Medicaid Grievance and Appeals System – Grievances, Appeals and Hearings

State(s):	LOB(s):
☐ Idaho ☐ Montana ☒ Oregon ☐ Washington ☐ Other:	☐ Commercial ☐ Medicare ☒ Medicaid ☐ PSA

Government Policy

This Policy outlines the requirements and actions of how PacificSource Community Solutions (PCS) will accept, process and respond to appeals, grievances, and contested hearings in line with Oregon Administrative Rules (OAR) 410-141-3875 through 410-141-3915, 410-141-3525, 410-141-3751 through 410-141-3915, 410-120-1860, 137-003-0501 through 137-003-0700, 410-141-3915, 410-141-3500, 410-141-3885, 943-005-0060(1)©, 943-005-0010, 410-141-3585, 410-141-3505.

This policy is subject to approval by the Oregon Health Authority (OHA) and must be submitted annually, as directed by OHA, or anytime thereafter upon a significant change.

Procedure: Grievances, Appeals and Hearings

1) The following definitions apply for purposes of this rule and OAR 410-141-3835 through 410-141-3915:
    a. “Appeal” means a review by PCS, pursuant to OAR 410-141-3890 of an adverse benefit determination.
    b. “Adverse Benefit Determination” means, any of the following, consistent with 42 CFR § 438.400(b):
        i. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
        ii. The reduction, suspension, or termination of a previously authorized service;
        iii. The denial, in whole or in part, of payment for a service. A payment denied soley because the claim does not meet the definition of a “clean claim” at CFR 447.45(b) is not an adverse benefit determination
        iv. The failure to provide services in a timely manner pursuant to 410-141-3515;
        v. PCS’ failure to act within the timeframes provided in these rules regarding the standard resolution of grievances and appeals;
        vi. For a resident of a rural area with only one MCE, the denial of a member’s request to exercise their legal right, under 42 CFR 438.52(b)(2)(ii), to obtain services outside the network; or
        vii. The denial of a member’s request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.
    c. “Contested Case Hearing” means a hearing before the Authority under the procedures of OAR 410-141-3900 and 410-120-1860;
    d. “Continuing benefits” means a continuation of benefits in the same manner and same amount while an appeal or contested case hearing is pending, pursuant to OAR 410-

141-3910;

e. “Grievance” means a member's expression of dissatisfaction to PCS or the Authority about any matter other than an adverse benefit determination, Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member’s rights regardless of whether remedial action is requested. A Grievance also includes a member’s right to dispute an extension of time proposed by PCS to make an authorization decision;
f. “Member.” With respect to actions taken regarding grievances, appeals and contested case hearings, references to a “member” include, as appropriate, the member, the member’s representative, and the representative of a deceased member’s estate. With respect to PCS notification requirements, a separate notice must be sent to each individual who falls within this definition;
g. “Notice of Adverse Benefit Determination” means the notice must meet all requirements found at 42 CFR 438.44.

2) PCS must establish and have an Authority approved grievance and appeal system in place for members. PCS shall create and implement a written process and procedures, which must comply with the requirements set forth in rules and contract, and include such documentation in its member and provider handbooks. Grievance and appeals requirements that shall include the following:
    a. Member rights to file a grievance at any time for any matter other than an adverse benefit determination;
    b. Member rights to appeal and request an MCE review of an adverse benefit
    c. determination, including the ability of providers and authorized representatives to appeal on behalf of a member;
    d. Member rights to request a contested case hearing regarding a PCS adverse benefit determination once the plan has issued a written notice of appeal resolution under the Administrative Procedures Act;
    e. An explanation of how PCS shall accept, acknowledge receipt, process, and respond to grievances, appeals, and contested case hearing requests within the required timeframes;
    f. Compliance with grievance and appeals requirements as part of state quality strategy and to enforce a consistent response to complaints of violations of consumer rights and protections;
    g. Specific to the appeals process, the policies shall:
        i. Consistent with confidentiality requirements, ensure PCS’ staff designated to receive appeals begins to obtain documentation of the facts concerning the appeal upon receipt;
        ii. Provide the member a reasonable opportunity to present evidence and testimony and make legal and factual arguments in person as well as in writing;
            1. PCS must inform members of this sufficiently in advance of the resolution timeframe for appeals.
        iii. PCS shall inform the member of the limited time available for this sufficiently in advance of the resolution timeframe for both standard and expedited appeals;
        iv. PCS shall provide the member and their representative the member’s case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by PCS (or at the direction of PCS) in connection with the appeal of the adverse benefit determination at no charge and sufficiently in advance of the standard resolution timeframe for appeals; and
        v. Ensure documentation of appeals in an appeals log maintained by PCS that complies with OAR 410-141-3915 and is consistent with contractual requirements.

3) PCS shall provide information to members regarding the following:
    a. An explanation of how PCS shall accept, process, and respond to grievances, appeals,

and contested case hearing requests, including requests for expedited review of grievances and appeals;
    b. Member rights and responsibilities; and
    c. How to file for a hearing through the state's eligibility hearings unit related to the member's current eligibility with OHP.
4) Grievance and Appeal System polices and procedures:
    a. Comply with state and federal laws.
        i. PCS shall adopt and maintain compliance with grievances and appeals process timelines in 42 CFR §§ 438.408(b)(1) and (2) and these rules; and
        ii. Are specifically designed to be culturally and linguistically responsive.
5) Upon receipt of a grievance or appeal, PCS shall:
    a. Within five business days, resolve or acknowledge receipt of the grievance or appeal to the member, authorized representative and/or the member's provider where indicated;
    b. Give the grievance or appeal to staff with the authority to act upon the matter;
    c. Obtain documentation of all relevant facts concerning the issues;
    d. Ensure staff and any consulting experts making decisions on grievances or appeals are:
        i. Not involved in any previous level of review or decision making nor a subordinate of any such individual;
        ii. Health care professionals with appropriate clinical expertise in treating the member's condition or disease, if the grievance involves clinical issues or if the member requests an expedited review. Health care professionals shall make decisions for the following:
            1. A grievance or appeal regarding denial of expedited resolution of an appeal or involves clinical issues.
    e. Take into account all comments, documents, records, and other information submitted by the member without regard to whether the information was submitted or considered;
    f. Not receive incentivized compensation for utilization management activities by ensuring that individuals or entities who conduct utilization management activities are not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.
        i. If the decision involves a grievance regarding denial of expedited resolution of an appeal.
        ii. If the decision involves a grievance or appeal involving clinical issues.
6) PCS shall analyze all grievances, appeals, and hearings in the context of quality improvement activity pursuant to OAR 410-141-3525 and 410-141-3875.
7) PCS shall keep all health care information concerning a member's request confidential, consistent with appropriate use or disclosure as defined in federal, state and CCO Contract requirements, and include providing member assurance of confidentiality in all written, oral, and posted material in grievance and appeal processes.
8) The following pertains to the release of a member's information:
    a. PCS and any provider whose authorizations, treatments, services, items, quality of care, or requests for payment are involved in the grievance, appeal, or hearing may use this information without the member's signed release for purposes of:
        i. Resolving the matter; or
        ii. Maintaining the grievance or appeals log as specified in 42 CFR 438.416.
        iii. If PCS needs to communicate with other individuals or entities not listed in subsection (a) above to respond to the matter, PCS shall obtain the member's signed release and retain the release in the member's record.
9) PCS shall give members any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to providing Certified or Qualified Health Care Interpreter services and toll-free numbers that have adequate TTY/TTD and Certified or Qualified Health Care Interpreter capability:
    a. Assistance from qualified community health workers, qualified peer wellness specialists, or personal health navigators to participate in processes affecting the member's care and services;

b. Free interpreter services or other services to meet language access requirements where required in 42CFR §438.10;
c. Providing auxiliary aids and services upon request including but not limited to toll-free phone numbers that have adequate TTY/TTD and interpreter capabilities; and
d. Reasonable accommodation or policy and procedure modifications as required by any disability of the member.
e. When PCS identifies that a member has an Authorized Representative, PCS should assist the member with completion of the Authorized Representative form.

10) PCS must consider members' literacy and language of preference (including accommodations such as alternative formats) in the development of processes and the development of the policies.
11) PCS, its subcontractors, and its participating providers may not:
    a. Discourage a member from using any aspect of the grievance, appeal, or hearing process or take punitive action against a provider who requests an expedited resolution or supports a member's appeal;
    b. Encourage the withdrawal of a grievance, appeal, or hearing request already filed; or
    c. Use the filing or resolution of a grievance, appeal, or hearing request as a reason to retaliate against a member or to request member disenrollment. Moreover, must protect the anonymity of members utilizing any of the rights afforded in the Grievance system.
12) In all administrative offices and in those physical, behavioral, and oral health offices where PCS has delegated responsibilities for appeal, hearing request, or grievance involvement, PCS shall have the following forms available:
    a. OHP Complaint Form (OHP 3001);
    b. MCE appeal forms (OHP 3302 or approved facsimile);
    c. The Health Systems Division Service Denial Appeal and Hearing Request form (3302) or approved facsimile.
13) In all investigations or requests from the Department of Human Services Governor's Advocacy Office, the Authority's Ombudsperson or hearing representatives, PCS, and participating providers shall cooperate in ensuring access to all activities related to member appeals, hearing requests, and grievances including providing all requested written materials in required timeframes as expeditiously as the affected member's health condition requires.
14) If at the member's request PCS continues or reinstates the member's benefits while the appeal or administrative hearing is pending, the benefits shall continue pending administrative hearing pursuant to OAR 410-141-3910.
15) Adjudication of appeals in a member grievance and appeals process may not be delegated to a subcontractor. If PCS delegates any other portion of the grievance and appeal process to a subcontractor, PCS must, in addition to the general obligations established under OAR 410-141-3505, do the following:
    a. Ensure the subcontractor meets the requirements consistent with this rule and OAR 410-141-3875 through 410-141-3915;
    b. Monitor the subcontractor's performance on an ongoing basis;
    c. Perform a formal compliance review at least once a year to assess performance, deficiencies, or areas for improvement;
    d. Ensure the subcontractor takes corrective action for any identified areas of deficiencies that need improvement.
    e. PCS must retain and keep accessible all subcontractor documentation, logs, and other records for the Grievance and Appeal System whether in paper, electronic, or other form for a minimum of 10 years.
    f. PCS must communicate these policies and procedures to subcontractors;
    g. PCS shall regularly monitor its subcontractors' compliance and take any necessary corrective action. PCS must document and retain all monitoring and corrective action activities for subcontractors.
16) Nondiscrimination Policy Statement, in accordance with all applicable laws including Title VI of the Civil Rights Act, ACA Section 1557, and ORS Chapter 659A, must be included with each Grievance and Appeals System notice.

17) PCS and its providers comply with applicable state and federal civil rights laws. It cannot treat people unfairly in any of its programs or activities because of a person's:
    a. Age;
    b. Color;
    c. Disability;
    d. Gender identity;
    e. Marital status;
    f. National origin;
    g. Race;
    h. Religion;
    i. Sex; or
    j. Sexual orientation
18) Contact information must be included verbatim. If member feels they were treated unfairly for any of the above reasons the member can contact any of the following:
    a. CCO: PCS Civil Rights Coordinator
       Web: www.communitysolutions.PCS.com/Member/DocumentsAndForms
       Phone: (888) 977-9299, TTY 711
       Email: crc@PCS.com
       Mail: PO Box 7068
       Springfield, OR 97475-0068
    b. Oregon Health Authority (OHA) Civil Rights
       Web: www.oregon.gov/OHA/OEI | Email: OHA.PublicCivilRights@state.or.us
       Phone: (844) 882-7889, 711 TTY
       Mail: Office of Equity and Inclusion Division
       421 SW Oak St., Suite 750,
       Portland, OR 97204
    c. Bureau of Labor and Industries Civil Rights Division
       Phone: (971) 673-0764
       Email: crdemail@boli.state.or.us
       Mail: Bureau of Labor and Industries Civil Rights Division
       800 NE Oregon St.,
       Suite 1045, Portland, OR 97232
    d. U.S. Department of Health and Human Services Office for Civil Rights (OCR)
       Web: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf
       Phone: (800) 368-1019, (800) 537-7697 (TDD)
       Email: OCRComplaint@hhs.gov
       Mail: Office for Civil Rights
       200 Independence Ave. SW, Room 509F, HHH Bldg.
       Washington, DC 20201

CCO Grievance Process Requirements

1) A member and, with the written consent of the member, a provider or an authorized representative may file a grievance at any time either orally or in writing, on behalf of a member.
    a. The grievance may be filed with PCS or the Authority.
    b. If the grievance is filed with the Authority, it shall be promptly forwarded to PCS.
2) PCS shall resolve each grievance and provide notice of the disposition as expeditiously as the member's health condition requires but no later than the following timeframes:
    a. Standard Resolution for Grievances:
        i. PCS shall provide written notice to the Member, within five (5) Business Days from the date of the Contractor's receipt of the Grievance, of one of the following:
            1. A decision on the Grievance has been made and what that decisions is;or
            2. That there will be a delay in PCS' decision, of up to 30 days. The written notice shall specify why the additional time is necessary. PCS' decision

will not exceed thirty (30) calendar days from the date of the receipt of the member Grievance.

3) PCS' notices of grievance and appeal system shall comply with OHA's formatting and readability standards in OAR 410-141-3585 and 42 CFR §438.10. PCS shall write the notice in language sufficiently clear that a layperson could understand the notice and make an informed decision. This includes translating notices for members who speak prevalent non-English languages. OHA defines "easily understood" as 6th grade reading level or lower using the Flesch-Kincaid readability scale. MCE uses a minimum 12-point font or large print (18 point).
4) PCS shall ensure that the individuals who make decisions on grievances follow all requirements in OAR 410-141-3875 MCE Grievance and Appeals System General Requirements.
5) When informing members of PCS' decision, PCS:
    a. Shall provide its decision related to oral grievances orally but shall also, in all instances, respond to all member grievances in writing with a notice of grievance resolution. Responses both orally and in writing shall be in the member's preferred language.
    b. Shall address each aspect of the member's grievance and explain the reason for the decision; and
    c. The language for the notice of Grievance resolution to the Member shall be sufficiently clear that a layperson could understand the disposition of the Grievance.
    d. Shall include in each notice of resolution to the member that is not in favor of the member, or for members who are dissatisfied with the disposition of a grievance, that they may present their grievance to the Department of Human Services (Department) Client Services Unit (CSU) toll free at 800-273-0557 or the Authority's Ombudsperson at 503-947-2346 or toll free at 877-642-0450.
6) In compliance with Title VI of the Civil Rights Act and ORS Chapter 659A, PCS shall review and report to the Authority, as outlined in the CCO contract, complaints that raise issues related to racial or ethnic background, gender identity, sexual orientation, socioeconomic status, culturally or linguistically appropriate service requests, disability status, and other identity factors for consideration in improving services for health equity.
    a. PCS has at least one designated individual responsible for receiving and resolving discrimination complaints related to racial or ethnic background, gender identity, sexual orientation, socioeconomic status, culturally or linguistically appropriate service requests, disability status, and other identity factors for consideration in improving services for health equity. The name and contact information for the designated individual must be communicated to members in the Nondiscrimination Statement.
7) If PCS receives a grievance related to a member's entitlement of continuing benefits in the same manner and same amount during the transition of transferring from one MCE to another MCE as defined in OAR 410-141-3850, PCS shall log the grievance and work with the receiving or sending MCE to ensure continuity of care during the transition.
8) PCS must allow Members to file a grievance (after receiving notice that an adverse benefit determination is upheld). The MCE must allow providers, or authorized representatives, acting on behalf of the Member and with the Member's written consent, to request an appeal, file a grievance, or request a state fair hearing request.
9) PCS shall give Members any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to providing Certified or Qualified Health Care Interpreter services and toll-free numbers that have adequate TTY/TTD and Certified or Qualified Health Care Interpreter capability.
    a. Assistance from qualified community health workers, qualified peer wellness specialists, or personal health navigators to participate in processes affecting the member's care and services;
    b. Free interpreter services or other services to meet language access requirements where required in 42CFR §438.10;
    c. Providing auxiliary aids and services upon request including but not limited to toll-free phone numbers that have adequate TTY/TTD and interpreter capabilities; and
    d. Reasonable accommodation or policy and procedure modifications as required by any disability of the member.

10) PCS shall not discourage any Member from using any aspect of the Grievance and Appeal System. Nor shall PCS:
    a. Encourage any Member to withdraw a Grievance, Appeal, or Contested Case Hearing request already filed;
    b. Use the filing or resolution of a Grievance, Appeal, or Contested Case Hearing request as a reason to retaliate against a Member or as a basis for requesting Member Disenrollment, or
    c. Take punitive action against a Provider who requests an expedited resolution or supports a Member's Grievance or Appeal.

CCO Appeal Requirements

1) A member, provider, or authorized representatives, acting on behalf of the member with the member's written consent, may file a standard or expedited appeal orally or in writing with PCS to:
    a. Express disagreement with an adverse benefit determination; or
    b. Contest PCS' failure to act within the timeframes provided in 42 CFR § 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.
2) PCS must allow the member, provider or authorized representative acting on behalf of the member, as state law permits, to file an appeal with PCS within 60 calendar days from the date on the adverse benefit determination.
3) PCS may have only one level of appeal for members, and members shall complete the appeals process with PCS prior to requesting a contested case hearing.
4) Upon receipt of a standard appeal, PCS shall, within five (5) business days, resolve or acknowledge receipt of the appeal to the member, authorized representative and/or the member's provider where indicated.
5) PCS must resolve each appeal and provide notice, as expeditiously as the member's health condition requires, within the state-established timeframe. For standard resolution of an appeal and notice to the affected parties, PCS shall establish a timeframe that is no longer than 16 days from the day PCS receives the appeal:
    a. If PCS fails to adhere to the notice and timing requirements in 42 CFR § 438.408 for either standard or expedited appeals, the member is considered to have exhausted PCS' appeals process. In this case, the member may initiate a contested case hearing;
    b. PCS may extend the timeframes from section (3) of this rule by up to 14 days if:
        i. The member requests the extension; or
        ii. PCS shows to the satisfaction of the Authority upon its request that there is need for additional information and how the delay is in the member's interest.
    c. If PCS extends the timeframes but not at the request of the member, PCS must:
        i. Make reasonable efforts, including as necessary multiple calls at different times of day, to give the member prompt oral notice of the delay;
        ii. Within two calendar days, give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if the member disagrees with that decision.
        iii. Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.
6) For purposes of this rule, an appeal includes a request from the Authority to PCS for review of a notice.
7) A member, authorized representative, or the provider on the member's behalf may request an appeal either orally or in writing directly to PCS for any notice or failure to act within the timeframes provided in 42CFR §438.408(b)(1) and (2) regarding the standard resolution of appeals by PCS:
    a. PCS shall ensure oral requests for appeal of a notice are treated as appeals to establish the earliest possible filing date without the need for written follow-up;

b. The member shall file the appeal with PCS no later than 60 days from the date on the notice.

8) Parties to the appeal include, as applicable:
    a. The member; or
    b. Member's authorized representative; or
    c. Provider acting on behalf of a member, with written consent from the member; or
    d. Legal representative of a deceased member's estate; and
    e. PCS
9) A separate notice must be sent to each individual identified as party to the appeal.
10) PCS shall resolve each standard appeal in time period defined above in section (4). PCS shall provide the member with a notice of appeal resolution as expeditiously as the member's health condition requires, within state-established timeframes, or within 72 hours for matters that meet the requirements for expedited appeals in OAR 410-141-3895.
11) If PCS or the Administrative Law Judge reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, PCS shall authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination.
12) If PCS or the Administrative Law Judge reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, PCS or the state shall pay for those services in accordance with the Authority policy and regulations.
13) The written notice of appeal resolution shall be in a format approved by the Authority. The notice shall contain, as appropriate, the same elements as the action/adverse benefit determination, as specified in OAR 410-141-3885, in addition to:
    a. The date the member filed the appeal with PCS
    b. The results of the resolution process and the date PCS completed the resolution;
    c. The effective date of the appeal decision; and
    d. For appeals not resolved wholly in favor of the member:
        i. Reasons for the resolution and a reference to the particular sections of the statutes and rules involved for each reason identified in the Notice of Appeal Resolution relied upon to deny the appeal;
        ii. The right of the member to request a standard or expedited contested case hearing with the Authority within 120 days from the date of PCS' Notice of Appeal Resolution and how to do so, which includes sending the Request to Review a Health Care Decision Appeal and Hearing Request form available at the OHA Website at https://www.oregon.gov/oha/HSD/OHP/Pages/Forms.aspx;
        iii. Explanation to the member that an expedited hearing will not be granted for post-service denials;
        iv. The right to continue to receive benefits while the hearing is pending and how to do so; and
        v. Information explaining that if PCS' adverse benefit determination is upheld in a hearing, the member may be liable for the cost of any continued benefits.
    e. For appeals resolved partially or wholly in favor of the member an explanation that the member may now access those benefits that were denied and how to do so.

Expedited CCO Appeal Requirements

1) PCS shall establish and maintain an expedited review process for all oral and written appeals, when PCS determines (for a request from the member) or when the provider on the member's behalf or supporting member's request, indicates that taking the time for a standard resolution could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function.
2) PCS shall ensure that punitive action is not taken against a provider who requests an expedited resolution.
3) Upon receipt of an expedited appeal, PCS shall within one business day acknowledge receipt of

the expedited appeal to the member and the member's provider where indicated, both orally and in writing.

4) PCS must resolve each expedited appeal and provide notice, as expeditiously as the member's health condition requires, within state-established timeframes not to exceed 72 hours after PCS receives the expedited appeal request. The timeline for an expedited appeal requested orally shall begin when there is established contact made between the member and PCS. For expedited appeals, PCS shall:
    a. Inform the member of the limited time available for receipt of materials or documentation for the review;
    b. Make reasonable efforts to call the member and the provider to tell them of the resolution within 72 hours after receiving the request; and
    c. Mail written confirmation of the resolution to the member within three days;
    d. Extend the timeframes by up to 14 days if:
        i. The member requests the extension; or
        ii. PCS shows (to the satisfaction of the Authority upon its request) that there is need for additional information and how the delay is in the member's interest.
    e. If PCS extends the timeframes not at the request of the member, PCS shall:
        i. Make reasonable efforts, including as necessary multiples calls at different times of day, to give the member prompt oral notice of the delay;
        ii. Within two calendar days, give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision.
        iii. Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.
5) PCS shall provide written notice, and make reasonable efforts including as necessary multiple calls at different times of day to provide oral notice, of the resolution of an expedited appeal.
6) If PCS denies a request for expedited resolution of an appeal, it must transfer the appeal to the standard timeframe, PCS shall:
    a. Resolve the appeal no later than 16 days from the day PCS receives the appeal with a possible 14-day extension;
    b. Make reasonable efforts to give the Member prompt oral notice of the denial including as necessary multiple calls at different times of day, and follow-up within two days with a written notice; and
    c. The written notice must state the right of a Member to file a grievance with PCS if he or she disagrees with that decision.
7) If PCS provides an expedited appeal but denies the services or items requested in the expedited appeal, PCS shall inform the member of the right to request an expedited contested case hearing and shall send the member a Notice of Appeal Resolution, in addition to Hearing Request and Information forms as set forth in OAR 410-141-3890.

Contested Case Hearings Requirements

1) PCS shall have a system in place to ensure its members, providers, or authorized representatives, acting on behalf of the member, have access to appeal PCS' action by requesting a contested case hearing:
    a. Contested case hearings are conducted pursuant to ORS 183.411 to 183.497 and the Attorney General's Uniform and Model Rules of Procedure for the Office of Administrative Hearings, OAR 137-003-0501 to 137-003-0700. Processes for contested case hearings are provided in OAR 410-120-1860 Contested Case Hearing Procedures.;
    b. If a provider filed an appeal on behalf of a member, as permitted in OAR 410-141-3890, the provider may subsequently request a contested case hearing on behalf of the member in accordance with the procedures in this rule;
    c. A provider that filed an appeal on the provider's own behalf for reasons set forth in OAR 410-120-1560 shall file a hearing request with the Authority no later than 30 days from

the date of PCS' notice of appeal resolution. Appeals brought on the provider's own behalf are not subject to this rule, which governs appeals brought by member or by a provider on the member's behalf but are governed by OAR 410-120-1560.

2) The member may not proceed to a hearing without first completing an appeal with their MCE and receiving written notice that PCS adverse benefit determination is upheld, subject to the exception under section (3), below:
    a. The member shall file a hearing request with the Authority using Service Denial Appeal and Hearing Request form (OHP 3302) or any other Authority-approved appeal or hearing request form no later than 120 days from the date of PCS' notice of appeal resolution. OHA prefers use of 3302 when using an NOAR.
    b. The Authority shall consider the request timely with the exception as noted for expedited hearing requests in OAR 410-141-3905;
    c. If the member sends a contested case hearing request directly to the Authority and the Authority determines that the member qualifies for a contested case hearing, PCS shall immediately submit the required documentation to the Authority's Hearings Unit following their request;
    d. If the member files a request for an appeal or contested case hearing with the Authority prior to the member filing an appeal with PCS, and if the request does not satisfy section (3) below, the Authority shall transfer the request to PCS and provide notice of the transfer to the member. PCS shall:
        i. Review the request immediately as an appeal of PCS' notice of adverse benefit determination;
        ii. Approve or deny the appeal within 16 days and provide the member with a notice of appeal resolution.
    e. If a member sends the contested case hearing request to PCS after PCS has already completed the initial plan appeal, PCS shall:
        i. Date-stamp the hearing request with the date of receipt; and
        ii. Submit the following required documentation to the Authority within two (2) business days:
            1. A copy of the hearing request, notice of action/adverse benefit determination, and notice of appeal resolution;
            2. All documents and records PCS relied upon to take its action, including those used as the basis for the initial action or the notice of appeal resolution, if applicable, and all other relevant documents and records the Authority requests as outlined in detail in OAR 410-141-3890.
3) If, after a member properly files an appeal, PCS fails to adhere to the notice and timing requirements in 42 CFR § 438.408, the Authority may consider the member to have exhausted PCS' appeals process for purposes of requesting a contested case hearing, as provided in OAR 410-141-3890(3). The Authority shall notify PCS of the Authority's decision to allow the member access to a contested case hearing.
4) Effective February 1, 2012, the method described in OAR 137-003-0520(8)-(10) is used in computing any period of time prescribed in OAR chapter 410, divisions 120 and 141 applicable to timely filing of requests for hearing. However, due to operational conflicts, the procedures needing revision, and the expense of doing so, the provisions in OAR 137-003-0520(9) and 137-003-0528(2) that allow hearing requests to be treated as timely based on the date of postmark do not apply to MCE member contested case hearing requests.
5) The parties to a contested case hearing include the following:
    a. The member;
    b. Member's authorized representative; or
    c. Provider acting on behalf of a member as an authorized representative, with written consent from the member; or
    d. Legal representative of a deceased member's estate; and
    e. PCS
6) The Authority shall refer the hearing request along with the adverse benefit determination or notice of appeal resolution to the Office of Administrative Hearings (OAH) for hearing.

Contested case hearings are requested using Authority form MSC 443 or other Authority-approved appeal or hearing request forms.

7) The Authority shall issue a final order, or the Authority shall resolve the case ordinarily within 90 days from the date PCS receives the member's request for appeal. The 90-day count does not include the days between the date PCS issued a notice of appeal resolution and the date the member filed a contested case hearing request.
8) For reversed appeal and hearing resolution services:
    a. For services not furnished while the appeal or hearing is pending. If PCS or the Administrative Law Judge reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, PCS shall authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination;
    b. For services furnished while the appeal or hearing is pending. If PCS or the Administrative Law Judge reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, PCS or the state shall pay for those services in accordance with the Authority policy and regulations.

Expedited Contested Case Hearings

1) PCS shall have a system in place to ensure its members and providers have access to expedited review for PCS' action by requesting an expedited contested case hearing. Contested case hearings are conducted pursuant to ORS 183.411 to 183.497 and the Attorney General's Uniform and Model Rules of Procedure for the Office of Administrative Hearings, OAR 137-003-0501 to 137-003-0700. Processes for expedited contested case hearings are provided in OAR 410-120-1860 Contested Case Hearing Procedures.
2) A request for an expedited hearing for a service that has already been provided (post-service) to the member will not be granted.
3) A member, or provider, who believes that taking the time for a standard resolution of a request for a contested case hearing could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function may request an expedited contested case hearing as described in OAR 410-141-3905.
4) The member may not request an expedited contested case hearing without first completing an appeal or expedited appeal with PCS, subject to the exception in OAR 410-141-3900(3). When a member files a hearing request prior to completion of a PCS appeal or expedited appeal, the Authority shall follow procedures set forth in OAR 410-141-3900.
5) Expedited hearings should be submitted to the OHA and can be requested orally, in writing, or online. May use Service Denial Appeal and Hearing Request form (OHP 3302), or other Division approved appeal or hearing request forms.
6) If a member, member representative, or the provider requests an expedited contested case hearing, the authority shall request documentation from PCS and PCS shall submit relevant and clinical documentation to the Authority within two working days. The Authority shall decide within two working days from the date of receiving the relevant documentation applicable to the request whether the member is entitled to an expedited contested case hearing.
7) If the Authority denies a request for an expedited contested case hearing, the Authority shall:
    a. Handle the request for a contested case hearing in accordance with OAR 410-120-1860; and
    b. Make reasonable efforts to give the member prompt oral notice of the denial and follow up within two days with a written notice.
8) If a member requests an expedited hearing, the Authority shall request documentation from PCS, and PCS shall submit relevant documentation including clinical documentation to the Authority within two working days.

Continuation of Benefits

1) A member who may be entitled to continuing benefits may request and receive continuing benefits in the same manner and same amount while an appeal or contested case hearing is pending:
    a. To be entitled to continuing benefits, the member can request continuation of benefits by phone, letter, fax, or by using the Review of Health Care Decision form and check the box requesting continuing benefits by:
        i. The tenth day following the date of the notice of adverse benefit determination or the notice of appeal resolution; or
        ii. The effective date of the action proposed in the notice, if applicable.
    b. PCS must continue the member's benefits if:
        i. The member or member's representative files the Appeal or Contested Case Hearing request timely;
        ii. The appeal or contested case hearing involves the termination, suspension, or reduction of previously authorized services;
        iii. The services were ordered by an authorized provider;
        iv. The period covered by the original authorization has not expired; and
        v. The member timely files for continuation of benefits. Timely files means filing on or before the later of the following:
            1. Within 10 days after the date of the NOABD; or
            2. The intended effective date of the Action proposed in the NOABD.
    c. In determining timeliness, delay for good cause as defined in OAR 137-003-0528 is not counted;
    d. If, at the member's request, PCS continues or reinstates the member's benefits while the appeal or contested case hearing is pending, pursuant to 42 CFR § 438.420(c), the benefits must be continued until one of the following occurs:
        i. The member fails to request a contested case hearing and continuation of benefits within 10 calendar days from the date of the Notice of Appeal Resolution (NOAR) letter;
        ii. The member withdraws the request for a contested case hearing; or
        iii. A final contested case hearing decision adverse to the member is issued.
2) PCS may, consistent with the state's usual policy on recoveries and as specified in the PCS contract, recover the cost of continued services furnished to the member while the appeal or state fair hearing was pending if the final resolution of the appeal or state fair hearing upholds PCS' adverse benefit determination.
3) For reversed appeal and hearing resolution services:
    a. Benefits not furnished while the hearing is pending, and PCS has decided to authorize services following the review of the Appeal, PCS must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires. PCS must take the following steps:
        i. Notify the member, the member's representative (if applicable) both orally and in writing and the member's provider in writing of the available services and how to access them;
        ii. Enter the prior authorization into the system or adjust the encounter data claim representing the service.
    b. Benefits furnished while the appeal is pending, and PCS has decided to authorize services following the review of the appeal, PCS or the Authority shall pay for those services in accordance with Authority policy and regulations.
    c. When the ALJ reverses PCS' decision to deny authorization of services, PCS can file written exceptions or present argument to the Proposed and Final Order within tend working days after the date the Proposed Order is issued by the ALJ (see OAR 410-120-1860). If written exceptions are filed the Order does not become a Final Order on the 11th work day and the services shall not be provided until the Final Order is issued by the OHA. Once a Final Order is issued and if the decision remains overturned the services shall be authorized or provided to the member within 72 hours of PCS receiving the final

order.

Grievance and Appeals System Recordkeeping

1) PCS shall maintain records of grievances and appeals and shall review the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the state quality strategy as stated in 42 CFR 438.416 and in alignment with contractual requirements.
2) PCS shall document and maintain a record, in a central location for each grievance and appeal. The MCE's record of each grievance and appeal must be accurately maintained in a manner accessible to the state and available upon request to CMS. The record shall include, at a minimum:
    a. A general description of the reason for the grievance or appeal;
    b. The members name and at a minimum the OHA ID#;
    c. The date the member, or members representative, or provider filed the grievance;
    d. Notice of Adverse Benefit Determination;
    e. If filed in writing, the appeal or grievance;
    f. If an oral filing was received, documentation that the appeal or grievance was received orally;
    g. Records of the review or investigation at each level of the appeal, grievance or contested case hearing, including dates of review;
    h. Notice of resolution of the appeal or grievance, including dates of each level;
    i. Copies of correspondence with the member and all evidence, testimony, or additional documentation provided by the member, the member representative, or the member's provider as part of the appeal, grievance, or contested case hearing process; and
    j. All written decisions and copies of all correspondence with all parties to the appeal, grievance, or contested case hearing.
3) PCS must retain and keep accessible all documentation, logs and other records for the Grievance and Appeal System whether in paper, electronic, or other form for a minimum of ten (10) years.
4) PCS must review the log monthly for completeness, accuracy, and compliance with required procedures.
5) PCS shall submit for the Authority's review the Grievance and Appeals Log, samples of Notices of Adverse Benefit Determination, and other reports as required under PCS contract.
6) PCS shall conduct analysis of its Grievances in the context of quality improvement activity, consistent with OAR 410-141-3875, and incorporate the analysis into the quarterly data provided to OHA under the Contract. The Grievance System Report and Grievance and Appeals Log shall be forwarded to the PCS Quality Improvement committee to comply with the Quality Improvement standards as follows:
    a. Review of completeness, accuracy, and timeliness of documentation;
    b. Compliance with written procedures for receipt, disposition, and documentation; and
    c. Compliance with applicable OHP rules.
7) PCS appeal and grievance data is gathered by race/ethnicity, language and disability (REALD) and Sexual Orientation and Gender Identity (SOGI).

Participating Providers and Subcontractors

1) PCS must ensure and monitor its participating providers and subcontractors to comply with the Grievance and Appeal System requirements in accordance with applicable law and the applicable provisions within contract.
2) PCS must provide to all participating providers and subcontractors, at the time they enter into a subcontract, written notification of procedures and timeframes for notices of adverse benefit determination, grievances, appeals, and contested case hearings as set forth in Exhibit I and must provide all of its participating providers and other subcontractors written notification of

updates to these procedures and timeframes within five (5) business days after approval of such updates by OHA.
3) PCS shall ensure and regularly monitor its subcontractors' compliance and take any necessary corrective action. PCS must document all monitoring and corrective action activities for subcontractors.

Appointment of Representative

1) A member may appoint any individual to act as his or her representative during the grievance process. An Appointment of Representative form is available and provided to plan members upon notification to the plan that someone else is filing on their behalf. Both the member and the appointed representative must sign the form. Alternatively, if the member has appointed a Power of Attorney for Healthcare or a legal guardian, that individual may act as the authorized representative in the grievance process.
2) Supporting documentation to validate the basis in which an individual acts as a member representative in the grievance process will be maintained in the case record.
3) Parents/legal guardians may submit a grievance in the matter of a minor child without requiring an Appointment of Representative form.

Confidentiality

1) The plan maintains all grievance information confidential in accordance with HIPAA Privacy Rules. The plan and any provider whose authorizations, treatments, services, items, quality or care, or requests for payment are alleged to be involved in the grievance have a right to use this information without a signed release from the member for purposes of resolving the grievance, maintaining the grievance log, and for health oversight purposes by the Division.
2) If the member or any other individual requests that their information be released to others, the plan will ask the member to provide a signed release of information. Except as provided in OAR 410-141-3260, or as otherwise authorized by all other applicable confidentiality laws, the plan will request an authorization for release of information from the member if the plan needs to communicate with other individuals in the resolution of the grievance. In the case of a minor, the signature should be from someone authorized to act on their behalf, such as a parent or legal guardian. This documentation will be part of the case file and maintained in the member's electronic records.

Appendix

Policy Number: [Policy Number]

Effective: 1/1/2022 **Next review:** 6/30/2024

Policy type: Government

Author(s):

Depts: [Dept]

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