WORK PROCESS

DEPARTMENT: Grievances and Appeals	**DOCUMENT NAME:** Grievance and Non-Coverage Appeals Policy
PAGE: 1 of 6	**REPLACES DOCUMENT:**
APPROVED DATE:	**RETIRED:**
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PRODUCT TYPE: All Products	**REFERENCE NUMBER:** LA.QI.11.04

SCOPE:

Corporate and Plan Compliance, Quality Improvement/Quality Management (QI/QM), Provider Relations, Population Health & Clinical Operations and Member Service departments.

PURPOSE:

To outline a grievance and non-coverage appeal process that meets all Federal and State guidelines and to ensure that LHCC has an effective and consistent process for acknowledging, investigating, resolving, and sending notification of grievances and non-coverage appeals in a timely manner. For UM and Benefit Appeal Process information, refer to policy LA.UM.08: Appeal of Adverse UM and Benefit Determinations for appeals regarding requests for review of a previous adverse decision by the Plan.

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The day to day responsibility for the coordination of the grievance and a non-coverage appeal process resides with the Grievance & Appeals Coordinator (Coordinator). One of the responsibilities of the Coordinator is to ensure the various deadlines are adhered to in accordance with state and federal laws. LHCC will ensure that the individuals who make decisions on grievances are individuals who were not involved in any previous level of review or decision-making.

A. Filing a Grievance or Non-coverage Appeal

1. **The member, the member's authorized representative, or provider, may file a grievance orally or in writing. For some non-coverage appeals, the state regulatory agency acting on behalf of the member may file the non-coverage appeal.**
2. **The Plan will give members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.**
3. **An oral grievance is generally received by a Customer Services Representative (CSR) through the Plan's toll-free customer service line. All inquiries received by CSRs are probed to validate the possibility of any inquiry actually being a grievance or non-coverage appeal.**

4. **The CSR opens a case in the customer relationship manager (CRM) documentation system or other designated system and documents the substance of the grievance or non-coverage appeal including relevant information as provided by the member and actions taken.**
5. **If the grievance or non-coverage appeal is resolved by the Customer Service Department at the time of submission (first call resolution), the Customer Service Department will document the resolved case in the member relations documentation system and mark the call complete as appropriate.**
6. **If the CSR is unable to resolve the issue in the first call the issue is routed to the Coordinator through Prime or other designated system the same business day.**
7. **Written correspondences regarding grievances or non-coverage appeals are received in the mailroom, date stamped and forwarded to the Coordinator the same business day.**
8. **The Coordinator documents receipt and a description of the grievance or non-coverage appeal and the date of acknowledgement in the tracking system.**
9. **A grievance or non-coverage appeal will be acknowledged in writing within *5 business days* of receipt of the grievance.**

B. Investigation/Research by the Grievance & Appeals Coordinator

1. **The Coordinator will research and gather supporting documentation regarding the grievance or non-coverage appeal. 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.**
2. **The Coordinator may send the grievance or non-coverage appeal to another department such as provider relations or member services for further investigation as appropriate.**
3. **If the Coordinator receives a grievance or non-coverage appeal that could be a quality of care issue, the grievance or non-coverage appeal case is routed to the QI Coordinator for investigation (LA.QI.17). Any grievance or appeal (non-coverage or medical necessity) related to a clinical issue, medical necessity decision or denial of expedited resolution of an appeal are routed to the Clinical Appeals Coordinator work queue for review and resolution.**

4. **As indicated, the Coordinator may call together an internal committee to review and resolve a grievance or non-coverage appeal.**

C. Timelines for Resolution

Grievances or non-coverage appeals will be resolved in a timely manner that is appropriate for the complexity of the grievance and the member's health condition. Generally, the health plan will adhere to the following guidelines:

- **a. First Call Resolutions: The grievance will be immediately resolved by the CSR during the call. First call resolutions do not require an acknowledgement letter or resolution letter.**
- **b. Standard grievances: Most grievances should be resolved within *ninety (90) days* of receipt or sooner be it oral or in writing.**
- **c. Standard non-coverage appeals: Most non-coverage appeals should be resolved within thirty (30) days of receipt or sooner.**
- **d. Urgent grievances and non-coverage appeals: Urgent situations that could seriously jeopardize the life or health of the member and require resolution prior to standard timeframes should be resolved within seventy-two (72) hours from receipt.**
- **e. Extension: The Plan may have the right to extend the timeframe for disposition of a standard grievance or non-coverage appeal in accordance with state guidelines [fourteen (14) calendar days] if the member requests the extension or the Plan demonstrates that there is need for additional information and how the delay is in the member's interest. 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.**

D. Resolution Letter

The Plan will notify the member and if applicable the member's representative (including provider or regulatory agency submitting on the member's behalf) of the grievance or non-coverage appeal resolution in writing within five (5) business days following the determination. The notice of resolution shall include the results of the resolution process, the date it was completed and further dispute rights, if any.

The written notice of resolution shall comply with the following requirements:

1. **The Plan will notify the Member when the Plan takes an action.**
2. **The notice will be in writing. It will be 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. **All Members must be informed that information is available in alternative languages, formats and how to access those formats.**
4. **The notice must at a minimum, include but is not limited to:**
    - **The dates, types, and amount of service requested (if the action pertains to a service authorization request);**
    - **The action the Plan has taken or intends to take is applicable;**
    - **The reasons for the action if applicable;**
    - **The procedures by which the Member may dispute the Plan's action;**
    - **The circumstances under which an expedited resolution is available and how to request it;**
    - **The circumstances under which a Member may continue to receive services, if relevant, pending resolution of the non-coverage appeal.**
    - **The date the action will be taken is applicable;**
    - **A reference to the Plan policies and procedures supporting the Plan's action if applicable;**
    - **Notification that the member, upon request, can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the decision was based.**
    - **Notification that the member is entitled to receive, upon request, reasonable access to and copies of all documents relevant to the appeal. Relevant documents include documents and records relied upon in making the decision and documents and records submitted in the course of making the decision**
    - **An address where written requests may be sent and a toll-free number that the Member can call to request the assistance of a Member representative to file a non-coverage appeal.**

5. **A copy of the resolution letter is maintained in the Plan's documentation system.**

E. Documentation of Grievances and Non-Coverage Appeals
All grievances and non-coverage appeals requests will be documented and kept on file in a secure, centralized location for a period of no less than ten years. Files will contain at a minimum:

- **Documentation of the substance of the grievance or non-coverage appeal and actions taken, including name of the member and associated provider and/or facility**
- **Investigation of the grievance or non-coverage appeal**
- **Date of reviews and the name and credentials of the reviewer(s) who made the final determination**
- **Notifications, including documentation of verbal and written notifications of acknowledgement, resolution, etc. of the grievance or non-coverage appeal**
- **All other correspondence and records associated with the grievance or non-coverage appeal**
- **Minutes or transcripts of appeal proceedings, if applicable**

REFERENCES

LA.UM.08 Appeal of UM Decisions
LA.QI.17 Monitoring Quality of Care
LA.QI.11.03.Appeal Process
LA.QI.11.02-Grievance Process

ATTACHMENTS

DEFINITIONS:
Grievance (Complaint): Grievance (Complaint) means any complaint or dispute expressing dissatisfaction with any aspect of the operations, activities, or behavior of a Marketplace health plan, or its providers, regardless of whether remedial action is

requested. (As defined https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Grievances.html)

Non-Coverage Appeal: A non-coverage appeal means review by the Plan of an unresolved grievance related to non-coverage issues (e.g., Plan denied a member's sixth request in 12 months to change primary care practitioners)

Adverse benefit determination, per 45 CFR 147.136(a)(2)(i) and 29 CFR 2560.503-1, means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. It also includes any rescission of coverage under 45 CFR 147.128 (whether or not the rescission has an adverse effect on a particular benefit at the time).

Urgent: 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.

REVISION LOG	DATE
New Work Process	10/21
No Revisions	7/22

WORK PROCESS APPROVAL

The electronic approval retained in Archer is considered equivalent to a physical signature.