

PROVIDER COMPLAINTS, GRIEVANCES AND APPEALS

Provider Complaints, Grievances and Appeals

AlohaCare's complete policies and procedures for Provider Complaints, Grievances and Appeals are available upon request.

Definitions:

Complaint – An oral or written communication made by a provider expressing dissatisfaction with any aspect of AlohaCare's operations, activities or behavior, whether or not any relief is requested, pertaining to the following:

- Benefits and limits
- Eligibility and enrollment
- Member issues
- Health plan issues

Grievance – An oral or written communication made by a provider expressing dissatisfaction with any aspect of AlohaCare's operations, activities or behavior pertaining to the following:

- Availability of service
- Delivery of service
- Quality of service
- Disagreement with, or request for, reconsideration of authorization denial or of services authorized at a reduced level
- Disagreement with the denial of a claim, in whole or in part, when the denial has been verified through our Claims Department as having been processed accurately
- Dispute regarding actions taken by AlohaCare that related to the provider's status within the provider network or actions taken by AlohaCare related to the provider's professional competency or conduct
- Any issue not resolved at the complaint level
- Complaint of any type that a provider asks to be dealt with at the grievance level

Appeal – An oral or written request made by a provider for review of an adverse decision of a grievance

How to file a Complaint

Written complaints should be sent to:

AlohaCare
Attention: Customer Service Department
1357 Kapiolani Blvd., Suite 1250
Honolulu, HI 96814

Verbal complaints may be made by calling the Customer Service Department at (808) 973-1650 (Oahu) or 1-800-434-1002 (toll free anywhere in the state of Hawaii) to explain the problem or concern. The staff receiving the complaint will deal with the concern immediately.



How to File a Grievance or Appeal

Written grievances or appeals should be sent to:

AlohaCare
Attention: Grievance Coordinator
1357 Kapiolani Blvd., Suite 1250
Honolulu, HI 96814

Providers may also call the Customer Service Department at (808) 973-1650 (Oahu) or 1-800-434-1002 (toll free anywhere in the state of Hawaii) and AlohaCare staff will assist the provider in filing the grievance or appeal by completing an AlohaCare Provider Grievance/Appeal Form.

All grievances and appeals requesting reconsideration of a non-certification based on medical necessity must be filed in writing within 180 calendar days after receipt of AlohaCare's decision. All other grievances and appeals may be filed no later than twelve (12) months from the occurrence generating the grievance/appeal.

Upon receipt of the grievance or appeal, notification of receipt will be sent to the provider within ten (10) calendar days.

AlohaCare will render a decision and notify the provider in writing within thirty (30) days of receipt of the grievance or appeal.

In instances where the provider and AlohaCare disagree about a clinical issue, the decision to provide or undergo medical services is ultimately made by the member in consultation with his/her treating provider. Should a grievance/appeal request not be approved, the member and provider may choose to proceed with the service with the understanding that AlohaCare has not approved payment. Payment disputes for such services will be resolved retrospectively by means of AlohaCare's complaints, grievances and appeals processes, which honor the provider's and member's right to due process.

How to File an Expedited Grievance or Appeal

Written expedited grievances or appeals should be mailed or faxed to:

AlohaCare
Attention: Expedited Appeal Request
1357 Kapiolani Blvd., Suite 1250
Honolulu, HI 96814

Providers may also call the Customer Service Department at (808) 973-1650 (Oahu) or 1-800-434-1002 (toll free anywhere in the state of Hawaii) and AlohaCare staff will assist in filing the expedited grievance. Specifically indicate that you are requesting an expedited grievance or appeal and provide details regarding the criteria below.

An expedited appeal shall be authorized if the application of the standard review time frame may:

- a. Seriously jeopardize the life or health of the member;
- b. Seriously jeopardize the member's ability to attain, maintain or regain maximum functioning; or
- c. Subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the expedited appeal.

The appropriate review will be completed within seventy-two (72) hours of receipt of the request.



Please do not indicate “expedited” on a request that does not meet the criteria stated above. Other types of “rush” requests will be accommodated by AlohaCare when possible. It is important for our mandatory state reporting that we identify expedited requests per the regulatory definitions.

Filing a Grievance or Appeal on Behalf of a Member

AlohaCare members have the right to file a grievance or appeal if they are dissatisfied with anything related to the care they are receiving or the actions or activities of the health plan.

Providers filing a grievance or appeal on behalf of a member must obtain and submit authorization from the member or personal representative on the “Authorization to Disclose Protected Health Information” form.

If the provider states he/she is filing a written grievance or appeal on behalf of the member, but does not attach a written authorization from the member, AlohaCare will contact the provider to verify that the provider is filing the appeal on behalf of the member with written authorization. If so, AlohaCare will request a faxed copy of the member’s authorization form. If the provider is not appealing or grieving on behalf of the member or does not have the member’s written authorization form, the request will be processed as a Provider Grievance.

No punitive action is taken against any provider who file grievances, appeals, expedited grievances, or who supports a member’s appeal or expedited appeal.

Peer Review Process

Peer reviewers are available to provide ad hoc specialist reviews for medical necessity and appropriateness as requested by an AlohaCare Medical Director. A peer reviewer is an AlohaCare credentialed provider or someone who meets AlohaCare’s credentialing standards and who is in the same profession in a similar specialty as a provider who would typically be managing the medical condition, procedure or treatment that is under review.

Peer reviewers are members of an AlohaCare Advisory Committee where possible. Depending on availability of reviewers, AlohaCare has the option to use other credentialed provider within the AlohaCare network. If an appropriate reviewer within the AlohaCare network is not available, AlohaCare will use an external peer review organization. Peer reviewers are not permitted to be anyone who was involved in the original or subsequent decisions related to the issue being reviewed nor be a subordinate of such an individual.

When serving as an ad hoc consultant, the peer reviewer(s) communicate with an AlohaCare Medical Director and discuss suggestions. Final actions remain the responsibility of the AlohaCare Medical Director.

Peer reviewers are available to review and issue an opinion in response to a provider’s dissatisfaction with AlohaCare’s final decision regarding medical necessity for a prior authorization requested, level of care, or length of stay filed through the grievance and appeal process.

The peer reviewer’s decision in the grievance/appeal process is binding on AlohaCare, and details of the decision are sent to the person requesting the grievance or appeal within the timeframes required in policies and procedures. (See Provider Grievances, Member Grievances and Appeals, and Expedited Grievance and Appeal Process policies and procedures)

Peer reviewers are available to participate on a first-level or second-level review hearing panel to review appeal related to a provider’s status in the network, or any action taken by AlohaCare related to a provider’s professional competency or conduct. The peer review panels are convened by the Medical Director. Members of a second-level panel are selected keeping in mind the requirement to not have been involved in either the initial decision or the first-level panel’s decision-making process.

Each panel consists of three qualified individuals of which one must be a participating provider who is not otherwise involved in network management and who is a clinical peer of the participating provider who has filed the dispute regarding a potential breach of performance issues, which may include, but are not limited to:

- Failure to adhere to AlohaCare's policies and procedures
- Providing and ordering health care services not in compliance with generally accepted standards of practice.
- Practice patterns falling outside of accepted norms.
- Professional conduct or competence that may be detrimental to a member's health and safety or to AlohaCare's reputation.

AlohaCare sends the provider a letter via certified mail which states:

- That a professional review action has been proposed to be taken against the provider and the reasons for the action
- That the provider has the right to file a grievance and request a timely hearing regarding the proposed action, and that the provider must request the hearing within thirty (30) days

If the provider does request a hearing in a timely manner, a hearing is scheduled and notice is given, stating:

- The place, time and date of the hearing, which is not less than thirty (30) days after the hearing notice
- A list of witnesses, if any, expected to testify to the peer review panel

For the peer review hearing, the provider has the right to:

- An arbitrator mutually acceptable to the provider and AlohaCare
- A hearing officer who is appointed by AlohaCare who is not in direct economic competition with the provider involved
- A panel of at least three individuals appointed by AlohaCare who are not in direct economic competition with the provider involved and at least one individual who is not involved in the provider network management, and who is a clinical peer of the participating provider that filed the dispute
- The right to the peer review hearing may be forfeited if the provider fails, without good cause, to appear.

At the hearing, the provider has the right to:

- Be represented by an attorney or any other person the provider chooses;
- Have a record made of the proceedings and receive copies of the record upon payment of any reasonable charges associated with their preparation;
- Call, examine, and cross-examine witnesses;
- Present evidence determined to be relevant by the hearing officer, arbitrator, or panel, regardless of its admissibility in a court of law; and
- Submit a written statement at the close of the hearing.

Upon completion of the peer review panel's hearing, the provider has the right to receive, via certified mail:

- The written recommendation of the arbitrator, officer, or panel, including a statement of the basis for the recommendations
- A written decision from AlohaCare, including a statement of the basis for the decision.
- If the decision of the first-level panel's hearing is adverse to the provider, information on the provider's right to appeal to a second-level panel. Processes for the second-level panel follow those for the first-level panel, as described in sections 3.2 through 3.6 of this policy and procedure.

Peer reviewers are not made available if:

- No adverse professional review action taken;
- If the suspension or restriction of clinical privileges is fourteen (14) days or less and an investigation is being conducted to determine the need for a professional review action;
- If an immediate suspension or restriction of clinical privileges, subject to subsequent notice and hearing or other adequate procedures, is necessary because failure to suspend or terminate the provider may result in an imminent danger to the health of any individual.

Time frames for resolution through peer-review policy and procedure hearing may exceed the standards stated in the Provider Grievances policy (thirty (30) days standard resolution time for grievances and appeals) due to the requirement to provide a minimum of thirty (30) days notice of peer review panel hearings to the provider.