

MDwise POLICY AND PROCEDURE			
TITLE: Marketplace Member Grievances			POLICY NO: MS M63
RESPONSIBLE DEPT: Member Services	DATE ISSUED: 08/08/13 DATE REVIEWED: 07/01/15 DATE REVIEWED:	DATE EFFECTIVE: 01/01/14 DATE EFFECTIVE: 08/01/15 DATE EFFECTIVE:	PAGE(s) including attachments: 9
Healthy Indiana Plan <input type="checkbox"/> Hoosier Healthwise <input type="checkbox"/> Hoosier Care Connect <input type="checkbox"/> Marketplace <input checked="" type="checkbox"/>			

PURPOSE:

This policy will ensure expeditious resolution of any member Grievance and to ensure that the procedure facilitates a thorough and consistent evaluation of the Grievance at issue.

POLICY:

The MDwise grievance system includes a grievance and appeal process as well as expedited and external review procedures and access to the Marketplace’s or Indiana Department of Insurance’s fair hearing system. Grievances and appeals are processed in accordance with IC 27-13-10, IC 27-13-10.1 and NCQA standards.

The MDwise grievance system is an integral part of the MDwise Quality Improvement (QI) Program. Grievances are recorded so MDwise may systematically and objectively evaluate, track, and trend member issues and take appropriate action (e.g. improvement opportunities). All grievance documentation is maintained for a period of three years after resolution.

Grievances may be submitted by the member or by a representative of the member’s choice, such as a family member, friend, guardian, or health care provider. This must be done within 60 days of the event or incident. MDwise acknowledges receipt of each grievance within 3 business days. MDwise notifies the member in writing within 20 business days (except if grievance is expedited), when the issue is resolved and informs them of their right to appeal an adverse decision if applicable.

Definitions

Grievances

Grievances are defined by MDwise as any dissatisfaction expressed by the member, or a representative on behalf of a member, about any matter other than an action, as defined below. This may include dissatisfaction related to the quality of care of services rendered or available, rudeness of a provider or employee, or the failure to respect member’s rights. Grievances are further defined as any dissatisfaction expressed by or on behalf of a member regarding the availability, delivery, appropriateness or quality of health care services and matters pertaining to the contractual relationship between a member and a MDwise individual contract holder for which the member has a reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of the dissatisfaction.

Appeal - An appeal is defined as an oral or written review of an action submitted by or on behalf of a member (including the member’s provider). An action as defined by MDwise is:

- Denial or limited authorization of a requested services, including the type or level of service
- Reduction, suspension or termination of a previously authorized service;

- Denial, in whole or in part, of payment for a service;
- Failure to provide services in a timely manner, as defined by NCQA;
- Failure of a Contractor to act within the required timeframes, or;
- The denial of a member's request to exercise his or her right to obtain services outside the tier one network or out of network entirely (if applicable).

Processing of Grievances

The MDwise Customer Services Department is responsible for the processing of grievances. All Grievances are thoroughly researched and documented, and as necessary, are referred for resolution beyond the Customer Service Department. If a delivery system receives a member Grievance directly (e.g. via provider on behalf of member), the delivery system must forward the Grievance to MDwise for processing. All member Grievances are acknowledged upon receipt, logged and tracked to ensure a timely response.

Grievances with the potential for impact on the quality of care or services provided are forwarded to the Quality Department for investigation and handling. These issues may include for example, member concern about office wait times, appointment access and availability, provider communication/attitude, quality of medical care or services provided, patient safety issues, utilization issues and facility adequacy.

MDwise provides that persons *not* involved in making the original decision resulting in the grievance shall review and render the grievance decision or resolution. This includes review by a subordinate of any person involved in the initial determination. Per MDwise standards, MDwise must ensure that a health care professional with clinical expertise in treating the member's condition or disease render the decision if the grievance involves a clinical issue or a denial of expedited resolution of an appeal

Member Assistance and Notification

At all levels of the grievance process, MDwise assists members in completing the necessary procedural steps. This includes providing interpretive services and hands on assistance through the toll-free MDwise customer service line. Members may file a grievance in writing or they may call MDwise customer service directly and a Customer Service Representative will assist the member in filing the grievance.

Members are provided with information on how to submit a grievance in the MDwise Member Policy, on the MDwise website, and in medical management determination letters sent to members when a service is denied.

In accordance with 760 IAC 1-59-7, MDwise also requires providers to post a brief statement of the member's right to file a grievance with MDwise, including the toll free telephone number, in each location where health care services are provided by or on behalf of MDwise. Provider orientation and the MDwise Provider Manual inform providers of the member grievance process and their rights during the review.

The MDwise grievance and appeal notification letters comply with NCQA language requirements. During the grievance process, MDwise allows the member the opportunity for representation by anyone he or she chooses, including a provider. MDwise informs members of these rights in all

communications about the grievance process and in all correspondence generated for a specific grievance.

Monitoring of Grievances

On a quarterly basis MDwise evaluates member Grievances according to frequency, type and trends over time to identify opportunities for improvement and assist in establishing priorities for internal quality improvement activities. These are reviewed by the applicable Operations Committee as well as by the Quality Management Team. Member Grievances regarding a specific provider are shared with the delivery systems for ongoing monitoring between credentialing cycles.

Response Timeframes

The MDwise grievance system includes a grievance and appeal process as well as expedited and external review procedures and access to both the Marketplace's and Indiana Department of Insurance's fair hearing system. Grievances and appeals are processed in accordance with IC 27-13-10 and IC 27-13-10.1, and NCQA standards.

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In the event of a clinically urgent grievance, MDwise makes every attempt to resolve the matter and notify the member as quickly as possible but no longer than 48 business hours of the request. These are considered "Expedited" grievances.