

Section 9

Appeals and Grievances

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Section 9

Appeals and Grievances

Provider Grievances and Administrative Appeals

AllWays Health Partners has a comprehensive process for resolving appeals and grievances.

An appeal is a request that AllWays Health Partners or Optum review an adverse action or denied claim, having provided documentation supporting the request for reconsideration. Appeal requests must be submitted in writing.

A grievance is any expression of dissatisfaction about any action or inaction by AllWays Health Partners other than an Adverse Action. Possible subjects for grievances include, but are not limited to, quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee of AllWays Health Partners, or failure to respect the member's rights. Grievances should be reported to AllWays Health Partners' Provider Service.

Requesting an Administrative Appeal

As described in the Billing Guidelines section or as contractually agreed, 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 decision, an appeal can be submitted to AllWays Health Partners' Provider Appeals Department.

Appeal requests must be submitted in writing within one of the following timeframes:

- 90 days from receipt of the EOP
- 90 days from receipt of EOP from other insurance
- 90 days from 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 request filing limit will not be considered.

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

Appeals may be sent to:

Mail: AllWays Health Partners
Appeals & Grievances Dept.
399 Revolution Drive
Suite 820
Somerville, MA 02145

Fax: 617-526-1902

Administrative Appeals Process

AllWays Health Partners' administrative appeals option applies only for services already rendered.

Administrative denial letters issued by AllWays Health Partners' Clinical Department informing the provider that AllWays Health Partners received insufficient documentation to make a medical necessity decision require the submission of a new approval request through AllWays Health Partners' Provider Portal, allwaysprovider.org. Providers should not appeal these denials. Instead, submit the additional information requested through allwaysprovider.org.

For denials on services already rendered, the AllWays Health Partners administrative appeals process includes two appeal levels:

- A Level I appeal is the initial request to AllWays Health Partners for reconsideration of a denied claim. Level I appeal submissions are reviewed and completed within 30 calendar days from the date AllWays Health Partners receives the request with all supporting documentation. If additional information is needed to finalize the appeal request, the provider will be notified in writing. The requested documentation must be submitted within 60 days from the date of AllWays Health Partners' Level I appeal letter.

- If approved, AllWays Health Partners will adjust the claim. The provider will be notified of the outcome via the AllWays Health Partners Explanation of Payment which should reflect the reprocessed claim(s) within two weeks once reprocessed.
- If denied, the provider will be notified in writing of the reason and when applicable, provided with instructions for filing a Level II appeal. A Level II appeal provides the option to request a reconsideration of the Level I appeal when the provider has new and/or additional information that supports the request for a second review. The request for a Level II appeal needs to be received by AllWays Health Partners within 60 days of the Level I appeal denial letter. Level II appeal decisions are considered final.

Appealing a Behavioral Health Service Denial

Provider appeals and grievances for behavioral health services are handled by Optum, AllWays Health Partners' Behavioral Health Partner. All behavioral health appeals should be submitted directly to Optum.

For more information, please refer to the Behavioral Health Provider Manual or contact Optum at 844-451-3519.

Post-Payment Claim Adjustments

AllWays Health Partners regularly reviews claims post payment and adjust as needed. Depending on the total dollars adjusted, AllWays Health Partners proactively notifies the provider of the scheduled adjustments. Providers who disagree with these adjustments can submit a letter of appeal or a completed AllWays Health Partners Provider Audit Appeal Form to AllWays Health Partners' Appeals department within 90 days of the Explanation of Payment (EOP) along with comprehensive documentation to support the dispute of relevant charges.

Appeals are reviewed within 30 calendar days from AllWays Health Partners' receipt of all required documentation. When appropriate, AllWays Health Partners will consult with clinicians or subject matter experts in the areas under consideration before finalizing the appeal request.

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 of the EOP. The appeal's receipt date will be consistent with the date AllWays Health Partners received the additional documentation.

The appeal determination will be final. If the appeal request is upheld, AllWays Health Partners will adjust the claims in question within 10 calendar days of the final determination notification. Providers are notified of the claim's reprocessing via the EOP.

Member Grievances and Inquiries

AllWays Health Partners is committed to ensuring member satisfaction and to the timely resolution of reports of dissatisfaction by a member (or the member's representative on file) about any action or inaction by AllWays Health Partners or a health care provider. AllWays Health Partners provides processes that allow for the adequate and timely resolution of member complaints/grievances.

Inquiries

AllWays Health Partners is also committed to timely responding to all member inquiries.

An inquiry is any oral or written question made to AllWays Health Partners' Customer Service regarding an aspect of AllWays Health Partners' operations that does not express dissatisfaction about AllWays Health Partners.

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.

Grievances

AllWays Health Partners investigates all reported incidents of dissatisfaction on the part of AllWays Health Partners and/or a provider. Possible subjects of grievances include, but are not limited to:

- *Quality of Care*— Concerns with the quality of the care and/or treatment provided by medical staff;
- *Access*— Reports of barriers to needed care in accordance with wait-time access 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 upon arrival, and geographic distance to a network provider;
- *Service/Administration*— Reports of poor member experiences, including rudeness by AllWays Health Partners and/or provider staff;
- *Billing and Financial*— A dispute of financial responsibility for rendered services and/or rendered as billed;
- *Provider's Facility*— Reports that a provider's facility is deemed inadequate, including but not limited to cleanliness of waiting room, restrooms, and overall physical access to the premises;
- *Privacy Violation*— Member reports that a provider and/or AllWays Health Partners violated or compromised protected health information (PHI);
- *Member Rights*— Reports of violation of a member's rights by a provider and/or AllWays Health Partners, including but not limited to Mental Health Parity Laws violations.

When a member designates an authorized representative to act on their behalf, 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 will only take place with the member.

AllWays Health Partners ensures that any parties involved in the resolution of grievances and any subsequent corrective actions have the necessary skills, training, and subject matter expertise 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 assistance to members, including interpreter services, TTY, and other options when explaining the grievance or appeal process and assisting with the completion of any forms.

Upon notification of a grievance, a Customer Service Professional logs the details of the grievance and refers the matter to the Appeals and Grievances Department. An acknowledgement letter follows within one business day requesting the member's review that AllWays Health Partners Customer Service accurately captured the details and to sign and return a copy 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 of this signed letter. The member's signature merely acknowledges that AllWays Health Partners has documented the details of the grievance correctly.

A 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 request that an internal appeal be expedited
- Any clinical issue

The AllWays Health Partners Appeals Committee will resolve a grievance when 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 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 where benefit limitations apply

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, when appropriate.

For grievances involving non-clinically related actions or omissions of a provider, assistance from the provider is requested in investigating the grievance. Network providers' adherence to the grievance process is monitored regularly to identify training and other interventions.

For grievances specific to a provider, the nature of the grievance will determine whether the matter is addressed directly with the clinician or with the site's administrator. In either case, the provider is contacted to discuss the matter and asked for a written response addressing all identified concerns, corrective actions taken and supporting documentation when applicable. 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.

Upon receipt and review of the provider's response, a written response is sent to the member containing the substance of the complaint, the findings and actions taken, while ensuring the appropriate confidentiality rights of all parties. At a minimum, the resolution will acknowledge receipt of the grievance and that it has been investigated.

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. 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 for 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.

Member Clinical Appeals

Expedited Clinical Appeals

Level I Expedited Appeal (Level II = n/a)

A member, member representative, or provider may request an expedited internal appeal when the member's life, health, or ability to attain, maintain, or regain maximum function would be seriously jeopardized by waiting 30 calendar days for a standard appeal resolution. Punitive action will not be taken against a provider who requests an expedited appeal on behalf of a member.

An expedited appeal must be filed within 30 calendar days of AllWays Health Partners' decision to deny, terminate, modify, or suspend a requested health care service.

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 they do not want to continue receiving services, as long as the appeal request is submitted within 10 days of the adverse action.

Provider expedited appeal requests will be granted unless AllWays Health Partners determines that the provider's request is unrelated to the member's health condition. To file an appeal on behalf of a member, the provider must submit to AllWays Health Partners a written authorization from the member, designating the provider as their appeal representative. The AllWays Health Partners Designation of Appeal Representative Form should be used for this purpose.

While AllWays Health Partners will not postpone the appeal pending receipt of the form, it must be provided within a reasonable time period. If an expedited appeal request is not granted, the provider will receive timely notification of the decision verbally, as well as written notification of the dismissal of the expedited appeal request within two calendar days.

The expedited appeal request will be processed in accordance with standard appeal time frames, with the member (or authorized representative) notified accordingly.

If the request is denied, the member will be notified of their right to file a grievance. If approved, a decision will be communicated within 72 hours of receipt. Providers are notified verbally and in writing on approved and denied requests.

The time frame for making expedited internal appeal resolutions may be extended for up to 14 calendar days if AllWays Health Partners receives a request for an extension. For extension requests not initiated by the member, AllWays Health Partners will notify the member in writing of their right to file a grievance

Expedited External Review

The expedited internal appeal process is limited to one appeal level. Otherwise, the decision may be appealed via the Office of Medicaid Board of Hearings (BOH). The appeal must be submitted within 20 days of an expedited appeal decision. An appeal submitted to the BOH within 21 to 30 days will be treated as a standard appeal.

To continue receiving ongoing services during a BOH expedited appeal, the Appeal must be requested within 10 calendar days of AllWays Health Partners' initial appeal decision to uphold the decision to deny, terminate, modify, or suspend a requested health care service.

If the BOH determines that the member submitted the request for a BOH appeal in a timely manner, and the appeal involves the reduction, suspension, or terminations of a previously authorized service, AllWays Health Partners will authorize continuing services until one of the following occurs:

- The member withdraws the BOH appeal; or
- The BOH issues an adverse decision to the member's appeal request.

Standard Clinical Appeals

Level I Standard 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. Punitive action will not be taken against a provider who requests an appeal on behalf of a member.

A member appeal must be filed within 30 calendar days of AllWays Health Partners' decision. However, a member can continue receiving ongoing services during an appeal, as long as the appeal is requested within 10 calendar days of AllWays Health Partners' decision.

In order to consider an appeal filed by a third-party, AllWays Health Partners must receive written authorization from the member designating the individual as their appeal representative. The AllWays Health Partners Designation of Appeal Representative Form should be used for this purpose. The appeal process will not be held up pending receipt of the form.

The completed, signed, and dated form must be received prior to the deadline for resolving the appeal. Otherwise, all communication will take place with the member.

When filing an appeal on behalf of a member, the provider must identify the specific 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.

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

The time frame for a standard appeal may be extended for up to five calendar days if the member requests an extension, or if AllWays Health Partners requests the extension having determined that it will be in the member's best interest and there is reasonable likelihood that receipt of more information within five calendar days would lead to an approval.

AllWays Health Partners' Appeals and Grievances Department will make reasonable efforts to provide verbal notification of the decision within one business day, with written notification to follow within 30 days of receipt of the appeal.

A clear description of the procedures for requesting a BOH external appeal, including enclosures of AllWays Health Partners' Appeals Process and Rights for MassHealth members and a Request for a Fair Hearing Form are included with any denial of appeal notice to the member.

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

Appeals and Grievances Department
AllWays Health Partners
399 Revolution Drive, Suite 820
Somerville, MA 02145

Standard Clinical Appeals (continued)**Standard External Reviews**

Once the AllWays Health Partners' appeal options have been exhausted, members may file an appeal with the Board of Hearings (BOH). The exhaustion requirement is satisfied if AllWays Health Partners has issued a decision following the Level I appeal.

BOH appeals of a standard internal appeal must be filed within 30 calendar days after the notification of decision on the final internal appeal.

Any services that are subject of a BOH appeal will continue, pending resolution of the appeal, unless the member specifically indicates that they do not want to receive continuing services, and the BOH receives a written request from the member within 10 calendar days from the notification of decision on the final internal appeal. If the BOH upholds an adverse action to deny, limit, or delay services and the member received continuing services while the BOH Appeal was pending, the member may be financially responsible for the cost of any requested services received during this time period.

Members must complete the Request for Fair Hearing form (included with the appeal decision notification) and submit it to the BOH. AllWays Health Partners can assist Members in completing this form.

Contact Information

Appeals and Grievances Department
AllWays Health Partners
399 Revolution Drive, Suite 820
Somerville, MA 02145

Phone: 800-462-5449

Fax: 617-526-1980

To initiate an external review, contact:

Board of Hearing (BOH)
Office of Medicaid
100 Hancock Street, 6th Floor
Quincy, MA 02171

Fax: 617-847-1204.

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. The request must be submitted in writing to AllWays Health Partners.

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.

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 appeal concerns the denial, modification, or termination of covered service that the member is receiving at the time of the adverse action, the member has the right to continue their benefits through the conclusion of the appeals process. There are timeframes for requesting continuation of coverage, as explained in the table above. Continued authorization will not, however, be granted for services that were terminated pursuant to the expiration of a defined benefit limit.

If the appeal 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 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 confirm in writing the agreement to a new time period for review. A reconsideration request can be initiated by contacting the individual identified in the AllWays Health Partners letter.

Consumer Protection from Collections and Credit Reporting During Appeals

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 going on. 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 at 844-451-3519.