

## POLICY AND PROCEDURE

<b>POLICY NAME:</b> Provider Complaints	<b>POLICY ID:</b> LA.PRVR.03
<b>BUSINESS UNIT:</b> LHCC	<b>FUNCTIONAL AREA:</b> Provider Solutions
<b>EFFECTIVE DATE:</b> 1/2012	<b>PRODUCT(S):</b> Medicaid
<b>REVIEWED/REVISED DATE:</b> 01/14, 11/14, 3/15, 10/15, 10/16, 10/17, 10/18, 5/19, 2/20, 1/21, 4/22, <u>03/23</u>	
<b>REGULATOR MOST RECENT APPROVAL DATE(S):</b> n/a	

### POLICY STATEMENT:

This policy outlines procedures for provider complaints.

### PURPOSE:

To have an established provider complaint system that ensures a provider complaint is resolved timely for both participating and non-participating providers.

### SCOPE:

Louisiana Healthcare Connections (Plan) Quality, Provider Solutions, Network Accounts, and Medical Management departments.

### DEFINITIONS:

**Adverse Action** – For the purposes of this Policy and Procedure, an adverse action is defined as:

- The denial or limited authorization of a requested service, including the type or level of service; or
- The reduction, suspension, or termination of a previously authorized service; or
- The failure to provide services in a timely manner, as defined by Section ~~7.3 and Section 7.52.10.9~~ of the 2020 RFPLDH Model Contract; or
- ~~The failure of the Plan to act within the timeframes provided in Section 10.6.5 of the 2020 RFP~~the LDH Model Contract; and

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- ~~Adverse Action~~—Any decision by the Plan to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested. 42 CFR 438.214

**Grievance and Appeal Coordinator (Provider Solutions Team)** – The Plan staff who monitor and coordinate processing of provider complaints (but not requests for administrative review filed by a provider on behalf of a member and with the member's written consent; the latter are monitored and coordinated by the Appeals and Grievance Coordinator in Member Grievance Department).

**Provider Complaint** – Any verbal or written expression, originating from a provider and delivered to any employee of the Plan, voicing dissatisfaction with a policy, procedure, payment or any other communication or action by the Plan.

**Claim Liaison (Provider Solutions Team)** – The Plan staff who initiate research and resolution of complaints and coordinate with other departments.

### POLICY:

For the purposes of this policy, a Provider Complaint is any verbal or written expression, originating from a provider and delivered to any employee of the Plan, voicing dissatisfaction with a policy, procedure, payment or any other communication or action by the Plan, excluding request of reconsideration or appeal for specific individual claims. It does include general complaints about claim payment policies. Note that member grievances and appeals filed by providers on behalf of a member should be documented and processed in accordance with member grievance and appeals policies.

Plan shall establish a Provider Complaint System with which to track the receipt and resolution of provider complaint from in-network and out-of-network providers. The provider complaint system will process provider complaints in accordance with all applicable State and Federal regulations and provider contracts. The system will be capable of identifying and tracking complaints received by phone, in writing, or in person, on any issue that expresses dissatisfaction with a policy, procedure, or any other communication or action by the Plan.

Plan shall track and trend provider inquiries/complaints/requests for information and take systemic actions as necessary and appropriate.

Plan will ensure that provider complaints are acknowledged with 3 business days of receipt; resolve and/or state the result communicated to the provider within 30 calendar days of receipt (this included LDH referrals). Complaints regarding proposed utilization management (UM) or adverse actions are excluded from this policy and covered under LA.UM.08 – Appeal of UM Decisions.

**Providers may file complaints via phone by calling 1-866-595-8133 or via email at [providercomplaints@louisianahealthconnect.com](mailto:providercomplaints@louisianahealthconnect.com).**

**If a provider is unable to reach a satisfactory resolution or get a timely response through the provider complaints process, the provider may escalate to one of the management or executive level contacts below:**

**~~Candace Campbell~~ Jennifer Pinkins, Director, Claim & Contract Support Services of Operation-Provider Solutions  
~~Candace.H.Campbell@louisianahealthconnect.com~~ Jennifer.P.Pinkins@louisianahealthconnect.com**

**Joseph Tidwell, Vice President of Network and Contracting  
~~jotidwell@centene~~ louisianahealthconnect.com**

**LDH has offered a direct contact email address as a final step. Providers may e-mail LDH staff at [ProviderRelations@la.gov](mailto:ProviderRelations@la.gov). LDH requests that providers be sure to include details on attempts to resolve the issue at the Health Plan level as well as contact information (contact name, provider name, e-mail, and phone number) so that LDH staff can follow up with any questions.**

For those decisions that are not a unique function of the Plan, the provider may file a complaint directly to the State of Louisiana Department of Health and Hospitals (LDH) and/or Medicaid Management Information Systems (MMIS).

#### **PROCEDURE:**

##### **1. Provider Complaints:**

- a. Plan has dedicated staff for providers to contact via telephone, electronic mail, surface mail, or in person, to ask questions, file provider complaints and resolve problems.
- b. The Provider is allowed thirty (30) days from the date of the occurrence of the event that is the subject of the complaint, to file a complaint orally or in writing.
- c. The Grievance and Appeal Coordinators (GAC) in the Provider Solutions Department serve as the designated staff to receive and process provider complaints. The Claim Liaisons (CL) in the Provider Solutions Department serves as the designated staff for initiating research and resolution on each complaint and collaborating with other internal departments, as appropriate.
- d. The GAC and provider consulting staff receive hands-on training on Provider Complaints and Member Grievances as part of their training to ensure they can differentiate between the two and channel each through the appropriate process.
- e. The GAC reviews the complaint at intake and provides an acknowledgment of receipt of the complaint within three (3) business days of receipt of the complaint in writing or in the same manner in which the complaint was received.
- f. The GAC routes the case through the OMNI software to the CL, which collaborates on a daily basis with appropriate internal department staff (i.e., Medical Management, Quality Improvement, Network Accounts, Provider Consultants, etc.) to thoroughly investigate each provider complaint using applicable statutory, regulatory and state contractual provisions, collecting all pertinent facts from all parties and applying Plan written policies and procedures.
- g. If providers call the provider hotline regarding the status of their request, Provider Service Representatives (PSRs) electronically access the status through the OMNI and respond to the provider's inquiry, usually on the same call.
- h. The Plan will resolve every complaint and provide written notice to the provider of the Plan's resolution/decision within 30 calendar days from the date the complaint was received.

h.i. Using the OMNI tool, the GAC tracks and monitors timeliness of resolution of provider complaints and identifies in advance potential barriers to their timely and complete resolution.

i.i. The Provider Complaints System requires that complaint reports are provided to the Performance Improvement Team (PIT), which includes Plan executives with the authority to monitor and require corrective action plans when appropriate.

j.k. A report on provider complaints and their status will be submitted to LDH on a monthly basis.

k.l. Providers are allowed to consolidate complaints of multiple claims that cover similar issues such as payment or coverage regardless of the number of individual patients or payment claims included in the bundled complaint.

l.m. Providers are allowed to present their cases in-person if they so request.

## **2. Limited Delegation by Plan**

- a. Plan delegates authority to provider subcontractors only through written delegation agreements.
- b. To the extent that Plan delegates utilization management or network management functions to provider subcontractors, Plan may delegate authority to the subcontractor to receive and determine requests for administrative review and provider appeals.
- c. The delegated subcontractor must follow the same timelines, accountabilities and processes set forth in this Policy and Procedure; however, the delegated subcontractor may designate other position titles for their staff provided that the individual's qualifications and responsibilities are at least equivalent to those set forth in this Policy and Procedure.
- d. Plan retains ultimate accountability for delegated services and conducts oversight of delegated vendors as outlined CC.QI.14 in Oversight of Delegated Vendors.

## **3. Appeal of Medical Necessity Adverse Action**

Appeals of UM decisions, wherein the provider is acting on behalf of a member (with the member's written consent), may be filed in accordance with the medical necessity appeal process (see LA.UM.08 Appeal of UM Decisions).

## **4. Description in Provider Manual**

All information regarding this policy is described in the Plan's Provider Manual which all providers receive upon contracting with Plan. Provider complaint system policies and procedures are also available to out-of-network providers upon written or verbal request. Plan may distribute a summary of these policies and procedures if the summary includes information about how the provider may access the full policies and procedures on the Plan website. This summary shall also detail how the provider can request a hard copy from Plan at no charge to the provider.

### **REFERENCES:**

LA.UM.08 Appeal of UM Decisions

CC.QI.14 Oversight of Delegated Vendors

Provider Manual

Current Louisiana Department of Health ~~Request for Proposals (RFP)~~ Model Contract 3.0

### **ATTACHMENTS:**

### **ROLES & RESPONSIBILITIES:**

### **REGULATORY REPORTING REQUIREMENTS:**

Which regulator(s) require reporting, what should be reported, when to report, and how to report/who to contact.

## REVISION LOG

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
Annual Review	Policy was revised according to DHH requirements and reporting	04/2013
Annual Review	<ul style="list-style-type: none"> <li>Changes – Added RFP language to policy regarding DHH-decision items, adding PR staff to training, and complaint consolidation language.</li> <li>RFP requirements – 10.6.2; 10.6.3; 10.6.4; 10.6.5</li> </ul>	11/19/14
Ad Hoc Review	<ul style="list-style-type: none"> <li>Updates to reflect current structure and process of Provider Complaints System and LHCC departmental organization</li> </ul> Updates to comply with RFP	03/23/15
Annual Review	No revisions	10/26/15
Annual Review	<ul style="list-style-type: none"> <li>Changed DHH to LDH</li> <li>Removed Provider Complaint Coordinator added Grievance and Appeal Coordinator in the Provider Solutions Department</li> <li>Removed Resolution Team added Claim Liaison in the Provider Solutions Department</li> <li>Updated PCC to GAC</li> </ul> Removed LA.QI.14 to CC.QI.14	10/24/16
Annual Review	<ul style="list-style-type: none"> <li>Changed DHH to LDH</li> </ul> Changed Provider Consultants to Provider Solutions	10/24/17
Annual Review	Changed CRM to Omni	10/24/18
Annual Review	Added the following language: Plan shall track and trend provider inquiries/complaints/requests for information and take systemic actions as necessary and appropriate.  Plan will ensure that provider complaints are acknowledged with 3 business days of receipt; resolve and/or state the result communicated to the provider within 30 business days of receipt (this included LDH referrals). If the plan is unable to resolve in 30 days, the plan must document why the issue goes unresolved; however, the issue must be resolved with 90 days.	05/16/19
Annual Review	Added the following language: Excluding request of reconsideration or appeal for specific individual claims.  Added how to contact the plan to file a complaint and the process to escalate  Updated the Action definition by removing bullet #3 and changing RFP year to 2020.  Changed the turnaround time for provider complaints to 30 calendar days	01/25/21
Annual Review	No Revisions	04/28/22
<u>Annual Review</u>	<u>Reformat to latest Policy Template</u> <u>Update Provider Complaint contact from Candace Kliesch to Jennifer Pinkins</u> <u>Updated contract references</u>	<u>03/14/23</u>

## POLICY AND PROCEDURE APPROVAL

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

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