Fidelis Care New York

FIDELIS MEDICAID ADVANTAGE PLUS (FMAP)
GRIEVANCE, APPEALS, & ACTION PROCESS
(DRAFT)

EFFECTIVE DATE: 08-09

APPROVALS: _____

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Vice President, Marketing and Senior Programs

Director, MLTC Program

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Director, Member Services

POLICY:

Members as well as subcontracted providers of the Plan are able to file an expression of dissatisfaction i.e. a grievance orally or in writing without fear of reprisal. Plan shall provide to all members written notice of member rights and of the grievance and of the appeal procedures in the Member Handbook.

PURPOSE:

- To provide member with an opportunity to voice his/her opinion and concerns if any, and have a progressive process for complaint resolution.
- To provide a process for tracking, evaluating, monitoring and addressing client grievances and appeals, and reporting this information to the Plan's quality management committee, governing board, and to NYSDOH.
- To provide a method of collecting and gathering information that will enhance the Plan's ability to promote wellness, quality care and customer satisfaction.
- To ensure that each member understands his/her rights to file a grievance or appeal regarding any disputes with the Plan.
- To ensure that the plan resolves member grievances and appeals promptly.
- To ensure prompt and appropriate resolution to an member's grievance and appeal by identifying and implementing an effective way to investigate and respond to the grievance or appeal as well as ensure compliance with the Centers for Medicare and Medicaid Services (CMS) regulations and the State Department of Health guidelines for Medicaid. For those services covered under both Medicare and Medicaid, an member of the Medicaid Advantage Plus Program will have the option to file a grievance or appeal using the Medicare process or the Medicaid process.

RESOURCES:NYS Department of Health Contract; NYS PHL 4408 and Article 49; 42 CFR Part 438, 42 CFR 422 Subpart M and the Medicare Managed Care Manual; Medicaid Advantage Plus(FMAP) Member Handbook

RESPONSIBLE PARTIES:

RN Care Managers, Director of Clinical Services, Administrator, Medical Director.

DEFINITIONS:

Grievance: A grievance is any expression by a member or representative on member's behalf of dissatisfaction about the care or treatment received from the Plan's staff or providers of covered services that does not pertain to a change in scope, amount or duration of a service. A "Same Day Grievance" is a grievance that is resolved by the Plan immediately.

Grievance Appeal: A second review of the grievance, which occurs when the member expresses dissatisfaction with the Plan's determination at the grievance stage.

Action: When the Plan: denies or limits services requested by a member or provider; decides that a requested service is not a covered benefit; reduces, suspends, or terminates services already authorized; denies payment for services; doesn't provide timely services; doesn't make grievance or appeal determinations within the required timeframes. An action is subject to appeal.

Action Appeal: A review of the Plan's Action as may be requested by the member, representative, or service provider.

Expedited grievance, expedited grievance appeals, and expedited appeals: In situations where the member or provider requests, and the Plan determines, there may be a significant health risk, the Plan will employ this process to assure a resolution within a shortened timeframe.

Inquiry: means a written or verbal question or request for information posed to Fidelis Medicaid Advantage Plus with regard to such issues as benefits, contracts, and organization rules. Neither member complaints nor disagreements with Fidelis MAP determinations are Inquiries.

GRIEVANCE SYSTEM-GENERAL REQUIREMENTS

A. Fidelis shall describe its Grievance System in the Member Handbook, and it will be accessible to non-English speaking, visually, and hearing impaired Members. The handbook shall comply with The Member Handbook Guidelines as per the Medicaid Advantage Plus (FMAP) contract guidelines.

B. Fidelis Medicaid Advantage Plus will provide members with any reasonable assistance in completing forms and other procedural steps for filing a grievance, grievance appeals or action appeals including, but not limited to, providing interpreter services and toll-free numbers with TTY/TDD and interpreter capability.

C. The member may designate a representative to file grievances, grievance appeals

and action appeals on his/her behalf.

D. Fidelis MAP will not retaliate or take any discriminatory action against the member because he/she filed a grievance/grievance appeal or action appeal.

E. Fidelis' procedures for accepting grievances, grievance appeals and action appeals shall include:

1. toll-free telephone number;

2. designated staff to receive calls;

3. "live" phone coverage at least 40 hours a week during normal business hours; and

4. a mechanism to receive after hours calls, including either:

   a. a telephone system available to take calls and a plan to respond to all such calls no later than on the next business day after the calls were recorded; or
   b. a mechanism to have available on a twenty-four (24) hour, seven (7) day a week basis designated staff to accept telephone Grievances, whenever a delay would significantly increase the risk to an Member's health.

F. Fidelis will ensure that personnel making determinations regarding Grievances, Grievance Appeals and Action Appeals were not involved in previous levels of review or determination-making. If any of the following applies, determinations will be made by qualified clinical personnel.

1. A denial of an Action Appeal based on lack of medical necessity.

2. A Grievance regarding denial of expedited resolution of an Action Appeal.

3. A Grievance, Grievance Appeal, or Action Appeal that involves clinical issues.

GRIEVANCE PROCESS:

Fidelis' Grievance process shall include the following regarding the handling of Member Grievances: as per Appendix F- MAP contract Grievance System Requirements

I. The member,or his or her designee may file a grievance expressing dissatisfaction with any aspect of his or her care other than an Action with Fidelis orally or in writing.
II. Fidelis must provider written acknowledgement of any grievance not immediately resolved, including the name, address and telephone number of the indivdual or department handling the grievance, within fifteen (15) business days of receipt of the grievance. The acknowledgement must identify any additional information required by Fidelis from any source to make a determination.If a grievance determination is made before the written acknowledgement is sent, Fidelis may include the acknowledgement with the notice of the determination. (one notice).
III. Grievances shall be reviewed by one or more qualified personnel.

IV. Grievances pertaining to clinical mater shall be reviewed by one or more licesed, certified or registered health care professionals in addition t whichever non-clinical personnel Fidelis designates.

PROCEDURE:

1. RN Care Manager, Clinical Supervisor, or Plan Administrator may receive an oral or written expression of dissatisfaction from a member or member's representative or service provider. The complaint will be documented in the member's record and recorded in a log by the Administrator. Upon receipt of the grievance, the Plan will contact the member in writing to acknowledge receipt and to describe the review process, unless the staff is able to address the member's concern to the member's full satisfaction within the same day.

2. The member's RN Care Manager will generally evaluate the nature of the complaint and decide whether it is administrative and/or clinical in nature.

3. The issue may be further investigated and addressed accordingly with the respective party, whether it is a staff member of the Plan or a subcontracted provider of service.

4. Issues may be further addressed by a Care Manager who was not involved in the event, by the Supervisor or Director of Clinical Services, or the Administrator. Issues involving clinical matters will be evaluated by a clinician. If an issue involves a subcontracting provider of service or provider's office staff, he or she will investigate the issue with the provider and determine whether corrective action must be or has been initiated.

5. The Administrator will evaluate and investigate any issues that involve a Care Manager, Supervisor or Director. If the issue cannot be resolved at this level of review and/or is clinical in nature, the case will be referred to the Medical Director.

6. Investigation and follow up will be tracked and documented electronically or in hardcopy, and may be copied to the subcontractor's file if applicable.

7. Plan staff will contact the member, family, or provider as may be needed for additional information.

8. All grievances, grievance appeals, and appeals of action shall be resolved in an expeditious manner in accordance with the processes and timeframes specified below.

9. Notices will be made in writing to the member or to the member's designee

10. The Administrator on a quarterly basis will provide the QM Committee with a report identifying findings and any trends for further evaluation or action, as well as a summary report to NYSDOH as required.

11. The Member, or his or her designee, may file a Grievance expressing dissatisfaction with any aspect of his or her care other than an Action with Fidelis orally or in writing.

12. Grievances pertaining to clinical matters shall be reviewed by one or more licensed, certified or registered health care professionals in addition to whichever non-clinical personnel Fidelis designates.

13. Fidelis will provide written acknowledgment of any Grievance not immediately resolved, including the name, address and telephone number of the individual or department handling the Grievance, within fifteen (15) business days of receipt of the Grievance. The acknowledgement will identify any additional information required by Fidelis from any source to make a determination. If a Grievance determination is made before the written acknowledgement is sent, Fidelis may include the acknowledgement with the notice of the determination (one notice). **(Appendix A- Grievance Acknowledgement Letter)**

14. Plan's answer will describe what was found when Plan reviewed grievance, whether the request if any for expediting was granted, and Plan's determination about grievance. Plan must notify the member of the determination by telephone for expedited grievances, and must provide written notice of the determination within 3 business days (expedited and standard). Plan will notify member in writing if grievance will be handled as an non-expedited grievance. **(Appendix B- Grievance Non-Expedited Letter Standard Grievance)**

15. Plan will review grievance and give member a written answer as fast as the member's condition requires, but in no longer than these timeframes:

A. Expedited: If a delay would significantly increase the risk to member's health, Plan will decide within 48 hours after receipt of necessary information. and no more than 7 calendar days from receipt of the grievance. The review period can be extended up to 14 days if member or provider requests it or Plan needs more information and the extension is in member's interest and is well documented. Member will be notified in writing of need for extension **(Appendix C- Notice of Grievance Extension)**

B. Standard: Plan will notify member of determination within 45 days of receipt of necessary information, but the process must be completed within 60 days of the receipt of the grievance. The review period can be increased up to 14 days if member or provider requests it or plan needs more information and the extension is in the member's interest and is well documented. Plan will notify member in writing of determination as outlined above. **(Appendix D- Grievance Determination Letter)**

GRIEVANCE DETERMINATION TIMEFRAMES:

PROCEDURE:

A. Fidelis' Grievance process shall indicate the following specific timeframes regarding Grievance determinations:

1. If Fidelis immediately resolves an oral Grievance to the Member's satisfaction, that Grievance will be considered a same day resolution and will

not require any further follow up with member. These same day grievances, although resolved, will be maintained in a log and will be reported to SDOH on quarterly basis as per contract regulations.

2. Whenever a delay would significantly increase the risk to an Member's health grievances shall be expedited and resolved within forty-eight (48) hours after receipt of all necessary information and no more than seven (7) days from the receipt of the Grievance. All other non-expedited grievances will be handled as standard grievances.

3. All other Grievances shall be resolved within forty-five (45) days after the receipt of all necessary information and no more than sixty (60) days from receipt of the Grievance. Fidelis shall maintain reports of Grievances unresolved after forty-five (45) days in accordance with Section 18 – FMAP Contract (Contractor Reporting Requirements).

B. Timeframes for Grievance determinations may be extended for up to fourteen (14) days from the date the extension notice is sent by Fidelis, if:

1. the Member, the Member's designee, or the Member's provider requests an extension orally or in writing; or

2. Fidelis can demonstrate or substantiate that there is a need for additional information and how the extension is in the Member's interest. Fidelis will send notice of the extension to the Member. Fidelis will maintain sufficient documentation of extension determinations to demonstrate, upon SDOH's request, that the extension was justified, and will explain in the written notice to the Member how the extension is in the best interest of the Member.

3. If Fidelis extended its review as provided in paragraph (2) above, Fidelis will resolve the Grievance and notice the Member by phone and in writing as fast as the Member's condition requires and within three (3) business days of its determination, but in no event later than the date the extension expires.

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GRIEVANCE DETERMINATIONS NOTICES

Fidelis' procedures regarding the determination of Member Grievances shall include the following:

A. Grievance Determinations by Fidelis shall be made in writing to the Member or his/her designee and include: **(Appendix D)**

1. the detailed reasons for the determination;

2. in cases where the determination has a clinical basis, the clinical rationale for the determination;

3. the procedures for the filing of a grievance appeal and notice of the right of the Member to contact the State Department of Health regarding his or her Grievance, including SDOH's toll-free number for Grievances.

B. If Fidelis was unable to make a Grievance determination because insufficient information was presented or available to reach a determination, Fidelis will send a written statement that a determination could not be made to the Member on the date the allowable time to resolve the Grievance has expired. **(Appendix I- Grievance Unable to Make Determination Letter)**

C. In cases where delay would significantly increase the risk to an Member's health, Fidelis shall provide notice of a determination by telephone directly to the Member or to the Member's designee, or when no phone is available, some other method of communication, with written notice to follow within three (3) business days.

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GRIEVANCE APPEAL PROCESS:

Members are free to exercise their right to request an appeal and have them resolved accurately, timely and with respect as well as:

- The right to request an expedited reconsideration as provided in this policy and procedure manual;
- The right to request and receive appeal data from Fidelis Medicaid Advantage Plus;
- The right to receive notice when an appeal is forwarded to the Independent Review Entity (IRE);
- The right to automatic reconsideration by an IRE contracted by CMS, when Fidelis Medicaid Advantage Plus upholds its original adverse determination in whole or in part.

PROCEDURE:

a) If member is not satisfied with the determination Plan made concerning a grievance, member may request a second review of issue by filing a grievance appeal. Member must file a grievance appeal in writing within 60 business days after receipt of Plan's initial determination about grievance.

b) Plan will send a written acknowledgement within 15 days of receipt of the request telling member the name, address, and telephone number of the individual designated to respond to the appeal. Fidelis will indicate what additional information, if any, must be provided for Fidelis to render a determination. **(Appendix E- Grievance Appeal Acknowledgement Letter)**

c) Grievance Appeals of clinical matters must be decided by personnel qualified to review the Appeal, including licensed, certified or registered health care professionals who did not make the initial determination, at least one of whom must be a clinical peer reviewer, as defined by PHL 4900 (2) (a)

d) Grievance Appeals of non-clinical matters shall be determined by qualified personnel at a higher level that the personnel who made the original grievance determination.

e) Plan will send written acknowledgement of the grievance appeal within 15 days of receipt of the request. If a determination is reached before the written acknowledgement is sent, the acknowledgement can be included with the notice of determination.

f) For Standard appeals, Plan will make the appeal determination as fast as the member's condition requires but within 30 business days after receipt of all necessary information to make a determination. **(Appendix F- Grievance Appeal Non-Expedited Letter- Standard Grievance Appeal)**

g) If a delay in making a determination would significantly increase the risk to member's health, Plan will use the Expedited grievance appeal process. For expedited grievance appeals, Plan will make appeal determination as fast as the member's condition requires but within 2 business days of receipt of necessary information.

h) For both standard and expedited grievance appeals, Plan will provide written notice of determination. The notice will include the detailed reasons for determination and, in cases involving clinical matters, the clinical rationale. The notice shall also inform the member of his/her right to contact the SDOH with his/her grievance, including the SDOH's toll-free number for grievances. **(Appendix G-Grievance Appeal Determination Letter)**

i) The Plan will maintain a file on each grievance and associated appeal (both expedited and standard), if any, that includes at a minimum: the date the grievance/grievance appeal was filed and a copy of the grievance/grievance appeal; the date of receipt of and a copy of the member's acknowledgement letter if any of the grievance/grievance appeal; all member/provider requests for expediting and the Plan's determination about the request; necessary documentation to support any extension; the determination made by the Plan, including the date, the staff titles, and if clinical the staff credentials, of the Plan's personnel who reviewed the grievance/grievance appeal.

j) If the request has not been made in writing within the 60 day timeframe Fidelis Medicaid Advantage Plus will not process the appeal and the plan will notify the member in writing that the appeal will be not be processed and no determination will be made. **(Appendix H- Denial of Request for Grievance Appeal)**

GRIEVANCE APPEAL DETERMINATION TIMEFRAMES:

Grievance Appeals shall be decided and notification provided to the Member no

more than:

1. two (2) business days after the receipt of all necessary information when a delay would significantly increase the risk to an Member's health; or

thirty (30) business days after the receipt of all necessary information in all other instances.

Action and Action Appeal process also included in MAP Service Authorization Policy. Below is a few excerpts from the MAP Service Auth policy and procedure. Please refer to Service Authorization for complete procedural process.

ACTION APPEALS PROCESS:

a.) Fidelis' Action Appeals process shall indicate the following regarding the Appeals of an Action:

I. the member, or his or her designee, will have no less than forty-five (45) days from the date of the notice of Action to file an Action Appeal. A member filing an Action Appeal within ten (10) days of the notice of Action or by the intended date of an Action, whichever is later, that involves the reduction, suspension, or determination of previously approved services may request "aid continuing" in accordance with Section 24.4 of NYS DOH Medicaid Advantage agreement.

II. The member may file a written Action Appeal or an oral Action Appeal. Oral Action Appeals must be followed by a written Action appeal. Fidelis may provide a written summary of an oral Action Appeal to the member(with the acknowledgement or separately) for the member to review and modify, if needed, and return to Fidelis. If the member or provider requests expedited resolution of the Action Appeal, the oral Action Appeal does not need to be confirmed in writing. The date of the oral filing of the Action Appeal will be the date of the Action Appeal for the purposes of the timeframes for resolution of Action Appeals. Action Appeals resulting from a Concurrent review must be handled as an expedited Action Appeal.

III. Fidelis must send a written acknowledgement of the Action Appeal, including the name, address and telephone of the individual or department handling the Action Appeal, within fifteen (15) days of receipt. If a determination is reached before the written acknowledgement is sent, Fidelis may include the written acknowledgement with the notice of Action Appeal determination. (one notice).

IV. Fidelis must provide the member reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. Fidelis must inform the member of the limited time to present such evidence in the case of an expedited Action Appeal. Fidelis must allow the member or his or her designee, both before and during Action appeals process, to examine the member's case file, including medical records and any other documents and records considered during the Action Appeals process. Fidelis will consider the member, his or her designee or legal estate representative of a deceased member a party to the Action Appeal.

V. Fidelis must have a process for handling expedited Action Appeals. Expedited resolution of the Action Appeal must be conducted when Fidelis determines or the provider indicates that a delay would seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. The member

may request an expedited review of an Action Appeal. Fidelis must agree to expedite the Appeal if the Appeal was the result of a denial of concurrent Service Authorization request. If Fidelis denies the member's request for an expedited review, Fidelis must handle the request under standard Action Appeal resolution timeframes, make reasonable efforts to provide prompt oral notice of the denial to the member and send written notice of the denial within two (2) days of the request for the expedited review determination and indicate in the notice that Fidelis will be handling the request under standard action appeal timeframes.

VI. Fidelis must ensure that punitive action is not taken against a provider who either requests an expedited resolution or supports a member's Appeal.

VII. Action Appeals of clinical matters must be decided by personnel qualified to review the Action Appeal, including licensed, certified or registered health care professionals who did not make the initial determination, at least one of whom must be a clinical peer reviewer, as defined by PHL 4900 (2)(a). Action Appeals on non-clinical matters shall be determined by qualified personnel at a higher level than the personnel who made the original determination.

TIMEFRAMES FOR RESOLUTION OF ACTION APPEALS:

a.) Fidelis Action Appeals process shall indicate the following specific timeframes regarding Action Appeals resolution:

I. Fidelis will resolve Action Appeals as fast as the member's condition requires, and no later than thirty (30) days from the date of the receipt of the Action Appeal.

II. Fidelis will resolve expedited Action Appeals as fast as the member's condition requires, within two (2) business days of receipt of necessary information and no later than three (3) business days of the date of the receipt of the Action Appeal.

III. Timeframes for Action Appeal resolution, in either (I) or (II) above, may be extended for up to fourteen (14) days if:

A.) the member, his or her designee, or the provider requests an extension orally or in writing; or

B.) Fidelis can demonstrate or substantiate that there is a need for additional information and the extension is in the member's best interest. Fidelis must send notice of the extension to the member and must maintain sufficient documentation of extension determinations to demonstrate, upon SDOH's request, that the extension was justified.

C.) Fidelis must inform the member in writing if it will be taking an extension and how the extension is in the best interest of the member.

IV. Fidelis will make a reasonable effort to provide oral notice to the member, his or her designee, and the provider where appropriate, for expedited Action Appeals at the time the Action Appeal determination is made.

V. Fidelis must send written notice to the member, his or her designee, and the provider where appropriate within two (2) business days of the Action Appeal determination.

ACTION APPEAL NOTICES:

a.) Fidelis shall ensure that all notices are in writing, in easily understood language and are accessible to non-English speaking and visually impaired Members. Notices shall include that oral interpretation and alternate formats of written material for Members with special needs are available and how to access the alternate formats.

i.) Notice to the Member that the Member's request for an expedited review has been denied shall state that the request will be reviewed under standard timeframes, including a description of the timeframes.

ii.) Notice to the Member regarding Fidelis-initiated extension shall include:

A. the reason for the extension;

B. an explanation of how the delay is in the best interest of the Member;

C. any additional information Fidelis requires from any source to make its determination;

D. the revised date by which Fidelis will make its determination;

E. the right of the Member to file a Grievance (as indicated in the Grievance System) regarding the extension;

F. the process for filing a Grievance with Fidelis and the timeframes within which a Grievance determination must be made;

G. the right of the member to designate a representative to file a grievance on behalf of the member; and

H. the right of the member to contact the New York State Department of Health regarding his or her grievance, including the SDOH's toll free number for complaints.

iii.) Notice to the member of an Action Appeal determination shall include:

A. the description of the Action that FMAP has taken or intends to take;

B. Date the Action Appeal process was completed

C. the results and reasons for the action, including the clinical rationale,if any;

D. If the determination is not in favor of the member, a description of the member's fair hearing rights, if applicable; including the appropriate Fair Hearing Notice;
   - the fact that FMAP will not retalliate or take any discriminatory action against the member because he or she has filed an Action Appeal;
   - the right of the member to designate a representative to file Action Appeals on his/her behalf;

E. the right of the member to contact the NYS Department of Health regarding his or her complaint, including the SDOH's toll-free number for complaints;

F. the notice entititled "Managed Care Action Taken" for denial of benefits or for termination or reduction in benefits, as applicable. **Appendix Q, Q-1**

G. For Action Appeals involving Medical Necessity or an experimental or investigational treatment, the notice must also include:

i. a clear statement that the notice constitutes the initial adverse determination and specific use of the terms “medical necessity” or “experimental/investigational”;
ii. the member's insurance coverage type;
iii. the procedure/service in question, and if available and applicable the name of the provider and developer/manufacturer of the health care service;
iv. statement that the memebr is eligible to file an External appeal and the timeframe for filing;
v. a copy of the "Standard Description and Instructions for Health care Consumers to Requst an Externanal Appeal" and the External Appeal application form;
vi. Fidelis' contact person and telephone number;
vii. the contact person, telephone number, company name and full address of the utilization review agent, if the determination was made by the agent

WHO MAY FILE AN APPEAL?

- The member (including his or her authorized representative).
- An assignee of the member (i.e. a physician or provider who has furnished a service to the member and formally agrees to waive any right to payment from the member for that service).
- The legal representative of a deceased member’s estate.
- Any other provider or entity (other than Fidelis Medicaid Advantage Plus) determined to have an interest in the proceeding.

Any of these parties can request an appeal, with the exception that only the member (or an member’s authorized representative) or a physician can request an expedited organization determination (that does not involve a request for payment of services).

FMAP will notify members of the availability of assistance for language, hearing, and/or speech issues if a member wants to file an appeal, and how to access that assistance.

1. The member, or his or her designee, will have no less than forty-five (45) days from the date of the notice of Action to file an Action Appeal. A member filing an Action Appeal within ten (10) days of the notice of Action or by the intended date of an Action, whichever is later, that involves the reduction, suspension, or determination of previously approved services may request and is entitled to receive continuation of aide services. Services will continue until the member either withdrawals the appeal, or the original authorization period expires or until 10 days after we send a notice of our determination of the appeal if the determination is not in your favor. Services will continue if requested with the fair hearing and will continue until fair hearing determination or unless member withdrawals fair hearing request.

REPRESENTATIVE FILING ON BEHALF OF THE MEMBER:

An member may appoint any individual (such as a relative, friend, advocate, an attorney or any physician) to act as his or her representative. A representative who is appointed by the court or who is acting in accordance with state law may also file an appeal for an member. Both the member making the appointment and the representative accepting the appointment must sign, date, and complete an appointment of representative form or similar written statement. If the appointed representative is an attorney, only the member needs to sign the appointment of representative form or similar statement.

The representative statement must include the member's name and Medicare number. The member may use Form CMS-1696-U4 or SSA-1696-U4, Appointment of Representative (available at Social Security offices), although it is not required. The member may also use the appointment of representative statement provided in the IRE Reconsideration Processing Manual.

A signed form or statement must be included with the member's appeal, a separate appointment of representative form or statement is required for each appeal.

A representative who is a surrogate acting in accordance with state law may file an appeal. A surrogate could include, but is not limited to, a court appointed guardian, an individual who has Durable Power of Attorney, or a health care proxy, or a person designated under a health care consent statute.

Fidelis Medicaid Advantage Plus will provide any reasonable assistance in completing forms and other procedural steps for filing a grievance, grievance appeal or action appeal, including but not limited to, providing interpreter services and toll-free numbers with TTY/TDD and interpreter capability at no charge to the member.

AUTHORITY OF A REPRESENTATIVE:

On behalf of the member, a representative may:

- Obtain information about the member's claim to the extent consistent with current federal and state law.

- Submit evidence.

- Make statements about facts and law.
- Make any request or give any notice about the proceedings.

RECORDS:

Fidelis shall maintain a file on each Grievance, Action Appeal and Grievance Appeal. These records shall be readily available for review by the SDOH, upon request. The file shall include:

A. date the Grievance was filed;

B. copy of the Grievance, if written;

C. date of receipt of and copy of the Member's written confirmation, if any;

D. log of Grievance determination including the date of the determination and the titles of the personnel and credentials of clinical personnel who reviewed the Grievance;

E. date and copy of the Member's Action Appeal or Grievance Appeal;

F. Member or provider requests for expedited Action Appeals and Grievance Appeals and Fidelis' determination;

G. necessary documentation to support any extensions;

H. determination and date of determination of the Action Appeals and Grievance Appeals;

I. the titles and credentials of clinical staff who reviewed the Action Appeals and Complaint Appeals; and

J. Complaints unresolved for greater that forty-five (45) days.