5160-26-08.4 **Managed health care programs: MCP grievance system.**

This rule does not apply to MyCare Ohio plans as defined in rule 5160-58-01 of the Administrative Code. Provisions regarding appeals and grievances for MyCare Ohio are described in Chapter 5160-58 of the Administrative Code.

(A) Definitions.

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

(1) An "action" is the managed care plan's (MCP's)

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

(b) Reduction, suspension, or termination of services prior to the member receiving the services previously authorized by the MCP;

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

(d) Failure to provide services in a timely manner as specified in rule 5160-26-03.1 of the Administrative Code; or

(e) Failure to act within the resolution timeframes specified in this rule.

(2) An "appeal" is the request for an MCP's review of an action.

(3) 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) of this rule.

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

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

(B) Each MCP must have written policies and procedures for an appeal and grievance system for members, in compliance with the requirements of this rule. The policies and procedures must be made available for review by the Ohio department of medicaid (ODM), and must include the following:

(1) A process by which members may file grievances with the MCP, in compliance with paragraph (H) of this rule;

(2) A process by which members may file appeals with the MCP, in compliance with paragraphs (C) to (G) of this rule; and

(3) A process by which members may access the state's hearing system through the Ohio department of job and family services (ODJFS) in compliance with paragraph (I) of this rule.

(C) Notice of action (NOA) by an MCP.

(1) When an MCP action has occurred or will occur, the MCP must provide the affected member(s) with a written NOA.

(2) The NOA must meet the language and format requirements for member materials specified in rule 5160-26-08.2 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 to the MCP;

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

(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;

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

(i) Oral interpretation is available for any language;

(j) Written translation is available in prevalent languages as applicable;

(k) Written alternative formats may be available as needed; and

(l) How to access the MCP's interpretation and translation services as well as alternative formats that can be provided by the MCP.

(3) An MCP 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, the MCP must issue an NOA simultaneously with the MCP's decision.

(b) For reduction, suspension, or termination of services prior to the member receiving the services previously authorized by the MCP, the MCP 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) Under the circumstances set forth in 42 C.F.R. 431.213 (October 1, 2015~~2013~~), the MCP must give notice on or before the date of action.

(c) For denial of payment for a noncovered service, MCPs must give notice simultaneously with the MCP's action to deny the claim, in whole or part, for a service that is not covered by medicaid, including a service that was determined through the MCP's prior authorization process as not medically necessary.

(d) For untimely prior authorization, appeal or grievance resolution, the MCP must give notice simultaneously with the MCP becoming aware of the action. A service authorization decision not reached within the timeframes specified in rule 5160-26-03.1 of the Administrative Code constitutes a denial and is thus considered to be an adverse action. Notice must be given on the date that the authorization decision

timeframe expires.

(D) Standard appeal to an MCP.

(1) A member, provider, or a member's authorized representative may file an appeal orally or in writing within ninety days from the date on the NOA. The ninety day period begins on the day after the mailing date of the NOA. An oral filing must be followed with a written appeal. The MCP must:

(a) Assist members that file an oral appeal by immediately converting an oral filing to a written record;

(b) Ensure that oral filings are treated as appeals to establish the earliest possible filing date for the appeal; and

(c) Consider the date of the oral filing as the filing date if the member follows the oral filing with a written appeal.

(2) Any provider acting on the member's behalf must have the member's written consent to file an appeal. The MCP must begin processing the appeal pending receipt of the written consent.

(3) The MCP must acknowledge receipt of each appeal to the individual filing the appeal. At a minimum, acknowledgment must be made in the same manner that the appeal was filed. If an appeal is 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) The MCP must consider the member, member's authorized representative, or estate representative of a deceased member as parties to the appeal.

(6) The MCP 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 (F) 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 to the member must also include information regarding:

(a) Oral interpretation that is available for any language;

(b) Written translation that is available in prevalent languages as applicable;

(c) Written alternative formats that may be available as needed;

(d) How to access the MCP's interpretation and translation services as well as alternative formats that can be provided by the MCP;

(e) The right to request a state hearing through the state's hearing system; and

(f) 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.

(E) Expedited appeals to an MCP.

(1) Each MCP 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) In utilizing an expedited appeal process, the MCP must comply with the standard appeal process specified in paragraph (D) of this rule, except the MCP must:

(a) Not require that an oral 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 oral 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 (F) of this rule;

(f) Make reasonable efforts to provide oral 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; and

(h) Notify ODM within one working day of any appeal that meets the criteria for expedited resolution as specified by ODM.

(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 (F) 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.

(F) 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) An MCP may request that the timeframe to resolve a standard or expedited appeal be extended up to fourteen calendar days. The MCP must seek such an extension from ODM prior to the expiration of the regular appeal resolution timeframe and its request must be supported by documentation that the extension is in the member's best interest. If ODM approves the extension, the MCP must immediately give the member written notice of the reason for the extension and the date by which a decision must be made.

(3) The MCP must maintain documentation of any extension request.

(G) Continuation of benefits for an appeal to the MCP.

(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 fifteen 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 services prior to the member receiving the 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 continuation 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) Fifteen calendar days pass following the mailing date of the MCP's notice to the member of an adverse appeal decision unless the member, within the fifteen-day timeframe, requests a state hearing in which case the benefits must be continued as specified in rule 5101:6-4-01 of the Administrative Code;

(c) A state hearing regarding the reduction, suspension or termination of services 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 ODM, 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.

(H) Grievances to an MCP.

(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 only with the MCP, orally or in writing, within ninety calendar days of the date that the member became aware of the issue.

(3) The MCP must acknowledge the receipt of each grievance to the individual filing the grievance. Oral 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) The MCP must review and resolve all grievances as expeditiously as the member's health condition requires. Grievance resolutions including member notification must meet the following timeframes:

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

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

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

(5) At a minimum, the MCP must provide oral notification to the member of a grievance resolution. However, if the MCP is unable to speak directly with the member 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 service or billing of a member due to the MCP's denial of payment for that service, the MCP must notify the member of his or her right to request a state hearing as specified in paragraph (I) of this rule, if the member has not previously been notified.

(I) Access to state's hearing system.

(1) The MCP must develop and implement written policies and procedures that ensure the plan's compliance with the state hearing provisions specified in division 5101:6 of the Administrative Code.

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

(3) When required by paragraph (C) of this rule and division 5101:6 of the Administrative Code, the MCP must notify members, and any authorized representatives on file with the MCP, of the right to a state hearing. The following requirements apply:

(a) If the MCP denies a request for the authorization of a service, in whole or in part, the MCP must simultaneously complete and mail or personally deliver the "Notice of Denial of Medical Services By Your Managed Care Plan" (ODM 04043, 7/2014 ~~formerly JFS 04043~~).

(b) If the MCP decides to reduce, suspend, or terminate services prior to the member receiving the services as authorized by the MCP, the MCP

must complete and mail or personally deliver no later than fifteen calendar days prior to the effective date of the proposed reduction, suspension, or termination, the "Notice of Reduction, Suspension or Termination of Medical Services By Your Managed Care Plan" (ODM 04066, 7/2014 ~~formerly JFS 04066~~).

(c) If the MCP learns that a member has been billed for services received by the member 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 the "Notice of Denial of Payment for Medical Services By Your Managed Care Plan" (ODM 04046, 7/2014 ~~formerly JFS 04046~~).

(d) If the MCP proposes enrollment in the coordinated services program (CSP), the MCP must complete and mail or personally deliver no later than fifteen calendar days prior to the effective date of the proposed enrollment, the "Notice of Proposed Enrollment in the Coordinated Services Program (CSP) " (ODM 01717, 7/2014 ~~formerly JFS 01717~~).

(e) If the MCP decides to continue enrollment in CSP, the MCP must simultaneously complete and mail or personally deliver the "Notice of Continued Enrollment in the Coordinated Services Program (CSP) " (ODM 01705, 7/2014 ~~formerly JFS 01705~~).

(f) If the MCP denies a CSP member's request to change designated provider(s) within the MCP's provider panel, the MCP must simultaneously complete and mail or personally deliver the "Notice of Denial of Designated Provider or Pharmacy in the Coordinated Services Program (CSP) " ~~(~~, ~~((~~ODM 01718, 7/2014 ~~formerly JFS 01718~~).

(4) The member or member's authorized representative may request a state hearing within ninety calendar days by contacting the ODJFS bureau of state hearings or local county department of job and family services (CDJFS). The ninety-day period begins on the day after the mailing date on the notice of action ~~state hearing form~~.

(5) There are no state hearing rights for a member(s) terminated from the MCP pursuant to an MCP-initiated membership termination as permitted in rule 5160-26-02.1 of the Administrative Code.

(6) Following the bureau of state hearings' notification to the MCP that a member has requested a state hearing the MCP must:

(a) Complete the "Appeal Summary for Managed Care Plans" (ODM 01959, 7/2014 ~~formerly JFS 01959~~) with appropriate attachments, and file it with the bureau of state hearings at least three business days prior to the scheduled hearing date. The appeal summary must provide all facts and documents relevant to the issue, and be sufficient to demonstrate the basis for the MCP's action or decision.

(b) Send a copy of the completed appeal summary to the ~~appellant~~member and the member's authorized representative, if applicable, the bureau of state hearings, the local agency, and the designated ODM contact.

(c) Continue or reinstate the benefit(s) specified in rule 5101:6-4-01 of the Administrative Code, if the MCP is notified that the member's state hearing request was received within the prior notification period.

(d) Not enroll the individual in the coordinated services program (CSP) if the MCP is notified that the member's state hearing request was received within the prior notification period.

(7) The MCP must participate in the hearing in person or by telephone, on the date indicated on the "State Hearing Scheduling Notice" (JFS 04002, rev. 01/2015 ~~09/2002~~) sent to the MCP by the bureau of state hearings.

~~(8) In addition to the MCP and member, other parties to a state hearing may include an authorized representative of a member, or the representative of the member's estate, if the member is deceased.~~

~~(9)~~(8) The MCP must comply with the state hearing officer's decision provided to the MCP via the "State Hearing Decision" (JFS 04005, rev. ~~03/2003~~01/2015). If the hearing officer's decision is to sustain the member's appeal, the MCP must submit, to the bureau of state hearings, the infomation required by ~~complete~~ the "State Hearing Compliance" non-fillable form (JFS 04068, rev. ~~05/2001~~01/2015). ~~A copy of the completed form~~, The information, including applicable documentation, is due by no later than the compliance date specified in the hearing decision, to the bureau of state hearings and the designated ODM contact. If applicable, the MCP must:

(a) Authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires.

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

~~(10)~~(9) The MCP must provide a copy of the state hearing forms referenced in this paragraph to ODM, as directed by ODM.

~~(11)~~(10) Upon request, the MCP's state hearing policies and procedures must be made available for review by ODM.

(J) Logging and reporting of appeals and grievances.

(1) The MCP must maintain records of all appeals and grievances including resolutions for a period of eight years and the records must be made available upon request to ODM and the medicaid fraud control unit.

(2) The MCP 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) The MCP is required to submit information regarding appeal and grievance activity as directed by ODM.

(K) Other duties of an MCP regarding appeals and grievances.

(1) The MCP 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 the member's appeal or grievance;

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

(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.

(2) The MCP 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; and

(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; or

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

(3) 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.

(4) Appeals and grievance procedures must include the participation of individuals authorized by the MCP to require corrective action.

(5) The MCP is prohibited from delegating the appeal or grievance process to another entity unless approved by ODM .

Effective:

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Certification

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Date

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