ADDENDUM TEMPLATE

STATE: Nebraska	**PLAN NAME:** Nebraska Total Care
EFFECTIVE DATE: 01/01/2018	**POLICY NUMBER ADDENDUM TO:** *CC.QI.11 - Member Grievance and Appeals System Description*
REVIEWED/REVISED DATE: 01/01/2018	**POLICY NAME ADDENDUM TO:** *NE.QI.11 -: Member Grievance System Description*
RETIRED DATE:	

SCOPE:

This addendum applies to *Nebraska Total Care.*

PURPOSE:

To provide contractually required information that varies from the Centene Corporate policy/procedure.

UNIQUE REQUIREMENTS:

[The unique requirements should be listed in the follow table, referencing the specific section of the Centene Corporate policy/procedure]

Section Number of Corporate P/P	Description of Unique Requirement	Line of Business
Page 3 of 16	13. 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 – **Nebraska Total Care submits a quarterly report with monthly data to the State.**	
Page 4 of 16	f. (2) - (see CC.QI.17 Potential Quality of Care Incidents) – **Nebraska Total Care uses NE.QI.17**	
Page 5 of 16	d. If the Plan extends the timeframe, it shall, for any extension not requested by the member, give the member written notice of the reason for the delay **within two (2) calendar days.**	
Page 6 of 16	(4) The procedures by which the member may appeal the Plan's grievance resolution: **Nebraska Total Care allows a second review of the grievance resolution.**	
Page 7 of 16	d. (2) - Standard Appeal Post-service –requires resolution in 60 calendar days (or per state timeframes if more stringent) – **Nebraska Total Care has a 30 day resolution timeframe for all standard appeals and does not delineate between a pre-service and post-service appeal request.**	
Page 8 of 16	2 (2 – bullet number 3) 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 – **Nebraska Total Care does not restrict the members ability to present information relevant to the appeal based on distance that the member can appeal in person.**	

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Page 9 of 16	2 (e) (1) - If the Plan determines that the extension may produce information in the member's favor, the G&A Coordinator may request a 14 calendar day extension. The member may also request a 14 calendar day extension. – **Nebraska Total Care will make reasonable efforts to provide verbal notice of the delay and provide written notice of the reason for the decision to extend the timeframe within two (2) calendar days. The member will have the right to file a grievance if he/she disagrees with the decision to delay.**	
Page 9 of 16	2 (e) (2) (2) The Plan must obtain State approval and member consent for the extension- (TEMPLATES; Appeal Plan Request for Appeal Timeframe Extension Letter and Member Approval for Appeal Extension Form). – **Nebraska Total Care does not require member permission to extend the timeframe of an appeal resolution if the plan shows (to the satisfaction of the State agency, upon its request) that there is need for additional information and how the delay is in the enrollee's interest. The plan will make reasonable efforts to give the enrollee prompt oral notice of the delay. Members may submit a grievance is they are not in agreement of the extension. Members may request a 14 calendar day extension for the resolution of the appeal during the appeal review process.**	
Page 13 of 16	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. –**Nebraska Total Care will authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires but no later than 72 hours from the date it receives notice reversing the determination.**	

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Section Number of Corporate P/P	Description of Unique Requirement	Line of Business
Page 14 of 16	Definition of an Appeal - 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. - **Nebraska Total Care has only one level of appeal.**	
Page 16 of 16	**POLICY AND PROCEDURE APPROVAL** The electronic approval retained in **Compliance 360**, Centene's P/P management software, is considered equivalent to a physical signature – **Should be RSA Archer**	

REFERENCES

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Page 3 of 16 DHHS RFP Attachment 38 states that the MCO will submit the Grievance System log (which contains all grievances, appeals and SFH) on a quarterly basis. **Page 4 of 16** See Archer: NE.QI.17 - Potential Quality of Care Reviews **Page 5 of 16** Electronic Code of Federal Regulations: **438.408 Resolution and notification: Grievances and appeals. (C)** ***Extension of time frames*** **(2) Requirements following extension (ii)** Within 2 calendar days give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision. **Page 6 of 16 CFR 438.400 Statutory basis, definitions, and applicability** *Appeal* means a review by an MCO, PIHP, or PAHP of an adverse benefit determination.

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NCQA UM8A 7–9: Appeal decisions – The decision for a preservice appeal and notification to the member within 30 calendar days of receipt of the request. / For Medicare and Medicaid only, decisions for postservice appeals and notifications to members must be within 30 calendar days of receipt of the request.

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Electronic Code of Federal Regulations: **438.06 Handling of grievances and appeals. (b) Special requirements. (4)** Provide the enrollee a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The MCO, PIHP, or PAHP must inform the enrollee or the limited time available for this sufficiently in advance of the resolution timeframe for appeals as specified in §438.408(b) and (c) in the case of expedited resolution.

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Electronic Code of Federal Regulations: **438.408 Resolution and notification: Grievances and appeals. (C) *Extension of time frames* (2) Requirements following extension (ii**) Within 2 calendar days give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision.

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Electronic Code of Federal Regulations: 438.408 Resolution and notification: Grievances and appeals.
(i) The enrollee requests the extension; or
(2) *Requirements following extension.* If the MCO, PIHP, or PAHP extends the timeframes not at the request of the enrollee, it must complete all of the following:
(i) Make reasonable efforts to give the enrollee prompt oral notice of the delay.
(ii) Within 2 calendar days give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision.
(iii) Resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

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Electronic Code of Federal Regulations: **438.424 Effectuation of reversed appeal resolutions.**
(a) *Services not furnished while the appeal is pending.* If the MCO, PIHP, or PAHP, or the State

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fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO, PIHP, or PAHP must authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. **Page 14 of 16** Electronic Code of Federal Regulations: **438.402 General Requirements: (b)** ***Level of Appeals.*** Each MCO, PIHP, and PAHP may have only one level of appeal for enrollees. **Page 16 of 16** See Centene's Website: https://archer.centene.com/RSAarcher/apps/ArcherApp/Home.aspx#home

REVISION LOG

REVISION:	**DATE:**

POLICY AND PROCEDURE ADDENDUM APPROVAL

The electronic approval retained in RSA Archer, the Company's P&P management software, is considered equivalent to a signature.