CORPORATE POLICY & PROCEDURE

	Policy Name: Appeals and Hearings
Department: Clinical Engagement	Policy Number: CE20
Version: 11~~9~~	Creation Date: 7/9/2008
Revised Date: 8/14/18, 4/1/19, 7/23/19, 10/22/19, 7/24/20, 8/~~0~~6/20	Review Date:

Line of Business: ☐ All

☒ Umpqua Health Alliance	☐ Umpqua Health Management
☐ Umpqua Health - Newton Creek	☐ Physician eHealth Services
☐ UHA Community Activities	☐ Umpqua Health Network
☐ Professional Coding and Billing Services	☐ ACE Network

Signature:

Approved By: F. Douglas Carr, MD, Chief Medical Officer Date: 8/10/2020

POLICY STATEMENT

Umpqua Health Alliance (UHA) has internal grievance procedures under which members, or providers acting on their behalf, may challenge an adverse benefit determination. UHA shall maintain its policies in accordance with the Coordinated Care Organization (CCO) Contract between UHA and the Oregon Health Authority (OHA, Authority, or State), OAR 410-141-3875 through 410-141-3915, and 42 CFR §§ 438.400 through 438.424. This policy applies in conjunction with related policies for adverse benefit determinations, member grievances, and member services.

PURPOSE

To provide all members with an appropriate means to appeal an adverse benefit determination.

RESPONSIBILITY

Member Services
Clinical Engagement

DEFINITIONS

Adverse Benefit Determination (ABD): The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit; the reduction, suspension, or termination of a previously authorized service or the denial of payment for a service; failure to provide services in a timely manner, as defined by the State; the failure of UHA to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals; the denial of a member's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network if they are a resident of a rural area with only one managed care organization; and the denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

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Appeal: A request by a UHA member or a member's representative for UHA to review an adverse benefit determination.

Clinical Advisory Panel: A panel comprised of practicing doctors and other health care experts.

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 member's rights regardless of whether remedial action is requested. Grievances include the member's right to dispute an extension proposed by the CCO to make an authorization decision.

Grievance System: The overall system that includes grievances and appeals handled at UHA and access to the OHA administrative hearing process.

Individual Service Plan Team (for members with developmental disabilities), parent or legal guardian of a minor below the age of consent, a Department of Human Services (DHS) or OHA case manager or other DHS or OHA designee. For members in the care or custody of DHS Children, Adults, and Families (CAF) or Oregon Youth Association (OYA), the member representative is DHS or OYA. For members placed by DHS through a Voluntary Child Placement Agreement (SCF form 499), the member representative is his or her parent or legal guardian. For the purpose of this policy, references to "member" may also include "member representatives." This may also include the legal representative of a deceased member's estate.

Member Representative: A person who can make OHP related decisions for a member who lacks the ability to make and communicate health care decisions to health care providers, including communication through persons familiar with the principal's manner of communicating if those persons are available. A member representative may be, in the following order of priority, a person who is designated as the member's health care representative as defined in ORS 127.505(13) (including an attorney-in-fact or a court-appointed guardian), a spouse, or other family member as designated by the member, a provider.

Timely Filing (as it applies to continuation of benefits): Means filing no later than the 10th day following the adverse benefit determination (ABD) or the notice of appeal resolution, or by the effective date of the proposed adverse benefit determination.

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PROCEDURES

Appeals

1. If a member disagrees with an ABD, they may file an appeal. UHA provides members with written information regarding the appeal and hearing process:
    a. Upon initial enrollment to OHP via the Client Handbook;
    b. Upon initial enrollment to UHA via the Member Handbook (see also policy MS3-Member Rights);
    c. Upon denial of a request for service;
    d. Upon discontinuance of a previously authorized service; and
    e. At any time upon request.
2. UHA will provide members with oral information regarding the appeal process upon request, or when a member or representative expresses concern or dissatisfaction.
3. If a member expresses that they need assistance in filling out any forms, requests a notice in a different language or format (e.g. auxiliary aids), or would like a qualified or certified interpreter, they may contact UHA Member Services for assistance by going to the office, calling the standard phone number, or by using the TTY or TTY toll free phone number; all contact information is posted on UHA's public website (MS5 – Requests for Interpreter or Alternative Format).
4. A member, a subcontractor or a provider with the member's written consent who disagrees with an ABD or is contesting the failure of UHA to act within the timeframes provided in 42 CFR § 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals may file an appeal with UHA. If a provider filed an appeal on behalf of a member, the provider may subsequently request a contested case hearing on behalf of the member in accordance with the procedures in OAR 410-141-3900.
5. UHA has one level of appeal for members, and members shall complete the appeals process with UHA prior to requesting a contested case hearing.
    a. UHA will acknowledge the receipt of an appeal to the member in writing for standard resolutions within five (5) business days of receipt.
    b. Expedited appeals are acknowledged orally and in writing within one (1) business day of receipt.
6. UHA resolves standard appeals and provides written notice of the disposition, as expeditiously as the member's heath condition requires, but is not longer than 16 days from the day UHA receives the appeal:
    a. If UHA fails to adhere to the notice and timing requirements in 42 CFR § 438.408, the member is considered to have exhausted UHA's appeals process. In this case, the member may initiate a contested case hearing;
    b. UHA may extend the timeframes by up to 14 days if:

i. The member requests the extension; or
ii. UHA shows to the satisfaction of the Authority, upon its request, that there is need for additional information and how the delay is in the member's interest.

c. If UHA extends the timeframes, but not at the request of the member, it shall:
i. Make reasonable efforts to give the member prompt oral notice of the delay; and
ii. Within 2 days, give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if the member disagrees with that decision.
iii. Resolves the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.

7. For expedited resolution of an appeal, UHA will complete the review in a timeframe that is no longer than 72 hours after receipt 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 OAR 410-141-3895.
   a. The review timeframe for an expedited review may be extended by up to 14 days if:
      i. The member requests the extension; or
      ii. UHA shows (to the satisfaction of the Authority upon its request) that there is need for additional information and how the delay is in the member's interest.
8. If UHA extends the expedited timeframes not at the request of the member or denies a request for an expedited appeal, then it will:
   a. Make reasonable efforts to give the member prompt oral notice of the delay;
   b. Within two (2) calendar days, give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision; and
   c. Transfer the appeal to the timeframe for standard resolution in accordance with OAR 410-120-1860.
9. All appeals that are granted extensions are resolved no later than the expiration date of the extension.
   a. If UHA approves a request for expedited appeal but denies the services or items requested in the expedited appeal, UHA will:
      i. Inform member of their right to request an expedited contested case hearing and send the member a Notice of Appeal Resolution (NOAR), Hearing Request and Information form as outlined in OAR 410-141-

3890.

10. The ABD notices and Appeal and Hearing Request form (OHP 3302) provides information on member's rights and the process for appealing:
    a. If after filing an oral appeal, a member or the provider on the member's behalf does not submit a written appeal request within the appeal timeframe, the appeal shall expire;
    b. UHA shall ensure the member is informed that they must file in writing unless the individual filing the appeal requests expedited resolution;
    c. UHA does not need to notify the member if it has already made attempts to assist the member in filling out the necessary forms to file a written appeal.
    d. The date of an oral appeal request will be treated as the received or filing date.
11. UHA, its subcontractors, and its participating providers may not:
    a. Discourage a member from using any aspect of the grievance, appeal, or hearing process or take punitive action against a provider who requests an expedited resolution or supports a member's appeal;
    b. Encourage the withdrawal of a grievance, appeal, or hearing request already filed; or
    c. Use the filing or resolution of a grievance, appeal, or hearing request as a reason to retaliate against a member or to request member disenrollment.
12. A member, their representative, legal representative of a deceased member's estate, or the provider on the member's behalf may request an appeal either orally or in writing directly to UHA for any notice or failure to act within the timeframes provided in 42 CFR § 438.408(b)(1) and (2) regarding the standard resolution of appeals by UHA:
    a. UHA shall ensure oral requests for appeal of a notice are treated as appeals to establish the earliest possible filing date, and unless the member requests an expedited resolution, the member shall follow an oral filing with a written, signed, and dated appeal;
    b. The member shall file the appeal with UHA no later than 60 days from the date on the notice.
13. UHA will ensure members that all information concerning a member's grievance or appeal will be kept confidential.
    a. UHA and any practitioner whose services, items, quality of care, authorization, treatment, or request for payment is alleged to be involved in the grievance or appeal, have a right to use this information for purposes of UHA resolving the grievance or appeal, for purposes of maintaining the appropriate logs, and for health oversight purposes by OHP, without a signed release from the member.
    b. If UHA must release any information related to the grievance or appeal to any other person or party, UHA will ask the member to sign an authorization to

release information prior to disclosing such information. UHA's investigation may be restricted and information will not be released without a signed authorization.

14. UHA ensures that the UHA staff or consulting experts, or any individuals who make decisions on appeals follow all requirements in OAR 410-141-3875 MCE Grievance and Appeals System General Requirements:
    a. Ensure staff and any consulting experts making decisions on the appeal are: Not receiving incentivized compensation for utilization management activities by ensuring that individuals or entities who conduct utilization management activities are not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member;
    b. Decision makers on grievances and appeals of adverse benefit determinations take into account all comments, documents, records, and other information submitted by the member or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination;
    c. Not involved in any previous level of review or decision making nor a subordinate of such individual;
    d. Health care professionals with appropriate clinical expertise in treating the member's condition or disease, if the grievance is based on lack of medical necessity, is regarding the denial of expedited resolution of an appeal, and/or involves clinical issues
15. The Appeal & Grievance Coordinator is responsible for receiving, processing, directing, and responding to appeals. Upon receipt of the appeal, the coordinator:
    a. Obtains documentation of all relevant facts concerning the issues, including taking into account all comments, documents, records, and other information submitted by the member or their representative.
    b. Investigates and resolves as expeditiously as the member's health condition requires and within the timeframes stated above for standard and expedited appeals.
    c. Provides members a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments.
    d. Informs members of the limited time available to present evidence and testimony, in person and in writing, and make legal and factual arguments in the case of an expedited appeal resolution. UHA informs members of this sufficiently in advance of the resolution timeframe for appeals.
16. UHA must continue the member's benefits while an appeal is in process if all the criteria

is met in the Continuation of Benefits section of this policy below.

17. UHA will provide members a copy of their case file (including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by UHA (or at the direction of UHA) in connection with the appeal of the adverse benefit determination. UHA provides the case file free of charge and sufficiently in advance of the resolution timeframe for standard and expedited appeal resolutions.
18. The member will be notified in writing with a notice of appeal resolution consistent with the notice requirements of 42 CFR § 438.404 and OAR 410-141-3885, and the Authority's formatting and readability standards in OAR 410-141-3585, 42 CFR §§ 438.408, and 438.10. UHA will also make reasonable effort to provide the member with oral notice of the resolution. This includes but is not limited to the following content and format:
    i. The results of the appeal resolution.
    ii. The date of the appeal resolution.
    iii. Written in language sufficiently clear that a layperson could understand the notice and make an informed decision (about appealing and following the process for requesting a hearing if applicable).
    iv. The process for requesting a hearing if applicable:
        1. The rules that govern representation at a hearing.
        2. The right to have an attorney or member representative present, and the availability of free legal help through Legal Aid Services and Oregon Law Center, including the telephone number of the Public Benefits Hotline 1-800-520-5292, TTY711.
19. If the original ABD is upheld wholly or partially, a NOAR notice is also mailed with the Appeal and Hearing Request Form (OHP 3302) explaining that they may file a hearing within 120 calendar days of the date of the notice of appeal resolution.
    a. The NOAR will include the results of the resolution and the date it was completed.
    b. The reasons for the resolution and a reference to the particular sections of the statutes and rules involved for each reason identified in the NOAR relied upon to deny the appeal.
    c. The right to request that benefits/services continue while the hearing is pending and how to do so.
    d. That the member may be hled liable for the cost of these benefits if the hearing decisions upholds the ABD.
20. A request for an OHA administrative hearing made without previous use of the appeal procedures may be forwarded to UHA to review as an appeal prior to the hearing.

a. If UHA had reinstated or continued the 's benefits pending the appeal, the benefits must be continued pending an administrative hearing.
b. If a portion of the request was overturned, UHA would also indicate in the notice details of those services that had a favorable outcome.

21. If the original ABD is overturned, UHA will issue a notice of appeal resolution within the required timeframes and must authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires, but no later than 72 hours from the date of notice reversing the determination. UHA must promptly correct the ABD taken up to the limit of the original request or authorization.
22. In the case that UHA fails to adhere to notice and timing requirements, the member is deemed to have exhausted the appeals process and may initiate a hearing.
23. The Appeal and Hearing Request Form (OHP 3302) is available on the OHA website, at Member Services, UHA's Clinical Engagement Office, and can be mailed to the member upon request.
24. UHA's participating providers are provided information about the Grievance System at the time they enter into a contract with UHA via provider orientation and training (PN6 – Provider Orientation & Training). This information is also available on the UHA website under the Provider Handbook section.
25. If a member expresses that they need assistance in filling out any forms, requests a notice in a different language or format (e.g. auxiliary aids), or would like a qualified or certified interpreter, they may contact UHA Member Services for assistance by going to the office, calling the standard phone number, or by using the TTY or TTY toll free phone number; all contact information is posted on UHA's public website (MS5 – Requests for Interpreter or Alternative Format).
26. Upon request UHA will provide members with a copy of their case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by UHA (or at the direction of UHA) in connection with the appeal of the adverse benefit determination. This information is provided free of charge and sufficiently in advance of the resolution timeframe for appeals as specified in 42 CFR §438.408 (b) and (c).
27. All appeals shall be documented in writing on the quarterly report log and an appeal chart must be created. The quarterly report log is submitted to the State as part of the State quality strategy. Categories and service types are applied consistent with Exhibit I of the CCO Contract deliverables.
28. Appeal trends may be reported to the Clinical Advisory Panel (CAP).

Continuation of Benefits

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1. A member who may be entitled to continuing benefits may request and receive continuing benefits in the same manner and same amount as previously authorized while an appeal or hearing is pending.
2. Timely filing means filing on or before the later of the following:
    a. Within ten (10) days after the date of the ABD; or
    b. The intended effective date of the action proposed by the ABD.
3. UHA will continue the member's benefits if all of the following apply:
    a. The member or member's representative timely files the appeal or hearing request.
    b. The appeal or hearing request involves the termination, suspension, or reduction of previously authorized services.
    c. An authorized provider ordered the services.
    d. The period covered by the original authorization has not expired.
    e. The member timely files for continuation of benefits (requests an appeal within 60 days).
4. The duration of continued benefits pending an appeal resolution or contested case hearing if at the member's request will continue until one of the following occurs:
    a. The member does not request a contested case hearing and continuation of benefits within 10 days from when UHA mails the NOAR.
    b. A final order resolves the contested case.
    c. The member withdraws the appeal or contested case hearing request.
5. If the final resolution of the appeal or hearing upholds UHA's ABD, UHA may recover from the member the cost of the services furnished to the member while the appeal or hearing was pending (see CCO Contract Exhibit I, section 6).

Administrative Hearings

1. A member may request a contested case hearing with the Authority after receiving notice that UHA notice of ABD is upheld or, in the case of UHA failing to adhere to the notice and timing requirements in 42 CFR § 438.408, the Authority may consider that the member has exhausted the appeals process and may initiate a contested case hearing.
2. If the member files a request for an appeal or hearing with the Authority prior to the member filing with UHA, the Authority shall transfer the request to UHA and provide notice of the transfer to the member.
3. OHA must receive the member's hearing request within 120 days of the date shown on the Notice of Appeal Resolution.
4. If the member requested that UHA continue or reinstate services while the appeal was pending, benefits must be continued pending the administrative hearing until one of the following:

a. The member withdraws the administrative hearing request;
b. 10 calendar days have passed after UHA notice of appeal resolution was issued and the member failed to request continuation of benefits;
c. A final order is issued to a member with an adverse resolution to that member; or
d. The time period or service limits of a previously authorized service have been met.

5. OHA will review the administrative hearing request and verify that the member was a UHA member at the time the ABD was taken and whether the hearing request was timely.
    a. Should UHA receive the administrative hearing request, UHA shall transmit that request to OHA including a copy of the member's ABD or notice of appeal resolution, as applicable, immediately.
6. Once OHA receives a valid administrative hearing request they will send a copy of the hearing request to UHA.
7. UHA shall cooperate with providing relevant information required for the hearing process to OHA on all administrative hearings within two (2) business days. This includes expedited hearings.
    a. An administrative notice of all documentation UHA relied upon to make its initial and appeal decisions.
    b. Copies of hearing requests, ABD, and NOAR.
8. If the hearing request is received by UHA from the member, UHA will date stamp the request and forward the request to OHA, following procedure #7 above.
9. Information regarding the member used for administrative hearings is handled in confidence.
    a. OHA, the member, their representative or the legal representative of a deceased member's estate, UHA, and any practitioner whose authorization, treatment, services, items, or request for payment is involved in the administrative hearing have a right to use this information for purposes of resolving the administrative hearing without a signed release from the member.
    b. OHA may also use this information for health oversight purposes and for other purposes authorized or required by law.
    c. The information may also be disclosed to the Office of Administrative Hearings and the administrative law judge assigned to the administrative hearing and to the Court of Appeals if the UHA member seeks judicial review of the final order.
    d. OHA will ask the member to authorize a release of information regarding the administrative hearing to any other individual.
10. The hearing will be scheduled through the Office of Administrative Hearings. Parties to

the administrative hearing shall include UHA, the member, the member's representative or legal representative of a deceased member's estate and provider acting on behalf of a member, with written consent from the member.

11. 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.
12. The Authority shall issue a final order or the Authority shall resolve the case ordinarily within 90 days from the date UHA receives the member's request for appeal. This does not include the number of days the member took to subsequently file a contested case hearing request. The final order is the final decision of OHA.
13. For reversed appeal and hearing resolution services:
    a. For services not furnished while the appeal or hearing is pending. If UHA or the Administrative Law Judge reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, UHA shall authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination;
    b. For services furnished while the appeal or hearing is pending. If UHA or the Administrative Law Judge reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, UHA or the state shall pay for those services in accordance with the Authority policy and regulations.
14. Should the administrative hearing decision uphold UHA's adverse benefit determination, UHA may recover the cost of service furnished to the member while the hearing is pending pursuant to 42 CFR § 431.230(b), to the extent that they were furnished solely because of the requirements of Exhibit I, Section 6 of the CCO Contract.

Documentation and Quality Improvement

1. UHA will maintain records of all the member's grievances and appeals. The record will be accurately maintained in a manner accessible to the State and available upon request. The record of each member grievance or appeal must contain, at a minimum, all of the following information:
    a. The member's name and ID.
    b. The date the member filed the grievance or appeal.
    c. The date received.
    d. The NOABD.

e. If filed in writing, the appeal or grievance.
f. If filed orally, documentation that the grievance or appeal was received orally.
g. A general description of the reason for the appeal or grievance.
h. The date of each review or, if applicable, review meeting;
i. Records of the review or investigation at each level of the appeal, grievance, or contested case hearing.
j. Notice of resolution of the grievance or appeal, including the dates of resolution at each level.
k. Copies of correspondence with the member and all evidence, testimony, or additional documentation provided by the member, the member's representative, or the member's provider as part of the grievance, appeal, or contested case hearing process.
l. All written decisions and copies of all correspondence with all parties to the grievance, appeal, or contested case hearing.
m. Notations about appeals and grievances the member decides to resolve in another way if the MCE is aware of this.

2. UHA shall retain documentation of appeals for the term of 10 years to permit evaluation (CO23 – Record Retention & Destruction Policy).
3. Each appeal and grievance shall be documented in the appropriate log. The quarterly report and grievance log shall be consistent with OHA requirements of the Exhibit I of CCO Contract deliverable.
4. All written decisions and copies of all correspondence with all parties to the appeal. The grievance coordinator is responsible for monitoring both appeals and grievances for completeness, accuracy, and timeliness of documentation, compliance with policies and procedures, and compliance with Oregon Health Plan Rules.
5. All quarterly reports are reviewed by the CAP.
6. UHA annually reviews and updates its grievance systems policies and procedures and its member notifications. Written notification of updates to these procedures and timeframes within 5 business days after approval of such updates by OHA.

Subcontracted Entities

1. If UHA subcontracts the grievance and appeal (see also #4 below) process to a subcontractor, it must:
   a. Ensure the subcontractor meets the requirements consistent with this rule and OAR 410-141-3835 through 410-141-3915;
   b. Monitor the subcontractor's performance on an ongoing basis;
   c. Perform a formal compliance review at least once a year to assess performance, deficiencies, or areas for improvement; and

d. Ensure the subcontractor takes corrective action for any identified areas of deficiencies that need improvement.

2. Subcontractors must also comply with the following guidelines:
   a. Maintain a log according to the criteria specified by OHA and submit to UHA no later than 21 days after the end of each quarter.
   b. Notice of appeal resolutions will be sent by the subcontractors on UHA's behalf. Copies of notices issued will be submitted to UHA no later than 21 days after the end of each quarter.
3. For hearings, subcontractors will forward all documentation to OHA and UHA and coordinate schedules to be available as expert witness during the hearing process.

3.4. UHA shall not subcontract to a subcontractor or participating provider the adjudication of an appeal, in accordance with OAR 410-141-3875(14).

Department	Standard Operating Procedure Title	SOP Number	Effective Date	Version Number
Clinical Engagement	Appeals	SOP-CE20-1	7/24/19	1
Clinical Engagement	Hearings	SOP-CE20-2	7/24/19	1