Policy

Policy Title:	Grievances and Appeals				
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____Brandie Lyday _____ _____11/15/2022_____
Approved by: Date Approved:

Overview

Description: True Heart Therapy (THT) recognizes that conflicts and misunderstandings may occur between members and THT about services and treatment priorities. THT values effective problem solving and dispute resolution at all levels. It is THT's goal to encourage members to express their concerns or dissatisfaction, and to create a respectful process that enables all parties to seek satisfactory resolution. The THT Executive Director reviews Appeals and Formal Complaints received from members to identify ways to improve the quality of services and the members' experience. Members have the right to exercise any of their rights related to the complaint, grievance and appeals process without fear of retaliation.

This policy identifies the responsibilities of THT with respect to Notices of Action/Adverse Benefit Determinations, Appeals, Formal Complaints, and OHA Contested Case Hearings for all THT behavioral health clients.

Policy

All individuals receiving services from THT have the right to receive medically necessary services and the right to file a complaint, or to appeal an action/adverse benefit determination. Additionally, with the written consent of the member, the member representative of a member may submit a complaint or appeal on behalf of the member. Members will be informed of their rights to initiate a complaint and to appeal decisions relating to their care. Complaints, grievances, and appeals will be submitted to the THT Executive Director for review.

Definitions

Adjudication: The act of a court or entity in authority when issuing an order, judgment, or decree, as in a final MCE claims decision or the Authority issuing a final hearings decision. This function is non-delegable under the Coordinated Care contracts in the context of hearings and appeals.

Adverse Benefit Determination: Any of the following, consistent with 42 CFR § 438.400(b):

a. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;

b. The reduction, suspension, or termination of a previously authorized service;

c. The denial, in whole or in part, of payment for a service;

d. The failure to provide services in a timely manner pursuant to 410-141-3515;

e. The MCE's failure to act within the timeframes provided in these rules regarding the standard resolution of grievances and appeals;

f. For a resident of a rural area with only one MCE, the denial of a member's request to exercise their legal right, under 42 CFR 438.52(b)(2)(ii), to obtain services outside the network; or

g. The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

See OAR 410-141-3875; 3885 for a member enrolled in an MCE.

Appeal: A review by an MCE, pursuant to OAR 410-141-3890, of an adverse benefit determination.

Business Day: Any day except Saturday, Sunday, or a legal holiday. The word "day" not qualified as business day means calendar day.

Expedited Appeal: When the member or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function as set forth in 410-120-1860. (410-141-3895)

Expedited Contested Case Hearing: A member or provider who believes that taking the time for a standard resolution of a request for a contested case hearing could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function may request an expedited contested case hearing. (410-141-3905)

Grievance: An expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. (OAR 410-120-0000(100)). A formal complaint submitted to a provider verbally, or in writing, by an individual, or the individual's representative, pertaining to the denial or delivery of services and supports. (OAR 309-019-0105).

Grievance System: The overall system that includes:

a. Grievances to an MCE on matters other than adverse benefit determinations;

b. Appeals to an MCE on adverse benefit determinations; and

c. Contested case hearings through the Authority on actions and other matters for which the member is given the right to a hearing by rule or statute.

Health Care Professionals: Individuals with current and appropriate licensure, certification, or accreditation in a medical, mental health, or dental profession who provide health services, assessments, and screenings for clients within their scope of practice, licensure, or certification. (410-120-0000(102))

Member: an OHP client enrolled with a Managed Care Entity (MCE).

Member Representative: An individual who can make OHP-related decisions for a member who is not able to make such decisions themselves.

Non-participating Provider: A provider that does not have a contractual relationship with an MCE and is not on their panel of providers.

Participating Provider: A provider that has a contractual relationship with an MCE and is on their panel of providers.

Provider: An individual, facility, institution, corporate entity, or other organization that supplies health services or items, also termed a rendering provider, or bills, obligates, and receives reimbursement on behalf of a rendering provider of services, also termed a billing provider (BP). The term provider refers to both rendering providers and BP unless otherwise specified. (410-120-0000(204))

Service Authorization Request: A Member's initial or continuing request for the provision of a service including member requests made by their provider or the member's authorized representative.

Procedures

Complaints and Grievances

1. Members or member representatives may file a complaint by providing a written description of the alleged offense. A THT Feedback Form is available but not required. The member or member representative may request assistance from THT staff to complete the paperwork and may file orally if their disability impairs their ability to file a written complaint. The complaint or grievance should contain as much information as possible concerning the alleged offense including:

a. Name and address of the person filing the compliant;

b. Name and address where the alleged offense took place;

c. A description, including the date, of the offense; and

d. A desired remedy.

2. Members filing a complaint should be encouraged to complete the Oregon Health Plan Complaint Form, OHP 3001.

3. For standard resolution of a grievance, the THT Executive Director shall resolve each grievance and provide notice of the disposition as expeditiously as the member's health condition requires. The THT Executive Director shall:

a. Within five (5) business days from the date of the Executive Director's receipt of the grievance, notify the member in their preferred language that a decision on the grievance has been made and what that decisions is; or

b. Promptly, but in no event more than five (5) business days after the date of the MCE's receipt of the grievance, notify the member in their preferred language that there shall be a delay in THT's decision of up to 30 days from the date on which the grievance was received by the Executive Director. The written notice shall specify why the additional time is necessary.

4. All individuals who make decisions on grievances will follow all requirements in OAR 410-141-3875 MCE Grievance and Appeals System General Requirements.

5. When informing members of THT's decision, the Executive Director:

a. May provide its decision related to oral grievances orally, but shall also, in all instances, respond to oral grievances in writing. Both oral and written responses shall be made in the member's preferred language;

b. Shall address each aspect of the grievance and explain the reason for the decision;

c. Shall respond in writing to written grievances in the member's preferred language. In addition to written responses, THT may also respond orally in the member's preferred language; and;

d. Shall notify members who are dissatisfied with the disposition of a grievance that they may present their grievance to the Department of Human Services (Department) Client Services Unit or the Authority's Ombudsperson.

6. Following resolution of the complaint, the complaint representative will:

a. Send a complaint resolution letter to the complainant using the Grievance Resolution Letter Member template found on THT's Google shared drive.

b. Create a resolution letter including the following information:

i. Specifically address each aspect of the grievance;

ii. Explain the reason(s) for the decision(s);

iii. Instruct the complainant that if dissatisfied with the decision about their grievance they may contact:

1. The Department of Human Services Client Services Unit or the Oregon Health Authority's Ombudsman at: 1-800-273-0557;

2. Disability Rights of Oregon at: 1-800-452-1694.

5. The complaints and the response/resolution letters will be reviewed quarterly by the Executive Director to evaluate and monitor patterns of complaints.

6. The Executive Director will log the complaint and resolution in the Complaint Log.

7. Health Share of Oregon CCO member complaints are sent to Health Share of Oregon CCO on a quarterly basis.

Appeals

Appeals shall be directed to the Executive Director to respond according to procedures outlined in Health Share of Oregon CCO compliant process documents.

Expedited Grievances and Appeals

In circumstances where the matter of the grievance is likely to cause harm to the individual before the grievance procedures outlined in these policies are completed, the member, or member representative, may request an expedited review.

1. Staff and consulting experts making decisions on expedited grievances shall be a health care professional with appropriate clinical expertise in treating the member's condition, if the grievance involves clinical issues.

2. The program administrator shall review and respond in writing to the grievance "as expeditiously as the member's health condition requires", but not to exceed 48 hours of receipt of the grievance. The written response shall include information about the appeal process. (OAR 309-019-0215)

3. The agency complaint representative must review the expedited grievance and/or appeal for an OHP member within 72 hours of receipt of the grievance, and shall: (OAR 410-141-3895)

   a. Inform the member of the limited time available for receipt of materials or documentation for the review;

   b. Make reasonable efforts to call the member and the provider to tell them of the resolution within 72 hours after receiving the request; and

   c. Mail written confirmation of the resolution to the member within three days after receiving the request.

4. The complaint representative will notify the following individuals of all Expedited Grievances:

   a. THT Executive Director.

Client Feedback Forms

1. THT Feedback Forms are located at the Beaverton office and on the website.

2. Staff will log the feedback in the Compliment/Feedback spreadsheet located on Google share drive.

3. Feedback and survey results will be utilized for quality improvement recommendations.