POLICY AND PROCEDURE

DEPARTMENT: Quality Improvement/Quality Management	**DOCUMENT NAME:** Member Grievance and Appeals System Description
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SCOPE:
Corporate and Plan Compliance, Quality Improvement/Quality Management (QI/QM), Provider Services, Medical Management and Member Service departments.

PURPOSE:
To outline the Member Grievance System that meets all Federal and State regulatory requirements, including a grievance and appeal process. It includes procedures for access to the State Fair Hearing (SFH) system and/or Independent External Review (IER) if the Member would like decision reconsideration if they feel the appeal finding is unacceptable regarding their care or service. **For the purpose of this policy the term grievance will cover both grievances and complaints.**

POLICY:
The Plan will maintain a procedure for the receipt and prompt resolution of all grievances, appeals and SFH and/or IER processes that complies with all applicable State and Federal laws The content and substance of a grievance or appeal, including all clinical care aspects involved, are fully investigated and documented according to applicable statutory, regulatory, and contractual provisions and the Plan's policies and procedures. Resolution and notification of such resolution is made as expeditiously as the Member's condition warrants but no later than the timeframes as outlined in this policy or per State or contractual requirements. Plan does not structure compensation in a manner that incentivizes an individual or entity to deny, limit or discontinue medically necessary service to any member.

PROCEDURE:

A. General Requirements

1. Members are notified upon enrollment of the procedure for requesting, processing and resolving Member grievances, appeals and SFH/IER. The notification explains specific instructions about how to contact the Plan's Member Services Department and identifies the Grievance and Appeals (G&A) Coordinator, the designated staff, who process grievances, appeals and SFH/IER.
2. Members may have only one level of internal appeal. Members must exhaust internal appeal processes prior to requesting a SFH. Should the Plan fail to adhere to the notice and timing requirements within the State contract and 42 C.F.R 438.408, the member is deemed to have exhausted the internal appear process and may initiate a SFH.
3. A Member, or Authorized Representative acting on the Member's behalf or a Provider, acting on behalf of the Member and with the Member's written consent, may file a grievance or appeal, and may request a SFH/IER. If the Member chooses

to elect an authorized representative, the Member's written consent is required before the Plan can process the request. Once the signed Authorized Representative Designation Form or other written, signed authorization designation is received, the resolution time clock begins.

4. A Member, or Member Authorized Representative, may file a grievance or appeal orally or in writing. Standard oral appeal requests must be followed in writing within the original timeframe allotted for requesting the appeal (See "C. Appeal Process" below). There are no time limits for requesting a grievance. The Plan gives Members reasonable assistance in completing forms and taking other procedural steps of the Member Grievance System, including, but not limited to, auxiliary aides and services, such as providing translation services, communication in alternative languages and toll-free numbers with TTY/TDD and interpreter capability.
5. The Plan gives the Member written notice of any action within the timeframes for each type of action and will not create barriers to timely due process.
6. The Plan's Member Services Department documents the grievance or appeal and completes a task in the member relations documentation system. If the grievance is resolved by the Member Services Department at the time of submission (first call resolution), the Member Services Department will document the resolved case in member relations documentation system and mark the call complete as appropriate. All first call resolution closed cases will be forwarded to the G&A Coordinator for notification requirements and reporting purposes.
7. If the grievance is not resolved at the time of the call, the Member Services Department will save the call and the case will be sent to the G&A Coordinator for review, investigation, and resolution.
8. The Plan takes into account all comments, documents, records, and other information submitted by the Member or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination, if applicable.
9. The Plan provides the Member a reasonable opportunity, orally and in writing, to present evidence, testimony, and make legal and factual arguments. The Plan informs the Member of the limited time available in advance of the resolution timeframe for grievance and appeals and in the case of expedited resolution.
10. The Plan provides the Member and his or her representative, free of charge and in advance of the resolution timeframe for grievance and/or appeals: the Member's case file, medical records involved, other documents and records, and any new or additional evidence used in the case upon the Member's request. The Plan includes information (including procedures and timeframes) regarding grievances and appeals in the Plan's Provider Manual and Member Handbook.
    a. The Plan provides a copy of the Provider Manual to all providers/ subcontractors at the time the Plan enters into agreements with said providers/subcontractors.

   b. A Member Handbook is distributed to all Members upon enrollment.
   c. The information is also posted on the Plan's web site and communicated annually through the Member and Provider Newsletters/Manuals.

11. The Plan includes, as parties to the appeal the Member and his or her representative or the legal representative of a deceased Member's estate.
12. The Plan maintains a record/log of all grievances, appeals and requests for SFH/IER that will be available to the State agency and CMS in electronic format upon request. The log will be specific to the Member; entries in the log will not be intermingled with entries of Members from the Plan's other lines of business. At minimum, the log will include:
    a. The Member's name and Member ID number;
    b. The name of the grievant or appellant if not the Member;
    c. The date of filing and description of the issue;
    d. The date of each review, or if applicable, review meeting;
    e. The resolution at each level of the appeal or grievance, if applicable;
    f. The date and description of the resolution at each level, if applicable;
    g. The date of the Member notification.
13. As part of the QI/QM process, the Plan tracks the grievances and appeals to identify trends. The trends are reviewed by the Grievance & Appeals Committee or Performance Improvement Team for identification of appropriate interventions and recommendations submitted to the Quality Committee. An analysis of the grievance system is included in the annual QI/QM Program Evaluation.
14. The Plan electronically provides the State agency with a monthly report of the grievances and appeals in accordance with the requirements outlined in the Contract, to include, but not be limited to: Member's name and Medicaid number, summary of grievances and appeals; date of filing; current status; resolution and resulting corrective action. Reports with Member identifying information are redacted and available for public inspection.
15. The Plan assures that no punitive action is taken against a Provider or Member who files a grievance, an appeal, requests an expedited appeal on behalf of a Member, or supports a Member's grievance, appeal or request for an expedited appeal.
16. All subcontractors, including those delegated for services, will meet the Member grievance and appeal system requirements for problems related to delegated services.
17. All Member grievances and appeals will be resolved and notification sent as expeditiously as the member's health condition requires, within State contract timeframes and no longer than dates stated with 42 C.F.R.438.408.
18. The Plan maintains records of all grievances and appeals. A copy of grievances logs and records of disposition of appeals will be retained for ten (10) years. If any litigation, claim negotiation, audit, or other action involving the documents or records has been started before the expiration of the ten (10) year period, the records shall be

retained until completion of the action and resolution of issues which arise from it or until the end of the regular ten (10) year period, whichever is later.

B. Grievance Process

1. Filing a Grievance
   a. The grievance process is the Plan's procedure for addressing Member grievances, which are expressions of dissatisfaction about any matter other than an adverse benefit determination.
   b. The Member, Member's Authorized Representative with the Member's written consent, or Provider acting on behalf of the Member with the Member's written consent, may file a grievance orally or in writing.
      (1) Oral grievances are generally received by the Member Services Department through the Plan's toll-free customer service line. All inquiries received by Member Services Department are probed to validate the possibility of any inquiry actually being a grievance or appeal.
      (2) Written grievances are received by mail, fax or email.
   c. If a Member would like an Authorized Representative, the Member must complete the **Member Authorized Representative Designation Form** or provide other written, signed documentation authorizing the person to act on their behalf.
   d. There is no time limit on when the Member or Member's authorized representative can file a grievance. A Member may file a grievance at any time.
   e. The Member Services Department opens a case in the member relations documentation system and documents relevant information as provided by the member.
2. If the grievance is resolved by the Member Services Department at the time of submission (first call resolution), the Member Services Department will document the resolved case in the member relations documentation system and marks the call complete as appropriate. All first call resolution closed cases will be forwarded to the G&A Coordinator for notification requirements and reporting purposes.
      (1) If the grievance is not resolved at the time of the call, the Member Services Department forwards the grievance case to the G&A Coordinator for investigation and resolution. The grievance notification to the G&A Coordinator must be completed on the same business day the call is received.
      (2) All quality of care cases will first be worked as a quality of care grievance and will be forwarded on the QI/QM Department for investigation, if warranted. The QI/QM Designee opens a case in the clinical documentation system and documents appropriately (see CC.QI.17 Potential Quality of Care Incidents).

3. **Acknowledgement of Grievance**
    a. Written acknowledgement of Member grievance is sent by the G&A Coordinator to the Member within 10 calendar days of receipt of the grievance.
    b. A copy of the Member specific grievance acknowledgement letter is attached to the Member's file in the member relations documentation system.

4. **Investigating a Grievance**
    a. The G&A Coordinator researches and gathers supporting documentation regarding the grievance. This may include contacting the Member for additional information, requesting information from the Provider office, researching the Member's claims history or reviewing the Member's care plan activity.
    b. The G&A Coordinator may consult with another department such as Provider Relations or Member Services Department for further investigation as appropriate.
    c. If the G&A Coordinator receives a grievance that could be a potential quality of care issue, the grievance case is investigated and resolved as a QOC grievance and a QOC referral is routed to the QI/QM Department designee for investigation within 1 (one) business day of the grievance being received. As indicated by State regulation, the G&A Coordinator may call together an internal committee to review and resolve a grievance. The date of each review or review must be documented in the member relations documentation system.
    d. Any grievance related to a clinical issue, medical necessity decision or denial of expedited resolution of an appeal are routed to the Medical Director or appropriate clinician for review and resolution.

5. **Timelines for Grievance Resolution**
    a. Grievances are resolved in a timely manner that is appropriate for the complexity of the grievance and the Member's health condition.
    b. Standard grievances: Grievances should be resolved and notices sent as expeditiously as possible, but no later than ninety (90) calendar days from the day the Plan received the initial grievance request.
    c. Urgent grievances: Urgent grievances are resolved as expeditiously as possible, no later than seventy-two (72) hours after the Plan receives the grievance.
    d. Extension: The Plan may extend the timeframe for disposition of a grievance for up to fourteen (14) calendar days if the Member requests the extension or the Plan demonstrates (to the satisfaction of the state agency, upon its request) that there is need for additional information and how the delay is in the Member's best interest.
        (1) If the Plan extends the timeframe, it shall, for any extension not requested by the Member, complete all of the following:
            (a) Make reasonable efforts to orally notify Member of the delay;

(b) Within 2 calendar days, provide the Member with written notification of the reason for the extension and inform Member of their right to file a grievance if they disagree with the extension;
(c) Resolve the grievance, if requested, as expeditiously as the Member's health condition warrants and no later than the date the extension expires.

6. **Grievance Resolution and Notification**
   a. Upon receipt of the findings, the G&A Coordinator will document the resolution in the member relations documentation system.
   b. The Plan notifies Member of the grievance resolution as soon as possible after the resolution determination not to exceed the total resolution timeframe of ninety (90) calendar days for a standard grievance or 72 hours for an urgent grievance.
      (1) The notice of resolution includes the results of the resolution process, the date it was completed and further appeal rights, if applicable.
      (2) It is in an easily understood language and format, be available in alternative formats, and in an appropriate manner that takes into consideration those with special needs;
      (3) It includes any information required by the State that relates to the Plan's notice of grievance resolution determination;
      (4) The notice includes procedures by which the member may appeal the Plan's grievance resolution;
   c. A copy of the Member specific resolution letter is attached to the Member's file in the member relations documentation system.

C. <u>Appeal Process</u>

1. **Filing an Appeal**
   a. The appeal process is the Plan's procedure for addressing Member appeals, which are requests for review of a previous decision by the Plan. Appeal rights may not be applicable for grievances related to coverage of care.
   b. The Member, Member's Authorized Representative with the Member's written consent, or Provider acting on behalf of the Member, with the Member's written consent, may file an appeal. An appeal must be filed within 60 calendar days from date on the adverse benefit determination notice or within 10 calendar days if the Member is requesting to continue benefits during the appeal investigation.
   c. An appeal request may be submitted several ways:
      (1) The Member may call in to the Member Services Department through the Plan's toll-free customer service line. All inquiries received by Member Services Department are probed to validate the possibility of any inquiry actually being a grievance or appeal. All oral inquiries seeking to appeal an adverse benefit

determination are treated as appeals to establish the earliest possible filing date for the appeal. The Clinical Appeal Coordinator is notified of the appeal and obtains the appeal information from the member relations documentation system and documents details of the request within the clinical documentation system.

(2) The Member may request an appeal either orally or in writing. Further, unless the Member requests an expedited resolution, an oral appeal must be followed by a written, signed appeal per 42 C.F.R. 438.402.

(3) The Member may submit the appeal by phone, mail, fax, email or in person.

(4) If a Member would like an authorized representative, the Member must complete the **Member Authorized Representative Designation Form** or provide other written, signed documentation authorizing the person to act on their behalf. If the Member chooses to elect an authorized representative, the Member's written consent is required before the plan can process the request. Once the Authorized Representative Designation Form is received, the resolution time clock begins. (see Attachment B. Authorized Representative or Provider requesting appeal)

(5) The Plan gives Members reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, auxiliary aides and services, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

d. Appeal resolution timeframes are as follows:

(1) Standard Appeal Pre-Service - Resolution and notification within 30 calendar days from the date the appeal was received by the Plan (or per state timeframes if more stringent).

(2) Standard Appeal Post-Service – Resolution and notification is 30 calendar days from the date appeal was received by the Plan (or per state timeframes if more stringent).

(3) Expedited Appeal - Resolution within 72 hours from the date the appeal was received by the Plan. Plan maintains an expedited review process for appeals when the Plan determines the Member request or the Provider indicates (in making the request on the Member's behalf or supporting the Member's request) that taking the time for a standard resolution could seriously jeopardize the Member's life, health or ability to attain, maintain, or regain maximum function.

e. The Plan acknowledges all oral and written Standard Appeals in writing within 10 calendar days of the receipt of a request for an appeal. Written Expedited Appeals acknowledgement occurs at the same time the resolution is determined and is included in the same notice, both acknowledging and resolving the appeal. Reasonable efforts must be made to provide Expedited Appeal resolution notification orally, as well as in writing.

f. The member and his or her representative has the right to examine the case file and receive free of charge the medical records, and any other documents and records,

including any new or additional evidence considered, relied upon, or generated by (or at the direction of) the Plan considered in connection with the appeal of the adverse benefit determination before and during the appeals process, upon Member request.

g. The Plan will provide the Member with reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments in reference to the appeal. The Plan will also inform the Member of the limited timeframe for providing such information prior to the resolution of both standard and expedited appeals.
h. The Plan ensures that the individuals who make decisions on appeals are individuals who were not involved in any previous level of review or decision-making nor a subordinate of any such individual, and who, if deciding any clinical decisions, are health care professionals who have the appropriate clinical expertise, as determined by the state agency, in treating the member's condition or disease; including appeals of denials lacking medical necessity.
i. Form and/or letter templates that are in the Plan's clinical documentation system are utilized to communicate with the Member. All Member communications, including appeal notices are provided in easily understood language and format, are available in alternative formats and in an appropriate manner that takes into consideration those with special needs. If the State has specific forms and/or templates, those will be utilized in lieu of Plan specific developed forms and/or templates.
j. Communication to the Member identifies circumstances under which a Member may continue to receive benefits pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the Member may be required to pay the costs of these services.

2. **Standard Appeal Process**
   a. The Clinical Appeal Coordinator is responsible for managing standard appeals from when the appeal request is received and through to resolution.
   b. Acknowledgement of the Standard Appeal
      (1) The Appeal Acknowledgement Letter for a Standard Appeal is sent within ten (10) calendar days of the receipt of the appeal request (or per state contract timeframe if more stringent).
      (2) The Member Appeal Acknowledgement Letter for a Standard Appeal is created and available in the clinical documentation system utilized by the Plan.
         - The acknowledgement letter includes notification of Member rights and appeal processes in a culturally and linguistically appropriate manner;
         - The Member's right to choose additional representation by anyone, including an attorney, physician, advocate, friend or family member to

represent him or her during the appeal process. The designation of their Authorized Representative must be submitted to the Plan in writing;
- The Member's right to submit comments, documents or other information relevant to the appeal;
- The Member's right to present information relevant to the appeal within a reasonable distance so that the member can appear in person if desired;
- The timeframe for resolution of the appeal;
- The Member's right to have the specified benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay for the cost of those services;
- Need for missing information, if applicable.

c. The Clinical Appeal Coordinator creates an appeal in the Plan's clinical documentation system; requests additional information as applicable and submits to Medical Director for review.
d. Resolution of the Standard Appeal
   (1) The Resolution of the Standard Appeal must be completed within 30 calendar days of receipt of the Standard Appeal request.
   (2) An Appeal Resolution Letter for a Standard Appeal is sent out as soon as possible after the resolution determination not to exceed thirty (30) calendar days from the appeal receipt. The Resolution letter will contain:
      - the appeal outcome;
      - the date it was completed and further appeal rights, if any, including the State Fair Hearing process, continuation of benefits and circumstances in which the Member may be held liable for service costs.

   When the adverse decision is upheld in whole or part, the written appeal decision notification must include the following elements when applicable:
      - Specific reasons for the appeal decision, in easily understood language. Easily understandable notification includes a complete explanation of the reason for the denial in plain language that does not include abbreviations or acronyms that are not defined, health care codes that are not explained, or medical jargon that a layperson would not understand
      - A reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based.
      - Notification that the Member can obtain, upon request and free of charge, a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based with any new or additional evidence.

- Notification that the Member is entitled to receive, upon request and at no cost, reasonable access to and copies of all documents relevant to the appeal including any new or additional evidence. Relevant documents include documents and records relied upon in making the appeal decision and documents and records submitted in the course of making the appeal decision.
- For medical necessity appeals, a list of titles (e.g. Medical Director, external physician reviewer), and qualifications (e.g. MD, DO), including specialty (e.g. predications, neurology, etc.) of the individual(s) conducting the medical necessity review, of individuals participating in the appeal review. (Participant names do not need to be included in the written notification to members, but must be provided to Members upon request). For benefit appeals, only the reviewer's/reviewer's title is required.
- A description of the next level of appeal to an external organization (i.e. State Fair Hearing or Independent Review Organization (IRO), etc.) as applicable and described further in section E. State Fair Hearing and/or Independent External Review below, along with any relevant written procedures and contact information. Appeal rights are required and provided whenever the organization makes a decision that is adverse to the Member.

(3) The Member–specific Appeal Resolution Letter for a Standard Appeal is created and available in the Member's file within the clinical documentation system utilized by the Plan. Based on the outcome of the resolution, a Member-specific resolution letter will be sent for all appeal approvals, appeal denials, and appeal partial denials.

(4) The Clinical Appeal Coordinator is responsible for updating and closing the case in the member relations documentation system. Letters will be created and available in the clinical documentation system.

e. Extension of Standard Appeal

(1) If the Plan determines that the extension may produce information in the Member's favor, the Clinical Coordinator may request a 14 calendar day extension. The Member may also request a 14 calendar day extension.

(2) The Plan must demonstrate to the State how the extension benefits the Member and the need for additional information is in the Member's favor. The Plan must obtain State approval for the extension, and make reasonable efforts to provide prompt oral notification to the Member of the delay. The Plan will also provide Member written notification within 2 calendar days of state approval to extend appeal resolution timeframe.

f. The Plan will resolve the appeal as expeditiously as the Member's health condition requires, and no later than the date the extension expires.
g. If the Member or Member representative is not satisfied with the decision to extend the timeframe, the Member may file a grievance with the Plan.

3. **Expedited Appeal Process**
   a. The Clinical Appeal Coordinator is responsible for managing Expedited Appeals from the date of appeal request through to resolution.
   b. Acknowledgement of the Expedited Appeal
      (1) The Clinical Appeal Coordinator calls the Member acknowledging the Expedited Appeal.
      (2) If the Expedited Appeal request is determined not to meet criteria, the Standard Appeal process will be followed and a letter will be sent to Member notifying them of appeal request change to the standard processing timeframe.
      (3) The Clinical Appeal Coordinator creates an appeal in the clinical documentation system; requests additional information as applicable and submits to Medical Director for review.
   c. An Expedited Appeal request must be granted to all requests concerning admissions, continued stay or other health care services for a Member who has received emergency services but has not been discharged from the facility. The Plan must provide an expedited appeal if a physician demonstrates that the standard timeframe for an appeal decision could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function.
   d. State contracts may dictate other situations where Expedited Appeals are allowed.
   e. If the Plan denies a request for an Expedited Appeal, the appeal must automatically be transferred to the standard processing timeframe. A reasonable attempt must be made to provide oral notification of the expedited request denial and followed up with written notice within 2 calendar days (CFR 438.410), or per state contract requirements if more stringent.
   f. Resolution of the Expedited Appeal
      (1) The resolution of the Expedited Appeal must be completed within 72 hours of receipt of the Expedited Appeal request.
      (2) Once a resolution is determined, reasonable attempts are made to verbally notify the Member. An Expedited Appeal Resolution letter will be issued following oral notification attempts.
      (3) The Expedited Appeal Resolution letter is created and available in the clinical documentation system. The Resolution letter will contain the appeal outcome, the date it was completed and further appeal rights, if any, including the State Fair Hearing process, continuation of benefits and circumstances in which the Member may be held liable for service costs. When the adverse decision is

upheld in whole or part, the written appeal decision notification must include the following elements when applicable:

- Specific reasons for the appeal decision, in easily understood language. Easily understandable notification includes a complete explanation of the reason for the denial in plain language that does not include abbreviations or acronyms that are not defined, health care codes that are not explained, or medical jargon that a layperson would not understand.
- A reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based.
- Notification that the Member can obtain, upon request and free of charge, a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based with any new or additional evidence.
- Notification that the Member is entitled to receive, upon request and at no cost, reasonable access to and copies of all documents relevant to the appeal including any new or additional evidence. Relevant documents include documents and records relied upon in making the appeal decision and documents and records submitted in the course of making the appeal decision.
- For medical necessity appeals, a list of titles (e.g. Medical Director, external physician reviewer), and qualifications (e.g. MD, DO), including specialty (e.g. predications, neurology, etc.) of the individual(s) conducting the medical necessity review, of individuals participating in the appeal review. (Participant names do not need to be included in the written notification to members, but must be provided to Members upon request). For benefit appeals, only the reviewer's/reviewer's title is required.
- A description of the next level of appeal to an external organization (i.e. State Fair Hearing or Independent Review Organization (IRO), etc.) as applicable and described further in section E. State Fair Hearing and/or Independent External Review below, along with any relevant written procedures and contact information (appeal rights are required and provided whenever the organization makes a decision that is adverse to the Member).

(4) The Clinical Appeal Coordinator is responsible for updating/closing the case in the member relations documentation system. Letters will be created and available in the clinical documentation system.

g. Extension of Expedited Appeal

(1) If Plan determines that the extension may produce information in the Member's favor, the Clinical Appeal Coordinator may request a 14 calendar day extension. The Member may also request a 14 calendar day extension.
(2) The Plan must obtain State consent for the extension. If the Member does not consent to the extension, the appeal will be decided with the information available before the timeframe expires. An appeal may be withdrawn by written request from the person who filed the appeal.

h. If the Member or Member representative is not satisfied with the decision to extend the timeframe, the Member may file a grievance with the Plan. The Plan will resolve the grievance as expeditiously as the Member's health condition warrants and no later than the date the extension expires.

D. Investigating an Appeal

1. The Plan will fully investigate and document the content of the appeal including all aspects of clinical care involved, without giving deference to the denial decision. All information will be taken into account regardless of whether the information was submitted or considered in the initial determination. Any additional information required to review the appeal request should be requested at this time and that request documented in the clinical documentation system. If no additional information is available, per the Provider and/or Member, this should also be documented.

2. The appeal will be reviewed by a person or people who were not involved in the prior adverse decision. The appointed person will neither be the individual who made the adverse determination nor a subordinate of such individual; however, if additional clinical information is received and meets criteria for coverage, the practitioner who made the initial adverse determination may review the case and overturn the previous decision. A nurse, pharmacist, or other appropriate qualified licensed health professional may also overturn the prior adverse decision if additional clinical information is received with the appeal request and the additional information meets criteria for coverage.

3. Appeals with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate will be reviewed by a clinical peer who holds an active, unrestricted license to practice medicine, or a health professional who is board-certified, if applicable, and who is of the same-or-similar health care profession and has similar credentials and licensure and appropriate training and experience as those who typically treat the condition or health problem in question in the appeal.

4. Appeal requests of a benefit denial that have the potential to be covered if medically necessary, based on health plan specific criterion, should be reviewed for medical

necessity at the initial denial and a medical necessity review completed again during the appeal. For benefits that will never be covered, the sole purpose of the appeal is to verify non-coverage of the benefit and should not be reviewed for medical necessity. Per the Federal Medicaid Act, the EPSDT benefit requires that requests and any subsequent appeals for Members under the age of 21 years old should be reviewed on a case-by-case basis to determine medical necessity to correct or ameliorate a physical or mental illness or any identified conditions.

E. Unable to Process an Appeal

1. The Plan may receive appeal requests that are unable to be processed for one of the following reasons;
   a. An appeal request is received outside of the sixty (60) calendar day timeframe;
   b. The written, signed appeal request is not received following the oral request for an appeal, within the resolution timeframe;
   c. The Member is not eligible for benefits or services at the time of the appeal request.
2. The Clinical Appeal Coordinator is responsible for updating/closing the case in the member relations documentation system. An Unable to Process letter will be created and available in the clinical documentation system and sent to the Member.
3. If the Member or Member representative is not satisfied with the decision to not process the appeal, the Member may file a grievance with the Plan.

F. State Fair Hearing and/or Independent External Review

1. **Receiving a Hearing Request**
   a. The Member, Member's Authorized Representative or Provider with the Member's written consent, may request a SFH/IER after the Plan's internal appeal process has been exhausted and the final appeal decision is found to be adverse to the Member.
   b. If the Plan fails to adhere to the notice and timing requirements of 42 CFR 438.408, the Member is deemed to have exhausted the internal appeal process and may request a State Fair Hearing.
   c. The parties to a SFH include the Plan, as well as the Member, and his/her representative or the representative of a deceased Member's estate.
   d. IER may be requested simultaneously with the SFH, when directed by the State.

2. **Timeframe for Hearing Request**
   a. A SFH and/or IER must be requested no later than 120 calendar days from the date of final appeal adverse benefit determination notice.
   b. The request must be submitted within ten (10) calendar days of the date of the final appeal adverse benefit determination notice, if the Member wishes to have continuation of benefits during the SFH/IER.

3. **Plan Follow-Up for SFH/IER**
    a. The Plan will cooperate with the State agency in the hearing process and submit a copy of the Member's appeal of the Plan's action; the contents of the appeal file including research, medical records and other documents used to make their decision and a summary of the Member's appeal; the evidence used by the Plan to make its decision; and a copy of the notice of resolution provided to the Member and to the State agency within the required timeframe.
    b. The State and/or IER group will contact the Plan with the Fair Hearing's final decision.
    c. The Clinical Appeal Coordinator is responsible for updating/closing the case in the member relations documentation system. Letters will created and available in the clinical documentation system.

G. Continuation of Benefits

1. Plan will continue the Member's benefits if all of the following are true:
    a. The Member files the appeal in a timely manner, meaning on or before the later of the following:
        (1) Within ten (10) calendar days of the date on the Plan's adverse benefit determination notice or
        (2) The intended effective date of the Plan's proposed adverse benefit determination.
    b. The Member files for an appeal timely in accordance with 42 CFR 438.402;
    c. The action involves the termination, suspension or reduction of a previously authorized course of treatment;
    d. The services were ordered by an authorized provider;
    e. The authorized period has not expired; and
    f. The Member requests extension of benefits.

2. If the Plan continues or reinstates the Member's benefits while the appeal is pending, the Plan will continue providing the benefits until one of the following occurs:
    a. The Member withdraws the request for an appeal or SFH;
    b. Ten (10) calendar days pass after the Plan mails the notice providing the resolution of the appeal against the Member, unless the Member, within the ten (10) calendar day timeframe, has requested a SFH with continuation of benefits until a SFH decision is reached;
    c. The SFH officer renders a decision that is adverse to the Member; and/or
    d. The Member's authorization expires or the Member reaches his/her authorized service limits.

3. If the final resolution of the SFH is adverse to the Member, the Plan may recover the costs of the services furnished while the SFH was pending to the extent that the services were furnished solely because of the requirement to continue benefits during the appeal.

4. If services were not furnished while the SFH was pending, and the SFH resolution reverses Plan's decision to deny, limit or delay services, Plan must authorize or provide the disputed services as quickly as the Member's health condition requires.

5. If services were furnished while the SFH was pending, and the SFH resolution reverses the Plan's decision to deny, limit or delay services, Plan will pay for disputed services in accordance with State policy and regulations.

REFERENCES
NCQA Health Plan Standards and Guidelines
CC.QI.17 Potential Quality of Care
Plan's State Specific Contract
Medicaid Federal Register 42 CFR 422.564-Grievance Procedures
Medicaid Federal Register 42 CFR 431.200-Fair Hearing
Medicaid Federal Register 42 CFR 438, Subpart F, Grievance and Appeals System
CMS, State Medicaid Manual Section 5124

POLICY AND PROCEDURE

DEPARTMENT: Quality Improvement/Quality Management	**DOCUMENT NAME:** Member Grievance and Appeals System Description
PAGE: 17 of 20	**REPLACES DOCUMENT:**
APPROVED DATE: 03/12	**RETIRED:** CC.UM.08
EFFECTIVE DATE: 03/12	**REVIEWED/REVISED:** 04/14, 06/15, 08/16, 03/2017, 01/2018, 10/2018, 1/2019, 2/2020
PRODUCT TYPE: Medicaid	**REFERENCE NUMBER:** CC.QI.11

ADDENDUMS

IA.QI.11 Iowa Total Care Grievance Syste

ATTACHMENTS

2_CC_TEMPLATE MEMBER AUTHORIZ

DEFINITIONS:

Adverse Benefit Determination (ABD): The 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 part of payment for a service; the failure to provide services in a timely manner; or the failure to act within the time frames specified for making or notifying the member of such action.

Appeal: request for a Plan to reconsider a previous decision regarding an adverse determination, including adverse medical necessity and benefit decisions. A member or authorized representative of a member may appeal any adverse decision. There may be several levels of appeal and the appeal process may be conducted internally or externally or both as required by State/Federal regulations.

Expedited appeal: a request to change an adverse determination regarding urgent care as defined below. Additionally, requests for an expedited appeal review must be granted to any request concerning admissions, continued stay or other health care services for a member who has received emergency services but has not been discharged from a facility.

External appeal: a request for an independent, external review of the final adverse determination made by the Plan through its internal appeal process. This may include, but is not limited to, Independent Review Entity, Quality Improvement Organization, or State Fair Hearing.

Pre-service appeal: regarding a request for provision of service; a request to change an adverse determination for care or service that the Plan must approve, in whole or in part, in advance of the member obtaining care or services.

Same-or-similar specialist: a health care practitioner who has appropriate training and experience in the field of medicine involved in the appeal case. "Same specialty" refers to a practitioner with similar credentials and licensure as those who typically treat the condition or health problem in question in the appeal. "Similar specialty" refers to a practitioner who has experience treating the same problems as those in question in the appeal, in addition to experience treating similar complications of those problems.

Urgent care: any request for medical care or treatment, with respect to which the application of the time period for making non-urgent care determinations, could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on the prudent layperson's judgment or, in the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

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PRODUCT TYPE: Medicaid	**REFERENCE NUMBER:** CC.QI.11

REVISION LOG	**DATE**
Changed Policy Name to Member Grievance System Description; added language to clarify that the term grievance will be used to refer to grievances and complaints to Purpose statement; added/updated language in Section A (General Requirements) #3, #10, #11, #12 and Section C (Appeals Process) #2, #6, #7 and changes the timeframe to apply for a State Fair Hearing to 120 calendar days; updated the record retention to 10 years to meet corporate standard; and grammatical edits.	8/2016
Added step 4 in the General Requirements; changed claimant to member; clarified that oral appeals require written follow-up only when required by State contract; and grammatical edits.	6/2015
Changed Policy Name to Member Complaint, Grievance, and Appeal System Description; added complaint definition and added language to clarify the nature of appeal referenced in this policy refers to appeal of the grievance decision.	4/2014
Revised P/P to include general guidelines for Member complaints/grievances, appeals, SFH/IER and Continuation of Benefits with Medicaid guidelines effective 07/01/2017, added Letter Templates, merged CC.QI.11.01 – Grievance Process with CC.QI.11-for Medicaid.	03/2017
Annual review. Merged UM appeals process (CC.UM.08) into this document and retired UM.08. Corrected typos, added new authorization party.	01/2018
Annual review with the following revisions: The requirement of the Authorized Representative Designation Form to start the grievance and appeal process. Clarification about the benefit denial process and updated the policy to include MegaReg language around single level appeal. Updated the Standard Appeal Post-Service timeframe for NCQA compliance. Removed letter templates and added Nebraska QI.11 addendum.	01/2019
Annual review. Updated the requirements for a standard appeal resolution notice to mirror that of expedited appeal resolutions. Added Unable to Process an Appeal information. Added appeals may be received in person. Included workflows for the oral appeal process for Members, authorized representatives and Providers. Changed clinically urgent grievances to urgent grievances. Updated QOC grievance process. Added information about the EPSDT review process.	2/2020

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in Compliance 360, Centene's P/P management software, is considered equivalent to a physical signature.

Vice President, Quality & Risk Adjustment, Accreditation: approval on file

POLICY AND PROCEDURE

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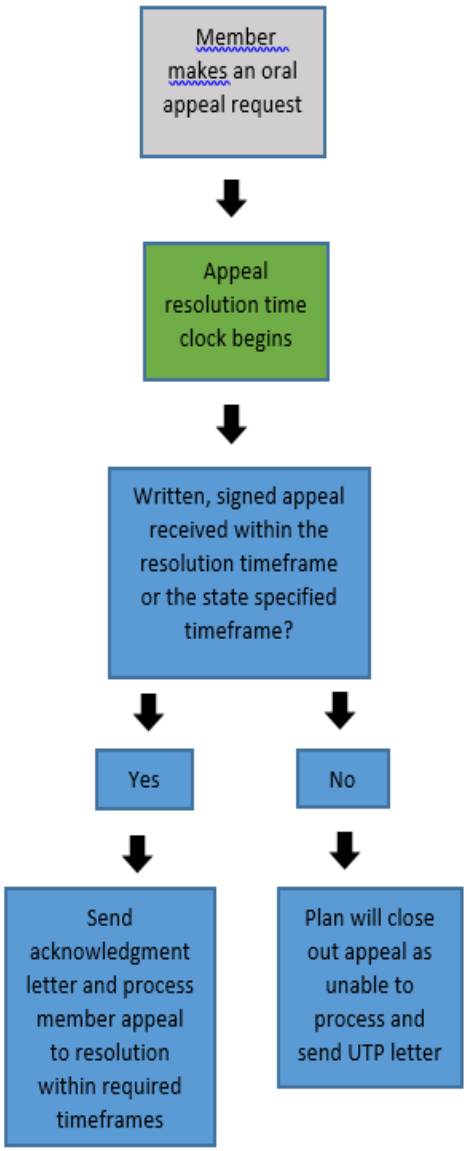
Attachment A. Member Oral Appeal Process



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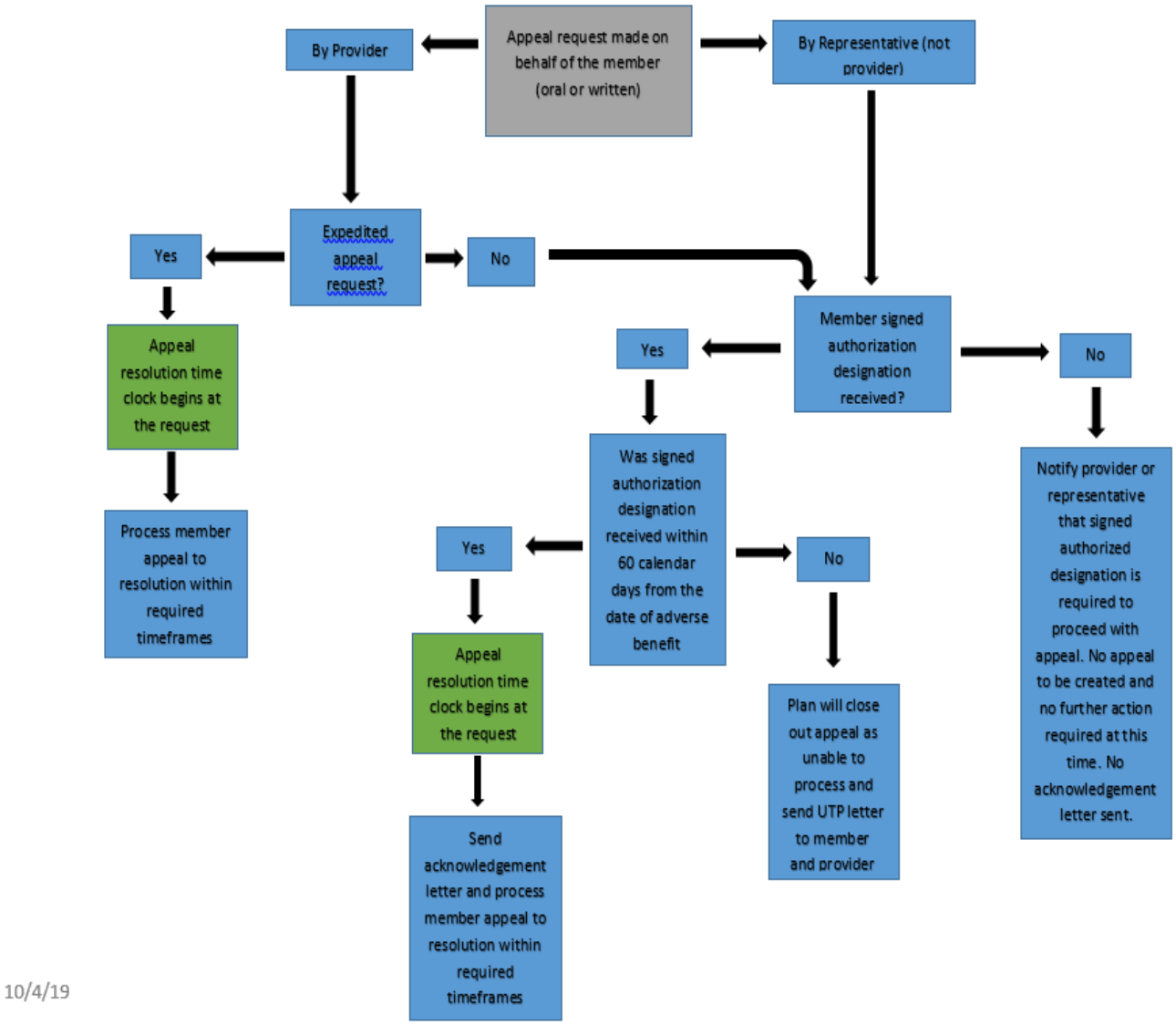
Attachment B. Provider or Authorized representative request



10/4/19