PREMIER ACCESS

ACCESS DENTAL

| Policy and Procedure | | | |
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| Policy Name: | **Grievance and Appeals** | Policy ID: | **GA.001.01** |
| Approved By: | Dental Director (signature on file) | Effective Date: | 05/18/2012 |
| States: | All States | Revision Date | 06/21/2013 |
| Application: | Government programs and Commercial DHMO | | |

*This policy applies for operations under Premier Access Insurance Company and Access Dental Plan. For the purposes of this Policy, Premier Access Insurance Company and Access Dental Plan shall be collectively referred to as "Premier Access".*

## Purpose

Under the direction of the Dental Director or designee, to provide a systematic process for Members/Providers to contact ***Premier Access*** for general inquires and to report grievances/appeals; to provide an effective process for resolving grievances/appeals in a timely manner; and to provide a mechanism for identifying systemic or Provider trends that may be deleterious to patient care.

## Policy

Members or their designee can file grievances for any incident or action that is the subject of the Member's dissatisfaction. Members/Providers may file grievances with ***Premier Access*** at any time.

A grievance must be completed within 30 calendar days of ***Premier Access'*** receipt of the grievance. Members shall not be discriminated against (including disenrollment) solely on the grounds that the Member filed a grievance. The Member grievance process is not a delegated entity function.

If ***Premier Access*** revises its grievance system, the applicable State regulatory agency and/or program shall be notified at least 30 calendar days in advance.

## Definitions

**"Grievance"** means a written or oral expression of dissatisfaction regarding ***Premier Access*** and/or Provider, including quality of care concerns, and shall include a complaint, dispute and request for reconsideration or appeal made by a ***Premier Access*** Member or the Member's representative. Where ***Premier Access*** is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.

**"Complaint"** is the same as a "grievance."

**"Complainant"** is the same as "grievant," and means the person who filed the grievance including the Member, a representative designated by the Member (e.g., patient advocate or ombudsperson), or the individual with authority to act on behalf of the Member.

**"Resolved"** means that a final conclusion has been reached with respect to the Member's submitted grievance, and there are no Member appeals that are pending within the ***Premier Access*** grievance system.

**"State"** means the applicable State agency under which the Member's program or plan is regulated.

**"Threshold language(s)"** mean the language(s) identified by ***Premier Access*** as the primary language for a specified number or percentage of Members. Unless otherwise required by program or contract requirements, threshold language(s) shall be determined for each program.

## Procedure

## Member Grievance/Appeal Submission

1. Members in all service areas may report grievances/appeals by any of the following methods:

**Mail:** ***Premier Access***
Grievance & Appeal Department
P.O. Box 255039
Sacramento, CA 95865-5039

**In Person:** Premier Access Corporate Office
8890 Cal Center Drive
Sacramento, CA 95826

**Phone:** 800-448-4733 (toll-free)
Monday through Fridays (except holidays)
8:00 a.m. to 6:00 p.m. (Pacific Standard Time)

**Website:** www.premierlife.com

2. Members in all service areas may also report grievances/appeals through their ***Premier Access*** provider during regular business hours.
3. The process for initiating a grievance/appeal, including the location and telephone number where grievances may be submitted, shall be included in the Member Evidence of Coverage (EOC) or Certificate of Insurance (COI) booklet and the Provider Manual.
4. When a Member submits a grievance/appeal by mail, he/she may do so by letter or by completing a Grievance Form.
5. A Grievance Form is included in the EOC or COI booklet disseminated to all new Members and in the Provider Manual. Grievance Forms are also available in Provider offices and online at the ***Premier Access*** website at: www.premierlife.com.
6. **Members with Cultural and Linguistic Needs:** The following are available to ***Premier Access*** Members with cultural and linguistic needs to assist them with reporting a grievance/appeal.
   - Grievance Forms are translated into threshold languages.
   - Free interpreting services, which are available 24 hours per day, 7 days per week by qualified interpreters from ***Premier Access'*** interpreting service vendor.
   - Standardized vital documents will be translated into threshold languages at no charge to Enrollees.
7. **Members with Disabilities:** Members who are hearing and speech impaired may use a relay service to report their grievances/appeals. The relay service available is based on the Member's state of residence. The information for the applicable relay service is provided in the Evidence of Coverage or Certificate of Insurance.
   - A relay service enables people, who use Text Telephones (TTYs) or personal computers (PC), to communicate with those who use voice telephones, and vice versa.
   - When a Member uses a relay service, he/she dials the relay service's toll-free number and asks the Relay Operator to dial the number of ***Premier Access***. The Relay Operator then stays on the line to "convey" the conversation between the Member and ***Premier Access***.
   - Relay services are available for Members' use 24-hours a day, 7 days per week.
8. ***Premier Access*** shall provide Members with assistance in the filing of a grievance at each location through which grievances may be submitted.
9. Members shall be notified of the grievance process upon enrollment and annually thereafter.

## Grievance/Appeal Receipt and Review

The following grievance/appeal process applies for all **non-exempt and non-expedited** grievances/appeals. (The processes for exempt and expedited grievances/appeals are described in subsequent sections of this policy.)

1. Grievances/appeals received via the ***Premier Access*** website or mail are routed to the Grievance/Appeal Department for handling. The Grievance/Appeal Department may also receive a grievance/appeal from a Member directly via phone.

2. Grievances/appeals may also be received by the Member Services Department via phone.
   - If the Member Services Representative determines the caller's concern qualifies as a grievance/appeal, the Member's file is marked as "C" to be followed up by the Grievances /Appeals Coordinator.
   - If the Member Services Representative is unable to classify the call as an inquiry or a grievance/appeal, it shall be considered a grievance/appeal and marked as "C".
3. All grievances/appeals are logged into an automated log with the date received by ***Premier Access***, the name of the complainant, the complainant's Member identification number, the name of the individual recording the grievances/appeal and a description of the grievance/appeal.
4. The Grievance/Appeals Coordinator shall assign a grievance/appeal Category Code. If necessary, the Grievance/Appeals Coordinator shall review the grievance/appeal with the Dental Director to assign a grievance/appeal Category Code. (For Category Codes, see Exhibit B)
5. Within 5 calendar days of receipt of a grievance/appeal, written acknowledgment shall be sent to the Complainant and treating Provider.
   - The written acknowledgment shall explain to the complainant that the grievance/appeal has been received, the date of receipt and the estimated date of resolution.
   - The written acknowledgment shall also include the name, telephone number and address of the ***Premier Access*** representative that the complainant can contact about the grievance/appeal.
   - Members shall be given a reasonable opportunity to present, in writing or in person before the Premier Access representative resolving the grievance, evidence, facts and law in support of their grievance.
   - The written acknowledgment to the Provider shall include a request for the following documentation:
     - A copy of all of the Member's relevant treatment records;
     - A copy of the Member's signed consent;
     - A copy of all relevant x-rays;
     - A copy of the Member's financial records pertaining to the service in question;
     - Any additional comments the Provider may have regarding the Member's grievance.
6. The Grievance/Appeals Coordinator and/or Dental Director or designee is responsible for obtaining necessary information to properly evaluate each grievance/appeal.
7. The Grievance/Appeals Coordinator, in conjunction with the Dental Director or designee, shall review all submitted information and may contact the Member and/or Provider as necessary.
8. The Dental Director reviews the grievance and determines appropriate action to be taken. This includes grievances regarding quality of care issues.
9. The Grievances/Appeals Coordinator, in conjunction with the Dental Director ensures that actions are implemented.
10. Grievances/appeals involving a ***Premier Access*** department or staff member shall be immediately referred to the management/supervisory staff who shall be responsible for implementing corrective actions as appropriate.
11. Licensed dentists determining grievances/appeals cannot have prior involvement in the initial denial decision, cannot have a vested interest in the case and cannot be a subordinate of the initial reviewer.
12. Designated dentists determining grievances/appeals must be appropriately licensed dentists with pertinent clinical knowledge and expertise.
13. The Dental Director or designated competent licensed dentist shall make a determination on appeals of specialty referral or claims denials.

### Grievance/Appeal Resolution

1. When a resolution is reached, an entry shall be logged into the system indicating that the grievance/appeal has been resolved and a letter of resolution shall be generated and mailed to the Member and Provider.
2. The letter of resolution shall contain a clear and concise explanation of the reasons for ***Premier Access'*** response.
   - For grievances/appeals involving the delay, denial, or modification of dental care services, based in whole or in part on dental necessity, the letter of resolution will describe the criteria used and the clinical reasons for its decisions.

- For grievances/appeals involving the delay, denial, or modification of dental care services, based in whole or in part on a finding that the proposed services are not a covered benefit under the Member's contract, the letter of resolution will clearly specify the provisions in the contract that exclude the coverage.

3. The Dental Director or designee shall review and approve the letter of resolution to ensure accuracy and clarity.
4. The Grievances/Appeals Coordinator shall mail a letter of resolution to the Member and Provider within 30 calendar days of receipt of the grievance/appeal by ***Premier Access***.
   - If ***Premier Access*** cannot resolve the grievance within 30 calendar days of ***Premier Access'*** receipt of the grievance, then ***Premier Access*** shall send written notification to the Member and Provider of the pending status of the complaint.
   - All grievances/appeals pended for 30 calendar days or more shall be tracked for completion and reported to the applicable State regulatory agency and/or program, as required.
5. Copies of the grievances and responses shall be maintained by ***Premier Access*** for five years and shall include a copy of all dental records, documents, applicable section Evidence of Coverage or Certificate of Insurance, and other relevant information upon which ***Premier Access*** relied in reaching its decision.

## Exempt Grievances (applicable for California only)

Grievances received over the telephone that are not coverage disputes, disputed dental care services involving medical necessity or experimental or investigational treatment, and that are resolved by the close of the next business day, are exempt from the requirement to send a written acknowledgement and resolution letter.

1. Exempt grievances shall be logged into the automated system upon receipt in the same manner as non-exempt grievances.
2. If a Member Services Representative receives a call that meets the criteria for an exempt grievance/appeal and the appropriate action is taken to respond to the caller's concern by the close of the next business day, the Member's record is updated in the automated system to indicate the matter has been "resolved" and a Category Code of "EG" for exempt grievances is assigned.
3. During review of Category Code "C" records assigned by the Member Services Department, the Grievance/Appeal Coordinator may take the appropriate action to resolve an issue within the allowed exemption timeframe. In this case, the Member's record is updated in the automated system to indicate the matter has been "resolved" and the Category Code is updated to "EG" for exempt grievances.
4. The automated log for tracking exempt grievances/appeals shall include the date of the call, the name of the complainant, the complainant's Member identification number, the nature of the grievance, nature of the resolution, and the name of the ***Premier Access*** staff person who took the call and resolved the grievance.

## Expedited Grievances

Expedited grievances are processed as follows:

1. ***Premier Access*** shall conduct an expedited grievance review in cases involving an imminent and serious threat to the health of the Enrollee, including severe pain or potential loss of life or major bodily function.
2. Expedited grievances shall be forwarded to the Dental Director or designee within 24 hours of receipt for review.
3. The Member shall be immediately notified, via telephone, of his/her right to contact the State regarding the grievance.
4. A written statement of the disposition or pending status of the expedited grievance shall be provided to the State and the Member within three (3) calendar days of receipt of the expedited grievance.
5. Premier Access shall notify the complainant verbally of the resolution of an expedited review.
6. The requirement that the Member must participate in ***Premier Access'*** grievance process prior to applying to the State for review of the expedited grievance shall be waived.
7. The State shall be able to contact ***Premier Access*** regarding expedited grievances 24 hours a day, seven days a week.
8. When contacted by the State, ***Premier Access*** shall respond within 30 minutes during normal business hours, and within one hour during non-work hours.
9. There shall be a ***Premier Access*** representative with the authority to resolve expedited grievances and authorize the provision of dental services covered under the Member's contract in a medically appropriate and timely manner, including making financial decisions for expenditure of funds without first having to obtain approval from superiors. (See Exhibit A: Emergency Grievances Representatives Contact List )

10. When a ***Premier Access*** Member reports a grievance to the State that qualifies as an expedited grievance, the State may contact the ***Premier Access*** corporate office directly during normal business hours.
11. After business hours, the State may contact the primary and/or back-up individuals listed in ***Premier Access'*** Emergency Grievances Representatives Contact List. (See Exhibit A: Emergency Grievances Representatives Contact List)

## Grievance Appeal

If ***Premier Access*** is unable to come to a grievance/appeal resolution that is satisfactory to the Member, the Member may appeal the decision.

1. The Member may submit an appeal to the State 30 calendar days after submitting a grievance/appeal to ***Premier Access.***
2. Appeals of grievance/appeal resolutions may be made in writing to the Dental Director, who shall present them to the Quality Management (QM) committee.
3. Members are encouraged to submit appeals to ***Premier Access*** within 45 calendar days from the date of the notification letter to the Member regarding initial grievance/appeal determination findings.
4. Members will be informed in writing of the disposition of the appeal within 30 calendar days of when the appeal request was received in writing.
5. **Applicable for California Managed Care members only:** Members may also appeal grievance/appeal decisions by requesting a Fair Hearing from the State. This information shall be included in the notification letter mailed to the Member following a determination. The following information related to filing grievances/appeals is included in the Evidence of Coverage booklet received by every new Member and also in the Provider Manual received by every new Provider. The information is also included in all grievance/appeal letters.

   *"The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at* ***(1-800-707-6453)*** *and use your health plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number* ***(1-888-HMO-2219)*** *and a TDD line* ***(1-877-688-9891)*** *for the hearing and speech impaired. The Department's Internet* ***Web site http://www.hmohelp.ca.gov*** *has complaint forms, IMR application forms and instructions online."*

6. **Applicable to California Medi-Cal Enrollees only**:

   The Member has the right to the Medi-Cal Fair Hearing process regardless of whether or not a complaint or grievance has been submitted or if the complaint or grievance has been resolved, when a health care service requested by the Member or Provider has not been provided. The State Department of Social Services' Public Inquiry Unit toll free telephone number is 1-800-952-5253. Or the MEMBER may write to:

Office of the Chief Administrative Law Judge
State Department of Social Service
c/o The Department of Health Care Services
P.O. Box 13189
Sacramento, CA 95813-3189

7. **Continuation of benefits during an appeal or State Fair Hearing:**
   The Plan will continue an Enrollee's benefits if:

   (a) The Enrollee or the Provider files the Appeal timely. "Timely" means filing on or before the later of the following:

   - Within ten days of the Plan's mailing the Notice of Action;
   - The intended effective date of the Plan's Proposed Action.

   (b) The Appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

   (c) The services were ordered by an authorized Provider;

   (d) The original period covered by the original authorization has not expired; and

   (e) The Enrollee requests extension of benefits.

## Reporting and Monitoring

1. Premier Access' grievance system shall track and monitor grievances received by the plan. The system shall:
   - monitor the number of grievances received and resolved;
   - whether the grievance was resolved in favor of the enrollee or plan;
   - and the number of grievances pending over 30 calendar days.
2. The reporting system shall track grievances under categories of Commercial, Medicare and Medi-Cal/other contracts.
3. The reporting system shall indicate whether an enrollee grievance has been submitted to:
   - the Medicare review and appeal system;
   - the Medi-Cal fair hearing process; or
   - arbitration.
4. The system shall be able to indicate the total number of grievances received, pending and resolved in favor of the enrollee at all levels of grievance review and to describe the issue or issues raised in grievances as:
   - coverage disputes
   - disputes involving medical necessity
   - complaints about the quality of care and
   - complaints about access to care (including complaints about the waiting time for appointments);
   - complaints about the quality of service; and
   - other issues.
5. Grievances/Appeal resolutions shall be reviewed by the Dental Director and Quality Management Manager and any quality of care issues shall be referred to the QM committee for review and action.
6. In the event that a Provider does not show improvement or is uncooperative with ***Premier Access'*** improvement efforts in resolving systemic interpersonal problems, the Dental Director shall consult with the QM Committee to determine the next appropriate corrective action, up to and including termination of the Provider's contract.
7. If warranted, the Provider shall be placed on probation pending the QM Committee's decision or recommendations. Recommendations may include further investigation through focused review or studies, education to the Provider or disciplinary action.
8. Any grievances alleging discrimination will be reported to QM Committee and forwarded to the State for review and appropriate action.
9. All grievances/appeals referred to external review shall be reported quarterly to the State until the review and any required actions to be taken by ***Premier Access*** are completed.
10. A summary of all grievances/appeals are reported to the QM Committee by the Quality Management Manager.

11. Standard and ad hoc reports shall be generated from the grievance log. These reports shall be run by authorized users as needed and shall be used for monitoring of the grievance process, as well as required reporting to regulatory entities. Standard reports can be run in summary or detailed format and include combinations of the following data:
    - Member name
    - Member identification number
    - Name of individual who recorded the grievance
    - Category
    - Status
    - Line of business
    - Date received
    - Date acknowledged
    - Date resolved
    - Number of days to acknowledge
    - Number of days to resolve
    - Resolution type (i.e. in favor of ***Premier Access*** or Provider, in favor of the Member).

    For grievances pended and unresolved for 30 calendar days or more, ***Premier Access*** shall have the ability to report the number of grievances pended at ***Premier Access'*** internal grievance/appeal process; the State's consumer complaint process; the State's Independent Medical Review system; an action filed or before a trial or appellate court; or other dispute resolution process.
12. For grievances referred to external review, ***Premier Access*** shall have the ability to report the number of grievances submitted to the State fair hearing process, the number undergoing arbitration and the nature of the unresolved grievances.
13. The Dental Director has the primary responsibility for the grievance process. The Dental Director shall perform continuous oversight and review of the grievance process.
14. The QM Committee reviews Grievance data to determine trends and initiate changes in policy or practice, as appropriate. The monitoring of grievance/appeal data should drive improvement activities and utilize information for systemic process and quality improvement initiatives.
15. The written record of grievances shall be reviewed periodically by ***Premier Access'*** Board of Directors, Public Policy Committee and the Dental Director.
16. For California plans, the Plan will comply with reporting requirements stated in 22 CCR 53858(e).
17. For Geographic Managed Care and Los Angeles Prepaid Health Plan, the Plan will comply with Quarterly Grievance Reporting contract requirements.

## References

This policy was previously tracked as Quality Management Program Policy and Procedure ***GA-01 – Grievance System.***

See also related policy: ***Policy QM.009.01, Performance Measures***

## Exhibits

- Exhibit A: Emergency Grievances Representatives Contact List
- Exhibit B: Grievance Category Codes
- Exhibit C: Grievance Process Flow Chart

## Revision History

| Revision Date: | Description |
| --- | --- |
| 05/18/2012 | Conversion to revised policy and procedure format and naming convention.<br>Addition of updated grievance category codes and updates to procedure description. |
| 01/01/2013 | Annual review. Update of contact information. |
| 03/19/2013 | DMHC Routine Dental Survey Audit |
| 04/10/2013 | Addition of Fair Hearings information due to Medi-Cal Contract, Exhibit A. |
| 06/21/2013 | Addition Changes due to Medi-Cal Contract, Exhibit A |

**EXHIBIT A**
**Grievance and Appeals**
**Emergency Grievances Representatives Contact List**

Primary Company Representative to Contact:

Dr. Cherag Sarkari, D.D.S., Dental Director
Telephone: (916) 563-6011
Cellular: (916) 718-2828
Email: DrSarkari@premierlife.com

Back-up Representatives:

Dr. Reza Abbaszadeh, D.D.S, Chief Executive Officer
Telephone: (916) 563-6010
Cellular: (916) 812-0407
Email: reza@premierlife.com

Terri Abbaszadeh, Vice President, Administration
Telephone: (916) 563-6020
Cellular: (916) 712-9100
Email: terri@premierlife.com

# Exhibit B
# Grievance and Appeals
# Grievance Category Codes

| Main Grievance Category | Code - Description |
|---|---|
| **Access to Care** | C1a - Unreasonable wait for appointment |
| | C1b - Facility limits availability of appointments |
| | C1c- No facility in the area |
| | C1d- Lack of telephone accessibility |
| | C1e - Inadequate # of facilities |
| | C1f - Emergency treatment not provided |
| | C1g - Emergency coverage unavailable |
| | C1h- Contracted specialist not available (endo, perio, pedo, oral surgeon, ortho) |
| | C2a - Unreasonable wait time in the office |
| | C2b - Unreasonable wait time in the operatory |
| | C3 - Transportation or shuttle problems |
| **Coverage Disputes** | C7Ca - Patient has dual coverage (e.g., Medi-Medi) |
| | C7Cb- Coordination of Benefits |
| | C7Cc - Non-Emergency Off Panel |
| | C7Cd - Out of Area Emergency |
| | C7Ce - Coverage Benefit Disputes |
| | C7Cf – Disputes Involving Medical Necessity |
| | C7Cg - Plan Denial of Benefits for Treatment |
| | C7Ch - Charged/ Quoted Incorrectly |
| | C7Ci - No Choice of Benefits Given |
| | C7Cj - Member unhappy with benefit |
| | C7Ck - Member not on eligibility list |
| | C7Cl - Premier Access/ ADP eligibility error |
| | C7Cm - Client eligibility error |
| | C7Cn - Member no longer eligible |
| | C7Co - Member never eligible |
| **Member Appeals** | C11a - Member appeal |
| | C11b - Fair Hearings |
| **Quality of Care** | C5a - Reception area unclean |
| | C5b - Reception area disorganized |
| | C5c - Treatment area unclean |
| | C6a - Diagnosis/ Treatment Misquote |
| | C6b - Treatment Premier Access Unclear |
| | C6c - Exclusions & Limitations not explained clearly |
| | C6d - Optional Treatment not explained |
| | C6e - Optional Treatment mandatory |
| | C7Aa - Member unhappy with treatment |
| | C7Ba - Dental Director/ Consultant Review |
| | C7Bb - Tx denied - poor prognosis |
| | C7Bc - Tx plan is not improving health |

| | |
|---|---|
| | C8a - Clinical indication not clear/ complex |
| | C8b - Quality of Care |
| | C8c - Sterilization/ Infection Control |
| | C8d - No Masks, gloves, glasses |
| | C9a - Second opinion: Member question dx/ tx plan |
| | C9b - Provider denial/ refusal of treatment |
| | C9c - Provider refusal to refer |
| | C10a - Pedodontic - Denied/ Behavior Management |
| | C10b - Pedodontic - Denied/ no attempts |
| | C10c - Pedodontic - Benefit Limit |
| | C10d - Specialty Referral - does not meet criteria |
| | C10e - Recommended treatment is not a benefit |
| **Quality of Service** | C4Aa - DDS/ Staff - Questions Unanswered |
| | C4Ab - DDS/ Staff - Appearance Unkempt |
| | C4Ac - DDS/ Staff - Encouraged Patient Transfer |
| | C4Ad - DDS/ Staff - Negative Comments regarding PA/ ADP |
| | C4Ae - DDS/ Staff – Rude |
| | C4Af - DDS/ Staff – Unprofessional |
| | C4Ag - DDS/Staff – Unfriendly |
| | C4Ah - Untenable Dr/ Patient relationship |
| | C4Ba - Slow to respond to member inquiries |
| | C4Bb - PA/ADP staff - Questions Unanswered |
| | C4Bc - PA/ ADP staff – Rude |
| | C4Bd - PA/ ADP staff – Unprofessional |
| | C4Be - PA/ADP staff – Unfriendly |
| | C6Aa - Language assistance/Plan |
| | C6Ab - Language assistance/ Provider |
| | C6Ac - Language assistance/ Materials |
| | C7D - This classification is used for any expedited grievance (within the policy definitions). |

**Grievance and Appeals**
**Grievance Process Flow Chart**