Appeals Process Information for Participants and Designated Representatives

What is an Appeal?

An appeal is an opportunity for you to state that you disagree with a decision that was made by the PACE program or its contracted providers concerning you and your plan of care.

Your Right to Appeal & Appeal Process

As a PACE participant, potential enrollee, or a designated representative, you have the right to appeal any decision by the PACE program regarding noncoverage of or nonpayment for a service. For example, you may appeal a decision by the PACE program to deny a service you requested, to stop a service you are getting, to reduce a service you are getting to fewer days, to involuntarily disenroll you from the program, and others.

The appeals process will be reviewed with you and/or your designated representative verbally and in writing at the time of enrollment, at least annually thereafter, and whenever the PACE program denies, reduces or ends a service. All appeals and related information will remain private.

The PACE program will continue to provide all required services during the appeals process. There will be no discrimination by the PACE program against you or your designated representative if you decide to file an appeal.

If you are enrolled in Medicaid, the PACE program will continue to provide the disputed services to you during the appeals process until the final decision is made, under the following conditions:

- The PACE program proposes to end or reduce services currently being provided to you;
- You request for continuation of the disputed services.
- If you choose to continue the services, *you do so with the understanding that you may be liable for the cost of those services if the appeal is not decided in your favor.*

ICHS PACE will arrange for your appeal to be reviewed by an appropriately credentialed impartial third party from outside the PACE organization who was not part of the original decision. The reviewer will not have a stake in the outcome of the appeal. You will be given an opportunity to give facts about the appeal in writing, over the phone, or in person.

Filing an Appeal

An appeal may be expressed either verbally or in writing. You may request help from a PACE staff member to complete the appeal process. You must submit the request to appeal within twenty (20) calendar days from the date you were notified by PACE of the reduced or eliminated services.

Standard appeals are those that are not urgent. The appeal will be reviewed and a decision will be made as quickly as your health calls for, but no later than 30 calendar days after the PACE program receives the appeal.

If you believe your life or health or your ability to regain or maintain maximum function could be seriously jeopardized without the disputed services, the PACE program will respond to the appeal

as quickly as your health condition requires, but no later than seventy-two (72) hours after receiving your appeal. This is called an *expedited appeal.* The 72-hour timeframe may be increased by fourteen (14) calendar days if you ask for an extension, or if the PACE program can explain to DSHS why more time is needed, and how the extension would be in your best interest.

To submit an appeal, you may express your appeal verbally or in writing to any PACE staff member, or deliver your appeal via mail, fax, or phone at the contacts listed below:

International Community Health Services – PACE Program
PACE Quality Administrator
803 South Lane Street
Seattle, Washington 98104
Fax: (206) 962-3301

Telephone: PACE Quality Administrator at (206) 462-7188, Monday-Friday 9:00AM-5:00PM. For the hearing impaired TTY: (206) 788-3774.

At any time during the appeals process, you may contact the King County ombudsman at (206) 477-1050 or ombudsman@kingcounty.gov for additional help and information.

The Appeal Decision
ICHS PACE will notify you and/or your designated representative verbally and in writing of the appeal decision. If the appeal decision is made in your favor, the PACE program will pay for or will provide the disputed services as quickly as your health condition requires. If the decision is not made in your favor, the PACE program will notify you, the Center for Medicare and Medicaid Services, and DSHS in writing. You still have the option to appeal again to an outside entity under either Medicare or Medicaid.

Your Additional Appeal Rights
If ICHS PACE makes a decision about your appeal that is not fully in your favor, you may file an external appeal either verbally or in writing through one of the options below. The process you choose depends upon whether you are eligible for Medicaid only, Medicare and Medicaid (dually eligible), Medicare only, or pay privately for PACE services. The PACE program will be available to assist you with the external appeal.

Medicaid Process
If you are enrolled in both *Medicaid and Medicare OR in Medicaid ONLY*, you may pursue a State Administrative Hearing once you have exhausted all appeals processes within the PACE program. You have 90 calendar days to request a State Administrative Hearing from the date when you received the Appeal Final Decision letter.
You can submit the appeal to:

Office of Administrative Hearings
PO Box 42489
Olympia, WA 98504
(360) 407-2700

Medicare Process

If you are currently enrolled in the PACE Program and enrolled in both *Medicare and Medicaid OR Medicare only*, you may choose to appeal using Medicare's external appeals process. If you choose to pursue Medicare's external appeal process, ICHS PACE will send your appeal to Medicare's Independent Review Entity (IRE) on your behalf. The IRE will contact the PACE program with the results of the review. The IRE will either uphold the original decision or change the decision and rule in your favor. If you choose to appeal on your own through Medicare, please call: 1-800-MEDICARE (1-800-633-4227) or for the hearing impaired TTY/TTD: 1-877-486-2048.

Private Pay & Other Process

If you are currently enrolled in the PACE program and *pay privately,* or are eligible for *Medicare only and are appealing a Denial of Enrollment or an Involuntary Disenrollment*, you can submit your appeal at any time during the appeals process by contacting:

Washington Department of Social and Health Services
PACE Program Manager
DSHS/Aging & Long-Term Support Administration
PO Box 45600
Olympia, WA 98504-5600

ICHS PACE Appeals Form

(Document steps in Medical Record)

Date Reported: __________ Participant: Last ___________ First ___________ Middle _________

Participant PACE ID: __________________

Person Filing Appeal: □ Participant □ Designated Representative (*name*):____________________

Date of Receipt by ICHS PACE: _________ **Staff Receiving Appeal**: ___________________
Time of Receipt *(required only if Expedited)*: ________AM / PM

❑ Standard Appeal Process
Date to Finalize Appeal (30 calendar days): _____________

❑ Expedited Appeal Process: The participant or designated representative believes that his/her life, health, or ability to regain or to maintain maximum function could be seriously jeopardized, absent provision of the service in dispute.
Date/Time for Response (72 hours from time of receipt): ____________________________
If Extended:
- Date to Finalize (additional 14 calendar days): _________________________________
- Reason for Extension: ____
  ____

Select Appeal Type:

❑ Decreased Center Attendance
❑ Denial of Enrollment
❑ Dentures
❑ Durable Medical Equipment
❑ Glasses
❑ Hearing Aid
❑ Home Modification(s)
❑ Increased Center Attendance
❑ Increased Home Care
❑ Involuntary Disenrollment
❑ Medical Procedure
❑ Medical Supplies
❑ Nursing Facility Placement (long term)
❑ Nursing Facility Placement (respite)
❑ Nursing Facility Placement (short term)
❑ Specialist Visit
❑ Surgical Procedure
❑ Transportation
❑ Discrimination
❑ Other: ____________

Explanation of Appeal:
□ *Check here if additional pages are attached to explain the appeal.*

____
____
____
____
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____

Desire to present additional information for consideration by impartial third party reviewer?
□ Yes: In person □ Yes: By phone □ Yes: In writing □ No

Documentation Considerations:

☐ or N/A: If this a **written** appeal attachment, include the *signed* document requesting the appeal.

☐ or N/A: If this is a **verbal** appeal, the person filing the appeal should sign and date this form, or note the reason for the absence of signature.

Printed Name of Person Filing the Appeal: ____

Signature *(or reason if unable to obtain)*: ____

Printed Name of Staff Receiving Appeal: ____

Signature of Staff Receiving Appeal: ____

STAFF MEMBER: IMMEDIATELY DELIVER THIS FORM AND ALL ATTACHMENTS TO THE PACE QUALITY ADMINISTRATOR FOR REVIEW AND RESPONSE.

Date Submitted to PACE QAA: ____________ Date Reviewed by PACE QAA: _______________

Date of Impartial Third Party Review: __________________ **Decision:**

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Resolution of Appeal: ☐ Approved ☐ Denied ☐ Partially Approved:

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If approved/partially approved, date service provided: ________________________________

Notification

Date participant verbally notified of outcome: ___________ Time *(if Expedited)*: ______________

By Whom (Staff Name & Title):____

Date participant notified of outcome in writing: __________ Time *(if Expedited)*: ______________
Notice will include an explanation of additional external appeal rights.

By Whom (Staff Name & Title):____

If Decision Not in Favor Of Participant

CMS (via HPMS) Notification Date: ____________

DSHS Notification Date: _____________

By Whom (Staff Name & Title):____

Request for External Appeal? ☐ Medicare Process ☐ Medicaid Process ☐ No