

MIDWEST HEALTH PLAN, INC.

POLICY NAME: MiChild Member Grievance and Appeals Policy and Procedure

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To promote member service and satisfaction, and in accordance with MCL 500.2213, MCL 550.1901-550.1929 (PRIRA), and 42CFR 438.400 – 438.424 (Subpart F), Midwest Health Plan (MHP) has a formal grievance and appeal procedure to address, resolve and track all member grievances and appeals. MHP ensures a full investigation of all grievances.

All members receive written information at the time of their enrollment with MHP which outlines the simplified process available to assist them with filing a complaint or grievance, and if necessary, an appeal. When an adverse determination occurs, the member receives a written response that contains the reasons for the adverse determination. This response also informs the member of the next steps in the internal and external appeal process. An adverse determination is when a determination is made that an admission, availability of care, continued stay, or other health care service has been reviewed, reduced, terminated or denied, or when MHP fails to respond in a timely manner to the member's grievance. When an adverse determination is made, any reasons for that decision will be in a written statement and all necessary forms provided to the member, along with MHP's appeal steps.

The toll-free number, the corporate address and an explanation of the complaint and grievance filing process, along with the appeals process, can be found in the MHP Member Handbook and the certificate of coverage provided to each new member when they enroll with the Plan and on MHP's web site of www.midwesthealthplan.com. This explanation includes how to file a complaint, grievance or appeal with the Plan, and the internal grievance appeal and resolution process.

A practitioner or member representative may act on behalf of the member at any and or all steps in the grievance process.

Definitions:

A **grievance** is defined as a complaint (oral or written expression of dissatisfaction) submitted by or on behalf of a member. MHP accepts grievances from any individual the member authorizes in writing to represent them including, but not limited to, a physician. Grievances include concerns related to:

- a) Quality of health care services, including safety issues
- b) Access and availability of care, including a complaint regarding an adverse determination made pursuant to utilization review
- c) Attitude and service of practitioners, providers, office staff, ancillary services, etc.

- d) Benefits or claims payment, handling or reimbursement for health care services
- e) Matters pertaining to the contractual relationship between MHP and a member.

An **appeal** is defined as a request for review of a decision about receiving or paying for covered services-“Denying, terminating, or reducing services” (adverse determination). This includes:

- a) The denial or limited authorization of a requested service, including the type or level or service
- b) The reduction, suspension, or termination of a previously authorized service
- c) The denial, in whole or in part, of payment for a properly authorized and covered service
- d) The failure to provide services in a timely manner, as defined by the State
- e) The failure of Midwest to act within the established time frames for grievance and appeal disposition

An **adverse determination** means a determination that an admission, availability of care, continued stay, or other health care service has been reviewed and denied, reduced, or terminated. Failure to respond in a timely manner to a request for a determination constitutes an adverse determination.

Types of appeals include:

- a) **Pre-service Appeal**: a request to change the decision on any case or service that must be made in whole or in part in advance of the member obtaining medical care or services
- b) **Post Service Appeal**: a request to change a decision on any review for care or services that have already been received
- c) **Expedited Appeal**: a request to change an urgent care request where the decision could seriously jeopardize the life or health of the member, could jeopardize the member’s ability to regain maximum function, or would subject the member to severe pain, not managed without the requested care
- d) **External Appeal**: a request for an independent external review of the final determination made by MHP through the internal appeal process. The **Independent Review Organization** (IRO) is an entity contracted to provide review services for MHP .

Independent Review Organization: is an entity that conducts independent external medical reviews of adverse health care treatment decisions. Independent review organizations serve a dual role: they advocate for the patient while making sure that each patient only receives what they deserve based upon medical fact. They also focus on eliminating wasteful and unnecessary treatments.

General Guidelines:

Overview: MHP has a 2-level internal member grievance process and an external review process

- Level 1 grievances are verbal or written member complaints which are resolved by customer service representatives with assistance from other departments when needed. Level 1 grievances also include appeals of adverse determinations.
- Level 2 grievance appeals are for situations when the member is dissatisfied with the resolution of their level 1 grievance or appeal. .
- External appeals are available when the member remains dissatisfied with the resolution of their level 2 grievance.

Filing a Complaint, Grievance or Appeal: All members receive written information at the time of their enrollment with MHP which outlines the process available to assist them with filing a complaint or grievance, and if necessary, an appeal. Any member may file (or have filed on his/her behalf) a grievance verbally by calling the toll free number of #1-888-654-2200 for Midwest Health Plan. A member may also file a written complaint or grievance by documenting the issue and faxing it to 313-581-6043, or visiting on site or mailing it directly to the Customer Services Department at the MHP corporate office at:

Midwest Health Plan, Inc.
Attn: Customer Service Department
5050 Schaefer Road
Dearborn, MI 48126

MHP Customer Services representatives are available to give enrollees assistance in completing forms and taking other procedural steps. MHP provides interpreter services and TTY/TDD toll-free numbers. MHP acknowledges receipt of each grievance and appeal.

Filing Timeframes and Methods: All initial grievances must be filed within two (2) years of the member's date of discovery of the problem, complaint or aggrieved situation. All appeals must be filed not more than 90 days after the date of Midwest's adverse determination. Grievances and appeals may be filed in writing, by telephone, or in person at MHP's corporate office. MHP assists members to document their grievance or appeal request as needed. Members have the right to submit written information or other materials for consideration with their grievance.

Authorized Representative: The member may designate an individual of their choosing to represent or assist them in their appeal, including their practitioner. MHP requires members to designate their representative in writing.

Administrator and Contact Person at Midwest Health Plan: The contact person or designee for Midwest Health Plan is the Director of Customer Services. The director can be reached at #313-581-3700, ext.6020, fax # 313-581-6043. If needed after normal business hours, the phones are answered by Team Health and this service can contact the manager.

Investigation: MHP ensures a full investigation of all grievances, including consideration of materials submitted by the member. Grievance resolution decisions are made based on information available at the time of the decision; regardless of whether this information was available at the time the initial decision was made.

Decision Makers: Grievance decision makers:

- Have no previous involvement with the case;
- Are not subordinates (i.e., direct reports) of previous decision makers on the case;
- If the case involves an adverse decision related to care or services that could be covered or not, depending on the circumstances, MHP obtains input from a same or similar specialist as the treating physician.

35 Day Time Frame for Resolution: MHP resolves all grievances within the following timeframes:

- The state of Michigan requires that MHP issue a written decision not later than 35 calendar days after submission by the member. The 35-day timeframe includes all 3 levels of the MHP grievance process (initial grievance, level 2 grievance appeal, and level 3 external appeal). The resolution timeframe is accumulated for each level of grievance the member requests. If MHP fails to issue a decision within the 35-day time frame, the decision is considered to be resolved in the member's favor. The 35 day time frame may be extended for up to ten (10) business days only if the information from the health care facility or health care professional that is necessary to make a decision, and is beneficial to the member, is not received by MHP. If MHP utilizes the 10 day extension, MHP will give the enrollee written notice of the reason for the delay. The member is sent a written statement of the decision or extension within 35 calendar days.
- Grievances and appeals may be submitted by a third party with written authorization. If a grievance or appeal is submitted by a third party but does not include a signed document authorizing the third party to act as an authorized representative for the beneficiary, the 35-day time frame begins on the date an authorized representative document is received by MHP. MHP will notify the beneficiary that an authorized representative form or document is required. For purposes of this section, "third party" includes, but is not limited to, health care providers.
- MHP attempts to resolve level 1 grievances that are not related to an adverse determination within 3 calendar days, and provide notification of resolution in plain English to the enrollee as to the progress of an investigation.
- MHP resolves any grievance appeal requests related to a pre-service adverse decision within 15 calendar days of receipt of the request for each grievance level, but no later than 35 calendar days after initial receipt. Grievance appeal requests related to a post-service adverse decision are resolved within 30 calendar days of receipt of the request for each grievance level, but no later than 35 calendar days after initial receipt. The member is contacted by phone or in writing within 7 to 10 business days.

Adverse Action/ Grievance Decision Notice Contents: All written adverse action and grievance resolution notices include the following elements:

- Action taken or decision in plain English, with benefits or medical necessity rationale
- Reason for action and reference to benefit provision, guideline, protocol, or other similar criterion on which the decision is based.
- Notification that member can obtain, upon request, a copy of the benefit provision, guideline, protocol, or other similar criterion on which the decision is based.

- Informs member he or she is entitled to receive free of charge copies of all documents, necessary forms, records and other relevant information upon request.
- List of titles and qualifications of the individuals participating in the review.
- For medical decisions, identifies health professionals (or informs that it is available upon request) whose advice obtained, regardless whether advice was relied upon in decision or not.
- The circumstances under which expedited resolution is available and how to request it.
- The enrollee's right to have benefits continue pending resolution of the appeal, how to request the benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these services.

Annual Review and Update: The Quality Improvement Committee reviews this procedure for revisions on an annual basis.

LEVEL I (GRIEVANCE PROCEDURE):

A. Complaints and Grievances received by Customer Service

1. MHP may receive a member grievance request in writing, by phone, or in person. The Director of Customer Service reviews all member grievances.

Examples of grievances are:

- a) Quality of health care services, including safety issues
 - b) Access and availability of care, including a complaint regarding an adverse determination made pursuant to utilization review
 - c) Attitude and service of practitioners, providers, office staff, ancillary services, health plan, etc.
 - d) Benefits or claims payment, handling or reimbursement for health care services
 - e) Matters pertaining to the contractual relationship between MHP and a member.
2. The Customer Service Representative (CSR) documents all grievances into the OAO computer system and logs the information into the excel grievance log. The CSR offers to assist the member or their representative if necessary, in documenting the complaint/ grievance in writing . The CSR prints a copy of the grievance from the OAO system and forwards to the Director of Customer Service.
 3. The CSR investigates the grievance by contacting those involved in the issue, including the PCP or other relevant individuals. Information is kept confidential and only shared with those persons directly involved in resolving the issue. If the grievance is resolvable at this level, the CSR documents the information in the note section of the OAO system.

4. If written explanation or further investigation is required by a PCP, site, or departmental director/supervisor, the information is forwarded to the relevant department for them to document their investigation and resolution. All ongoing written records of concerns, actions taken, and resolutions are kept by the CSR. They must investigate and return the file to the departmental director within 5 calendar days.
 - All clinical issues (quality of care, dissatisfaction with a diagnosis, misdiagnosis, safety issues, etc.) are forwarded to the Director of Quality Improvement for investigation and resolution.
 - All claim issues that cannot be resolved by the CSR are forwarded to the Director of Financial Operations.
 - All Utilization issues that cannot be resolved by the CSR are forwarded to the Director of Health Services for follow-up.
5. When the investigation and resolution has been completed, the Director of Customer Service reviews all information and the final disposition, and ensures that all of the member's concerns have been addressed. Unless the grievance was submitted in writing, the CSR contacts the member within 15 days of receipt of the complaint by phone to inform them of the grievance resolution. If the member is dissatisfied with the resolution, the CSR explains their further appeal rights and the external review process. All communication with member is entered into the OAO database.
6. MHP provides notification of grievance outcomes and resolution determinations to all involved participating providers/physicians.

B. Appeal of an Adverse Determination Procedure

When MHP makes a decision subject to appeal, a written adverse action notice is sent to the enrollee and the requesting provider, if applicable. Adverse action notices for the suspension, reduction or termination of services are provided at least 12 days prior to the change in services.

Appeals of an adverse determination are received, logged, and tracked by the Health Services Appeals Coordinator. Timeframe standards are established for pre-service, post-service, expedited, and external appeals.

Appeals Time frame Standards:

Appeal Type	Timeframe
Pre-service Appeal	15 calendar days from date of appeal request to date of notification.
Post-service Appeal	35 calendar days from date of appeal request to date of notification
Expedited Appeal	Up to 72 hours from date of request to date of notification

Appeal of an Adverse Determination (pre and post-service appeals)

1. When the request for non-urgent preservice or post-service care is denied by the MHP Medical Director, MHP gives members written confirmation of the decisions within 15 calendar days of receipt of the request. The member (or authorized representative) is notified of their appeal rights and procedure. The member (or authorized representative) has up to 180 calendar days to file an appeal.
2. Preservice and post-service appeals are to be in writing to the MHP Medical Director (or designee).
3. The Health Services Appeals coordinator is responsible for logging and tracking appeals, maintaining the appeals file, and for sending determination letters to members and providers.
4. If the MHP Medical Director cannot reverse the adverse determination
 - a. A physician not involved in the initial denial will review the case.
 - b. The physician reviewer will be of the same specialty of the requesting physician with similar credentials and licensure.
5. Pre-service appeals will be resolved within 15 calendar days of the request for appeal. Post-service appeals will be resolved within 30 calendar days of the request for appeal.
6. Notification in writing to the member will be sent within 2 calendar days of the decision.
7. Procedures for additional levels of appeal are provided to the member when the adverse determination is upheld.

Expedited Appeal

1. When the request for urgent care is denied by the MHP Medical Director, MHP gives members written confirmation of the decisions within 72 hours of receipt of the request.
2. The member (or authorized representative) may file an expedited appeal for a denied urgent care request.
3. All requests concerning admissions, continued stay or other emergency service related appeals are considered for expedited appeal.
4. The Health Services Appeals coordinator is responsible for logging and tracking appeals, maintaining the appeals file, and for sending determination letters to members and providers.
5. MHP will complete the entire expedited appeal process within 72 hours of receipt of the appeal request.
6. Verbal notification is given within 72 hours of receipt of the appeal request, with written notification within 3 calendar days.
7. Due to the required time frames required to complete two level review, each level will be completed by a MHP practitioner in the same or similar specialty, independent of each other; i.e. not partners in the same specialty group.

LEVEL TWO (GRIEVANCE APPEAL PROCEDURE):

A. Level Two Grievance appeals received by Customer Service

1. If the member is not satisfied with the resolution in the level one grievance, they have the right to file a grievance appeal in writing, by phone, or in person. The Director of Customer Service reviews all grievance appeals.

2. The CSR documents the substance of grievance appeals and the actions taken in the OAO database and on the excel grievance log.
3. The CSR investigates the substance of grievance appeals, including any aspect of clinical care involved, and forwards to the respective department for resolution.
4. The CSR notifies the member of the disposition of grievance appeals and their right to further appeal, as appropriate.
5. When the investigation and resolution has been completed, the Director of Customer Service reviews all information and the final disposition, and ensures that all of the member's concerns have been addressed. Unless the grievance was submitted in writing, the CSR contacts the member by phone to inform them of the grievance resolution. If the member is dissatisfied with the resolution, the CSR explains their further appeal rights and the external review process. All communication with member is entered into the OAO database.
6. MHP provides notification of grievance outcomes and resolution determinations to all involved participating providers/physicians.

B. Level Two - Appeal of an Adverse Determination Procedure – Health Services

1. When the request for non-urgent pre-service or post-service 1st level appeal is upheld by the MHP Physician Reviewer, MHP gives members written confirmation of the decisions within 15 calendar days of receipt of the request.
2. Requests for 2nd level appeal must be in writing and must be received within 180 days of the 1st level appeals decision
3. The Health Services Appeals coordinator is responsible for logging and tracking appeals, maintaining the appeals file, and for sending determination letters to members and providers.
4. The MHP Medical Director will review the 2nd level appeal
5. If the MHP Medical Director cannot reverse the adverse determination
 - a. The physician members of the Quality Improvement Committee will convene to review the appeal
6. The appeal will be resolved within 15 days of the request for 2nd level appeal
7. Notification in writing to the member and member will be sent within 2 calendar days of the decision
8. The decision of the Quality Improvement Committee is the final internal decision.

EXTERNAL APPEAL

1. Members may request an independent review of final decisions on medical necessity denials
The member (or authorized representative) has 180 calendar days from the date of the final internal decision to file a request for an independent review.
2. The case will be submitted for review to an Independent Review Organization (IRO)
3. The IRO has 30 calendar days to render a decision on non urgent appeals
4. The IRO has 72 hours to render a decision on urgent appeals. The treating physician or MHP may identify an urgent appeal

5. External Reviews are logged and tracked by the Health Services Appeal Coordinator. Data is reviewed for patterns of denials which are upheld / overturned. This information is used to improve the quality of clinical decision making
6. The IRO is responsible for communicating the decision to the member and to MHP
7. If the denial is overturned by the IRO, MHP will communicate to the member when service or payment will be received
8. The IRO decision is binding to MHP
9. After the member has exhausted the internal appeal process, the member has the right to request a hearing with the Commissioner of Financial and Insurance Regulation.

INTERNAL EXPEDITED GRIEVANCE/APPEALS PROCEDURE:

An **expedited review** of a grievance or appeal will be processed when the standard resolution time frame would seriously jeopardize the life or health of a member, or would jeopardize the member's ability to regain maximum function. An expedited process applies if a physician, orally or in writing, substantiates that the standard time frame would jeopardize the life or health of a member. The enrollee or provider must file a request for an expedited appeal within 10 days of the adverse determination. The decision will be rendered no later than seventy-two (72) hours after receipt of the expedited grievance. The expedited grievance decision is made by a physician with no prior involvement in the previous adverse decision, and who is not a subordinate of previous decision makers. The determination will be based upon the information available to him/her at that time. The member, or the member's representative, or the practitioner acting on behalf of the member will be notified of the determination in the most expedient manner (eg. – telephone, facsimile, overnight express mail). MHP provides oral and written notification of the appeal review decision and the further appeal processes available to the member not later than three (3) calendar days, or two (2) business days, whichever is earlier.

If beneficiary requests an extension of Midwest's internal 72 hour time frame, the grievance/appeal is moved to the standard 35 day decision time frame. In this case, MHP will notify the member within 2 days that an extension would move the expedited process from the expedited process to the standard 35 day process. If the member still requests the extension, the expedited grievance/appeal will be moved to the standard time frame. If the member withdraws the request for an extension, the decision on the expedited grievance/appeal shall be made within 72 hour of receipt.

Within ten (10) days after the initial determination by MHP, the member, or a person, including, but not limited to, a physician, authorized in writing to act on behalf of the member, may request under the Patient's Right to Independent Review Act, a review of the matter by an independent review organization and would be filed with OFIR.

Upon receipt of a notice of a decision from OFIR reversing the adverse determination or final adverse determination, Midwest immediately shall approve the coverage that was the subject of the adverse determination or final adverse determination.

MHP will not take any punitive actions towards a provider who requests or supports an expedited appeal on behalf of an enrollee.

GRIEVANCE TRACKING, TRENDING & REPORTING:

Statistics related to member inquiries, complaints and grievances, and health services appeals are reported monthly on the Continuous Monitors Report and are reviewed and analyzed for trends at Quality Improvement Committee meetings.

Complaints related to practitioner offices are further analyzed by practice site location by the Quality Improvement Department to identify quality of care issues and to identify office sites that require a Credentialing site visit.

The QI Committee identifies and addresses sources of the members' dissatisfaction and makes recommendations for follow-up and improvement measures as needed.

Quarterly and annual reports are submitted to the Quality Improvement Committee and the Board. Semi-annual reports are submitted to the MDCH as per the contractual requirements. Annual summary reports are submitted to the Insurance Commissioner. Summary data is available to DCH upon request.

RECORD RETENTION AND STORAGE

Midwest Health Plan will maintain written records of all complaints and medical services documents on site for 2 years following the year the grievance was filed that include:

- Member name
- Member identifiers
- PCP (physician) or hospital identifiers
- Date of complaint or grievance
- Plan representative handling of the complaint or grievance
- Summary of each issue
- Plan's response to the issue(s)
- Notation of resolution
- Member notification date and time

Records associated with the grievance process will be retained and stored for 7 years following the final decision or close of the appeal off site with a storage company. If any litigation, claim negotiation, audit or other action involving the records is started before the expiration of the 7 year period, the records are retained until completion of the action and resolution of all issues that arise from it or until the end of the regular 7 year period, whichever is later.

Complaint, grievance and appeal files will be made available to DCH, OFIR, or the accreditation bodies for review upon request.