

## **Information**

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## **Appeals with the Managed Care Organizations**

If you receive a letter or are told that your services are cut or reduced, there are two appeal processes available to you:

1. One is to appeal with the Managed Care Organization (Amerigroup, Sunflower or United) where a different doctor than what has been connected to your case, reviews the case information and any new documentation you send and determines if s/he agrees with you or the original decision.
2. The second is a state fair hearing which is through the State of Kansas and is more formal, usually done on the phone through a conference call. There is no expense to this.
  - You can file the appeal with the Managed Care Organization (p1-2), then the State Fair Hearing (p2-4); or you can file both at the same time. See details for the processes below.
  - Check the date at the top of the page on the letter you received from the Managed Care Organization (Amerigroup, Sunflower, or United). You have 30 days (plus three if it was mailed) to turn in an appeal. You can call or write a letter just stating that you want to appeal the decision.
  - ***DO NOT WAIT. Turn it in right away. You can always dismiss the action if you decide not to go forward with the appeal. They do not make exceptions for missed deadlines.***

## **Managed Care Organization (MCO) Appeal Process**

- Members who have experienced an adverse action with an MCO (Amerigroup, Sunflower, or United) may appeal the decision through the MCO defined process within 30, plus 3 calendar days if mailed, of the adverse action. The MCO must inform the member of the action in a notice. This notice is called a “Notice of Action.” If an appeal is started with the MCO, the MCO must send a letter to the member within five business days acknowledging receipt of the appeal request. The MCO must resolve the appeal within 30 business days.
- **Note:** Members may request a State Fair Hearing (SFH) with the Office of Administrative Hearings (OAH) at the same time that they appeal an action taken by their MCO, or wait until after the MCO makes a final decision and then request a SFH if dissatisfied with the MCO’s final decision.
- Expedited Appeal – Members may file an expedited appeal when the member’s health requires a decision made as expeditiously as possible. MCOs must resolve an expedited appeal within three days. If more time is needed to gather additional information the MCO may request the additional time from KDHE/HCF. When an expedited appeal is requested, the member may not file a SFH concurrently.

### **How it works:**

- Check the date at the top of the page on the letter you received from the Managed Care Organization (Amerigroup, Sunflower, or United). You have 30 days (plus three if it was mailed) from the date at the top of the Notice of Action letter to turn in an appeal. You can call or write a letter just stating that you want to appeal the decision. ***DO NOT WAIT. Turn it in right away.*** ***You can always dismiss the action if you decide not to go forward with the appeal. They do not make exceptions for missed deadlines.***
- It would be best to lay out a summary of why you need the services they are not providing.
- It would also be very helpful to include documentation from the medical provider (doctor, neurologist, physical therapist, occupational therapist, etc.) who best knows you or the person you are helping and can explain briefly that they need the services and why. It would probably be helpful if the medical provider knows the specific things that are being denied listed in the letter and why. (If it is the plan of care hours being reduced, ask for the detail and note what services specifically so the provider can help explain why those services are needed based on your issues.)
- The deadline for this information is the same as the appeal deadline [30 days (plus three if it was mailed) from the date at the top of the Notice of Action letter].

## **Filing an Appeal**

Members should refer to their MCO's member handbook for information regarding how to request an appeal with their MCO. MCO member handbooks can be found on the MCO's website. MCO websites can be reached via the KanCare website at <http://www.kancare.ks.gov/>

### ▪ **Amerigroup appeal process**

([https://www.myamerigroup.com/Documents/KSKS\\_Member\\_Handbook\\_ENG.pdf](https://www.myamerigroup.com/Documents/KSKS_Member_Handbook_ENG.pdf))

There may be times when we say we will not pay for all or part of the care your provider recommended. If we do this, you (or your provider on your behalf and with your written consent) can appeal the decision.

An appeal is when you ask Amerigroup to look again at the care your provider asked for and we said we will not pay for. You must file for an appeal within 30 calendar days of when you get our first letter that says we will not pay for a service (an additional three days is allowed if the notice is mailed to you).

An appeal can be filed by:

- You
- A person helping you
- Your PCP or the provider taking care of you at the time

If you want your provider to file an appeal for you, he or she must have your written permission, unless you are asking for an expedited appeal.

You can appeal our decision in two ways:

- You can call Member Services at 1-800-600-4441 (TTY 711) or call us direct at 913-749-5955 (TTY 711) to file your appeal. Let us know if you want someone else to help you with the appeal process, such as a family member, friend or your provider.
- You can send us a letter to the address below – include information such as the care you are looking for and the people involved.

Central Appeals Processing  
Amerigroup Kansas, Inc.  
P.O. Box 62429  
Virginia Beach, VA 23466-2429

When we get your letter or appeal form, we will send you a letter within five business days. The letter will let you know we got your appeal.

After we receive your appeal:

- A different provider than the one who made the first decision will look at your appeal
- We will send you and your provider a letter with the answer to your appeal:
  1. Within three calendar days **if your appeal is expedited**
  2. Within 30 calendar days from when we get your appeal **if your appeal is not expedited**
- If more time is needed, we may extend the time period by 14 days

Our letter will:

- Let you and your provider know what we decide

- Tell you and your provider how to find out more about the decision and your rights to a fair hearing

### **Expedited appeals**

If we or your provider feels that taking the time for the standard appeals process, which is usually 30 calendar days, could seriously harm your life or your health, we will review your appeal quickly.

We will call you and let you know the answer to your expedited appeal. We will also send you a letter.

We will do this within three calendar days.

If we or your provider does not feel your appeal needs to be reviewed quickly, we will:

- Call you right away and
- Send you a letter within two calendar days to let you know that your appeal will be reviewed within 30 calendar days

If the decision on your expedited appeal upholds our first decision and we will not pay for the care your doctor asked for, we will call you and send you a letter. This letter will:

- Let you know how the decision was made
- Tell you about your rights to request an administrative hearing

### **If you receive an Explanation of Benefits (EOB), you do not need to call or do anything at that time, unless you or your provider wants to appeal the decision.**

A payment appeal is when you or your provider asks Amerigroup to look again at the service we said we would not pay for. You (or your provider on your behalf) must ask for a payment appeal within 30 days of receiving the EOB.

- If you are not responsible for payment of a service you received:
  1. You do not need to submit a payment appeal, but
  2. Your provider can submit a payment appeal for review
- If you are responsible for payment of a service you received (for example, if your doctor [with your written consent], asks for a service that is not medically needed, or your doctor tells you that a service is not covered, and you agree to pay for it before you get care) and you want to file a payment appeal, you can either:
  - Call Member Services or
  - Mail your request and medical information for the service to:

Central Appeals Processing  
Amerigroup Kansas, Inc.  
P.O. Box 61599  
Virginia Beach, VA 23466-2429

If you appeal by phone, you must also write us within 10 days, letting us know you want to appeal. If we do not receive your written request, your appeal will not be reviewed. If you want your provider to file an appeal for you, he or she must have your written permission.

### **State fair hearing**

You have the right to ask for a state fair hearing at any time, unless you want to file an expedited appeal. If you want to file an expedited appeal, you must go through the Amerigroup appeal process before you can ask for an expedited state fair hearing. In the case of a standard appeal, you must ask for a state fair hearing within 30 calendar days from the date you get the letter from Amerigroup that tells you the result of your appeal (an additional three days is allowed if the notice is mailed to you).

- **Sunflower appeal process** (<http://www.sunflowerstatehealth.com/for-members/member-resources/filing-a-complaint/>) Scroll down half a page to where the appeal part starts.

### **Medical Necessity Appeals**

An appeal is the request for review of a “Notice of Adverse Action.” A “Notice of Adverse Action” is the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or part of payment for a service excluding technical reasons; the failure to render a decision within the required timeframes; or the denial of a member’s request to exercise his/her right under 42 CFR 438.52(b)(2)(ii) to obtain services outside the Sunflower State network.

### **Standard Appeals**

A member, the member’s authorized representative or a provider acting on behalf of the member and with the member’s written consent may file an appeal either orally or in writing. If someone else is going to file a grievance for you, we must have your written permission for that person to file your grievance or appeal. This form is to assign your right to file a grievance or appeal to someone else. A doctor acting for you can file a grievance or appeal for you. Oral appeals must be confirmed in writing unless the request is for an expedited appeal. For standard authorization decisions, the appeal **must be filed within 30 calendar days** of the date on the Notice of Adverse Action. If the member is requesting continuation of services while the appeal is being reviewed, the appeal must be submitted within 10 calendar days of the Notice of Adverse Action.

A member may review the appeal case file and submit additional information to be considered as part of the appeal. Appeals will be reviewed by a healthcare professional with appropriate expertise in the subject of the appeal who was not involved in the original adverse determination.

The member or the member’s authorized representative may request an OAH State fair hearing at any time during the standard appeal process.

**Expedited appeals** may be filed when either Sunflower State or the member’s provider determines that the time expended in a standard resolution could seriously jeopardize the member’s life or health or ability to attain, maintain, or regain maximum function. Nopunitive action will be taken against a provider that requests an expedited resolution or supports a member’s appeal. In instances where the member’s request for an expedited appeal is denied, the appeal must be transferred to the timeframe for standard resolution of appeals. Decisions for expedited appeals are issued as expeditiously as the member’s health condition requires, not exceeding 72 hours from the initial receipt of the appeal. Sunflower State shall make reasonable efforts to provide the member with prompt verbal notice of any decisions that are not resolved wholly in favor of the member and shall follow-up in writing.

If the member does not agree with the resolution of an expedited appeal, the member or the member's authorized representative may request an OAH State fair hearing after exhausting the Plan expedited Appeal process..

There will be no retaliation against any member or representative for filing an appeal with Sunflower State.

Sunflower State Health Plan  
Appeals Department  
Four Pine Ridge Drive, Suite 200  
8325 Lenexa Drive  
Lenexa, KS 66214  
Phone: 1-877-644-4623  
Fax: 1-888-453-4755

- Authorized Representative Form  
(<http://www.sunflowerstatehealth.com/files/2012/06/grievance-representative-form.pdf>)

▪ **United Healthcare appeal process**

(<http://www.uhcommunityplan.com/content/dam/communityplan/plandocuments/handbook/en/KS-MemberHandbook.pdf>) (Go to page 36)

### **What Is an Appeal?**

An appeal is your request for a review of an Adverse Action. An Action is when we:

- Deny or limit a service you want;
- Reduce, suspend or terminate payment for a service you are getting;
- Fail to authorize a service in the required time; or
- Fail to respond to a grievance or appeal in the required time.

### **How Do I File an Appeal With UnitedHealthcare Community Plan?**

You or someone acting for you can file an appeal by calling or writing to UnitedHealthcare Community Plan. Call **1-877-542-9238 (TTY: 711)** or write to:

Grievance and Appeals  
P.O. Box 31364  
Salt Lake City, UT 84131-0364

You must file your appeal within 30 days from the date you get a Notice of Action. If you need help writing or filing an appeal, call Member Services at **1-877-542-9238 (TTY: 711)**

If someone else, such as your provider or family member is going to file for you, we need your written permission.

If you file an appeal, we will send you a letter within 5 business days telling you that we got your appeal.

We will review your appeal and send you a decision within 30 business days of getting the appeal. The letter will tell the reason for our decision. We will tell you what to do if you don't like the decision. This letter will be a Notice of Action. **HCBS Appeals**

If your appeal about HCBS services related to a reduction in services is denied, you will not have to repay UnitedHealthcare Community Plan for the service(s) continued during the appeal, unless fraud is present.

### **What Can I Do if I Need Immediate Care?**

If you or your doctor wants a fast decision because your health is at risk, call Member Services at **1-877-542-9238 (TTY: 711)** for an expedited review. UnitedHealthcare Community Plan will call you with our decision within 3 business days of getting your request for an expedited review. This time may be extended up to 14 days if you ask for this or if we show a need for more information and the delay is in your interest. Extensions are approved by the State of Kansas. You will receive written notice of the reason for the extension if it is approved.

You will get a letter with our decision and the reason for our decision. We will tell you what to do if you don't like the decision.

### **How Do I File a State Fair Hearing Request?**

If you disagree with an Action by UnitedHealthcare Community Plan, you or someone acting for you can file for a State Fair Hearing. You file with the Kansas Office of Administrative Hearings (OAH):

- You may file for a State Fair Hearing at the same time that you appeal to UnitedHealthcare Community Plan.
- Or you may file for a State Fair Hearing instead of appealing to UnitedHealthcare Community Plan.
- **Expedited** appeals are the exception, in this case, you must first go through the UnitedHealthcare Community Plan appeals process before requesting an expedited State Fair Hearing.

You must file for a State Fair Hearing within 30 days from the date you get a Notice of Action from UnitedHealthcare Community Plan. To request a State Fair Hearing, write to:

Office of Administrative Hearings 1020 S. Kansas Avenue Topeka, KS 66612

The State Fair Hearing request form can be found online at [www.oah.ks.gov/request.htm](http://www.oah.ks.gov/request.htm).

## **State Fair Hearing Process**

- Consumers dissatisfied with the MCO decision may make a written request for a State Fair Hearing to the Office of Administrative Hearing (OAH). This can be done at the same time the consumer is appealing a decision with the MCO, or after the MCO appeal process is complete. The request must be in writing within 30 days of the notice of the decision, with three additional days added to allow for delivery via mail (33 days).
- Members may request a State Fair Hearing (SFH) with the Office of Administrative Hearings (OAH) at the same time that they appeal an action taken by their MCO, or wait until after the MCO makes a final decision and then request a SFH if dissatisfied with the MCO's final decision.
- All hearing dates, resolutions, and notifications follow the timelines prescribed by the Office of Administrative Hearings. If neither the consumer nor the State request that the KDHE State Appeals Committee (SAC) review the decision, the decision becomes final thirty (30) days from the date of the order.

To file a State Fair Hearing, consumers should write a letter within 30 plus 3 calendar days if mailed of the adverse action. The letter should be sent to

Office of Administrative Hearings  
1020 S. Kansas Ave.  
Topeka, Kansas 66612

- Frequently Asked Questions (<http://www.oah.ks.gov/faqs-other.htm>)

### **How it works:**

- Check the date at the top of the page on the letter you received from the Managed Care Organization (Amerigroup, Sunflower, or United). You have 30 day (plus three if it was mailed) to turn in an appeal. You can call or write a letter just stating that you want to appeal the decision. ***DO NOT WAIT. Turn it in right away. You can always dismiss the action if you decide not to go forward with the appeal. They do not make exceptions for missed deadlines.*** Be sure to include your name, address, telephone number, and a copy of the notice of action you are appealing.
- The hearing is your chance to tell your side to an impartial Presiding Officer. Hearings are sometimes in Topeka, but usually done by telephone.
- You can request to review information relied upon by the agency in making the decision or taking the final action prior to the hearing.
- You may have an attorney represent you at the hearing. The attorney will be at your expense. If you hire an attorney, he or she must be licensed in the State of Kansas and enter their appearance on your behalf prior to the hearing. If you choose Kansas Legal Services or Disability Rights Center of Kansas, they do not charge a fee. (see contact information on page 10).
- It would be best to lay out a summary of why you need the services the organization is not providing in detail.
- It would also be very helpful to include documentation from the medical provider (doctor, neurologist, physical therapist, occupational therapist, etc.) who best knows you or the person you are helping and can explain briefly that they need the services ***and why***. It would probably

be helpful if the medical provider knows the specific things that are being denied listed in the letter and why. (If it is the plan of care hours being reduced, ask for the detail and note what services specifically so the provider can help explain why those services are needed based on your issues.) **Deadlines for this information will come by letter from the Office of Administrative Hearing. Be sure to read every letter from them thoroughly.**

- The State Fair Hearing is conducted by a Presiding Officer that is an administrative law judge, who is an impartial individual. He or she will enter an initial order based upon what is presented by the agency and by you at the hearing.
- The **most frequent mistake** made by individuals during the process of preparing is failing to read the notices and documents issued as part of the hearing process. Read everything you receive **very carefully**.

**Continuation of Services**: If an MCO's action reduces, suspends or terminates previously authorized HCBS Program services, those services will continue for 33 days from the mailing date of the Notice of Action to allow you time to file an MCO appeal or ask for a State Fair Hearing. If you ask for an MCO appeal or a State Fair Hearing, your current HCBS Program services will continue for the duration of your MCO appeal or the date of the decision in your State Fair Hearing.

If your MCO appeal is denied or the action taken by your MCO is approved by the Office of Administrative Hearings, you will **not** have to repay your MCO for service(s) provided during your MCO appeal and/or State Fair Hearing, unless fraud has occurred.

## **Legal Services**

### **The Disability Rights Center of Kansas**

The Disability Rights Center of Kansas (DRC) is a public interest legal advocacy agency empowered by federal law to advocate for the civil and legal rights of Kansans with disabilities. DRC is the Official Protection and Advocacy System for Kansas and is a part of the national network of federally mandated and funded protection and advocacy systems. As such, DRC advocates for the rights of Kansans with disabilities under state or federal laws (ADA, the Rehabilitation Act, Federal Medicaid Act, Kansas Act Against Discrimination, etc.) Website: Disability Rights Center. Contact next page:

#### **Contact Information**

635 SW Harrison, Suite 100

Topeka, KS 66603-3726

Voice: (785) 273-9661

Toll Free Voice: (877) 776-1541

### **Kansas Legal Services**

Kansas Legal Services is a statewide non-profit organization dedicated to helping low-income Kansans meet their basic needs through the provision of essential legal, mediation and employment training services. Kansas Legal Services can assist individuals with cases involving housing, employment, juvenile issues (delinquent, termination of parental rights), income maintenance, Indian laws, family issues, health, individual rights and consumer issues.

#### **Legal Assistance Toll Free Central Intake Line**

Phone: (800) 723-6953

Main Office: (785) 233-2068 (voice)