

HealthChoices Behavioral Health

(link: <http://www.dpw.state.pa.us/Disable/MentalHealthServices/003670135.htm>)

Complaint, Grievance, and Fair Hearing Processes

The PA Office of Mental Health and Substance Abuse Services (OMHSAS)

(link: <http://www.dpw.state.pa.us/Child/BehavHealthServChildren/>)

NOTE: This information is written as advice to a consumer. Families may act as a minor child's representative for these processes.

What Do I Do If I Have A Problem With My Behavioral Healthcare?

- Call your Behavioral Health Care Managed Care Plan
- You can ask for a staff person to work through the complaint, grievance, and/or fair hearing process with you
- Your plan can assign someone to help you who has not been involved in the problem or in the denial of service

What Is A Complaint?

- A complaint is when you tell your plan you are not happy with your provider or a decision made by your plan.
- Examples:
 - You are unhappy with the care you are getting
 - You are unhappy that you cannot get a service because it is not covered
 - You are unhappy that you have not received services that you have been approved to get

What Should I Do If I Have A Complaint (1st Level)?

- Call your plan at their toll free number and explain your complaint, or
- Write down your complaint and mail it to your plan
- This is called a ***first level complaint***

When Should I File A Complaint?

- You must file your complaint **within 45 days*** of getting a letter telling you that:
 - You cannot get a service because it is not covered
 - Your plan will not pay a provider for a service you received
 - Your plan did not decide a 1st level complaint or grievance within 30 days
- You must file a complaint **within 45 days*** of the date you should have received a service if your provider did not give you the service
- **You may file all other complaints at any time**

What To Do To Continue Getting Services...

- If you have been receiving services that are being reduced, changed or stopped **because they are not covered services for you** and you file a complaint that is hand-delivered or postmarked within 10 days of the date on the letter (notice) telling you that the services you have been receiving are not covered services for you, the services will continue until a decision is made.

What Happens After I File A 1st Level Complaint?

- Your plan will send you a letter telling you they received your complaint.
 - The letter will tell you that your plan will make a decision about your complaint within 30 days of when you filed it,
 - It will tell you how to get help with the complaint process,
 - It will tell you that you can send the plan any information that will help decide your complaint, and you can see any information the plan has about your complaint

If You Filed A Complaint Because Of One Of The Reasons Listed Below, You Can Be Included In The First Level Complaint Review, In Person, Or By Phone*:

- You are unhappy that your plan has decided you cannot get a service you want because it is not a covered service.
- You are unhappy that you have not received services that you have been approved to get.
- You are unhappy that your plan will not pay a provider for a service you received.
- You are unhappy that your plan did not decide a first level complaint or grievance within 30 days.

What Happens After My Complaint Is Decided?

- Your plan will send you a decision letter within 5 business days of making a decision on your complaint
- The letter will tell you the reasons for the decision
- The letter will also tell you how to file a **second level complaint** if you are not happy with the first level complaint decision

Second Level Complaint

- If you are not happy with your plan's first level complaint decision, you may file a **second level complaint**
- The 1st level decision letter will tell you that you must file a second level complaint **within 45 days** of receiving the 1st level decision letter
- You can call your plan to file a 2nd level complaint, or send your complaint in writing to your plan

WHAT TO DO TO CONTINUE GETTING SERVICES...

- If you have been receiving services that are being reduced, changed or stopped **because they are not covered services for you** and you file a second level complaint that is hand-delivered or postmarked within 10 days of the date on the first level complaint decision letter, the services will continue until a decision is made.

What Happens After I File A 2nd Level Complaint?

- Your plan will send you a letter telling you they received your complaint.
 - The letter will tell you that your plan will make a decision about your complaint within 30 days
 - It will explain the 2nd level complaint process
 - It will tell you that you may come to the second level complaint review committee meeting to talk about your complaint, or participate by phone
 - You will be given at least 15 days advance written notice of the meeting date, place, and time

Second Level Complaint Review Committee

- The second level complaint is decided by a committee; at least 1/3 of the committee will be made up of consumers
- The remaining 2/3 of the committee will be county and/or plan staff who were not involved in the issue or the decision.
- You have the right to be present at the second level review committee, and may bring a representative to help you
- If you are unable to attend, the committee will conduct the meeting as if you were present
- The second level complaint decision must be based solely on information presented and discussed during the committee meeting

What Happens After My 2nd Level Complaint Is Decided?

- Your plan will send you a decision letter within 5 business days of the committee's decision on your 2nd level complaint
- The letter will tell you the reasons for the decision
- The letter will also tell you how to file for ***an external complaint*** if you are not happy with the 2nd level complaint decision

What To Do To Continue Getting Services...

- If you have been receiving services that are being reduced, changed or stopped **because they are not covered services for you** and you file an external complaint that is hand-delivered or postmarked within 10 days of the date on the second level complaint decision letter, the services will continue until a decision is made.

External Complaint Review

- If you are not happy with the 2nd level complaint decision, you may file an external complaint with the Dept of Health or the Dept of Insurance
- The 2nd level complaint decision letter will tell you that you have 15 days to file for an external review, and tell you how to do so
- The Dept of Health or the Dept of Insurance will review your complaint and make a decision within 60 days

QUESTIONS ABOUT COMPLAINTS?

What If My Plan Doesn't Approve A Service For Me?

- If your plan does not completely approve a service for you, they must tell you in a letter (denial notice)
- The letter will tell you that **you have 45 days from receiving the letter** to file a **1st level grievance** if you disagree with the decision
- You may call you plan and tell them your grievance, or write them a letter
- Your provider may file a grievance for you if you give them written permission to do so

What is a Grievance?

- A grievance is what you file when you do not agree with your plan's decision that a service you or your provider asked for is not medically necessary.
- You can file a grievance if your plan does any of these things:

- Denies a service
- Approves less than what was asked for
- Approves a different service from the one that was asked for

What To Do To Continue Getting Services...

- If you have been receiving services that are being reduced, changed or stopped, and you file a grievance that is hand-delivered or postmarked within 10 days of the date on the letter (notice) telling you that the services you have been receiving are being reduced, changed, or stopped, the services will continue until a decision is made.

What Happens After I File A 1st Level Grievance?

- Your plan will send you a letter telling you they received your grievance, and explaining the 1st level grievance process
- The letter will tell you that you may be included in the first level grievance review in person or by phone if you want to be*
 - You have 10 days from the date on this letter to contact your plan if you want to be included in the 1st level grievance review
- A decision on your 1st level grievance will be made within 30 days*

What Happens After My Grievance Is Decided?

- Your plan will send you a decision letter within 5 business days of making a decision on your grievance
- The letter will tell you the reasons for the decision
- The letter will also tell you how to file a **second level grievance** if you are not happy with the first level grievance decision

Second Level Grievance

- If you are not happy with your plan's first level grievance decision, you may file a **second level grievance**
- The 1st level decision letter will tell you that you must file a second level grievance **within 45 days** of receiving the 1st level decision letter
- You can call your plan to file a 2nd level grievance, or send your grievance in writing to your plan

What To Do To Continue Getting Services...

- If you have been receiving services that are being reduced, changed or stopped, and you file a second level grievance that is hand-delivered or postmarked within 10 days of the date on the first level grievance decision letter, the services will continue until a decision is made.

What Happens After I File A 2nd Level Grievance?

- Your plan will send you a letter telling you they received your 2nd level grievance.
 - The letter will tell you that your plan will make a decision about your grievance within 30 days
 - It will explain the 2nd level grievance process
 - It will tell you that you may come to the second level grievance review committee meeting to talk about your grievance, or participate by phone
 - You will be given advance notice of the meeting date, place, and time

Second Level Grievance Review Committee

- The second level grievance is decided by a committee; at least 1/3 of the committee will be made up of consumers
- The remaining 2/3 of the committee will be county and/or plan staff who were not involved in the issue or the decision. **One member of the panel MUST BE an appropriately qualified medical professional.**
- You have the right to be present at the second level review committee, and may bring a representative to help you
- If you are unable to attend, the committee will conduct the meeting as if you were present
- The second level grievance decision must be based solely on information presented and discussed during the committee meeting

What Happens After My 2nd Level Grievance Is Decided?

- Your plan will send you a decision letter within 5 business days of making a decision on your 2nd level grievance
- The letter will tell you the reasons for the decision
- The letter will also tell you how to file for **an external grievance** if you are not happy with the 2nd level grievance decision

External Grievance Review

- If you are not happy with the 2nd level grievance decision, you may file an external grievance with your plan
- The 2nd level grievance decision letter will tell you that you have 15 days to file an external grievance, and tell you how to do so
- Your plan will forward your external grievance to the Dept of Health
- The Dept of Health assigns a doctor or licensed psychologist to review your grievance and make a decision within 60 days

What To Do To Continue Getting Services...

- If you have been receiving services that are being reduced, changed or stopped and you request an external grievance review that is hand-delivered or postmarked within 10 days of the date on the second level grievance decision letter, the services will continue until a decision is made.

What If My Health Is At Immediate Risk?

- If your health is at immediate risk, and your doctor believes your complaint or grievance must be decided quickly, your doctor may send a statement to your plan requesting an **EXPEDITED REVIEW** of your complaint* or grievance
- Your plan will then make a decision on your complaint or grievance within 3 business days

What Is A DPW Fair Hearing?

- In some cases you can ask the Department of Public Welfare to hold a hearing because you are unhappy about or do not agree with something your plan did or did not do. These hearings are called “fair hearings”. You can ask for a fair hearing at the same time you file a complaint or grievance or you can ask for a fair hearing after your plan decides your first or second level complaint or grievance.
- You can go to the hearing in person, or participate by phone

What Kind Of Things Can I Request A Fair Hearing About?

You Can Ask For A Fair Hearing...

- Your plan decided to deny, decrease or approve a service different than the service your provider requested because it was not medically necessary
- Your plan denied a service because it is not a covered service
- Your plan decided not to pay a provider for a service you received AND the provider can bill you for the service*
- Your plan did not decide your complaint or grievance within 30 days*
- Your provider did not give you a service by the time you should have received it*

When Do I Have To Ask For A Fair Hearing?

- within 30 days of getting a letter from your plan about any of those 5 issues, **OR** within 30 days of getting a letter from your plan telling you its decision after you filed a complaint or grievance about any of those 5 issues.

How do I ask for a Fair Hearing?

You must ask for a fair hearing in writing and send your request to:

Department of Public Welfare
Office of Mental Health and Substance Abuse Services
Division of Grievances and Appeals
Beechmont Building #32, 2nd Floor
PO Box 2675
Harrisburg, PA 17105-2675

What To Do To Continue Getting Services...

- If you have been receiving services that are being reduced, changed or stopped, and your request for a fair hearing is hand-delivered or postmarked within 10 days of the date on the letter telling you that your plan has reduced, changed, or stopped your services, or telling you your plan's decision about your first or second level complaint or grievance, your services will continue until a decision is made.

What Happens After I Ask For A Fair Hearing?

- You will get a letter from DPW's Bureau of Hearings and Appeals telling you where the hearing will be held and the date and time for the hearing. You will receive this letter at least 10 days before the date of the hearing.
- The Fair Hearing will be held and decided **within 90 days** of your request

What If My Health Is At Immediate Risk?

- If your health is at immediate risk, and your doctor believes your fair hearing must be decided quickly, your doctor may send a statement to DPW requesting an **EXPEDITED** fair hearing
- DPW's Bureau of Hearings and Appeals will then hold an **EXPEDITED FAIR HEARING*** within 3 business days

What If I Need Help Or Have Questions About My Complaint, Grievance, And Fair Hearing Rights?

- Call Your Plan
- Call Your Local Legal Aid Office

- Call the Pennsylvania Health Law Project at 1-800-274-3258