

# Section 10

## Appeals and Grievances

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## Section 10

# Appeals and Grievances

## Provider Grievances and Administrative Appeals

Complaints regarding reimbursement, a specific claim rejection, or any other provider issue should be reported to AllWays Health Partners Provider Service.

- A grievance (or complaint) is a statement of dissatisfaction with AllWays Health Partners' actions or services.
- An appeal is a request for AllWays Health Partners to reconsider an adverse action or denied claim submitted with documentation supporting the request for reconsideration.

### Requesting an Administrative Appeal

As described in the Billing Guidelines Section of the Provider Manual, providers can request a review and possible adjustment of a previously processed claim within 90 days of the Explanation of Payment (EOP) date on which the original claim was processed. If the provider is not satisfied with the outcome of the request, an appeal can be submitted to AllWays Health Partners' Appeals and Grievances Department.

An appeal is a request for reconsideration of a claim denial by AllWays Health Partners. Appeal requests must be submitted in writing within one of the following timeframes:

- 90 days of receipt of the AllWays Health Partners Explanation of Payment (EOP)
- 90 days of receipt of the EOP from another insurance, when applicable
- 90 days of the date of the claims adjustment letter

The appeal must include additional, relevant information and documentation to support the request. Requests received beyond the 90-day appeal requests filing limit will not be considered.

When submitting a provider appeal, please use the [Request for Claim Review Form](#).

Appeals may be submitted as follows:

Mail AllWays Health Partners  
Appeals and Grievances Dept  
399 Revolution Drive, Suite 810  
Somerville, MA 02145

Fax 617-526-1980

### Administrative Appeal Process

AllWays Health Partners has established a comprehensive process to resolve provider grievances and appeals:

- Appeals are reviewed by AllWays Health Partners' Provider Appeals department. Appeal reviews are completed within 30 calendar days from the date of AllWays Health Partners' receipt of the appeal request and all supporting documentation.
- If the appeal request is approved, the claim is adjusted, and the provider is notified via AllWays Health Partners' EOP (Providers should allow an additional two weeks for the appealed claim to be reprocessed and reflected in a future EOP).
- When the appeal request is denied, the provider is notified in writing of the reason, and when applicable, provided with instructions for filing an external appeal.
- If additional information is needed to review the appeal, the provider is notified in writing and allowed an additional 60 days from the date of AllWays Health Partners' response letter to submit the required information.

Providers who are notified in writing by AllWays Health Partners of the administrative denial of an authorization request due to the absence of supporting documentation to establish medical necessity should proceed as follows:

- If the service has not yet taken place, do not submit an appeal. Instead, create a new request through [allwaysprovider.org](http://allwaysprovider.org) with the supporting documentation.
- If the service has already taken place and the claim has denied, submit an appeal request with the supporting documentation.

## Appealing a Behavioral Health Service Denial

Optum is AllWays Health Partners' Behavioral Health Partner and is delegated all Behavioral Health (BH) related matters, including grievances/complaints and appeals. All BH related grievances/complaints and appeals must be submitted to Optum directly.

For more information, please refer to the Behavioral Health provider manual or contact Optum.

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## Provider Audit Appeals

### General Claims Audit Appeal Requests

For claims audited and adjusted post-payment, if the provider disagrees with the reason for the adjustments, a letter of appeal or a completed AllWays Health Partners Provider Audit Appeal Form may be submitted to AllWays Health Partners' Appeals Department within 90 days of the EOP.

The request must be accompanied by comprehensive documentation to support the dispute of relevant charges. To the extent that the provider fails to submit evidence of why the adjustment is being disputed, the provider will be notified of AllWays Health Partners' inability to thoroughly review the request. The provider can resubmit the appeal within the 90 days EOP window. The appeal's receipt date will be consistent with the date AllWays Health Partners received the additional documentation.

AllWays Health Partners will review the appeal and, when appropriate, consult with AllWays Health Partners clinicians or subject matter experts in the areas under consideration. The appeal request will be processed within 30 calendar days from AllWays Health Partners' receipt of all required documentation.

The appeal determination will be final. If the appeal request is approved, AllWays Health Partners will adjust the claims in question within 10 calendar days of the provider's notification of the final determination.

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## Member Inquiries, Complaints, and Grievances

AllWays Health Partners is committed to ensuring the satisfaction of our members and the timely resolution of all inquiries and reports of dissatisfaction by a member (or his/her authorized representative) about any action or inaction by AllWays Health Partners or a health care

provider. AllWays Health Partners provides processes for members that allow for the adequate and timely resolution of inquiries and grievances/complaints.

### Inquiries

An inquiry is any oral or written question made by, or on behalf of, a member to AllWays Health Partners or its designees that is not the subject of an adverse determination or adverse action, and that does not express dissatisfaction about AllWays Health Partners or its operations, processes, services, benefits, or providers.

Upon receipt of an inquiry, AllWays Health Partners' Customer Service Representative will document the matter and, to the extent possible, attempt to resolve it at the time of the inquiry.

### Complaints and Grievances

While grievances are typically reported by members, AllWays Health Partners will investigate all reported incidents when there are member care and other concerns. Possible subjects for grievances include, but are not limited to:

- *Quality of Care*—A member's perception of poor provision of clinical care and/or treatment by medical staff
- *Access*—A member reports of inability to access needed care in accordance with wait-time standards or in a manner that met the member's perceived needs
  - Access is defined as the extent to which a member can obtain services (telephone access and scheduling an appointment) at the time they are needed. It can also include wait time to be seen once the member arrives for a visit or geographic access to a network provider
- *Service/Administration*—A member asserts that there was a problem with interpersonal relationships, such as rudeness on the part of a provider or AllWays Health Partners staff person and/or deficiencies in what would generally be considered good customer or patient service
- *Billing and Financial*—A member's dispute of responsibility for rendered services, cost-sharing amounts, or other financial obligations
- *Provider's Facility*—A member asserts the provider's facility was inadequate, including, but not limited to cleanliness of waiting room, restrooms, and overall physical access to the premises
- *Privacy Violation*—A member reports that his or her

protected health information (PHI) was released, misdirected, or violated by AllWays Health Partners or a provider

- *Member Rights*—A member reports that his or her member rights were violated by AllWays Health Partners or a provider. This can include a member’s allegation that AllWays Health Partners is not providing behavioral health services in the same way that physical health services are provided, as required by Mental Health Parity Laws

Grievances are researched and resolved as expeditiously as warranted, but no later than 30 calendar days from the verbal or written notice of the grievance.

Members may designate a representative to act on their behalf and such representative is granted all the rights of a member with respect to the grievance process, unless limited in writing by the member, law, or judicial order.

The member must complete and return a signed and dated Designation of Appeal or Grievance Representative Form prior to the deadline for resolving the grievance. If the signed form is not returned, communication can only take place with the member.

AllWays Health Partners ensures that any parties involved in the resolution of inquiries, grievances, and any subsequent corrective actions have the necessary knowledge, skills, training, credentials, and authority to make and implement sound decisions and that they have not been involved in any previous level of review or decision-making. Members or their representatives are provided with a reasonable opportunity to present evidence and allegations of fact or law, in person as well as in writing.

A member may file a complaint or grievance by telephone, fax, letter, or in person. AllWays Health Partners Customer Service Professionals provide reasonable assistance, including, but not limited to, providing full interpreter services, toll-free numbers (including TTY/TTD access), explaining the grievance or appeal process, and assisting with the completion of any forms. All grievances are logged and when conveyed verbally to a Customer Service Professional, the process includes a reduction of the oral grievance to writing.

Received grievances are referred to the Appeals and Grievances Coordinator who will send the member or member’s representative an acknowledgment letter within one business day. The letter instructs the member

or member’s representative to sign and return a copy of the letter to AllWays Health Partners prior to the deadline for resolving the grievance. However, the investigation of a member’s grievance is not postponed pending return the signed letter. The member or authorized representative’s signature simply acknowledges that AllWays Health Partners has captured the details of the grievance correctly.

An AllWays Health Partners health care professional with the appropriate clinical expertise in treating the medical condition, performing the procedure or providing treatment that is the subject of a grievance will make an initial assessment as to the clinical urgency of the situation and establish a resolution time frame accordingly if the grievance involves:

- The denial of a member or member’s representative’s request that an internal appeal be expedited
- Any clinical issue

The AllWays Health Partners Appeal Committee will resolve a grievance if the subject of the grievance involves:

- The denial of payment for services received because of failure to follow prior authorization/referral procedures
- The denial of a member or member representative’s request for an internal appeal because the request was not made in a timely fashion
- The denial of coverage for non-covered services
- The denial of coverage for services with benefit limitations
- Reduction in AllWays Health Partners Provider payment due to copayments, deductibles, or coinsurance

When the subject matter involves the act or omission on the part of an AllWays Health Partners employee, resolution is made by the employee’s department, unless circumstances warrant as determined by the Appeals and Grievance Manager, that resolution should be made external to the employee’s department.

For grievances involving non-clinically related actions or omissions of a provider, the Grievance Coordinator requests assistance from the provider to investigate the grievance. Network providers’ adherence to the grievance process is monitored regularly to identify training and other interventions.

For grievances/complaints concerning a provider, the nature of the complaint determines whether the matter is addressed directly with the clinician or with the site administrator. In either case, the provider is contacted to discuss the matter and asked for a written response stating the facts, including supporting documentation when appropriate. To allow timely completion of the review of all relevant information within the specified time frame, a response from the provider is expected within five business days unless otherwise agreed upon. The response must address all identified concerns and include corrective actions for each when applicable.

Upon receipt of the provider’s response and review of all relevant information, a written response is sent to the member containing the substance of the complaint, as well as findings and actions taken in response, taking into consideration the confidentiality rights of all parties. At a minimum, the resolution will acknowledge receipt of the grievance and that it has been investigated. If the grievance resolution results in an adverse action, the response letter will advise the member of his or her right to appeal the decision.

## Behavioral Health Inquiries and Grievances

Management of all behavioral health–related inquiries and grievances is delegated to AllWays Health Partners’ Behavioral Health Partner, Optum.

For more information, please see the Behavioral Health Provider Manual or contact Optum.

## Dental Services Inquiries and Grievances

AllWays Health Partners delegates the grievance process for routine dental services for certain Commercial/QHP members to Delta Dental.

Please verify the member’s dental coverage with AllWays Health Partners Customer Service Department.

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## Member Clinical Appeals

### Expedited Clinical Appeals

AllWays Health Partners will provide an expedited appeal process if it is believed that the member’s health, life, or ability to regain maximum function may be put at risk by waiting 30 calendar days for a standard appeal decision. AllWays Health Partners will grant a request for an expedited appeal, unless the request is not related to the member’s health condition.

Members have the right to apply for an expedited external review at the same time a request for internal expedited review is requested. (See “Commercial Expedited External Review” section on how to submit an external review.)

AllWays Health Partners will continue to authorize disputed services during the formal appeal process if those services had initially been authorized by AllWays Health Partners, unless the member indicates that s/he does not want to continue receiving services.

AllWays Health Partners will provide an expedited appeal process under certain circumstances:

- When an appeal is submitted by or on behalf of a member who is inpatient in a hospital, resolution will be provided prior to the member’s discharge from the hospital.
- When the treating provider certifies that the requested service or equipment is medically necessary and that there is a substantial and immediate risk of serious harm should the service or equipment not be provided pending the outcome of the normal appeal process, resolution will be made within 48 hours.
- When an expedited appeal is submitted by or on behalf of a member with a terminal illness, resolution will be provided within 72 hours and a written response within five business days from the receipt of the appeal.
- If the appeal for a member with a terminal illness is upheld, the member or representative may request a conference with a AllWays Health Partners medical director. The conference should be scheduled within 10 calendar days of the notification of the determination, or within 5 calendar days if the treating provider has consulted with AllWays Health Partners’ Chief Medical Officer or Medical Director and it has been determined that the conference should be at an earlier date. Decisions on expedited appeals will be made within 72 hours of receipt.

### Expedited External Review

Members or their representatives can file an expedited external appeal at the same time that they file an internal expedited appeal or if they are dissatisfied with the expedited internal appeal decision. A request must be made to the Department of Health (DPH) Office of Patient Protection (OPP) within four months after the expedited internal appeal decision, but within two days if they wish to receive continuing services without liability.

An application fee of \$25.00, payable to the OPP, must accompany the request. The application fee may be waived if the OPP determines that payment of the fee would result in an extreme financial hardship for the member.

Members or their representative should also submit a copy of AllWays Health Partners' final adverse determination letter along with the request. OPP will complete the expedited appeal within 72 hours of receipt.

## Standard Clinical Appeals

A treating provider may file a clinical appeal on behalf of a member for any decision made by AllWays Health Partners to deny, terminate, modify, or suspend a requested health care benefit based on failure to meet medical necessity, appropriateness of health care setting, or criteria for level of care or effectiveness of care.

An appeal must be filed within 180 calendar days of AllWays Health Partners' decision to deny, terminate, modify, or suspend a requested health care service.

In order to file an appeal on behalf of a member, or if an individual other than the member or legal guardian requests the appeal, AllWays Health Partners must be provided with written authorization from the member designating the provider as the appeal representative. The Designation of Appeal Representative Form should be used for this purpose. The member must complete and return a signed and dated copy of this form prior to the deadline for resolving the appeal. Failure to return the signed form means communication can only take place with the member. The appeal process will not be held up pending receipt of the form.

When filing an appeal on behalf of a member, the provider must identify the specific requested benefit that AllWays Health Partners denied, terminated, modified, or suspended, the original date of AllWays Health Partners' decision, and the reason(s) the decision should be overturned. The Provider may request a peer-to-peer discussion with the AllWays Health Partners medical director involved in the Internal Appeal regarding these matters.

Appeals may be filed by telephone, mail, fax, or in person. AllWays Health Partners will send a written acknowledgment of the appeal on behalf of a member, along with a detailed notice of the appeal process, within one business day of receiving the request.

An appeal will be conducted by a health care professional that has the appropriate clinical expertise in treating the medical condition, performing the procedure, or providing the treatment that is the subject of the Adverse Action, and who was not involved in the original Adverse Action.

When an appeal is submitted by or on behalf of a member with a terminal illness, resolution will be provided within five business days of the request. For a standard Internal Appeal resolution, AllWays Health Partners will complete the appeal and contact the provider within 30 calendar days with the outcome of the review.

The time frame for a standard appeal may be extended for up to 15 additional calendar days due to circumstances beyond AllWays Health Partners' control and providing that the member or representative agree to the extension.

The Appeal and Grievance Coordinator will make reasonable efforts to provide oral notice to the member/member representative within one business day of the decision being made with a written notice to follow within 30 days of receipt of the appeal.

AllWays Health Partners will continue to authorize disputed services during the formal appeal process if those services had initially been authorized by AllWays Health Partners. Continued authorization will not, however, be granted for services that were terminated pursuant to the expiration of a defined benefit limit.

Providers, if acting in the capacity of an authorized representative, may request that AllWays Health Partners reconsider an appeal decision if the provider has or will soon have additional clinical information that was not available at the time the decision was made. Upon a reconsideration request, AllWays Health Partners will agree in writing to a new time period for review. To initiate reconsideration, contact the Appeal Coordinator.

Appeals may be filed by telephone, mail, fax, or in person. AllWays Health Partners will send a written acknowledgment of the appeal on behalf of a member, along with a detailed notice of the appeal process within one business day of receiving the request.

An appeal will be conducted by a health care professional that has the appropriate clinical expertise in treating the medical condition, performing the procedure, or providing the treatment that is the subject of the Adverse Action, and who was not involved in the original Adverse Action.

When an appeal is submitted by or on behalf of a member with a terminal illness, resolution will be provided within five business days of the request.

For a standard Internal Appeal resolution, AllWays Health Partners will complete the appeal and contact the provider within 30 calendar days with the outcome of the review.

The time frame for a standard appeal may be extended for up to 15 additional calendar days due to circumstances beyond AllWays Health Partners' control and providing that the member or representative agree to the extension.

The Appeals and Grievances Coordinator will make reasonable efforts to provide oral notice to the member/member representative within one business day of the decision being made with a written notice to follow within 30 days of receipt of the appeal.

AllWays Health Partners will continue to authorize disputed services during the formal appeal process if those services had initially been authorized by AllWays Health Partners. Continued authorization will not, however, be granted for services that were terminated pursuant to the expiration of a defined benefit limit. Providers, if acting in the capacity of an authorized representative, may request that AllWays Health Partners reconsider an appeal decision if the provider has or will soon have additional clinical information that was not available at the time the decision was made. Upon a reconsideration request, AllWays Health Partners will agree in writing to a new time period for review. To initiate reconsideration, contact the Appeal Coordinator.

#### Contact Information

AllWays Health Partners  
Appeals and Grievances Department  
399 Revolution Drive, Suite 810  
Somerville, MA 02145  
Phone: 855-444-4647  
Fax: 617-526-1980

#### Standard External Reviews

As part of every written appeal decision that upholds an original decision to deny, terminate, modify, or suspend a requested health care benefit, a member or authorized representative is informed in detail of additional appeal options and the procedures for accessing those options.

Members (or their authorized representatives) have the option of requesting an external appeal with the Office

of Patient Protection (OPP) if they are not satisfied with the final outcome of AllWays Health Partners' appeal process.

In order to activate the external review process with the Office of Patient Protection you will be asked to:

- Complete and submit the Request for Independent External Review of a Health Insurance Grievance form (enclosed with the Notice of Decision from AllWays Health Partners) to the Office of Patient Protection within four months of receiving AllWays Health Partners' written decision on your appeal
- Submit a \$25 fee to the Office of Patient Protection along with your request. The Office of Patient Protection may waive the fee in circumstances of financial hardship
- Submit a copy of AllWays Health Partners' final adverse determination letter to the Office of Patient Protection along with your request

OPP will complete the appeal within 45 days of receipt of the appeal.

#### Contact Information

AllWays Health Partners  
Appeals and Grievance Department  
399 Revolution Drive, Suite 810  
Somerville, MA 02145  
Phone: 855-444-4647  
Fax: 617-526-1980

#### To initiate an external review, contact:

Office of Patient Protection (OPP)  
Health Policy Commission  
50 Milk Street, 8th Floor  
Boston, MA 02109  
Phone: 800-436-7757  
Fax: 617-624-5046

#### Access to Appeal File by Member or Member Representative

Members or their representative have the right to receive a copy of all documentation used in the processing of their appeal, free of charge.

Limitations may be imposed, only if, in the judgment of a licensed health care professional, the access requested is reasonably likely to endanger the life or physical safety of the individual or another person.

The member (or an authorized representative) must submit their request in writing to AllWays Health Partners and it will be processed by the Appeal and

Grievance Coordinator, in consultation as necessary with the Compliance Office.

Requests for access to appeal files will be processed as quickly as possible, taking into consideration the member's condition, the subject of the appeal, and the time frames for further appeals.

#### *Continuation of Ongoing Services During Appeal*

If the internal appeal filed concerns the denial, modification, or termination of an AllWays Health Partners covered service that the member is receiving at the time of the adverse action, the member has the right to continue his or her benefits through the conclusion of the appeals process. Continued authorization will not, however, be granted for services that were terminated pursuant to the expiration of a defined benefit limit.

If the internal appeal filed concerns the denial, modification, or termination of a non-covered service that the member is receiving, and AllWays Health Partners does not reverse the adverse action, the member may be liable for payment of the service.

#### *Notification of Decision*

If AllWays Health Partners does not act upon an appeal within the required timeframe, or an otherwise agreed upon extension, the appeal will be decided in the member's favor. Any extension deemed necessary to complete review of an appeal must be authorized by mutual written agreement between the member (or an authorized representative) and AllWays Health Partners.

#### *Reconsideration of Appeal Decision*

Providers, if acting in the capacity of an authorized representative, may request that AllWays Health Partners reconsider an appeal decision if the provider has or will soon have additional clinical information that was not available at the time the decision was made. Upon a reconsideration request, AllWays Health Partners will agree in writing to a new time period for review. To initiate reconsideration, contact the individual identified in the decision letter upon receipt.

## **Consumer Protection from Collections and Credit Reporting During Appeals**

Effective 7/1/15, Massachusetts Law requires health care providers (and their agents) to abstain from reporting a member's medical debt to a consumer credit reporting agency or sending members to collection agencies or debt collectors while an internal or external appeal is on-going. This consumer protection also extends for 30 days following the resolution of the internal or external appeal.

## **Behavioral Health Appeals**

Management for all behavioral health related appeals is delegated to AllWays Health Partners' Behavioral Health Partner, Optum.

For more information, please see the Behavioral Health Provider Manual or contact Optum.

## **Dental Services Appeals**

AllWays Health Partners delegates the internal grievance/appeal process for routine dental services for some Commercial/QHP members to Delta Dental. Please verify the member's dental coverage with AllWays Health Partners' Customer Service Department.