THE APPEALS PROCESS IN MEDICAID MANAGED CARE, FAMILY HEALTH PLUS AND CHILD HEALTH PLUS B PLANS

Why does it matter what type of problem I have with my Medicaid managed care plan?
You have many legal rights to challenge decisions by your plan, and a good chance of getting the care you need by doing so. However, the procedures are complicated, and have different rules and names depending on what the problem is. There are two major kinds of problems:

- **“Medical necessity” cases**: These involve decisions made by a medical professional that even though your health plan covers a certain type of medical care, you do not need it (or you don’t need more if you are already getting it).
- **Everything else**: These include any complaints you have about your plan or your provider, such as discrimination, lack of access to office and services, or poor quality of care. They also include any decisions by your plan not to give you services—regardless of whether they are medically necessary—because they are not covered by your plan, or you have not followed the rules in trying to get them.

Is it worth challenging decisions by my Medicaid managed care plan?
YES. Very few people appeal decisions made by their plans, but most of those who do appeal win more coverage. Always appeal any denial of coverage for care that you and your doctor think is necessary.

Can my Medicaid managed care plan punish my doctor or me for filing a complaint?
NO. Your health plan is definitely not permitted to penalize either you or your doctor for filing a complaint or appeal.

What are the major ways I can formally complain about my Medicaid managed care plan?
- **Utilization Review Appeal**: only for questions of “medical necessity”
- **Grievance**: for any issue other than “medical necessity”
- **External Appeal**: for questions of “medical necessity” or if your plan denies coverage because they say a service is experimental; can be used when you have been turned down at the Utilization Review Appeal stage.
- **Fair Hearing (Medicaid and Family Health Plus only; not for Child Health Plus B)**: for any type of problem, and can be requested at the same time as the other kinds of complaints/appeals are in process.
- **Discrimination complaint**: if your complaint involves failure to accommodate a disability, or any other form of discrimination (ethnic origin, age, etc.).

What is the difference between a complaint and an appeal?
In a **complaint**, you are bringing a problem to the attention of someone else, for the first time. You can complain informally or, more officially, “file a complaint” with your provider, your health plan, or a government agency like Medicaid.

An **appeal** is a request to someone who made a decision (one that you think is wrong) that they look at the decision again considering new information from you and/or your doctor, and make a new decision. When you make a **complaint**, and the agency you complain to decides not to do what you have asked them to do, you can usually **appeal** their decision one or more times.

When and how would I request a “utilization review”?
If you disagree with the type or amount of medical treatment your plan provides, you can ask for a “utilization review.” You or your doctor can ask the plan to review any decision about medical necessity.
or experimental services. If they don’t make a decision within a certain amount of time, or if they say no, you can ask for an appeal of the utilization review.

- From the time they receive all the information they need, the plan is allowed to take 3 business days to decide whether to approve care you haven’t received yet. If you are already getting care and want it continued, they can take only one day to decide after getting informational the information they need. If they are deciding whether to pay for care you received already, they can take up to 30 days to decide.
- If they turn down your request, they must tell you the reason in writing, and explain how you can appeal their decision. For decisions about treatment which you are still receiving, or have not yet received, they must not only send a letter, but also notify you and your doctor by telephone as soon as the decision is made.

**How can I appeal a decision on a utilization review?**

You can appeal by telephone or in writing within 45 business days after getting your plan’s decision.

- The plan will send you a letter within 15 days to let you know they have received your complaint. The letter will give the name and contact information for the person working on your complaint, and let you know if the plan needs any more information. You have the right to appear before an Appeals Committee.
- If your health would be in danger from a delay, you can appeal by telephone or by fax and the plan must call you with its decision within 2 business days. Otherwise, they have 60 days to give you a decision, including the reasons behind it. If you are still not satisfied, you can request an external review and (if you have Medicaid or Family Health Plus) a Fair Hearing.

**When and how would I file a “grievance”?**

You can file a grievance for any complaint that does not involve “medical necessity.” Your complaint can be made by telephone or in writing, and sent by fax, e-mail, or regular mail.

- The plan will send you a letter within 15 days to let you know they have received your complaint. The letter will give the name and contact information for the person working on your complaint, and let you know if the plan needs any more information.
- After the plan has all the information it needs, they will send you a letter with their decision and their reasons for it. The letter will also say how to appeal the decision and include any forms you need to do so. If your health would be in danger from a delay, the plan will call you with its decision within 2 business days, and send the letter in 3 business days. If your complaint is about a referral or about benefits, you will get the letter in 30 days; for all other complaints, the letter will come in 45 days.

**How can I appeal a decision on my grievance?**

To file an appeal, send a letter within 60 business days after getting your plan’s decision.

- The plan will send you a letter within 15 days to let you know they have received your complaint. The letter will give the name and contact information for the person working on your complaint, and let you know if the plan needs any more information. You have the right to appear before an Appeals Committee.
- If your health would be in danger from a delay, the plan will call you with its decision within 2 business days. Otherwise, they have 30 days to give you a decision, including the reasons behind it. If a plan makes a decision without contacting your doctor, he or she can ask for “reconsideration” without going through the appeal process. “Reconsideration” is supposed to take only 24 hours for a new decision.

This information is only for members of Medicaid managed care, Family Health Plus, and Child Health Plus B plans in New York. Commercial managed care plans may have different rules.
When and how would I request an “external appeal”?
If the plan will not cover a medical service your doctor asked for because they say it is not “medically necessary” or is experimental, you can ask New York State for an “external appeal.” You must already have been turned down at your plan’s first level of the utilization review appeal process.

- Within 45 days after you receive a “notice of final adverse determination” from your plan’s first level of appeal, fill out an external appeal application and send it to the State Department of Insurance. You and your doctors will have to give information about your medical problem. Applications are available from the Department of Insurance by calling 1-800-400-8882 or visiting their website: [www.ins.state.ny.us](http://www.ins.state.ny.us/extapp/extappqa.htm).
- Your appeal will be decided in 30-35 business days. You and the plan will be told the decision within two days after it is made. If your doctor says that a delay will cause serious harm to your health, you can file an “expedited appeal,” which must be decided in 3 days or less. The reviewer will tell you and your plan the decision right away by phone or fax. Later, a letter will be sent repeating the decision.

When and how would I request a “Fair Hearing”?
If you are covered by Medicaid managed care or by Family Health Plus, you have a fourth way to formally complain about your health plan: the Medicaid Fair Hearing process. (This cannot be used for Child Health Plus B beneficiaries.)

You can use a Fair Hearing to appeal any decision by your health plan that you think is wrong. You must request the Fair Hearing within 60 days of the date of the decision by your health plan. If you are requesting a Fair Hearing concerning services you are already receiving, ask for Aid Continuing within 10 days of the date on the notice from your health plan telling you these services are ending, so that you can continue to receive them until you get a decision on your hearing.

- You can ask for a Fair Hearing and an external appeal at the same time. If they result in opposite decisions, the Fair Hearing decision will overrule the external appeal decision.
- If you lose your Fair Hearing, you can appeal in New York State Supreme Court. You must file an appeal within 4 months of the date of your Fair Hearing decision. It is best to get a lawyer to help you with this kind of appeal.

What do I need to do for any kind of formal complaint or appeal?

- **Keep written notes for yourself:** Write down the names of people you speak to, the date that you talk to them, what they say they will do for you, and when they will do it.
- **Keep a paper copy of everything** you send to the health plan or government agency, and send papers by certified mail.
- **Get written explanations of decisions:** Whenever your plan makes a decision that you disagree with, call the member services department and request a written explanation of their reasons. If they send you an explanation that you don’t understand, call them and ask them to explain what it means in plain English, or whatever language you understand best.
- **Find out what the timing rules are for your complaint or appeal:** There are always deadlines in complaint procedures, for you and the health plan. If you wait too long to complain, you may miss your chance. If they take too long to answer, you may automatically win your case. Follow the timelines for submitting your appeal: submit it on time, and keep calling to find out the status.
- **Ask for a quick answer if you need it:** Sometimes you need an answer immediately, because health care has to be given right away, or is already being given and cannot be interrupted. Let
your plan know this, and ask them what you have to do to “expedite” your appeal. In many cases, you can get a decision in 2 business days.

- **Find out who is making decisions**: Ask your doctor or the member services department of your health plan who is deciding what to do about your request or complaint. You have a right to know the name of the person, their department, how to contact them, and whether or not they are a medical doctor.
- **Get your doctor to help you**: by writing a letter explaining why you need the care. If possible, have your doctor call the health plan’s medical director on your behalf.

What are some common reasons why my Medicaid managed care plan might have to change its mind after turning down my request for a service?

- **Pre-authorization denials** If you did not get pre-authorization for a service which requires it, the plan may refuse to pay for a service it would otherwise cover. It may also refuse to pay for follow-up visits for services that were not pre-authorized, even if you asked for approval for later visits. If you were physically or mentally unable to request pre-authorization, or couldn’t ask because of a special situation, the plan may reverse their decision and pay for the care.
- **Denials of care as experimental or investigational** Most health plans only pay for services that have been proven safe and effective, rejecting those they consider “experimental” or “investigational.” Your doctor may be able to show that a new service has been proven safe and effective, contrary to the plan’s belief.
- **“Cosmetic” services not covered**. Your plan may think the only purpose for a service is cosmetic, when your doctor can show that it is medically necessary.
- **“Late filing of claim”** Sometimes you and the doctor sent in your claim on time, but the plan made a mistake and took too long to process it. This is where it is helpful to have a receipt for certified mail.
- **“Lack of information”** If you and your doctor submitted the right medical information, make sure that it arrived at the right department in the health plan. Again, a certified mail receipt can help to show you sent the information.
- **“Not a covered benefit”** Sometimes your plan will make a mistake about what your contract covers, or the service you received is not described correctly in your doctor’s claim.
- **“Non-participating provider”** The health plan can make a mistake in typing in your doctor’s information and think that he or she is not in their network.

Who can help me challenge decisions by my health plan?

- **Your doctor** is your best ally. If your doctor does not recommend care, it will be harder to get the health plan to provide it. You may need to find another health professional to help you get care.
- **Friends and family** can come with you to hearings, help you gather information, and find other doctors and medical professionals to support your case.
- **An advocate from CIDNY** or another community organization can help communicate with your doctor, health plan, Medicaid, and other government agencies.
- **Any other professional** who knows you and your needs—other doctors, nurses, physical therapists, mental health professionals, social workers, caseworkers, teachers—can write a letter supporting your case and/or come with you to a hearing.
- **Government agencies** can take complaints and sometimes give advice. The state Attorney General has a Health Care Bureau that focuses on managed care complaints.
- **Lawyers** may be necessary, especially for an appeal of a Fair Hearing denial. You may be able to get legal advice or a lawyer from a legal services agency listed at the end of this fact sheet.
What kind of “reasonable accommodations” is a person with a disability entitled to in the appeals process?

It can be helpful to discuss your needs in advance with an expert in disability rights, such as an advocate from CIDNY or a lawyer from the New York Legal Assistance Group (NYLAG). They often know what is most commonly done to accommodate people with a particular disability. Typical accommodations are:

- American Sign Language interpreters for the deaf.
- Allowing you to bring a guide dog or other helper animal to hearings.
- Providing written case materials in Braille, large type or audiotape format for a person with a visual impairment.
- Holding hearings in an accessible location, meaning that you can get to the room, move around inside the room, and reach a usable bathroom in a reasonable amount of time from the room.
- Taking time and providing assistance for you to understand the terms of the discussion, during the hearing, especially if you have a cognitive impairment.
- Allowing breaks for eating, if you have diabetes.
- Scheduling hearings at a time of day when you can get accessible transportation to arrive on time.
- Having an advocate speak for a person with mental illness who cannot respond to questions directly.

When would I want to file a complaint of discrimination?

For people with disabilities, it can be helpful to file a discrimination complaint when your health care plan or provider is not making accommodations that you need, especially when they are not difficult to provide.

- If the only way you can get to the doctor’s office is Access-A-Ride, and they are late in bringing you to your appointment, your doctor cannot refuse to see you because you are late.
- If you need someone to help you dress and undress for your examination, someone from the doctor’s staff must help you.
- If you have a communication disability, such as blindness or deafness, or a cognitive disability, such as dyslexia or traumatic brain injury, you are entitled to have information presented to you in a way you can understand, remember and use.
- If you are too large to fit on a standard examination table, your plan must offer providers who have examination equipment that fits you.

To file a complaint about your plan or provider:

- New York State Department of Health, Office of Managed Care: 800-206-8125.
- New York State Commission on Quality of Care and Advocacy for Persons with Disabilities: 800-624-4143 (voice/TTY).

For assistance in preparing for an appeal:

- CIDNY’s Managed Care Consumer Assistance Program: 212-674-2300 (voice); 212-674-5619 (TTY).
- Legal Aid Society’s Health Care Hotline: 212-577-3575.
- New York Legal Assistance Group’s General Legal Services Unit: 212-613-5000, option 3.
- New York State Commission on Quality of Care and Advocacy for Persons with Disabilities: 800-624-4143 (voice/TTY)

To file a complaint about discrimination against people with disabilities

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• U.S. Department of Justice, Civil Rights Division: 800-514-0301 (voice); 800-514-0383 (TTY)
• New York City Commission on Human Rights: 212-306-7500 (voice); 212-306-7686 (TTY)