Apple Health grievances and appeals

Author
Northwest Justice Project

Last Review Date
April 29, 2025

Your rights and things you can do if you have any issues with your Apple Health Managed Care Plan.

1. Why grieve or appeal

If you're on an Apple Health Managed Care plan (https://www.hca.wa.gov/free-or-low-cost-health-care/i-need-medical-dental-or-vision-care/apple-health-managed-care), you might at some point disagree with something that someone in the plan tells you. Or you might feel something isn't right.

Maybe the plan refuses to cover a service you need, or you want to stay with a doctor who's dropping out of your plan. You might feel you've been treated unfairly by a provider or the plan.

If there's anything about your plan or your health care that you're not satisfied with, your managed care plan's Member Handbook briefly discusses your options. We explain it all here in more detail. We also explain your rights when you need a faster ("expedited") decision.

> Keep a written record of what you asked for, when, and how, a copy of anything you sent in writing, and any response or records you get.
>
> Read any written notice the plan sends you about a decision it made that is unfavorable to you. Make sure you understand its reason. Note any deadlines.

2. Before grievance or appeal

Here are some things you can try right away. If none of these works, you should think about filing a grievance or appeal.

Contact the customer service office. Your plan must help all members with complaints and appeals. Their customer service might help solve your problem. Your plan member card or welcome letter has the phone number. Generally, the plan must treat your call as a grievance or appeal and follow the appropriate rules.

> Don't wait too long for customer service to solve the problem. Don't let any appeal deadlines pass without action.

Ask the plan to pay for a second opinion if you're unsure about the first medical opinion you get about a health problem. When you ask, your plan must pay for a second opinion from **another provider in the plan's network of providers who contract with the plan.** If the plan says no, you can appeal that decision.

> **You might be able to get a second opinion from someone outside the network**, if you have good reason. If the plan refuses, ask for a fair hearing. Ask the fair hearing judge to authorize a second opinion outside the network.

Ask for an Exception to Rule (ETR) for services the plan says it doesn't cover ("non covered" services). If the plan grants your ETR request, you may not need to file a grievance or appeal. At the same time, you can still appeal the plan's decision that the service isn't covered if you disagree with that.

> For a child under age 21, you must make an appeal instead of an ETR.

If your plan approves less care than you asked for, or for a shorter period or less frequently than you asked for, you can **ask for a Limitation Extension** to get the full amount of care your provider says you need. You or your provider

must explain in writing why you need this care. You should include:

- How much improvement you've had related to the service
- The probability that you'll keep improving if the care is extended
- The probability that you'll get worse if it's not extended

Send your health plan the explanation and any records you or your provider want the plan to review. The plan will send you a written decision.

> You can ask for an appeal **and** an LE. You can ask for an LE before you appeal the original denial. If your LE request is denied, you can appeal that denial also.

3. Children and youth

All children and youth under age 21 with Medicaid have EPSDT coverage (https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment). Under EPSDT, all medical services that Medicaid can pay are covered. It doesn't matter if Washington doesn't cover them for adults.

EPSDT's only requirement is that the medical services be medically necessary, safe and effective, and not experimental. You should appeal denials of your child's health services for other reasons such as "noncovered". You shouldn't need to ask for an Exception to Rule.

4. Grievance

You'll get a written plan notice when the plan makes a decision that's unfavorable to you. It should explain

- Your right to file a grievance or appeal
- How to do this
- Any deadlines you must meet

The plan must give you a copy of its grievance and appeal process. Usually that information is in your member handbook.

A **grievance** is an expression of dissatisfaction about anything not considered an appeal. You can file a grievance any time you're dissatisfied with services you're getting or not getting from a health plan or doctor, pharmacy, or other provider with your health plan. **Examples** are concerns about the quality of your care or being treated unfairly or rudely. **You have no right to appeal the plan's decision on your grievance.**

To make a grievance, call your plan. Follow up with a written grievance. The plan must let you know its decision within **45 days** of getting your complaint.

5. Appeal

A health plan appeal is a request that the health plan change a decision or action affecting your health care (an "adverse benefit determination").

Example: the plan denies payment for a procedure your doctor recommended.

You can ask for a plan appeal if:

- The plan has said it will deny, limit, change, or stop a service requested or previously authorized for you.
- The plan has denied payment for a service.
- The plan doesn't provide services timely.

You should start the appeal verbally and follow up in writing. Your verbal appeal starts the clock on the deadline for the plan to respond. It also stops the clock on your deadline to appeal. This matters if the plan is stopping services you get, and you must keep getting those services while your appeal is determined. You must follow up in writing to get the appeal heard and decided.

Your written appeal request should list the services the plan is stopping or denying and explain why you need them. **Ask your provider for help.** You can send the provider's information to the plan yourself or ask the provider to do it and send you a copy.

> When asking for an appeal, ask the health plan to send you copies of all records about the dispute free of charge, as soon as possible.

6. Appeal deadlines

You can get continued services (called **continued benefits**) **during your health plan appeal if you ask for this right away**. If you're appealing a denial of reduction in services, you have the right to keep getting the service during the appeal process, as often as you were originally getting it and in the same amount.

The deadline to ask for appeal and qualify for continued benefits is the later of these:

- Within **10 days** of when the plan mails you a letter saying your care may be stopped or changed
- By the date your care is scheduled to stop or change

If you lose your appeal, you may have to pay the plan for some or all the continued benefits you got during the first 60 days of the appeal process.

If you don't need continued benefits, you have 60 days to appeal after the date on the letter the plan sent you notifying you of its adverse decision.

7. Appeal rights

You can get the health plan's file about you, including your medical records, any other relevant written materials, any other materials the plan considered, made or caused to be made regarding the issue, and any material the plan will consider in your appeal. The plan must provide you with these free of charge and in enough time before the appeal hearing so you can review them and get ready for the hearing.

You can give evidence about your situation in person, by phone or in writing that your health plan must consider when it decides your appeal.

You can argue to the plan in person, by phone, or in writing about why they should agree with your appeal.

8. Fair hearing

A fair hearing is a kind of appeal that you use when the health plan doesn't solve your problem. In a fair hearing, usually an administrative law judge (ALJ) at the Office of Administrative Hearings (OAH) considers the case and makes the decision. The ALJ doesn't work for your health plan, HCA or DSHS.

You must complete your health plan appeal before you can get a fair hearing, unless the plan doesn't decide on your appeal within the allowed time. In that case, you're considered ("deemed") to have completed the plan appeal stage. You can then ask for a fair hearing right away.

You can ask for a fair hearing if either of these is true:

- You disagree with the plan's decision in your plan appeal.
- The plan doesn't make a decision on your appeal or grievance in the required time.

If you had continued benefits during your appeal and you want to keep getting them during the fair hearing process, you must ask for a fair hearing and continued benefits within 10 days of the date on the letter the plan sent you with their decision in your plan appeal. Otherwise, the agency must get

your request 120 days after getting your plan's appeal decision.

The rules for fair hearings are in WAC 182-538-110(8)-(10) (http://apps.leg.wa.gov/wac/default.aspx?cite=182-538-110) and WAC 182-526-0200 (http://apps.leg.wa.gov/wac/default.aspx?cite=182-526-0200). Other medical services programs hearing rules (http://apps.leg.wa.gov/wac/default.aspx?cite=182-526) may also apply.

If nothing in WAC Chapter 182-526 (http://apps.leg.wa.gov/wac/default.aspx?cite=182-526) applies, WAC Chapter 10-08 (http://apps.leg.wa.gov/wac/default.aspx?cite=10-08) may apply.

9. After fair hearing

If you don't agree with the fair hearing decision, you can first ask for a free **Independent Review (IR)**. IR is a review by an Independent Review Organization (IRO), a committee outside your health plan.

You must ask your health plan for an IR in writing and send OAH a copy of the request **within 21 days** of the day they mailed you the decision in your fair hearing. If you miss the 21-day deadline, ask anyway. If your plan or HCA refuses to give you IR, you may be able to challenge it in court. Try to talk to a lawyer right away.

> The Insurance Commissioner's website (https://fortress.wa.gov/oic/consumertoolkit/Search.aspx?searchtype=indrev)

has IR decisions in other cases. Look for favorable decisions for situations like yours to point out to the reviewer.

If you get a favorable IRO decision, ask the plan to follow it based on RCW 48.43.535(8) (https://app.leg.wa.gov/RCW/default.aspx?cite=48.43.535) and WAC 182-538-110(10) (https://app.leg.wa.gov/wac/default.aspx?cite=182-538-110). If the plan refuses to follow the IRO decision and asks the BOA to review it, you can object based on these laws. Contact a lawyer right away.

If you don't ask for IR, or the IR decision isn't favorable to you, you can **ask the Board of Appeals to review the fair hearing or IRO decision**. There are a few ways to do this:

- **By mail** to Board of Appeals – Health Care Authority, P.O. Box 42700, Olympia, WA 98504-2700.
- **By hand delivery** to the Board of Appeals at 626 8th Ave. S.E., Olympia WA.
- **By fax** to the Board of Appeals at 1-360-507-9018. You must also mail a copy.

Your BOA review request should

- Ask for review
- Say why the fair hearing or IRO decision was wrong
- List testimony and written materials from your fair hearing supporting your view

> You can't provide new information or records in a BOA review.

The BOA must get your review request by 5 pm on the 21st day after the date they mailed your fair hearing decision to you. If you asked for IR, the time to ask for the BOA review is longer: Your deadline after IR is 5 pm on the 21st day after the date they mailed the IR decision to you. **You can call BOA** at 1-844-728-5212 to be sure BOA got your request.

> The BOA may but doesn't have to approve an extension of time.

If you disagree with the BOA's decision, you may appeal it to Superior Court . The deadline for filing is 30 days after the date they mail the decision to you. The process is complicated. Get help or advice from a lawyer.

10. Expedited decision

If you need a faster decision at any time in the appeal and review process, your appeal, fair hearing, or review request must

- Say you want an **expedited** decision
- Explain why your health, life or ability to function will be harmed or put at risk if you don't get a quick decision

Different deadlines apply.

To ask your health plan for an expedited health plan appeal, ask your health provider to write a letter to the plan explaining why you need an expedited appeal. Ask your provider for a copy of their letter.

Your health plan generally has 2 calendar days after getting your expedited appeal request to decide to give you one. If they decide to do it, they generally must decide on your appeal within 72 hours of getting your appeal request. They can take up to 14 more calendar days to decide whether to give you an expedited appeal or to decide your expedited appeal.

If the plan extends these deadlines without your agreement, they must let you know right away, including the reason for the delay. If they refuse to give you an expedited appeal decision, you can make a grievance about this.

An ALJ must give you the decision about whether to hold an expedited hearing verbally and in writing. You might have to wait 3 – 4 days for this decision.

An **expedited IRO review** must result in verbal or written notice of its decision to you 72 hours from when it gets your expedited review request. If the IRO gives initial notice of the decision verbally, it must provide a written decision notice within 48 hours after the verbal notification.

You can also **ask the Board of Appeals (BOA)** for an expedited review of the ALJ's or IRO's decision.

11. Get more help

The Health Care Authority Customer Service Center (https://fortress.wa.gov/hca/p1contactus/Client_WebForm.aspx) may be able to help you.

- Phone: 1-800-562-3022
- Email: askmedicaid@hca.wa.gov (mailto:askmedicaid@hca.wa.gov)
- TTD: Dial 7-1-1 through Washington Relay