

Overview

The Plan maintains distinct grievance and appeals processes for members and providers, as well as access to the State Hearing system. Providers have the right to participate in these processes on behalf of patients and to challenge the failure of the Plan to cover a specific service. Members or their representatives can call the Provider Hotline to file an appeal or a grievance.

Definitions

An *appeal* is a request for review of an action taken by or on behalf of the Plan. A member, a member's representative, or a provider acting on behalf of the member and with the member's written consent may file an appeal. Examples of actions that can be appealed include but are not limited to the following:

- Denial or limited authorization of a requested service, including the type or level of service;
- The reduction, suspension or termination of a previously authorized service;
- The denial, in whole or in part, of payment for a service;
- The failure to provide services in a timely manner, as defined by the state.

A *grievance* is an expression of dissatisfaction about any matter other than an action that could be appealed. Specifically, a *grievance* is an expression of dissatisfaction with any aspect of the managed care Plan or provider's operation, provision of health care services, activities or behaviors. A member or a member's representative, acting on behalf of the member and with the member's written consent, may file a grievance within 90 days of the date the member became aware of the issue.

Possible subjects for grievances include but are not limited to the following:

- Quality of care of services provided
- Rudeness of the provider or staff

- Failure to respect the member's rights

The Plan ensures that decision-makers on grievances and appeals were not involved in previous levels of review or decision-making. These decision-makers are health care professionals with clinical expertise in treating the member's condition/disease, or have sought advice from providers with expertise in the field of medicine related to the request when deciding any of the following:

- An appeal of a denial based on lack of medical necessity;
- A grievance regarding denial of expedited resolution of an appeal;
- A grievance or appeal involving clinical issues.

No health care provider may be penalized by a managed care plan for providing testimony, evidence, records or any other assistance to an enrollee who is disputing a denial, in whole or in part, of a health care treatment or service or claim thereof.

Submission of Member Appeals

Any party to an action appropriate for appeal, including a member or a member's authorized representative, may request that the action be reconsidered.

The member, member's representative or provider (with member's written consent) may file a request for an expedited or standard appeal determination. A provider may file a statement with the member's appeal request supporting the need for an expedited resolution. The request must be a statement by the physician him/herself and not from an office staff member.

The Plan will not take, or threaten to take, any punitive action against any provider acting on behalf or in support of a member requesting a standard or expedited appeal.

The Plan gives members reasonable assistance in completing forms and other procedural steps for an

appeal, including, but not limited to, providing interpreter services and TTY/TDD toll-free telephone numbers with interpreter capability. To arrange interpreter services, please contact Member Services for assistance.

Members are provided reasonable opportunity to present evidence and allegations of fact or law, in person as well as in writing. If the request for reconsideration is submitted after 90 calendar days, then good cause must be shown for the Plan to accept the late request. Examples of good cause include but are not limited to the following:

- The member did not personally receive the Notice of Action, or he/she received it late;
- The member was seriously ill, which prevented a timely appeal;
- There was a death or serious illness in the member's immediate family;
- An accident caused important records to be destroyed;
- Documentation was difficult to locate within the time limit;
- The member had incorrect or incomplete information concerning the appeal process;
- The member lacked capacity to understand the time frame for filing a request for reconsideration.

Questions regarding the filing or status of an appeal should be directed to Member Services, which will coordinate with Appeals as appropriate.

A member of the Member Services or Appeals team will be in contact with the provider within two business days of the inquiry.

A member, a member's representative or a provider may file an appeal request verbally or in writing within 90 days of the date on the Notice of Action.

If filed verbally through Member Services, the request must then be supplemented with a written, signed appeal request to the Plan. For verbal filings, the time frame for resolution begins on the date the verbal request was called into Member Services. The Plan will assist the member to ensure that a written appeal is filed immediately by converting a verbal filing into a written record. If the member follows the verbal filing with a written appeal, this appeal will supersede the written record.

If the member wishes to use a representative, then he/she must complete an Appointment of Representative statement. The member and the person who will be representing the member must sign the statement. An Appointment of Representative form is available in the **Forms** section of this manual.

An acknowledgement of receipt will be provided to the person filing the appeal within three business days. If the appeal is filed verbally, a verbal acknowledgement will be provided. If filed in writing, written acknowledgement will be provided.

The Plan must make a determination on an appeal within the following time frames:

- Expedited Request: **3 business days**
- Standard Request: **15 calendar days**

Members have the right to request continuation of benefits during an appeal or State Hearing. The member may be liable for the cost of any continued benefits if the Plan's action is upheld at the discretion of the Ohio Department of Job & Family Services (ODJFS).

The Plan will continue the member's benefits if:

- The appeal or hearing request is filed timely, meaning on or before the later of the following:
 1. Within 10 business days of the date on the Notice of Action (add five calendar days if the notice is sent via U.S. mail).

2. The intended effective date of the Plan's action.

- The appeal involves the termination, suspension or reduction of a previously authorized course of treatment;
- The services were ordered by an authorized provider;
- The original period covered under the original authorization has not expired; and
- The member requests continuation of benefits.

If the Plan continues or reinstates member benefits while the appeal is pending, the member's benefits will be continued until one of following occurs:

- The member withdraws the appeal;
- Ten calendar days pass from the date of the Plan's Notice of an Adverse Appeal Decision and the member has not requested a State Hearing with continuation of benefits within the 10-day time frame (add five calendar days if the notice is sent via U.S. mail);
- A State Hearing or appeal decision adverse to the member is made; or
- The authorization expires or authorized service limits are met.

This process shall also be available for dissatisfaction concerning the timeliness of services or the timeliness of grievance responses.

Request for Appeal Determinations

Request for Expedited Determination

A request for an expedited appeal may be made verbally by calling Member Services or in writing by mail to the Appeals department.

A written appeal is not required.

The plan has a responsibility to review all appeals and expedite those that warrant quicker action. In order to meet criteria for expedited review, it must be shown that applying the standard procedure could seriously jeopardize the member's life, health or ability to regain maximum function.

The Plan will make a determination on whether processing will be expedited or standard within one business day from the receipt of the request.

Appeals selected for expedited processing will be determined within three business days from receipt of the request. The Plan will make reasonable efforts to notify the member of the disposition of their request verbally and also in writing.

A request for payment of a service already provided to a member is not eligible to be reviewed as an expedited reconsideration.

Denial of Expedited Request

If the Plan denies the request for an expedited determination, the Plan will automatically transfer the request for an expedited determination (no later than one business day from the date the Plan received the request) to the standard reconsideration process. The Plan will then make its determination as expeditiously as the member's health condition requires but no later than 15 calendar days from the date the initial appeal request was received.

Request for Standard Pre-Service Determination

A request for a standard appeal determination may be made verbally by calling Member Services or in writing by mail to the Appeals department. The Plan will make a determination and provide notification within 15 calendar days from receipt of the standard request.

Request for Retrospective Determination

The provider and member must complete an Appointment of Representation statement, which can be found in the **Forms** section of this manual to file a request for a retrospective determination.

The Plan will make a determination and provide notification within 30 calendar days from receipt of the retrospective request.

14-Day Extension

The Expedited and Standard Appeal determination periods noted above may be extended up to 14 calendar days if the member requests an extension or if the Plan justifies a need for additional information and documents how an extension is in the best interest of the member. If an extension is not requested by the member, the Plan will obtain prior approval from ODJFS, and if approved, will provide the member with written notice of the reason for the delay and the date by which a decision must be made.

Affirmation of Denial

If the Plan upholds the action and/or denial, then the member, the member's representative or the provider will be notified in writing of the decision, as well as any additional appeal rights.

Reversal of Denial

If the Plan overturns the action, it will notify the member and provider verbally and in writing.

The Plan will authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires if the services were not furnished while the appeal was pending and the decision is to reverse a decision to deny, limit or delay services.

The Plan also will pay for disputed services, in accordance with state policy and regulations if the

services were furnished while the appeal was pending and the disposition reverses a decision to deny, limit or delay services.

State Hearing

The member has the right to request a State Hearing in addition to pursuing the Plan's appeals process.

Parties to the State Hearing include the Plan, as well as the member and his/her representative, or the representative of a deceased member's estate. A provider can be a representative or a witness in a hearing process.

The member or a member's representative with written consent may request a State Hearing within 90 days from the date on the State Hearing notice. The request may be sent to the following address:

Ohio Department of Job & Family Services
Bureau of State Hearings
P.O. Box 182825
Columbus, OH 43218-2825

The Plan will continue the member's benefits while the State Hearing is pending if:

- The State Hearing is filed timely, meaning on or before the following:
 - Within 15 days of the mailing date on the State Hearing notice (add five calendar days if the notice is sent via U.S. mail).
- The State Hearing involves the termination, suspension or reduction of a previously authorized course of treatment.

If the Plan continues or reinstates the member's benefits while the State Hearing is pending, the benefits will be continued until one of following occurs:

- The member withdraws the request for State Hearing;

- A State Hearing decision adverse to the member is made; or
- The authorization expires or authorized service limits are met.

The Plan will authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires, if the services were not furnished while the State Hearing was pending and reverses a decision to deny, limit or delay services.

The Plan will pay for disputed services, in accordance with state policy and regulations, if the services were furnished while the State Hearing was pending and reverses a decision to deny, limit or delay services.

At the discretion of ODJFS, the member may be liable for the cost of continued benefits if the Plan's action is upheld.

Submission of Provider Appeals

Providers have 90 days* from the original utilization management denial or claim denial to file a provider appeal. Cases appealed after that time will be denied for untimely filing. There is no second level consideration for cases denied for untimely filing. If the provider feels they have filed their case within the appropriate time frame, they may send proof. Acceptable proof of timely filing will only be in the form of a registered postal receipt signed by a representative of the Plan, or similar receipt from other commercial delivery services.

A Provider may file an appeal by submitting a letter of appeal and/or an appeal form with supporting documentation such as medical records. Appeal forms may be found in the **Forms** section of this manual.

- The Plan is not responsible for payment of medical records generated as a result of a provider inquiry. Any invoices received by the Plan for such charges will be redirected to the provider.

* *Subject to change*

- Cases received without the necessary documentation will be denied for lack of information.

The Plan has 60 days to review the case for medical necessity and conformity to Plan guidelines. During this time, the Plan may request additional information from the provider in order to complete a review of the case.

- It is the responsibility of the provider to provide the requested documentation within 60 days of the denial to re-open the case. Records and documents received after that time frame will not be reviewed and the case will remain closed.

If it is determined that the provider has complied with Plan protocols and that the appealed services were medically necessary, the denial will be overturned. The provider will be notified of this decision in writing.

The provider may file a claim for payment, if they have not already done so. If a claim has been previously submitted and denied, it will be adjusted for payment after the decision to overturn the denial has been made. The Plan will ensure that claims are processed and comply with the federal and state requirements.

**Submission
of Provider
Termination
Appeal
Request**

If a provider termination is initiated by the Plan, regardless of whether the termination is for cause or not, the Plan will notify the provider of the termination decision in writing, via certified mail.

Providers will be informed as to their right to petition the termination action, the process and timing for reconsideration of the termination decision. The termination reconsideration request must be filed within 15 days of receipt of the Plan's termination notice.

The Plan will send the provider an acknowledgement of the termination reconsideration request in writing within five business days of receipt. The Plan may request additional information from the provider in order to review the termination reconsideration request. If this is

the case, the provider has three business days to submit the required documentation. If not received within three business days, the Plan will continue to process the termination reconsideration request.

A panel reviews the termination reconsideration request and upon determination will send an outcome letter to the provider stating that the termination reconsideration request is either overturned or upheld.

Termination Overturn

If the Plan overturns the termination of the provider, the Plan will ensure there is no lapse in the period of the provider's participation with the Plan.

Termination Upheld

If the Plan upholds its termination of the provider, the Plan will notify members 45 calendar days prior to the effective termination date. The notification will include the following:

- PCP's name and last date the PCP is available to provide care; and
- The name, location, telephone number and effective date of the member's newly assigned PCP.

Members will also be informed on how to select a different PCP and the Plan telephone number they can call for further assistance.

The Plan will also notify members who:

- Were seen two or more times within the past 12 months
- Have an open OB authorization (as applicable)
- Received an open authorization

Members with these circumstances will be notified 45 days prior to the termination effective date of a participating hospital, specialist or a significant ancillary provider.

Submission of Grievances

A member or a member's representative acting on behalf of the member, may file a grievance either verbally or in writing within 90 calendar days of the date that the member became aware of the issue. A verbal request may be followed up with a written request, but the time frame for resolution begins the date the Plan receives the verbal filing.

If the member wishes to appoint another person as their representative, he/she must complete an Appointment of Representative statement. The member and the person who will be representing the member must sign the statement. This form is available in the **Forms** section of this manual.

The Plan will send an acknowledgement of receipt to the person filing the grievance within three business days. If the grievance is filed verbally, a verbal acknowledgement will be provided. If filed in writing, written acknowledgement will be provided.

The Plan will make a determination on the grievance notification within the following time frames:

- Within **two business days** of receipt if the grievance is regarding access to Medicaid-covered services
- Within **30 calendar days** of receipt for non-claims related grievances
- Within **60 calendar days** of receipt of claims-related grievances

The Plan gives members reasonable assistance in completing forms and other procedural steps, including but not limited to the provision of interpreter services and TTY/TDD toll-free telephone numbers with

interpreter capability. Refer to the **Quick Reference Guide** for the appropriate contact information.

Members will be provided reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing.

Request for Expedited Grievance Reconsideration

A member, a member representative or a provider acting on behalf of a member may file a request for an expedited grievance determination verbally or in writing. A verbal request can be filed by calling Member Services. A written request can be mailed or faxed directly to the Grievance department. A determination on the expedited request will be made within 72 hours of receipt of the expedited request.

A request for an expedited grievance determination can be made for complaints related to Plan's decisions to:

- A grievance regarding denial of expedited resolution of an appeal; or
- A grievance or appeal that involves clinical issues.

Request for Standard Grievance Determination

A grievance will be investigated, a determination made and a closure letter sent to the complainant (and ODJFS upon request), within two, 30 or 60 calendar days of receipt of the standard request.

The closure letter will include:

- The results and date of the grievance resolution;
- Notice of the right to request a Second-Level grievance to the Plan;
- The time limit to file a Second-Level request (standard is 30 calendar days from the date of the notice); and
- Information on how to present the case at the Second-Level Grievance Committee either in

person or via teleconference.

14-Day Extension

The Plan may extend the time frames for a determination on a standard grievance by up to 14 calendar days if the member requests an extension or if the Plan shows that there is need for additional information (to the satisfaction of the state, upon its request) and includes how the delay is in the member's interest.

**Grievances
Filed Against
a Provider**

If a member files a grievance against a provider in reference to the quality of care or service provided, the Plan will fax and mail a request to the provider for a response. The provider is given 10 business days to respond and submit medical records for review. If a provider has not responded within the 10 business days, a second fax and letter is sent giving an additional five business days to respond.

Continued failure to respond may result in the provider's panel being closed to new patients and/or will be interpreted as the provider not in disagreement with the member's issue.

The case is then forwarded to the Quality Improvement department for further investigation.

If the provider does respond, the case is referred to a Plan nurse who reviews the medical records to determine if a quality issue exists. If the nurse feels a quality issue may exist, the case is referred to a Plan medical director for review. If he/she determines a quality issue exists, the case is referred to the Quality Improvement department for further investigation. If no quality issue is identified, the case is entered into the Plan's database for tracking and trending purposes.

**Submission
of Provider Claim
Reconsiderations****Claim Reconsiderations**

A Provider may file a Claim Reconsideration by submitting a letter with supporting documentation such

as medical records. The Claim Reconsideration must be submitted within 90 days of the Remittance Advice/Explanation of Benefits issue date. Claim Reconsideration requests received after that time will be denied for untimely filing. If a provider feels they have filed their case within the appropriate time frame, they may send proof to the Plan.

For written requests, acceptable proof of timely filing will only be in the form of a registered postal receipt signed by a representative of the Plan, a similar receipt from other commercial delivery services or a fax confirmation.

- The Plan is not responsible for payment of medical records generated as a result of provider initiated claim reconsideration requests. Any invoices received by the Plan for such charges will be redirected to the provider.
- Cases received without the necessary documentation will be denied for lack of information.

A decision on a claim reconsideration request will be made within **60 days** of receipt.