

COMPLAINTS, GRIEVANCES & APPEALS

Section 7

Medicaid Family Health Plus Child Health Plus

Checking Our Decisions: Utilization Review

The Plan has established utilization review teams to ensure its resources are sufficient to meet member needs. Doctors and nurses are on the Utilization Review Board. Their job is to be sure the treatment given is medically needed and right for the condition at hand. They do this by checking the member's treatment plan against medically acceptable standards. Utilization Review will occur whenever judgment about medical necessity or experimental services are made.

The provider, a member, or the member's designee can make a request or review our decision about a specific treatment plan. Our failure to make a timely decision has the same effect as a denial. Therefore, if we don't give you or the member a decision in the allowed time, you, the member, or the member's designee can ask for an appeal.

For **Medicaid/FHP** The Plan must send notice of denial on the date review timeframes expire.

We will review past care (retrospective review), care that the member is seeking (prior approvals or prospective review) and care that the member is now getting and wants to continue to get more of (concurrent review). Just call Member Services at **(800) 288-5441** and ask for Utilization Review.

The following treatments or services must be approved before the member receives them:

- All specialist visits by a participating provider require authorization from the member's Primary Care Physician (PCP);
- Surgical procedures, inpatient services, specialty services by non-participating providers;
- Some tests require prior authorization by the member's PCP and the WellCare Medical Management department;

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- Experimental or investigational health care services requested by the member.

To get approval for these treatments or services, the member must:

- Consult with his or her PCP. After assessing the member's medical needs, his or her PCP will take care of getting the necessary authorizations for medical services.
- Three business days after we get the required information, we will decide the case. We will let you, the member, and/or the member's designee know by telephone and in writing.

If the member is receiving care or treatment that should be continued, or if additional services are needed, we will review the request and make our decision within one business day following receipt of the information required. We notify the provider, the member and/or the member's designee by telephone and in writing.

When an adverse determination is rendered without provider input, the provider has the right to reconsideration. The reconsideration shall occur within one (1) business day of receipt of the request and shall be conducted by the enrollee's health care provider and the clinical peer reviewer making the initial determination.

If we do not approve the member's request for services, we will tell him or her or the member's designee how you, the PCP, can appeal. Your options for asking for an appeal from us or the State will be explained.

Adverse determinations will be made by a clinical peer reviewer. A written notice of an adverse determination (initial adverse determination) will be sent to the member and provider and will include:

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- a) the reason for the determination including the clinical rationale, if any;
- b) instructions on how to initiate internal appeals (standard and expedited appeals) and eligibility for external appeals;
- c) notice of the availability, upon request of the enrollee or the enrollee's designee of the clinical review criteria relied upon to make such determination and;
- d) the notice will also specify what, if any, additional necessary information must be provided to or obtained by the Plan in order to render a decision.

For **Medicaid/FHP** notice will also include:

- e) description of Action to be taken;
- f) statement that the Plan will not retaliate or take discriminatory action if appeal is filed;
- g) process and timeframe for filing/reviewing appeals, including enrollee right to request expedited review;
- h) enrollee right to contact DOH with the 1-800 number, regarding their complaint;
- i) Fair Hearing notice including aid to continue rights and;
- j) statement that notice is available in other languages and formats for special needs and how to access these formats.

Appeal of Utilization Review Decisions

The enrollee or their designee, and for retrospective UR denials, the provider, may appeal an adverse determination on an expedited or standard appeal

