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Health Partners Provider Manual Appeals & Grievances



Purpose: This chapter provides guidelines for understanding the appeal and grievance procedures used at Health Partners.

Topics:

- Disputes
- Grievances
- Sanctions and Appeals

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Overview

Health Partners provides several types of appeals to providers who are dissatisfied with our decisions. Depending on the nature of the issue, providers may be able to choose between more than one available appeal avenue. This section of the Provider Manual describes three of these appeal options. Appeal options include:

- Appeals of Inpatient Utilization Review Decisions (see *Appealing Inpatient Utilization Review Decisions* on page 6-16)
- Provider Quality of Care Sanctions and Appeals (see *Provider Quality of Care Sanctions and Appeals* on page 7-13)
- Health Partners Provider Dispute and Appeal Process (Medicaid only)

This process is only available to appeal decisions regarding credentialing denials, provider terminations by the Plan, and provider claim denials. It may not be used to appeal decisions that regard medical necessity, or provider sanctions.

- Provider-Initiated Member Appeals (Act 68)

With the member's consent, a provider may appeal (grieve) a Health Partners decision on behalf of the member. A provider who pursues this appeal process may not additionally use the informal dispute resolution process described in Section V to appeal the same matter.

Provider Dispute & Appeal Process (Medicaid only)

This Provider Dispute & Appeal Process is available only for the Health Partners Medicaid program, and may not be used for any issues concerning medical necessity decisions, nor for provider sanctions (see Provider Quality of Care Sanctions and Appeals on page 7-13)

A Provider Dispute is a written communication to Health Partners, from a participating Medicaid provider, expressing dissatisfaction with a decision (other than a medical necessity decision or a provider sanction) that directly impacts the provider. The three matters that providers may bring through Health Partners' Provider Dispute & Appeal process are as follows:

- Provider credentialing denial by the Plan;
- Provider termination action by the Plan; and,
- Provider claim denials (for reasons other than medical necessity). Providers are encouraged to follow the Claim Reconsideration process for quick resolution to billing and payment errors (see Claim Reconsiderations on page 9-24). Providers may, however, access the Dispute & Appeal Process for initial claim denials. If a Provider chooses to use the Dispute & Appeal Process for initial claim denials, the Dispute & Appeal Process filing deadlines apply, and the Claim Reconsideration process is no longer available as a resolution process.

Any initial claim denials presented through the Claim Reconsiderations process that result in continued provider dissatisfaction, may be presented through the Dispute & Appeal Process. The Dispute & Appeal Process filing deadlines apply.

The Provider Dispute & Appeal Process provides for the settlement of applicable issues as follows:

Disputes

Providers have the right to file a dispute regarding provider credentialing denial, provider termination, and claim denials (including denied payment for services already rendered). Providers have thirty (30) calendar days from the date of the written notice (credentialing denial, termination or claim denial) from Health Partners to file a dispute. All disputes must be in writing and mailed to:

Complaint & Grievance Unit
Attn: Provider Dispute & Appeal Process
Health Partners
901 Market Street, Suite 500
Philadelphia, PA 19107

A provider representative (i.e., co-worker, friend, the provider's attorney, etc.) can assist the provider in filing a dispute. If a provider representative files a dispute on behalf of a provider, the provider must provide Health Partners with written authorization stating that said provider representative may act on the provider's behalf. The provider is given ten (10) calendar days to provide the proper authorization for said provider representation. The dispute process begins the date upon which the written authorization from the provider is received by Health Partners' Complaint & Grievance (C&G) Unit.

1st Level Dispute Process

The initial dispute is a 1st Level Dispute. After Health Partners' C&G Unit receives the request for the dispute process by the provider or the provider representative, Health Partners will initiate the 1st Level Dispute panel. The panel will consist of at least one person who has the authority, training and expertise to address and resolve Provider Dispute issues. The 1st Level Dispute panel has thirty (30) calendar days from the date of receipt of the 1st Level Dispute request to investigate and render a decision. The C&G Unit has five (5) business days from the date of the 1st Level Dispute panel's resolution to forward the decision notification letter to the provider.

If the provider is dissatisfied with the decision, the provider may appeal the dispute to Health Partners' 2nd Level Dispute (Internal Appeal) process.

2nd Level Dispute Process (Internal Appeal)

Following resolution of his/her 1st Level Dispute, a provider has the right to file a 2nd Level Dispute (Appeal). The 2nd Level Dispute (Appeal) by the provider is due within thirty (30) calendar days of the date of the 1st Level Dispute decision notification letter. All 2nd Level Disputes (Appeals) must be in writing and mailed to:

Complaint & Grievance Unit
Attn: Provider Dispute & Appeal Process
Health Partners
901 Market Street, Suite 500
Philadelphia, PA 19107

The C&G Unit will appoint a 2nd Level Dispute review committee which shall:

- Include health care providers/peers not employed by Health Partners, comprising at least one-fourth (1/4th) of the membership of the Committee;
- Include Committee members who have the authority, training and expertise to address and resolve Provider Disputes (Appeals);
- Have access to data necessary to assist committee members in making decisions; and
- Document meetings and decisions of the Committee.

Prior to the 2nd Level Dispute (Appeal) hearing, Health Partners will send a letter to the provider informing him/her of his/her right to appear before the 2nd Level Dispute (Appeal) panel. The provider's authorized representative (if applicable) also has the right to be present at the 2nd Level Dispute (Appeal) hearing. The provider must give the name of the provider representative to Health Partners at least two (2) business days prior to the 2nd Level Dispute (Appeal) hearing. Additionally, the same rules apply for appointing a provider representative as described above in the "Disputes" section.

The 2nd Level Dispute (Appeal) panel has thirty (30) calendar days from the date of receipt of the 2nd Level Dispute (Appeal) request to hold a hearing and render a decision. The C&G Unit has five (5) business days from the date of the 2nd Level Dispute (Appeal) panel's resolution to forward the decision notification letter to the provider. The decision of the 2nd Level Dispute (Appeal) Committee is final and binding.

Provider-Initiated Member Appeals (Act 68)

This information pertains to both Health Partners (Medicaid) and KidzPartners (CHIP) members.

With the written permission of the member, Pennsylvania Act 68 gives providers the right to appeal on behalf of the member. While a provider may request the member's written consent prior to treatment, he or she may not (as a condition of treatment) require that the member sign a document authorizing the provider to file a grievance.

Applicable regulations provide specific requirements and timeframes that must be adhered to. When the member gives the provider permission to file a grievance, the provider must assure timely compliance with the requirements, since he or she has assumed the member's grievance and appeal rights. The member, however, may rescind consent at any time.

When the provider initiates a member appeal, he or she may not bill the member for the services that are the subject of the grievance until an external grievance review has been completed, or unless the member has rescinded the consent. Health Partners Medicaid members may never be billed or balance billed for covered services.

In situations where the provider is prohibited from billing the member, or if the provider chooses to never bill the member for the services being grieved, he or she may drop the grievance. The provider must notify the member or the member's legal representative in order to do so.

A member may ask another person to serve as his/her representative in the appeal process. This person is then termed the "member's representative." If the representative is a health care provider, the provider must have the member's written consent to file/pursue a grievance. Either the member or the member's legal representative may provide this consent.

The written consent giving a provider authority to file/pursue a grievance as the member's representative must contain each of the following:

- The member's name, address, date of birth, and Plan identification number.
- When the member is a minor or legally incompetent: The name, address and relationship to the member of the person signing the consent on behalf of the member.
- The name, address and identification number of the health care provider who is obtaining consent from the member.
- The name and address of the Plan that will receive the grievance.
- A description of the specific service(s) (whether coverage was provided or denied) that the consent will apply to.
- The signature and date of signature of the member, or (if a minor or legally incompetent) the member's legal representative; and the signature and date of signature of a witness.

The written consent must also include the following statements:

- The member or member's legal representative may not file a grievance about the service(s) listed in the consent form unless the member or member's legal representative rescinds the consent in writing. The member or member's legal representative has the right to rescind this consent at any time during the grievance process.
- If the provider fails to file the grievance, or does not continue to pursue the grievance through the second-level review process, the consent of the member or member's legal representative will be rescinded automatically.

- The member (or the member's legal representative, if the member is a minor or legally incompetent) has read (or has been read) this consent document, and has had it explained to his/her satisfaction. The member or member's legal representative understands the information in the member's consent form.

A member may rescind his/her consent at any time throughout the grievance process. If the member rescinds consent, he/she may continue the grievance from the point at which consent was rescinded. A member may not file a separate grievance on the same matter. If a member files a grievance, he/she may, at any time during the grievance process, choose to give consent to a health care provider to continue the grievance on behalf of the member. A member's legal representative may similarly exercise these member rights.

Please note that, if a provider uses the following process, he or she may not also use the informal dispute resolution process described under Appeals of Inpatient Utilization Review Decisions to appeal the same matter. For more information, see page 6-16.

Grievances (Act 68)

When Health Partners denies, decreases, or approves a service or item different than the service or item requested because it is not medically necessary, a written grievance may be filed by the member, member's legal representative, or health care provider or other member's representative (with the appropriate written consent of the member) to request that Health Partners reconsider its decision. Specifically, a decision may be grieved that:

- Denies, or provides limited authorization for, a requested service, including its type or level.
- Reduces, suspends or terminates a service that was previously authorized.
- Denies the requested service and approves an alternative.
- Denies payment, fully or in part, for a service, based on lack of medical necessity.

Provider-Initiated Member Appeals - First-Level Review

The member, or member's representative, or provider (with member's written consent) must file the grievance within 45 days from Health Partners' decision, or from the date of receipt of notification about the decision.

If a provider who has consent to file an appeal later chooses not to pursue the grievance, he or she must notify the member, or the member's legal representative, within 10 days from receipt of a standard written denial and any first-level, second-level or external review decision.

A provider appealing with consent of the member should send the written grievance to:

Attention: Grievance Specialist
Health Partners
901 Market Street, Suite 500
Philadelphia, PA 19107

When a grievance is received, Health Partners issues a written confirmation to the member, the member's representative (if designated), and the provider (if the provider has filed the grievance with member consent). The letter will provide additional information about the first-level grievance review process, including:

- Classification of the matter as a grievance versus a complaint. The member, member's representative, or provider may question this classification by contacting the Department of Health.
- The right of the member to appoint a representative to act on his/her behalf at any time during the internal grievance process.

- The ability of the member, member's representative, or provider that filed the grievance (with member consent) to review information related to the grievance upon request. They may also submit additional information to Health Partners for consideration.
- The right of the member or member's representative to request that a Health Partners staff member (who has not participated in the utilization management decision) help prepare the first-level grievance, at no charge.

A committee whose members have not been involved in any prior decision regarding the grievance will provide the first-level grievance review. A licensed physician or an approved licensed psychologist (practicing in the same or similar specialty that would typically consult on the health care services in question) will be a committee member. Health Partners will provide the member, member's representative, or provider that filed a grievance with member consent access to all information about the matter being decided. Health Partners will allow for written information or other additional material to be introduced in support of the grievance. The member, member's representative, or provider may directly voice the remedy or corrective action which they are asking of Health Partners.

Health Partners will reach a decision within 30 days from receiving a grievance. A 14-day extension may be requested by the member, member's representative, or the provider who filed the grievance with written consent of the member. Health Partners will notify the member, member's representative, and provider within five business days of the committee's decision. This notice will include the basis for the decision, and will explain how to request a second-level review of the decision. The notice will specifically include:

- A statement of the matter reviewed by the first-level committee.
- The specific reasons for the committee's decision.
- Corresponding provisions that were the basis for the decision, and how to obtain copies of any documents used.
- The scientific or clinical judgment behind the decision.
- Information on how to file a request for a second-level review of the decision. This request must be filed within 45 days of receipt of the decision of the first-level grievance committee.

Provider-Initiated Member Appeals - Second-Level Review

When a second-level grievance is received, Health Partners issues a written confirmation to the member, the member's representative (if designated), and the health care provider. The letter will provide additional information about the second-level grievance review process, including:

- How to request that a Health Partners staff member (who has not participated in any discussion of the issue being grieved) help prepare the second-level grievance, at no charge.
- Notice that the member, member's representative, and provider will be given 15 days written, advance notice of the scheduled second-level review, and that they have the right to attend and participate.

A committee with three or more members who have not been involved in any prior decision regarding the grieved issue will provide the second-level grievance review. A licensed physician or an approved licensed psychologist (practicing in the same or similar specialty that would typically consult on the health care services in question) will be a committee member.

At the second-level review, the member, member's representative and provider have the right to attend, and to present to the committee. Health Partners will provide the member, member's representative, and provider with at least 15 days written, advance notice of the scheduled second-level review date.

Health Partners will consider the member's access to transportation, as well as any disabilities or language barriers, and will make reasonable accommodation to permit the member, member's representative, and the provider participate, in person or by conference call. When the member, member's representative, or the provider cannot attend the review in person, Health Partners will provide the opportunity to communicate with the committee by other appropriate means, such as telephone.

Second-level review attendance is limited to these people:

- Review committee members who are not employees of Health Partners
- Appropriate Plan representatives
- The member or the member's representative(s), including legal representation and/or any attendant necessary for the member's participation in and understanding of the proceedings
- The provider who grieved the matter with the member's consent
- Any pertinent witnesses

All persons attending this meeting will need to identify themselves and their role in the grievance process for the member and any representatives for the member that are present. The committee will base the second-level review decision on the materials and testimony presented during the review meeting only. Committee members may not discuss the case prior to the review meeting. Committee members must attend the review meeting in person, or participate actively by telephone or video conference (and have an opportunity to review any information introduced at the review meeting prior to voting), or they may not vote. An attorney may represent the committee's interests at the review meeting, but may not argue the Plan's position or represent its staff. A summary of the meeting's proceedings will be produced from an electronic recording. This summary will become part of the grievance record, and will be included in the information the Plan sends if there is a request for an external grievance review.

Health Partners will complete the second-level review and reach a decision within 45 days from receiving the request for review. Health Partners will notify the member, member's representative, and provider in writing within five business days of the committee's decision. This notice will include the basis for the decision, and will explain the procedures and timeframes for the member, member's representative, or provider to request an external grievance review. The notice will specifically include:

A statement of the matter reviewed by the second-level committee

- The specific reasons for the committee's decision
- Corresponding provisions that were the basis for the decision, and how to obtain copies of any documents used
- The scientific or clinical judgment behind the decision, applying the terms of the plan to the member's specific medical circumstances

Expedited Grievances

If the member's life, health or ability to regain maximum function would be jeopardized by delay caused by the standard review process, an Expedited Grievance may be filed. The member, member's representative, or provider (with written consent of the member) may file this request by calling Health Partners.

To obtain an expedited review, Health Partners must be provided with written certification from the member's physician that the member's life, health, or ability to regain maximum function would be jeopardized by delay. This certification must include the physician's clinical rationale and facts that support his/her opinion.

The expedited grievance will be put into writing and reviewed by a Health Partners medical director. The expedited grievance process will follow the process described above under Provider-Initiated Member Appeals (Act 68 Process) - Second-Level Review, with these exceptions:

- A 48-hour timeframe applies.
- If the member cannot attend the hearing in person due to the short timeframe, the hearing may be held by telephone. In this case, all information presented will be read into the record.
- If the member cannot be provided with a copy of the report of the same or similar specialist prior to the expedited hearing, Health Partners may read the report into the record at the hearing, and provide a copy of the report to the member at that time.
- To allow Health Partners to conform to the time requirements of this section, it is the responsibility of the member, member's representative, or provider to provide information to the Plan in an expedited manner.

Health Partners will conduct an expedited internal review and issue a decision within 48 hours of receiving an expedited review request, accompanied by a physician's certification, from the member, member's representative, or provider (with written consent of the member). The decision notice to the member, member's representative, or provider will state the basis for the decision and include any clinical rationale. It will also give the procedure for requesting an expedited external review and, if applicable, a DPW Fair Hearing. (Fair Hearings are not available in the CHIP program.) The member, member's representative, or provider (with written consent of the member) has two business days from receipt of the expedited grievance decision to request an expedited external review and a DPW Fair Hearing.

If an expedited external review is requested, Health Partners will submit a request to the Pennsylvania Department of Health by fax and telephone within 24 hours of receiving a request from the member, member's representative, or provider with member's written consent. The Department of Health will assign a certified review entity (CRE) to the case within one business day of receiving the expedited review request. The CRE will make a decision within two business days following its receipt of the case file.

When the expedited external grievance is requested by a provider, both Health Partners and the provider must establish escrow accounts in the amount of half the expected cost of the review. If the CRE's decision is then against the provider in full, the provider shall pay all fees and costs associated with the external grievance. If the CRE's decision is against the Plan, in full or in part, Health Partners will pay the fees and costs associated with the external grievance review, regardless of who initiated it.

External Grievances

A member, member's representative, or provider with written consent of the member, may request an external review following denial of a second-level grievance. Act 68 provides for the following external grievance process standards:

Within 15 days of receiving the second-level grievance review decision, the member, member's representative, or provider who filed the grievance may file a request with Health Partners for an external review. If this request is filed by a provider, he or she must provide the name of the member and a copy of the member's written consent for the provider to file the external grievance.

Within five business days of receiving the request, Health Partners will notify the Pennsylvania Department of Health, the member and the provider that an external grievance review request has been filed. Health Partners' notification to the Pennsylvania Department of Health shall be by phone and fax, and include a request for DOH to assign a certified review entity (CRE). The Department of Health is responsible for notifying the provider or member about the assigned CRE, including its name, address and phone number, within two business days. When the external grievance is requested by a provider, both Health Partners and the provider must establish escrow accounts in the amount of half the expected cost of the review.

Within 15 days of the request for external review, Health Partners will submit the case file to the designated CRE. The Plan will also send the provider or member a list of all the documents sent to the CRE. Within 60 days of filing the request for an external grievance review, the CRE will review the case and issue a written decision. The CRE will send its decision to the member, member's representative, provider, Plan, and the Pennsylvania Department of Health.

Following the CRE's decision, Health Partners will authorize the health care service(s) and pay the claim(s) found by the CRE to be medically necessary and appropriate. Despite authorization(s)/payment(s), Health Partners (or the member, member's representative, or provider with written consent of the member) may still appeal the CRE's decision to a court of competent jurisdiction. If the CRE's decision is against the provider in full, the provider shall pay all fees and costs associated with the external grievance. If the CRE's decision is against the Plan, in full or in part, Health Partners will pay the fees and costs associated with the external grievance review, regardless of who initiated it.

Sanctions and Appeals

In certain situations, a provider may be subject to review and sanctions by Health Partners' Medical Affairs Committee. The provider has certain appeal rights concerning these Medical Affairs Committee decisions. For more information, see the Provider Quality of Care Sanctions and Appeals section on page 7-13

Provider Complaint Procedure

A credentialed provider may initiate a complaint against Health Partners (for issues other than denial of credentialing, claims payment, or provider termination) by contacting the Provider Services Helpline (see Table 1: Service Department Contact Information on page 1-13). All provider complaints requiring follow-up action will be documented on a Provider Issue form. Each complaint must be addressed within seven (7) business days.

Binding Arbitration Hearing

In the event that any complaint or dispute related to a provider's performance under the provider's participating provider agreement with Health Partners (except complaints or disputes involving credentialing, claims payment, or provider termination and/or member complaints, grievances or appeals) is not resolved to the provider's satisfaction, the provider may request a binding arbitration hearing. In this event, the provider must correspond via certified mail with the President and Chief Executive Officer of Health Partners to request a binding arbitration and clearly describe within this correspondence the underlying complaint for which arbitration is requested. The provider must pursue this option within 10 days of the appealable dispute.

The dispute will be referred to arbitration before a panel comprised of three (3) individuals. Both the provider and Health Partners will select one panel representative each, within 10 working days of receipt of the request for arbitration. The two panel representatives will then select a third panel representative to create the three-person

arbitration board. If the two representatives cannot agree on the third representative within 14 days of the request for selection, the third panelist shall be drawn by lot from two candidates (one selected by the provider and one selected by Health Partners).

Upon selection of the third arbitrator, the arbitration board must issue its decision as expeditiously as possible in accordance with the procedures of the American Arbitration Association for handling such matters. Matters concerning level of care/placement decisions shall be reviewed and decided by the panel immediately. The arbitration proceeding will be conducted according to the prevailing rules of the American Arbitration Association. The decision of the arbitration board shall be binding and subject to review by the Pennsylvania Department of Health.

The entire cost of the arbitration proceeding shall be borne by the losing party.

Note: *Health Partners will not exclude a provider from its provider network because the provider advocated on behalf of a member in a utilization management appeal or another dispute with Health Partners over appropriate medical care. Additionally, Health Partners cannot terminate a contract or employment with a health care provider for filing a grievance on a member's behalf.*