GRIEVANCE AND APPEAL PROCESS
WELLPOINT WASHINGTON, INC.

Who do I call for help at my health plan?

If you need help, call **833-731-2167** or for **TTD/TTY**, call **711**. We will keep your information private. If you do not speak English, we can help. If you need any information in a language other than English, call us at **877-644-4613 (TDD/TTY: 866-862-9380)**. We will provide language assistance at no cost to you.

To file a grievance or appeal, contact:

ATTN: Quality Management Dept.
Wellpoint Washington, Inc.
705 5th Ave. S., Ste. 300
Seattle, WA 98104

Web: wellpoint.com/wa/medicaid
Phone: 833-731-2167 (TTY 711)
Fax: 855-292-3770

GRIEVANCE PROCESS: How do I report a complaint?

You or your authorized representative have the right to file a complaint. This is called a grievance. We will help you file a grievance. Grievances are complaints about:

- The way you were treated.
- The quality of care or services you received.
- Problems getting care.
- Billing issues.
- Attitude and Service.

If you need help filing a grievance, call **833-731-2167 (TTY 711)**. We will let you know we received your grievance within two business days. We will try to take care of your grievance right away. We will investigate and resolve your grievance within 45 calendar days and tell you how it was resolved. You have the right to appeal an adverse decision (if any made) by us.

If you are a client with behavioral health needs, the Ombuds is someone that can help you with questions and filing grievances. If you need information about how to contact your local Ombuds, call **833-731-2167 (TTY 711)** or go to **wellpoint.com/wa/medicaid**.

STANDARD AND EXPEDITED APPEAL PROCESS: How do I request the review of a denied service?

An appeal is a request to review a denied service or referral. You can appeal our decision if a service was denied, reduced, or ended early. Below are the steps in the appeal process:

STEP 1: Wellpoint Appeal
STEP 2: State Administrative Hearing
STEP 3: Independent Review

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STEP 4: Health Care Authority (HCA) Board of Appeals Review Judge

Continuation of services during the appeal process
If you want to keep getting previously approved services while we review your appeal, you must file your appeal within 10 calendar days of the date on your denial letter. If the final decision in the appeal process agrees with our decision, you may need to pay for services you received during the appeal process.

STEP 1 – Wellpoint Standard and Expedited Appeal: How do I ask for an appeal?
You or your authorized representative have the right to file an appeal. You or your authorized representative have 60 calendar days after the date of the Wellpoint denial letter to ask for an appeal. You or your representative may request an appeal over the phone, in person, or in writing. You have the right and the opportunity to submit written comments, documents, or other additional information relevant to the appeal. Additional information (including comments and/or documents) to support your appeal may be submitted over the phone, in writing, or in person. Within five calendar days, we will let you know in writing that we got your standard appeal, or 72 hours for an expedited appeal. We will notify you and/or your authorized representative if there is a delay and resolve appeals as expeditiously as your health requires. Wellpoint can help you file your appeal. If you need help filing an appeal, call **833-731-2167 (TTY 711).**

STEP 1: Ask for an appeal with Wellpoint
Phone: **833-731-2167 (TTY 711)**
Fax: **844-759-5953**
Address: **ATTN: Quality Management Dept.**
Wellpoint Washington, Inc.
705 5th Ave. S., Ste. 300
Seattle, WA 98104

You have the right to receive assistance from Ombuds for filing the appeal. You may choose someone, including a lawyer or provider, to represent you and act on your behalf. You must sign a consent form allowing this person to represent you. Wellpoint does not cover any fees or payments to your representatives. That is your responsibility.

Before or during the appeal, you or your representative may request copies of all the documents in this appeal file, and the guidelines or benefit provisions used to make the decision. These will be sent to you free of charge. Wellpoint will send you our

decision in writing within 14 calendar days, unless we tell you we need more time. Our review will not take longer than 28 calendar days. We will keep your appeal private.

If you or your provider want a fast decision because your health is at risk, call **833-731-2167 (TTY 711)** for a quick review (called "expedited" review) of the denial. You may ask for a quick review if your physical or mental health is at serious risk or it involves a mental health drug authorization. You may file an expedited appeal either orally or in writing. Wellpoint will contact you with our decision within 72 hours of getting your request for an expedited review.

If you ask for an expedited appeal, but Wellpoint decides your health is not at risk, we will follow the regular appeal timeframe. We will send you a letter telling you the decision and the reason for the change within two calendar days of your appeal request.

The expedited timeframe may be extended up to 14 calendar days if additional information to process your appeal is needed, and the delay is in your best interest. If Wellpoint extends the timeframe, we will send you a letter within two calendar days of your appeal request. We will tell you why the extension is needed. You can also ask for an extension.

STEP 2 – State Administrative Hearing: How do I ask for a legal review?
If you disagree with the Wellpoint appeal decision, you can ask for a State Administrative Hearing. You must complete the Wellpoint appeal process before you can have a hearing. You must ask for a hearing within 120 calendar days of the date on the appeal decision letter stating the denial was upheld. When you ask for a hearing, you need to say what service was denied, when it was denied, and the reason it was denied. Your provider may not ask for a hearing on your behalf. You may ask for a quick decision if your health is at risk.

STEP 2: Ask for a State Administrative Hearing
Contact the Office of Administrative Hearings (1OAH)
Phone: **800-583-8271**
Address: P.O. Box 42489, Olympia, WA 98504-2489

You may consult with a lawyer or have another person represent you at the hearing. If you need help finding a lawyer, check with the nearest Legal Services Office or call the NW Justice CLEAR line at **888-201-1014** or visit their website at **nwjustice.org**.

You may ask for a quick decision if your health is at risk. A judge will make a decision within four working days after receiving the request. If the judge decides your health is not a risk, OAH will call you and send you a letter within four working days of the request. Your hearing will change to the standard timeframe.

STEP 3 – Independent Review: How do I ask for an Independent Review?
An Independent Review is a review by a doctor or specialist who does not work for Wellpoint. If you do not agree with the decision from the State Administrative Hearing, you can ask for an Independent Review within 21 calendar days of the hearing decision or you may go directly to Step 4. Call **833-731-2167 (TTY 711)** for help. You may ask for a quick decision if your health is at risk. Any extra information you want us to look at must be given to us within five working days of asking for the Independent Review. If you ask for this review, your case will be sent to an Independent Review Organization (IRO) within three working days. You do not have to pay for this review. Wellpoint will let you know the decision.

STEP 3: Ask for an Independent Review
Contact Wellpoint
Phone: **833-731-2167 (TTY 711)**
Fax: **844-759-5953**
Address: **ATTN: Quality Management Dept.**
Wellpoint Washington, Inc.
705 5th Ave. S., Ste. 300
Seattle, WA 98104

STEP 4 – Health Care Authority (HCA) Board of Appeals: How do I ask for another legal review?
You can ask for a final review of your case by the HCA Board of Appeals Review Judge. You must ask for this within 21 calendar days after the IRO decision is mailed. The decision of the HCA Board of Appeals is final.

STEP 4: Ask for a review by the HCA Board of Appeals
Phone: **360-725-0910**; toll-free: **844-728-5212**
Fax: **360-507-9018**
Address: P.O. Box 42700, Olympia, WA 98504-2700

OTHER INFORMATION
Billed for services: If you get a bill for healthcare services, call **833-731-2167 (TTY 711)**.

Second Opinion: At any time, you can get a second opinion about your healthcare or condition. Call **833-731-2167 (TTY 711)** to find out how to get a second opinion.

Children under 21: The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive healthcare services for children under age 21 who are covered by Medicaid. Managed Care Organizations (MCO's) are required to provide any additional healthcare services that are coverable under the Federal Medicaid program and found to be medically necessary to treat, correct, or reduce illnesses and conditions that are discovered. When a medically necessary covered service is denied, appeal rights will be provided. For children under the age of 21, the Exception to Rule (ETR) process does not apply.

Non-covered benefit

Exception to Rule: You or your provider may ask Wellpoint to approve a service that is not a covered benefit. For adults, this is called an Exception to Rule (ETR).

- It must be asked for before you get the service.
- To be approved, your provider must give us documentation that your condition is so different from most people.
- No other covered, less costly service will meet your need.
- The request must meet the rules in Washington Administrative Code (WAC) 182-501-0160 for approval.

ETR decisions are final and cannot be appealed.

Appeal: You may ask for an appeal, State Administrative Hearing, and then Independent Review to make sure we correctly determined the service is not covered. You can ask for an appeal at the same you or your provider asks for an Exception to Rule.

Limited Benefit:

Limitation Extension: Your provider may ask Wellpoint to approve more services for you than your benefit package allows. It may be more in scope, number, length of time, or how often a service is provided. An example is more adult physical therapy visits than the 12 visits the benefit allows. This is called a Limitation Extension (LE). To be approved, it must meet the rules in Washington Administrative Code (WAC) 182-501-0169:

- It must be asked for before you get more of the service.
- Your condition must show it is improving due to the services you have already received.

- Your condition must show it will likely continue to improve with more services, and that it will likely worsen without continued services.

You can ask for an appeal at the same time as your provider asks for a Limitation Extension.

Funding for some services is limited by available money: If you receive services that are paid for by Medicaid dollars, you have the right to appeal a decision that stops or limits those services. Some services are paid for with State-only or Federal block grant dollars. If the State-Only or block grant money runs out, we cannot approve the service for you even if we agree the services are needed. There is no appeal process if a service is ended due to State-Only or block grant money running out. You will be notified if this situation applies to you.