5101:3-26-08.4 **Managed health care programs: MCP grievance system.**

(A) General requirements

(1) For the purposes of this rule the following terms are defined as:

(a) An "action" is the MCP's:

(i) Denial or limited authorization of a requested service, including the type or level of service;

(ii) Reduction, suspension, or termination of a previously authorized service;

(iii) Denial, in whole or part, of payment for a service;

(iv) Failure to provide services in a timely manner as specified in paragraphs (A)(7)(c) ~~and (A)(7)(d)~~ of rule 5101:3-26-03.1 of the Administrative Code or

(v) Failure to act within the timeframes specified in paragraph (G) of this rule.

(b) An "appeal" is the request for a review of an action.

(c) A "grievance" is an expression of dissatisfaction with any aspect of the MCP's or provider's operation, provision of health care services, activities, or behaviors, other than an MCP's action as defined in paragraph (A)(1)(a) of this rule.

(d) "Resolution" means a final decision is made by the MCP and the decision is communicated to the member.

(e) "Notice of action (NOA)" is the written notice an MCP must provide to members when an MCP action has occurred or will occur.

(2) For the purposes of filing grievances or appeals on behalf of a member under the age of eighteen, written consent to file is not required when the individual filing the grievance or appeal belongs to the member's assistance group.

(3) Each MCP must develop and implement a grievance system for members that includes an appeals process, a grievance process, and a process to access the

state's hearing system as specified in this rule. MCPs must have written grievance system policies and procedures and, upon request, the MCP's policies and procedures must be made available for review by ODJFS.

(4) MCPs must give members all reasonable assistance in filing an appeal, a grievance, or a state hearing request including but not limited to:

(a) Explaining the MCP's process to be followed in resolving their appeal or grievance.

(b) Completing forms and taking other procedural steps as outlined in this rule.

(c) Providing oral interpreter and oral translation services, sign language assistance and access to the grievance system through a toll-free number with text telephone yoke (TTY) and interpreter capability.

(5) Members are not required to exhaust the MCP's appeal or grievance process in order to access the state's hearings system.

(6) MCPs must ensure that the individuals who make decisions on appeals and grievances are individuals who:

(a) Were not involved in previous levels of review or decision-making.

(b) Are health care professionals who have the appropriate clinical expertise in treating the member's condition or disease if deciding any of the following:

(i) An appeal of a denial that is based on lack of medical necessity.

(ii) A grievance regarding the denial of an expedited resolution of an appeal.

(iii) An appeal or grievance that involves clinical issues.

(7) The procedure to be followed to file an appeal, grievance, or state hearing request must be described in the MCP's member handbook and must include the telephone number(s) for the MCP's toll-free member services hotline, the MCP's mailing address, and a copy of the optional form(s) that members may use to file an appeal or grievance with the MCP. Copies of the form(s) to file

an appeal or grievance must also be made available through the MCP's member services program.

(8) Grievance system procedures must include the participation of individuals authorized by the MCP to require corrective action.

(9) MCPs are prohibited from delegating the appeal or grievance process to another entity.

(B) Notice of action (NOA)

(1) When an MCP action has or will occur, the MCP must provide the affected member(s) with a written NOA. The NOA must meet the language and format requirements specified in paragraph (B)(2) of rule 5101:3-26-08.2 of the Administrative Code and explain:

(a) The action the MCP has taken or intends to take;

(b) The reasons for the action;

(c) The member's or authorized representative's right to file an appeal;

(d) If applicable, the member's right to request a state hearing;

(e) Procedures for exercising the member's rights to appeal or grieve the action;

(f) Circumstances under which expedited resolution is available and how to request it;

(g) If applicable, the member's right to have benefits continue pending the resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay for the cost of these services; and

(h) The date that the notice is being issued.

(2) MCPs must give members a written NOA within the following timeframes:

(a) For a decision to deny or limit authorization of a requested service,

including the type or level of service, MCPs must issue an NOA simultaneously with the MCP's decision MCP service authorization decisions must be made in accordance with the timeframes specified in paragraphs (A)(7)(c)(v), (A)(7)(c)(vi), and ~~(A)(7)(d)~~ (A)(7)(c)(viii) of rule 5101:3-26-03.1 of the Administrative Code.

(b) For reduction, suspension or termination of a previously authorized ~~Medicaid-covered~~ service, MCPs must give notice fifteen calendar days before the date of action except:

(i) If probable recipient fraud has been verified, the MCP must give notice five calendar days before the date of action.

(ii) The MCP must give notice on or before the date of action in accordance with 42 ~~CFR~~ C.F.R. 431.213 (2005).

(c) For denial of payment for a service, MCPs must give notice simultaneously with the MCP's action to deny, the claim in whole or part.

(d) For untimely service or grievance resolution, MCPs must give notice simultaneously with the MCP becoming aware of the action. Service authorization decisions not reached within the timeframes specified in paragraphs (A)(7)(c)(v), (A)(7)(c)(vi), and ~~(A)(7)(d)~~ (A)(7)(c)(viii) of rule 5101:3-26-03.1 of the Administrative Code, constitute a denial and are thus adverse actions. Notice must be given on the date that the authorization decision timeframe expires.

(C) Standard appeal process

(1) A member, provider or member's authorized representative may file an appeal verbally or in writing within ninety days from the date on the NOA. MCPs must ensure that verbal filings are treated as appeals to establish the earliest possible filing date for the appeal. A verbal filing must be followed with a written appeal. The MCP must assist the member to ensure that a written appeal is filed by immediately converting a verbal filing to a written record. If the member follows the verbal filing with a written appeal, this appeal will ~~supercede~~ supersede the written record, however, the date of the verbal filing must be considered the filing date of the appeal~~,~~.

(2) The member's authorized representative and a provider acting on the member's behalf must have the member's written consent to file an appeal. MCPs must

begin processing the appeal pending receipt of the written consent.

(3) MCPs must acknowledge receipt of each appeal to the individual filing the appeal. Verbal acknowledgment is acceptable, however, if the appeal is initially filed in writing, written acknowledgment must be made by the MCP within three working days of the receipt of the appeal.

(4) The MCP must provide members a reasonable opportunity to present evidence and allegations of fact or law, in person as well as in writing. The member and/or member's authorized representative must be allowed to examine the case file, including medical records and any other documents and records, before and during the appeals process.

(5) MCPs must consider the member, member authorized representative, or estate representative of a deceased member as parties to the appeal.

(6) MCPs must review and resolve each appeal as expeditiously as the member's health condition requires but the resolution timeframe must not exceed fifteen calendar days from the receipt of the appeal unless the resolution timeframe is extended as outlined in paragraph (E) of this rule.

(7) The MCP must provide written notice to the member, and to the member's authorized representative if applicable, of the resolution including, at a minimum, the decision and date of the resolution.

(8) For appeal decisions not resolved wholly in the member's favor the written notice must also include information regarding:

(a) The right to request a state hearing;

(b) How to request a state hearing; and if applicable:

(i) The right to continue to receive benefits pending a state hearing,

(ii) How to request the continuation of benefits, and

(iii) If the MCP action is upheld at the state hearing that the member may be liable for the cost of any continued benefits.

(9) For appeals decided in favor of the member, the MCP must:

(a) Authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires if the services were not furnished while the appeal was pending.

(b) Pay for the disputed services if the member received the services while the appeal was pending.

(D) Expedited appeals

(1) MCPs must establish and maintain an expedited review process to resolve appeals when the MCP determines, or the provider indicates in making the request on the member's behalf or supporting the member's request, that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.

(2) MCPs must comply with the standard appeal process specified in paragraph (C) of this rule, except MCPs must:

(a) Not require that a verbal filing be followed with a written, signed appeal.

(b) Make a determination within one working day of the appeal request whether to expedite the appeal resolution.

(c) Make reasonable efforts to provide prompt verbal notification to the member of the decision to expedite or not expedite the appeal resolution.

(d) Inform the member of the limited time available for the member to present evidence and allegations of fact or law in person or in writing.

(e) Resolve the appeal as expeditiously as the member's health condition requires but the resolution timeframe must not exceed three working days from the date the MCP received the appeal unless the resolution timeframe is extended as outlined in paragraph (E) of this rule.

(f) Make reasonable efforts to provide verbal notice of the appeal resolution in addition to the required written notification.

(g) Ensure that punitive action is not taken against a provider who requests an

expedited resolution or supports a member's appeal.

(3) If the MCP denies the request for expedited resolution of an appeal the MCP must:

(a) Transfer the appeal to the standard resolution timeframe of fifteen calendar days from the date the appeal was received unless the resolution timeframe is extended as outlined in paragraph (E) of this rule;

(b) Provide the member written notice of the denial to expedite the resolution within two calendar days of the receipt of the appeal, including information that the member can grieve the decision.

(E) Appeal resolution extensions

(1) A member may request that the MCP extend the timeframe to resolve a standard or expedited appeal up to fourteen calendar days.

(2) MCPs may request that the timeframe to resolve a standard or expedited appeal be extended up to fourteen calendar days. MCPs must submit documentation that the extension is in the member's best interest to ODJFS for prior approval. If ODJFS approves the extension, the MCP must immediately give the member written notice of the reason for the extension and the date that a decision must be made.

(3) MCPs must maintain documentation of any extension request.

(F) Continuation of benefits

(1) The MCP must continue a member's benefits when an appeal has been filed if the following conditions are met:

(a) The member or authorized representative files the appeal on or before the later of the following:

(i) Within ten working days of the MCP mailing the NOA, or

(ii) The intended effective date of the MCP's proposed action;

(b) The appeal involves the termination, suspension or reduction of a

previously-authorized course of treatment;

(c) The services were ordered by an authorized provider;

(d) The authorization period has not expired; and

(e) The member requests the extension of benefits.

(2) If the MCP continues or reinstates the member's benefits while the appeal is pending, the benefits must be continued until one of the following occurs:

(a) The member withdraws the appeal;

(b) Ten calendar days pass following the MCP's notice to the member of an adverse appeal decision unless the member, within the ten day timeframe, requests a state hearing with continuation of benefits and therefore the benefits must be continued as specified in rule 5101:6-4-01 of the Administrative Code;

(c) A state hearing regarding the continuation of the benefits is decided adverse to the member; or

(d) The initial time period for the authorization expires or the authorization service limits are met.

(3) At the discretion of ODJFS, the MCP may recover the cost of the continuation of services furnished to the member while the appeal was pending if the final resolution of the appeal upholds the MCP's original action.

(G) Grievance process

(1) A member or authorized representative can file a grievance. An authorized representative must have the member's written consent to file a grievance on the member's behalf.

(2) Grievances may be filed verbally or in writing, only with the MCP, within ninety calendar days of the date that the member became aware of the issue.

(3) MCPs must acknowledge the receipt of each grievance to the individual filing the grievance. Verbal acknowledgment is acceptable, however, if the grievance is filed in writing, written acknowledgment must be made within

three working days of receipt of the grievance.

(4) MCPs must review and resolve all grievances as expeditiously as the member's health condition requires. Grievance resolutions including member notification must meet the following time frames:

(a) Within two working days of receipt if the grievance is regarding access to ~~Medicaid-covered~~ services.

(b) Within thirty calendar days of receipt for non claims-related grievances except as specified in paragraph (G)(4)(a) of this rule.

(c) Within sixty calendar days of receipt for claims-related grievances.

(5) At a minimum, the MCP must provide verbal notification to the member of a grievance resolution. However, if the MCP is unable to speak directly with the member and/or the resolution includes information that must be confirmed in writing, the resolution must be provided in writing simultaneously with the MCP's decision.

(6) If the MCP's resolution to a grievance is to affirm the denial, reduction, suspension, or termination of a ~~Medicaid-covered~~ service or billing of a member due to the MCP's denial of payment for that service, the MCP must notify the member of their right to request a state hearing as specified in paragraph (H) of this rule, if the member has not previously been notified.

(H) Access to state hearing process

(1) MCPs must notify members of their right to a state hearing as follows:

(a) If the MCP denies a request for the authorization of a ~~Medicaid-covered~~ service, in whole or in part, the MCP must complete and simultaneously mail or personally deliver to the member the "Notice of Denial, Reduction, Suspension or Termination of Your Medical Services by Your Managed Care Plan~~,~~" (JFS 04043, rev. 07/03).

(b) If the MCP decides to reduce, suspend, or terminate a previously authorized service, the MCP must complete and mail or personally deliver to the member no later than fifteen calendar days prior to the proposed reduction, suspension, or termination, the "Notice of Denial, Reduction, Suspension or Termination of Your Medical Services by Your Managed Care Plan~~,~~" (JFS 04043).

(c) If the MCP learns that a member has been billed for services received by the member ~~by a provider~~ due to the MCP's denial of payment, and the MCP upholds the denial of payment, the MCP must immediately complete and mail or personally deliver to the member the~~,~~ "Notice of Denial of Payment for Medical Services by Your Managed Care Plan~~,~~" (JFS 04046, rev. 08/02).

(2) MCPs must ~~simultaneously fax~~ submit a copy of the state hearing forms referenced in paragraph (H)(1) of this rule to ~~the~~ ODJFS ~~designee on~~ within three working days of the date that the form is mailed or personally delivered to the member.

(3) The MCP, member, and member's authorized representative are parties to the state hearing.

(I) Logging and reporting of appeals and grievances.

(1) MCPs must maintain records of all appeals and grievances including resolutions for a period of six years and the records must be made available upon request to ODJFS and the MFCU.

(2) MCPs must identify a key staff person responsible for the logging and reporting of appeals and grievances and assuring that the grievance system is in accordance with this rule.

(3) MCPs are required to submit information at least monthly regarding appeal and grievance activity to ODJFS.

Effective:

R.C. 119.032 review dates: 07/01/2008

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Certification

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Date

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