ELDERPLAN, Inc.
POLICIES AND PROCEDURES

SECTION: EP-1101 Grievance and Appeals	SUBJECT: Member Grievance Rights	EFFECTIVE DATE: DRAFT	

I. Policy

Elderplan will act to insure that the grievance rights of all appropriate parties are communicated to the involved parties and carried out by the Plan in accordance with all applicable State regulations. Elderplan enrollees, enrollee's designees and health care providers will be knowledgeable regarding their rights to file a grievance, the proper timeline for such submissions and the time frame for processing of the grievance.

"Grievance" means an expression of dissatisfaction with any matter other than an action by the member or provider on the member's behalf about care and treatment. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness by a provider or employee, or failure to respect the enrollee's rights. A grievance can be verbal or in writing. Elderplan will designate qualified personnel who were not involved in any previous level of review or decision-making to review the grievance, and if the grievance pertains to clinical matters, the personnel will include licensed, certified or registered health care professionals.

II. GRIEVANCES

Grievances can be reported to any staff member at Elderplan, including nurses and field staff. Grievances that can be immediately (same day) decided to the member's satisfaction do not need to be responded to in writing. Elderplan staff (i.e. Member Services Coordinators, Appeals and Grievance Coordinators, etc.) will document the grievance and decision in the Elderplan call tracking system and log and track the grievance and decision for quality improvement purposes. Clinical grievances must be decided by clinical staff (i.e. Nurse, Clinical Supervisor, etc.) and the results will be documented in the Elderplan call tracking system.

If the grievance cannot be decided immediately (same day), Elderplan will decide if the grievance is expedited or standard. The decision as to whether a grievance meets expedited criteria will rest with the Appeals and Grievances Manager for non-clinical issues and with the Medical Director for clinical decisions.

If Elderplan determines, or the provider indicates, that a delay would seriously jeopardize the enrollee's life or health or ability to attain, maintain or regain maximum function then the grievance will be handled as expedited. A member may also request an expedited review of a grievance.

Expedited and Standard Grievance Procedures

1. Elderplan will send written acknowledgement of the grievance (see attachment “G0 – Grievance Acknowledgement Letter”) within 15 business days of receipt. If a decision is reached before the written acknowledgement is sent, Elderplan will include the written acknowledgement with the notice of decision (see attachment “G4 – Grievance Resolution Letter”).

2. Grievances must be decided as fast as member’s condition requires, but no more than:
   a. Expedited: 48 hours from receipt of all necessary information and *no more than 7 calendar days from the receipt of the grievance.*
   b. Standard: 45 calendar days from receipt of all necessary information and no more than 60 calendar days from receipt of the grievance.

   Grievances are tracked and investigated by the Appeals and Grievances Department.

3. Up to a 14 calendar day extension is allowable. An extension may be requested by the member or by a provider on the member’s behalf (written or verbal). Elderplan may also initiate an extension if it can justify the need for additional information and if the extension is in the member’s interest. If additional information is needed a letter (see attachment “G1 – Grievance Ack – Need Info Letter”) will be sent to the member indicating any information necessary in deciding the grievance. In all cases, extensions must be well documented.

4. If an expedited grievance is requested, the Associate Director of Clinical Services will determine if the grievance meets the criteria for an expedited grievance. If not, a letter (see attachment “D0 – Expedited Denial Letter”) will be sent to the member and the grievance will be handled as a standard grievance.

5. Elderplan must notify the member of their decision by phone for expedited grievances and provide written notice of the decision (see attachment “G4 – Grievance Resolution Letter”) within 3 business days of the decision (expedited and standard).

III. APPEALED GRIEVANCE DETERMINATIONS

The member has 60 business days after the receipt of notice of a grievance decision to file a written appeal. In the event that a grievance appeal is received after the 60 day limit a letter (see attachment "G6 – Grievance Appeal Denial – 60 Days Letter") will be sent to the member. The appeal may be submitted by letter or on a form supplied by Elderplan. Upon receipt of a written appeal, Elderplan must decide if the appeal is an expedited or standard appeal. A member or provider may also request an expedited review of a grievance appeal. The determination of a grievance appeal on a non-clinical matter will be made by qualified personnel at a higher level than the personnel who made the initial grievance determination. Grievance appeal determinations with a clinical basis will be made 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 will be a clinical peer reviewer.

Grievance Appeal – Expedited and Standard Procedures

1. Elderplan must send written acknowledgement of a grievance appeal (see attachment "G2 – Grievance Appeal Acknowledgment Letter") within 15 business days of receipt of the request. If a decision is reached before the written acknowledgement is sent, Elderplan may include the written acknowledgement with the notice of decision (see attachment "G5 – Grievance Appeal Resolution Letter").

2. Grievance appeals must be decided as fast as member's condition requires, but no more than:

   a. Expedited: 2 business days of receipt of all necessary information.

   b. Standard: 30 business days of receipt of necessary information.
   Grievance appeals are tracked and investigated by the Appeals and Grievances Department.

3. Elderplan must provide written notice of their decision. The notice must include the reason for the determination, and in cases where the determination has a clinical basis, the clinical rationale for the determination. And the right to contact DOH regarding the complaint

4. If an expedited grievance appeal is requested, the Appeals and Grievances Manager for non-clinical issues and with the Medical Director for clinical decisions will determine if the grievance appeal meets the criteria for an expedited grievance. If not, a letter (see attachment "D0 – Expedited Denial Letter") will be sent to the member and the grievance appeal will be handled as a standard grievance.

5. There is no further appeal.

Responsible Personnel for Grievances and Grievance Appeals

1. The intake and coordination of appeals and grievances will be handled by the Appeals and Grievances Coordinators. The Director of Appeals and Grievances is responsible for overseeing these activities. Appeals and Grievances will be responsible for sending notices to members, responding to all appeals and grievances, reporting and maintaining logs and files. The Appeals and Grievances Department will be responsible for collecting all information needed by the Appeals and Grievances Committee to render a decision.
2. The Appeals and Grievances Committee, made up of administrative and clinical peer reviewers, may render adverse determinations in the appeal process. Only clinical peer reviewers at a higher level and other than the clinician who rendered the original determination will review appeals. The Committee will meet as quickly as needed to decide outstanding appeals on a timely basis and will meet on an ad hoc basis for expedited appeals.
3. The individuals who make decisions on grievances and grievance appeals are individuals who:
   - Were not involved in any previous level of review or decision- making, and
   - If deciding any of the following, are health care professionals who have appropriate clinical expertise in treating the enrollee's condition or disease:
     - A grievance regarding denial of expedited resolution of an appeal
     - A grievance or appeal that involves clinical issues.

IV. REQUIRED PLAN DOCUMENTATION ON GRIEVANCES AND GRIEVANCE APPEALS

Elderplan must maintain a file on each grievance and associated appeal, if any. The file must include (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 enrollee's acknowledgement letter (see attachments 1, 2, 4 and 5), if any, of the grievance/grievance appeal;

- All member/provider requests for expedited grievances/grievance appeals and Elderplan's decision about the request;
- Necessary documentation to support any extensions, and
- The determination made by Elderplan, including investigation notes and determination factors used to arrive at the decision, the date of the determination, titles, and in the case of a clinical determination, the credentials of the plan's personnel who reviewed the grievance/grievance appeal.

Elderplan Letters for Grievances and Grievance Appeals

1. G0 - Grievance Acknowledgment Letter
2. G1 - Grievance Ack – Need Info Letter
3. G2-- Grievance Appeal Ack Letter
4. G4 - Grievance Resolution Letter
5. G5 - Grievance Appeal Resolution Letter
6. G6 - Grievance Appeal Denial – 60 Days Letter
7. D0 – Expedited Denial Letter