A. **General Requirements**

1. The BH-MCO must have written policies and procedures for registering, responding to, and resolving Complaints and Grievances (at all levels) as they relate to the MA population.

2. All Complaint, Grievance, and Fair Hearing policies and procedures developed by a BH-MCO must be approved in writing by the Department prior to their implementation.

3. The Complaint and Grievance processes must be fair, easy to understand, easy to follow, easily accessible and respectful of the Member’s rights.

4. The BH-MCO policies and procedures regarding Member Complaints and Grievances must be provided to Members in written form:
   a. Upon enrollment into the BH-MCO,
   b. Upon Member request, and
   c. At least 30 Days before a Department-approved change becomes effective.

5. The BH-MCO must require Network Providers to display information about how to file a Complaint or a Grievance and the Complaint and Grievance process at all Network Provider offices.

6. The BH-MCO may not charge Members a fee for filing a Complaint or Grievance.

7. The BH-MCO must require Network Providers to display a notification that Members will not incur a fee for filing Complaints or Grievances at any level of the process at all Network Provider offices.

8. The BH-MCO must operate a toll-free telephone service for Members to use to file Complaints and Grievances and to follow up on Complaints and Grievances filed by Members. The phone service must be operated 24 hours a day, 7 Days a week by appropriately trained staff. Voice mail or recorded messages are not allowed. The BH-MCO must provide Members with the number of the toll-free telephone service.
9. The BH-MCO must designate and train sufficient staff to be responsible for receiving, processing, and responding to Member Complaints and Grievances in accordance with the requirements in this Appendix.

10. All County and BH-MCO staff involved in the Complaint and Grievance processes and all review committee members must receive training in the areas related to their responsibility at least annually or more frequently, if needed.

11. All County and BH-MCO staff involved in the Complaint and Grievance processes and all review committee members must have the necessary orientation, knowledge, and experience to make a determination about assigned issues and must analyze information and resolve disputed issues in a fair and nondiscriminatory manner.

12. All review committee proceedings shall be conducted in a manner that is informal and impartial to avoid intimidating the Member or the Member’s representative.

13. The BH-MCO must identify a lead person responsible for overall coordination of the Complaint and Grievance processes, including the provision of information and instructions to Members.

14. The BH-MCO must maintain an accurate log of all Complaints and Grievances, which includes, at a minimum:

   a. Identifying information about the Member
   b. A description of the reason for the Complaint or Grievance
   c. The date the Complaint or Grievance was received
   d. The date of the review or review meeting (if applicable)
   e. The decision
   f. The date of the decision
   g. If the second level Complaint review committee or the Grievance review committee included a consumer representative

The BH-MCO must provide the log to the Department or CMS upon request.

15. The BH-MCO must retain all Complaint and Grievance records, which must include a copy of any document reviewed by the Complaint or Grievance review committee and the Complaint or Grievance log, for 10 years from the date the Complaint or Grievance was filed.
16. The BH-MCO must allow the Member or the Member’s representative if the Member has provided the BH-MCO with written authorization that indicates that the representative may be involved and/or act on the Member’s behalf access to all relevant documents pertaining to the subject of the Member’s Complaint or Grievance, including any new or additional evidence considered, relied upon, or generated for the Complaint or Grievance review and, if an Investigator was assigned, any information obtained as part of the investigation. The BH-MCO may not charge Members or their representatives for copies of the documentation.

17. The BH-MCO must ensure that there is a link between the Complaint and Grievance processes and the Quality Management and Utilization Management programs.

18. The BH-MCO may not use the time frames or procedures of the Complaint or Grievance process to avoid the medical decision process or to discourage or prevent a Member from receiving medically necessary care in a timely manner.

19. The BH-MCO must accept Complaints and Grievances from Members who have disabilities which are in alternative formats including: TTD/TTY for telephone inquiries and Complaints and Grievances from Members who are deaf or hearing impaired; Braille; recording; or computer disk; and other commonly accepted alternative forms of communication. The BH-MCO must make its employees who receive telephone Complaints and Grievances aware of the speech limitation of some Members who have disabilities so they treat these Members with patience, understanding, and respect.

20. The BH-MCO must provide Members who have disabilities assistance with preparing and presenting their case at Complaint or Grievance reviews at no cost to the Member. This includes, but is not limited to:
   
   a. Providing qualified sign language interpreters for Members who are deaf or hearing impaired;

   b. Providing information submitted on behalf of the BH-MCO at the Complaint or Grievance review in an alternative format accessible to the Member filing the Complaint or Grievance. The alternative format version must be supplied to the Member before the review and at the review, so the Member can discuss and/or refute the content during the review; and

   c. Providing personal assistance to Members with other physical limitations with copying and presenting documents and other evidence.
21. The BH-MCO must provide language interpreter services when requested by a Member at no cost to the Member.

22. The BH-MCO must offer Members the assistance of a BH-MCO staff member throughout the Complaint and Grievance processes at no cost to the Member. The BH-MCO staff member cannot have been involved in and cannot be a subordinate of anyone who was involved in any previous level of review or decision-making on the issue that is the subject of the Complaint or Grievance.

23. The BH-MCO must require that anyone who participates in making the decision on a Complaint or Grievance was not involved in and is not a subordinate of anyone who was involved in any previous level of review or decision-making on the issue that is the subject of the Complaint or Grievance.

24. Upon receipt of a Complaint or Grievance, the BH-MCO must offer to provide Members with names and contact information of advocacy organizations available to assist Members.

25. If the outcome of a Member’s Complaint or Grievance indicates that a corrective plan of action and/or follow-up is needed to address quality of care concerns, the BH-MCO must implement the corrective plan of action and/or follow-up.

26. If a Member continued to receives services at the previously authorized level because the Member filed a Complaint, Grievance, or Fair Hearing to dispute a decision to discontinue, reduce, or change a service that the Member has been receiving within one Day from the mail date on the written notice of decision if acute inpatient services were being discontinued, reduced, or changed or within 10 Days from the mail date on the written notice of decision if any other services were being discontinued, reduced, or changed, the BH-MCO must pay for the services pending resolution of the Complaint, Grievance, or Fair Hearing.

27. The BH-MCO must notify the Member when the BH-MCO fails to decide a first level Complaint or Grievance within the time frames specified in this Appendix, using the template supplied by the Department as Attachment 1a of this Appendix. This notice must be mailed to the Member one Day following the date the decision was to be made.
28. The BH-MCO must notify the Member when it denies payment after a service(s) has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program, using the template supplied by the Department as Attachment 1b of this Appendix. The notice must be mailed to the Member on the day that the decision is made to deny payment.

29. The BH-MCO must notify the Member when it denies payment after a service(s) has been delivered because the service(s) provided is not a covered service(s) for the Member, using the template supplied by the Department as Attachment 1c of this Appendix. The notice must be mailed to the Member on the day that the decision is made to deny payment.

30. The BH-MCO must notify the Member when it denies payment after a service(s) has been delivered because the BH-MCO determined that the emergency room service(s) was not medically necessary, using the template supplied by the Department as Attachment 1d of this Appendix. This notice must be mailed to the Member on the day the decision is made to deny payment.

31. The BH-MCO must notify the Member when it denies the Member’s request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities, using the template supplied by the Department as Attachment 1e of this Appendix. This notice must be mailed to the Member on the day the decision is made to deny the request to dispute a financial liability.

32. The BH-MCO must include Attachments 10a and 10b of this Appendix when sending a letter or notice to a Member and a Member’s representative if the Member has provided the BH-MCO with written authorization that indicates that the representative may be involved and/or take action on the Member’s behalf.

B. Complaint Requirements

1. Definition: A Complaint is a dispute or objection regarding a participating health care Provider or the coverage, operations, or management of a BH-MCO, which has not been resolved by the BH-MCO and has been filed with the BH-MCO or with the Department of Health or the Insurance Department, including but not limited to:

   a. a denial because the requested service is not a covered service;

   b. the failure of the BH-MCO to meet the required time frames for providing a service;
c. the failure of the BH-MCO to decide a Complaint or Grievance within the specified time frames;

d. a denial of payment by the BH-MCO after a service(s) has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program;

e. a denial of payment by the BH-MCO after a service(s) has been delivered because the service(s) is not a covered service(s) for the Member;

f. a denial of a Member’s request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities; or

g. a member’s dissatisfaction with the BH-MCO or a Provider.

Note: Complaints do not include requests to reconsider a decision concerning the medical necessity and appropriateness of a covered health care service.

2. First Level Complaint Process

a. A BH-MCO must permit a Member to designate a representative, which may include the Member’s Provider, if the Member provides the BH-MCO with written authorization that indicates that the representative may be involved and/or act on the Member’s behalf. Failure to provide written authorization that the representative may be involved and/or act on the Member’s behalf may not delay the Complaint process.

b. A Member or Member’s representative (if designated) may file a Complaint either orally or in writing. Oral Complaints about the following must be committed to writing by the BH-MCO and must be provided to the Member or Member’s representative (if designated) for signature:

i. a denial because the requested service is not a covered service;

ii. the failure of the BH-MCO to meet the required time frames for providing a service;

iii. the failure of the BH-MCO to decide a Complaint or Grievance within the specified time frames;
iv. a denial of payment after a service(s) has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program;

v. a denial of payment after a service(s) has been delivered because the service(s) is not a covered service(s) for the Member; or

vi. a denial of a Member’s request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities.

The Member’s or Member’s representative’s signature may be obtained at any point in the process, and failure to obtain a signed Complaint may not delay the Complaint process.

c. If the Complaint disputes one of the following, the Member or Member’s representative (if designated) must file a Complaint within 60 Days from the date of the incident complained of or the date the Member receives written notice of a decision:

i. a denial because the requested service is not a covered service;

ii. the failure of the BH-MCO to meet the required time frames for providing a service;

iii. the failure of the BH-MCO to decide a Complaint or Grievance within the specified time frames;

iv. a denial of payment after a service(s) has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program;

v. a denial of payment after a service(s) has been delivered because the service(s) is not a covered service(s) for the Member; or

vi. a denial of a Member’s request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities.

For all other Complaints, there is no time limit for filing a Complaint.
Appendix H
January 1, 2019

d. A Member who files a Complaint to dispute a decision to
discontinue, reduce, or change a service that the Member has been
receiving on the basis that the service is not a covered service must
continue to receive the disputed service at the previously authorized
level pending resolution of the Complaint, if the Complaint is filed
orally, hand delivered, faxed, or post-marked within one Day from
the mail date on the written notice of decision if acute inpatient
services are being discontinued, reduced, or changed or within 10
Days from the mail date on the written notice of decision if any other
services are being discontinued, reduced, or changed.

e. The BH-MCO must send the Member and Member’s representative
(if designated) an acknowledgment letter upon receipt of the
Complaint, which can be no later than 5 business days after receipt of
the Complaint if further information is needed to determine the issue
the Complaint is about.

If the Complaint disputes one of the following:

i. a denial because the requested service is not a covered
   service;

ii. the failure of the BH-MCO to meet the required time
    frames for providing a service;

iii. the failure of the BH-MCO to decide a Complaint or
    Grievance within the specified time frames;

iv. a denial of payment after a service(s) has been delivered
    because the service(s) was provided without authorization
    by a provider not enrolled in the Pennsylvania Medical
    Assistance Program;

v. a denial of payment after a service(s) has been delivered
    because the service(s) is not a covered service(s) for the
    Member; or

vi. a denial of a Member’s request to dispute a financial liability,
    including cost sharing, copayments, premiums, deductibles,
    coinsurance, and other Member financial liabilities

the BH-MCO must use the template supplied by the Department as
Attachment 2b of this Appendix.

For all other Complaints, the BH-MCO must use the template
supplied by the Department as Attachment 2a of this Appendix.
f. Upon receipt of the Complaint, the BH-MCO must assign an Investigator who was not involved in and is not the subordinate of anyone who was involved in any previous review or decision-making on the issue that is the subject of the Complaint and who will not benefit financially from the resolution of the Complaint. The Investigator is responsible for obtaining from the Member and any other individuals involved with the Complaint all relevant documents pertaining to the subject of the Complaint. The Investigator must treat the Member and any other individuals involved with the Complaint equally and with respect. The investigator must provide to the first level Complaint review committee at least 2 Days prior to the Complaint review all information obtained as part of the investigation. The Investigator must attend the Complaint review and present the information obtained as part of the investigation to the first level Complaint review committee. The Investigator cannot be involved in the Complaint review committee’s decision.

g. The Complaint review for Complaints not involving a clinical issue must be performed by a Complaint review committee, which must include one or more employees of the BH-MCO who were not involved and are not subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Complaint.

h. The Complaint review for Complaints involving a clinical issue must be performed by a Complaint review committee, which must include one or more employees of the BH-MCO who were not involved in and are not the subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Complaint. At least one individual on the committee must meet the qualifications described in Appendix AA, section C.3 for an individual that can deny a request for services based on medical necessity and this individual must decide the Complaint. Other appropriate individuals may participate in the review.

i. The BH-MCO must afford the Member a reasonable opportunity to present testimony and evidence and make legal and factual arguments, in person as well as in writing. The BH-MCO must allow the Member or anyone the Member chooses to present the Member’s position to the Complaint review committee.
j. The Member must be provided the opportunity to appear before the Complaint review committee. The BH-MCO must be flexible when scheduling the Complaint review to facilitate the Member’s attendance. The Complaint review must be conducted at a time and place that is convenient for the Member. If the Member cannot appear in person at the Complaint review, the BH-MCO must provide an opportunity for the Member to communicate with the Complaint review committee by telephone or videoconference.

k. The Complaint review committee may ask individuals who attend the Complaint review in person, by telephone, or by videoconference questions related to the subject of the Complaint.

l. The Member may elect not to attend the Complaint review meeting, but the meeting must be conducted with the same protocols as if the Member was present.

m. If the Member’s Provider did not file the Complaint, the Member’s Provider may participate in the Complaint review only if the Member consents to the Provider being present at the Complaint review. The BH-MCO must document the Member’s consent in the Complaint record.

n. County or BH-MCO staff may attend the Complaint review for training purposes if the Member consents to the staff person attending the Complaint review. The BH-MCO must document the Member’s consent in the Complaint record.

o. The BH-MCO must maintain as part of the Complaint record a sign-in sheet that includes the date and time of the review meeting; who was present at the review meeting and why the individual was present at the review meeting; if the individual attended the review meeting in person, by phone, or by videoconference; the affiliation and job title of anyone present at the review meeting other than the Member; and documentation that all individuals present at the review meeting other than the Member have acknowledged that they will keep the information discussed during the review meeting confidential. All individuals that are present at the review meeting in person must sign the sign-in sheet.

p. The decision of the Complaint review committee must take into account all comments, documents, records, and other information submitted by the Member or the Member’s representative (if designated) without regard to whether such information was submitted or considered previously. The decision of the Complaint review committee must be based solely on the information presented.
at the review.

q. The Complaint review committee must complete its review of the Complaint as expeditiously as the Member’s health condition requires.

r. The Complaint review committee must prepare a summary of the issues presented and decisions made, which must be maintained as part of the Complaint record.

s. The BH-MCO must send a written notice of the Complaint decision to the Member, Member’s representative (if designated), service Provider, and prescribing Provider (if applicable), within 30 Days from the date the BH-MCO received the Complaint, unless the time frame for deciding the Complaint has been extended by up to 14 Days at the request of the Member. The BH-MCO must document a Member’s request for an extension in the Complaint record.

s. If the Complaint disputes the following the BH-MCO must use the template supplied by the Department as Attachment 3b of this Appendix to send written notice of the Complaint decision:

i. a denial because the requested service is not a covered service;

ii. the failure of the BH-MCO to meet the required time frames for providing a service;

iii. the failure of the BH-MCO to decide a Complaint or Grievance within the specified time frames;

iv. a denial of payment after a service(s) has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program;

v. a denial of payment after a service(s) has been delivered because the service(s) is not a covered service(s) for the Member; or

vi. a denial of a Member’s request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities.
For all other Complaints, the BH-MCO must use the template supplied by the Department as Attachment 3a of this Appendix to send written notice of the Complaint decision.

t. If the Complaint disputes one of the following, the Member may file a request for a Fair Hearing, a request for an external review, or both a request for a Fair Hearing and a request for an external review:

i. a denial because the requested service is not a covered service;

ii. the failure of the BH-MCO to meet the required time frames for providing a service;

iii. the failure of the BH-MCO to decide a Complaint or Grievance within the specified time frames;

iv. a denial of payment by the BH-MCO after a service(s) has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program;

v. a denial of payment by the BH-MCO after a service(s) has been delivered because the service(s) is not a covered service(s) for the Member; or

vi. a denial of a Member’s request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities.

The Member or Member’s representative may file a request for a Fair Hearing within 120 Days from the mail date on the written notice of the BH-MCO’s first level Complaint decision.

The Member or Member’s representative, which may include the Member’s Provider, with proof of the Member’s written authorization for the representative to be involved and/or act on the Member’s behalf, may file a request for an external review in writing with either the Department of Health or the Insurance Department within 15 Days from the date the Member receives written notice of the BH-MCO’s first level Complaint decision.

For all other Complaints, the Member or Member’s representative, which may include the Member’s Provider, with proof of the Member’s written authorization for the representative to be involved
and/or act on the Member’s behalf, may file a second level Complaint either in writing, by fax, or orally within 45 Days from the date the Member receives written notice of the BH-MCO’s first level Complaint decision.

3. Second Level Complaint Process

a. A BH-MCO must permit a Member to designate a representative, which may include the Member’s Provider, if the Member provides the BH-MCO with written authorization that indicates that the representative may be involved and/or act on the Member’s behalf. Failure to provide written authorization that the representative may be involved and/or act on the Member’s behalf may not delay the Complaint process.

b. A second level Complaint must be filed within 45 Days from the date the Member receives written notice of the BH-MCO’s first level Complaint decision.

c. The BH-MCO must send the Member and Member’s representative (if designated) an acknowledgment letter using the template supplied by the Department as Attachment 4 of this Appendix upon receipt of the second level Complaint, which can be no later than 5 business days after receipt of the second level Complaint if further information is needed to determine the issue the Complaint is about.

d. The second level Complaint review must be performed by a Complaint review committee made up of 3 or more individuals who were not involved in and are not subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Complaint.

e. At least one-third of the second level Complaint review committee may not be an employee of the BH-MCO or a related subsidiary or Affiliate.

f. At least 20% of the second level Complaint review committees in a year must include a consumer representative on the review committee.

g. If the Complaint involves mental health services for an adult, the consumer representative must have received or is currently receiving mental health services. If the Complaint involves substance abuse services, the consumer representative must have received or is currently receiving substance abuse services.
Appendix H  
January 1, 2019

h. If the Complaint involves mental health services for a child or adolescent, the consumer representative may be a parent or guardian of a child or adolescent who has received or is currently receiving mental health services or an individual who has received or is currently receiving mental health services. If the Complaint involves substance abuse services for a child or adolescent, the consumer representative may be a parent or guardian of a child or adolescent who has received or is currently receiving substance abuse services or an individual who has received or is currently receiving substance abuse services.

i. The BH-MCO must provide to the second level Complaint review committee at least 2 days prior to the second level Complaint review meeting the first level Complaint record, which must include a copy of any document reviewed by the first level Complaint review committee.

j. A committee member who does not personally attend the second level Complaint review meeting may not be part of the decision-making process unless that person actively participates in the review by telephone or videoconference and has the opportunity to review all information presented at the meeting.

k. The second level Complaint review committee may not discuss the Complaint prior to the review meeting.

l. The BH-MCO must afford the Member a reasonable opportunity to present testimony and evidence and make legal and factual arguments, in person as well as in writing. The BH-MCO must allow the Member or anyone the Member chooses to present the Member’s position to the second level Complaint review committee.

m. The Member must be provided the opportunity to appear before the second level Complaint review committee. The BH-MCO must be flexible when scheduling the second level Complaint review to facilitate the Member’s attendance. The second level Complaint review must be conducted at a time and place that is convenient for the Member. If the Member cannot appear in person at the second level Complaint review, the BH-MCO must provide an opportunity for the Member to communicate with the second level Complaint review committee by telephone or videoconference.

n. The BH-MCO must give the Member at least 15 Days advance written notice of the second level Complaint review date. The BH-MCO must document in the Complaint record the date that it notified the Member of the review date.
o. The Member may elect not to attend the second level Complaint review meeting, but the meeting must be conducted with the same protocols as if the Member was present.

p. A facilitator must attend the second level Complaint review meeting to ensure that the review meeting is conducted in accordance with the requirements set forth in this Appendix. The facilitator may not contribute to the discussion of the second level Complaint review committee or be involved in the decision of the second level Complaint review committee.

q. A BH-MCO staff member that is prepared to provide information on the BH-MCO’s position on the issue the Complaint is about must attend the second level Complaint review meeting. The BH-MCO staff member may not be present during the discussion of the decision and may not be involved in the decision of the second level Complaint review.

r. If the Member’s Provider did not file the Complaint, the Member’s Provider may participate in the Complaint review only if the Member consents to the Provider being present at the Complaint review. The BH-MCO must document the Member’s consent in the Complaint record.

s. The second level Complaint review committee may ask individuals who attend the Complaint review meeting in person, by telephone, or by videoconferences question related to the subject of the Complaint.

t. County or BH-MCO staff may attend the Complaint review for training purposes if the Member consents to the staff person attending the Complaint review. The BH-MCO must document the Member’s consent in the Complaint record.

The BH-MCO must maintain as part of the Complaint record a sign-in sheet that includes the date and time of the review meeting; who was present at the review meeting and why the individual was present at the review meeting; if the individual attended the review meeting in person, by phone, or by videoconference; the affiliation and job title of anyone present at the review meeting other than the Member; and documentation that all individuals present at the review meeting other than the Member have acknowledged that they will keep the information discussed during the review meeting confidential. All individuals that are present at the review meeting in person must sign the sign-in sheet.
u. The decision of the second level Complaint review committee must take into account all comments, documents, records, and other information submitted by the Member or the Member’s representative (if designated) without regard to whether such information was submitted or considered previously. The decision of the second level Complaint review committee must be based solely on the information presented at the review.

v. The second level Complaint review committee must complete its review of the Complaint as expeditiously as the Member’s health condition requires.

w. The testimony taken by the second level Complaint review committee (including the Member’s comments) must be either recorded and a summary prepared or transcribed verbatim and a summary prepared and maintained as part of the Complaint record.

x. The BH-MCO must send a written notice of the second level Complaint decision to the Member, Member’s representative (if designated), service Provider, and prescribing Provider (if applicable), using the template supplied by the Department as Attachment 5 of this Appendix, within 45 Days from the date the BH-MCO received the second level Complaint.

y. The Member or Member’s representative, which may include the Member’s Provider, with proof of the Member’s written authorization for the representative to be involved and/or act on the Member’s behalf, may file in writing a request for an external review of the second level Complaint decision with either the Department of Health or the Insurance Department within 15 Days from the date the Member receives the written notice of the BH-MCO’s second level Complaint decision.
4. External Complaint Process

a. If a Member files a request for an external review of a Complaint decision that disputes a decision to discontinue, reduce, or change a service that the Member has been receiving on the basis that the service is not a covered service, the Member must continue to receive the disputed service at the previously authorized level pending resolution of the external review, if the request for external review is filed orally, hand delivered, or post-marked within one Day from the mail date on the written notice of the BH-MCO’s Complaint decision if acute inpatient services are being discontinued, reduced, or changed or within 10 Days from the mail date on the written notice of the BH-MCO’s Complaint decision if any other services are being discontinued, reduced, or changed.

b. Upon the request of either the Department of Health or the Insurance Department, the BH-MCO must transmit all records from the BH-MCO’s Complaint review to the requesting department within 30 Days from the request in the manner prescribed by that department. The Member, the Provider, or the BH-MCO may submit additional materials related to the Complaint.

c. The Department of Health and the Insurance Department will determine the appropriate agency for the review.

5. Expedited Complaint Process

a. The BH-MCO must conduct an expedited review of a Complaint if the BH-MCO determines that the Member’s life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Complaint process or if a Member or a Member’s representative (if designated) provides the BH-MCO with written certification from the Member’s Provider that the Member’s life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Complaint process. The certification must include the Provider’s signature.

b. A request for an expedited review of a Complaint may be filed either in writing or orally.

c. Upon receipt of an oral or written request for expedited review, the BH-MCO must inform the Member of the right to present testimony and evidence and make legal and factual arguments, in person as well as in writing and of the limited time available to do so.
Appendix H  
January 1, 2019

d. If the Provider certification is not included with the request for an expedited review and the BH-MCO cannot determine based on the information provided that the Member’s life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Complaint process, the BH-MCO must inform the Member that the Provider must submit a certification as to the reason why the expedited review is needed. The BH-MCO must make a reasonable effort to obtain the certification from the Provider. If the Provider certification is not received within 72 hours from the Member’s request for an expedited review, the BH-MCO must decide the Complaint within the standard time frames as set forth in this Appendix, unless the time frame for deciding the Complaint has been extended by up to 14 Days at the request of the Member. If the BH-MCO decides that expedited consideration within the initial or extended time frame is not warranted, the BH-MCO must make a reasonable effort to give the Member prompt oral notice that the Complaint is to be decided within the standard time frame and send a written notice within 2 business days of the decision to deny expedited review, using the template supplied by the Department as Attachment 6a of this Appendix.

e. A Member who files a request for expedited review of a Complaint to dispute a decision to discontinue, reduce, or change a service that the Member has been receiving on the basis that the service is not a covered service must continue to receive the disputed service at the previously authorized level pending resolution of the Complaint, if the request for expedited review is filed orally, hand delivered, or post-marked within one Day from the mail date on the written notice of the BH-MCO’s decision if acute inpatient services are being discontinued, reduced, or changed or within 10 Days from the mail date on the written notice of the BH-MCO’s decision if any other services are being discontinued, reduced, or changed.

f. Expedited review of a Complaint must be conducted by a Complaint review committee that includes at least one individual who meets the qualifications described in Appendix AA, Section C.3 for an individual that can deny a request for services based on medical necessity. Other appropriate individuals may participate in the review, but an individual who meets the qualifications described in Appendix AA, Section C.3 for an individual that can deny a request for services based on medical necessity must decide the Complaint.
g. The members of the expedited Complaint review committee may not have been involved in and may not be the subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Complaint.

h. The Complaint review committee must prepare a summary of the issues presented and decisions made, which must be maintained as part of the expedited Complaint record.

i. The BH-MCO must issue the decision resulting from the expedited review in person or by phone to the Member, Member’s representative (if designated), service Provider, and prescribing Provider (if applicable) within either 48 hours of receiving the Provider’s certification or 72 hours of receiving the Member’s request for an expedited review, whichever is shorter, unless the time frame for deciding the expedited Complaint has been extended by up to 14 Days at the request of the Member. The BH-MCO must document a Member’s request for an extension in the Complaint record. In addition, the BH-MCO must mail written notice of the decision to the Member, Member’s representative (if designated), service Provider, and prescribing Provider (if applicable), within 2 business days of the decision using the template supplied by the Department as Attachment 6b of this Appendix.

j. The Member or the Member’s representative, which may include the Member’s Provider, with proof of the Member’s written authorization for the representative to be involved and/or act on the Member’s behalf, may file a request for an expedited external Complaint review with the BH-MCO within 2 business days from the date the Member receives the BH-MCO’s expedited Complaint decision. A Member who files a request for an expedited external Complaint review that disputes a decision to discontinue, reduce, or change a service that the Member has been receiving must continue to receive the disputed service at the previously authorized level pending resolution of the expedited external Complaint review if the request for expedited external Complaint review is filed orally, hand delivered, faxed, or post-marked within one business day from the mail date on the written notice of the BH-MCO’s decision if acute inpatient services are being discontinued, reduced, or changed or within 2 business days from the mail date on the written notice of the BH-MCO’s decision if any other services are being discontinued, reduced, or changed.

k. A request for an expedited external Complaint review may be filed either in writing or orally.
l. The BH-MCO must follow Department of Health guidelines relating to submission of requests for expedited external Complaint reviews.

m. The Member or the Member’s representative may file a request for a Fair Hearing within 120 Days from the mail date on the written notice of the BH-MCO’s expedited Complaint decision.

n. The BH-MCO may not take punitive action against a Provider who requests expedited resolution of a Complaint or supports a Member’s request for expedited review of a Complaint.

C. Grievance Requirements

1. Definition: A Grievance is a request to have a BH-MCO or utilization review entity reconsider a decision concerning the medical necessity and appropriateness of a covered service.

   A Grievance may be filed regarding a BH-MCO’s decision to:

   a. deny, in whole or in part, payment for a service;

   b. deny or issue a limited authorization of a requested service, including a determination based on the type or level of a service;

   c. reduce, suspend, or terminate a previously authorized service; and

   d. deny the requested service but approve an alternative service.

2. Grievance Process

   a. A BH-MCO must permit a Member to designate a representative, which may include the Member’s Provider, if the Member provides the BH-MCO with written authorization that indicates that the representative may be involved and/or act on the Member’s behalf. Failure to provide written authorization that the representative may be involved and/or act on the Member’s behalf may not delay the Grievance process.

   b. A Member or Member’s representative (if designated) may file a Grievance either orally or in writing. An oral Grievance must be committed to writing by the BH-MCO and must be provided to the Member or Member’s representative (if designated) for signature. The Member’s or Member’s representative’s signature may be obtained at any point in the process, and failure to obtain a signed Grievance may not delay the Grievance process.
c. The Member or Member’s representative (if designated) must file a Grievance within 60 Days from the date the Member receives written notice of decision.

d. A Member who files a Grievance to dispute a decision to discontinue, reduce, or change a service that the Member has been receiving must continue to receive the disputed service at the previously authorized level pending resolution of the Grievance, if the Grievance is filed orally, hand delivered, faxed, or post-marked within one Day from the mail date on the written notice of decision if acute inpatient services are being discontinued, reduced, or changed or within 10 Days from the mail date on the written notice of decision if any other services are being discontinued, reduced or changed.

e. The BH-MCO must send the Member and Member’s representative (if designated) an acknowledgment letter using the template supplied by the Department as Attachment 7 of this Appendix upon receipt of the Grievance, which can be no later than 3 business days after receipt of the Grievance if further information is needed to determine the issue the Grievance is about.

f. In order for the Provider to represent the Member in the conduct of a Grievance, the Provider must obtain the written consent of the Member and submit the written consent with the Grievance. A Provider may obtain the Member’s written permission at the time of treatment. The BH-MCO must assure that a Provider does NOT require a Member to sign a document authorizing the Provider to file a Grievance as a condition of treatment. The written consent must include:

   i. The name and address of the Member, the Member’s date of birth, and identification number,

   ii. If the Member is a minor, or is legally incompetent, the name, address, and relationship to the Member of the person who signed the consent,

   iii. The name, address, and plan identification number of the Provider to whom the Member is providing consent,

   iv. The name and address of the BH-MCO to which the Grievance will be submitted,

   v. An explanation of the specific service which was provided or denied to the Member to which the consent will apply,
vi. The following statement: “The Member or the Member’s representative may not submit a Grievance concerning the services listed in this consent form unless the Member or the Member’s representative rescinds consent in writing. The Member or Member’s representative has the right to rescind consent at any time during the Grievance process.”,

vii. The following statement: “The consent of the Member or the Member’s representative shall be automatically rescinded if the Provider fails to file a Grievance or fails to continue to prosecute the Grievance through the review process.”,

viii. The following statement: “The Member or the Member’s representative, if the Member is a minor or is legally incompetent, has read, or has been read, this consent form, and has had it explained to his/her satisfaction. The Member or the Member’s representative understands the information in the Member’s consent form.”; and

ix. The dated signature of the Member, or the Member’s representative, and the dated signature of a witness.

g. The Grievance review must be performed by a Grievance review committee made up of 3 or more individuals who were not involved in and are not subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Grievance.

h. The Grievance review committee must include at least one individual who meets the qualifications described in Appendix AA, Section C.3 for an individual that can deny a request for services based on medical necessity. Other appropriate individuals may participate in the review, but an individual who meets the qualifications described in Appendix AA, Section C.3 for an individual that can deny a request for services based on medical necessity must decide the Grievance.

i. At least one-third of the Grievance review committee may not be an employee of the BH-MCO or a related subsidiary or Affiliate.

j. At least 20% of all Grievance review committees in a year must include a consumer representative on the review committee.

k. If the Grievance involves mental health services for an adult, the consumer representative must have received or is currently receiving
mental health services. If the Grievance involves substance abuse services, the consumer representative must have received or is currently receiving substance abuse services.

l. If the Grievance involves mental health services for a child or adolescent, the consumer representative may be a parent or guardian of a child or adolescent who has received or is currently receiving mental health services or an individual who has received or is currently receiving mental health services. If the Grievance involves substance abuse services for a child or adolescent, the consumer representative may be a parent or guardian of a child or adolescent who has received or is currently receiving substance abuse services or an individual who has received or is currently receiving substance abuse services.

m. A committee member who does not personally attend the Grievance review meeting may not be part of the decision-making process unless that person actively participates in the review by telephone or videoconference and has the opportunity to review all information presented at the meeting.

n. The Grievance review committee may not discuss the Grievance prior to the review meeting.

o. The BH-MCO must afford the Member a reasonable opportunity to present testimony and evidence and make legal and factual arguments, in person as well as in writing. The BH-MCO must allow the Member or anyone the Member chooses to present the Member’s position to the Grievance review committee.

p. The Member must be provided the opportunity to appear before the Grievance review committee. The BH-MCO must be flexible when scheduling the Grievance review to facilitate the Member’s attendance. The Grievance review must be conducted at a time and place that is convenient for the Member. If the Member cannot appear in person at the Grievance review, the BH-MCO must provide an opportunity for the Member to communicate with the Grievance review committee by telephone or videoconference.

q. The BH-MCO must give the Member at least 15 Days advance written notice of the Grievance review date. The BH-MCO must document in the Grievance record the date that it notified the Member of the review date.
r. The Member may elect not to attend the Grievance review meeting, but the meeting must be conducted with the same protocols as if the Member was present.

s. A facilitator must attend the Grievance review meeting to ensure that the review meeting is conducted in accordance with the requirements set forth in this Appendix. The facilitator may not contribute to the discussion of the Grievance review committee or be involved in the decision of the Grievance review committee.

t. A BH-MCO staff member that is be prepared to provide information on the BH-MCO’s decision about the medical necessity and appropriateness of the requested services must attend the Grievance review meeting. The BH-MCO staff member may not be present during the discussion of the decision and may not be involved in the decision of the Grievance.

u. If the Member’s Provider did not file the Grievance, the Member’s Provider may participate in the Grievance review only if the Member consents to the Provider being present at the Grievance review. The BH-MCO must document the Member’s consent in the Grievance record.

v. The Grievance review committee may ask individuals who attend the Grievance review in person, by telephone, or by videoconference questions related to the subject of the Grievance.

w. County or BH-MCO staff may attend the Grievance review for training purposes if the Member consents to the staff person attending the Grievance review. The BH-MCO must document the Member’s consent in the Grievance record.

x. The BH-MCO must maintain as part of the Grievance record a sign-in sheet that includes the date and time of the review meeting; who was present at the review meeting and why the individual was present at the review meeting; if the individual attended the review meeting in person, by phone, or by videoconference; the affiliation and job title of anyone present at the review meeting other than the Member; and documentation that all individuals present at the review meeting other than the Member have acknowledged that they will keep the information discussed during the review meeting confidential. All individuals that are present at the review meeting in person must sign the sign-in sheet.

y. The decision of the Grievance review committee must take into account all comments, documents, records, and other information
submitted by the Member or Member’s representative (if designated) without regard to whether such information was submitted or considered in the initial determination of the issue. The decision of the Grievance review committee must be based solely on the information presented at the review.

z. The Grievance review committee must complete its review of the Grievance as expeditiously as the Member’s health condition requires.

aa. The testimony taken by the Grievance review committee (including the Member’s comments) must be either recorded and a summary prepared or transcribed verbatim and a summary prepared and maintained as part of the Grievance record.

bb. The BH-MCO must send a written notice of the Grievance decision to the Member, Member’s representative (if designated), service Provider, and prescribing Provider (if applicable), within 30 Days from the date the BH-MCO received the Grievance, unless the time frame for deciding the Grievance has been extended by up to 14 Days at the request of the Member. The BH-MCO must document a Member’s request for an extension in the Grievance record.

cc. The BH-MCO must use the appropriate template supplied by the Department as Attachment 8a (overturned decisions), Attachment 8b (partially overturned decisions), and Attachment 8c (upheld decisions) of this Appendix to send written notice of the Grievance decision:

i. Overturned: The review committee determined that the evidence presented supports the reversal or alteration of a prior decision concerning the medical necessity and appropriateness of the health care service.

ii. Partially Overturned: The review committee determined that the evidence presented supports the partial reversal or alteration of a prior decision concerning the medical necessity and appropriateness of the health care service.

iii. Upheld: The review committee determined that the evidence presented does not support the reversal or alteration of a prior decision concerning the medical necessity and appropriateness of the health care service.

dd. The Member may file a request for a Fair Hearing, a request for an external review, or both a request for a Fair Hearing and a request for
external review.

The Member or Member’s representative may file a request for a Fair Hearing within 120 Days from the mail date on the written notice of the BH-MCO’s Grievance decision.

The Member or Member’s representative, which may include the Member’s Provider, with proof of the Member’s written authorization for the representative to be involved and/or act on the Member’s behalf, may file a request with the BH-MCO for an external review of a Grievance decision by a certified review entity (CRE) appointed by the Department of Health. The request must be filed in writing or orally within 15 Days from the date the Member receives the written notice of the BH-MCO’s Grievance decision.

3. External Grievance Process

a. The BH-MCO must process all requests for external Grievance review. The BH-MCO must follow the protocols established by the Department of Health to meet all time frames and requirements necessary for coordinating the request and notification of the decision to the Member, Member’s representative, if the Member has designated one in writing, service Provider, and prescribing Provider.

b. A Member who files a request for external Grievance review that disputes a decision to discontinue, reduce, or change a service that the Member has been receiving must continue to receive the disputed service at the previously authorized level pending resolution of the external Grievance review, if the request for external Grievance review is filed orally, hand delivered, or post-marked within one Day from the mail date on the written notice of the BH-MCO’s Grievance decision if acute inpatient services are being discontinued, reduced, or changed or within 10 Days from the mail date on the written notice of the BH-MCO’s Grievance decision if any other services are being discontinued, reduced, or changed.

c. Within 5 business days of receipt of the request for an external Grievance review, the BH-MCO must notify the Member, the Member’s representative (if designated), the Provider if the Provider filed the request for the external Grievance review, and the Department of Health that the request for an external Grievance review has been filed.

d. The external Grievance review must be conducted by a CRE not directly affiliated with the BH-MCO.
e. Within 2 business days from receipt of the request for an external Grievance review, the Department of Health will randomly assign a CRE to conduct the review. The BH-MCO and assigned CRE will be notified of this assignment.

f. If the Department of Health fails to select a CRE within 2 business days from receipt of a request for an external Grievance review, the BH-MCO may designate a CRE to conduct a review from the list of CREs approved by the Department of Health. The BH-MCO may not select a CRE that has a current contract or is negotiating a contract with the BH-MCO or its Affiliates or is otherwise affiliated with the BH-MCO or its Affiliates.

g. The BH-MCO must forward all documentation regarding the Grievance decision, including all supporting information, a summary of applicable issues, and the basis and clinical rationale for the Grievance decision, to the CRE conducting the external Grievance review. The BH-MCO must transmit this information within 15 Days from receipt of the Member’s request for an external Grievance review.

h. The BH-MCO must inform the Member that within 15 Days from receipt of the request for an external Grievance review by the BH-MCO, the Member, the Member’s representative (if designated), or the Member’s Provider may supply additional information to the CRE conducting the external Grievance review for consideration. The BH-MCO must document in the Grievance record the date the Member was informed that the Member could supply additional information to the CRE conducting the external Grievance review for consideration. The BH-MCO must also inform the Member that the Member must provide the BH-MCO at the same time with copies of the additional information submitted so that the BH-MCO has an opportunity to consider the additional information.

i. Within 60 Days from the filing of the request for the external Grievance review, the CRE conducting the external Grievance review must issue a written decision to the BH-MCO, the Member, the Member’s representative, and the Provider (if the Provider filed the Grievance with the Member’s consent) that includes the basis and clinical rationale for the decision. The standard of review must be whether the service was medically necessary and appropriate under the terms of the BH-MCO contract.
j. The external Grievance decision may be appealed by the Member, the Member’s representative, or the Provider to a court of competent jurisdiction within 60 Days from the date the Member receives notice of the external Grievance decision.

4. Expedited Grievance Process

a. The BH-MCO must conduct an expedited review of a Grievance if the BH-MCO determines that the Member’s life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Grievance process or if a Member or a Member’s representative (if designated) provides the BH-MCO with written certification from the Member’s Provider that the Member’s life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Grievance process. The certification must include the Provider’s signature.

b. A request for an expedited review of a Grievance may be filed either in writing via mail or fax or be filed orally.

c. The expedited review process is bound by the same rules and procedures as the Grievance review process with the exception of time frames, which are modified as specified in this section.

d. Upon receipt of an oral or written request for expedited review, the BH-MCO must inform the Member of the right to present testimony and evidence and make legal and factual arguments, in person as well as in writing and of the limited time available to do so.

e. If the Provider certification is not included with the request for an expedited review and the BH-MCO cannot determine based on the information provided that the Member’s life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Grievance process, the BH-MCO must inform the Member that the Provider must submit a certification as to the reasons why the expedited review is needed. The BH-MCO must make a reasonable effort to obtain the certification from the Provider. If the Provider certification is not received within 72 hours from the Member’s request for an expedited review, the BH-MCO must decide the Grievance within the standard time frames as set forth in this Appendix, unless the time frame for deciding the Grievance has been extended by up to 14 Days at the request of the Member. If the BH-MCO decides that expedited consideration within the initial or extended time frame is not warranted, the BH-MCO must make a reasonable effort to give the Member prompt oral notice that the
Grievance is to be decided within the standard time frame and send a written notice within 2 business days of the decision to deny expedited review, using the template supplied by the Department as Attachment 8d of this Appendix.

f. A Member who files a request for expedited review of a Grievance to dispute a decision to discontinue, reduce, or change a service that the Member has been receiving must continue to receive the disputed service at the previously authorized level pending resolution of the Grievance, if the request for expedited review is filed orally, hand delivered, faxed, or post-marked within one Day from the mail date on the written notice of the BH-MCO’s decision if acute inpatient services are being discontinued, reduced, or changed or within 10 Days from the mail date on the written notice of the BH-MCO’s decision if any other services are being discontinued, reduced, or changed.

g. Expedited review of a Grievance must be performed by a Grievance review committee made up of 3 or more individuals who were not involved in and are not subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Grievance.

h. The Grievance review committee must include at least one individual who meets the qualifications described in Appendix AA, Section C.3 for an individual that can deny a request for services based on medical necessity. Other appropriate individuals may participate in the review, but the individual who meets the qualifications described in Appendix AA, Section C.3 for an individual that can deny a request for services based on medical necessity must decide the Grievance.

i. At least one-third of the Grievance review committee may not be an employee of the BH-MCO or a related subsidiary or Affiliate.

j. The Grievance review committee must prepare a summary of the issues presented and decisions made, which must be maintained as part of the Grievance record.

k. The BH-MCO must issue the decision resulting from the expedited review in person or by phone to the Member, Member’s representative (if designated), service Provider, and prescribing Provider (if applicable), within either 48 hours of receiving the Provider’s certification or 72 hours of receiving the Member’s request for an expedited review, whichever is shorter, unless the time frame for decided the expedited Grievance has been extended by up
to 14 Days at the request of the Member. The BH-MCO must document a Member’s request for an extension in the Grievance record.

1. The BH-MCO must send written notice of the Grievance decision to the Member, Member’s representative (if designated), service Provider, and prescribing Provider (if applicable), within 2 business days of the decision using the appropriate template supplied by the Department as Attachment 9a (overturned decisions), Attachment 9b (partially overturned decisions), and Attachment 9c (upheld decisions) of this Appendix:

i. Overturned: The review committee determined that the evidence presented supports the reversal or alteration of a prior decision concerning the medical necessity and appropriateness of the health care service.

ii. Partially Overturned: The review committee determined that the evidence presented supports the partial reversal or alteration of a prior decision concerning the medical necessity and appropriateness of the health care service.

iii. Upheld: The review committee determined that the evidence presented does not support the reversal or alteration of a prior decision concerning the medical necessity and appropriateness of the health care service.

m. The Member or the Member’s representative, which may include the Member’s Provider, with proof of the Member’s written authorization for the representative to be involved and/or act on the Member’s behalf, may file a request for an expedited external Grievance review with the BH-MCO within 2 business days from the date the Member receives the BH-MCO’s expedited Grievance decision. A Member who files a request for an expedited external Grievance review that disputes a decision to discontinue, reduce, or change a service that the Member has been receiving must continue to receive the disputed service at the previously authorized level pending resolution of the expedited external Grievance review if the request for expedited external Grievance review is filed orally, hand delivered, faxed, or post-marked within one business day from the mail date on the written notice of the BH-MCO’s decision if acute inpatient services are being discontinued, reduced, or changed or within 2 business days from the mail date on the written notice of the BH-MCO’s decision if any other services are being discontinued, reduced, or changed.
n. A request for an expedited external Grievance review may be filed either in writing or orally.

o. The BH-MCO must follow Department of Health guidelines relating to submission of requests for expedited external Grievance reviews.

p. The Member or the Member’s representative may file a request for a Fair Hearing within 120 Days from the mail date on the written notice of the BH-MCO’s expedited Grievance decision.

q. The BH-MCO may not take punitive action against a Provider who requests expedited resolution of a Grievance or supports a Member’s request for expedited review of a Grievance.

D. Department’s Fair Hearing Requirements

1. Fair Hearing: A hearing conducted by the Department’s Bureau of Hearings and Appeals or a Department designee.

2. Department’s Fair Hearing Process

a. A Member must file a Complaint or Grievance with the BH-MCO and receive a decision on the Complaint or Grievance before filing a request for a Fair Hearing. If the BH-MCO failed to provide written notice of a Complaint or Grievance decision within the time frames specified in this Appendix, the Member is deemed to have exhausted the Complaint or Grievance process and may request a Fair Hearing.

b. The Member or the Member’s representative may request a Fair Hearing within 120 Days from the mail date on the written notice of the BH-MCO’s Grievance decision for any of the following:

i. The denial, in whole or in part, of payment for a requested service based on lack of medical necessity;

ii. The reduction, suspension, or termination of a previously authorized service;

iii. The denial of a requested service but approval of an alternative service.

c. A Member or the Member’s representative may request a Fair Hearing within 120 Days from the mail date on the written notice of the BH-MCO’s first level Complaint decision for any of the following:
Appendix H
January 1, 2019

i. The denial of a requested service because the service is not a covered service;

ii. The failure of the BH-MCO to meet the required time frames for providing a service;

iii. The failure of the BH-MCO to decide a Complaint or Grievance within the specified time frames;

iv. The denial of payment after a service(s) has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program;

v. The denial of payment after a service(s) has been delivered because the service(s) is not a covered service(s) for the Member;

vi. The denial of a Member’s request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities.

d. The request for a Fair Hearing must include a copy of the written notice of decision that is the subject of the request unless the BH-MCO failed to provide a written notice of the Complaint or Grievance decision within the time frames specified in this Appendix.
Requests for Fair Hearings must be mailed or faxed to:

**Department of Human Services**  
**Office of Mental Health Substance Abuse Services**  
**Division of Quality Management**  
**Commonwealth Towers, 12th Floor**  
**P.O. Box 2675**  
**Harrisburg, PA 17105-2675**

or

717-772-7827

A Member who files a request for a Fair Hearing that disputes a decision to discontinue, reduce, or change a service that the Member has been receiving must continue to receive the disputed service at the previously authorized level pending resolution of the Fair Hearing, if the request for a Fair Hearing is hand delivered or post-marked within one Day from the mail date on the written notice of decision if acute inpatient services are being discontinued, reduced, or changed or within 10 Days from the mail date on the written notice of decision if any other services are being discontinued, reduced or changed.

 Upon the receipt of the request for a Fair Hearing, the Bureau of Hearings and Appeals or the Department’s designee will schedule a hearing. The Member and the BH-MCO will receive notification of the hearing date by letter at least 10 Days before the hearing date, or a shorter time if requested by the Member. The letter will outline the type of hearing, the location of the hearing (if applicable), and the date and time of the hearing.

The BH-MCO is a party to the hearing and must be present. The BH-MCO, which may be represented by an attorney, must be prepared to explain and defend the issue on appeal. The Bureau of Hearings and Appeals’ decision is based solely on the evidence presented at the hearing. The absences of the BH-MCO from the hearing will not be reason to postpone the hearing.

The BH-MCO must provide Members, at no cost, with records, reports, and documents relevant to the subject of the Fair Hearing.

The Bureau of Hearings and Appeals will issue an adjudication within 90 Days of the date the Member filed the first level Complaint or the Grievance with the BH-MCO, not including the number of Days before the Member requested the Fair Hearing. If the Bureau of Hearings and Appeals fails to issue an adjudication within 90 Days of receipt of the request for the Fair Hearing, the BH-MCO must comply with the requirements at 55 Pa. Code § 275.4 regarding
the provision of interim assistance upon the request for such by the Member. When the Member is responsible for delaying the hearing process, the time limit by which the Bureau of Hearings and Appeals must issue the adjudication prior to interim assistance being afforded will be extended by the length of the delay attributed to the Member.

k. The Bureau of Hearings and Appeals’ adjudication is binding on the BH-MCO unless reversed by the Secretary of Human Services. Either party may request reconsideration from the Secretary within 15 Days from the date of the adjudication. Only the Member may appeal to Commonwealth Court within 30 Days from the date of the adjudication or from the date of the Secretary’s final order, if reconsideration was granted. The decisions of the Secretary and the Court are binding on the BH-MCO.

3. Expedited Fair Hearing Process

a. A Member or the Member’s representative may file a request for an expedited Fair Hearing with the Department either orally or in writing.

b. A Member must exhaust the Complaint or Grievance process prior to filing a request for an expedited Fair Hearing.

c. The Bureau of Hearings and Appeals will conduct an expedited Fair Hearing if a Member or a Member’s representative provides the Department with a signed written certification from the Member’s Provider that the Member’s life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Fair Hearing process or if the Provider provides testimony at the Fair Hearing which explains why using the usual time frame would place the Member’s life, physical or mental health, or ability to attain, maintain, or regain maximum function in jeopardy.

d. A Member who files a request for an expedited Fair Hearing that disputes a decision to discontinue, reduce, or change a service that the Member has been receiving must continue to receive the disputed service at the previously authorized level pending resolution of the Fair Hearing, if the request for an expedited Fair Hearing is hand delivered, faxed, or post-marked within one Day from the mail date on the written notice of decision if acute inpatient services are being discontinued, reduced, or changed or within 10 Days from the mail date on the written notice of decision if any other services are being discontinued, reduced or changed.
e. Upon the receipt of the request for an expedited Fair Hearing, the Bureau of Hearings and Appeals or the Department’s designee will schedule a hearing.

f. The BH-MCO is a party to the hearing and must be present. The BH-MCO, which may be represented by an attorney, must be prepared to explain and defend the issue on appeal. The absence of the BH-MCO from the hearing will not be reason to postpone the hearing.

g. The BH-MCO must provide the Member, at no cost, with records, reports, and documents, relevant to the subject of the Fair Hearing.

h. The Bureau of Hearings and Appeals will issue an adjudication within 3 business days from receipt of the Member’s oral or written request for expedited review.

i. The Bureau of Hearings and Appeals’ adjudication is binding on the BH-MCO unless reversed by the Secretary of Human Services. Either party may request reconsideration from the Secretary within 15 Days from the date of the adjudication. Only the Member may appeal to Commonwealth Court within 30 Days from the date of adjudication or from the date of the Secretary’s final order, if reconsideration was granted. The decisions of the Secretary and the Court are binding on the BH-MCO.

E. **Provision of and Payment for Services Following Decision**

1. If the BH-MCO, the Bureau of Hearings and Appeals, or the Secretary reverses a decision to deny, limit, or delay services that were not furnished during the Complaint, Grievance, or Fair Hearing process, the BH-MCO must authorize or provide the disputed service as expeditiously as the Member’s health condition requires but no later than 72 hours from the date it receives notice that the decision was reversed. If the BH-MCO requests reconsideration, the BH-MCO must authorize or provide the disputed service or item pending reconsideration unless the BH-MCO requests a stay of the Bureau of Hearings and Appeals’ decision and the stay is granted.

2. If the BH-MCO, the Bureau of Hearings and Appeals, or the Secretary reverses a decision to deny authorization of services, and the Member received the disputed services during the Complaint, Grievance, or Fair Hearing process, the BH-MCO must pay for those services that the Member received.
F. Quality Review of Complaints and Grievances

1. The Primary Contractor is responsible for monitoring the Complaint and Grievance processes for compliance with this Appendix and the Program Evaluation Performance Summary (PEPS). The monitoring must include a review of the following:

   a. The Member Handbook to confirm that it describes the Complaint, Grievance, and Fair Hearing processes in accurate and easy to understand language;
   b. Complaint and Grievance decisions to determine if decisions were made within required time frames;
   c. Written notification letters;
   d. Investigations of the Complaint;
   e. When reviews are scheduled to ensure that the reviews are held in a time and place that is convenient for the Member;
   f. Complaint and Grievance trainings; and
   g. The adherence of members of the review committee to the requirements of this Appendix.

2. The Primary Contractor and BH-MCO must provide the Department with evidence of the BH-MCO’s compliance with this Appendix. This evidence must include the percentage of Complaint and Grievance cases, by level, reviewed by the Primary Contractor.

3. If as a result of the Primary Contractor’s monitoring of the Complaint and Grievance processes for compliance with this Appendix and PEPS, the Primary Contractor discovers that corrective plans of action and/or follow up activities are needed, the BH-MCO must implement the corrective plans of action and/or follow up activities.

4. When reporting on Complaint decisions, the Primary Contractor must include the following classifications:

   a. Substantiated: The available information supported the Member’s Complaint and a corrective plan of action is needed.
   b. Unsubstantiated: The available information did not support the Member’s Complaint.
ATTACHMENT 1a

Notice for Failure of BH-MCO to Meet Complaint or Grievance Time Frames

[Date the notice is mailed (1 day after the date the decision was to be made)]
[Member or Parent/Guardian Name]
[Address]
[County]

RE: [Member’s name, DOB, and Member or Denial Identifier]
Subject: Your [Complaint][Grievance]

Dear [Member or Parent/Guardian Name]:

[BH-MCO Name] has not told you its decision on your [Complaint][Grievance] about [identify subject of Complaint/Grievance], filed on [date], within [number that is 30 or fewer days] days, as required. We expect to be able to tell you our decision about your [Complaint][Grievance] by [date].

If you are unhappy that [BH-MCO Name] has not told you about its decision on your [Complaint/Grievance] within [#] days of getting it, you may file a Complaint with [BH-MCO Name] or ask for a Fair Hearing from the Department of Human Services.

1) File a Complaint

If you want to file a Complaint with [BH-MCO Name] about the delay in deciding your [Complaint][Grievance], you must file the Complaint within 60 days from the date you get this notice.

[BH-MCO Name] will tell you its decision about this new Complaint within [30, unless the BH-MCO will be using a shorter time frame to provide notice of first level Complaint decisions] days from when [BH-MCO Name] gets your Complaint.

To file a Complaint:

- By Phone: Call [BH-MCO Name] at [#];
- [Include if available] By Fax: Fax a letter to [BH-MCO FAX #]; or
- By Mail: Mail a letter to the following address:

[BH-MCO address for filing Complaint]
2) **Ask for a Fair Hearing**

If you want to ask for a Fair Hearing from the Department of Human Services about the delay in deciding your [Complaint][Grievance], your request for a Fair Hearing must be in writing and must be postmarked or received **within 120 days from the date on this notice**.

Your request for a Fair Hearing needs to include the following information:

- Your (the Member’s) name and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone; and
- The reason(s) you are asking for a Fair Hearing, or a copy of this notice.

Mail your request for a Fair Hearing to the following address:

Department of Human Services  
Office of Mental Health Substance Abuse Services  
Division of Quality Management  
Commonwealth Towers, 12th Floor  
P.O. Box 2675  
Harrisburg, PA 17105-2675

OR

Fax your request for a Fair Hearing to: 717-772-7827.

The Department will make a decision within 90 days from when you filed your [Complaint][Grievance] with [BH-MCO Name], not including the number of days between the date on this notice and date you asked for a Fair Hearing. The Department will send you a decision in writing.

If you need help filing a Complaint or asking for a Fair Hearing, or have any questions, you can call [BH-MCO Name] at [Phone #], the Pennsylvania Legal Aid Network at 1-800-322-7572 ([www.palegalaid.net](http://www.palegalaid.net)), or the Pennsylvania Health Law Project at 1-800-274-3258 ([www.phlp.org](http://www.phlp.org)).

Sincerely,

[BH-MCO Name]

cc: [Member Representative, if designated]
ATTACHMENT 1b
Notice for Payment Denial Because the Service Was Provided Without Authorization by a Provider Not Enrolled in the Pennsylvania Medical Assistance Program

THIS IS NOT A BILL

[Date the notice is mailed (date decision is made to deny payment)]
[Member or Parent/Guardian Name]
[Address]
[County]

RE: [Member’s name, DOB, and Member or Denial Identifier]

Dear [Member or Parent/Guardian Name]:

[BH-MCO Name] has reviewed the request for payment from [provider’s name] to be paid for [identify specific service] you received on [date]. Your provider’s request for payment has been denied because [provider’s name] is not enrolled in the Pennsylvania Medical Assistance Program and did not ask [BH-MCO Name] for approval to provide the service to you.

[PROVIDER’S NAME] MAY BILL YOU FOR THIS SERVICE.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY FILE A COMPLAINT with [BH-MCO Name] within 60 days from the date you get this notice. [BH-MCO Name] will tell you its decision about your Complaint within [30, unless the BH-MCO will be using a shorter time frame to provide notice of first level Complaint decisions] days from when [BH-MCO Name] gets your Complaint.

To file a Complaint

• By Phone: Call [BH-MCO Name] at [#];
• [Include if available] By Fax: Fax a letter to [BH-MCO FAX #]; or
• By Mail: Mail a letter to the following address:

[BH-MCO address for filing Complaint]

If you file a Complaint, you may ask [BH-MCO Name] to see any information used to make this decision, at no cost to you. To ask for information used to make this decision:

• By Phone: Call [BH-MCO Name] at [#];
• [Include if available] By Fax: Fax a letter to [BH-MCO Fax #]; or
• By Mail: Send a letter to the following address:

[Address for records information]

If you need help filing a Complaint or have any questions, you can call [BH-MCO Name] at [Phone #], the Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).

Sincerely,

[BH-MCO Name]

cc: [Provider]
ATTACHMENT 1c

Notice for Payment Denial Because the Service Was Not a Covered Service for the Member

THIS IS NOT A BILL

[Date the notice is mailed (date decision is made to deny payment)]
[Member or Parent/Guardian Name]
[Address]
[County]

RE: [Member’s name, DOB, and Member or Denial Identifier]

Dear [Member or Parent/Guardian Name]:

[BH-MCO Name] has reviewed the request from [provider's name] to be paid for [identify specific service] you received on [date]. Your provider’s request for payment has been denied. The service you received is not a covered service because:

________ It is not covered under the Medical Assistance Program; OR

________ It is not part of your benefit package; OR

________ [Provider’s name] is not in [BH-MCO Name]’s provider network and did not ask [BH-MCO Name] for approval to provide the service to you.

[PROVIDER’S NAME] MAY BILL YOU FOR THIS SERVICE ONLY IF [PROVIDER’S NAME] TOLD YOU THAT THE SERVICE WAS NOT COVERED FOR YOU BEFORE YOU GOT THE SERVICE.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY FILE A COMPLAINT with [BH-MCO Name] within 60 days from the date you get this notice. [BH-MCO Name] will tell you its decision about your Complaint within [30, unless the BH-MCO will be using a shorter time frame to provide notice of first level Complaint decisions] days from when [BH-MCO Name] gets your Complaint.

To file a Complaint

• By Phone: Call [BH-MCO Name] at [#];
• [Include if available] By Fax: Fax a letter to [BH-MCO FAX #]; or
• By Mail: Mail a letter to the following address:
[BH-MCO address for filing Complaint]

If you file a Complaint, you may ask [BH-MCO Name] to see any information used to make this decision, at no cost to you. To ask for information used to make this decision:

- By Phone: Call [BH-MCO Name] at [#];
- [Include if available] By Fax: Fax a letter to [BH-MCO Fax #]; or
- By Mail: Send a letter to the following address:

[Address for records information]

If you need help filing a Complaint or have any questions, you can call [BH-MCO Name] at [Phone #], the Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).

Sincerely,

[BH-MCO Name]

cc: [Provider]
Notice for Denial of Payment After a Service(s) Has Been Delivered
Because the Emergency Room Service(s) Was Not Medically Necessary

THIS IS NOT A BILL

Date the notice is mailed (date decision is made to deny payment)
[Member or Parent/Guardian Name]
[Address]
[County]

RE: [Member’s name, DOB, and Member or Denial Identifier]

Dear [Member or Parent/Guardian Name]:

[BH-MCO Name] has reviewed the request for payment from [provider's name] to be paid for [identify specific service] you received on [date]. Your provider’s request for payment has been denied.

The service you received was not medically necessary because:

[Explain at a 6th-grade reading level in detail every reason for denial. In addition to explanation for decision, include specific references to approved medical necessity guidelines, rules, or protocols on which the decision is based, in easily understood language. If denied because of insufficient information, identify all additional information needed to render decision.]

[PROVIDER’S NAME] MAY NOT BILL YOU FOR THIS SERVICE. YOU CAN SHOW THIS NOTICE TO [PROVIDER’S NAME] IF [PROVIDER’S NAME] SENDS YOU A BILL.

Sincerely,

[BH-MCO Name]

cc: [Provider]
ATTACHMENT 1e
Notice for Denial of Request to Dispute Financial Liability

THIS IS NOT A BILL

[Date the notice is mailed (date decision is made to deny request to dispute financial liability)]
[Member or Parent/Guardian Name]
[Address]
[County]

RE: [Member’s name, DOB, and Member or Denial Identifier]

Dear [Member or Parent/Guardian Name]:

[BH-MCO Name] has reviewed your disagreement with [BH-MCO Name]’s decision that you have to pay [describe financial liability] to [Provider’s name] for the [identify specific service] you received on [date]. [BH-MCO Name] has denied your request because: [Explain in detail at a 6th-grade reading level every reason for denial. If denied because of insufficient information, identify all additional information needed to render decision.]

IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY FILE A COMPLAINT with [BH-MCO Name] within 60 days from the date you get this notice. [BH-MCO Name] will tell you its decision about your Complaint within [30, unless the BH-MCO will be using a shorter time frame to provide notice of first level Complaint decisions] days from when [BH-MCO Name] gets your Complaint.

To file a Complaint

• By Phone: Call [BH-MCO Name] at [#];
• [Include if available] By Fax: Fax a letter to [BH-MCO FAX #]; or
• By Mail: Mail a letter to the following address:

[BH-MCO address for filing Complaint]

If you file a Complaint, you may ask [BH-MCO Name] to see any information used to make this decision, at no cost to you. To ask for information used to make this decision:

• By Phone: Call [BH-MCO Name] at [#];
• [Include if available] By Fax: Fax a letter to [BH-MCO FAX #]; or

Commonwealth of Pennsylvania
HealthChoices Behavioral Health
HealthChoices Behavioral Health Amendment – January 1, 2019
• By Mail: Send a letter to the following address:

[Address for records information]

If you need help filing a Complaint or have any questions, you can call [BH-MCO Name] at [Phone #], the Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).

Sincerely,

[BH-MCO Name]

cc: [Provider]
ATTACHMENT 2a

First Level Complaint Acknowledgment Letter

BH-MCO: Use this template for all Complaints EXCEPT for those involving the following:

1. A denial because the requested service is not a covered service.
2. Failure of the BH-MCO to meet the required time frames for providing a service.
3. Failure of the BH-MCO to decide a Complaint or a Grievance within the specified time frames.
4. A denial of payment after a service(s) has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program.
5. A denial of payment after a service(s) has been delivered because the service(s) is not a covered service(s) for the Member.
6. A denial of a Member’s request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities.

[Date the letter is mailed]
[Member or Parent/Guardian Name]
[Address]
[County]

RE: [Member’s name, DOB, and Member or Complaint Identifier]

Subject: Your Complaint

Dear [Member or Parent/Guardian Name]:

[BH-MCO Name] received your Complaint about:

- [list each Complaint issue].

The Complaint was received on [date of receipt].

The First Level Complaint Process

A committee of one or more [BH-MCO Name] staff members will meet to make a decision about your Complaint. This is called the “Complaint review.” The [BH-MCO Name] staff on the committee were not involved in and do not work for someone who was involved in the issue you filed your Complaint about.
At any time during the Complaint review process, you can have someone you know represent you or act for you. This person is “your representative.” If you decide to have someone represent you or act for you, tell [BH-MCO Name], in writing, the name of that person and how we can reach him or her.

You and your representative may appear at the Complaint review in person or by phone. [Or if videoconference is available: You and your representative may appear at the Complaint review in person, by phone, or by videoconference.] If you would like to attend the Complaint review and have not already told [BH-MCO Name], call [BH-MCO Name] at [BH-MCO #] within 7 days from the date of this letter and tell [BH-MCO Name] that you want to attend the Complaint review. You may also bring a family member, friend, lawyer or other person to help you during the Complaint review. If you decide that you do not want to attend, that will not affect the decision of the committee.

[BH-MCO Name] will mail you a letter within [date that is no more than 30 days from receipt of the Complaint] days from the date you filed your Complaint to tell you the decision on your Complaint.

You or your representative may ask [BH-MCO Name] to see any information about the issue you filed your Complaint about, at no cost to you.

You may also send information that you have about your Complaint to [BH-MCO Name]:

Use the following to ask for information about your Complaint or to send information to [BH-MCO Name]:

- By Phone: Call [BH-MCO Name] at [#];
- [Include if available] By Fax: Fax a letter to [BH-MCO FAX #]; or
- By Mail: Send a letter to the following address:

[BH-MCO Address]

If you think your issue is really a Grievance and should not be treated as a Complaint, you may call or write to the Pennsylvania Department of Health:

Pennsylvania Department of Health
Bureau of Managed Care
Room 912, Health & Welfare Building
625 Forster Street
Harrisburg, PA 17120-0701
Telephone: 1-888-466-2787; Fax: 1-717-705-0947
AT&T Relay: 1-800-654-5984 (for persons with hearing impairments)
If you need more information on what a Grievance is, you can read your Member handbook or call [BH-MCO Name] at [Phone #].

To get help with your Complaint

- If you need help with your Complaint, call [BH-MCO Name] at [Phone #] and [BH-MCO Name] will assign someone who has not been involved in the Complaint issue and who does not work for anyone who was involved in the Complaint issue to help you.
- If you have any questions, you can call [BH-MCO Name] at [Phone #], the Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).

Sincerely,

[BH-MCO Name]

cc: [Member Representative, if designated]
BH-MCO: Use this template **ONLY** for Complaints involving the following:

1. A denial because the requested service is not a covered service.
2. Failure of the BH-MCO to meet the required time frames for providing a service.
3. Failure of the BH-MCO to decide a Complaint or a Grievance within the specified time frames.
4. A denial of payment after a service(s) has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program.
5. A denial of payment after a service(s) has been delivered because the service(s) is not a covered service(s) for the Member.
6. A denial of a Member’s request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities.

<table>
<thead>
<tr>
<th>[Member or Parent/Guardian Name]</th>
</tr>
</thead>
<tbody>
<tr>
<td>[Address]</td>
</tr>
<tr>
<td>[County]</td>
</tr>
</tbody>
</table>

RE: [Member’s name, DOB, and Member or Complaint Identifier]

Subject: Your Complaint

Dear [Member or Parent/Guardian Name]:

On [date of receipt Complaint] [BH-MCO Name] received your Complaint that:

- [Number] you have not received your [identify type of services] in the time you should have received them.
- [Number] you did not receive a decision on the [Complaint] [Grievance] that you filed on [date Complaint or Grievance was filed] in the time you should have received it.
- [Number] you disagree with the decision to deny the request for [identify specific services] because the requested service is not a covered service for you.
- [Number] you disagree with the decision to deny payment to [provider’s name] because [provider’s name] is not enrolled in the Pennsylvania Medical Assistance Program.
Appendix H
January 1, 2019

Assistance Program and did not receive authorization to provide [identify specific services] to you.

____ you disagree with the decision to deny payment to [provider’s name] because the [identify specific services] you received is not a covered service.

____ you disagree with [BH-MCO Name]’s decision that you have to pay [describe financial liability] to [Provider’s name] for the [identify specific service] you received on [date].

Your Complaint is also about:

• [list each Complaint issue].

The Complaint Process

A committee of one or more [BH-MCO Name] staff members will meet to make a decision about your Complaint. This is called the “Complaint review.” The [BH-MCO Name] staff on the committee were not involved in and do not work for someone who was involved in the issue you filed your Complaint about.

At any time during the Complaint review process, you can have someone you know represent you or act for you. This person is “your representative.” If you decide to have someone represent you or act for you, tell [BH-MCO Name], in writing, the name of that person and how we can reach him or her.

You and your representative may appear at the Complaint review in person or by phone. [Or if videoconference is available: You and your representative may appear at the Complaint review in person, by phone, or by videoconference.] If you would like to attend the Complaint review and have not already told [BH-MCO Name], call [BH-MCO Name] at [BH-MCO #] within 7 days from the date of this letter and tell [BH-MCO Name] that you want to attend the Complaint review. You may also bring a family member, friend, lawyer or other person to help you during the Complaint review. If you decide that you do not want to attend, that will not affect the decision of the committee.

[BH-MCO Name] will mail you a letter within [date that is no more than 30 days from receipt of the Complaint] days from the date you filed your Complaint to tell the decision on your Complaint.

You or your representative may ask [BH-MCO Name] to see any information about the issue you filed your Complaint about, at no cost to you.
You may also send information that you have about your Complaint to [BH-MCO Name]:

Use the following to ask for information about your Complaint or to send information to [BH-MCO Name]:

- By Phone: Call [BH-MCO Name] at [#];
- [Include if available] By Fax: Fax a letter to [BH-MCO FAX #]; or
- By Mail: Send a letter to the following address:

[BH-MCO Address]

[BH-MCO: Include the following paragraph only if the Complaint is about the failure of the BH-MCO to meet the required time frames for providing a service]To ask for an early decision

If your doctor or psychologist believes that waiting [30, unless the BH-MCO will be using a shorter time frame to provide notice of Complaint decisions] days to get a decision could harm your health, you may ask that your Complaint be decided more quickly. For your Complaint to be decided more quickly:

- You must ask for an early decision by:
  - Calling [BH-MCO Name] at [#]; or
  - [Include if available] Faxing a letter to [BH-MCO Name] at [Fax #]
- Your doctor or psychologist should fax a signed letter to [BH-MCO fax #] within 72 hours of your request for an early decision that explains why [BH-MCO Name] taking [30, unless the BH-MCO will be using a shorter time frame] days to tell you the decision about your Complaint could harm your health.

[BH-MCO Name] will tell you the decision about your Complaint within 48 hours from when [BH-MCO Name] gets your doctor’s or psychologist’s letter, or within 72 hours from when [BH-MCO Name] gets your request for an early decision, whichever is sooner, unless you ask [BH-MCO Name] to take more time to decide your Complaint. You can ask us to take up to 14 more days to decide your Complaint.

If you think your issue is really a Grievance and should not be treated as a Complaint, you may call or write to the Pennsylvania Department of Health:

Pennsylvania Department of Health
Bureau of Managed Care
Room 912, Health & Welfare Building
625 Forster Street
Harrisburg, PA  17120-0701
If you need more information on what a Grievance is, you can read your Member handbook or call us at [BH-MCO Name] at [Phone #].

**To get help with your Complaint**

- If you need help with your Complaint, call [BH-MCO Name] at [Phone #] and [BH-MCO Name] will assign someone who has not been involved in the Complaint issue and who does not work for anyone who was involved in the Complaint issue to help you.
- If you have any questions, you can call [BH-MCO Name] at [Phone #], the Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).

Sincerely,

[BH-MCO Name]

cc: [Member Representative, if designated]
ATTACHMENT 3a

First Level Complaint Decision Notice

BH-MCO, Use this template for all Complaints EXCEPT for those involving the following:

1. A denial because the requested service is not a covered service.
2. Failure of the BH-MCO to meet the required time frames for providing a service.
3. Failure of the BH-MCO to decide a Complaint or a Grievance within the specified time frames.
4. A denial of payment after a service(s) has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program.
5. A denial of payment after a service(s) has been delivered because the service(s) is not a covered service(s) for the Member.
6. A denial of a Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities.

[Date the notice is mailed (date of Complaint decision)]
[Member or Parent/Guardian Name]
[Address]
[County]

RE: [Member's name, DOB, and Member or Complaint Identifier]

Subject: Decision About Your First Level Complaint

Dear [Member or Parent/Guardian Name]:

[BH-MCO Name] has reviewed your Complaint received on [date].

Based on a review of all information provided, the first level Complaint review committee has decided that:

• [List each Complaint issue and the decision separately in its own bullet at a 6th grade reading level.]

The reasons for this decision are:

[Explain at a 6th grade reading level in detail every reason for the decision on each Complaint issue. In addition to explanation for decision, include if applicable specific references to approved medical necessity guidelines, rules, or protocols on which the decision is based, in easily understood]
language. If denied because of insufficient information, identify all additional information needed to render decision.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY FILE A SECOND LEVEL COMPLAINT with [BH-MCO Name] within 45 days from the date you get this notice. [BH-MCO Name] will tell you the decision on your second level Complaint within [45, unless the BH-MCO will be using a shorter time frame to provide notice of second level Complaint decisions] days from when [BH-MCO Name] receives your second level Complaint.

To file a second level Complaint:

- By Phone: Call [BH-MCO Name] at [#];
- [Include if available] Fax: Fax a letter to [BH-MCO FAX #]; or
- By Mail: Mail a letter to the following address:

[BH-MCO Address for filing Complaint]

Ask for Information Used to Make This Decision

You or your representative make ask [BH-MCO Name] to see any information used to decide your first level Complaint, at no cost to you.

To ask for information used to decide your first level Complaint:

- By Phone: Call [BH-MCO Name] at [#];
- [Include if available] Fax: Fax a letter to [BH-MCO FAX #]; or
- By Mail: Send a letter to the following address:

[Address for records information]

To get help with a second level Complaint

- If you need help filing your second level Complaint or any other help with your second level Complaint, call [BH-MCO Name] at [Phone #] and [BH-MCO Name] will assign someone who has not been involved in the Complaint issue and who does not work for anyone who was involved in the Complaint issue to help you.
- If you have any questions, you can call [BH-MCO Name] at [Phone #], the Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).
Sincerely,

[BH-MCO Name]

cc: [Member Representative, if designated]  
    [Provider, if applicable]
ATTACHMENT 3b

Complaint Decision Notice

BH-MCO, Use this template ONLY for Complaints involving the following:

1. A denial because the requested service is not a covered service.
2. Failure of the BH-MCO to meet the required time frames for providing a service.
3. Failure of the BH-MCO to decide a Complaint or a Grievance within the specified time frames.
4. A denial of payment after a service(s) has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program.
5. A denial of payment after a service(s) has been delivered because the service(s) is not a covered service(s) for the Member.
6. A denial of a Member’s request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities.

[Date the notice is mailed (date of the Complaint decision)]
[Member or Parent/Guardian Name]
[Address]
[County]

RE: [Member's name, DOB, and Member or Complaint Identifier]

Subject: Decision About Your Complaint

Dear [Member or Parent/Guardian Name]:

[BH-MCO Name] has reviewed your Complaint received on [date].

Based on a review of all information provided, the Complaint review committee has decided that:

- [List each Complaint issue and the decision separately in its own bullet at a 6th grade reading level.]

The reasons for this decision are:

[Explain at a 6th grade reading level in detail every reason for the decision on each Complaint issue. In addition to explanation for decision, include specific references to approved medical necessity guidelines, rules, or]
protocols on which the decision is based, in easily understood language. If
denied because of insufficient information, identify all additional
information needed to render decision.]

[BH-MCO: Include the following paragraph only if the Complaint challenges a denial because the service is not a covered service.]

**To continue getting services**

If you have been getting the services that are being reduced, changed, or denied and your request for an external review or a Fair Hearing (see instructions below) is hand-delivered, faxed, or postmarked **within 1 day from the date on this notice if acute inpatient services are being reduced, changed, or denied or within 10 days from the date on this notice if any other services are being reduced, changed, or denied**, the services will continue until a decision is made.

**IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY DO ONE OR BOTH OF THE FOLLOWING:**

1) **Ask for an External Review**

You may ask for an “external review” of the Complaint decision from the Pennsylvania Department of Health or the Pennsylvania Insurance Department **within 15 days from the date you get this notice**.

To ask for an external review of your Complaint, send your request to one of the following addresses:

**Pennsylvania Department of Health**
Bureau of Managed Care
Room 912, Health & Welfare Building
625 Forster Street
Harrisburg, PA 17120-0701
Telephone: 1-888-466-2787
Fax: 1-717-705-0947
AT&T Relay: 1-800-654-5984 (for persons with hearing impairments)

**Pennsylvania Insurance Department**
Bureau of Customer Service
1321 Strawberry Square
Harrisburg, PA 17120
Telephone: 1-877-881-6388

Commonwealth of Pennsylvania
HealthChoices Behavioral Health
HealthChoices Behavioral Health Amendment – January 1, 2019
Your request for external review by either Department must include the following information:

- Your (the Member’s) name, address, and day time telephone number;
- Your (the Member’s) [BH-MCO Name] identification number;
- [BH-MCO Name]’s name;
- A brief description of the issue;
- A copy of this notice.

If you send your request for external review to the wrong Department, that Department will send it to the other Department.

2) **Ask for a Fair Hearing**

You may ask for a Fair Hearing from the Department of Human Services. Your request for a Fair Hearing must be in writing and must be postmarked or received within 120 days from the date on this notice. Your request should include the following information:

- Your (the Member’s) name and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- The reason(s) you are asking for a Fair Hearing, or a copy of this notice;
- A copy of the original denial notice, if available. **[BH-MCO: Include this last item only for Complaints challenging a denial because a service is not a covered service or because the service was provided without authorization by a non-MA provider.]**

Mail your request for a Fair Hearing to the following address:

Department of Human Services  
Office of Mental Health Substance Abuse Services  
Division of Quality Management  
Commonwealth Towers, 12th Floor  
P.O. Box 2675  
Harrisburg, PA 17105-2675

OR

Fax your request for a Fair Hearing to: 717-772-7827.

The Department will make a decision within 90 days from when you filed your Complaint with [BH-MCO Name], not including the number of days between the date on this notice and the date you asked for a Fair Hearing. The Department will send you a decision in writing.
To ask for an early decision

If your doctor or psychologist believes that waiting the usual time frame for deciding a Fair Hearing could harm your health, you may ask that the Fair Hearing take place more quickly. For a decision to be made more quickly:

- You can ask for an early decision by calling the Department at 1-877-356-5355 or by faxing a letter to 1-717-772-7827.

- Your doctor or psychologist must fax a signed letter to 1-717-772-7827 explaining why taking the usual amount of time to decide your request for a Fair Hearing could harm your health. If your doctor or psychologist does not send a letter, your doctor or psychologist must testify at the Fair Hearing to explain why taking the usual amount of time to decide your request for a Fair Hearing could harm your health.

The Department will schedule a telephone hearing and tell you its decision within 3 business days from when it receives your request.

Ask for Information Used to Make This Decision

You or your representative may ask [BH-MCO Name] to see any information used to decide your Complaint, at no cost to you.

To ask for information used to decide your Complaint:

- By Phone: Call [BH-MCO Name] at [#];
- [Include if available] By Fax: Fax a letter to [BH-MCO FAX #]; or
- By Mail: Send a letter to the following address:

  [Address for records information]

Help with Your Request for an External Review or a Fair Hearing

- If you need help asking for an external review, call [BH-MCO Name] at Phone [#] and [BH-MCO Name] will assign someone who has not been involved in the Complaint issue and does not work for anyone who was involved in the Complaint issue to help you.

- If you have any questions, or need help filing a request for a Fair Hearing, you can call [BH-MCO Name] at [Phone #], the Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).
Sincerely,

[BH-MCO Name]

cc:  [Member Representative, if designated]  
     [Provider, if applicable]
ATTACHMENT 4

Second Level Complaint Acknowledgment Letter

[DATE the letter is mailed]
[Member or Parent/Guardian Name]
[Address]
[County]

RE: [Member’s name, DOB, and Member or Complaint Identifier]

Subject: Your Second Level Complaint

Dear [Member or Parent/Guardian Name]:

[BH-MCO Name] received your second level Complaint about:

- [list each Complaint issue].

The Complaint was received on [date of receipt].

Second Level Complaint Process

A committee of 3 or more people, including at least one person who does not work for [BH-MCO Name], will meet to make a decision about your Second Level Complaint. This is called the “Complaint review.” The [BH-MCO Name] staff on the committee were not involved in and do not work for someone who was involved in the issue you filed your Complaint about.

At any time during the Complaint review process, you can have someone you know represent you or act for you. This person is “your representative.” If you decide to have someone represent you or act for you, tell [BH-MCO Name], in writing, the name of that person and how we can reach him or her.

You and your representative may appear at the Complaint review in person or by phone. [Or if videoconference is available: You and your representative may appear at the Complaint review in person, by phone, or by videoconference.] If you would like to attend the Complaint review and have not already told [BH-MCO Name], call [BH-MCO Name] at [BH-MCO #] within 7 days from the date of this letter and tell [BH-MCO Name] that you want to attend the Complaint review. You may also bring a family member, friend, lawyer or other person to help you during the Complaint review. We will send you another letter at least 15 days before the date of the Complaint review, telling you the place, date, and
time of the review. If you decide that you do not want to attend, that will not affect the decision of the committee.

[BH-MCO Name] will mail you a letter within [date that is no more than 45 days from receipt of the second level Complaint] days from the date you filed your second level Complaint to tell you the decision on your second level Complaint.

You or your representative may ask [BH-MCO Name] to see any information about the issue you filed your Complaint about, at no cost to you.

You may also send information that you have about your Complaint to [BH-MCO Name]:

Use the following to ask for information about your Complaint or to send information to [BH-MCO Name]:

- By Phone: Call [BH-MCO Name] at [#];
- [Include if available] By Fax: Fax a letter to [BH-MCO FAX #]; or
- By Mail: Send a letter to the following address:

[BH-MCO Address]

To get help with your Complaint

- If you need help with your Complaint, call [BH-MCO Name] at [Phone #] and [BH-MCO Name] will assign someone who has not been involved in the Complaint issue and who does not work for anyone who was involved in the Complaint issue to help you.
- If you have any questions, you can call [BH-MCO Name] at [Phone #], the Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).

Sincerely,

[BH-MCO Name]

cc: [Member Representative, if designated]
Second Level Complaint Decision Notice

[Date the notice is mailed (date of the second level Complaint decision)]
[Member or Parent/Guardian Name]
[Address]
[County]

RE: [Member’s name, DOB, and Member or Complaint Identifier]

Subject: Decision About Your Second Level Complaint

Dear [Member or Parent/Guardian Name]:

[BH-MCO Name] has reviewed your second level Complaint received on [date]. Based on a review of all information provided, the second level Complaint review committee has decided that:

- [List each Complaint issue and the decision separately in its own bullet at a 6th grade reading level.]

The reasons for this decision are:

[Explain at a 6th grade reading level in detail every reason for the decision on each Complaint issue. In addition to explanation for decision, include if applicable specific references to approved medical necessity guidelines, rules, or protocols on which the decision is based, in easily understood language. If denied because of insufficient information, identify all additional information needed to render decision.]

IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY ASK FOR AN EXTERNAL REVIEW OF THE SECOND LEVEL COMPLAINT DECISION from the Pennsylvania Department of Health or the Pennsylvania Insurance Department within 15 days from the date you get this notice.

To ask for an external review of your Complaint, send your request to one of the following addresses:

Pennsylvania Department of Health
Bureau of Managed Care
Room 912, Health & Welfare Building
625 Forster Street
Harrisburg, PA 17120-0701
Your request for external review by either Department must include the following information:

- Your (the Member's) name, address, and day time telephone number;
- Your (the Member’s) [BH-MCO Name] identification number;
- [BH-MCO Name]’s name;
- A brief description of the issue;
- A copy of this notice.

If you send your request for external review to the wrong Department, that Department will send it to the other Department.

**Ask for Information Used to Make this Decision**

You or your representative may ask [BH-MCO Name] to see any information used to decide your second level Complaint at no cost to you.

To ask for information used to decide your second level Complaint:

- By Phone: Call [BH-MCO Name] at [#];
- [Include if available] By Fax: Fax a letter to [BH-MCO FAX #]; or
- By Mail: Send a letter to the following address:

  [BH-MCO Address]

**Help with Your Request for External Review**

- If you need help asking for an external review, call [BH-MCO Name] at [Phone #] and [BH-MCO Name] will assign someone who has not been involved in the Complaint issue and does not work for anyone who was involved in the Complaint issue to help you.
- If you have any questions, you can call [BH-MCO Name] at [Phone #], the Pennsylvania Legal Aid Network at 1-800-322-7572.
Sincerely,

[BH-MCO Name]

cc:  [Member Representative, if designated]
     [Provider, if applicable]
ATTACHMENT 6a

Notice of Failure to Receive Provider Certification for an Expedited Complaint

[Date the notice is mailed (no more than 2 days after date of decision to deny expedited review)]

[Member or Parent/Guardian Name]
[Address]
[County]

RE: [Member’s name, DOB, and Member or Complaint Identifier]

Subject: Request for Expedited Complaint

Dear [Member or Parent/Guardian Name]:

[BH-MCO Name] received your Complaint about [identify subject of Complaint], on [date] and your request to have the Complaint decided more quickly than the usual [30, unless the BH-MCO will be using a shorter time frame to provide notice of first level Complaint decisions]-day time frame. As we told you in the notice that you have filed your Complaint about, in order for your Complaint to be decided more quickly, your [doctor][psychologist] should have sent us a signed letter stating that taking the usual amount of time to decide the Complaint could harm your health. [BH-MCO Name] also asked your [doctor][psychologist] for this letter.

[BH-MCO Name] has not received your [doctor’s][psychologist’s] letter and the information provided does not show that taking the usual amount of time to decide your Complaint could harm your health. [BH-MCO Name] will be deciding your Complaint in the usual time frame of [30, unless the BH-MCO will be using a shorter time frame to provide notice of first level Complaint decisions] days from when we first got your Complaint.

The Complaint Process

A committee of one or more [BH-MCO Name] staff members will meet to make a decision about your Complaint. This is called the “Complaint review.” The [BH-MCO Name] staff on the committee were not involved in and do not work for someone who was involved in the issue you filed your Complaint about.

At any time during the Complaint process, you can have someone you know represent you or act for you. This person is “your representative.” If you decide
to have someone represent you or act for you, tell [BH-MCO Name], in writing, the name of that person and how we can reach him or her.

You and your representative may appear at the Complaint review in person or by phone. [Or if videoconference is available: You and your representative may appear at the Complaint review in person, by phone, or by videoconference.] If you would like to attend the Complaint review and have not already told [BH-MCO Name], call [BH-MCO Name] at [BH-MCO #] within 7 days from the date of this letter and tell [BH-MCO Name] that you want to attend the Complaint review. You may also bring a family member, friend, lawyer or other person to help you during the Complaint review. If you decide that you do not want to attend, that will not affect the decision of the committee.

[BH-MCO Name] will mail you a letter within [date that is no more than 30 days from receipt of the Complaint] days from the date you filed your Complaint to tell you the decision on your Complaint.

You or your representative may ask [BH-MCO Name] to see any information about the issue you filed your Complaint about, at no cost to you.

You may also send information that you have about your Complaint to [BH-MCO Name]:

Use the following to ask for information about your Complaint or to send information to [BH-MCO Name]:

- By Phone: Call [BH-MCO Name] at [#];
- [Include if available] By Fax: Fax a letter to [BH-MCO FAX #]; or
- By Mail: Send a letter to the following address:

[BH-MCO Address]

To get help with your Complaint

- If you need help with your Complaint, call [BH-MCO Name] at [Phone #], and [BH-MCO Name] will assign someone who has not been involved in the Complaint issue and who does not work for anyone who was involved in the Complaint issue to help you.
- If you have any questions, you can call [BH-MCO Name] at [Phone #], the Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).

Sincerely,
[BH-MCO Name]

cc: [Member Representative, if designated]
[Provider]
Expedited Complaint Decision Notice

[Date Notice Mailed (no more than 2 days after the date of the decision)]

Date notice is mailed
[Member or Parent/Guardian Name]
[Address]
[County]

RE: [Member's name, DOB, and Member or Complaint Identifier]

Subject: Decision About Your Expedited Complaint

Dear [Member Name]:

[BH-MCO Name] has reviewed your Complaint received on [date].

Based on a review of all information provided, the Complaint review committee has decided that:

- [List each Complaint issue and the decision separately in its own bullet at a 6th grade reading level.]

The reasons for this decision are:

[Explain at a 6th grade reading level in detail every reason for the decision on each Complaint issue. In addition to explanation for decision, include specific references to approved medical necessity guidelines, rules, or protocols on which the decision is based in easily understood language. If denied because of insufficient information, identify all additional information needed to render decision.]

[BH-MCO: Include the following paragraph only if the Complaint challenges a denial because the service is not a covered service.]
IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY DO THE FOLLOWING:

Ask for an Expedited External Review

You may ask for an “expedited external review” of the Complaint decision from the Pennsylvania Department of Health **within 2 business days from the date you get this notice.**

To ask for an expedited external review of your Complaint:

- By Phone: Call [BH-MCO Name] at [#];
- [Include if available] By Fax: Fax a letter to [BH-MCO FAX #]; or
- By Mail: Send a letter to the following address:

[BH-MCO Address for requesting external review]

[BH-MCO: Include the following paragraphs on Fair Hearings only if the Complaint is about the following: Failure to provide services in a timely manner or a denial of a service because the service is not a covered service.]

Ask for a Fair Hearing

You may also ask for a Fair Hearing from the Department of Human Services.

**To ask for an early decision**

If your doctor or psychologist believes that waiting the usual time frame for deciding a Fair Hearing (within 90 days) could harm your health, you may ask that the Fair Hearing take place more quickly. For a decision to be made more quickly:

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To continue getting services

If you have been getting the services that are being reduced, changed, or denied and your request for an external review or a Fair Hearing (see instructions below) is made orally, hand-delivered, faxed, or postmarked **within 1 day from the date on this notice if acute inpatient services are being reduced, changed, or denied or within 10 days from the date on this if any other services are being reduced, changed, or denied,** the services will continue until a decision is made.
• You can ask for an early decision by calling the Department at 1-877-356-5355 or by faxing a letter to 1-717-772-7827.

• Your doctor or psychologist must fax a signed letter to 1-717-772-7827 explaining why taking the usual amount of time to decide your request for a Fair Hearing could harm your health. If your doctor or psychologist does not send a letter, your doctor or psychologist must testify at the Fair Hearing to explain why taking the usual amount of time to decide your request for a Fair Hearing could harm your health.

The Department will schedule a telephone hearing and tell you its decision within 3 business days from when it receives your request.

Even if you no longer need an early decision, you may ask for a Fair Hearing in writing. Your request for a Fair Hearing must be and postmarked or received within 120 days from the date on this notice.

Your request should include the following information:

• Your (the Member's) name and date of birth;
• A telephone number where you can be reached during the day;
• Whether you want to have a hearing in person or by telephone;
• The reason(s) you are asking for a Fair Hearing, or a copy of this notice;
• A copy of the original denial notice, if available. [BH-MCO: Include this last item only for Complaints challenging a denial because the service is not a covered service.]

Mail your request for a Fair Hearing to the following address:

Department of Human Services
Office of Mental Health Substance Abuse Services
Division of Quality Management
Commonwealth Towers, 12th Floor
P.O. Box 2675
Harrisburg, PA 17105-2675

OR

Fax your request for a Fair Hearing to: 717-772-7827.

The Department will issue a decision within 90 days from when you filed your Complaint with [BH-MCO Name], not including the number of days between the date on this notice and the date you asked for a Fair Hearing. The Department will send you a decision in writing.
Ask for Information Used to Make This Decision

You or your representative make ask [BH-MCO Name] to see any information used to decide your Complaint, at no cost to you.

To ask for information used to decide your Complaint:

- By Phone: Call [BH-MCO Name] at [#];
- [Include if available] By Fax: Fax a letter to [BH-MCO FAX #]; or
- By Mail: Send a letter to the following address:

[Address for records information]

Help with Your Request for Expedited External Review [Include Fair Hearing, if applicable]

- If you need help asking for an external review, call [BH-MCO Name] at [Phone #] and [BH-MCO Name] will assign someone who has not been involved in the Complaint issue and does not work for anyone who was involved in the Complaint issue to help you.
- If you have any questions, [BH-MCO: Include the following, if applicable] or need help filing a request for a Fair Hearing, you can call [BH-MCO Name] at [Phone #], the Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).

Sincerely,

[BH-MCO Name]

cc:  [Member Representative, if designated]
     [Provider, if applicable]
ATTACHMENT 7

Grievance Acknowledgment Letter

[Date the letter is mailed]
[Member or Parent/Guardian Name]
[Address]
[County]

RE: [Member’s name, DOB, and Member or Grievance Identifier]

Dear [Member or Parent/Guardian Name]:

[BH-MCO Name] received your Grievance about:

The denial of the following services:

- [list all services denied]
- [include each individual service in its own bullet]
- [include specifics of the request, including hours per week, service type, and dates requested]

The Grievance was received on [date of receipt].

The Grievance Process

A committee of 3 or more people, which includes a licensed doctor or licensed psychologist, and at least one person who does not work for [BH-MCO Name], will meet to decide your Grievance. This is called the “Grievance review.” The [BH-MCO Name] staff on the committee were not involved and do no work for someone who was involved in the issue you filed your Grievance about.

At any time during the Grievance process, you can have someone you know represent you or act for you. This person is “your representative.” If you decide to have someone represent you or act for you, tell [BH-MCO Name], in writing, the name of that person and how we can reach him or her.

You and your representative may appear at the Grievance review in person or by phone. [OR if videoconference is available: You and your representative may appear at the Grievance review in person, by phone, or by videoconference.] If you would like to attend the Grievance review and have not already told [BH-MCO Name], call [BH-MCO Name] at [BH-MCO #] within 7 days from the date...
of this letter and tell [BH-MCO Name] that you want to attend the Grievance review. You may also bring a family member, friend, lawyer or other person to help you during the Grievance review. We will send you another letter at least 15 days before the date of the Grievance review, telling you the place, date, and time of the review. If you decide that you do not want to attend, that will not affect the decision of the committee.

[BH-MCO Name] will mail you a letter within [date that is no more than 30 days from receipt of the Grievance] days from the date you filed your Grievance to tell you the decision on your Grievance.

You or your representative may ask [BH-MCO Name] to see any information that [BH-MCO Name] used to make the decision about the issue you filed your Grievance about, at no cost to you.

You may also send information that you have about your Grievance to [BH-MCO Name]:

Use the following to ask for information used to make the decision you filed your Grievance about or to send information about your Grievance to [BH-MCO Name]:

- By Phone: Call [BH-MCO Name] at [#];
- [Include if available] By Fax: Fax a letter to [BH-MCO FAX #]; or
- By Mail: Send a letter to the following address:

[BH-MCO Address]

If you think your issue is really a Complaint and should not be treated as a Grievance, you may call or write to the Pennsylvania Department of Health:

Pennsylvania Department of Health
Bureau of Managed Care
Room 912, Health & Welfare Building
625 Forster Street
Harrisburg, PA 17120-0701
Telephone: 1-888-466-2787; Fax: 1-717-705-0947
AT&T Relay: 1-800-654-5984 (for persons with hearing impairments)

If you need more information on what a Complaint is, you can read your Member handbook or call [BH-MCO Name] at [Phone #].

To get help with your Grievance

- If you need help with your Grievance, call [BH-MCO Name] at [Phone #] and [BH-MCO Name] will assign someone who has not been involved in
the Grievance issue and does not work for anyone who was involved in
the Grievance issue to help you.

- If you have any questions, you can call [BH-MCO Name] at [Phone #],
  the Pennsylvania Legal Aid Network at 1-800-322-7572
  (www.palegalaid.net), or the Pennsylvania Health Law Project at 1-800-
  274-3258 (www.phlp.org).

Sincerely,

[BH-MCO Name]

cc:  [Member Representative, if designated]
     [Provider]
ATTACHMENT 8a

Grievance Decision Notice
[Use for Grievances that are overturned]

[Date the notice is mailed]
[Member or Parent/Guardian Name]
[Address]
[County]

RE: [Member's name, DOB, and Member or Grievance Identifier]

Subject: Decision About Your Grievance

Dear [Member or Parent/Guardian Name]:

[BH-MCO Name] reviewed your Grievance received on [date] about the denial of [identify type of services requested] services.

Based on a review of all information provided, the Grievance review committee has decided that the decision to deny services is overturned and you should receive all of the requested services.

The following services were requested on [include date of the original requested services]:

- [list all services requested]
- [include each individual service requested in its own bullet]
- [include specifics of the request, including hours per week, service type, and dates requested]

The following services were authorized:

- [list all services approved]
- [designate if a service was approved other than requested]
- [include each individual service approved in its own bullet]
- [include specifics of the services approved, including hours per week, service type, and dates requested]
- [if no services were approved do not include this category]

The following services were denied:

- [list all services denied]
- [include each individual service denied in its own bullet]
As a result of the decision of the Grievance review committee the following services have been authorized effective [include date of the decision] until [include date authorized services will end]:

- [list all services approved, list must be the same as the list of services originally requested]

The reasons for this decision are:

[Explain at a 6th grade reading level in detail every reason for the decision. In addition to explanation for decision, include specific references to approved medical necessity guidelines, rules, or protocols on which decision is based in easily understood language.]

Sincerely,

[BH-MCO Name]

cc: [Member Representative, if designated]  [Provider]
ATTACHMENT 8b

Grievance Decision Notice
[Use for Grievances that are partially overturned]

[Date the notice is mailed]
[Member or Parent/Guardian Name]
[Address]
[County]

RE: [Member’s name, DOB, and Member or Grievance Identifier]

Subject: Decision About Your Grievance

Dear [Member or Parent/Guardian Name]:

[BH-MCO Name] has reviewed your Grievance received on [date] about the denial of [identify type of services requested] services.

Based on a review of all information provided, the Grievance review committee has decided that the decision to deny services is partially overturned.

The following services were requested on [include date of original requested services]:

- [list all services requested]
- [include each individual service requested in its own bullet]
- [include specifics of the request, including hours per week, service type, and dates requested]

The following services were authorized:

- [list all services approved]
- [designate if a service was approved other than requested]
- [include each individual service approved in its own bullet]
- [include specifics of the services approved, including hours per week, service type, and dates requested]
- [if no services were approved do not include this category]

The following services were denied:

- [list all services denied]
- [include each individual service denied in its own bullet]
- [include specifics of the services denied, including hours per week, service type, and dates requested]
As a result of the decision of the Grievance review committee the following services have been authorized from [include date of the decision] until [include date authorized services will end]:

- [list all approved services]
- [designate if a service was approved other than requested]
- [include each individual service approved in its own bullet]
- [include specifics of the services approved, including hours per week, service type, and dates requested]

As a result of the decision of the Grievance review committee the following services have been denied:

- [list all services denied]
- [include each individual service denied in its own bullet]
- [include specifics of the service denied, including hours per week, service type, and dates requested]

The reasons for this decision are:

[Explain at a 6th grade reading level in detail every reason for the decision. In addition to explanation for decision, include specific references to approved medical necessity guidelines, rules, or protocols on which decision is based in easily understood language. If denied because of insufficient information, identify all additional information needed to render decision.]

To continue getting services

If you have been getting the services that are being reduced, changed, or denied and your request for an external review or a Fair Hearing (see instructions below) is received by the BH-MCO or the Department of Human Services or postmarked within 1 day from the date on this notice if acute inpatient services are being reduced, changed, or denied or within 10 days from the date on this notice if any other services are being reduced, changed, or denied, the services will continue until a decision is made.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY DO ONE OR BOTH OF THE FOLLOWING:

1) Ask for an External Review
You may ask for an “external review” of the Grievance decision **within 15 days from the date you get this notice**. An external review is a review by a licensed doctor who does not work for [BH-MCO Name].

To ask for an external review of your Grievance:

- By Phone: Call [BH-MCO Name] at [#];
- [Include if available] By Fax: Fax a letter to [BH-MCO FAX #]; or
- By Mail: Send a letter to the following address:

  **[BH-MCO Address for requesting external review]**

[BH-MCO Name] will send your request to the Pennsylvania Department of Health. The Department of Health will send you more information about the external review process.

2) **Ask for a Fair Hearing**

You may ask for a Fair Hearing from the Department of Human Services. Your request for a Fair Hearing must be in writing and must be postmarked or received **within 120 days from the date on this notice**. Your request should include the following information:

- Your (the Member’s) name and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- The reason(s) you are asking for a Fair Hearing, or a copy of this notice; and
- A copy of the original denial notice, if available.

Mail your request for a Fair Hearing to the following address:

  Department of Human Services  
  Office of Mental Health Substance Abuse Services  
  Division of Quality Management  
  Commonwealth Towers, 12th Floor  
  P.O. Box 2675  
  Harrisburg, PA 17105-2675

OR

Fax your request for a Fair Hearing to: 717-772-7827.

The Department will make a decision within 90 days from when you filed your Grievance with [BH-MCO Name], not including the number of days between the
date on this notice and the date you asked for a Fair Hearing. The Department will send you a decision in writing.

**To ask for an early decision**

If your doctor or psychologist believes that waiting the usual time frame for deciding a Fair Hearing could harm your health, you may ask that the Fair Hearing take place more quickly. For a decision to be made more quickly:

- You can ask for an early decision by calling the Department at 1-877-356-5355 or by faxing a letter to 1-717-772-7827.

- Your doctor or psychologist must fax a signed letter to 1-717-772-7827 explaining why taking the usual amount of time to decide your request for a Fair Hearing could harm your health. If your doctor or psychologist does not send a letter, your doctor or psychologist must testify at the Fair Hearing to explain why taking the usual amount of time to decide your request for a Fair Hearing could harm your health.

The Department will schedule a telephone hearing and tell you its decision within 3 business days from when it receives your request.

**Ask for Information Used to Make This Decision**

You or your representative may ask [BH-MCO Name] to see any information [BH-MCO Name] used to decide your Grievance, at no cost to you.

To ask for the information used to decide your Grievance:

- By Phone: Call [BH-MCO Name] at [#];
- [Include if available] By Fax: Fax a letter to [BH-MCO FAX #]; or
- By Mail: Send a letter to the following address:

  [Address for records information]

**Help with Your Request for External Review or Fair Hearing**

- If you need help asking for an external review, call [BH-MCO Name] at [Phone #] and [BH-MCO Name] will assign someone who has not been involved in the Grievance issue and does not work for anyone who was involved in the Grievance issue to help you.

- If you have any questions, or need help filing a request for a Fair Hearing, you can call [BH-MCO Name] at [Phone #], the Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).
Sincerely,

[BH-MCO Name]

cc: [Member Representative, if designated]
    [Provider]
ATTACHMENT 8c

Grievance Decision Notice
[Use for Grievances that are upheld]

[Date the notice is mailed]
[Member or Parent/Guardian Name]
[Address]
[County]

RE: [Member’s name, DOB, and Member or Grievance Identifier]

Subject: Decision About Your Grievance

Dear [Member or Parent/Guardian Name]:

[BH-MCO Name] has reviewed your Grievance received on [date] about the denial of [identify type of services requested] services.

Based on a review of all information provided, the Grievance review committee has decided that the decision to deny services is upheld. As a result of the decision of the Grievance review committee there is no change in the services authorized for you.

The following services were requested on [include date of original requested services]:

- [list all services requested]
- [include each individual service requested in its own bullet]
- [include specifics of the request, including hours per week, service type, and dates requested]

The following services were authorized:

- [list all services approved]
- [designate if a service was approved other than requested]
- [include each individual service approved in its own bullet]
- [include specifics of the services approved, including hours per week, service type, and dates requested]
- [if no services were approved do not include this category]

The following services were denied:

- [list all services denied]
Appendix H
January 1, 2019

- [include each individual service denied in its own bullet]
- [include specifics of the services denied, including hours per week, service type, and dates requested]

The reasons for this decision are:

[Explain at a 6th grade reading level in detail every reason for the denial. In addition to explanation for decision, include specific references to approved medical necessity guidelines, rules, or protocols on which the decision is based in easily understood language. If denied because of insufficient information, identify all additional information needed to render decision.]

To continue getting services

If you have been getting the services that are being reduced, changed, or denied and your request for an external review or a Fair Hearing (see instructions below) is received by the BH-MCO or the Department of Human Services or postmarked within 1 day from the date on this notice if acute inpatient services are being reduced, changed, or denied or within 10 days from the date on this notice if any other services are being reduced, changed, or denied, the services will continue until a decision is made.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY DO ONE OR BOTH OF THE FOLLOWING:

1) Ask for an External Review

You may ask for an “external review” of the Grievance decision within 15 days from the date you get this notice. An external review is a review by a licensed doctor who does not work for [BH-MCO Name].

To ask for an external review of your Grievance:

- By Phone: Call [BH-MCO Name] at [#];
- [Include if available] By Fax: Fax a letter to [BH-MCO FAX #]; or
- By Mail: Send a letter to the following address:

[BH-MCO Address for requesting external review]

[BH-MCO Name] will send your request to the Pennsylvania Department of Health. The Department of Health will send you more information about the external review process.
2) **Ask for a Fair Hearing**

You may ask for a Fair Hearing from the Department of Human Services. Your request for a Fair Hearing must be in writing and must be postmarked or received **within 120 days from the date on this notice**. Your request should include the following information:

- Your (the Member’s) name and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- The reason(s) you are asking for a Fair Hearing, or a copy of this notice; and
- A copy of the original denial notice, if available.

Mail your request for a Fair Hearing to the following address:

Department of Human Services  
Office of Mental Health Substance Abuse Services  
Division of Quality Management  
Commonwealth Towers, 12th Floor  
P.O. Box 2675  
Harrisburg, PA 17105-2675

OR

Fax your request for a Fair Hearing to: 717-772-7827.

The Department will make a decision within 90 days from when you filed your Grievance with [BH-MCO Name], not including the number of days between the date on this notice and the date you asked for a Fair Hearing. The Department will send you a decision in writing.

**To ask for an early decision**

If your doctor or psychologist believes that waiting the usual time frame for deciding a Fair Hearing could harm your health, you may ask that the Fair Hearing take place more quickly. For a decision to be made more quickly:

- You can ask for an early decision by calling the Department at 1-877-356-5355 or by faxing your request to 1-717-772-7827.
- Your doctor or psychologist must fax a signed letter to 1-717-772-7827 explaining why taking the usual amount of time to decide your request for a Fair Hearing could harm your health. If your doctor or
psychologist does not send a letter, your doctor or psychologist must testify at the Fair Hearing to explain why taking the usual amount of time to decide your request for a Fair Hearing could harm your health.

The Department will schedule a telephone hearing and tell you its decision within 3 business days from when it receives your request.

Ask for Information Used to Make This Decision

You or your representative may ask [BH-MCO Name] to see any information used to decide your Grievance, at no cost to you.

To ask for the information used to decide your Grievance:

- By Phone: Call [BH-MCO Name] at [#];
- [Include if available] By Fax: Fax a letter to [BH-MCO FAX #]; or
- By Mail: Send a letter to the following address:

[Address for records information]

Help with Your Request for External Review or Fair Hearing

- If you need help asking for an external review, call [BH-MCO Name] at [Phone #] and [BH-MCO Name] will assign someone who has not been involved in the Grievance issue and does not work for anyone who was involved in the Grievance issue to help you.
- If you have any questions, or need help filing a request for a Fair Hearing, you can call [BH-MCO Name] at [Phone #], the Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).

Sincerely,

[BH-MCO Name]

cc: [Member Representative, if designated]
    [Provider]
Notice of Failure to Receive Provider Certification for an Expedited Grievance

[Date the notice is mailed (no more than 2 business days after date of decision to deny expedited review)]
[Member or Parent/Guardian Name]
[Address]
[County]

RE: [Member’s name, DOB, and Member or Grievance Identifier]

Subject: Request for Expedited Grievance

Dear [Member or Parent/Guardian Name]:

[BH-MCO Name] received your Grievance about [identify subject of Grievance], on [date] and your request to have the Grievance decided more quickly than the usual [30, unless the BH-MCO will be using a shorter time frame to provide notice of Grievance decisions]-day time frame. As we told you in the notice that you have filed your Grievance about, in order for your Grievance to be decided more quickly, your [doctor][psychologist] should have sent us a signed letter stating that taking the usual amount of time to decide the Grievance could harm your health. [BH-MCO Name] also asked your [doctor][psychologist] for this letter.

[BH-MCO Name] has not received your [doctor’s][psychologist’s] letter and the information provided does not show that taking the usual amount of time to decide your Grievance could harm your health. [BH-MCO Name] will be deciding your Grievance in the usual time frame of [30, unless the BH-MCO will be using a shorter time frame to provide notice of Grievance decisions] days from when we first got your Grievance.

The Grievance Process

A committee of 3 or more people, which includes a licensed doctor or licensed psychologist, and at least one person who does not work for [BH-MCO Name], will meet to decide your Grievance. This is called the “Grievance review.” The [BH-MCO Name] staff on the committee were not involved and do not work for someone who was involved in the issue you filed your Grievance about.

At any time during the Grievance process, you can have someone you know represent you or act for you. This person is “your representative.” If you decide...
to have someone represent you or act for you, tell [BH-MCO Name], in writing, the name of that person and how we can reach him or her.

You and your representative may appear at the Grievance review in person or by phone. [OR, if videoconference is available: You and your representative may appear at the Grievance review in person, by phone, or by videoconference.] If you would like to attend the Grievance review and have not already told [BH-MCO Name], call [BH-MCO Name] at [BH-MCO #] within 7 days from the date of this letter and tell [BH-MCO Name] that you want to attend the Grievance review. You may also bring a family member, friend, lawyer or other person to help you during the Grievance review. We will send you another letter at least 15 days before the date of the Grievance review, telling you the place, date, and time of the review. If you decide that you do not want to attend, that will not affect the decision of the committee.

[BH-MCO Name] will mail you a letter within [date that is no more than 30 days from receipt of the Grievance] days from the date you filed your Grievance to tell you the decision on your Grievance.

You or your representative may ask [BH-MCO Name] to see any information about the issue you filed your Grievance about, at no cost to you.

You may also send information that you have about your Grievance to [BH-MCO Name]:

Use the following to ask for information about your Grievance or to send information to [BH-MCO Name]:

- By Phone: Call [BH-MCO Name] at [#];
- [Include if available] By Fax: Fax a letter to [BH-MCO FAX #]; or
- By Mail: Send a letter to the following address:
  
  [BH-MCO Address]

**To get help with your Grievance**

- If you need help with your Grievance, call [BH-MCO Name] at [Phone #] and [BH-MCO Name] will assign someone who has not been involved in the Grievance issue and who does not work for anyone who was involved in the Grievance issue to help you.
- If you have any questions, you can call [BH-MCO Name] at [Phone #], the Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).
Sincerely,

[BH-MCO Name]

cc: [Member Representative, if designated]
[Provider]
ATTACHMENT 9a

Expedited Grievance Decision Notice
[Use for expedited Grievances that are overturned]

[Date the notice is mailed (no more than 2 business days after date of decision)]
[Member or Parent/Guardian Name]
[Address]
[County]

RE: [Member’s name, DOB, and Member or Grievance Identifier]

Subject: Decision About Your Expedited Grievance

Dear [Member or Parent/Guardian Name]:

[BH-MCO Name] reviewed your Grievance received on [date] about the denial of [identify type of services requested] services.

Based on a review of all information provided, the Grievance review committee has decided that the decision to deny services is overturned and you should receive all of the requested services.

The following services were requested on [include date of the original requested services]:

- [list all services requested]
  - [include each individual service requested in its own bullet]
  - [include specifics of the request, including hours per week, service type, and dates requested]

The following services were authorized:

- [list all services approved]
  - [designate if a service was approved other than requested]
  - [include each individual service approved in its own bullet]
  - [include specifics of the services approved, including hours per week, service type, and dates requested]
  - [if no services were approved do not include this category]

The following services were denied:

- [list all services denied]
  - [include each individual service denied in its own bullet]
[include specifics of the services denied, including hours per week, service type, and dates requested]

As a result of the decision of the Grievance review committee the following services have been authorized effective [include date of the decision] until [include date authorized services will end]:
  • [list all services approved, list must be the same as the list of services originally requested]

The reasons for this decision are:

[Explain at a 6th grade reading level in detail every reason for the decision. In addition to explanation for decision, include specific references to approved medical necessity guidelines, rules, or protocols on which decision is based in easily understood language.].

Sincerely,

[BH-MCO Name]

cc: [Member Representative, if designated]
    [Provider]
ATTACHMENT 9b

Expedited Grievance Decision Notice
[Use for expedited Grievances that are partially overturned]

[Date the notice is mailed (no more than 2 business days after date of decision)]
[Member or Parent/Guardian Name]
[Address]
[County]

RE: [Member’s name, DOB, and Member or Grievance Identifier]

Subject: Decision About Your Expedited Grievance

Dear [Member or Parent/Guardian Name]:

[BH-MCO Name] has reviewed your Grievance received on [date] about the denial of [identify type of services requested] services.

Based on a review of all information provided, the Grievance review committee has decided that the decision to deny services is partially overturned.

The following services were requested on [include date of original requested services]:

- [list all services requested]
- [include each individual service requested in its own bullet]
- [include specifics of the request, including hours per week, service type, and dates requested]

The following services were authorized:

- [list all services approved]
- [designate if a service was approved other than requested]
- [include each individual service approved in its own bullet]
- [include specifics of the services approved, including hours per week, service type, and dates requested]
- [if no services were approved do not include this category]

The following services were denied:

- [list all services denied]
- [include each individual service denied in its own bullet]
As a result of the decision of the Grievance review committee the following services have been authorized from [include date of the decision] until [include date authorized services will end]:

- [list all approved services]
- [designate if a service was approved other than requested]
- [include each individual service approved in its own bullet]
- [include specifics of the services approved, including hours per week, service type, and dates requested]

As a result of the decision of the Grievance review committee the following services have been denied:

- [list all services denied]
- [include each individual service denied in its own bullet]
- [include specifics of the service denied, including hours per week, service type, and dates requested]

The reasons for this decision are:

[Explain at a 6th grade reading level in detail every reason for the decision. In addition to explanation for decision, include specific references to approved medical necessity guidelines, rules, or protocols on which decision is based in easily understood language. If denied because of insufficient information, identify all additional information needed to render decision.]

**To continue getting services**

If you have been getting the services that are being reduced, changed, or denied and your request for an external review or a Fair Hearing (see instructions below) is received by the BH-MCO or the Department of Human Services or postmarked within 1 day from the date on this notice if acute inpatient services are being reduced, changed, or denied or within 10 days from the date on this notice if any other services are being reduced, changed, or denied, the services will continue until a decision is made.
1) Ask for an Expedited External Review

You may ask for an “expedited external review” of the Grievance decision from the Pennsylvania Department of Health **within 2 business days from the date you get this notice**. An external review is a review by a licensed doctor who does not work for [BH-MCO Name].

To ask for an expedited external review of your Grievance:

- By Phone: Call [BH-MCO Name] at [#];
- [Include if available] By Fax: Fax a letter to [BH-MCO FAX #]; or
- By Mail: Send a letter to the following address:

  [BH-MCO Address for requesting external review]

[BH-MCO Name] will send your request to the Pennsylvania Department of Health. The Department of Health will send you more information about the expedited external review process.

2) Ask for a Fair Hearing

You may also ask for a Fair Hearing from the Department of Human Services.

**To ask for an early decision**

If your doctor or psychologist still believes that waiting the usual time frame for deciding a Fair Hearing (within 90 days) could harm your health, you may ask that the Fair Hearing take place more quickly. For a decision to be made more quickly:

- You can ask for an early decision by calling the Department at 1-877-356-5355 or by faxing a letter to 1-717-772-7827;
- Your doctor or psychologist must fax a signed letter to 1-717-772-7827 explaining why taking the usual amount of time to decide your request for a Fair Hearing could harm your health. If your doctor or psychologist does not send a letter, your doctor or psychologist must testify at the Fair Hearing to explain why taking the usual amount of time to decide your request for a Fair Hearing could harm your health.

The Department will schedule a telephone hearing and tell you its decision within 3 business days from when it receives your request.

Even if you no longer need an early decision, you may ask for a Fair Hearing in writing. Your request for a Fair Hearing must be postmarked or received **within**
120 days from the date on this notice. Your request should include the following information:

- Your (the Member’s) name and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- The reason(s) you are asking for a Fair Hearing, or a copy of this notice; and
- A copy of the original denial notice, if available.

Mail your request for a Fair Hearing to the following address:

Department of Human Services  
Office of Mental Health Substance Abuse Services  
Division of Quality Management  
Commonwealth Towers, 12th Floor  
P.O. Box 2675  
Harrisburg, PA 17105-2675

OR

Fax your request for a Fair Hearing to: 717-772-7827.

The Department will make a decision within 90 days from when you filed your Grievance with [BH-MCO Name], not including the number of days between the date on this notice and the date you asked for a Fair Hearing. The Department will send you a decision in writing.

Ask for Information Used to Make This Decision

You or your representative may ask [BH-MCO Name] to see any information used to decide your Grievance, at no cost to you.

To ask for the information used to decide your Grievance:

- By Phone: Call [BH-MCO Name] at [#];
- [Include if available] By Fax: Fax a letter to [BH-MCO FAX #]; or
- By Mail: Send a letter to the following address:

[Address for records information]

Help with Your Request for External Review or Fair Hearing

- If you need help asking for an external review, call [BH-MCO Name] at [Phone #] and [BH-MCO Name] will assign someone who has not been
involved in the Grievance issue and does not work for anyone who was involved in the Grievance issue to help you.

- If you have any questions, or need help filing a request for a Fair Hearing, you can call [BH-MCO Name] at [Phone #], the Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).

Sincerely,

[BH-MCO Name]

cc: [Member Representative, if designated]
[Provider]
ATTACHMENT 9c

Expedited Grievance Decision Notice
[Use for expedited Grievances that are upheld]

[Date the notice is mailed (no more than 2 business days after date of decision)]
[Member or Parent/Guardian Name]
[Address]
[County]

RE: [Member’s name, DOB, and Member or Grievance Identifier]

Subject: Decision About Your Expedited Grievance

Dear [Member or Parent/Guardian Name]:

[BH-MCO Name] has reviewed your Grievance received on [date] about the denial of [identify type of services requested] services.

Based on a review of all information provided, the Grievance review committee has decided that the decision to deny services is upheld. As a result of the decision of the Grievance review committee there is no change in the services authorized for you.

The following services were requested on [include date of original requested services]:

- [list all services requested]
- [include each individual service requested in its own bullet]
- [include specifics of the request, including hours per week, service type, and dates requested]

The following services were authorized:

- [list all services approved]
- [designate if a service was approved other than requested]
- [include each individual service approved in its own bullet]
- [include specifics of the services approved, including hours per week, service type, and dates requested]
- [if no services were approved do not include this category]

The following services were denied:
Appendix H
January 1, 2019

• [list all services denied]
• [include each individual service denied in its own bullet]
• [include specifics of the services denied, including hours per week, service type, and dates requested]

The reasons for this decision are:

[Explain at a 6th grade reading level in detail every reason for the denial. In addition to explanation for decision, include specific references to approved medical necessity guidelines, rules, or protocols on which the decision is based in easily understood language. If denied because of insufficient information, identify all additional information needed to render decision.]

To continue getting services

If you have been getting the services that are being reduced, changed, or denied and your request for an external review or a Fair Hearing (see instructions below) is received by the BH-MCO or the Department of Human Services or postmarked within 1 day from the date on this notice if acute inpatient services are being reduced, changed, or denied or within 10 days from the date on this notice if any other services are being reduced, changed, or denied, the services will continue until a decision is made.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY DO ONE OR BOTH OF THE FOLLOWING:

1) Ask for an Expedited External Review

You may ask for an “expedited external review” of the Grievance decision from the Pennsylvania Department of Health within 2 business days from the date you get this notice. An external review is a review by a licensed doctor who does not work for [BH-MCO Name].

To ask for an expedited external review of your Grievance:

• By Phone: Call [BH-MCO Name] at [#];
• [Include if available] By Fax: Fax a letter to [BH-MCO FAX #]; or
• By Mail: Send a letter to the following address:

[BH-MCO Address for requesting external review]
[BH-MCO Name] will send your request to the Pennsylvania Department of Health. The Department of Health will send you more information about the expedited external review process.

2) **Ask for a Fair Hearing**

You may also ask for a Fair Hearing from the Department of Human Services.

**To ask for an early decision**

If your doctor or psychologist still believes that waiting the usual time frame for deciding a Fair Hearing (within 90 days) could harm your health, you may ask that the Fair Hearing take place more quickly. For a decision to be made more quickly:

- You can ask for an early decision by calling the Department at 1-877-356-5355 or by faxing a letter to 1-717-772-7827;
- Your doctor or psychologist must fax a signed letter to 1-717-772-7827 explaining why taking the usual amount of time to decide your request for a Fair Hearing could harm your health. If your doctor or psychologist does not send a letter, your doctor or psychologist must testify at the Fair Hearing to explain why taking the usual amount of time to decide your request for a Fair Hearing could harm your health.

The Department will schedule a telephone hearing and tell you its decision within 3 business days from when it receives your request.

Even if you no longer need an early decision, you may ask for a Fair Hearing in writing. Your request for a Fair Hearing must be and postmarked or received within **120 days from the date on this notice**. Your request should include the following information:

- Your (the Member’s) name and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- The reason(s) you are asking for a Fair Hearing, or a copy of this notice; and
- A copy of the original denial notice, if available.

Mail your request for a Fair Hearing to the following address:

Department of Human Services  
Office of Mental Health Substance Abuse Services  
Division of Quality Management
Commonwealth Towers, 12th Floor
P.O. Box 2675
Harrisburg, PA 17105-2675

OR

Fax your request for a Fair Hearing to: 717-772-7827.

The Department will make a decision within 90 days from when you filed your Grievance with [BH-MCO Name], not including the number of days between the date on this notice and the date you asked for a Fair Hearing. The Department will send you a decision in writing.

Ask for Information Used to Make This Decision

You or your representative may ask [BH-MCO Name] to see any information used to decide your Grievance, at no cost to you.

To ask for the information used to decide your Grievance:

- By Phone: Call [BH-MCO Name] at [#];
- [Include if available] By Fax: Fax a letter to [BH-MCO FAX #]; or
- By Mail: Send a letter to the following address:

  [Address for records information]

Help with Your Request for External Review or Fair Hearing

- If you need help asking for an external review, call [BH-MCO Name] at [Phone #] and [BH-MCO Name] will assign someone who has not been involved in the Grievance issue and does not work for anyone who was involved in the Grievance issue to help you.
- If you have any questions, or need help filing a request for a Fair Hearing, you can call [BH-MCO Name] at [Phone #], the Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).

Sincerely,

[BH-MCO Name]

cc: [Member Representative, if designated]
    [Provider]
ATTACHMENT 10a

Non-Discrimination Notice

Notice will be distributed separately. The Department is still revising.
ATTACHMENT 10b

Language Assistance Services

English
ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call: [BH-MCO phone number] (TTY phone number).

Spanish
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al [BH-MCO phone number] (TTY phone number).

Russian
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните [BH-MCO phone number] (TTY phone number).

Chinese
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 [BH-MCO phone number] (TTY phone number).

Vietnamese
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số [BH-MCO phone number] (TTY phone number).

Arabic
انتهاء: إذا كنت تتحدث العربية، فإن خدمات مساعدة اللغة، مجانًا، متوفرة لك. اتصل بالرقم: [BH-MCO phone number] (TTY phone number).

Nepali
ध्यान दिनुहोस्: यदि तपाईं नेपाली बोलनुहुन्छ भने, भाषा सहायता सेवाहरू, नि: शुल्क, तपाईँलाई उपलब्ध छ। सम्पर्क गर्नु: [BH-MCO phone number] (TTY phone number)।

Korean
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. [BH-MCO phone number] (TTY: phone number) 번으로 전화해 주십시오.

Cambodian/Khmer
កម្មារបសិនេបើអកនិយម។អកប្រឹងប្រាក់ប្រឹងការដឹកជញ្ជូនជាច្រើនកុម្រប្រញាពីស្នូតម្រូរដែលមាន: [BH-MCO phone number] (TTY phone number)។
ATTENTION: Si vous parlez français, des services d’aide linguistique vous sont proposés gratuitement. Appelez le [BH-MCO phone number] (TTY phone number).

Burmese
အထူးဂရုပြုရန်: သင်အင်္ဂလိပ်ထက်အခြားဘာသာစကားတစ်ခုကိုမပြောတတ်လျင်, တာဝန်ခံအခမဲ့ဘာသာစကားအကူအညီများနှင့် အချက်အချက် [BH-MCO phone number] (TTY phone number).

Haitian Creole
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele [BH-MCO phone number] (TTY phone number).

Portuguese
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para [BH-MCO phone number] (TTY phone number).

Bengali
সতর্কতা: যদি আপনি বাঙালি, বিনামূল্যে ভাষা সহায়তা সেবা, আপনার জন্য উপলব্ধ। কল করুন: [BH-MCO phone number] (TTY phone number).

Albanian
KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në [BH-MCO phone number] (TTY phone number).

Gujarati
સાવધાન: જો તમે ગુજરાતી બોલતા હોવ તો ભાષા સહાય સેવાઓ મફતમાં ઉપલબ્ધ છે. કૉલ કરો: [BH-MCO phone number] (TTY phone number).