



Keystone First

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Provider Dispute/Appeal Procedures; Member Complaints, Grievances, and Fair Hearings



July 1, 2018



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Provider Dispute/Appeal Procedures

Providers have the opportunity to request resolution of Disputes or Formal Provider Appeals that have been submitted to the appropriate internal Keystone First department.

Informal Provider Disputes Process

Network Providers may request informal resolution of Disputes submitted to Keystone First through its Informal Provider Dispute Process.

What is a Dispute?

A Dispute is a verbal or written expression of dissatisfaction by a Network Provider regarding a Keystone First decision that directly impacts the Network Provider. Disputes are generally administrative in nature and do not include decisions concerning medical necessity.

Examples of Disputes include, but are not limited to:

- Service issues with Keystone First, including failure by Keystone First to return a Provider's calls, frequency of site visits by Keystone First's Provider Account Executives and lack of Provider Network orientation/education by Keystone First
- Issues with Keystone First processes, including failure to notify Network Providers of policy changes, dissatisfaction with Keystone First's Prior Authorization process, dissatisfaction with Keystone First's referral process and dissatisfaction with Keystone First's Formal Provider Appeals Process
- Contracting issues, including dissatisfaction with Keystone First's reimbursement rate, incorrect capitation payments paid to the Network Provider and incorrect information regarding the Network Provider in Keystone First's Provider database

Filing a Dispute

Network Providers wishing to register a Dispute should contact the Provider Services Department at 800-521-6007, or contact his/her/its Provider Account Executive. Written Disputes should be mailed to the address below and must contain the words "Informal Provider Dispute" at the top of the request:

Provider Network Management Department
Keystone First
Philadelphia, PA 19113

See Section VI, Claims and Claims Disputes, for specific filing requirements related to Claims Disputes.

On-Site Meeting

Network Providers may request an on-site meeting with a Provider Account Executive, either at the Network Provider's office or at Keystone First to discuss the Dispute. Depending on the



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nature of the Dispute, the Provider Account Executive may also request an on-site meeting with the Network Provider. The Network Provider or Provider Account Executive must request the on-site meeting within seven (7) calendar days of the filing of the Dispute with Keystone First. The Provider Account Executive assigned to the Network Provider is responsible for scheduling the on-site meeting at a mutually convenient date and time.

Time Frame for Resolution

Keystone First will investigate, conduct an on-site meeting with the Network Provider (if one was requested), and issue the informal resolution of the Dispute within sixty (60) calendar days of receipt of the Dispute from the Network Provider. The informal resolution of the Dispute will be communicated to the Network Provider by the same method of communication in which the Dispute was registered (e.g., if the Dispute is registered verbally, the informal resolution of the Dispute is verbally communicated to the Network Provider and if the Dispute is registered in writing, the informal resolution of the Dispute is communicated to the Network Provider in writing).

Relationship of Informal Provider Dispute Process to Keystone First's Formal Provider Appeals Process

The purpose of the Informal Provider Dispute Process is to allow Network Providers and Keystone First to resolve Disputes registered by Providers in an informal manner that allows Network Providers to communicate their Dispute and provide clarification of the issues presented through an on-site meeting with Keystone First. Network Providers may appeal most Disputes not resolved to the Provider's satisfaction through the Informal Provider Dispute Process to Keystone First's Formal Provider Appeals Process. The types of issues that may not be reviewed through the Keystone First Formal Provider Appeals Process are listed in the "Formal Provider Appeals Process" section of this Manual. Appeals must be submitted in writing to Keystone First's Provider Appeals Department. Procedures for filing an appeal through Keystone First's Formal Provider Appeals Process, including the mailing address for filing an appeal, are set forth in the "Formal Provider Appeals Process" Section. The filing of a Dispute with Keystone First's Informal Provider Dispute Process is not a prerequisite to filing an appeal through Keystone First's Formal Provider Appeals Process.

In addition to the Informal Provider Dispute Process and the Formal Provider Appeals Process, Health Care Providers may, in certain instances, pursue a Member Complaint or Grievance appeal on behalf of a Member. A comprehensive description of Keystone First's Member Complaint, Grievance and Fair Hearings Process is located in this Section of the Manual. Additionally, information on the relationship with Keystone First's Informal Provider Dispute and Formal Provider Appeal Processes can be found in "Relationship of Provider Formal Appeals Process to Provider Initiated Member Appeals" and "Requirements for Grievances filed by Providers on Behalf of Members" in this Section of the Manual.

In order to simplify resolution of Emergency Department payment level issues, which often arise because a claim was submitted without an Emergency Department summary and/or requires a



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review of medical records, participating hospital Providers are encouraged to address such payment issues through Keystone First's informal Emergency Department Payment Level Reconsideration Process before attempting to resolve such issues through the Formal Provider Appeals Process. For complete details see the Claims and Claims Dispute section of the manual.

Formal Provider Appeals Process

Both Network and Non-Participating Providers may request formal resolution of an appeal through Keystone First's Formal Provider Appeals Process. This process consists of two levels of review and is described in greater detail below.

What is an Appeal?

An appeal is a written request from a Health Care Provider for the reversal of a denial by Keystone First, through its Formal Provider Appeals Process, with regard to two (2) major types of issues. The two (2) types of issues that may be addressed through Keystone First's Formal Provider Appeals Process are:

- Disputes not resolved to the Network Provider's satisfaction through Keystone First's Informal Provider Dispute Process
- Denials for services already rendered by the Health Care Provider to a Member including, denials that:
 - (a) do not clearly state the Health Care Provider is filing a Member Complaint or Grievance on behalf of a Member (even if the materials submitted with the Appeal contain a Member consent) or
 - (b) do not contain a Member consent for a Member Complaint or a consent that conforms with applicable law for a Grievance filed by a Health Care Provider on behalf of a Member (see Provider Initiated Member Appeals in this Section of the Manual for required elements of a Member consent for a Grievance. **Note: these requirements do not apply to Complaints.**)

Examples of appeals include, but are not limited to:

- The Health Care Provider submits a Claim for reimbursement for inpatient services provided at the acute level of care, but Keystone First reimburses for a non-acute level of care because the Health Care Provider has not established medical necessity for an acute level of care.
- A Home Care Provider has made a total of ten (10) home care visits but only seven (7) visits were authorized by Keystone First. The Health Care Provider submits a Claim for ten (10) visits and receives payment for seven (7) visits.
- Durable Medical Equipment (DME) that requires Prior Authorization by Keystone First is issued to a Member without the Health Care Provider obtaining Prior Authorization from Keystone First (e.g., bone stimulator). The Health Care Provider submits a Claim



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for reimbursement for the DME and it is denied by Keystone First for lack of Prior Authorization.

- Member is admitted to the hospital as a result of an Emergency Room visit. The inpatient stay is for a total of fifteen (15) hours. The hospital provider submits a Claim for reimbursement at the one-day acute inpatient rate but Keystone First reimburses at the observation rate, in accordance with the hospital's contract with Keystone First.

Types of issues that may not be appealed through Keystone First's Formal Provider Appeals Process are:

- Claims denied by Keystone First because they were not filed within Keystone First's 180-day filing time limit; Claims denied for exceeding the 180-day filing time limit may be appealed through Keystone First's Informal Provider Dispute Process outlined in this Manual.
- Denials issued as a result of a Prior Authorization review by Keystone First (the review occurs prior to the Member being admitted to a hospital or beginning a course of treatment); denials issued as a result of a Prior Authorization review may be appealed by the Member, or the Health Care Provider, with written consent of the Member, through Keystone First's Member Complaint and Grievance Process outlined in the Section titled Complaints, Grievances and Fair Hearings for Members following the Provider Appeal Process.
- Provider terminations based on quality of care reasons may be appealed in accordance with the Keystone First Provider Sanctioning Policy outlined in Section VIII; and credentialing/recredentialing denials may be appealed as provided in the credentialing/recredentialing requirements outlined in Section VIII.

First Level Appeal Review

Filing a Request for a First Level Appeal Review

Health Care Providers may request a First Level Appeal review by submitting the request in writing within 60 calendar days of: (a) the date of the denial or adverse action by Keystone First or the Member's discharge, whichever is later or (b) in the case where a Health Care Provider filed an Informal Provider Dispute with Keystone First, the date of the communication by Keystone First of the informal resolution of the Dispute and (c) the appeal is not related to a claims issue. The request must be accompanied by all relevant documentation the Health Care Provider would like Keystone First to consider during the First Level Appeal review.

Requests for a First Level Appeal Review should be mailed to the appropriate Post Office Box below and must contain the words "First Level Outpatient Formal Provider Appeal", or "First Level Inpatient Formal Provider Appeal", as appropriate at the top of the request:

**Inpatient Appeal:
Provider Appeals Department
Keystone First**

**Outpatient Appeal:
Provider Appeals Department
Keystone First**



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**P.O. Box 7307
London, KY 40742**

**P.O. Box 7316
London, KY 40742**

Keystone First will send the Health Care Provider a letter acknowledging Keystone First's receipt of the request for a First Level Appeal Review within ten business days of Keystone First's receipt of the request from the Health Care Provider.

Physician Review of a First Level Appeal

The First Level Appeal Review is conducted by a board certified Physician Reviewer who was not involved in the decision making for the original denial or prior appeal review of the case. The Physician Reviewer will issue a determination to uphold, modify or overturn the denial based on:

- Clinical judgment
- Established standards of medical practice
- Review of available information including but not limited to:
 - Keystone First medical and administrative policies
 - Information submitted by the Health Care Provider or obtained by Keystone First through investigation
 - The Network Provider's contract with Keystone First
 - Keystone First's contract with DHS and relevant Medicaid laws, regulations and rules

Time Frame for Resolution of a First Level Appeal

Health Care Providers will be notified in writing of the determination of the First Level Appeal review, including the clinical rationale, within 60 calendar days of Keystone First's receipt of the Health Care Provider's request for the First Level Appeal review. If the Health Care Provider is dissatisfied with the outcome of the First Level Appeal review, the Health Care Provider may request a Second Level Appeal review. See the "Second Level Appeal Review" topic in this Section of the Manual.

Second Level Appeal Review

Filing a Request for a Second Level Appeal Review

Health Care Providers may request a Second Level Appeal by submitting the request in writing within thirty (30) calendar days of the date of Keystone First's First Level Appeal determination letter. The request for a Second Level Appeal Review must be accompanied by any additional information relevant to the Appeal that the Health Care Provider would like Keystone First to consider during the Second Level Appeal Review. Requests for a Second Level Appeal Review of an Appeal should be mailed to the appropriate Post Office Box below and must contain the words "Second Level Outpatient Formal Provider Appeal" or "Second Level Inpatient Formal Provider Appeal", as appropriate, at the top of the request.

Inpatient Appeals:

Outpatient Appeals:



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Provider Appeals Department
Keystone First
P.O. Box 7307
London, KY 40742

Provider Appeals Department
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P.O. Box 7316
London, KY 40742

Keystone First will send the Health Care Provider a letter acknowledging Keystone First's receipt of the request for a Second Level Appeal Review within ten business days of Keystone First's receipt of the request from the Health Care Provider.

Appeals Panel Review of a Second Level Appeal

A board certified Physician Reviewer, who was not involved in the decision-making for the original denial, or prior appeal review of the case, will review the appeal. The Physician Reviewer will issue a recommendation, including the clinical rationale, to Keystone First's Appeals Panel to uphold, overturn or modify the denial based upon clinical judgment, established standards of medical practice, and review of Keystone First medical and administrative policies, available information submitted by the Health Care Provider or obtained by Keystone First through investigation, the Health Care Provider's contract with Keystone First, Keystone First's contract with DHS and relevant Medicaid laws, regulations and rules. The Physician Reviewer's recommendation will be provided to the Appeals Panel for consideration and deliberation.

The Appeals Panel is comprised of at least one-quarter (1/4) health care provider/ peer representation. The panel is comprised of members who have the authority, training and expertise to address and resolve Provider Appeals issues at least three individuals, including one Physician Reviewer contracted by Keystone First but not employed with Keystone First (peer representative) and two other management staff from Keystone First's Provider Network Management, Provider Appeals, or Claims Departments.

The Appeals Panel will issue a determination including clinical rationale, to uphold, modify, or overturn the original determination based upon:

- Clinical judgment
- Established standards of medical practice
- Review of available information including but not limited to:
 - Keystone First medical and administrative policies
 - Information submitted by the Provider or obtained by Keystone First through investigation
 - The Provider's contract with Keystone First
 - Keystone First's contract with DHS and relevant Medicaid laws, regulations and rules



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Time Frame for Resolution

Health Care Providers will be notified in writing of the determination of the Second Level Appeal Review within 60 calendar days of Keystone First's receipt of the Health Care Provider's request for a Second Level Appeal Review. The outcome of the Second Level Appeal Review is final

Member Complaints, Grievances and Fair Hearings

First Level Complaints

1. A Complaint is a dispute or objection regarding a Network Provider or the coverage, operations or management policies of Keystone First that has not been resolved by Keystone First and has been filed with Keystone First or the Department of Health or the Insurance Department of the Commonwealth. The term includes, but is not limited to:
 - a. Keystone First denied a requested service/item because it is not a covered benefit;
 - b. Keystone First failed to meet the required timeframes for providing a service/item;
 - c. Keystone First failed to decide a Complaint or Grievance within the specified timeframes;
 - d. Keystone First denied payment after a service had been delivered because the service/item was provided without authorization by a Health Care Provider not enrolled in the Pennsylvania Medical Assistance Program; or
 - e. Keystone First denied payment after a service had been delivered because the service/item provided is not a covered service/item for the Member
 - f. Keystone First denied a Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance and other Member financial liabilities.

This term does not include a Grievance.

2. Members or a Member's representative, which may include the Member's Health Care Provider, with proof of the Member's written authorization may file a Complaint within sixty (60) days from the date of the incident complained of or the date the Member receives written notice of the decision if the Complaint involves any of the issues listed in items (a)-(f) in the definition of the term "Complaint" in paragraph 1 above. For all other Complaints, there is no time limit for filing.
3. Upon receipt of the Complaint, Keystone First will send the Member and other appropriate parties a DHS approved acknowledgment letter.
4. The Member is afforded a reasonable opportunity to present evidence and testimony and make legal and factual arguments, in person, by telephone or videoconference as well in writing.
5. Keystone First will give the Member at least seven (7) days advance written notice of the First Level Complaint review date using the DHS supplied template.



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6. If a First Level Complaint is filed to dispute a decision to discontinue, reduce or change a service/item that the Member has been receiving on the basis that the service/item is not a covered benefit, the Member must continue to receive the disputed service/item at the previously authorized level pending resolution of the First Level Complaint, if the First Level Complaint is made orally, hand delivered or post-marked within ten (10) days from the mail date on Keystone First's written notice of the decision. Keystone First also honors a verbal filing of a First Level Complaint within ten (10) days of receipt of the written denial decision in order to continue services.
7. The First Level Complaint Review Committee performs the First Level Review. For Complaints not involving a clinical issue, the committee is composed of one or more employees of Keystone First who were not involved in and are not the subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Complaint.
8. For Complaints involving clinical issues, the First Level Complaint Review Committee shall include one or more employees of Keystone First and a licensed physician in the same or similar specialty that typically manages or consults on the service or item in question. The physician on the committee decides the Complaint. All members of the First Level Complaint Review Committee cannot have been involved in or be subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Complaint.
9. The First Level Complaint Review Committee completes its review of the Complaint as expeditiously as the Member's health condition requires, but no more than thirty (30) days from receipt of the Complaint, which may be extended by up to fourteen (14) days at the request of the Member if the Complaint involves any of the issues listed in items (a)-(f) in the definition of the term "Complaint" in paragraph 1 above.
10. The committee prepares a summary of the issues presented and decisions made, which is maintained as part of the Complaint record.
11. Keystone First sends a written notice, using the template supplied by DHS, of the First Level Complaint Decision to the Member and other appropriate parties, within thirty (30) days from receipt of the Complaint by Keystone First, unless an up to fourteen (14) day extension was granted to the Member.

If the Complaint disputes one of the following, the Member may file a request for a Fair Hearing, a request for an external review, or both a request for a Fair Hearing and a request for an external review:

- Keystone First denied a requested service/item because it is not a covered benefit;
- Keystone First failed to meet the required timeframes for providing a service/item;
- Keystone First failed to decide a Complaint or Grievance within the specified timeframes;
- Keystone First denied payment after a service had been delivered because the service/item was provided without authorization by a Health Care Provider not enrolled in the Pennsylvania Medical Assistance Program; or



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- Keystone First denied payment after a service had been delivered because the service/item provided is not a covered service/item for the Member.
- Keystone First denied a Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance and other Member financial liabilities.

The Member or Member's representative may file a request for a Fair Hearing within 120 days from the mail date on the written notice of Keystone First's written notice of the First Level Complaint decision.

The Member or Member's representative, which may include the Member's Provider, with proof of the Member's written authorization for the representative to be involved and/or act on the Member's behalf, may file a request for an external review in writing with either DOH or PID within fifteen (15) days from the date the Member receives written notice of the PH-MCO's first level Complaint decision.

For all other Complaints:

The Member or Member's representative, which may include the Member's Provider, with proof of the Member's written authorization for the representative to be involved and/or act on the Member's behalf, may file a second level Complaint either in writing or orally within forty-five (45) days from the date the Member receives written notice of Keystone First's first level Complaint decision.

Second Level Complaints

1. Upon receipt of the Second Level Complaint, Keystone First sends the Member and other appropriate parties a DHS approved acknowledgment letter.
2. The Second Level Review for Complaints not involving a clinical issues is performed by a Second Level Complaint Review Committee, which is composed of three or more individuals who were not involved in and are not subordinates of an individual involved in any previous level of review or decision-making on the matter under review.
3. The second level complaint review for Complaints involving clinical issues, must be conducted by a second level Complaint Review Committee made up of three (3) or more individuals who were not involved in are not subordinates of an individual involved in any previous level of review or decision-making that is the subject of the Complaint. The second level Complaint Review Committee must include a licensed physician in the same or similar specialty that typically manages or consults on the service or item in question. Other appropriate Providers may participate in the review, but the licensed physician must decide the second level Complaint.
4. At least one-third of the Second Level Complaint Review Committee may not be employed by Keystone First or a related subsidiary or affiliate.
5. A committee member who does not personally attend the second level Complaint review meeting may not be part of the decision-making process unless that committee member



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actively participates in the review by telephone or videoconference and has the opportunity to review all information presented during the review.

6. The Member is afforded a reasonable opportunity to present evidence and testimony and make legal and factual arguments, in person or videoconference as well in writing.
7. Keystone First will give the Member at least fifteen (15) days advance written notice of the First Level Complaint review data, using the DHS supplied template. If the Member cannot appear in person at the review an opportunity for the Member to communicate with the second level Complaint Review Committee by telephone or videoconference will be provided.
8. The decision of the Second Level Complaint Review Committee is based solely on the information presented at the review, including all comments, documents, records and other information submitted by the Member or the Member's representative without regard to whether such information was submitted or considered previously. Testimony taken by the committee (including the Member's or the Member Representative's comments) is tape-recorded, or transcribed verbatim and a summary prepared and maintained as part of the Complaint record.
9. Keystone First sends a written notice, using the template supplied by DHS, of the Second Level Complaint Decision to the Member and other appropriate parties, within forty-five (45) days from the date the second level complaint was received.
10. The Member or Member representative may file a request for an External Review of the Second Level Complaint Decision with either the Department of Health or the Insurance Department within fifteen (15) days from the date the Member receives the written notice of Keystone First's Second Level Complaint Decision.

External Complaint Process

1. If a Member or Member Representative files a request for an External Review of a Second Level Complaint Decision to dispute a decision to discontinue, reduce or change a service/item that the Member has been receiving on the basis that the service/item is not a covered benefit, the Member will continue to receive the disputed service/item at the previously authorized level pending resolution of the External Review, if the request for External Review is hand delivered or post-marked within ten (10) days from the mail date on the written notice of Keystone First's Second Level Complaint Decision.
2. Upon the request of either the Department of Health and/or the Insurance Department, all records from the First Level Review and Second Level Review shall be transmitted to the appropriate department by Keystone First within thirty (30) days from the request in the manner prescribed by that department. The Member, Member Representative or the Health Care Provider or Keystone First may submit additional materials related to the Complaint.
3. The Department of Health and/or the Insurance Department will determine the appropriate agency for the review.



Expedited Complaints

1. An expedited Complaint review must be conducted if Keystone First determines or if a Member or Member's representative, (with proof of the Member's written authorization) provides Keystone First with certification from the Member's Provider (including the Provider's signature) that the Member's life, health, mental health or ability to attain, maintain or regain maximum function would be placed in jeopardy by following the regular Complaint process. A request for an Expedited Complaint review may be requested either by fax, orally, email or in writing. Upon receipt of a verbal or written request for expedited review, Keystone First verbally informs the Member or Member representative of the right to present evidence and allegations of fact or of law in person as well as in writing and of the limited time available to do so.
2. If an Expedited Complaint is filed to dispute a decision to discontinue, reduce or change a service/item that the Member has been receiving on the basis that the service/item is not a covered service/item, then the Member will continue to receive the disputed service/item at the previously authorized level pending resolution of the Expedited Complaint, if the Expedited Complaint is made orally, hand delivered, faxed, emailed or post-marked within ten (10) days from the mail date on the written notice of the decision. A signed Health Care Provider certification stating that the Member's life, health or ability to attain, maintain or regain maximum function would be placed in jeopardy following the regular Complaint process must be provided to Keystone First. The Health Care Provider certification is required regardless of the manner in which the Expedited Complaint is filed. If the Health Care Provider certification is not included with the request for an expedited review, Keystone First informs the Member that the Health Care Provider must submit a certification as to the reasons why the expedited review is needed.
3. Keystone First makes a reasonable effort to obtain the certification from the Health Care Provider. If the Health Care Provider certification is not received within seventy-two (72) hours of the Member's request for Expedited Review, Keystone First makes a reasonable effort to give the Member prompt verbal notice that the Complaint is to be decided within the standard timeframe (unless the timeframe for deciding the Complaint has been extended by up to fourteen (14) days at the request of the Member), and sends a written notice (using the template specified by DHS) within two (2) days of the decision to deny expedited review. If Keystone First does not accept an Expedited Complaint because of lack of physician certification in any form, the Member or Member representative can file a complaint regarding Keystone First's refusal to accept an expedited request. The Expedited Complaint Review Process is bound by the same rules and procedures as the Second Level Complaint Review Process with the exception of timeframes, which are modified as specified in this section.
4. The Expedited Complaint review is performed by the Expedited Complaint Review Committee, which shall include a licensed physician in the same or similar specialty that typically manages or consults on the service or item in questions. Other appropriate Providers may participate in the review, but the licensed physician must decide the Complaint. The member of the Expedited Complaint Review Committee may not have been involved in and may not be the subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Complaint.



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5. Keystone First prepares a summary of the issues presented and decisions made, which is maintained as part of the Expedited Complaint Record.
6. Keystone First issues the decision resulting from the Expedited Review in person or by phone to the Member and other appropriate parties within forty-eight (48) hours of receiving the Health Care Provider's certification or seventy-two (72) hours of receiving the Member's request for an Expedited Review, whichever is shorter, unless the time frame for deciding the expedited Complaint has been extended by up to fourteen (14) days at the request of the Member. In addition, Keystone First mails written notice of the decision, using the template supplied by DHS, to the Member and appropriate other parties within two (2) business days of the decision.
7. The Member or Member representative may file a request for an Expedited External Complaint review with Keystone First within two (2) business days from the date the Member receives Keystone First's Expedited Complaint Decision. Keystone First follows Department of Health guidelines when handling requests for Expedited External Complaint Reviews.

Grievances

Grievance Process

1. A Grievance is a request by a Member, Member representative, or a Health Care Provider, with proof of the member's written authorization for the representative or Health Care Provider to be involved and/or act on a member's behalf, to have Keystone First reconsider a decision solely concerning the medical necessity and appropriateness of a health care service. If Keystone First is unable to resolve the matter, a Grievance may be filed regarding a Keystone First decision to:
 - a. Deny, in whole or in part, payment for a service/item;
 - b. Deny or issue a limited authorization of a requested service/item, including a determination based on the type or level of service/item;
 - c. Reduce, suspend or terminate a previously authorized service/item;
 - d. Deny the requested service/item but approve an alternative service/item
 - e. Deny a request for a benefit limit exception (BLE)

This term does not include a Complaint.

2. Members, Member representatives, and/or Health Care Providers, if the Health Care Providers filed the Grievance with consent, have forty sixty (60) days from the date the Member, Member representative, and/or Health Care Provider, if the Health Care Providers filed the Grievance with consent, receives the written notice of denial to file a Grievance.
3. Upon receipt of the Grievance, Keystone First sends the Member and appropriate other parties a DHS approved acknowledgement letter.
4. If a Grievance is filed to dispute a decision to discontinue, reduce or change a service/item that the Member has been receiving, the Member continues to receive the disputed



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service/item at the previously authorized level pending resolution of the Grievance, if the Grievance is made orally, hand delivered or post-marked within ten (10) days from the mail date on the written notice of the decision.

5. The Grievance review is performed by the Grievance Review Committee, which is made up of three (3) or more individuals who were not involved in and are not the subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Grievance. At least one-third of the Grievance Review Committee may not be employees of Keystone First or a related Affiliate. The Committee must include a licensed physician, in the same or similar specialty that typically manages or consults on the service/item in question. The physician on the committee decides the Grievance.
6. The Member is afforded a reasonable opportunity to present evidence and testimony and make legal and factual arguments, in person as well in writing.
7. Keystone First will give the Member at least fifteen (15) days advance written notice of the review date, using the DHS supplied template. If the Member cannot appear in person at the review an opportunity for the Member to communicate with the Grievance Review Committee by telephone or videoconference will be provided.
8. The Grievance Review Committee completes its review of the Grievance as expeditiously as the Member's health condition requires. The committee prepares a summary of the issues presented and decisions made, which is maintained as part of the Grievance record.
9. Keystone First sends a written notice of the Grievance Decision, using the template supplied by DHS, to the Member and other appropriate parties, within thirty (30) days from receipt of the Grievance by Keystone First, unless an up to fourteen (14) day extension was granted by request of the Member, Member representative, and/or Health Care Provider, if the Health Care Provider filed the grievance with consent may file a request for a Fair Hearing, a request for an external review, or both a request for Fair Hearing and a request for an external review.
10. The Member or Member representative may file a request for a DHS Fair Hearing within one hundred and twenty days (120) from the mail date on the written notice of the Grievance decision.
11. The Member or Member representative may file a request with Keystone First for an external review of a Grievance decision by a certified review entity (CRE) appointed by DOH. The request must be filed in writing or verbally with fifteen (15) days from the date the Member receives the written notice of the Grievance decision.

External Grievances

1. All requests for External Grievance Review are processed through Keystone First. Keystone First is responsible for following the protocols established by the Department of Health in meeting all time frames and requirements necessary in coordinating the request and notification of the decision to the Member, Member representative, and/or Provider, if the Health Care Provider filed the Grievance with consent, service provider and prescribing provider.
2. Within five (5) business days of receipt of the request for an External Grievance Review, Keystone First notifies the Member, the Member's representative (if designated), the Health



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Care Provider, and the Department of Health that the request for External Grievance Review has been filed.

3. If a Member, Member representative, and/or Health Care Provider, if the Provider filed the Grievance with consent, files an External Grievance to dispute a decision to discontinue, reduce or change a service/item that the Member has been receiving, then the Member will continue to receive the disputed service/item at the previously authorized level pending resolution of the External Grievance, if the External Grievance is made orally, hand delivered or post-marked within ten (10) days from the mail date on the written notice of the Grievance decision.
4. The External Grievance Review is conducted by independent medical review entity (CRE) certified by the Pennsylvania Department of Health to conduct External Grievance Reviews.
5. Within two (2) business days from receipt of the request for an External Grievance Review, the Department of Health randomly assigns an independent medical review entity (CRE) to conduct the review. Keystone First and assigned CRE entity are notified of this assignment.
6. If the Department of Health fails to select a CRE within two (2) business days from receipt of a request for an External Grievance Review, Keystone First may designate a CRE to conduct a review from the list of CRE's approved by the Department of Health. Keystone First will not select a CRE that has a current contract or is negotiating a contract with Keystone First or its affiliates or is otherwise affiliated with Keystone First or its affiliates.
7. Keystone First forwards all documentation regarding the decision, including all supporting information, a summary of applicable issues, the basis and clinical rationale for the decision to the CRE conducting the External Grievance Review. The transmission of information takes place within fifteen (15) days from receipt of the Member's request for an External Grievance Review.
8. Within the same fifteen (15)-day period, Keystone First will provide the Member or Member's representative or Health Care Provider, if the Health Care Provider filed the Grievance with consent, with a list of documents being forwarded to the CRE for the External Review.
9. Within fifteen (15) days from receipt of the request for an External Grievance Review by Keystone First, the Member, Member representative, and/or Health Care Provider, if the Health Care Provider filed the Grievance with consent may supply additional information to the CRE conducting the External Grievance Review for consideration. Copies must also be provided at the same time to Keystone First so that Keystone First has an opportunity to consider the additional information.
10. Within sixty (60) days from the filing of the request for the External Grievance Review, the CRE conducting the External Grievance Review issues a written decision to Keystone First, the Member, the Member's representative and the Health Care Provider (if the Health Care Provider filed the Grievance with the Member's consent), that includes the basis and clinical rationale for the decision. The standard of review shall be whether the service/item was Medically Necessary and appropriate under the terms of Keystone First's contract.
11. The External Grievance Decision shall be subject to appeal to a court of competent jurisdiction within sixty (60) days from the date the Member, Member representative, and/or Health Care Provider, if the Health Care Provider filed the Grievance with consent receives notice of the External Grievance Decision.



Expedited Grievances

1. An Expedited Review must be conducted if Keystone First determines or if a Member or Member's representative, (with proof of the Member's written authorization) provides Keystone First with certification from the Member's Provider (including the Provider's signature) that the Member's the Member, Member representative, and/or Health Care Provider, if the Health Care Provider filed the Grievance with consent, believes that the Member's life, health, mental health or ability to attain, maintain or regain maximum function would be placed in jeopardy by following the Standard Grievance Process. An Expedited Grievance Review may be requested in writing, by fax, by email or verbally..
2. Upon receipt of a request for Expedited Review, Keystone First verbally informs the Member, Member representative, and/or Health Care Provider, if the Health Care Provider filed the Grievance with consent, of the right to present evidence and allegations of fact or of law in person as well as in writing and of the limited time available to do so.
3. If an Expedited Grievance is filed to dispute a decision to discontinue, reduce or change a service/item that the Member has been receiving, then the Member will continue to receive the disputed service/item at the previously authorized level pending resolution of the Expedited Grievance, if the Expedited Grievance is made orally, hand delivered or post-marked within ten (10) days from the mail date on the written notice of the decision.
4. A signed Health Care Provider certification that the Member's life, health or ability to attain, maintain or regain maximum function would be placed in jeopardy by following the Standard Grievance Process must be provided to Keystone First. The Health Care Provider certification is required regardless of the manner in which the Expedited Grievance is filed.. If the Health Care Provider certification is not included with the request for an expedited review, Keystone First informs the Member that the Health Care Provider must submit a certification as to the reasons why the Expedited Review is needed.
5. Keystone First makes a reasonable effort to obtain the certification from the Health Care Provider.
6. If the Health Care Provider certification is not received within seventy-two (72) hours of the Member's request for Expedited Review.,Keystone First makes a reasonable effort to give the Member prompt verbal notice that the Grievance is to be decided within the standard timeframe (unless the time frame has been extended by up to fourteen (14) days at the request of the Member), and sends a written notice using the DHS supplied template within two (2) days of the decision to deny Expedited Review.
7. If Keystone First does not accept an Expedited Grievance because of lack of physician certification in any form, the Member or Member representative can file a Complaint regarding Keystone First's refusal to accept an Expedited Request. Appeal rights are included in Keystone First's letter to the Member/Member representative denying the Expedited Request.
8. The Expedited Grievance Review is performed by the Expedited Grievance Review Committee, made up of three or more individuals which shall include a licensed physician in the same or similar specialty that typically manages or consults on the service or item in questions. Other appropriate Providers may participate in the review,



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but the licensed physician must decide the Complaint. The members of the Expedited Complaint Review Committee may not have been involved in and may not be the subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Complaint.

9. Keystone First prepares a summary of the issues presented and decisions made which are maintained as part of the Expedited Grievance record.
10. Keystone First issues the decision resulting from the Expedited Review in person or by phone to the Member and other appropriate parties within forty-eight (48) hours of receiving the Health Care Provider's certification or seventy-two (72) hours of receiving the Member's request for an Expedited Review, whichever is shorter, unless the time frame for deciding the expedited Grievance has been extended by up to fourteen (14) days at the request of the Member. In addition, Keystone First mails written notice of the decision to the Member and other appropriate parties within two (2) business days of the decision using the template specified by DHS
11. The Member, Member representative, and/or Health Care Provider, if the Health Care Provider filed the Grievance with consent, may file a request for an Expedited External Grievance Review with Keystone First within two (2) business days from the date the Member, Member representative, and/or Health Care Provider, if the Health Care Provider filed the Grievance with consent, receives Keystone First's Expedited Grievance Decision. Keystone First follows Department of Health guidelines when handling requests for expedited external Grievance Reviews.
12. The Member or Member representative may file a request for a DHS Fair Hearing within one hundred and twenty (120) days from the mail date on the written notice of the Expedited Grievance Decision.

DHS Fair Hearing

DHS Fair Hearing

1. A DHS Fair Hearing is a hearing conducted by DHS, Bureau of Hearings and Appeals or its designee.
2. A Member must file a Complaint or Grievance with Keystone First and receive a decision on the Complaint or Grievance before filing a request for a Fair Hearing. If Keystone First fails to provide written notice of a Complaint or Grievance decision within each processes's required time frames, the Member is deemed to have exhausted the Complaint or Grievance process and may request a Fair Hearing.
3. Members or Member representatives may request a DHS Fair Hearing within one hundred and twenty (120) days from the mail date on the initial written notice of decision or within one hundred and twenty (120) days from the mail date on the written notice of Keystone First's Complaint decision or Grievance decision for any of the following:
 - a. the denial, in whole or part, of payment for a requested service/item if based on lack of medical necessity;
 - b. the denial or a requested service/item on the basis that the service or item is not a covered benefit;



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- c. the denial or issuance of a limited authorization of a requested service/item, including the type or level of service/item;
 - d. the reduction, suspension, or termination of a previously authorized service/item;
 - e. the denial of a requested service/item but approval of an alternative service/item;
 - f. the failure to provide services/items in a timely manner, as defined by the DHS;
 - g. the failure of Keystone First to decide a Complaint or Grievance within the required time frames;
 - h. Keystone First denies payment after a service(s)/item(s) has been delivered because the service/item was provided without authorization by a Provider not enrolled in the MA Program; or
 - i. Keystone First denies payment after a service(s)/item(s) has been delivered because the service(s)/item(s) provided is not a covered benefit for the Member.
 - j. The denial of a Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance and other Member financial liabilities.
2. The request for a DHS Fair Hearing must include a copy of the written notice of decision that is the subject of the request, unless Keystone First failed to provide written notice of the Complaint or Grievance decision within the time frames required for each process. A Fair Hearing may be requested as follows:

Fax: 1-717-772-6328

Mail: Department of Human Services
OMAP – HealthChoices Program
Complaint, Grievance and Fair Hearings
P.O. Box 2675
Harrisburg, Pennsylvania 17105-2675

3. A Member who files a request for a DHS Fair Hearing to dispute a decision to discontinue, reduce or change a service/item that the Member has been receiving must continue to receive the disputed service/item at the previously authorized level pending resolution of the DHS Fair Hearing, if the request for a DHS Fair Hearing is hand delivered, faxed, emailed, or post-marked within ten (10) days from the mail date on the Keystone First's written notice of First Level Complaint or Grievance decision.
4. Upon receipt of the request for a DHS Fair Hearing, DHS's Bureau of Hearings and Appeals or a designee will schedule a hearing. The Member and Keystone First will receive notification of the hearing date by letter at least ten (10) days in advance, or a shorter time if requested by the Member. The letter will outline the type of hearing, the location of the hearing (if applicable), and the date and time of the hearing.
5. Keystone First is a party to the hearing and must be present. Keystone First, which may be represented by an attorney, must be prepared to explain and defend the issue on appeal. DHS's decision is based solely on the evidence presented at the hearing. The failure of Keystone First to participate in hearing will not be reason to postpone the hearing.
6. Keystone First will provide the Member, at no cost, with records, reports, and documents, relevant to the subject of the DHS Fair Hearing.



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7. If the Bureau of Hearings and Appeals has not taken final administrative action within ninety (90) days of the receipt of the request for a DHS Fair Hearing, Keystone First will follow the requirements at 55 Pa. Code 275.4 regarding the provision of interim assistance upon the request for such by the Member. When the Member is responsible for delaying the hearing process, the time limit for final administrative action will be extended by the length of the delay attributed to the Member (55 Pa. Code 275.4).
8. The Bureau of Hearings and Appeals adjudication is binding on Keystone First unless reversed by the Secretary of DHS. Either party may request reconsideration from the Secretary within fifteen (15) days from the date of the adjudication. Only the Member may appeal to Commonwealth Court within thirty (30) days from the date of adjudication (or from the Secretary's final order, if reconsideration was granted). The decisions of the Secretary and the Court are binding on Keystone First.

Expedited Fair Hearing Process

1. A request for an Expedited DHS Fair Hearing may be filed by the Member or Member's representative, with proof of the Member's written authorization for the representative to be involved and/or act on the Member's behalf, with DHS either in writing or orally.
2. A Member must exhaust the Complaint or Grievance process prior to filing a request for an expedited Fair Hearing.
3. An Expedited DHS Fair Hearing will be conducted if a Member or a Member's representative provides DHS with written certification from the Member's Health Care Provider that the Member's life, health, mental health or ability to attain, maintain or regain maximum function would be placed in jeopardy by following the regular DHS Fair Hearing process. This certification is necessary even when the Member's request for the Expedited DHS Fair Hearing is made orally. The certification must include the Health Care Provider's signature. The Health Care Provider may also testify at the DHS Fair Hearing to explain why using the usual timeframes would place the Member's health in jeopardy.
4. A Member who files a request for an Expedited DHS Fair Hearing to dispute a decision to discontinue, reduce or change a service/item that the Member has been receiving must continue to receive the disputed service/item at the previously authorized level pending resolution of the DHS Fair Hearing, if the request for an Expedited DHS Fair Hearing is hand delivered or post-marked within ten (10) days from the mail date on the written notice of decision.
5. Upon the receipt of the request for an Expedited DHS Fair Hearing, DHS's Bureau of Hearings and Appeals or a designee will schedule a hearing.
6. Keystone First is a party to the hearing and must participate in the hearing. Keystone First, which may be represented by an attorney, must be prepared to explain and defend the issue on appeal. The failure of Keystone First to participate in the hearing will not be reason to postpone the hearing.
7. Keystone First will provide the Member, at no cost, with records, reports, and documents, relevant to the subject of the DHS Fair Hearing.
8. The Bureau of Hearings and Appeals has three (3) business days from the receipt of the Member's oral or written request for an Expedited Review to process final administrative action



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9. The Bureau of Hearings and Appeals adjudication is binding on Keystone First unless reversed by the Secretary of DHS. Either party may request reconsideration from the Secretary within fifteen (15) days from the date of the adjudication. Only the Member may appeal to Commonwealth Court within thirty (30) days from the date of adjudication (or from the Secretary's final order, if reconsideration was granted). The decisions of the Secretary and the Court are binding on Keystone First.

Provision of and Payment for Service of Item Following the Decision

If Keystone First, Bureau of Hearings and Appeals, or the Secretary reverses a decision to deny, limit, or delay a service or item that was not furnished during the Complaint, Grievance, or Fair Hearing process, Keystone First must authorize or provide the disputed service or item as expeditiously as the Member's health condition requires but no later than seventy-two (72) hours from the date it receives notice that the decision was reversed. If Keystone First requests reconsideration, Keystone First must authorize or provide the disputed service or item pending reconsideration unless Keystone First requests a stay of the Bureau of Hearings and Appeals decision and the stay is granted.

If Keystone First, Bureau of Hearings and Appeals, or the Secretary reverses a decision to deny authorization of a service or item, and the Member received the disputed service or item during the Complaint, Grievance, or Fair Hearing process, Keystone First must pay for the service or item that the Member received

General Procedures for Complaints and Grievances

The following procedures apply to all levels of Complaints and Grievances for Members:

1. Keystone First does not charge Members a fee for filing a Complaint or Grievance at any level.
2. Keystone First designates and trains sufficient staff to be responsible for receiving, processing, and responding to Member Complaints and Grievances in accordance with applicable requirements and using letter templates supplied by DHS.
3. Keystone First staff performing Complaint and Grievance reviews have the necessary orientation, clinical training and experience to make an informed and impartial determination regarding issues assigned to them.
4. Keystone First does not use the time frames or procedures of the Complaint and Grievance process to avoid the medical decision process or to discourage or prevent the Member from receiving Medically Necessary care in a timely manner.
5. Keystone First accepts Complaints and Grievances from individuals with disabilities in alternative formats, including: TTY/TDD (for telephone inquiries and Complaints and Grievances from Members who are hearing impaired), Braille, audio tape, computer disk and other commonly accepted alternative forms of communication. Keystone First informs employees who receive telephone Complaints and Grievances of the speech limitation of some Members with disabilities so they can treat these individuals with patience, understanding, and respect.



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6. Keystone First offers Members the assistance of Keystone First staff throughout the Complaint and Grievance process at no cost to the Member. Keystone First also offers Members the opportunity to be represented by a Keystone First staff member at no cost to the Member.
7. Keystone First ensures that anyone who participates in making the decision on a Complaint or Grievance was not involved in and is not the subordinate of anyone who was involved in any previous level of review or decision-making in the case at issue.
8. Keystone First permits the Member or Member representative (which includes the Member's Health Care Provider), with proof of the Member's written authorization or consent for the representative to be involved and/or act on the Member's behalf, to file a Complaint or Grievance either verbally or in writing. The written authorization or consent must comply with applicable laws, contract requirements and Keystone First procedures. Health Care Providers wishing to file a Complaint on behalf of a Member must have the Member's written consent. There are separate consent requirements for Grievances under Act 68 which are not applicable to Complaints. For more information on the specific consent requirements for Grievances, please see the section titled "Requirements for Grievances filed by Providers on Behalf of Members" found in this Section of the Manual.
9. At any time during the Complaint and Grievance process, the Member or their representative may request access to documents, copies of documents, records, and other information relevant to the subject of the Complaint or Grievance. This information is provided at no charge.
10. If Keystone First does not decide a First Level Complaint or Grievance within the timeframes specified within the Policy, Keystone First notifies the Member and other appropriate parties using a DHS approved letter template. The letter is mailed by Keystone First one day following the date the decision on the First Level Complaint or Grievance was to be made.
11. Oral requests for Complaints and Grievances are committed to writing by Keystone First and provided to the Member and Member representative for signature through a DHS approved acknowledgement letter. The signature may be obtained at any point in time in the Complaint and Grievance process. If the Member or Member representative's signature is not received, the Complaint or Grievance is not delayed.
12. Keystone First provides Members with disabilities assistance in presenting their case at Complaint or Grievance reviews at no cost to the Member. This includes: providing qualified sign language interpreters for Members who are severely hearing impaired, providing personal assistance to Members with other physical limitations in copying and presenting documents and other evidence, and providing information submitted on behalf of the Keystone First at the Complaint or Grievance review in an alternative format accessible to the Member filing the Complaint or Grievance. The alternative format version will be supplied to the Member at or before the review, so the Member can discuss and/or refute the content during the review.
13. Keystone First provides foreign language interpreter services when requested by a Member, at no cost to the Member.
14. A Member who consents to the filing of a Complaint or Grievance by a Health Care



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Provider may not file a separate Complaint or Grievance. Keystone First will ensure that punitive action is not taken against a Health Care Provider who either requests an Expedited Resolution of a Complaint or Grievance or supports a Member's request for an Expedited Review of a Complaint or Grievance. The Member retains the right to rescind consent throughout the Complaint and Grievance process upon written notice to Keystone First and the Health Care Provider.

15. The Member or Member representative has the opportunity to submit written documents, comments or other information relating to the Complaint or Grievance, and to present evidence and allegations of fact or law in person, as well as in writing, at both levels of the internal Complaint and Grievance process.
16. Keystone First takes into account all information submitted by the Member or Member representative regardless of whether such information was submitted or considered during the initial or prior level of review.
17. Keystone First is flexible when scheduling the review to facilitate the Member's attendance. The Member is given at least seven (7) days advance written notice of the review date for First Level Reviews. The Member is given at least fifteen (15) days advance written notice of the review date for Second Level Reviews.
18. If the Member cannot appear in person at the review, Keystone First provides the Member with an opportunity to communicate with the committee by telephone. The Member may elect not to attend the review meeting, but the meeting is conducted with the same protocols as if the Member were present.
19. Committee proceedings are informal and impartial to avoid intimidating the Member or Member representative. Persons attending the committee meeting and their respective roles at the review will be identified for the Member and Member representative in attendance.
20. Keystone First may provide an attorney to represent the interests of the committee and to ensure the fundamental fairness of the review and that all disputed issues are adequately addressed. In the scope of the attorney's representation of the committee, the attorney will not argue Keystone First's position or represent Keystone First or Keystone First staff.
21. The committee may question the Member and the Member representative, the Health Care Provider and Keystone First staff representing Keystone First's position.
22. A committee Member who does not personally attend the review may not be part of the decision-making process unless that committee Member actively participates in the review by telephone and has the opportunity to review all information introduced during the review.
23. Members and their representatives may also pursue issues through the separate and distinct DHS Fair Hearing process. Members or their representatives may file a request for a DHS Fair Hearing or an expedited DHS Fair Hearing after the Complaint and Grievance process has been exhausted.



Relationship of Provider Formal Appeals Process to Provider Initiated Member Grievances

If a Health Care Provider submits a request for an appeal through Keystone First's Grievance Appeals Process and a Member consent has been provided that conforms with applicable law for Act 68 Member Appeals filed by a Health Care Provider on behalf of a Member (specific requirements for Health Care Providers related to Grievances filed by Providers on Behalf of Members are set forth below), the appeal will be processed through the Keystone First's Act 68 Member Grievance Process.

If the appeal is processed through the Act 68 Member Grievance Process, the Health Care Provider waives his/her right to file an appeal through Keystone First's Formal Provider Appeals Process, unless otherwise specified in the Health Care Provider's contract with Keystone First.

If the Health Care Provider has either failed to provide written Member consent or the written Member consent does not conform to applicable law regarding Grievances filed by Health Care Providers on behalf of Members (specific requirements are set forth below under Requirements for Grievances filed by Providers on Behalf of Members), the appeal will be processed through Keystone First's Formal Provider Appeals Process. Keystone First will notify the Health Care Provider in writing that the appeal will be processed through Keystone First's Formal Provider Appeals Process because the requisite Member consent was not provided by the Health Care Provider and offer the Health Care Provider the opportunity to resubmit a Member consent that conforms to applicable law for Grievances filed by Health Care Providers on behalf of Members.

If a Health Care Provider, with written consent of the Member, appeals a denial through the Act 68 Member Grievance Process at any time prior to or while the Formal Provider Appeal is pending, the Formal Provider Appeal will be terminated and the Formal Provider Appeal closed. Keystone First will notify the Health Care Provider in writing if a Formal Provider Appeal has been closed for this reason.

Requirements for Grievances filed by Providers on Behalf of Members

Member Consent Requirements for Grievances

Pennsylvania Act 68 gives Health Care Providers the right, with the written permission of the Member, to pursue a Grievance on behalf of a Member. A Health Care Provider may ask for a Member's written consent in advance of treatment but may not require a Member to sign a document allowing the filing of a Grievance by the Health Care Provider as a condition of treatment. There are regulatory requirements for Health Care Providers that specify items that must be in the document giving the Health Care Provider permission to pursue a Grievance on behalf of a Member, and the time frames to notify Members of the Health Care Provider's intent to pursue or not pursue a Grievance on behalf of a Member. These requirements are important because the Health Care Provider assumes the Grievance rights of the Member.



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The Member may rescind the consent at any time during the Grievance process. If the Member rescinds consent, the Member may continue with the Grievance at the point at which consent was rescinded. The Member may not file a separate Grievance for the same issue listed in the consent form signed by the Member which the Health Care Provider is pursuing. A Member who has filed a Grievance may, at any time during the Grievance process, choose to provide consent to a Health Care Provider to continue with the Grievance instead of the Member. The Member's consent is automatically rescinded upon the failure of the Health Care Provider to file or pursue a Grievance on behalf of the Member. The Health Care Provider, having obtained consent from the Member or the Member's legal representative to file a Grievance, has 10 days from receipt of the Medical Necessity denial and any decision letter from a First, Second or External Review upholding Keystone First's decision to notify the Member or the Member's legal representative of his or her intention not to pursue a Grievance.

It is important for Health Care Providers to remember they may not bill Keystone First Members for covered services. If a Health Care Provider assumes responsibility for filing a Grievance and the subject of the Grievance is for non-covered services provided, then the Health Care Provider may not bill the Member until the External Grievance Review is completed or the Member rescinds consent for the Health Care Provider to pursue the Grievance. If the Health Care Provider chooses to never bill the Member for non-covered services that are the subject of the Grievance, the Health Care Provider may drop the Grievance with notice to the Member.

The consent document giving the Health Care Provider authority to pursue a Grievance on behalf of a Member shall be in writing and must include each of the following elements:

- The name and address of the Member, the Member's date of birth, and the Member's identification number.
- If the Member is a minor, or is legally incompetent, the name, address and relationship to the Member of the person who signs the consent for the Member.
- The name, address and identification number of the Health Care Provider to whom the Member is providing the consent.
- The name and address of the plan to which the Grievance will be submitted.
- An explanation of the specific service for which coverage was provided or denied to the Member to which the consent will apply.
- The following statements:
 - The Member or the Member's representative may not submit a Grievance concerning the services listed in this consent form unless the Member or the Member's legal representative rescinds consent in writing. The Member or the Member's legal representative has the right to rescind consent at any time during the Grievance process.
 - The consent of the Member or the Member's legal representative is automatically rescinded if the Health Care Provider fails to file a Grievance, or fails to continue to prosecute the Grievance through the Review Process.



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- The Member or the Member's legal representative, if the Member is a minor or is legally incompetent, has read, or has been read this consent form, and has had it explained to his/her satisfaction. The Member, or the Member's legal representative understands the information in the Member's consent form.
- The consent document must also have the dated signature of the Member, or the Member's legal representative if the Member is a minor or is legally incompetent, and the dated signature of a witness.

Note: The Pennsylvania Department of Health has developed a standard Enrollee (Member) consent form that complies with the provisions of Act 68. The form can be found at under "Provider Initiated Grievance and Enrollee Consent Form" on the Pennsylvania Department of Health website or in Appendix VI of the Provider Manual.

Escrow Requirements for External Grievances (Including Expedited External Grievances)

If a Health Care Provider requests an External Grievance Review, the Health Care Provider and Keystone First must each establish escrow accounts in the amount of half the anticipated cost of the review. The Health Care Provider will be given more specific information about the escrow requirement at the time of the filing of the External Grievance. If the External Grievance Decision is against Keystone First, in part or in full, Keystone First pays the cost. If the decision is against the Member, in part or in full, Keystone First pays the cost. If the decision is against the Health Care Provider in full, the Health Care Provider pays the cost.