Jason Neufeld, Esq

Grievance / Internal Appeal Notes

I would like to thank the Florida Health Justice Project for their unwavering dedication to advocating for expanding health care access for vulnerable Floridians and for their permission to reprint some of the materials contained herein. You can learn more about their mission and efforts here: https://www.floridahealthjustice.org/

What is the difference between a grievance and an appeal?

Each plan is required to have a grievance and appeal process that complies with the federal Medicaid managed care regulations. The major difference between a grievance and an appeal is that an **internal appeal should be filed when there is an "adverse benefit determination (ABD),"** while a grievance would be filed if the enrollee is unhappy with the plan. For example, an enrollee could file a grievance if he or she was treated rudely.[1]

What is an Adverse Benefit Determination (ABD)? [2]

Adverse benefit determinations include:

- Denial, reduction, suspension, termination or delay of a previously authorized service;
- Denial or limited authorization of a requested service determination based on "requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit" (e.g., 2 hours of speech therapy/week for 6 months were prescribed, and the plan approved only 1 hour/week for one month);
- Failure to provide service in a timely manner as defined by the state;
- Failure of plan to act within required timeframes for resolution of grievance or appeal; and
- Denial in whole or in part of payment for a service of a request to dispute cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities. In addition, ABDs include the denial of an enrollee's request for an out-of-network service if the enrollee lives in a rural area and there is only one plan.

What is the time standard for filing a grievance or appeal?

A grievance can be filed at any time, and an appeal can be filed within 60 calendar days from the date of the ABD. Resolution must be had within 30 days from the day the health plan receives the appeal (or resolved within 90 days if a grievance).

[1] 42 C.F.R. § 438.400(b); Fla. Admin. Code R. 59G-1.100(2)(b) (definition of "grievance")

[2] 42 C.F.R. § 438.400(b); Fla. Admin. Code R. 59G-1.100(2)(b) (definition of "adverse benefit determination")

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Is there a statutory right to a fair hearing?

Under the federal Medicaid statute, Medicaid beneficiaries have the right to a fair hearing if a claim for medical assistance is denied or not acted on with reasonable promptness.

You have 120 days after the managed care plan sends notice that they are upholding the ABD (i.e. after the internal appeal is decided) to file for a fair hearing.[3]

Is there a requirement that the plan appeal process be exhausted before filing a fair hearing?

Enrollees must first exhaust the managed care plan's internal appeal process. Thus, a fair hearing can only be requested after notice that the adverse benefit determination has been upheld in the Medicaid plan appeal process.

Filing and handling a grievance or appeal with plan.

Grievances or appeals can be filed orally or in writing. The best practice is to file in writing with the plan.

The plan must provide written notice acknowledging the receipt of the grievance or appeal within five business days.

ALWAYS REQUEST A COPY OF CLIENT'S "CARE PLAN" (CLIENT MAY WISH TO REQUEST THIS DIRECTLY FROM THEIR MANAGED CARE PLAN'S CASE MANAGER).

WITH INTERNAL APPEAL, INCLUDE EVIDENCE. E.G. IF HOURS APPROVED ARE INSUFFICIENT, GET A TREATING DOCTOR TO WRITE A LETTER BASED ON MEDICAL NECESSITY. SEE SAMPLE LETTER BELOW.

Where to file fair hearings and who are the parties?

Medicaid appeals related to services for persons enrolled in a managed care plan are directed to AHCA. See Fla. Stat. § 409.285(2).

You can ask for a Fair Hearing by calling the Medicaid Helpline at 1-877-254-1055 (TDD 1-866-467-4970), or in writing by:

- Email – MedicaidHearingUnit@ahca.myflorida.com

[3] FAC 59G-1.100 https://ahca.myflorida.com/content/download/5924/file/59G-1.100_Medicaid_Fair_Hearings.pdf

- Fax – (239) 338-2642
- Mail – Agency for Health Care Administration
  Medicaid Hearing Unit
  P.O. Box 60127
  Ft. Myers, Florida 33906

When asking for a Fair Hearing, please include your name, phone number, mailing address, and email (if available). Please provide the name of the Medicaid recipient, their Medicaid ID number and some details about the services that were denied, reduced or stopped. You can also submit any notices related to the Hearing Request. It is also important to tell us your preferred method of contact: mail or email.

https://ahca.myflorida.com/medicaid/florida-medicaid-complaints/medicaid-fair-hearings

How to ensure continuation of benefits pending appeal and state fair hearing if the ABD is a termination, reduction, or suspension of current services?

If an adverse action is a denial, termination, suspension, or reduction of a previously authorized medical service, the enrollee has the right to receive continued coverage of the medical service pending the outcome of an appeal and fair hearing. The importance of the right to "aid pending" for low-income individuals was recognized by the United States Supreme Court in the seminal case of Goldberg v. Kelly, 397 U.S. 254, 261 (1970). Accordingly, services must be continued if all the following occur:

- Appeal involves termination, suspension, or reduction of previously authorized service
- Services ordered by authorized provider
- Period covered by original authorization not expired
- Enrollee timely files for continued benefits on or before ten calendar days of the plan's notice of adverse benefit determination.

FILE A COMPLAINT

(just do it so AHCA is aware)

Enrollees who are having trouble accessing services or who are encountering other problems with their managed care plan can file an official complaint. It is important that AHCA be made aware of these issues. It is also important that advocates provide assistance and documentation. and individual complaints can often be resolved through this process.

https://ahca.myflorida.com/medicaid/florida-medicaid-complaints/florida-medicaid-recipients-how-to-file-a-complaint

If you are enrolled with a Statewide Medicaid Managed Care Plan, you should first contact your plan

for help. The phone number for your plan is printed on your Plan ID Card. You can also find the phone number for your plan on the General Plan Contact Information

1. You may submit a complaint using your Member Portal account. The Member Portal also allows you to select and change your plan, check on the status of a complaint, and receive important updates. If you do not have a Member Portal account, we encourage you to create one by visiting the Member Portal registration page .
2. To submit a complaint online without a Member Portal account you may use the Florida Medicaid Complaint Form .
3. To submit a complaint by phone, please call the Medicaid Helpline at 1-877-254-1055 (TDD 1-866-467-4970). Staff are available to assist you Monday through Friday, 8am-5pm EST.

Already submitted a complaint? Find your Complaint Status here.

What are enrollee rights in appeals?

Enrollees have the right to:

- make legal and factual arguments in person and in writing.[4]
- present evidence, including new evidence not available at time of decision.[5]
- review medical records and case files free of charge and in advance of the hearing.

Right to full discovery (request for production of documents, requests for admission, depositions.

IF REQUESTING ADDITIONAL BENEFITS, HAVE SUPPORTING DOCUMENTS TO INDICATE: WHY ARE THEY REQUESTING ADDITIONAL HOURS (MAJOR CHANGE IN HEALTH?, NOT ENOUGH APPROVED INITIALLY?).

GET LETTER FROM DOCTOR EXPLAINING WHY ADDITIONAL HOURS. NOT JUST FOR HOMEMAKER SERVICES (ALSO COMPANION AND RESPITE CARE). ONCE SUBMITTED TO CASE MANAGER. MY EXPERIENCE IS THAT YOU ARE LIKELY TO GET AT LEAST AN ADDITIONAL FEW HOURS.

MAKE SURE YOU GET A NEW DESIGNATED REP FORM SIGNED WITH COMPLETE AND SIGNED REQUEST FOR APPEAL. SUBMIT WITH INTERNAL APPEAL DOCUMENTS. ALSO SUBMIT WHAT THE NEEDS ARE WITH TWO LETTERS FROM A DOCTOR (DIFFERENT DOCTORS, MAYBE PRIMARY AND SPECIALIST OR HOSPICE DOCTOR).

HAVE CLIENT SUBMIT A LETTER EXPLAINING WHAT THEY ARE GOING THROUGH. THEN SUBMIT MEDICAL RECORDS, PHYSICIAN NOTES, HOSPICE PAPERWORK, LAB REPORTS.

[4] 42 C.F.R. § 438.406(b)(4)

[5] 42 C.F.R. § 438.406(b)(5)

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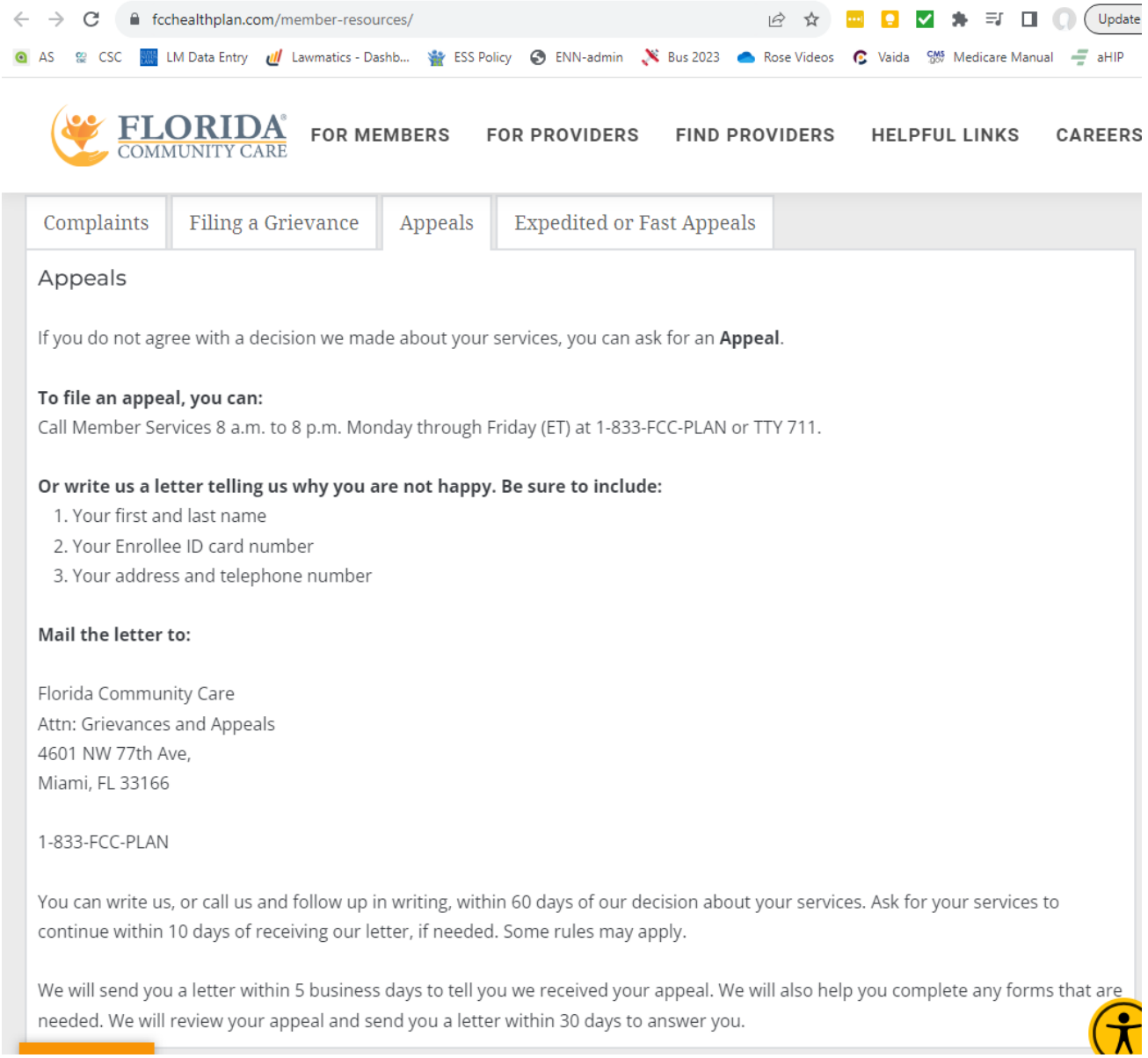
IN DOCTOR'S LETTER OF EXPLANATION: SEPARATE THE PATIENT'S AT-HOME NEEDS BY DAY: MON, TUES, WED, THUS, FRI, SAT, SUN (EXPLAIN WHAT NEEDS ARE PER DAY, WHAT HOURS AND SERVICES PATIENT NEEDS TO REMAIN SAFELY AT HOME AND WHY THEY ARE "MEDICALLY NECESSARY." ALSO EXPLAIN CAREGIVERS NEEDS, PATIENT NEEDS, ETC...).

SAMPLE INTERNAL APPEALS CONTACT INFO FOR FCC AND HUMANA
(very easy to google)

Florida Community Care: https://fcchealthplan.com/member-resources/



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EXAMPLE #2: Humana
(copied and pasted from their website with their actual AOR form)

https://www.humana.com/medicaid/florida-medicaid/member-support/grievance-or-appeal

Your appeal and grievance rights

As a Humana Healthy Horizons in Florida member, you can **appeal** a decision that we make about your healthcare or share a **grievance** you have with any aspect of your healthcare. We want to hear about this from you and see how we can help.

Appeals

An **appeal** is a request for us to reconsider a decision we make. For example:

- Your doctor may ask us for permission for you to have a certain procedure
- Our medical director reviews the request and decides that we cannot give permission (called an **Adverse Benefit Determination**)
- **Get answers to frequently asked questions about how we notify you of an Adverse Benefit Determination, PDF opens new window**
- We send this information to your provider and/or to you
- You and/or your provider disagree with our decision
- You and/or your provider file an appeal

You must file an **appeal** orally or in writing within 60 calendar days from the date of our decision. An **appeal** may take up to 30 days to process.

Grievances

A **grievance** is a formal complaint or dispute expressing dissatisfaction with any aspect of the operations, activities or behavior of Humana or its providers. For example:

- You call Customer Care and feel your wait time is longer than you want to wait.
- You visit your doctor and are unsatisfied about an aspect of your visit.
- You file a grievance with us to tell us about your experience.

You must file a **grievance** orally or in writing. You can file a **grievance** at any time after the experience about which you are dissatisfied. A **grievance** may take up to 90 days to process.

You can find more information about appeals and grievances in your **Member Handbook**.

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If you need an expedited appeal or grievance process, call us at **888-259-6779 (TTY: 711)**, Monday – Friday, 8 a.m. – 8 p.m., Eastern time.

Filing a grievance or appeal Online

Use our **online form**[6], opens new window, to file a grievance or appeal. When filling out the form, please provide as much information as possible.

You can use this form to:

- Submit a grievance and tell us how you are dissatisfied with your experience.
- File an appeal for a denied medical service, medical device, and/or prescription medication

After you file a grievance or appeal with our online form:

- You will get a confirmation email with details of your submission.

You can get information about the status of any grievance or appeal you submit through our form by:

- Calling the number on the back of your Member ID card to check the status of a grievance.
- Using our **online appeal tracker, opens new window** to check the status of a medical appeal

In writing

To file a grievance or appeal, you must submit a grievance or appeal form to tell us what happened. Please provide as much information as you can so we can help resolve your issue.

Find grievance and appeal forms[7]

You will need these things to get started:

- Your name, member ID, telephone number and address

[6] https://resolutions.humana.com/grievances-appeals-forms/file-a-report
[7] https://www.humana.com/medicaid/florida-medicaid/member-support/documents-forms

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- A completed **Appointment of Representative (AOR) form**, if you are submitting a complaint or appeal on behalf of a Humana member, or another type of representative form (see below section for more information)
- Your service or claim number
- Your provider name
- The date of your service
- The reason you're submitting the appeal or complaint and what you want to happen
- Any supporting documentation, like receipts for services, medical records, or a letter from your provider that you want to include

Send your completed grievance and appeal form to:

Humana Healthy Horizons in Florida
P.O. Box 14546
Lexington, KY 40512-4546
Attn: Grievance & Appeals Department

You will get a letter from us within 5 business days after we get your appeal or complaint.

By phone: Call Customer Care at 800-477-6931 (TTY: 711)**,** Monday – Friday, from 8 a.m. – 8 p.m., Eastern time.

Find grievance and appeal forms
Filing on behalf of another member
If you are filing an appeal or grievance on behalf of a member (other than yourself), you need an **Appointment of Representative (AOR) form** on file with Humana so that you are authorized to work with Humana on the member's behalf.

You also may use other appropriate legal documentation that shows your authorized representative status (such as power of attorney)

AOR forms are active for one year from the date the form is signed by both the member and the representative, unless revoked.

Download, print, and complete the AOR form, found on the Document and Forms page; sign the form; and return it to us.

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Humana

Grievance and Appeal Office

APPOINTMENT OF REPRESENTATIVE FORM

Member Name _____ **Member ID Number** _____

Reference Number _____

The member **will complete this section.**

I choose _____ to advocate for me.
(The legal guardian or representative name goes here.)

- ✓ My legal guardian or representative can discuss everything about my medical services.
- ✓ My legal guardian or representative can have all the documents directly related to my case.

_____ **The member signs here.** _____ **Date**

Address: _____ Phone Number: _____

_____

_____

The legal guardian or representative **will complete this section.**

I am the _____ of _____.
(spouse, child, friend, lawyer, or other) (The member's name goes here.)

I agree to advocate or represent for _____.
(The member's name goes here.)

_____ **The** legal guardian or representative **needs to sign here.** _____ **Date**

Address: _____ Phone Number: _____

_____

_____

GHHJ3ZVES – Medicaid AOR Form 7.0.1.23

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MEDICAL CENTER

Internal Medicine

2504 Biscayne Boulevard | Miami, FL 33137
Phone: 786 598-4560 | Fax: 786-598-4561

[redacted] MD
MOUNT SINAI MIDTOWN
MOUNT SINAI INTERNAL MEDICINE MIDTOWN
2504 BISCAYNE BLVD
MIAMI FL 33137-4518
Dept: 786-598-4560
Dept Fax: 786-598-4561

5/26/2022

Patient: [redacted]
Date of Birth:
Date of Visit:

To Whom It May Concern:

I am writing this letter on behalf of my patient [redacted] in order to appeal for her to get care in her home 7 days a week.

[redacted] has been a patient of mine since 2014. She suffers from dementia with behavioral disturbance, anxiety, and depression. She needs constant supervision and support as she is at high risk for fall due to poor balance, chronic neuropathy, and osteoarthritis of both hips and knees. She needs constant supervision and support as she also has been noted to wander; most recently has been getting up and getting dressed at 1 am and 3 am. We try not to give her sedating medications due to high risk for fall and significantly increased risk of fracture due to osteoporosis.

[redacted] suffers from atrial fibrillation and coronary artery disease and is under the care of a cardiologist. Due to dementia, she is unable to self-medicate and check her blood pressure. She had been hospitalized several times in the past due to hypertensive emergency and therefore crucial that her blood pressure is monitored regularly.

All her activities of daily living require full assistance. She is not able to bathe or cook for herself. She cannot be left alone. It is against her wishes to be in a nursing home and she is not fit to live without support independently. It is in my professional opinion that she receive home attendant care 7 days a week. Her son [redacted] is very involved in her care and is concerned of his mother's living situation.

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[redacted] is not able to take care of herself in an independent living situation if she does not have help in her home full time. Without this support, she would not only decline but this could also lead to her demise.

Thank you for your attention to this matter.

If you have any questions or concerns, please do not hesitate to call.

Sincerely,

[redacted] MD
Internal Medicine