FloridaCare Health Plans

V. GRIEVANCE PROCEDURES

Grievance Procedure

Floridacare Health Plans, Inc. (FCHP) has a grievance and appeal procedure which complies with applicable state and federal law ("The Grievance Procedure"). We will try to resolve any problems you may encounter over the telephone, but sometimes, additional steps are necessary. In these cases, we have a Grievance Procedure available that provides channels for you, or a provider acting on your behalf, to voice your concerns and have them reviewed and addressed at several levels within the Plan.

The Grievance Procedure includes informal as well as formal grievance steps. A grievance is not considered formal until a written request for grievance review or a completed FCHP "Formal Grievance/Appeal Form" requesting formal action is received by FCHP's Grievance & Appeal Administrator. You have one year from the date of the event/occurrence upon which the complaint is based to file a verbal or written request for grievance review.

Level 1 – Informal Grievance or Complaint

If you have a complaint, please discuss your concern with our Customer Service Department by calling 305-294-9292 or visiting FCHP during normal working hours. In accordance with Section 641.47 (5) F.S., a complaint is any expression of dissatisfaction by a Subscriber, including dissatisfaction with the administration, claims practices, or provision of services, which relates to the quality of care provided by a provider pursuant to FCHP's contract and which is submitted to FCHP or to a state agency. Every attempt will be made to resolve your concern during your initial phone call or visit.

If you are not satisfied with our response, you have the right to file a formal written grievance. In accordance with Section 641.47 (10) F.S., a grievance is a written complaint submitted by or on the behalf of a Member or provider to the plan or the agency regarding the: availability, coverage for the delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review; claims payment, handling, or reimbursement for health care services; or matters pertaining to the contractual relationship between a Member or provider and the plan or agency.

You may write us a letter specifically requesting a grievance review. Ask our Customer Service Department to provide you with a FCHP "Formal Grievance / Appeal Form".

If necessary, a Customer Service Representative will assist you with preparing your grievance. You may file a Grievance or Complaint one of three ways:

Level 2 – Formal Grievance

If you disagree with the outcome of the Level – 1 review of an informal grievance, FCHP provides members with an optional Level – 2 Formal Grievance process. Level – 2 grievances may be submitted in writing, as long as it is received by FCHP within 30 days of your receipt of the Level – 1 determination. You may also file your formal grievance with the Florida Agency for Health Care Administration or the Florida Department of Financial Services. Please be sure to include all additional information and copies of pertinent documentation such as your medical records.

If your grievance is due to an adverse determination and denied, you also have the right to request a Level – 2 formal grievance within 30 days of the determination. An adverse determination is a determination by us that an admission, availability of care, continued stay, or other health care service was reviewed and, based upon the information provided, is not a covered benefit under your plan. Coverage for the requested service is therefore denied, reduced or terminated.

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All formal grievances will be acknowledged by FCHP within five (5) business days of receipt. You will receive written notification from FCHP of the grievance outcome once a determination has been made, or within thirty (30) business days from the date of receipt. If your grievance involves activities which occurred outside the service area, or requires the collection of information from outside the service area, FCHP shall have an additional thirty (30) days in addition to each of the response / notice periods set forth above, to process your grievance.

If you disagree with our Level – 2 determination, you may request either verbally or in writing a review by the FCHP Grievance Review Panel ("the Panel"). For adverse determinations, the majority of the Panel will be persons who have the appropriate expertise, and who were not involved in the initial adverse determination. A person who was previously involved in the adverse determination may appear before the Panel to present information or answer questions. Each party related to the grievance has the right to appear in person to present arguments. The Panel will issue a final decision to the Subscriber, and provider if any, who files on behalf of the Subscriber, within thirty (30) business days of a request for a Panel review. All grievances will be finalized within sixty (60) days of receipt of the formal grievance, unless thirty (30) additional days are needed to collect information outside the FCHP service area.

Expedited (Urgent) Grievance Review

In all cases where the standard 30-day grievance review time frame would jeopardize your life, health, or ability to regain maximum function, you, your legal representative, or physician authorized to act on your behalf (who is directly involved in your treatment or diagnosis) may file a request for an expedited (urgent) grievance review. You may request this review either verbally or in writing by contacting FCHP as specified above. This process only applies to a pre-service or concurrent, and not retrospective, denial. For example, this does not apply to a request for payment of services already rendered but denied, other claims review, or reimbursement. If the expedited review process does not resolve a difference of opinion between FCHP and the Member or the provider acting on behalf of the Member, the Member or provider may submit a written grievance to the Subscriber Assistance Program.

FCHP will, after review and validation of your request, expedite the grievance procedure, and render a determination within seventy-two (72) hours of receipt of your request. This review will be conducted by appropriate clinical peers who were not involved in the initial determination within twenty-four (24) hours after receiving a request for an expedited appeal. We will decide within seventy-two (72) hours and notify you of our decision. Any verbal notice will be followed with written notice within two (2) working days.

Level 3 – State Appeals

If you do not accept the decision of the Panel, you have the right to appeal to the Florida Agency for Health Care Administration (AHCA) or the Department of Financial Services (FDFS) within one (1) year from the date of receipt of our decision. If you appeal FCHP's decision, your grievance will be reviewed by the Subscriber Assistance Program. You also have the right to contact AHCA or DFS at any time to inform them of an unresolved grievance. The Subscriber Assistance Program will not hear a grievance if the Member has not completed the entire FCHP Grievance process, nor if the Member has instituted an action pending in the state or federal court.

Other Agencies

Pursuant to Florida law, FCHP may not provide information to you concerning the outcome of quality of care complaints. If you need further assistance, you may contact:

- The Florida Agency for Health Care Administration
  and the Subscriber Assistance Program
  2727 Mahan Drive, Mail Stop 26
  Tallahassee, Florida 32308
  Telephones 1-888-419-3456 and
  1-850-921-5458

- The Florida Department of Financial Services
  Division of Consumer Services
  200 East Gaines Street
  Tallahassee, Florida 32399
  Telephone 1-800-342-2762