



## APPEALS AND GRIEVANCES

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#### **Member Grievances / Complaints**

A grievance is an expression of dissatisfaction from a member, member's representative or provider on behalf of a member about any matter other than an action.

A member may file a grievance about any matter related to their coverage or care, without concern of reprisal from the Company, its employees or providers.

A member or provider, acting on behalf of the member, with the consent of the member may file a grievance or complaint either verbally or in writing. A verbal request may be followed up with a written request, but the time frame for resolution begins the date the plan receives the verbal filing.

If the member wishes to appoint another person as his/her representative, he/she must complete an appointment of representative statement, located in the **Forms** section of the Provider Manual. The member and the person who will be representing the member must sign the statement.

Grievances or complaints include but are not limited to:

- The quality of care or quality of service given by a provider;
- Rudeness of a provider or a provider's employee; or
- Failure to respect the member's rights.

A member or member's representative or provider on behalf of a member must file the grievance/complaint directly with the Grievance Department. In fulfilling the grievance process requirements, 'Ohana shall:

- Send a written acknowledgement of the grievance/complaint within five business days.
- Convey a disposition, in writing, of the grievance resolution within 30 calendar days



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of the initial expression of dissatisfaction.

- Include clear instructions as to how to access the state's grievance review process on the written disposition of the grievance.

The Enrollee is made aware their rights to have an authorized representative and appropriate toll-free numbers as well TTY/TTD numbers in the Member handbook. Customer Service will serve as the intake point of grievance submission and to provide appropriate assistance with language support in accordance with all Customer Service policies.

Member may request a State grievance review, within thirty (30) days of the grievance decision from the health plan. A State grievance review may be made by contacting the MQD office, by calling the MQD Health Plan Liaison or mailing a request to:

Med-QUEST Division  
Health Coverage Management Branch  
PO Box 700190  
Kapolei, HI 96709-0190

WellCare will in no way discriminate against either members or providers for filing or supporting a grievance or appeal. WellCare (and its employees and agents) shall not take any punitive, retaliatory or adverse action against a:

- a. Member who request to file a grievance or appeal; or
- b. Provider who files a grievance on behalf of the member or who supports a member's appeal

There is not a timeframe for a member to file a grievance.

#### **Request for Standard Member Grievance**

A grievance will be investigated, determination made and closure letter sent to the complainant within 30 calendar days of receipt of the standard request.



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#### Determination

The closure letter will include the substance of the grievance/complaint, results, any actions taken and date of the grievance resolution., For decisions not wholly in the member's favor, the letter will include:

- The results, any actions taken and date of the grievance resolution;
- Notice of the right to request a State Grievance Review.
- The time limit to file a State Grievance Review (standard is 30 calendar days from the date of the notice); and
- Where to send to send it to:  
Med-QUEST Division  
Health Care Services Branch  
P.O. Box 700190  
Kapolei, HI 96709-0190  
Or call: (808) 692-8094

The Grievance Review determination made by MQD is final.

#### Grievances Filed Against a Provider

If a member files a grievance against a provider in reference to the quality of care or service provided, the Plan will call, fax and/or mail a request to the provider for a response. The provider is given 10 business days to respond and/or submit medical records for review. If a provider has not responded within 10 business days, a second call, fax and/or letter is sent giving an additional five business days to respond.

Continued failure to respond may result in the provider's panel being closed to new patients and/or will be interpreted to mean that the provider does not disagree with the member's issue. The case is then forwarded to the Quality Improvement department for further investigation.



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For Quality of Service issues, a provider relations representative (PR rep) will then be required to reach out the provider to discuss the issue. A site visit may be necessary to validate/dispute the grievance. Findings from the research will be forwarded back to the Grievance coordinator for closure/resolution.

For Quality of Care issues, the case is then referred to a Quality Improvement (QI) nurse who reviews the medical records to determine if a quality issue exists. If the nurse feels a quality issue exists, the case is referred to the Plan medical director for review. If he/she determines a quality issue exists, the case is referred to the Utilization Management Medical Advisory Committee (UMAC which serves as the peer review committee) for further investigation. If no quality issue is identified, the case is entered into the Plan's database for tracking and trending purposes. If the Quality of care issue has been substantiated by the peer review committee, the physician will be notified in writing within thirty (30) days of the closure of the committee. The quality information may be submitted to the provider's quality file and discussed during re-credentialing of the provider. For issues that require immediate action, the issue will be brought before the Board of Directors for further action and potentially termination of contract with the provider. Trended

#### 14-Day Extension

The Expedited, Standard Pre-Service and Retrospective determination periods noted above may be extended by up to 14 calendar days, if the member requests an extension or if the Plan justifies a need for additional information and documents how the extension is in the interest of the member. If an extension is not requested by the member, the Plan will provide the member with written notice of the reason for the delay.

#### Medicaid Fair Hearing

The member has the right to request a Medicaid Fair Hearing in addition to pursuing the Plan's grievance



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process. If this process is chosen, the member waives his/her further rights to appeal to the Subscriber Assistance Program.

The provider, acting on behalf of the member and with the member's written consent, may also request a Medicaid Fair Hearing.

Parties to the Medicaid Fair Hearing include the Plan, as well as the member and his/her representative or the representative of a deceased member's estate.

The member, the representative or provider may only request a Medicaid Fair Hearing within 30 days of the date of the notice of action and/or denial. The request must be sent to the following address:

State of Hawai'i Department of Human Services  
Administrative Appeals Office  
P.O. Box 339  
Honolulu, HI 96809

The Plan will continue the member's benefits while the Medicaid Fair Hearing is pending if:

1. The Medicaid Fair Hearing is filed in a timely manner, meaning on or before the latter of the following:
  - Within 10 calendar days of the date on the notice of action, (add five calendar days if the notice is sent via U.S. mail).
  - The intended effective date of the Plan's proposed action.
2. The Medicaid Fair Hearing involves the termination, suspension or reduction of a previously authorized course of treatment;
3. The services were ordered by an authorized provider;
4. The authorization period has not expired; and



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5. The member requests extension of benefits.

If the Plan continues or reinstates the member's benefits while the Medicaid Fair Hearing is pending, the benefits will be continued until one of following occurs:

1. The member withdraws the request for Medicaid Fair Hearing.
2. Ten days pass from the date of the plan's adverse plan decision and the member has not requested a Medicaid Fair Hearing with continuation of benefits until a Medicaid Fair Hearing decision is reached (add five days if the notice is sent via U.S. mail).
3. A Medicaid fair hearing decision adverse to the member is made.
4. The authorization expires or authorized service limits are met.

The Plan will authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires if the services were not furnished while the Medicaid Fair Hearing was pending and the Medicaid Fair Hearing officer reverses a decision to deny, limit, or delay services.

The Plan will pay for disputed services, in accordance with state policy and regulations, if the services were furnished while the Medicaid Fair Hearing was pending and the Medicaid Fair Hearing officer reverses a decision to deny, limit or delay services.

The Plan will not take punitive action against a provider who requests a Medicaid Fair Hearing on the member's behalf or supports a member's request.



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#### Member Appeals Process

An appeal is a request that is made when the member, member representative or provider (on behalf of the member with consent) request a review for reconsideration of any adverse decision, or action organizationA request for an appeal can be made for the following actions:

- The Plan denies or limits a service requested by the provider or member
- The Plan reduces or stops services already previous approved
- The Plan does not pay for health care services that were rendered
- Failure to authorize services in the required timeframes
- Failure to render a decision on an appeal in the required timeframe

‘Ohana Health Plan (the Plan) established and maintains a system for the resolution of appeals initiated by members or by providers, acting on behalf of a member and with the member’s consent, with respect to the denial, termination or other limitation of covered health care services.

Appeals received from a provider without a member’s consent will not qualify for this process and will be processed as an administrative appeal. For further information see the Provider Payment Dispute/Administrative Appeals entry in this manual section.

An appeal may be filed when the Plan issues a notice of action to a Plan member. A member, provider or authorized representative on behalf of the member with the member’s consent, may request a review for reconsideration of any adverse decision, or within 30 calendar days of the notice of action. An oral appeal may be submitted in order to establish the appeal submission date; however, this must be followed by a written request. The Plan will assist the member, provider or authorized representative in this process.

Appeals may be verbal (followed-up in writing) or written to:



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'Ohana Health Plan  
PO Box 31368  
Tampa, FL 33631-3368  
Toll Free: 1-888-846-4262

For standard resolution of an appeal, the Plan will resolve the appeal and provide a written notice of disposition to the parties as expeditiously as the member's health condition requires, but no more than 30 calendar days from the day the Plan receives the appeal.

The Plan may extend the resolution time frame by up to 14 calendar days if the member requests the extension, or the Plan shows (to the satisfaction of the Med Quest Division (MQD), upon its request for review) that there is need for additional information and how the delay is in the member's interest. For any extension not requested by a member, the Plan will give the member written notice of the reason for the delay.

The Plan will include the following in the written notice of the resolution:

- The results of the appeal process and the date it was completed; and
- For appeals not resolved wholly in favor of the member: The right to request a state administrative hearing, and clear instructions about how to access this process;
  - The right to request an expedited state administrative hearing if applicable;
  - The right to request to receive benefits while the hearing is pending and how to make the request; and
  - A statement that the member may be held liable for the cost of those benefits if the hearing decision upholds the Plan's action.



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The Plan shall notify the provider within 30 days of the resolution but it need not be in writing.

#### **Expedited Appeal Process**

The Plan maintains an expedited review process for appeals. The member, his or her representative or a provider may file an expedited appeal either orally or in writing. No additional follow-up will be required. An expedited appeal is only appropriate when the Plan determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life, health or ability to attain, maintain or regain maximum function.

The Plan ensures that punitive action is not taken against a provider who requests an expedited resolution or who supports a member's appeal.

For expedited resolution of an appeal, the Plan will resolve the appeal and provide written notice to the affected parties as expeditiously as the member's health condition requires, but no more than 72-hours from the time the Plan received the appeal. The Plan will make reasonable efforts to also provide oral notice to the member with the appeal determination.

The Plan may extend the expedited appeal resolution time frame by up to 14 calendar days if the member requests the extension or the Plan needs additional information and demonstrates to the MQD that the extension of time is in the member's interest.

The Plan will notify an MQD Plan liaison within 24 hours regarding expedited appeals if an expedited appeal has been granted by the Plan or if an expedited appeal time frame has been requested by the member or the Plan.

The Plan will provide the reason it is requesting a 14 day extension to the MQD Plan Liaison. The Plan will notify the MQD Plan Liaison within 24 hours (or



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sooner if possible) from the time the expedited appeal is lost.

For any extension not requested by the member, the Plan will give the member written notice of the reason for the delay. If the Plan denies a request for expedited resolution of an appeal, it will:

- Transfer the appeal to the time frame for standard resolution;
- Make reasonable efforts to give the member prompt oral notice of the denial;
- Follow-up within two days of written notice; and
- Inform the member orally and in writing that they may file a grievance for the denial of the expedited process.

The Plan will provide the member a reasonable opportunity to present evidence and allegations of fact or law, in person as well as in writing. The Plan will inform the member of limited time available to present this information.

#### **State Administrative Hearing for Regular Appeals**

If the member is not satisfied with the Plan's written notice of disposition of the appeal, he or she may file for a state administrative hearing within 30 days of the receipt of the notice of disposition (denial). At the time of the denied appeal determination, the Plan will inform the member, the member's representative, the provider acting on behalf of the member or the representative of a deceased member's estate that he or she may access the state administrative hearing process. The member has a right to representation at the State administrative hearing to include, at a minimum, the member themselves or they may use legal counsel, a relative, a friend, or other spokesperson.

The member, or his or her representative, may access



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the state administrative hearing process by either calling the member's eligibility worker or submitting a letter to the Administrative Appeals Office (AAO) within 30 days from the receipt of the member's appeal determination to the following address:

State of Hawai'i Department of Human Services  
Administrative Appeals Office  
PO Box 339  
Honolulu, HI 96809

The state will reach its decision within 90 days of the date the member filed the request for an administrative hearing with the state.

#### **Expedited State Administrative Hearings**

The member may file for an expedited state administrative hearing only when the member requested or the Plan has provided an expedited appeal and the action of the appeal was determined to be adverse to the member (action denied). In this situation, the Plan will inform the member that he or she must contact an MQD plan liaison within three days of the receipt of the denial from the Plan.

An expedited state administrative hearing must be heard and determined within three business days with no opportunity for extension on behalf of the state. The Plan will collaborate with the state to ensure that the best results are provided for the member and to ensure that the procedures are in compliance with state and federal regulations.

In the event of an expedited state administrative hearing, the Plan will submit information that was used to make the determination, e.g. medical records, written documents to and from the member, provider notes, etc. The Plan will submit this information to the MQD within 24 hours of the decision to deny the expedited appeal.

#### **Continuation of Benefits During an Appeal or State Administrative Hearing**



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The Plan will continue the member's benefits if:

- The member requests an extension of benefits;
- The appeal or request for state administrative hearing is filed in a timely manner, meaning on or before the later of the following:
  - Within 10 business days of the Plan mailing the notice of adverse action; or
  - The intended effective date of the Plan's proposed adverse action.
- The appeal or request for state administrative hearing involves the termination, suspension or reduction of a previously authorized course of treatment;
- The services were ordered by an authorized provider; and
- The original authorization period has not expired.

If the Plan continues or reinstates the member's benefits while the appeal or state administrative hearing is pending, the Plan will continue all benefits until one of following occurs:

- The member withdraws the appeal;
- The member does not request a state administrative hearing within 10 business days from when the Plan mails a notice of adverse action;
- A state administrative hearing decision adverse to the member is made; or
- The authorization expires or authorization service limits are met.



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If the final resolution of the state administrative hearing is adverse to the member, that is, upholds the Plan's adverse action, then the Plan may recover the cost of the services furnished to the member while the appeal is pending.

If the Plan or the state reverses a decision to deny, limit or delay services that were not furnished while the appeal was pending, the Plan will authorize or provide these disputed services promptly, and as expeditiously as the member's health condition requires.

If the Plan or the state reverses a decision to deny authorization of services and the member received the disputed services while the appeal was pending, the Plan shall pay for those services.

#### **External Review Procedures**

After exhausting all internal grievance and appeal procedures available within the Plan and the DHS, the member, the member's provider or the member's authorized representative may file a request for an external review of a managed care plan's final internal determination with the state of Hawai'i's Insurance Commissioner.

An external review is the process by which an independent review is made of a decision made by the Plan.

Under the Hawai'i Revised Statutes, Section 432E-6, after exhausting all internal appeal procedures available for the plan, enrollees have the option of requesting an external review.

A written request for external review must be received by the Insurance Commissioner's Office within 60 days from the date of the Plan's final internal determination. This request may be filed by the enrollee, the enrollee's treating provider or appointed representative to the following address:



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Department of Commerce and Consumer Affairs  
Insurance Division  
Health Insurance Branch  
P.O. Box 3614  
Honolulu, Hawai'i 96811  
Telephone: (808) 586-2804  
Fax: (808) 587-5379

Upon a showing of good cause, the commissioner may appoint a three-member panel to hear the case. The panel is made up of a provider licensed to practice and practicing medicine in Hawai'i and not involved in the complaint, a representative from a managed care plan not involved in the complaint and the insurance commissioner or the commissioner's designee. If the amount in controversy is less than \$500, the commissioner may conduct a review hearing without appointing a review panel. The hearing must take place within 60 days of the request for the external review unless this deadline is waived by the parties.

The insurance commissioner, upon a majority vote of the panel, shall issue an order affirming, modifying or reversing the managed care plan's final internal determination within 30 days of the hearing.

This process does not apply to claims or allegations of health provider malpractice, professional negligence or other professional fault against participating providers.

### **Provider Grievances / Complaints**

#### **Provider Complaint**

'Ohana shall have a provider complaint, grievance and appeals process that provides for the timely and effective resolution of any dispute between the Plan and provider(s).

A provider complaint is an expression of dissatisfaction made by a provider in the following areas:

- Benefits and limits, for example limits on



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behavioral health services or formulary;

- Eligibility and enrollment, for example, inability to confirm enrollment or identify the PCP, and member issues, including members who fail to meet appointments or do not call for cancellations;
- Interaction with the member is not satisfactory, such as the member is rude or unfriendly or other member related concerns;
- Plan complaints, including difficulty contacting the Plan or its subcontractors because of long wait times and/or busy lines, etc.; or problems with the Plan's staff behavior, delays in claim payments, denial of claims, claims not paid correctly or other health plan issues.

#### Provider Grievance

A provider's expression of dissatisfaction about:

- Issues related to availability of health services from the Plan to a member, such as delays in obtaining or inability to obtain emergent/urgent services, medications, specialty care, ancillary services such as transportation and/or medical supplies.

Provider complaints and provider grievances shall be resolved within 60 days of the day following the date of submission to the Plan. 'Ohana shall give the provider 30 calendar days from the decision of the grievance/complaint to file an appeal.

The Plan will ensure that punitive action is not taken against a provider who files or supports a grievance on a member's behalf.

The Plan will make a determination on a grievance within the following time frames:

- Standard request: 60 calendar days



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The Plan gives members reasonable assistance in completing forms and other procedural steps including, but not limited to, providing interpreter services and toll-free numbers with TTY/TDD and interpreter capability. Members will be provided reasonable opportunity to present evidence and allegations of fact or law, in person as well as in writing.

#### **Provider Complaint System**

A provider may file a written complaint to dispute the Plan's policies, procedures or any aspect of its administrative functions, including proposed actions, no later than 30 calendar days from the date the provider becomes aware of the issue generating the complaint.

Provider complaints may be filed in writing via mail or fax to:

'Ohana Health Plan  
Attn: Grievance Department  
PO Box 31384  
Tampa, FL 33631-3384  
Fax: (866) 388-1769

A provider complaint will be thoroughly investigated using applicable statutory, regulatory and contractual provisions, collecting all pertinent facts from all parties and applying the Plan's written policies and procedures.

'Ohana will also ensure that Plan executives with the authority to implement corrective action are involved in the provider complaint process. In the event the outcome of the review of the provider complaint is adverse to the provider, the Plan shall provide a written notice of adverse action to the provider.

A provider may also contact the Plan's Customer Service department, where dedicated staff is available to answer questions, assist in filing a provider complaint and resolve any issues. The appropriate Customer Service department contact



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information can be found in the **Quick Reference Guide** section of this manual.

#### **Administrative Appeals/ Provider Payment Dispute**

Although it is our intent to satisfy you as an 'Ohana network Provider, 'Ohana recognizes that there may be instances where you need to file a complaint or appeal a decision. The 'Ohana claims payment resolution procedure is outlined below and is in compliance with the State of Hawai'i Department of Commerce and Consumer Affairs Regulations.

#### **Verbal Inquiries**

A Provider may make a verbal claim inquiry to check the status of a previously submitted claim by contacting the Provider Hotline during normal business hours. Please refer to the **Quick Reference Guide** of this manual for contact information.

#### **Electronic Inquiries**

'Ohana has the capability to receive an ANSI X12N 276 health claim status inquiry and generate an ANSI X12N 277 health claim status response through Centene Corporation. For more information on conducting these transactions electronically please contact our EDI Assistance line which is listed in this manual's **Quick Reference Guide**.

#### **Informal Claim Payment Resolution Procedure – Adjustment Requests**

An informal claim resolution procedure precedes the formal claim resolution procedure. The informal claim resolution procedure allows providers to make complaints verbally, in written correspondence, faxes, Web inquires and e-mails.

In order to resolve claims issues verbal or written requests by participating providers must be received by 'Ohana within 60 calendar days from receipt of 'Ohana's explanation of payment (EOP) and non-participating providers have 365 days from receipt of



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the EOP.

The informal claim resolution process can be used for the following claim issues:

- Deletions in claims payments;
- Denial of claims;
- Claims not paid correctly; and
- Any aspect of 'Ohana's claims functions, including proposed actions.

'Ohana will review the claim or claim-related issue for resolution and respond to the provider within 60 days of the day after the date of submission to the Plan.

'Ohana will maintain a log of all informally filed provider claim complaints. The logged information will include the provider's name, date of the complaint, nature of the complaint and disposition.

To initiate the informal claim resolution procedure, a provider should contact 'Ohana's Provider Services Department either verbally or in writing. The appropriate contact information is found on this manual's **Quick Reference Guide**.

### **Formal Claim Resolution Procedure**

In the event the disputed claim for informal resolution is not resolved to the provider's satisfaction within 60 calendar days after the provider commenced the informal claim resolution procedure, the provider will have 30 calendar days from that point to submit the matter to the formal claim resolution procedure by submitting a written explanation to include additional information outlining specific details that may justify reconsideration of the disputed claim.

'Ohana's receipt of the provider's written notice initiates the formal claim resolution process. The provider must submit written notice that specifies the



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basis of the formal claim dispute and includes the EOP to the Claim Appeals fax or mailing address that appears on this manual's **Quick Reference Guide**.

A panel of one or more individuals selected by 'Ohana will conduct the formal claim resolution procedure within 10 business days of 'Ohana's receipt of the written formal review request. Any individual who has been involved in any previous consideration of the dispute may not be on the 'Ohana panel. Panel members must be knowledgeable about the policy, legal and clinical issues involved in the matter.

'Ohana's medical director or another licensed physician designated by the medical director may serve as a consultant to the panel. The panel will inform the provider of the opportunity to appear in person before the panel or to communicate with the panel if the provider is unable to appear in person and question the panel in regard to issues involved in the dispute.

Within 10 business days of the initial receipt of the provider's written formal review request, the panel will deliver 'Ohana's written determination of the dispute to the provider. The written determination will include, as applicable, a detailed explanation of the factual, legal policy and clinical basis of the panel's determination.

'Ohana will maintain a log of all formally filed Provider claim disputes. The logged information will include the provider's name, date of dispute, nature of dispute and disposition. 'Ohana will submit annual reports to the Department of Human Services regarding the number and type of provider disputes.

Providers may access a timely payment dispute resolution process. A payment dispute is any dispute between the health care provider and 'Ohana for reason(s) including, but not limited to, requests for additional explanation as to services or treatment rendered by a health care provider, inappropriate or unapproved referrals initiated by the providers, billing disputes, timely filing and notification/ preauthorization



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issues. No action is required by the member.

#### **Administrative Appeals**

An administrative appeal is a payment dispute between the health care provider and 'Ohana for service already provided where the provider does not agree with the results of 'Ohana's claim adjudication. No action is required by the member. Administrative appeals include appeals received from a provider without member consent that are related to a medical necessity determination.

Providers will not be penalized for filing a payment dispute. Appeals must be submitted in writing to 'Ohana's Appeals department. The letter must detail the reason for the appeal and be accompanied by any and all supporting documentation, such as the EOP and/or medical records. The Appeals Department will receive, distribute and coordinate all administrative appeals. Appeals may be mailed to:

'Ohana Health Plan  
PO Box 31368  
Tampa, FL 33631-3368

The provider should file an appeal, which must be received within 90 days of the paid date of the provider's EOP.

The Appeals Department will research and determine the current status of a payment dispute. If additional information is needed, a letter will be sent to the provider. If the requested information is not received within 60 calendar days, the Appeals Department will send a denial letter to the provider.

Payment disputes received with supporting clinical documentation will be retrospectively reviewed. Established clinical criteria will be applied to the payment dispute. After retrospective review, the payment dispute may be approved or forwarded to the Plan medical director for further review and resolution.

- The provider must submit a written appeal



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to the Appeals department with all applicable documentation supporting the provider's position regarding the adjudication of the claim. The written appeal must be received within 90 calendar days of the provider's EOP.

- 'Ohana's Appeals Department will render a written determination within 60 calendar days of the receipt of the appeal.
- If additional information is requested, the provider must submit the additional information within 60 calendar days. If the information is not received within 60 calendar days, the appeal will be denied and closed because of incomplete information.

Questions regarding 'Ohana's provider payment dispute process should be directed to your 'Ohana local provider relations representative or the Provider Hotline. Refer to the **Quick Reference Guide** for contact information.

### **Submission of Provider Termination Appeal Request**

If a provider termination is initiated by the Plan, regardless of whether the termination is for cause or not, the Plan will notify the provider of the termination decision in writing, via certified mail, of the reason.

Providers will be informed as to their right to appeal the action and the process and timing for reconsideration of the termination decision. The appeal request must be filed within 30 calendar days of receipt of the Plan's termination notice. The Plan will send an acknowledgement letter to the provider within five business days of receipt of the appeal request.

The Plan may request additional information from the provider in order to review the appeal. If this is the case, the provider has 10 business days to submit the required documentation. If the documentation is not received within 10 business days, the Plan will continue to process the appeal.

A panel will review the appeal request and, upon



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determination, send an outcome letter to the provider stating that the appeal has been overturned or upheld.

#### **Termination Overturned**

If the Plan overturns the termination of the provider, the Plan will ensure that there is no lapse in the period of the provider's participation with the Plan.

#### **Termination Upheld**

If the Plan upholds its termination of the provider, the Plan will notify members 30 calendar days prior to and no later than five business days after the termination effective date of their assigned PCP. Members will be requested to select a new PCP within 30 calendar days. If the member does not respond, a new PCP will be assigned to the member. The member will be notified in writing of their new PCP and given a choice to change their PCP by contacting Customer Service.

The Plan will also notify members of the termination of a participating hospital, specialist or a significant ancillary provider within the service area that has been seen two or more times within the past 12 months, 30 days prior to and no later than five business days after the termination effective date.