Member's Provider, with proof of the Member's written authorization for the representative to be involved and/or act on the

Member's behalf, may file a request for an expedited external Grievance review with the BH-MCO within 2 business days from the date the Member receives the BH-MCO's expedited Grievance decision. A Member who files a request for an expedited external Grievance review that disputes a decision to discontinue, reduce, or change a service that the Member has been receiving must continue to receive the disputed service at the previously authorized level pending resolution of the expedited external Grievance review if the request for expedited external Grievance review is filed orally, hand delivered, faxed, or post-marked within one business day from the mail date on the written notice of the BH-MCO's decision if acute inpatient services are being discontinued, reduced, or changed or within 2 business days from the mail date on the written notice of the BH-MCO's decision if any other services are being discontinued, reduced, or changed

n. A request for an expedited external Grievance review may be filed either in writing or orally.

o. The BH-MCO must follow PID's BMC guidelines relating to submission of requests for expedited external Grievance reviews.

p. The Member or the Member's representative may file a request for a Fair Hearing within 120 Days from the mail date on the written notice of the BH-MCO's expedited Grievance decision.

q. The BH-MCO may not take punitive action against a Provider who requests expedited resolution of a Grievance or supports a Member's request for expedited review of a Grievance.

D. Department's Fair Hearing Requirements

1. Fair Hearing: A hearing conducted by the Department's Bureau of Hearings and Appeals or a Department designee.

2. Department's Fair Hearing Process

a. A Member must file a Complaint or Grievance with the BH-MCO and receive a decision on the Complaint or Grievance before filing a request for a Fair Hearing. If the BH-MCO failed to provide written notice of a Complaint or Grievance decision within the time frames specified in this Appendix, the Member is deemed to have exhausted the Complaint or Grievance process and may request a Fair Hearing.

b. The Member or the Member's representative may request a Fair Hearing within 120 Days from the mail date on the written notice of the BH-MCO's Grievance decision for any of the following:

i. The denial, in whole or in part, of payment for a requested service based on lack of medical necessity;
ii. The reduction, suspension, or termination of a previously authorized service;

iii. The denial of a requested service but approval of an alternative service.

c. A Member or the Member's representative may request a Fair Hearing within 120 Days from the mail date on the written notice of the BH-MCO's first level Complaint decision for any of the following:

i. The denial of a requested service because the service is not a covered service;

ii. The failure of the BH-MCO to meet the required time frames for providing a service;

iii. The failure of the BH-MCO to decide a Complaint or Grievance within the specified time frames;

iv. The denial of payment after a service(s) has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program;

v. The denial of payment after a service(s) has been delivered because the service(s) is not a covered service(s) for the Member;

vi. The denial of a Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities.

d. The request for a Fair Hearing must include a copy of the written notice of decision that is the subject of the request unless the BH-MCO failed to provide a written notice of the Complaint or Grievance decision within the time frames specified in this Appendix.

e. Requests for Fair Hearings must be mailed or faxed to:

Department of Human Services
Office of Mental Health Substance Abuse Services
Division of Quality Management
Commonwealth Towers, 12th Floor
P.O. Box 2675
Harrisburg, PA 17105-2675
or
717-772-7827

f. A Member who files a request for a Fair Hearing that disputes a decision to discontinue, reduce, or change a service that the Member has been receiving must continue to receive the disputed service at the previously authorized level pending resolution of the Fair Hearing, if the request for a Fair Hearing is hand delivered or post-marked within one Day from the mail date on the written notice of decision if acute inpatient services are being discontinued, reduced, or changed or within 10 Days from the mail date on the written notice of decision if any other services are being discontinued, reduced or changed. If the request for a Fair Hearing is not hand delivered or post-marked within one Day from the mail date on the written notice of decision if acute inpatient services are being discontinued, reduced, or changed or within 10 Days from the mail date on the written notice of decision if any other services are being discontinued, reduced or changed, services can be discontinued.

g. Upon the receipt of the request for a Fair Hearing, the Bureau of Hearings and Appeals or the Department's designee will schedule a hearing. The Member and the BH-MCO will receive notification of the hearing date by letter at least 10 Days before the hearing date, or a shorter time if requested by the Member. The letter will outline the type of hearing, the location of the hearing (if applicable), and the date and time of the hearing.

h. The BH-MCO is a party to the hearing and must be present. The BH-MCO, which may be represented by an attorney, must be prepared to explain and defend the issue on appeal. The Bureau of Hearings and Appeals' decision is based solely on the evidence presented at the hearing. The absences of the BH-MCO from the hearing will not be reason to postpone the hearing.

i. The BH-MCO must provide Members, at no cost, with records, reports, and documents relevant to the subject of the Fair Hearing.

j. The Bureau of Hearings and Appeals will issue an adjudication within 90 Days of the date the Member filed the first level Complaint or the Grievance with the BH-MCO, not including the number of

Days before the Member requested the Fair Hearing. If the Bureau of Hearings and Appeals fails to issue an adjudication within 90 Days of receipt of the request for the Fair Hearing, the BH-MCO must comply with the requirements at 55 Pa. Code § 275.4 regarding the provision of interim assistance upon the request for such by the Member. When the Member is responsible for delaying the hearing process, the time limit by which the Bureau of Hearings and Appeals must issue the adjudication prior to interim assistance being afforded will be extended by the length of the delay attributed to the Member.

k. The Bureau of Hearings and Appeals' adjudication is binding on the BH-MCO unless reversed by the Secretary of Human Services. Either party may request reconsideration from the Secretary within 15 Days from the date of the adjudication. Only the Member may appeal to Commonwealth Court within 30 Days from the date of the adjudication or from the date of the Secretary's final order, if reconsideration was granted. The decisions of the Secretary and the Court are binding on the BH-MCO.

3. Expedited Fair Hearing Process

a. A Member or the Member's representative may file a request for an expedited Fair Hearing with the Department either orally or in writing.

b. A Member must exhaust the Complaint or Grievance process prior to filing a request for an expedited Fair Hearing.

c. The Bureau of Hearings and Appeals will conduct an expedited Fair Hearing if a Member or a Member's representative provides the Department with a signed written certification from the Member's Provider that the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Fair Hearing process or if the Provider provides testimony at the Fair Hearing which explains why using the usual time frame would place the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function in jeopardy

d. A Member who files a request for an expedited Fair Hearing that disputes a decision to discontinue, reduce, or change a service that the Member has been receiving must continue to receive the disputed service at the previously authorized level pending resolution of the Fair Hearing, if the request for an expedited Fair Hearing is hand delivered, faxed, or post-marked within one Day from the mail date on the written notice of decision if acute inpatient services are being

discontinued, reduced, or changed or within 10 Days from the mail date on the written notice of decision if any other services are being discontinued, reduced or changed If the request for an expedited Fair Hearing is not hand delivered or post-marked within one Day from the mail date on the written notice of decision if acute inpatient services are being discontinued, reduced, or changed or within 10 Days from the mail date on the written notice of decision if any other services are being discontinued, reduced or changed, services can be discontinued.

e. Upon the receipt of the request for an expedited Fair Hearing, the Bureau of Hearings and Appeals or the Department's designee will schedule a hearing.

f. The BH-MCO is a party to the hearing and must be present. The BH-MCO, which may be represented by an attorney, must be prepared to explain and defend the issue on appeal. The absence of the BH-MCO from the hearing will not be reason to postpone the hearing.

g. The BH-MCO must provide the Member, at no cost, with records, reports, and documents, relevant to the subject of the Fair Hearing.

h. The Bureau of Hearings and Appeals will issue an adjudication within 3 business days from receipt of the Member's oral or written request for expedited review.

i. The Bureau of Hearings and Appeals' adjudication is binding on the BH-MCO unless reversed by the Secretary of Human Services. Either party may request reconsideration from the Secretary within 15 Days from the date of the adjudication. Only the Member may appeal to Commonwealth Court within 30 Days from the date of adjudication or from the date of the Secretary's final order, if reconsideration was granted. The decisions of the Secretary and the Court are binding on the BH-MCO.

E. Provision of and Payment for Services Following Decision

1. If the BH-MCO, the Bureau of Hearings and Appeals, or the Secretary reverses a decision to deny, limit, or delay services that were not furnished during the Complaint, Grievance, or Fair Hearing process, the BH-MCO must authorize or provide the disputed service as expeditiously as the Member's health condition requires but no later than 72 hours from the date it receives notice that the decision was reversed. If the BH-MCO requests reconsideration, the BH-MCO must authorize or provide the disputed service or item pending reconsideration unless the BH-MCO

requests a stay of the Bureau of Hearings and Appeals' decision and the stay is granted.

2. If the BH-MCO, the Bureau of Hearings and Appeals, or the Secretary reverses a decision to deny authorization of services, and the Member received the disputed services during the Complaint, Grievance, or Fair Hearing process, the BH-MCO must pay for those services that the Member received.

3. If the Bureau of Hearing and Appeals affirms a decision to deny authorization of services and the Member did not request reconsideration from the Secretary within 10 Days from the date of the adjudication or the Secretary affirms a decision to deny authorization of services, and the Member received the disputed services during the Complaint, Grievance, or Fair Hearing process, the services can be discontinued.

4. If a Member requests both an external review and a Fair Hearing, and the decisions rendered as a result of both the external review and Fair Hearing are in conflict with one another, the BH-MCO must abide by the decision most favorable to the Member. In the event of a dispute or uncertainty regarding which decision is most favorable to the Member, the BH-MCO must submit the matter to OMHSAS' Quality Assurance/Risk Management Coordinator for review and resolution.

F. Quality Review of Complaints and Grievances

1. The Primary Contractor is responsible for monitoring the Complaint and Grievance processes for compliance with this Appendix and the Program Evaluation Performance Summary (PEPS). The monitoring must include a review of the following:

   a. The Member Handbook to confirm that it describes the Complaint, Grievance, and Fair Hearing processes in accurate and easy to understand language;
   b. Complaint and Grievance decisions to determine if decisions were made within required time frames;
   c. Written notification letters;
   d. Investigations of the Complaint;
   e. When reviews are scheduled to ensure that the reviews are held in a time and place that is convenient for the Member;
   f. Complaint and Grievance trainings; and
   g. The adherence of members of the review committee to the requirements of this Appendix.

2. The Primary Contractor and BH-MCO must provide the Department with evidence of the BH-MCO's compliance with this Appendix. This evidence

must include the percentage of Complaint and Grievance cases, by level, reviewed by the Primary Contractor.

3. If as a result of the Primary Contractor's monitoring of the Complaint and Grievance processes for compliance with this Appendix and PEPS, the Primary Contractor discovers that corrective plans of action and/or follow up activities are needed, the BH-MCO must implement the corrective plans of action and/or follow up activities.

4. When reporting on Complaint decisions, the Primary Contractor must include the following classifications:

    a. Substantiated: The available information supported the Member's Complaint and a corrective plan of action is needed.
    b. Unsubstantiated: The available information did not support the Member's Complaint.