	Title: Enrollee Grievance and Appeals	Version: 3
	Owner: Melissa Mitchell (Director of Production)	Approved: 03/22/2018

Purpose: To establish Dental Care Organization's (DCO's) policy on how to process, respond to and resolve grievances and appeals. This policy aims to receive and resolve grievances and appeals in a manner that is fair, efficient and confidential and takes into account the needs, rights and responsibilities of the involved parties.

Responsibility: Quality Improvement (QI)/Utilization Review (UR) Committee

Scope: Advantage Dental Services, LLC

Definitions:

Action:

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 in part, of payment for a service;
The failure to provide services in a timely manner;
The failure to act within required timeframes; or
The denial of a request to obtain out of network services.

Appeal – A request by a member or representative for review of an Action**.**

Complaint – A member's or member's representative's expression of dissatisfaction to Advantage or to an Advantage provider about any matter other than an Action. Complaints may also be referred to as grievances, concerns, problems or issues.

Forms: n/a

References: 42 CFR 438.100; 42 CFR 438.228; 42 CFR 438.402; 42 CFR 438.406; 42 CFR 438.410; OAR 410-141-3230-3255

Policy:

The following procedures are for use in all complaints and appeals, whether oral or written, filed with DCO involving any disagreement with any DCO Action or any dissatisfaction with DCO or its providers. DCO shall afford enrollees, including enrollees that are aged, blind, disabled having complex medical needs, or Special Health Care Needs, the full use of the procedures and shall cooperate in the Medical Assistance Program (MAP) hearings process. Any hearing requests made outside of DCO's complaint and appeal process or without previous use of DCO's complaint and appeal process shall be reviewed by DCO through DCO's complaint and appeal process upon notification by MAP.

DCO shall inform enrollees both orally and in writing about DCO's complaint and appeal procedures. This shall be done through enrollee materials distributed at the time of enrollment in DCO and through customer service communications. DCO shall assure the enrollee of the confidentiality in the complaint and appeal process in the materials and communications provided.

Every enrollee will be provided with reasonable assistance with the compliant, appeals and general grievance process such as help with filling out forms, steps in filing, availability of interpreter services and toll free numbers that have adequate TTY/TTD capacity.

The DCO and its participating providers will not:

a. Discourage a member from filing a complaint, appeal, or hearing request or take punitive action against a provider who requests an expedited resolution or supports a member's appeal;
b. Encourage the withdrawal of a compliant, appeal, or hearing request already filed; or
c. Use the filing or resolution of a complaint, appeal, or hearing request as a reason to retaliate against a member or to request member disenrollment.

1. DESIGNATED STAFF FOR GRIEVANCE AND APPEALS PROCESS: DCO has designated the following staff responsible for the complaints and appeals in the grievance and appeals process:

a. Vice President of Dental Services: The Vice President of Dental Services or their designee(s), who are licensed dentists shall be responsible for review and oversight of the written and oral complaint and appeal process. The responsible party assures, by review, that all complaints are managed, documented, and reported according to written procedure.

b. Case Management Department: The DCO's Case Management Department shall be responsible for receiving, processing and responding to enrollee complaints. The Case Management Department will prepare an analysis of all complaints, both written and verbal, for review by the QI/UR Committee. After completion of an investigation by Case Management, and review by the Vice President of Dental Services or their designee(s), who are licensed dentists, Case Management shall review and reply in writing to the enrollee within required timeframes for grievance and appeals processing.

c. QI/UR Committee: QI/UR Committee reviews all appeals and the minutes of the Committee meetings shall reflect this. QI/UR Committee also reviews and approves the complaint process and receives an analysis of all the complaints filed.

2. CONFIDENTIALITY OF GRIEVANCE AND APPEALS PROCESS: DCO shall keep all information concerning an enrollee's complaint or appeal confidential. The staff is trained and notified of this at the time of employment. All information concerning an enrollee's complaint or appeal is kept confidential, except that the Coordinated Care Organization (CCO) and MAP have a right to this information without a signed release from the enrollee. DCO shall assure enrollees that complaints and appeals are handled in confidence consistent with ORS 411.320, 42 CFR 431.300, the HIPAA Privacy Rules, and other applicable federal and state confidentiality laws and regulations.

In the event a complaint needs to be shared with other parties (other than treating providers) to resolve the issue, the DCO will ask the enrollee to sign a release form consenting to sharing of information. This form will be retained in the enrollee's record.

3. COMPLAINT PROCESS

a. The DCO ensures all grievance and/or complaint reporting according to Oregon Administrative Rules to meet quality assessment and performance improvement goals.
b. Credentials of the reviewer are documented clearly in the review process in order to determine that the appropriate level of clinical provider was involved in making the decision.
c. Receipt of a Complaint. DCO shall make available MAP complaint forms (OHP 3001) in all plan administrative offices and in all dental offices where staff have been designated to respond to complaints. Enrollees have the right to register a complaint in the following manner:

(1) Through the Practitioner/Staff:

(i) An enrollee or their representative may relate any incident or concern to a practitioner or other staff person orally or in writing.

(ii)There is no timeline for submission of an enrollee complaint that does not involve a disagreement with a DCO Action.
(iii) Complaints may also be termed grievances, concerns, problems, or issues by the enrollee or their representative.

(iv) The practitioner or staff person shall either:
(a) Contact the enrollee within 48 business hours of receipt of an oral or written complaint, resolve the complaint within 5 days of receipt and communicate the complaint and its resolution to DCO: or
(b) Direct the enrollee to the Case Management Department or DCO's Customer Service, who are designated to receive complaints as identified in DCO's MAP Enrollee Handbook.

(2) Through the DCO Internal Complaint Process:

(i) Enrollees may choose to utilize DCO's internal complaint procedure. If the enrollee makes a complaint to DCO's Customer Service, the Customer Service Representative (CSR) shall inform the enrollee of the complaint process. The CSR shall:
   a. Contact the enrollee within 48 business hours of receipt of the oral or written complaint and resolve the issue within 5 days; or
   b. Direct the issue to Case Management.

(ii) Case Management will work with the enrollee to resolve the issues directed to them and will notify the enrollee of the resolution within 5 days of receipt of the complaint, or, if more time is needed, notify the enrollee with 5 days that the issue requires more time to resolve.
(iii) If it is determined by the DCO that the complaint is regarding a denial of services, the complaint will immediately be transferred to the appeals process.
(iv) If the enrollee does not wish to attempt to resolve the complaint through the use of DCO's internal complaint process, they shall be notified that the enrollee has the right to seek

resolution through another process within the plan or through a state process, such as the Governor's Advocacy Office.

(3) <u>Filing a Complaint</u>.

(i)Complaint: The enrollee or their representative may make a complaint either orally or in writing through DCO's internal complaint process. There is no timeline for submission of an enrollee complaint. The following procedures apply:

(i) Response: DCO shall respond as expeditiously as the enrollee's health conditions require but no later than five (5) business days from the date the complaint is received by DCO. DCO shall either: (a) make a decision on the complaint and notify the enrollee or the resolution, or (b) notify the enrollee in writing within 5 days that a delay in DCO's decision of up to 30 calendar days from the date the complaint was received by DCO is necessary to resolve the complaint. The written notice shall specify the reasons the additional time is necessary.

(ii) Resolution: DCO's response will be communicated to the enrollee orally or in writing within the timelines described above but no later than 30 calendar days from the date of receipt of the complaint. A written resolution will be made if the complaint was received in writing. The written and oral resolution of the complaint shall review each element of the enrollee's complaint and address each of those concerns specifically, including the reasons for DCO's resolution.

(iii) If an enrollee is not satisfied with DCO's resolution of the complaint, the written resolution notifies enrollees that they may present their complaint to the Governor's Advocacy Office.

c. The DCO shall review and report to the Oregon Health Authority (OHA) complaints that raise issues related to racial or ethnic background, gender identity, sexual orientation, socioeconomic status, culturally or linguistically appropriate service request, disability status, and other identity factors.

d. <u>Complaint Log</u>. All complaints made to the DCO shall be entered into a log and addressed in the context of quality assurance activity. The log identifies the enrollee, the date of the complaint, the nature of the complaint, the resolution and the date of resolution. All complaints that the enrollee chooses to resolve through another process, and that DCO is notified of, shall be noted in the complaint log.

4. NOTICE OF ACTION AND APPEAL PROCESS

a. <u>Appeal of Notice of Adverse Benefit Determination</u>. Notice of Adverse Benefit Determination letters are sent as set forth in the Notice of Adverse Benefit Determination Policy and the Pre-Authorization Policy. Enrollee may appeal a Notice of Adverse Benefit Determination either through the DCO Appeal process or by requesting a MAP Administrative Hearing. The enrollee must go through DCO's Appeal process before requesting a MAP Administrative Hearing.

(1) <u>Appeal through DCO Appeal Process:</u>

(i) **Deadline to File Appeal**: Enrollee must file an appeal with DCO no later than 60 calendar days from the date on the Notice of Action. Any appeal received by DCO will be promptly transferred to the Case Management Department to begin the appeal process. Enrollee can file an appeal directly

with DCO, either orally or in writing by contacting DCO Customer Service. If filed orally, the enrollee will be notified that they must follow up with a written and signed appeal within the appeal timeframe unless it is an expedited request. Oral inquiries seeking to appeal a Notice of Adverse Benefit Determination are treated and documented as an appeal. If a written appeal request does not follow the oral appeal within the appeal timeframe, the appeal shall expire unless it is an expedited request.

(ii) **Present Evidence**: Enrollee has a reasonable opportunity to present evidence and allegations orally or in writing. Enrollees have an opportunity, before and during the appeal process, to examine the enrollee's file, including medical records and any other documents or records to be considered during the appeal process.

(iii) **Parties to Appeal**: Enrollee may include, the enrollee's representative or legal representative if a deceased enrollee's estate in the appeal process.

(iv) **Response to Appeal:** DCO shall resolve each appeal and provide the enrollee with a Notice of Appeal Resolution as expeditiously as the enrollee's health condition requires but no later than 16 calendar days from the date DCO receives the appeal. DCO may extend the timeframe set forth above up to 14 calendar days as approved by the MAP Hearings Unit Staff if the enrollee requests an extension or if DCO shows a need for additional information and the delay is in the enrollee's interest. If the timeframe is extended DCO must make reasonable efforts to give the enrollee prompt oral notice of the delay and, within two days, give the enrollee written notice of the reason for the delay.

(v) **Expedited Resolution**: If the enrollee requests expedited resolution of the appeal and such request is granted, DCO shall resolve the appeal and make reasonable efforts to call the enrollee and provider with notice no later than 72 hours after DCO receives the appeal. The DCO will mail written confirmation of the resolution to the enrollee within 3 calendar days. This timeframe may be extended as described above in paragraph (iv). If DCO denies enrollee's request for expedited resolution, DCO will transfer the appeal to the time frame for standard resolutions, make reasonable efforts to give the enrollee prompt oral notice of the denial, and follow-up within 2 calendar days with a written notice.

(vi) **Resolution of Appeal**: DCO must provide a written Notice of Appeal Resolution to the enrollee. The written Notice of Appeal Resolution must include the results of the appeal and the date it was completed. If the resolution was not in the enrollee's favor, the notice must also include the reasons for the resolution and a reference to the statutes and rules involved for each reason relied upon to deny the appeal. The notice must also inform the enrollee of his/her right for a MAP Administrative Hearing, how to request one, and attach the Notice of Hearing Rights (DMAP 3030) and Hearing Request Forms (MSC 0443). The notice must also state the enrollee's right to receive benefits while the hearing is pending, how to make the request, and that the enrollee will be liable for those benefits if the hearing upholds DCO's decision.

(vii) **Request for MAP Administrative Hearing**. If an enrollee is unsatisfied with DCO's resolution of the appeal, the enrollee may request a MAP Administrative Hearing. The request must be made within 120 calendar days from the date on the Notice of Appeal Resolution. DCO must retain a complete record of the appeal for more than 120 days so that if the enrollee requests a MAP

Administrative Hearing, the record can be submitted to MAP Hearing Unit within 2 business days. (OAR 410-141-0262(19)).

(viii) **No Retaliation:** A provider will not be subject to punitive action for requesting an expedited resolution or for supporting an enrollee's request for an appeal or expedited resolution.

(ix) **Continuation of Benefits:** DCO shall continue the enrollee's benefits if: (1) the enrollee or the enrollee's representative files the appeal or administrative hearing request timely; (2) the appeal or administrative hearing request involves the termination, suspension or reduction of a previously authorized covered service; (3) the covered services were ordered by an authorized provider; (6) the original period covered by the original authorization has not expired; and (5) the enrollee requests an extension of benefits.

(1) Definitions: For purposes of this paragraph, "timely" means the filing was on or before the later of: (1) within 10 days after the DCO mailed the Notice of Action or (2) the intended effective date of the DCO's proposed action.

(2) Duration of Benefits: If, at the enrollee's request, the DCO continues or reinstates the enrollee's benefits while the appeal is pending, the benefits must be continued until one of the following occurs: (1) the enrollee withdraws the appeal; (2) the enrollee does not request a contested case hearing within 10 days from when the DCO mails an adverse decision; (3) a contested case hearing decision is adverse to the enrollee; (4) OHA issues an appeal decision that is adverse to the enrollee; or (5) the enrollee is no longer eligible for benefits under the Oregon Health Plan (i.e. the authorization expires or authorization service limits are met).

(3) Enrollee's Responsibilities for Services Furnished While the Appeal is Pending: If the final resolution of the appeal is adverse to the enrollee (i.e. upholds the DCO's decision to deny the service), the DCO may recover from the enrollee the cost of the services furnished to the enrollee while the appeal was pending.

(4) Services While An Appeal is Pending:

a. *Services Not Furnished*: If DCO or a contested case hearing reverses a decision to deny, limit or delay services and those services were NOT provided while the appeal was pending, then DCO shall authorize the services to be performed promptly and as expeditiously as the enrollee's health condition requires.

b. *Services Furnished*: If DCO or a contested case hearing reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, then DCO will pay for the services.

(2) Appeal through MAP Administrative Hearing.

(i) If the enrollee files a request for a MAP Administrative Hearing without first requesting an appeal through DCO, MAP will transfer the request to the DCO and provide notice of the transfer to the

member. The DCO will complete the appeal process within 14 days and provide a Notice of Appeal Resolution.

(ii) If the member sends the Hearing request to the DCO after the DCO has already completed the initial plan appeal, the DCO will date-stamp the hearing request and submit it to the OHA along with the Notice of Adverse Benefit Determination and Notice of Appeal Resolution and all documents and records the DCO relied upon to take its action.

(3) Designated People to Review Appeals and Appeal Decision Making: The appeal will be reviewed, investigated, considered or heard by: (a) DCO's Vice President of Dental Services or their designee(s), who are licensed dentists; and (b) the QI/UR Committee which is responsible for internal review and with the authority to make a final clinical or administrative decision at the DCO level. Individuals who make decisions on appeals will be individuals who: (a) were neither involved in any previous level of review or decision-making nor a subordinate of any such individual; (b) if deciding on clinical necessity or clinical issues, are individuals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease; and (c) take into account all comments, documents, records, and other information submitted by the enrollee or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.

(4) Use of both DCO Appeal Process and MAP Administration Hearing:

(i) If the enrollee chooses to use DCO's appeal procedure as well as the MAP hearing process, DCO will ensure either that the appeal procedure is completed within 14 days, unless an extension is requested, then DCO will have up to 30 days.

(ii) DCO's Case Management Department may encourage the enrollee to use the DCO's appeal procedure, but will not discourage the enrollee from requesting a MAP Administrative Hearing.

(iii) If the enrollee files a request for a MAP Administrative Hearing, MAP must immediately notify DCO. DCO will review the Hearing Request as an Appeal under this policy.
(iv) The designated Case Management Department will begin the process of establishing the facts concerning the denial of service or service coverage upon receipt of the appeal.

(vi) Neither implementation of a MAP Administrative Hearing decision nor an enrollee's request for a hearing may be a basis for a request by DCO for disenrollment of an enrollee.

5. APPEAL AND COMPLAINT LOG.

a. DCO will maintain a written log which contains the following information: enrollee name, date received, date completed, Primary Care Dentist (PCD) name, type of complaint or appeal, resolution of the complaint or appeal, written reply, hearing filed, and reviewed. For complaints this information should be included: the date of the complaint, nature of the complaint, the disposition of the complaint. For appeals the following information should be included: the date of the Notice of Action, the date of the appeal, the nature of the appeal, whether continuing benefits were requested and provided, the resolution and date of resolution of the appeal.

b. DCO shall monitor the written log on a monthly basis for receipt, disposition and documentation of all written and oral complaints and appeals. Review of complaints and appeals shall contain the following components: completeness, accuracy, timeliness of documentation and compliance of plan procedures for handling complaints and appeals.

c. DCO shall maintain current complaints and appeals and previous year complaints and appeals on file in office with all other complaints and appeals being sent to storage to maintain for length of 10 years to permit evaluation subject to the DCO's record retention policy.

d. Complaints shall be reviewed by QI/UR Committee bi-monthly.

Approvals:
Date: 03/22/2018

Approved by:

Lorena Reinhart (Executive Assistant), Executive Assistant, Operations

07/31/2012				
06/06/2014	Jeanne Dysert	Tamara Kessler	Missy Mitchell	Laura Donadio
02/23/2015	Jeanne Dysert	Tamara Kessler	Missy Mitchell	Laura Donadio
02/23/2016	Jeanne Dysert	Tamara Kessler	Missy Mitchell	Jeff Dover
10/19/2016	Jeanne Dysert	Tamara Kessler	Missy Mitchell	Jeff Dover
02/14/2017	Jeanne Dysert	Tamara Kessler	Missy Mitchell	
07/12/2017	Jeanne Dysert	Tamara Kessler	Missy Mitchell	
07/27/2017	QI/UR Committee			
03/12/2018	Jeanne Dysert	Tamara Kessler	Missy Mitchell	Rose Novak