WelbeHealth
8399 Garvey Avenue
Rosemead, CA 91770
(800) 851-0966

INFORMATION FOR PARTICIPANTS ABOUT THE APPEALS PROCESS

All of us at Pacific PACE, LLC (dba WelbeHealth) share responsibility for your care and your satisfaction with the services you receive. Our appeals process is designed to enable you and/or your representative the opportunity to respond to a decision made by the Interdisciplinary Team regarding your request for a service or payment of a service. At any time, you wish to file an appeal, we are available to assist you. If you do not speak English, a bilingual staff member or translation services will be available to assist you.

You will not be discriminated against because an appeal has been filed. WelbeHealth will continue to provide you with all the required services during the appeals process. The confidentiality of your appeal will be maintained throughout and after the appeals process and information pertaining to your appeal will only be released to authorized individuals.

When WelbeHealth decides not to cover or pay for a service you want, you may take action to change our decision. The action you take—whether verbally or in writing— is called an "**appeal."** You have the right to appeal any decision about our failure to approve, furnish, arrange for, or continue what you believe are covered services or to pay for services that you believe we are required to pay.

You will receive written information on the appeals process at enrollment (see your *Participant Enrollment Agreement Terms and Conditions*) and annually after that. You will also receive this information and necessary appeals forms whenever WelbeHealth modifies, defers, or denies a request for a service or request for payment.

Definitions:

A. An **appeal** is defined as a participant's action taken with respect to the PACE organization's noncoverage of, or nonpayment for, a service, including denials, reductions, or termination of services.

B. A **representative** is the person who is acting on your behalf or assisting you, and may include, but is not limited to, a family member, a friend, a PACE staff or a person legally identified as Power of Attorney for Health Care/Advanced Directive, Conservator, Guardian, etc.

C. **Standard and Expedited Appeals Processes**: There are two types of appeals processes - standard and expedited. Both processes are described below.

   If you request a **standard appeal**, your appeal must be filed within one-hundred-and eighty (180) calendar days of when your request for service or payment of service was denied, deferred, or modified. This is the date which appears on the Notice of Action for Service or Payment Request. (The 180 calendar-day limit may be extended for good cause.) We will respond to your appeal as quickly as your health requires, but no later than thirty (30) calendar days after we receive your appeal.

   If you believe that your life, health, or ability to get well is in danger without the service you want, you or any treating physician may ask for an **expedited appeal**. If the treating physician asks for an expedited appeal for you, or supports you in asking for one, we will automatically decide on your appeal as promptly as your health requires, but no later than seventy-two (72) hours after we receive your request for an appeal. We may extend this time up to fourteen (14) calendar days if you ask for the extension or if we justify to the Department of Health Care Services the need for more information and how the delay benefits you.

   If you ask for an **expedited appeal** without support from a treating doctor, we will decide if your health condition requires us to decide on an expedited basis.

If we decide to deny you an **expedited appeal**, we will let you know within seventy-two (72) hours. If this happens, your appeal will be considered a standard appeal.

Note: For WelbeHealth participants enrolled in Medi-Cal – WelbeHealth will continue to provide the disputed service(s) if you choose to continue receiving the service(s) until the appeals process is completed. If our initial decision to NOT cover or reduce services is upheld, you may be financially responsible for the payment of disputed service(s) provided during the appeals process.

The information below describes the appeals process for you or your representative to follow should you or your representative wish to file an appeal:

A. If you or your representative has requested a service or payment for a service and WelbeHealth denies, defers, or modifies the request, you may appeal the decision. A written "*Notice of Action of Service or Payment Request*" (NOA) will be provided to you and/or your representative who will explain the reason for the denial, deferral or modification of your service request or request for payment.
B. You can make your appeal either verbally (in person or by telephone) or in writing to the WelbeHealth Program staff of the center you attend. The staff will make sure that you are provided with written information on the appeals process, and that your appeal is documented in the appropriate form. You will need to provide complete information of your appeal so the appropriate staff person can help to resolve your appeal in a timely and efficient manner. You or your representative may present or submit relevant facts and/or evidence for review. To submit relevant facts and/or evidence in writing, please send it to the address listed below. Otherwise, you or your representative may submit this information in person. If staff need more information, the Quality Improvement Coordinator will contact you.
C. If you wish to make your appeal by telephone, you may contact our Quality Improvement Coordinator at TOLL-FREE PHONE#, during our normal hours of

operation, Monday through Friday 8:00am-4:30pm to request an appeal form and/or to receive assistance in filing an appeal. For the hearing impaired (TTY/TDD), please call 711.

D. If you wish to submit your appeal in writing, please ask a staff person for an appeal form. Please send your written appeal to:

WelbeHealth
Attention: Quality Improvement Department
8399 Garvey Avenue
Rosemead, CA 91770

E. WelbeHealth will send you a written acknowledgement of receipt of your appeal within five (5) working days for a standard appeal. For an expedited appeal, we will notify you or your representative within one (1) business day by telephone or in person that the request for an expedited appeal has been received.

F. The reconsideration of WelbeHealth's decision will be made by a person(s) not involved in the initial decision-making process in consultation with the Interdisciplinary Team. We will ensure that this person(s) is both impartial and appropriately credentialed to decide regarding the necessity of the services you requested.

G. Upon WelbeHealth's completion of the review of your appeal, you or your representative will be notified in writing of the decision on your appeal. As necessary and depending on the outcome of the decision, WelbeHealth will inform you and/or your representative of other appeal rights you may have if the decision is not in your favor. Please refer to the information described below:

The Decision on your Appeal:

A. ***If we decide fully in your favor*** on a **standard appeal** for a request for ***service***, we are required to provide or arrange for services as quickly as your health condition requires, but no later than thirty (30) calendar days from when we

received your request for an appeal. **If we decide in your favor** on a request for ***payment***, we are required to make the requested payment within sixty (60) calendar days after receiving your request for an appeal.

B. **If we <u>do not</u> decide fully in your favor** on a **<u>standard appeal</u>** or if we fail to provide you with a decision within thirty (30) calendar days, you have the right to pursue an external appeal through either the Medicare or Medi-Cal program (see **Additional Appeal Rights**, below). We also are required to notify you as soon as we decide and to notify the federal Center for Medicare and Medicaid Services and the Department of Health Care Services. We will inform you in writing of your **external** appeal rights under Medicare or Medi-Cal managed care, or both. We will help you choose which external program to pursue if both are applicable. We also will send your appeal to the appropriate external program for review.

   If we decide fully in your favor on an **<u>expedited appeal</u>**, we are required to get the service or give you the service as quickly as your health condition requires, but no later than seventy-two (72) hours after we receive your request for an appeal.

   If we <u>do not</u> decide in your favor on an **<u>expedited appeal</u>** or fail to notify you within seventy-two (72) hours, you have the right to pursue an external appeal process under either Medicare or Medicaid (see **Additional Appeal Rights**). We are required to notify you as soon as we decide and to notify the Center for Medicare and Medicaid Services and the Department of Health Care Services. We let you know in writing of your external appeal rights under the Medicare or Medi-Cal program, or both. We will help you choose which to pursue if both are applicable. We also will send your appeal to the appropriate external program for review.

Additional Appeal Rights under Medi-Cal and Medicare:

A. If we do not decide in your favor on your appeal or fail to provide you with a decision within the required time, you have additional appeal rights. Your

request to file an external appeal can be made either verbally or in writing. The next level of appeal involves a new and impartial review of your appeal request through either the Medicare or Medi-Cal program.

B. The **Medicare program** contracts with an "Independent Review Organization" to provide external review on appeals involving PACE programs. This review organization is completely independent of WelbeHealth.
C. The **Medi-Cal program** conducts their next level of appeal through the State hearing process. If you are enrolled in Medi-Cal, you can appeal if WelbeHealth wants to reduce or stop a service you are receiving. Until you receive a final decision, you may choose to continue to receive the disputed service(s). However, you may have to pay for the service(s) if the decision is not in your favor.
D. If you are enrolled in the **Medicare Medi-Cal program or both**, we will help you choose which external appeal process you should follow. We also will send your appeal on to the appropriate external program for review.
E. If you are not sure which program you are enrolled in, ask us. The Medicare and Medi-Cal external appeal options are described below.

<u>Medi-Cal External Appeals Process</u>:

A. If you are enrolled in both **Medicare and Medi-Cal OR Medi-Cal only** and choose to appeal our decision using Medi-Cal's external appeals process, we will send your appeal to the California Department of Social Services. At any time during the appeals process, you may request a State hearing through:

California Department of Social Services
State Hearings Division
P.O. Box 944243, Mail Station 19-37
Sacramento, CA 94244-2430
Telephone: 1-800-952-5253
Facsimile: (916) 229-4410
TDD: 1-800-952-8349

B. If you choose to request a State hearing, you must ask for it within ninety (90) calendar days from the date of receiving the *Notice of Action (NOA) for Service or Payment Request* from WelbeHealth.
C. You may speak at the State hearing or have someone else speak on your behalf such as someone you know, including a relative, friend, or an attorney. You may also be able to get free legal help. Attached is a list of Legal Services offices in if you would like legal services assistance.
D. If the Administrative Law Judge's (ALJ) decision is in favor of your appeal, WelbeHealth will follow the judge's instruction as to the time for providing you with services you requested or payment for services for a standard or expedited appeal.
E. If the ALJ's decision is **not** in favor of your appeal, for either a standard or an expedited appeal, there are further levels of appeals, and we will assist you in pursuing your appeal.

Medicare External Appeals Process:

A. If you are enrolled in **both Medicare and Medi-Cal OR Medicare only** and choose to appeal our decision using Medicare's external appeals process, we will send your appeal file to the current contracted Medicare appeals entity to impartially review the appeal. The contracted Medicare appeals entity will contact us with the results of their review. The contracted Medicare appeals entity will either maintain our original decision or change our decision and rule in your favor.