Advantage Dental
From DentaQuest

Policy Name: Enrollee Grievance and Appeals	**Policy Number: PL024-Enrollee Grievance and Appeals-CARE**
Type of Policy: DCO	**Effective Date: 7/31/2012**
Responsible Department: Plan Operations	
Page Number (s): 7	**Revised Date: 04/24/2019**
Approved By: Clinical and Credentialing Sub-Committee	**Approved Date: 7/17/2019**

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.

DEFINITIONS:

Adverse Benefit Determination-The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit. The reduction, suspension, or termination of a previously authorized service or the denial of payment for a service.

Appeal – A request by an enrollee or enrollee's representative for review of an Adverse Benefit Determination**.**

Grievance – An expression of dissatisfaction by an enrollee or enrollee's representative about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested.

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

FORMS: OHP Grievance Form (OHP 3001)

POLICY:
The following procedures are for use in all grievances and appeals filed with the DCO, whether oral or written. The 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 Oregon Health Authority (OHA) hearings process. Any hearing requests made outside of DCO's grievance and appeal process or without previous use of DCO's grievance and appeal process shall be reviewed by DCO grievance and appeal process upon notification by OHA.

DCO shall inform enrollees both orally and in writing about DCO's grievance and appeal procedures. This shall be done through enrollee materials distributed at the time of

enrollment in DCO and through communications with the Enrollee Services Department. The DCO shall assure the enrollee of the confidentiality in the grievance and appeal process in the materials and communications provided.

Every enrollee will be provided with reasonable assistance with the appeals and grievance process. This assistance may include 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 enrollee from filing a grievance, appeal, or hearing request or take punitive action against a provider who requests an expedited resolution or supports a enrollee's appeal;
b. Encourage the withdrawal of a grievance, appeal, or hearing request already filed; or
c. Use the filing or resolution of a grievance, appeal, or hearing request as a reason to retaliate against an enrollee or to request enrollee disenrollment.

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

A. Vice President of Clinical Services: The Vice President of Clinical Services or their designee(s), who are licensed dentists, shall be responsible for review and oversight of the written and oral grievance and appeal process.
B. Case Management Department: The DCO's Case Management Department shall be responsible for receiving, processing and responding to enrollee grievances and ensuring that all grievances are managed, documented, and reported according to written procedure. After completion of an investigation by Case Management, and review by the Vice President of Clinical 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. The Case Management Department will prepare an analysis of all grievances, both written and verbal, for review by the Clinical and Credentialing Sub-Committee.
C. Clinical and Credentialing Sub-Committee: The committee reviews all appeals and the minutes of the committee meetings shall reflect this. The committee also reviews and approves the grievance process and receives an analysis of all the grievances filed.

2. CONFIDENTIALITY OF GRIEVANCE AND APPEALS PROCESS: DCO shall keep all information concerning an enrollee's grievance or appeal confidential. The staff is trained and notified of this at the time of employment. All information concerning an enrollee's grievance or appeal is kept confidential, except that the Coordinated Care Organization (CCO) and OHA have a right to this information without a signed release from the enrollee. DCO shall assure enrollees that grievances 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 grievance 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. GRIEVANCE PROCESS

The enrollee or their representative may make a grievance either orally or in writing through DCO's internal grievance process. There is no timeline for submission of an enrollee grievance.

A. The DCO ensures all grievance reporting is completed 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. DCO shall make available OHA grievance forms (OHP 3001) in all administrative offices and in all dental offices where staff have been designated to respond to grievances. Enrollees have the right to register a grievance in the following manner:

1) <u>Through the Provider/Staff:</u>

a) An enrollee or their representative may relate any incident or concern to a provider or other staff orally or in writing.
b) The provider or staff shall direct the enrollee to the Case Management Department or Enrollee Services Department, who are designated to receive grievances as identified in the DCO's welcome packet. If the grievance is received by the provider orally or in writing the provider should submit the grievance/grievance information to the Case Management Department by fax at 1-541-516-4356.

2) <u>Through the DCO Internal Grievance Process:</u>

a) Enrollees may choose to utilize DCO's internal grievance procedure. If the enrollee files a grievance to DCO's Enrollee Services, the Enrollee Services Representative (MSR) shall inform the enrollee of the grievance process. The MSR shall:
    i. Attempt to resolve the grievance over the phone as a one-call resolution; or
    ii. File an oral grievance on behalf of the enrollee; or
    iii. Mail an OHA grievance form (OHP 3001) to the enrollee

All oral and one-call resolution grievances will be sent to the Case Management Department for documentation and additional follow up as needed.

b) Case Management will work with the enrollee to resolve all grievances and notify the enrollee as expeditiously as the enrollee's health conditions require but no later than 5 business days from the date of receipt of the grievance. If more time is needed, notify the enrollee that there shall be a delay in the DCO's decision of up to 30 days. The written notice shall specify why the additional time is necessary.
c) If it is determined by the DCO that the grievance is regarding a denial of services, the grievance will immediately be transferred to the appeals process.
d) If the enrollee does not wish to attempt to resolve the grievance through the use of DCO's internal grievance process, they shall be notified that the enrollee has the right to seek resolution through the Department of Human Services (Department) Client Services Unit or the OHA's

Ombudsperson.

e) 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 grievance. A written resolution will be made if the grievance was received in writing. The written and oral resolution of the grievance shall review each element of the enrollee's grievance and address each of those concerns specifically, including the reasons for DCO's resolution.

f) If an enrollee is not satisfied with DCO's resolution of the grievance, the written resolution notifies enrollees that they may present their grievance to the Department of Human Services (Department) Client Services Unit or the OHA's Ombudsperson.

D. The DCO shall review and report to the Oregon Health Authority (OHA) grievances 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.

4. NOTICE OF ACTION AND APPEAL PROCESS

A. Appeal of Notice of Adverse Benefit Determination. 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 through the DCO Appeal process. The enrollee must go through DCO's Appeal process before requesting an OHA Administrative Hearing.

1) Appeal through DCO Appeal Process:

a) **Deadline to File Appeal**: Enrollee must file an appeal with DCO no later than 60 calendar days from the date on the Notice of Adverse Benefit Determination. Any appeal received by DCO will be promptly transferred to the Utilization Management Department to begin the appeal process. Enrollee can file an appeal directly with DCO, either orally or in writing by contacting DCO Enrollee Services. 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.

b) **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.

c) **Parties to Appeal**: Parties to appeal may include the DCO, Coordinated Care Organization (CCO), enrollee or enrollee's representative, or legal representative of an enrollee's estate.

d) **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 OHA 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.

e) **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 72 hours. This timeframe may be extended as described above in paragraph (d). 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 days with a written notice.

f) **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 their right for a contested hearing or expedited hearing with OHA, how to request one, and attach the Health Systems Division Service Denial Appeal and Hearing Request form (OHP 3302) The notice must 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.

g) **Request for contested hearing**. If an enrollee is unsatisfied with DCO's resolution of the appeal, the enrollee may request a contested hearing or expedited hearing with OHA. 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 hearing, the record can be submitted to the OHA Hearing Unit within 2 business days. (OAR 410-141-0262(19)).

h) **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.

i) **Continuation of Benefits:** DCO shall continue the enrollee's benefits if: (1) the enrollee or the enrollee's representative files the appeal or contested hearing request timely; (2) the appeal or contested hearing request involves the termination, suspension or reduction of a previously authorized covered service; (3) the covered services were ordered by an authorized provider; (4) the original period covered by the original authorization has not expired; and (5) the enrollee requests an extension of benefits.

j) **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.

k) **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 hearing within 10 days from when the DCO mails an adverse decision; (3) a contested 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).

l) **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.

m) **Services while an appeal is pending:**

i. *Services Not Furnished:* If DCO or a contested 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.

ii. *Services Furnished*: If DCO or a contested 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) <u>Hearing through OHA:</u>

a) If the enrollee files a request for a contested hearing or expedited hearing through OHA without first requesting an appeal through DCO, OHA will transfer the request to the DCO and provide notice of the transfer to the enrollee. The DCO will complete the appeal process within 16 days and provide a Notice of Appeal Resolution.

b) If the enrollee sends the hearing request to the DCO after the DCO has already completed the appeal, the DCO will date-stamp the hearing request and submit it to 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) <u>Appeal review and decision making:</u> The appeal will be reviewed, investigated, considered or heard by the DCO's Vice President of Clinical Services or their designee(s), who are licensed dentists; who are 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.

5. APPEAL AND GRIEVANCE 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 grievance or appeal, resolution of the grievance or appeal, written reply, hearing filed, and reviewed. For grievances this information should be included: the date of the grievance, nature of the grievance, the disposition of the grievance. For appeals the following information should be included: the date of the Notice of Adverse Benefit Determination, 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 grievances and appeals. Review of grievances and appeals shall contain the following components: completeness, accuracy, timeliness of documentation and compliance of plan procedures for handling grievances and appeals.

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

Reviewed and Revised By:

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
04/23/2019	Missy Mitchell	Phebe Ditzler	Rosa Pedraza	