

# VI. Appeals, Complaints & Grievances



## A. Definition of Terms

In compliance with State requirements, *ValueOptions* defines the following terms related to Enrollee or Provider concerns with the NorthSTAR program:

- **Administrative Appeal:** A request by a member, member-designated representative, or provider to reconsider an administrative adverse determination.
- **Administrative Denial:** A denial of services, or claims payment for services, based on reasons other than a lack of medical necessity.
- **Adverse Determination:** A determination that the health care services furnished or proposed to be furnished to an enrollee are not medically necessary.
- **Clinical Appeal:** A request by a member, member-designated representative, or provider to review an adverse medical necessity determination made in response to a request for services.
- **Complaint:** Any dissatisfaction expressed by a complainant orally or in writing to *ValueOptions* with any aspect of *ValueOptions*' operation, including but not limited to dissatisfaction with plan administration; procedures related to review or appeal of an adverse determination; the denial, reduction or termination of a service for reasons not related to medical necessity; the way service is provided or disenrollment decisions made. Complaint does not include a misunderstanding or a problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to the satisfaction of the Enrollee. It does not include a provider's or Enrollee's oral or written dissatisfaction or disagreement with an adverse determination.
- **Grievance:** A verbal or written communication from a complainant of dissatisfaction with the outcome of a complaint resolution.
- **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 benefits, explain a process, check on the status of a claim/invoice) that does not meet the definition of a "complaint" or an "appeal".

## B. Complaint Process

An important component of the *ValueOptions*' Quality Management Program is the complaint resolution process. There is a defined complaint process that meets State requirements. Complaints may be oral or written, by Enrollees or providers and are responded to within **five (5) business days** from receipt of the complaint and resolved within **thirty (30) calendar days**. The complainant receives both an acknowledgement and a resolution letter within the timeframes specified above. The resolution letter provides a determination or details regarding what was specifically done to address the complaint. Additional complaint and appeal process options are attached to the resolution letter. This includes Texas Department of Insurance and NorthSTAR

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complaint contact information. At no time will *ValueOptions* retaliate or take any discriminatory action against an Enrollee or Provider due to filing a complaint, grievance or an appeal.

## 1. How to initiate a complaint:

1. Contact *ValueOptions*' Member Services at 1-888-800-6799 to speak directly to a *ValueOptions*' Customer Service representative. This representative assists in documenting the nature of the complaint.
2. Mail written complaints directly to the attention of the:  
*ValueOptions*' Complaint and Appeal Department  
1199 South Beltline Road, Suite 100  
Coppell, Texas 75019
3. Contact the *ValueOptions*' Complaint and Appeal voice mail directly at (972) 906-2720, and leave a message regarding the complaint. The complaint is then documented by a *ValueOptions*' Complaint and Appeal Coordinator. The *ValueOptions* Complaint and Appeal Department staff is available between 8:00 am and 5:00 pm central standard time.
4. Fax complaints directly to *ValueOptions*' Complaint and Appeal Department at (972) 906-2780.
5. An Enrollee may designate a representative to file complaints on their behalf. There are no time limits for the filing of a complaint.
6. *ValueOptions* sends an acknowledgement letter within 5 business days with an attached complaint form to provide additional complaint details when an oral complaint is made. Completion of this form is optional. The form may be completed and mailed or faxed back to the attention of the Complaint and Appeals Department using the contact information provided in this section.
7. *ValueOptions*' Enrollee/Provider Services Unit is accessible to non-English speaking Enrollees through a language translation service and a TDD system for the hearing impaired.

## 2. Complaint Resolution:

- All complaints are investigated in coordination with the appropriate *ValueOptions*' department and handled by the Complaint and Appeal Coordinator. Written notification includes clinical or contractual rationale, if appropriate, for the outcome of the investigation.
- All complaints are aggregated by provider and complaint type to assist with the identification of trends and quality of care concerns. Aggregate reports are presented periodically to the Quality Management Committee (QMC).

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- Complaints are resolved within 30 calendar days and a resolution letter is mailed to the Provider or Enrollee initiating the complaint.
- Complaint resolution letters include the procedure for requesting the next level of review.
- Medicaid Enrollees may request a Fair Hearing with the State. This option is not available to Providers, but is an Enrollee option.
- Non-Medicaid Enrollees may request a complaint panel that includes an equal number of *ValueOptions* staff to Enrollees and Providers. This option is not available to Providers, but is an Enrollee option.

## **C. Administrative Appeal Process**

Administrative appeals are handled in the same manner as complaints. Administrative appeals may be oral or written, by Enrollees or Providers and are responded to within **five (5) business days** from receipt of the appeal and resolved within **thirty (30) calendar days**. The appellant receives both an acknowledgement and a resolution letter within the timeframes specified above. The resolution letter provides an appeal determination (uphold or overturn initial decision) and a brief description of the rationale for the determination. Additional complaint and appeal process options are attached to the resolution letter. This includes Texas Department of Insurance and NorthSTAR complaint contact information.

An Enrollee may designate a representative to file appeals on their behalf. Providers and Facilities may also file appeals related to claims and other administrative denials. In accordance with the NorthSTAR contract, administrative appeals must be filed within **60 calendar days** from the administrative denial.

### **1. How to initiate an administrative appeal (claims appeal)**

A valid administrative appeal is initiated when:

1. A member, provider, facility rendering service, or the member's designated representative has requested an appeal.
2. The request includes at least the member's name or identification number and the dates of service for which a denial of services or claims payment
3. The request is received within the appropriate appeal time frame.
4. Mail written administrative appeals directly to the attention of the:

*ValueOptions* Complaint and Appeal Department  
1199 South Beltline Road, Suite 100  
Coppell, Texas 75019.

5. Fax administrative appeals directly to *ValueOptions* Complaint and Appeal Department at (972) 906-2780.

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6. As part of the appeals process, a member, member-designated representative, provider or facility rendering service is given the opportunity to submit written comments, documents, records, and other information relating to the appeal. *ValueOptions* takes all submitted information into account in considering the appeal regardless of whether such information was submitted or considered in the initial decision.
7. *ValueOptions* sends an acknowledgement letter within 5 business days informing the appellant of the receipt of the administrative appeal.
8. For appeal status, contact the *ValueOptions*' Complaint and Appeal voice mail directly at (972) 906-2720, and leave a message regarding your appeal. Please include your contact information, Enrollee name and NorthSTAR identification number, and Dates of Service that you are appealing. The *ValueOptions*' Complaint and Appeal Department staff is available between 8:00 am and 5:00 pm central standard time.
9. For claims payment status or other questions regarding claims, contact *ValueOptions*' Claims Customer Service at 1-888-800-6799 to speak directly to a Claims Customer Service representative.

## 2. Administrative Appeal Resolution:

1. When *ValueOptions* receives an appeal request, the Complaint and Appeal Coordinator verifies timeliness and that it is an administrative appeal (versus a clinical appeal).
2. The requestor is informed of what additional information, if any, is required to conduct the appeal and the timeframes for submission of such information.
3. When an appeal is requested, but requested information is not received within the decision timeframe, the appeal decision is made based on whatever information is available and a decision is rendered within the appropriate timeframes.
4. When a valid administrative appeal has been initiated, the Service Center Vice President designee conducts the review. The Complaint and Appeal Coordinator assigns the appeal to an appropriate subject matter expert, who did not participate in the previous decision.
5. A full investigation into the substance of an appeal is conducted. The appeal reviewer considers all information available. This can include information submitted by the provider, facility or member representative since the initial determination, as well as, *ValueOptions*' internal system documentation (clinical notes and claims history).
6. Based on a review of all available information, the reviewer determines whether the original issues that led to the administrative denial have been resolved. If not, the original decision is upheld and appropriate notice issued within the applicable timeframe.
7. Administrative appeals are resolved within 30 calendar days and a resolution letter is mailed to the Provider or Enrollee initiating the appeal.
8. Appeal resolution letters include the procedure for requesting the next level of review.

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9. Medicaid Enrollees may request a Fair Hearing with the State. This option is not available to Providers, but is an Enrollee option.
10. Non-Medicaid Enrollees may request a complaint panel that includes an equal number of *ValueOptions* staff to Enrollees and Providers. This option is not available to Providers, but is an Enrollee option.

### **3. Favorable Administrative Appeal Resolution:**

- If the original administrative issues have been resolved in favor of the appellant and no further clinical review is required, the Provider is notified that the initial administrative denial was overturned. Claims are reprocessed in order to complete the appeal process. The Provider may be requested to submit corrected claims within a designated timeframe in order to reprocess the claim.
- If the review determines that the original administrative issues have been resolved in favor of the appellant, but further clinical review is required, the Provider is notified that the initial administrative denial was overturned and forwarded to clinical for a review of medical necessity in order to act on the original request for services. The appeal is forwarded to the appropriate clinical staff member for a medical necessity review and determination.

### **D. Grievance Process**

Enrollees or Providers may challenge the unsatisfactory disposition of a complaint or an administrative decision. All complaint and administrative appeal resolution letters provide an attachment with information regarding obtaining additional review. *ValueOptions* offers one level of internal appeal for administrative appeal decisions.

### **E. Clinical Adverse Determination Procedures**

1. During an authorization review, the *ValueOptions* Care Manager requests clinical information about the consumer's condition and response to treatment in order to assure that the requested level of service meets medical necessity. At times, the Care Manager may indicate that she/he cannot authorize the requested level of care due to the apparent lack of medical necessity. In these instances, the Care Manager may discuss alternative levels of care or treatment plans that can be authorized. If the provider does not feel that these alternative suggestions are clinically appropriate, and believes that the requested level of care is the one that is required, the case is referred to a Peer Advisor for a Peer Review.
2. The *ValueOptions* Peer Advisor evaluates the case and attempts to discuss the care of the Enrollee with the treating Provider by phone.
3. An Enrollee or Provider may request an Expedited Appeal if treatment involves inpatient hospitalization or the situation is of an emergency or urgent nature. Notice of adverse

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determination must be given within **one (1) business day** by telephone or by fax followed by written notice within **three (3) days**.

4. Provider and Enrollee are notified of the denial determination within **three (3) days** if patient is not hospitalized.
5. Notification of denials at all levels of care include:
  - Reason for the adverse determination
  - The clinical basis for the adverse determination
  - The medical necessity criteria utilized in making the determination
  - Instructions for filing an appeal
  - The address and phone number of the Texas Department of Insurance
  - The right of the Enrollee to have his or her case reviewed by an Independent Review Organization (IRO) or Fair Hearing

## **F. Appeal Process: Clinical Appeals**

### **1. Expedited Appeals**

An Enrollee or Provider may request an Expedited Appeal if treatment involves inpatient hospitalization or the situation is an emergency or of an urgent nature. The case is reviewed by a Peer Advisor not previously involved in the adverse determination. The time frame for investigation and resolution of the appeal is concluded in accordance with the medical immediacy of the case, but in no event will it exceed **one (1) business day**. Written notification of the outcome of the Expedited Appeal follows within **three (3) business days**. Instructions for filing the next level of appeal is given in the written notification, along with the instructions for filing a Fair Hearing or an IRO review.

### **2. Non-Emergency Appeal Process**

1. A Provider, an Enrollee, or an Enrollee's representative may request an Appeal of an adverse determination within 180 days of the adverse determination.
2. When a *ValueOptions* Representative receives notification of an Appeal, the Complaint and Appeals Coordinator is alerted, so that she/he can log and track the Appeal in the tracking system.
3. *ValueOptions* sends an Acknowledgement Letter, listing the specific information for the review, within **five (5) working days** from the request for an Appeal.
4. The Level I Appeal is conducted by a *ValueOptions* Peer Advisor, who is a licensed Psychiatrist or a licensed Ph.D. Psychologist, with expertise in the area under review. The Peer Advisor must be someone who did not render the original adverse decision in the case.

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5. The Provider and Enrollee are notified of the Appeal determination within **fifteen days** (calendar days) (**15**) from the date *ValueOptions* receives all of the information necessary to evaluate the appeal (or sooner according to the immediacy of the health condition).
6. If the denial is upheld, the Enrollee or Provider may then file a written Level II Appeal within **ten days (10)** of receipt of the Level I decision.
7. When a Level II Appeal is received, an Acknowledgement Letter, listing the specific information for the review, is sent within **five (5) working days** from the receipt of the Appeal.
8. The *ValueOptions* Medical Director forwards the appeal to a provider of the same or similar specialty as one who typically manages the medical condition, procedure, or treatment under discussion for review of the adverse determination.
9. The Level II reviewer renders an opinion in writing within **fifteen (15) working days** of the receipt of the request for the specialty review.
10. Once again, the Enrollee is advised of his/her right to request a Fair Hearing or a review by an IRO.
11. If the Level II appeal is upheld, the non-Medicaid Enrollee can notify *ValueOptions* of his or her intent to request an IRO.
12. The *ValueOptions* Complaint and Appeals Coordinator assists the Enrollee with completing the IRO request form and filing with the Texas Department of Insurance (TDI), if necessary. TDI will randomly assign the case to a participating IRO.
13. *ValueOptions* cooperates fully with the designated IRO, forwarding no later than **three (3) business days** after receiving the request for the information below:
  - Any medical records of the enrollee relevant to the review
  - Any documents used in making previous determinations
  - Copies of previous notifications of adverse determinations
  - Any additional information or documentation received in support of the appeal
  - A list of providers who have provided care to the Enrollee and may have information relevant to the appeal.
14. *ValueOptions* is responsible for reimbursement to the IRO.
15. The IRO notifies the Enrollee, a person acting of behalf of the Enrollee, or the Enrollee's provider, and *ValueOptions* of the determination within **fifteen (15) days** after receiving all information necessary to make a determination (or within **twenty [20]** days of the receipt of request for a review).
16. The *ValueOptions* NorthSTAR Clinical Director (Utilization Management Coordinator) prepares reports on utilization of adverse determinations and appeals for submission to the State, as needed.

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## **G. Tracking and Trending**

The *ValueOptions* NorthSTAR Quality Manager is responsible for ensuring that all complaints and grievances are resolved within the specified time frames. Duties include review of all logs, as well as reports of complaints and grievances, on a monthly basis to identify trends in the types of issues received. The Quality Manager also prepares reports on utilization appeals for submission to the State, as needed. Trends identified and any indicated action plans are shared with the *ValueOptions* NorthSTAR Quality Improvement Committee on a quarterly basis.

**PLEASE SEE SECTION XI (CLAIM AND BILLING INFORMATION), FOR  
DETAILED INFORMATION REGARDING CLAIMS APPEALS**