



POLICY - PROCEDURE

1799 - Member Grievance Policy - Procedure - IN Marketplace

Effective Date: 05/16/2024

Business Owner:	Acuna, Celeste	Approver:	Mayo, Faustino
Line of Business:	IN - Marketplace		
Department:	Grievance & Appeals	Policy Number:	1799

Purpose:

To outline the member grievance (complaint) process and how CareSource manages and processes them. The Grievance and Appeals Department will ensure all grievances (complaints) are processed in accordance with contractual, federal/state regulations, and accreditation standards.

Definitions:

Appeal - A review by the Plan of an adverse benefit determination.

Authorized Representative - An authorized individual who represents a Covered Person in an internal appeal or external review process of an adverse benefit determination and who is any one of the following:

1. A person to whom the member has given appropriate written consent to represent them in an internal appeals process or external review process of an adverse benefit determination.
2. A person authorized by law to provide substituted consent for the member.

Grievance - An expression of dissatisfaction with any aspect of CareSource, its providers, delegates/vendors, operations, provision of health care services, activities, or behaviors. Complaints are considered grievances.

Provider - A health care professional or a facility.

Member - An individual, including a Subscriber or Dependent, who is properly enrolled under the Plan.

Resolution - A final decision made by the Plan related to the grievance and communicated to the member.

Policy Statement:

It is the policy of CareSource to provide a grievance (complaint) system that allows members or their authorized representatives a forum for expressing grievances (complaints).

Process Steps:

For issues related to Adverse Benefit Determinations, the first course of action for members is to file a grievance.

Grievances can be filed at any time. There is no timely filing requirement for grievance submissions.

1. Members can submit a grievance to CareSource using the following methods:
 - A. In writing, by sending a letter to the following address:

CareSource Marketplace
Attn: Member Appeals
PO Box 1947
Dayton, OH 45401
 - B. By calling Member Services at 1-833-230-9284 (TTY 711); or
 - C. By arranging to meet with a CareSource representative in person.
2. During the member interaction, if the issue requires additional actions to be taken it is the Customer Advocate's responsibility to route all member grievances to the Grievance and Appeals Department.
3. The procedure to be followed to file a grievance request is also described in the CareSource Member Handbook and Explanation of Coverage. It includes CareSource's toll-free Member Services phone number, mailing address, and a copy of the optional form(s) that members may use to file a grievance with CareSource.
4. CareSource will acknowledge grievances submitted orally or in writing, within three (3) business days of receipt. The notice will contain the name, address and telephone number of the department designated to coordinate the review and will notify the member of their right to submit written material to the reviewer regarding the grievance.
5. Grievances related to quality of care issues will be forwarded to the Quality Improvement (QI) Department within one (1) business day for investigation and follow-up by qualified clinical personnel.
 - A. Note: All member-facing departments have been trained on Grievance identification and the appropriate process to communicate Member Grievances to the Customer

Advocacy Grievance Department. Such training includes process for submission of urgent Grievances to the QI Department.

6. CareSource will give members at no cost all reasonable assistance in filing a grievance, including but not limited to:
 - A. Explaining our process to be followed in resolving the grievance.
 - B. Completing forms and taking other procedural steps as outlined in this policy.
 - C. Providing oral interpreter and oral translation services, sign language assistance, and access to our grievance system through a toll-free number with text telephone yoke (TTY) and interpreter capability.
7. All grievances received by CareSource will be tracked and documented in a workflow system that will capture the substance of the grievance including the member's reason for filing the grievance, all actions taken related to the grievance including but not limited to the member's previous grievance history and follow-up activities associated with the grievance, and the findings of the investigation conducted to resolve the member's grievance.
8. Member requests for urgent/expedited grievances will be referred to a Clinical Appeals Nurse. The nurse will review the request within 24 hours to determine if it requires expedited processing. Expedited decisions are for situations when making the decision within the standard time frame could seriously jeopardize a member's life or health or ability to attain, maintain, or regain maximum function. If the member's request does not meet expedited criteria, the member's request will be treated as a standard request.
9. CareSource will investigate, resolve and notify the member of the disposition of their grievance in writing as quickly as possible, but no later than seventy-two (72) hours after receipt for clinically urgent cases and within fifteen (15) business days after receipt of an adverse benefit review grievance for standard requests and twenty (20) business days for non-adverse grievances. For clinically urgent cases, the member will also receive notification of the determination orally.
10. If unable to resolve a member grievance within the resolution period, CareSource will notify the member in writing of the reason for the delay before the end of the resolution period and will notify the member in writing within an additional ten (10) business days of the CareSource's resolution.
11. Individuals that make decisions on grievances are individuals who:
 - A. Are authorized by CareSource to require corrective action.
 - B. Were not involved in previous levels of review or decision-making.
 - C. If required, are healthcare professionals having appropriate clinical expertise treating the member's condition or disease if deciding any of the following:
 - i. A grievance regarding the denial of an expedited resolution of an appeal.
 - ii. A grievance involving clinical issues.

12. CareSource will issue a written decision in response to formal grievances that includes the following information:
 - A. The decision reached by CareSource
 - B. The reasons, policies and procedures that are the basis of the decision
 - C. Notice of the member's right to appeal the decision
 - D. The department, address, and telephone number through which a member may contact a CareSource qualified representative to obtain more information about the decision or the right to appeal.
13. In scenarios involving expedited resolution, an attempt will be made to notify the member of the resolution verbally.
14. If a member is dissatisfied with a grievance resolution, the Member may contact CareSource Customer Care to discuss their grievance. If the Member is unsatisfied with CareSource's decision regarding their grievance, the Member or the Member's Authorized Representative may submit an appeal, orally or in writing, within one hundred eighty (180) days of receiving notice of CareSource's decision. CareSource will acknowledge receipt of the member's appeal within three (3) business days after receiving the appeal request.
15. CareSource will not under any circumstances delegate the member grievance process to another entity.
16. CareSource ensures that no punitive or retaliatory action is taken against a member that files a grievance or appeal or a provider that supports a member's grievance.
17. CareSource will maintain records of all grievances including documentation regarding the resolution of Grievances for a period of ten (10) years.
18. The Grievance and Appeals Department will be responsible for the logging and reporting of grievances and assuring that the grievance system meets the requirements of the Department of Insurance.
19. CareSource will submit information regarding grievance activity as directed by the Department of Insurance.
20. All CareSource departments will ensure compliance with grievance guidelines and timeframes within their respective areas. They will also maintain departmental procedures for corrective action.

Appeal of a Grievance Resolution

1. Members have 180 days from receipt of the grievance resolution notice to file the appeal of a grievance resolution.
2. Members may file an appeal of a grievance resolution verbally or in writing.

3. CareSource will provide the following language services to members if requested during the appeal process:
 - A. Oral interpretation for any language.
 - B. Written translation in prevalent language as applicable.
 - C. Written alternative formats may be available as needed.
 - D. Assistance with accessing CareSource's interpretation and translation services as well as alternative formats.
4. CareSource will investigate the substance of the appeal, including all issues relevant to the appeal and document its findings.
5. CareSource will send an acknowledgement letter to the member within 3 business days after receiving the appeal of the grievance resolution.
6. The appeal of the grievance resolution will be reviewed by qualified individuals.
7. The qualified individuals will be made up of reviewers who did not participate in the initial matter that created the grievance nor involved with the initial investigation of the grievance.
8. The member will be sent a written resolution notice that includes a reference to the benefit provision, guideline, protocol, reasons, policies, procedures, evidence, documentation or other similar criteria on which the appeal decision was based;
9. Notification that the member can obtain, upon request, reasonable access to and copies of all documents, including a copy of the clinical criteria/guideline, as relevant to the appeal decision was based;
10. The notice must include the title of each reviewer for a benefit appeal or, for the medical necessity review, the title, qualifications (e.g., MD, DO, PhD) and specialty (e.g., pediatrician, general surgeon, neurologist, clinical psychologist) of each clinical reviewer and the title for each nonclinical reviewer. It must also specifically state that these individuals participated in the appeal review. Participant names do not need to be included in the written notification to members, but must be provided to members upon request; and
11. The department, address, and telephone number through which the member may contact a qualified representative to obtain more information about the resolution of the appeal, the procedures governing the appeal, and further remedies allowed by law.
12. For appeals, the organization will issue written notification of the decision to the member or the member's authorized representative that includes the following: (If the notice is sent electronically including e-mail or facsimile then an agreement must be signed in advance on receiving such notices electronically)
 - A. The decision reached;
 - B. Date of service or preservice request date
 - C. A statement of CareSource's understanding of the member's appeal;

- D. A description of the resolution reached by CareSource stated in clear terms and the contract basis or medical rationale for the resolution stated in sufficient detail for the member to respond further to CareSource's position and in a culturally and linguistically appropriate manner;
- E. Notice of the enrollee's right to further remedies allowed by law;
- F. A reference to the benefit provision, guideline, protocol, reasons, policies, procedures, evidence, documentation or other similar criteria on which the appeal decision was based;
- G. Notification that the member can obtain, upon request at no cost, reasonable access to and copies of all documents, including a copy of the clinical criteria/guideline, as relevant to the appeal decision was based;
- H. The department, address, and telephone number through which the member may contact a qualified representative to obtain more information about the resolution of the appeal, the procedures governing the appeal, and further remedies allowed by law.
- I. The member's 2nd level appeal rights to submit an external review request.

13. All grievances and appeals received by CareSource will be tracked in a workflow system that will document the substance of the appeal including the member's reason for appealing the previous decision, all actions taken including but not limited to the member's previous appeal history and follow-up activities associated with the appeal, and the findings of the investigation conducted to resolve the member's issue.

14. Standard appeals will be resolved within 45 business days for pre and post service denials and 72 hours for expedited appeals.

Mental Health Parity Addiction Equity Act

The Grievance and Appeals process does not scrutinize Mental Health and Substance Abuse (MH/SUD) benefits (Claims) any more than Medical and Surgical (M/S) claims/benefits and has a comparable process. CareSource will maintain compliance with the Mental Health Parity Addiction Equity Act (MHPAEA) within the Grievance and Appeals process to ensure that the standards are applied equally to both Medical/Surgical and Mental Health/Substance Use Disorder providers.

Related Citation(s):

URAC Core 35

CareSource Evidence of Coverage – Section 8

NCQA RR: 2 Element A

Record Retention Policy

IC §27-13-10-7: Resolution of Grievances

IC §27-8-28-16: Policies & Procedures for timely resolution of grievances

ME 7, Element B, Factors 1-5

Related Document(s):

1242 - Adverse Benefit Determination Appeals Policy - IN Marketplace

REVIEW/REVISION HISTORY	
Date	Description of changes
02/2024	<ul style="list-style-type: none">- Initial release- Annual review completed- Combined 1461 - Member Grievance Policy - IN Marketplace and 1461.01 - Member Grievance Procedure - IN Marketplace to create this Policy-Procedure. Upon publication of this Policy-Procedure, 1461 and 1461.01 will be archived.- Corrected formatting- Added definitions- Made grammatical changes- Process Step #9: Updated resolution timeframe for adverse benefit review grievances to 15 business days- Process Step #10: Updated wording for clarity and accuracy- Process Step #12: Added missing content- Updated Related Citation(s) section- Updated Related Document(s) section
05/2024	<ul style="list-style-type: none">- Process Step 7 - Added detailed content regarding the information included in the documentation of a grievance.- Added Appeal of a Grievance Resolution section to outline relevant timeframes and guidelines for processing and resolving the appeal of a grievance resolution- Updated the Related Citation(s) section