| BEACON HEALTH OPTIONS | | POLICIES AND PROCEDURES |
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| **Policy Number**: PR205.1 | **Category**: A | **Page** 1 |
| **Title**: Provider Complaints, Grievances and Appeal Processes | **Original Date of Issue**: 1/30/16 | |
| **Keyword Search**: denial, inquiry, primary account, file a grievance, file an appeal | **Date Approved**: 4/30/17 | |

*Beacon Health Options Policies and Procedures cover the operations of all entities within the BVO Holdings, LLC corporate structure, including but not limited to Beacon Health Strategies LLC, Beacon CBHM LLC and Beacon Health Options, Inc.*

| **Reviewed** ✔ | **Revised** ☐ | **New** ☐ | Approval Signatures: |
|---|---|---|---|
| **Functional Area(s) Involved in Review**: National Networks | | | Cynthia Troxler<br>Vice President and General Manager |
| | | | |
| **Service Center/Engagement Center**: All | | | |
| **Previous Approval Date**: 4/30/16 | | | **Next Annual Review Due**: 4/30/18 |

I. Purpose:

It is Beacon Health Options policy that providers achieve timely resolution to their complaints, grievances and appeals. This policy provides the processes by which effective resolution may be sought related to:

- Provider agreement
- Denial of service appeals (may be filed by a provider, a member, or a member-authorized representative, who may be a provider acting on behalf of a member)
- Other general complaints

II. Department(s), Service Center(s) and Committee(s) affected:

A. National Network Services (Contracting, Credentialing, Provider Relations)

B. National Network Operations

III. Definitions:

A. Complaint – A verbal or written communication from a member, member-designated representative, client, or provider ("Complainant") of dissatisfaction with some aspect of the Beacon Health Options processes or services **other than** a denial of services based on medical necessity or denial of claims/invoice payments related to services.

B. Grievance – A verbal or written communication from a complainant of dissatisfaction with the outcome of a complaint resolution. Grievances, as herein defined, are not administrative appeals. [Note: some contracts and regulatory authorities use the term "grievance" as synonymous with "appeal" and, where applicable, these terms may be defined and mapped differently in local policies and procedures.]

C. Inquiry – An oral or written communication from an external party seeking information or requesting an action or assistance (e.g., request to check eligibility, clarify benefit, explain a process, check on the status of a claim/invoice) that does not meet the definition of a "complaint", "grievance" or an "appeal". Inquiries are handled according to the Beacon Health Options Customer Service Policy and Procedure (CS101) "Inquiry Documentation". When a communication is not distinguishable as an inquiry or a complaint, it is handled as a complaint.

IV. Procedures:

A. Provider contract disputes and general complaint and grievances about or from a provider will be handled by the Provider Relations in the following ways:

1. Primary Account for which the complaint is attached (e.g. Boeing member complaint about a provider in Illinois, CASC Provider Relations staff will be responsible for investigating and finding resolution within prescribed timeframes.) ;
2. If no primary account is attached to the complaint, then the state in which the provider practices will dictate who handles the complaint (e.g. Illinois provider complains about credentialing TAT or rates. GLSC Provider Relations staff will be responsible for investigating and finding resolution within prescribed timeframes.)
3. Any Provider Relations Director or designee covering an area at the time. Provider Relations staff will include service center and account management staff where indicated.

In the Provider contract, contractual problems may be resolved in the following manner:

1. Complaints are reviewed and fully processed until the provider is satisfied, does not file a timely complaint or appeal, or exhausts right to appeal.
2. A decision becomes final whenever a provider does not exercise right to appeal or when a decision is made in the last step and the right to appeal no longer exists.
3. This process excludes complaints or appeals regarding reimbursement rates for multiple network participation. Beacon Health Options reserves the right to amend or adjust reimbursement schedules per network.

Level One

i. Initial complaints from a provider should be submitted in writing to the local service center or provider relations department within ten (10) business days of the event that gave rise to the complaint or within ten (10) business days from the time the provider should have reasonably first become aware of the event.

ii. Correspondence should include all documentation in support of the complaint and should provide, at a minimum, the following information:

- The specific term or provision in the provider agreement in dispute. It is helpful if the provider attaches a fully executed copy of the agreement
- a clear and concise description of the nature of the complaint and how the action allegedly violated the provider agreement
- the specific remedy requested for resolution

The Beacon Health Options Local Provider Relations and/or Contracting Staff will review the documentation and investigate the concern. The local Provider Relations director or their designee will respond in writing to the provider within thirty (30) business days of receipt of complaint.

Level Two

i. If the provider is not satisfied with the response received from Beacon Health Options, a Level Two complaint may be filed within ten (10) business days of receipt of a Level One response, or in the absence of a Level One response, within fifteen (15) Business days of submission of the complaint to the local service center or provider relations department.

ii. The written complaint must contain, at a minimum, the same information required in the initial complaint as well as any additional information pertinent to the grievance.

iii. The Level Two complaint will be reviewed by different Local Provider Relations and/or Contracting staff than those who made the Level 1 determination and/or Vice President of National Provider Relations.

iv. The Local Provider Relations director or their designee will provide a final written response within thirty (30) business days of receipt of the Level Two complaint.

B. General Complaint and Grievance

1. Complaints – Providers have the opportunity to voice complaints related to issues other than those discussed above (e.g. service complaints, complaints about Beacon Health Options policies and procedures). Note: Some contracts specify different standards for responding to complaints and grievances and may employ different terminology. The standards outlined below are typical of most contracts managed by Beacon Health Options. Variances by contract can be verified by:

    a. Complaints can be made by calling or writing:

i. Local Provider Relations Units

ii. Local Contracting Units

iii. National Provider Line

iv. A Beacon Health Options Client or Member

v. Executive Management

b.

i. All complaints are acknowledged verbally or in writing. Staff at Beacon Health Options will investigate and attempt to reach a satisfactory resolution of your complaint within 30 calendar days of receipt of the complaint (3 calendar days for complaints involving urgent care).

ii. A one-time extension of 15 calendar days can be taken by Beacon Health Options when a resolution cannot be reached within the required timeframe and the extension is solely for the benefit of the member.

iii. A provider will be notified verbally or in writing of the proposed action to resolve (or the reason why no action can be taken).

2. Grievances – If a provider is not satisfied with the efforts of Beacon Health Options to resolve a complaint, a provider may request a formal "grievance", either verbally or in writing, within 90 calendar days from receiving notice of a complaint resolution. The procedure for filing a grievance will be communicated to the provider along with the notice of a complaint resolution.

   a. A review decision response to a grievance will be by a Beacon Health Options staff member or committee, none of whom were involved in the efforts to resolve the initial complaint.

      i. Notice of the grievance decision will be issued within 30 calendar days of receipt of your grievance request.

      ii. A one-time extension of 15 calendar days can be taken by Beacon Health Options when resolution cannot be reached within the required timeframe and the extension is solely for the benefit of the member.

      Some contracts allow for additional grievance options outside of this grievance procedure. If so, the procedure for accessing any additional grievance options will be communicated to you as part of the notice of the grievance decision.

C. Complaint/Grievance Correspondence and Documentation

1. All complaints and grievances must be documented in the Beacon Health Options computer system (Service-Connect) as a "complaint" or "grievance" using the following:

**Contact: Name and Phone#**

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| Category | Use either Provider or Member |
| Source | Use either Correspondence or Telephone |
| Receive Date | Type date correspondence or telephone call was received by Beacon Health Options® |
| Inquiry Type | Use Complaint L1 |
| Related Services | Use the appropriate level of care in question (i.e. inpatient) |
| Reason 1 | Use CGA019 – Complaint Received |
| Reason 2 | Nature of Complaint:<br>i.e.<br>PRS009 W-9 UPDATE REQUEST<br>PRU001 DISENROLLMENT ISSUE |
| Reason 3 | Major Category:<br>CGA067 ACCESS ISSUES<br>CGA068 CLINICAL ISSUES<br>CGA069 CARE DISRUPTION ISSUES<br>CGA070 SERVICE ISSUES<br>CGA071 CLAIMS ISSUES<br>CGA116 QUALITY OF PRACTITIONER OFFICE SITE |
| Urgent | R |
| Acknowledgement Letter | Type Date sent and Check off Box |

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| Completion Method | Use Correspondence |
| Resolution Code | Use CGA525 – Complaint Resolved |
| Resolution Letter Date | Type Date of written decision and check off box |
| Action | Use Close, Pend etc. |
| Action Reason Code | Use appropriate code; example AIN002 - close |

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|---|---|
| Member Information | Capture member ID# |
| Provider Information | Capture provider ID# |
| Inquiry Notes | If this is an request for an Complaint:<br>Please encourage provider or member to submit in writing or provide the necessary information for the |

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| --- | --- |
| | verbal Complaint to be handled:<br><br>1) Please provide in your inquiry who is filing the complaint<br>2) Provide the dates of service in question<br>3) Provide the reason why the member or provider is filing the complaint<br>4) If there were extenuating circumstances that occurred please provide the reason<br>5) Please provide the address of where we can send the determination and acknowledgement letter |

**Complaint Pend Queue:**
Inquiry is pended to the appropriate complaint queue.

2. All complaints and grievance correspondence from and to the provider needs to be documented in ServiceConnect, for telephonic or for written correspondence, and be scanned in to the provider file in NetworkConnect.
   a. All written correspondence must have providers MHS number including their written correspondence to Beacon Health Options®.
   b. Written correspondence must be submitted to Network Operations Central Support who will then scan to a providers file in NetworkConnect.

D. Complaint and Grievance Documentation and Monitoring Process

   1 Provider Relations and Contracting Staff will follow the complaint process outlined in Q306.

   2 All response letters will be reviewed and approved prior to being sent to the provider by the Vice President of National Provider Relations.

E. Clinical and Administrative Appeals: – Provider Relations will follow Policy and Procedures C301and C305

F. Provider Appeals related to Credentialing, Sanctions and Terminations: Provider Relations will follow Policy and Procedures N701, N703, and N710.

V. Attachments

None. Please see Q306A