Complaints, Grievances and Medical Necessity Reviews

Learning the Process

Health Partners Plans

Agenda

- What is a Complaint?
- What is a Grievance?
- How to request a Complaint or Grievance on behalf of a Member
- What is the Complaint and Grievance process?
- Prior authorization review processes

What is a Complaint?

Under the State's HealthChoices Program these terms are as follows:

Member Complaint: a dispute or objection regarding a participating provider or the coverage, operations, or management of a Medicaid plan. There are two categories of Complaints.

Category 1: resulting from an Adverse Benefit Determination (ABD) including:

- A denial because a requested service or item is not a covered service
- HPP's failure to provide a service or item in a timely manner, as defined by the State
- HPP's failure to decide a Complaint or Grievance within the specified time frames
- A denial of payment by HPP after a service or item has been delivered because the service or item was provided without authorization by a provider not enrolled in the MA Program

What is a Complaint?

Category 1: Results from an Adverse Benefit Determination (ABD)

- A denial of payment by the plan after a service or item has been delivered because the service or item provided is not a covered service for the Member, or
- A denial of a Member's request to dispute a financial liability, including cost-sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities.

**For a member to file a Complaint in this category, they must have received a decision or denial notice from HPP.*

Category 2: All other Member Complaints

- These complaints are general expressions of dissatisfaction such as complaints about the quality of care or services, or rudeness of a provider or employee.

What is a Complaint?

Example of Category 1 Complaint:

Member would like to file a complaint about the denial of an x-ray of her mouth that was performed at a recent dental visit. The x-ray was denied because it was not a covered benefit under her plan.

Example of Category 2 Complaint:

Member would like to file a complaint about her Primary Care Physician's office because she feels that the staff are rude and not helpful.

What is a Grievance?

The State defines a Grievance as a request to have HPP reconsider a decision concerning the **Medical Necessity and appropriateness** of a covered service.

A Grievance may be filed regarding a decision to:

- Deny, in whole or in part, payment for a service or item
- Deny or issue a limited authorization of a requested service or item, including a determination based on the type or level of service or item
- Reduce, suspend, or terminate a previously authorized service or item
- Deny the requested service or item but approve an alternative service or item, or
- Deny a request for a Benefit Limit Exception (BLE).

All Grievances are the result of an ABD/decision notice.

What is a Grievance?

Example of a Grievance

The member would like to file a grievance for the denial of the request for a CT of her abdomen that she says she needs as part of her cancer treatment to see if the tumor is shrinking. The CT was denied by the plan because it did not meet the frequency standards in the Imaging Guidelines.

Ways to file a Complaint or Grievance

- The Complaint and Grievance process is for Members to bring such issues to the Plan for appropriate processing and resolution
- Complaints and Grievances may come into the plan in a number of ways:
  - Member calls into the Plan with his/her Complaint or Grievance
  - Member writes to the Plan (via letter, email, or fax) with his/her Complaint or Grievance
  - Member visits the Plan and brings the Complaint or Grievance in person to the plan
  - Member asks an authorized representative (friend, family member, attorney, provider) to file the Complaint or Grievance on his/her behalf

How to request a Complaint or Grievance on behalf of a Member?

- As a Provider you may be asked by the Member to file a Complaint or Grievance on the member’s behalf

- A Provider can request a Complaint or Grievance *on behalf of a Member* as long as they have obtained written member consent prior to submitting the request to the Plan *(new 2020 DHS HealthChoices requirement)*.

How to request a Complaint or Grievance on behalf of a Member?

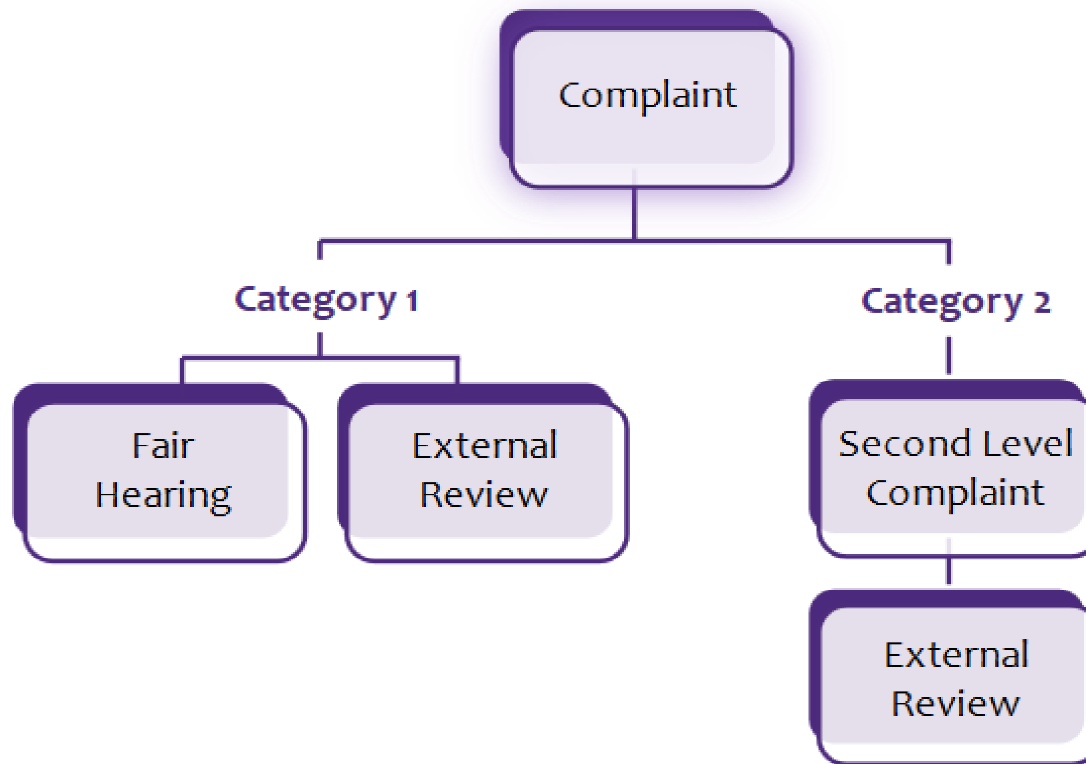
- To request a Complaint or Grievance on behalf of a member, a Provider will need to:
  - Complete and submit the **Complaint & Grievance Request Form** that is attached to the Denial Notice, or any other document indicating the reason for requesting the Complaint or Grievance; **AND**
  - Submit the request with **Form GG20 (for Medicaid)** or **Form 7-S (for CHIP)**, the Consent for Provider to File a Grievance For Member form.
  - **These BOTH must be submitted WITH the request** for a Complaint or Grievance.
    - *Note: this form can be used for a Complaint or Grievance (even though it only references Grievance in the title).
    - This exact form does not need to be used. As long as the document submitted with the request includes the same/similar required information as well as the member's (or member's representative's) signature.

How to request a Complaint or Grievance on behalf of a Member?

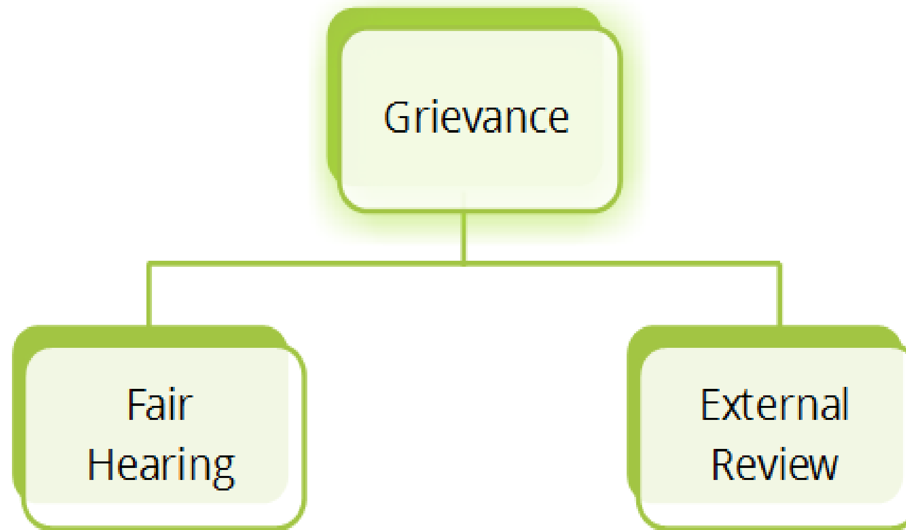
These forms can be found on the Provider Portal at the links below:

- https://piacc.navimedix.com/sign-in?ReturnUrl=/
- https://hpconnect.alderaplatform.com/

Complaint Process



Grievance Process



Timeframes

Timeframe	Category 1 Complaint	Category 2 Complaint	2nd Level Complaint	Grievance
Timeframe to file	60 Days	No limit	45 days	60 days
Decision timeframe*	30 days	30 days	45 days	30 days

*The member or member's representative may extend this timeframe upon request by up to 14 days.

Questions?

- Contact Jennifer Macfarlane, Director of HPP's Complaint, Grievance & Appeals Unit
  - Jennifer Macfarlane
  - 215-991-4333
  - jmacfarlane@hpplans.com

Utilization Management

Prior Authorization Review Process

Health Partners Plans HPP

Utilization Management Prior Authorization Review Process

- Prior Authorizations are based on medical necessity, covered services under a given plan benefits package, and clinical appropriateness using clinical criteria and guidelines, including InterQual that are the accepted standard of care in the medical community.

- The physician reviewer can override the criteria if the requested service is medically necessary in his/her professional judgment. Individual member assessment must occur.

Utilization Management
Prior Authorization Review Process

Servicing Providers seeking authorization are required to submit their requests utilizing correct Medicaid codes, valid physician orders and current clinical documentation that supports the medical necessity of the requested service/item including quantities requested and brand name.

Benefit Limit Exception Request

Benefit limit exceptions will be reviewed according to Federal and State guidelines.

Documentation provided should support one or more of the following criteria:

- The Member has a serious chronic systemic illness or other serious health condition, and without the additional service the member's life would be in danger, **or**
- The Member has a serious chronic illness or other serious health condition, and without the additional service the Member's health will get much worse, **or**
- The Member would need more costly services if the exception is not granted, **or**
- The member would have to go into a nursing home or institution if the exception is not granted

Program Exception Request

Program exceptions will be reviewed based on DHS definition of medical necessity and HPP's approved medical necessity criteria.

Examples of program exceptions include but are not limited to:

- Requests to exceed limits for items or services that are on the fee schedule if the limits are not based in statute or regulation.
- Requests for items or services that are not on the fee schedule but are within the scope of an existing benefit.
- Requests for items or services that are not on the fee schedule but are outside the scope of an existing benefit.

Experimental and Investigational

- Experimental and investigational services (e.g., devices, drugs, procedures, supplies, technologies, treatments) are services whose safety or efficacy is not known or are services that are used in a way that departs from generally accepted standards of practice in the medical community.
- Services determined by HPP to be investigational, experimental, cosmetic or not medically necessary are excluded from coverage for all lines of business.

QUESTIONS?

Thank you for your participation!

Health Partners Plans HPP