OMH Summary on Managed Care Grievances & Appeals Process

Behavioral Health Medicaid Managed Care: Grievances and Appeals Process
By OMH Division of Managed Care
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Behavioral Health services are being carved into managed care. As result, providers, consumers, and their authorized representatives may now file complaints and appeals with their managed care plans.

Consumer and Provider Complaints
There may be times when a Medicaid consumer or a provider is not satisfied with the care or services that a managed care plan is providing to a consumer. In those situations, consumers and providers may file a formal complaint with the plan, the State, or both.

To file a complaint with a managed care plan:
A provider, a consumer, or a consumer's authorized representative can file a complaint with the plan. A member can send a complaint in writing, via e-mail, or by phone. Specific information about how to file a complaint can be found in the member handbook. The managed care plan will review the complaint and notify the person who made the complaint about the decision. If the person who made the complaint disagrees with the plan's decision, that person can file a "complaint appeal" with the managed care plan. If the person still disagrees with the plan's decision, he or she can file a complaint with the State.

To file a complaint with the State
A provider, a consumer, or a consumer's authorized representative can contact the New York State Department of Health (DOH) at any time by phone or in writing. NYSDOH Managed Care Complaint Line: 1-800-206-8125 Email: managedcarecomplaint@health.ny.gov

Consumer and Provider Appeals
Consumers and providers have the right to appeal a managed care plan's decision regarding payment or approval of treatment and services. Prior to the carve-in of behavioral health services, most behavioral health providers did not have the right to file an independent appeal for behavioral health services that were denied to a Medicaid recipient. Under behavioral health managed care, these providers will have an independent right to file an appeal with the managed care plan and an external appeal with NYS Department of Financial Services (DFS). A full description of the process, instructions and time frame to ask for these appeals is included in the member handbook and provider manual. Enrollee appeal information is also provided when a plan denies coverage for a service.

There are three different types of appeals:
1. Internal Appeal: A provider, consumer, or consumer's authorized representative can file an appeal with the plan by calling or writing to the plan. An internal appeal is available in certain

circumstances. For example, when a plan denies coverage because it (a) determined that a service was not medically necessary or was not a covered benefit, (b) approved a service, but for less than the amount, duration and scope requested, (c) denied payment for a service, in whole or in part.

2. Independent External Appeal: If the plan upholds its denial after the Internal Appeal because a service was not medically necessary, was experimental/investigational, or was out-of-network, a provider, consumer or consumer's authorized representative may be eligible to ask for an External Appeal with the DFS. To find out more about External Appeals or to request an application, contact the managed care plan, call DFS at 1-800-400-8882, or visit the DFS website at www.dfs.ny.gov.

3. Fair Hearing: A consumer or authorized representative can ask for a Fair Hearing with the NYS Office of Temporary and Disability Assistance (OTDA). A consumer does not need to file an Internal Appeal or External Appeal before he or she can request a fair hearing. Providers do not have an independent right to ask for a Fair Hearing. o In addition to decisions regarding denials of coverage or payment, a Fair Hearing is also available to appeal Medicaid enrollment, disenrollment, and eligibility determinations.

To request a fair hearing contact: NYS Office of Temporary and Disability Assistance by phone (1-800-342-3334) or visit the website: www.otda.ny.gov/hearings/

"AID TO CONTINUE": Getting Services During An Appeal

In some cases, a consumer may be able to continue to receive services that are scheduled to end or be reduced while he or she waits for the plan appeal or fair hearing to be decided. To qualify for this, the consumer must request a fair hearing within 10 days from being told that the request for services is denied or by the date the change in services is scheduled to occur.

http://omh.ny.gov/omhweb/resources/newsltr/2015/july.pdf