

Community Health Plan of Washington Grievance and Appeal Process

Who do I call for help with my health plan?

If you need help, accommodation, or require documents in an alternative format or language, such as large print, Braille, or audio, please call Community Health Plan of Washington (CHPW) at 1-866-907-1906 (TTY: 711) 8 a.m. to 5 p.m., Monday through Friday. We will provide language assistance at no cost to you and keep your information private.

To file or to get help with a Grievance or Appeal, contact Community Health Plan of Washington:

Community Health Plan of Washington
Attn: Appeals and Grievances
1700 7th Ave, Suite 900
Seattle, WA 98101

Web: individualandfamily.chpw.org
Phone: 1-866-907-1906 (TTY:711)
Fax: 206-613-8984
Email: AppealsGrievances@chpw.org
Monday to Friday, 8 a.m. - 5 p.m.

If you are a client with behavioral health needs, the Ombuds is someone who can help you with questions and filing grievances or appeals. If you need information about how to contact your local Ombuds, call 1-866-907-1906 (TTY:711) or go to individualandfamily.chpw.org/member-center/behavioral-health

How do I report a complaint? (Grievance Process)

You or your authorized representative have the right to file a written or verbal complaint expressing dissatisfaction with any aspect of care or service that does not involve a denial of benefits. This is called a grievance. Grievances are complaints about:

- The way you were treated
- The quality of care or services you received
- Problems getting care
- Billing issues
- Attitude and service

We will inform you or your representative that we received your grievance within two business days. We will investigate and resolve your grievance within 45 calendar days and tell you how it was resolved. We may take additional time to complete our review if we establish that the 45-day time frame cannot reasonably be met due to our inability to obtain necessary information from a person or entity not affiliated with or under contract with us. We will provide written notice of the delay to you, which will explain the reasons for the delay. You have the right to appeal an adverse decision (if any made) by us.

To file or to get help with a Grievance, contact Community Health Plan of Washington:

Community Health Plan of Washington
Attn: Cascade Select Grievances
1700 7th Ave, Suite 900
Seattle, WA 98101

Web: individualandfamily.chpw.org
Phone: 1-866-907-1906 (TTY: 711)
Fax: 206-652-7050
Monday to Friday, 8 a.m. - 5 p.m.

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How do I request a review of a denied service? (Appeal Process)

If we decline to provide payment or benefits, in whole or in part, and you disagree with that decision, you have the right to request that we review our determination through an appeals process. You have 180 days from the receipt of an adverse benefit decision to request a written or verbal appeal. If you choose to designate someone else to represent you, all communication will be sent to that person. To appoint a representative, you must complete an appeal consent form, which is not necessary if you appeal on your own.

To submit an Appeal or to get help with the Appeal process, contact Community Health Plan of Washington:

**Community Health Plan of Washington
Attn: Cascade Select Appeals Coordinator
1700 7th Ave, Suite 900
Seattle, WA 98101**

**Phone: 1-866-907-1906 (TTY:711)
Fax: 206-613-8984
Monday to Friday, 8 a.m. - 5 p.m.**

What happens next?

If you appeal, we will review our decision and provide you with a written determination. If we continue to deny the payment, coverage, or service requested or you do not receive a timely decision, you may be able to request an external review of your claim by an independent third party, who will review the denial and issue a final decision.

Review of Adverse Benefit Determination

An adverse benefit determination means a denial, reduction, or termination of, or failure to provide or make payment for, in whole or in part, services, based on any of the following:

- An individual's eligibility to participate in a plan or health insurance coverage
- A determination that a benefit is not a covered benefit
- A limitation on an otherwise covered benefit
- A utilization review determination
- A determination that a service is Experimental, Investigational, or not Medically Necessary or appropriate

Any adverse benefit determination on the basis of Experimental or Investigational services must be made by us in writing within 20 working days of receipt of a fully documented request. Any extension of the review period beyond 20 working days may only be done with the informed written consent of the covered person.

Appeals are made up of two levels:

- Level 1 - Internal appeal
- Level 2 - External appeal to an Independent Review Organization (IRO)

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Internal Review

Once you are notified of an adverse benefit determination, you can request an appeal within 180 days. Your appeal will be reviewed by individuals not involved in the original determination, including any information you provide. If medical judgment is involved, the reviewer will consult with a qualified health care professional to ensure that the decision aligns with clinical standards. A written determination will be provided.

To submit or to get help with the Internal Review, contact Community Health Plan of Washington:

**Community Health Plan of Washington
Attn: Cascade Select Appeals Coordinator
1700 7th Ave, Suite 900
Seattle, WA 98101**

**Phone: 1-866-907-1906 (TTY:711)
Fax: 206-613-8984
Monday to Friday, 8 a.m. - 5 p.m.**

We will acknowledge your appeal request within 72 hours and provide any new evidence or rationale at no cost. Before or during the appeal, you or your representative may request copies of all the documents in this appeal file, and the guidelines or benefit provisions used to make the decision. These will be sent to you free of charge. You can request additional time to respond to this new information. Our decision will be communicated in writing within 14 days. If we need more time, we will notify you that we are extending the review, and we will communicate our decision within 30 days. If more than 30 days are required, we will seek your written consent. If you are not satisfied with our decision, you may request an external review.

Expedited Appeals

You or your authorized representative may request an Expedited Appeal if you are currently receiving or have been prescribed treatment or benefits that would end because of the adverse benefit determination; or if your Provider believes that a delay in treatment based on the standard review time may seriously jeopardize your life, overall health, or ability to regain maximum function, or would subject you to severe and intolerable pains, or if the adverse benefit determination is related to an admission, availability of care, continued stay, or emergency health services and you have not been discharged from the emergency room or transport services.

To request or to get help with an Expedited Appeal, contact Community Health Plan of Washington:

**Community Health Plan of Washington
Attn: Cascade Select Appeals Coordinator
1700 7th Ave, Suite 900
Seattle, WA 98101**

**Phone: 1-866-907-1906 (TTY:711)
Fax: 206-613-8983
Monday to Friday, 8 a.m. - 5 p.m.**

We will respond to your request for an Expedited Appeal as soon as possible, and in no event longer than 72 hours from receipt of your request for an Expedited Appeal. We may inform you of our decision orally, but we will also send you a written copy of our decision within 72 hours of the date of the decision.

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External Review

You may request review of a CHPW determination by a certified Independent Review Organization (“IRO”) if: (i) you are not satisfied with our resolution of your Appeal, (ii) we have granted your request for an external review of Formulary Exception request, (iii) you have received an adverse determination under the Washington State Balance Billing Protection Act, or (iv) you want to contest a retrospective denial or modification of an approved authorization due to a change in CHPW’s medical necessity determination, as permitted under RCW 48.43.525. An IRO is an independent organization of medical reviewers who are certified by the Commissioner to review medical and other relevant information. Review by an IRO is called “External Review”. There is no cost to you for an External Review.

We must receive your request for an External Review within 180 days of the date of our final internal adverse benefit determination. You may also request External Review if we do not meet the timelines above for resolving your appeal, and we do not have good cause for the delay. We may require that you complete our Internal Review process prior to requesting External Review. If we waive this requirement, and later reverse our adverse benefit determination, we will notify you, and the IRO, immediately.

If you are requesting External Review to address a retrospective denial or modification of an approved authorization due to a change in CHPW’s determination of medical necessity, you are not required to file a grievance or appeal prior to requesting External Review.

To request or to get help with an External Review, contact Community Health Plan of Washington:

Community Health Plan of Washington

Attn: Cascade Select Independent Review Request
1700 7th Ave, Suite 900
Seattle, WA 98101

Phone: 1-866-907-1906 (TTY: 711)
Fax: 206-613-8984
Monday to Friday, 8 a.m. - 5 p.m.

Once we receive your request for External Review, or we approve your request for External Review of a Formulary Exception request, we will arrange for review by a certified IRO, which we select on a rotating basis. We will provide you with the name and contact information of the IRO within 1 day of giving the IRO notice of your request for External Review. We will send your request and relevant information to the IRO for review within three business days of receiving the request. The IRO will accept additional information in writing from you for up to five business days from the date we notify them of your request for External Review.

CHPW is bound by the decision made by the IRO. If the IRO overturns our final internal adverse benefit determination, we will implement their decision promptly. If the IRO upholds the final internal adverse benefit determination, there is no further review available under this plan's internal appeals or External Review process. You may, however, have other remedies available under state or federal law.

For non-urgent cases, the IRO must provide its determination within the earlier of fifteen (15) days after the IRO receives the necessary information or twenty (20) days of receipt of your request.

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You may request an expedited External Review if our adverse benefit determination concerns either:

- An admission, availability of care, continued stay, or health care service for which you received Emergency Care Services but you have not yet been discharged from a facility; or
- A medical condition for which the standard External Review time frame would seriously jeopardize your life or health or jeopardize your ability to regain maximum function; or
- You have requested an expedited Internal Review and we waive the requirement to complete Internal Review prior to requesting External Review.

Upon receipt of a valid request for expedited External Review, the IRO must make a determination to uphold or reverse our adverse benefit determination as soon as possible, but in no event more than 72 hours after the IRO receives your request for expedited External Review. The IRO will notify you, and us, of their decision. If the IRO provides oral notification of their decision, they must also send written notice within 48 hours of their decision.

Appeals Regarding Ongoing Care

If you appeal a decision to change, reduce, or end coverage for ongoing care deemed no longer Medically Necessary, we will suspend our denial during the internal appeal and External Review periods. Benefits provided during this time do not reverse the denial. If upheld, you must repay all amounts paid for those services and cover any difference between our Allowed Amount and the Provider's billed charge.

Other resources to help you:

For questions about your appeal rights, this notice, or for assistance, you can contact the Washington State Office of the Insurance Commissioner (OIC). The Washington State Office of the Insurance Commissioner's Consumer Protection Division provides ombudsman services for Washington consumers who have questions or complaints about health care appeals.

You can contact the Washington State Office of the Insurance Commissioner at:

Washington State Office of the Insurance Commissioner

Phone: 1-800-562-6900

Fax: 360-586-2018

The OIC complaint form can be accessed at:

<https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status.com>

TDD/TTY: 360-725-7080

Email: CAP@oic.wa.gov

Billed for services: If you have questions about a bill you received for health care services, call 1-866-907-1906.

Second Opinion: At any time, you can get a second opinion about your health care or condition. Call 1-866-907-1906 to find out how to get a second opinion.