

NHP/NHIC-Grievance Resolution Policy and Procedure for Network PlatinumPlus

Abstract/Purpose:

To define the Network Health Plan/Network Health Insurance Corporation's grievance process for Network PlatinumPlus members.

I. POLICY:

All verbal or written grievances received at Network Health Plan/Network Health Insurance Corporation (NHIC) will be investigated and resolved in a consistent and timely manner, in accordance with the guidelines outlined in Section 42 of The Code of Federal Regulations, §422.564, (Grievance Procedures). The grievance process meets all Centers for Medicare and Medicaid Services (CMS) guidelines and National Committee of Quality Assurance (NCQA) standards. An expedited process will be implemented whenever a grievance has been determined to be of an urgent clinical nature. All grievances will be monitored, tracked and trended in a central database maintained by the Customer Service Department and reported at least quarterly to the Quality Improvement Committees and/or Service Subcommittee. A grievance may be made by or on behalf of our member.

II. APPLICABLE DEFINITIONS:

Authorized Representative:

Any individual authorized by an enrollee, or a surrogate who is acting in accordance with state law on behalf of the enrollee, in order to obtain an organization determination or deal with any level of the appeals process. Representatives are subject to the rules described in 20 CFR Part 404, Subpart R.

Appointment of Representative Form:

Documentation of authorization of an appointed representative to grieve on behalf of the member, may be in the form of a signed written authorization, or through legal documentation such as court ordered guardian, durable power of attorney, or healthcare power of attorney.

Centers for Medicare and Medicaid Services (CMS):

CMS is a Federal agency within the U.S. Department of Health and Human Services. Programs for which CMS is responsible include Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), HIPAA, and CLIA.

Central Complaint Area (CCA):

Customer Service Department

Complaint:

Any expression of dissatisfaction to an organization, provider, facility or Quality

Improvement Organization (QIO) by an enrollee made orally or in writing. This can include concerns about the operations of providers, insurers, or organizations such as: waiting times, the demeanor of health care personnel, the adequacy of facilities, the respect paid to enrollees, the claims regarding the right of the enrollee to receive services or receive payment for services previously rendered. It also includes the organizations' refusal to provide services the enrollee believes he or she is entitled. A complaint could be either a grievance or an appeal, or a single complaint could include both. Every complaint must be handled under the appropriate grievance or appeal process.

Complainant:

The member or an authorized representative appointed by the member to act on his or her behalf.

Department of Insurance Inquiry (DOI):

A request from the state Department of Insurance for information concerning an inquiry, Grievance or Appeal filed by or on behalf of a member through the Office of the Commissioner of Insurance (OCI) state regulatory agency.

Grievance:

Any complaint or dispute, other than one involving an organization determination, expressing dissatisfaction with the manner in which an organization or delegated entity provides health care services, regardless of whether any remedial action can be taken. An enrollee may make the complaint or dispute, either orally or in writing, to an organization, provider, or facility. A grievance may also include a complaint that an organization refused to expedite an organization determination or reconsideration, or invoked an extension to an organization determination or reconsideration time frames. In addition, grievances may include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided health service, procedure, or item. Grievance issues may also include complaints that a covered health service procedure or item during a course of treatment did not meet accepted standards for delivery of health care.

Inquiry:

Any oral or written request to an organization, provider, or facility, without an expression of dissatisfaction, e.g., a request for information or action by an enrollee.

Member:

An eligible individual who has elected the Network Platinum*Plus* plan offered by an NHIC.

Member Advocate:

The Plan Representative responsible for handling and investigation of all grievances, appeals and expedited appeals in the Appeals and Grievance Department.

Office of the Commissioner of Insurance (OCI):

Organization that ensures that the insurance industry responsibly and adequately meets the insurance needs of Wisconsin citizens. OCI's Mission is to lead the way in informing and protecting the public and responding to its insurance needs. OCI protects insurance consumers and ensures a competitive insurance environment.

Plan Representative:

NHIC Representatives who are trained and experienced in addressing member's grievances and appeals. This includes the Customer Service Representatives who are assigned to answer member telephone calls placed to the Customer Service Department as well as departmental Managers, Member Advocates, Quality Coordinators, or other designated employees of NHIC. In order to better service NHIC members, employees in each department who have member interaction are trained to receive member inquiries and grievances in order to allow response to occur in a timely manner.

Quality of Care Issue:

Any oral or written expression of dissatisfaction with quality of care, service or access.

III. **PROCESS:**

A. **TIME FRAME FOR PROCESSING GRIEVANCES**

The Member Advocate is responsible for processing, investigating and responding to grievances within forty-five (45) calendar days of receipt of member/complainant's complaint.

B. **RECEIPT AND CASE ASSIGNMENT**

1. A Plan Representative receives an oral or written grievance. All written grievances must be date stamp, even if received by a plan representative. The Plan representative will complete a Complaint and Appeal Form (COAF) and forward it to the Appeals and Grievance Department.
2. A Member Advocate will verify date stamp, log all grievances in the Appeals and Grievance database, assign a case number and assign a Member Advocate.

C. **GRIEVANCE INVESTIGATION**

An acknowledgement letter will be sent to the member/complainant with five (5) business days advising them that the plan has received the grievance (see documents #NPP-AG14-12/04 and NPP-AG18-12/04). However, if the grievance is resolved within (5) business days, no

acknowledgment letter is sent. The member/complainant will receive a grievance closure letter (see document #NPP-AG16-12/04).

1. The Member Advocate assigned to the case will check the grievance to determine that it is either from the member or from a properly appointed representative of the member. If the appeal is not written by the member or authorized representative, the Member Advocate will send written notification to the unauthorized representative that NHIC cannot consider the request, without written documentation of the representative's legal right to represent the member (see document #AG04-AOR-12/04). The written notification will include an Appointment of Representative (AOR) form so that appropriate authorization may be obtained (see document #NPP-AG03-12/04).
2. The Advocate conducts a thorough investigation ensuring that each issue listed is researched (or any other issue identified during his/her review).
3. If the Member Advocate determines there is a clinical urgency or a quality of care issue or if the grievance pertains to clinical care or access, the Member Advocate will forward the case file to the Quality Improvement Department for the investigation process.
 - a. The QI Department will investigate the grievance and notify the Advocate when the investigation is completed. The Advocate will document the completion of the investigation in the Grievance and Appeals Database, and continue with the final response and case closure.
4. If the case must be extended beyond 45 calendar days, the Advocate will send written notification to the member/representative of the delay (see document# NPP-AG17-12/04)
5. The Advocate will document the substance of the grievance, all steps taken in the investigation (i.e. medical records request) and the final response will be documented in the Appeals and Grievance Database.

D. FINAL RESPONSE TO THE MEMBER/COMPLAINANT

When the Member Advocate has received all pertinent information to resolve the issue, a draft closure letter is prepared and forwarded to the Customer Service Manager for their review.

1. All closure letters will be carefully checked for content, spelling and grammar to ensure that Network Health Plan/Network Health Insurance Corporation's communication is clear, concise, accurate, and at an appropriate level of understanding.
2. Copies of closure letters involving all Quality of Service complaints against a contracted Network Health Plan/Network Health Insurance Corporation provider will be forwarded to the appropriate parties involved (i.e. practice manager, providers or facility) for review, tracking and trending.
3. The member will receive a written response including the disposition of the grievance within 45 calendar days (see document #NPP-AG16-12/04 and #NPP-AG19-12/04).

NOTE: In cases where the member/complainant has received billing statements from a provider's office where the Member Advocate has determined through research that there is no member liability other than the member's copayment, and where the Member Advocate has obtained either written or verbal proof from the provider that the appropriate adjustment has been made to the member's account, the Advocate will draft a closure letter notifying the member of the outcome and follow-up with the provider to ensure the member's account is clear.

4. Upon closure, if applicable the Member Advocate will telephone the member/complainant to advise of the outcome and address any questions or concerns.

E. CLOSURE OF CASE

1. The closure date and resolution are entered into the appropriate data bases and documented on the COAF form.
2. Complete Grievance checklist.
3. Print and file database call logs in the case file.
4. The completed file is retained in the Appeals & Grievances Department for future reference. Files may be destroyed after seven (7) years.

F. ISSUE TRACKING AND TRENDING PURPOSES

To ensure that problem areas are identified, shared among other Network Health Plan/Network Health Insurance Corporation Departments and

resolved at the root cause by Network Health Plan/Network Health Insurance Corporation, the Medicare Appeals and Grievances Manager reports trended issues identified within the Department through the following channels:

- Quality Management Committee
- Director of Medicare Compliance

IV. **DEPARTMENT OF INSURANCE INQUIRY (DOI or OCI)**

All Department of Insurance Inquiries (DOI) should be forwarded directly to the Member Advocate. The Advocate will date stamp the DOI, initiate a COAF, and log the substance of the DOI into the Appeals and Grievance Database and call log.

A. **DOI (OCI) Process**

0. The Member Advocate is responsible for reviewing and investigating all issues that relate to the inquiry. When or where appropriate, corrective action should be taken.
1. Within ten (10) calendar days, the Member Advocate must contact the member. Within twenty (20) calendar days the Member Advocate must complete the investigation and prepare a written response to the member and to the OCI.

NOTE: If the Member Advocate determines that the grievance should be classified as an appeal, the case will be processed according to the Appeals Process.

2. The Member Advocate will update the appropriate databases with the final determination and will file the completed inquiry in a locked filing cabinet, retained in the Customer Service Department.

B. **TRACKING AND TRENDING PURPOSES:**

0. Grievance and Appeal tracking and trending database will be maintained by the Customer Service Manager.
 - . Information regarding tracking grievances and appeals will include, but is not limited to, primary codes, secondary call type codes and severity level codes (Attachment C), compliance to resolution time frames set forth in this policy, benefit interpretations and contract language; members, employers group, product, providers, etc.

- a. The Customer Service Manager will prepare trending reports and analysis regarding the types and volume of grievances and appeals.
1. Tracking and trending reports will be submitted to the Quality Management Committee and the Service Sub Committee on a quarterly basis.