

Partners

Provider Grievances and Appeals Policy

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Provider Grievances and Appeals

Partners Health Management

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Provider Grievance and Appeals Policy

1. Overview

It is the policy of Partners Health Management (Partners) to respect participating providers' rights while also holding them accountable in fulfilling Partners' obligations to ensure an adequate and quality provider network while protecting members, other stakeholders and public funds (Medicaid and non-Medicaid). To this end, and consistent with controlling authorities including applicable contracts, laws, regulations and accreditation requirements, Partners maintains a robust, formal process consistent with its written agreements to address and reconsider certain actions or decisions by Partners against participating providers before becoming final.

2. Purpose

Partners handles provider appeals and grievances promptly, consistently, fairly, and in compliance with State and federal law and North Carolina Department of Health and Human Services (NCDHHS) requirements, via the robust provider appeal and grievance system described here. While streamlined with other due processes at Partners, the provider appeal and grievance system is distinct from that offered to members, recipients and other stakeholders. It includes a grievance/complaint process for providers to bring issues to Partners, an appeals/disputes process for providers to challenge certain Partners decisions, and information regarding access to a state level review through the North Carolina Office of Administrative Hearings (NCOAH) or other forums as appropriate. By this policy and other materials and communications, Partners intends to and will be transparent with providers regarding appeal and grievance/complaint processes and procedures.

The purpose is not to create another perceived "layer of litigation," but to provide a user-friendly, streamlined due process by which Partners can reconsider its own actions and decisions and be certain of its position before issuing a final formal decision in response to disputes by participating providers over which the provider has appeal rights. This Policy and Procedure should be interpreted as a mandatory alternative dispute process (ADR) to further, formal litigation and disputation as allowed by law.

As defined in official procedures, not all disputes are subject to this process. Provider disputes not covered by this policy and procedure are treated as grievances/complaints. Grievances/complaints are an expression of dissatisfaction about any matter other than an adverse benefit determination.

3. Definitions

Unless otherwise defined, the terminology in this policy and procedure (P&P) is based on and superseded by the definitions in controlling legal authorities, including but not limited to 42 C.F.R. Part 438; N.C.G.S. Ch. 122C, 108C and 108D; the current contract with the Division of Health Benefits (NC Medicaid), Attachment F:

PIHP (Prepaid Inpatient Health Plan): Per federal law 42 CFR 438.2, a PIHP is an entity that: (1) Provides medical services to enrollees under contract with the state agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use state plan payment rates; (2) provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract.

PHP (Prepaid Health Plan): Per state law, N.C.G.S. §108D-1(30) and N.C.G.S. §122C-3(29b), a prepaid health plan is, as defined in N.C.G.S. §58-93-5, an entity that is under a capitated contract with the Department for the delivery of Medicaid and NC Health Choice services, or a local management entity/managed care organization (LME/MCO) that is under a capitated contract with the Department to operate a BH IDD tailored plan.

Partners is both a federal PIHP and a North Carolina PHP.

Applicant: A provider who is seeking to participate in the network of Partners, as set forth by law and contract, including N.C.G.S. §108D-1(3), including (6), (27), (31) and §108D-2(2) and (10).

Closed Provider Network (also referred to as Network, Closed Network, Provider Network, and PIHP Closed Provider Network): The network of providers that have contracted with (i) a local management entity/managed care organization operating the combined 1915(b) and (c) waivers or (ii) an entity operating a Behavioral Health and Intellectual/Developmental Disabilities Tailored Plan to furnish mental health, intellectual or developmental disabilities, and substance abuse services to enrollees.

Provider Enrollment: When referring to providers, this means the process of submitting a request for consideration to become a provider in the PIHP Closed Network, unless the context is referring to the process of submitting an online enrollment application via NCTracks for consideration to become a provider in the NC Medicaid or Health Choice programs. When referring to members, this means the process through which a beneficiary selects or is auto enrolled into a Standard Plan, Tailored Plan, Statewide Specialized Foster Care Plan and/or Tribal Option to receive North Carolina Medicaid or NC Health Choice benefits through the Medicaid Managed Care program. This P&P is limited to the enrollment of providers into Partners' provider network. Disputes as to the second meaning of member "enrollment and eligibility" is handled by NCDHHS directly.

NCDHHS or Department: The North Carolina Department of Health and Human Services, which is the designated single state Medicaid agency for the state of North Carolina.

Days: Except as otherwise noted, refers to calendar days. The terms *working day* and *business day* shall each mean a day on which the Division of Health Benefits and Partners are officially open to conduct their affairs.

DHB: The Division of Health Benefits also known as NC Medicaid, which is overseen by NCDHHS.

DMH/DD/SAS: The Division of Mental Health, Developmental Disabilities and Substance Abuse Services.

Grievance: As defined in 42 CFR §438.400(b) for members, including “an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances/complaints 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 enrollee’s rights regardless of whether remedial action is requested.” Similarly, a provider grievance/complaint is an oral or written complaint or dispute by a provider over any aspects of the operations, activities, or behavior of Partners *except for any dispute over for which the provider has appeal rights*. This P&P covers disputes over which a provider has such appeal rights. For grievance/complaint rights, providers are treated like all other stakeholders under due process.

Medical Assistance Program (Medicaid): DHB’s program to provide medical assistance to eligible citizens of the state of North Carolina, established pursuant to Chapter 58, Articles 67 and 68 of the North Carolina General Statutes and Title XIX of the Social Security Act, 42 U.S.C. 1396 et. seq.

NC Medicaid Program: The fee-for-service program operated by NCDHHS for the provision of health care services to Medicaid beneficiaries based on the payment methods set forth in the State-funded Benefits plan and the applicable policies and procedures of DHB. Enrollment contracting in the PIHP Partners’ Closed Network is distinct from enrollment into the NC Medicaid Program handled by NCDHHS.

NCTracks: The multi-payer Medicaid Management Information System for the NC Department of Health and Human Services.

Network Provider/Participating Provider: A provider contracted into Partners’ network, as defined elsewhere. “Network Provider” is also defined in 42 CFR 438.2 [“Network provider means any provider, group of providers, or entity that has a network provider agreement with an MCO, PIHP or PAHP, or a subcontractor, and receives Medicaid funding directly or indirectly to order, refer or render covered services as a result of the state’s contract with an MCO, PIHP or PAHP. A network provider is not a subcontractor by virtue of the network provider agreement.”] [Per NCGS § 108D-1(13), a network provider is, “An appropriately credentialed provider of mental health, intellectual or developmental disabilities, and substance abuse services that has entered into a contract for participation in the closed network of one or more local management entity/managed care organizations.”] Participating provider means any physician, hospital, ancillary, or other health care provider that has contracted, directly or indirectly, with Partners to provide Covered Services to Covered Persons, which has been approved for participation by Partners, and that is designated by Partners as a “participating provider” in the Tailored Plan network.

OA: North Carolina Office of Administrative Hearings.

Out-of-Network Provider: Any person or entity providing covered services who is not a member of the Participating Provider network.

PSV: Primary Source Verification.

State: The state of North Carolina.

State Plan: The North Carolina State Plan for Medical Assistance submitted under Title XIX of the Social Security Act and N.C.G.S. §108A-54 and approved by CMS.

Subcontract: An agreement which is entered into by PIHP in accordance with the subcontracting requirements in Partners' contract with NCDHHS.

Subcontractor: Any person or entity which has entered into a subcontract with PIHP. [Per 42 C.F.R. 438.2, a network provider is not a subcontractor merely by virtue of its provider agreement with Partners.] Distinctions:

- a. Provider enrollment and contracting are distinct. DHB screens and determines provider enrollment into and disenrollment from the North Carolina Medicaid and medical assistance plan or program and from that pool of enrolled providers, Partners has full authority to create and manage its closed provider network, through contracting and up to termination. Participating providers and network providers are providers *contracted* with Partners, so excludes applicants and non-contracted providers, even if enrolled by state or credentialed by state or an LME-MCO.

4. Policy

Partners shall not discriminate or retaliate against any provider based on any action taken by the provider under the Provider Grievances and Appeals Section of the Contract (Section V.B.4.v.) or under the Member Grievances and Appeals Section of the Contract (Section V.B.1.vi.) taken on behalf of a member.

Partners shall handle provider appeals and grievance/complaint promptly, consistently, fairly, and in compliance with state and federal law and NCDHHS' requirements.

Partners shall be transparent with providers regarding its appeals and grievance/complaint processes and procedures.

Partners shall accept and resolve provider grievances/complaints regarding Partners Plan referred from NCDHHS.

A participating provider must submit a request in writing using the Dispute Resolution form, which can be found on Partners' website or via the provider web portal, no later than 30 calendar days from which provider receives written notice from Partners of the decision giving rise to the right to appeal, or Partners should have taken a required action and failed to take such actions.

This provider dispute process is intended to be an informal reconsideration by Partners of its decision or action; however, Partners shall allow providers to be represented by an attorney during the Appeals process.

Partners shall limit the issue on appeal in cases of suspension or withhold of provider payment to whether Partners had good cause to commence the withhold or suspension of provider payment. Partners will not address whether the provider has or has not committed fraud or abuse.

Partners will offer providers appeal rights as described in Section VII. Attachment I, for Medicaid, NC Health Choice, and State-funded providers.

Partners must allow a participating provider to appeal an adverse decision. Appeals to Partners will be available to a network provider for the following reasons:

1. Program Integrity related findings or activities
2. Finding of waste, or abuse by Partners
3. Finding of or recovery of an overpayment by Partners
4. Withhold or suspension of a payment related to waste, or abuse concerns
5. Termination of, or determination not to renew, an existing contract for Local Health Department care/case management service
6. Determination to de-certify an Advanced Medical Home+ or CMA (applicable to Medicaid providers only)
7. Violation of terms between Partners and provider

Partners must allow a provider to appeal an adverse decision. Appeals to Partners will be available to an out-of-network provider for the following reasons:

1. An out-of-network payment arrangement
2. Finding of waste or abuse by Partners
3. Finding of or recovery of an overpayment by Partners

Partners will ensure the Grievance and Appeals system complies with TP RFA, Section V.A.1.iv.

5. Procedure

Provider Grievances/Complaints

Partners has a process and staff capable of reviewing provider Grievance and Appeal outcomes to identify trends and existing operational or clinical opportunities to improve the provider experience. It is the policy of Partners Health Management (Partners) to provide and encourage providers, the right and ability to bring any expression(s) of dissatisfaction via a grievance/complaint (substantially synonymous) to the attention of Partners in compliance with accreditation requirements, federal and state laws and regulations, state contracts, and any other controlling authorities. Grievances/complaints are accepted by all staff, in all forms and formats, including oral, written and anonymous. Grievances/complaints will be processed formally or informally as appropriate. Partners will comply with all regulatory expectations regarding timeframes for investigation, resolution and notification. However, Partners may not exceed 90 calendar days for full investigation, resolution, and notification of grievances/complaints, unless permitted/required by regulatory authority. Providers can submit grievances/complaints through Partners provider web portal. Please refer to Grievance/Complaint Management Policy P&P 6.00U for reference.

Partners shall provide information regarding provider Appeals to the Department upon request.

- I. Grievance/Complaint Defined: Under federal Medicaid managed care law, 42 C.F.R. 438.400(b), a grievance/complaint is “an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances/complaints 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 enrollee’s rights regardless of whether remedial action is requested. Grievances/complaints includes an enrollee’s right to dispute an extension of time proposed by [Partners] to make an authorization decision.” Partners generally uses “grievances” and “complaints” synonymously, especially in this Policy and Procedure (P&P), for ease of our stakeholders.
- II. The Grievance/Complaint Process
 - A. Partners Office of Legal Affairs (OLA) is responsible for the grievance/complaint process, which includes the following tasks:
 1. Intake and reviewing submitted grievances/complaints.
 2. Assigning grievances/complaints to appropriate person(s) and department(s) for resolution.
 3. Ensuring complete and timely resolution of those grievances/complaints by those who have been assigned.
 4. Compiling/submitting all required aggregate reporting requirements unless otherwise noted.
 - B. Any Partners staff may receive grievances/complaints via phone calls (including TTY/TTD), e-mail, in-person, in writing or on Partners’ provider web portal. A form is also accessible on every page of the Partners website, <https://www.partnersbhm.org/feedback/>.
 - C. Any Partners staff member receiving a grievance/complaint will document the substance of the grievance/complaint on the grievance/complaint screen of Partners provider data management system. [NCQA RR 2 A.1]
 - D. Once input, the information from the grievance/complaint screen is opened by the Office of Legal Affairs for processing and documenting in the Partners provider data management system grievance/complaint module for resolution, tracking, and trending purposes. [NCQA RR 2 A.1]
 - E. Assignment of grievances/complaints: Grievances/complaints are assigned to applicable departments within Partners based on the nature of the grievance/complaint. Assignments are made from the Grievance Coordinator to the designated department representative. All grievances/complaints are researched, and appropriate resolutions determined by assigned staff. All issues, findings and resolutions are documented in the grievance/complaint module. Any grievances/complaints involving clinical issues are reviewed and decided by persons who have the clinical expertise in treating the member/recipient’s condition and have not been involved in any previous level of review. [NCQA RR 2 A.2]
 - F. Tracking of resolution: The Office of Legal Affairs will document all actions taken and track the timeliness of grievance/complaint resolution per department for Partners, along with the number and outcome of grievance/complaint decisions that progress to higher levels of review. Patterns, trends and compliance will be reported in Quality Improvement Committee (QIC), Incident Review Committee (IRC), Member and Family Advisory Committee (CFAC), Human Rights Committee (HRC) of Partners Board and other applicable venues. (See exemptions). [NCQA RR 2 A.1]
 - G. Timing:

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1. Routine grievances/complaints will include acknowledgment, in writing, within five (5) calendar days of receipt of each grievance/complaint as confirmation that the process has started. [NCQA RR 2 A.4] This communication shall include whether the complaint will be addressed informally or by conducting an investigation. Partners shall issue a Notice of Acknowledgement to notify the provider of receipt of the grievance/complaint.
 - a. If a grievance/complaint relates to the denial of an expedited appeal request, Partners will acknowledge receipt of the grievance/complaint, in writing via trackable mail, within 24 hours of receipt of the grievance/complaint.
 2. Unless resolved on the initial contact, inquiries are made to appropriate parties to gather information needed for resolution. Partners will provide written notice of resolution of the grievance/complaint to the provider in a timely manner, generally within thirty (30) calendar days from the date Partners receives the grievance/complaint. Grievance/Complaint resolution timeframes may be extended up to 14 calendar days if:
 - a. The provider requests the extension; or
 - b. Partners shows (to the satisfaction of the state agency, upon its request) that there is a need for additional information and how the delay is in the best interest of the members/recipients. If Partners extends the timeframe for any reason other than at the provider's request, Partners will:
 - i. Make reasonable efforts to give the complainant notice of the delay;
 - ii. A written notice will be mailed to the complainant within two days per 42 CFR subsection 438.402 explaining the reason for the delay. [NCQA RR 2 A.4];
 - iii. Resolve the grievance/complaints expeditiously as the member/recipient's health condition requires and no later than the date the extension expires. 42 C.F.R. §§ 438.408(b)(1) and 438.408(c)(2).

III. Appealing Resolution of Grievances/Complaints

- A. If the complainant is not satisfied with the initial grievance/complaint resolution, the complainant may timely file an appeal in writing, to Partners CEO, c/o the Grievance Coordinator, to start the grievance/complaint appeals process. The Grievance Coordinator will promptly forward the grievance/complaint appeal request to the General Counsel's designee to coordinate a Partners internal hearing. Decision-makers on grievance/complaint appeals involving clinical issues must include one or more health care professionals with clinical expertise in treating the member condition and have not been in any previous level of review or decision-making, as well as other applicable staff.
- B. On a case-by-case basis, assistance from leadership of any department can be requested to assist in facilitating a quality decision. Key Partners subject matter experts may be invited to attend appropriate hearings to advise the panel.
- C. The request for appeal must be received within 15 working days (informal) or 21 calendar days (formal) from the date of the resolution/investigation report/letter. Partners will provide notification within five working days to the grievant and/or provider that the appeal has been received. The appeal is limited to the items identified in the original grievance/complaint record and/or the investigation report.
- D. The Partners CEO will:
 1. Convene a Panel: Per 10A NCAC § 27G .7002(b)(3)(J), the CEO will timely convene an ad hoc appeal review committee (aka, panel) by approving – or not rejecting within two business days of recommendation – the General Counsel's designee's recommended panel. That panel should be

composed so as to assure no conflicts of interest and a reasonable cross-functional and diverse composition, including disability affiliation(s) and other experience or qualifications relevant to the issue(s) in the grievance/complaint. The panel may recommend appointment to the panel qualified non-members of the panel as needed to ensure this composition. The panel may also require or request attendance of appropriate non-panel individuals to serve in consulting and fact-finding roles to ensure thorough investigation of the grievance/complaint is conducted by the panel. The panel's recommendations to the CEO will be by majority vote. [NCQA RR 2 B.2.]

2. Issue a Decision: The CEO will issue an independent, written decision after reviewing the appeal review panel's recommendation to uphold or overturn the findings. The panel's recommendation should come in the form of a proposed letter and explanatory cover memorandum, addressed to the CEO and the General Counsel for legal advice, sufficient to enable the CEO to affirm, amend or reject the recommended decision. The decision letter will include the following: the summary of the statement of the grievance/complaint, highlights of grievant's arguments, statement of action requested by the grievant, the committee's evaluation, and the committee's conclusion. The decision letter copy is retained in the file and will be dated and mailed to the appellant within 20 working days (informal, 10A NCAC § 27G.7002(b) (5) (B)) and 28 calendar days (formal, 10A N.C.A.C. § 27G.7003 (a) (9)) from receipt of the appeal. The panel's recommendation letter and memorandum should be delivered to the CEO and General Counsel at least 10 calendar days before these deadlines. [NCQA RR 2 B.1.]
- E. If the CEO or his designee refers the grievance/complaint to the state or local government agency responsible for the regulation and oversight of the provider, the Office of Legal Affairs department will send a letter to the grievant informing him or her of the referral and the contact person at the agency where the referral was made.
 1. The Office of Legal Affairs will contact the state or local government agency where the referral was made within 80 working days of the date Partners received the grievance/complaint to determine the actions the state or local government agency has taken in response to the grievance/complaint.
 2. The Office of Legal Affairs will communicate the status of the state or local government agency's response to the provider.
- F. When a grievance/complaint investigation involving a Category-B provider identifies an issue which if substantiated by the Division of MHDDSAS could result in a revocation or suspension of the provider's funding pursuant to 10A NCAC 26C .0501 through .0504, then the Office of Legal Affairs and Provider Network department will document the issue or issues creating the grievance/complaint and notify the Division of MHDDSAS of the issue within 24 hours.
- G. Providers may submit a grievance/complaint to NCDHHS if they are dissatisfied with Partners' resolution of a grievance/complaint.

Grievances/complaints are resolved purely internally by Partners without any right to appeal as with an ABD, although grievances/complaints may be referred to other authorities, including the State, for review.

Provider Appeals

- I. Initiation of the Provider Appeals Resolution Process
 - A. A participating provider can submit a request in writing using the Provider Appeals/Dispute Resolution Form, which can be found on the Partners' website or the provider web portal, within 30 calendar days on which:

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1. Provider receives written notice from Partners of the decision giving rise to the right to appeal.
 2. Partners should have taken a required action and failed to take such actions.

If the provider fails to meet the timeframes to request initiation of the Provider Appeals Process, Partners' decision becomes final, and the provider may not further exercise the Provider Appeals Process. The action or decision being disputed shall not pend or be extended during this dispute process unless expressly agreed in advance in writing by Partners. However, Partners will extend the timeframe by up to, but no longer than 30 calendar days for providers to request an appeal for good cause shown as determined by Partners. Partners will consider the voluminous nature of required evidence/supporting documentation, as good-cause reasons to extend the timeframe.

- B. The provider will receive a copy of the Provider Appeals/Dispute Resolution Form, along with the notification of action or decision taken by the LME/MCO/Tailored Plan. A provider may also contact Partners by telephone or in-person, and the appropriate staff person will assist the provider with obtaining a copy of the Provider Appeals/Dispute Resolution Form.
 - C. The Provider Appeals Resolution Form collects the following information, at a minimum:
 1. The nature of the problem
 2. Previous attempts, if any, to resolve it
 3. Any other pertinent information that the provider feels is important
 - D. In addition, the provider may submit additional information in writing either by electronic mail, surface mail, special delivery, hand delivery, provider web portal or other source of written communication. The provider will not submit originals unless requested to do so. Partners is under no obligation to return documents submitted by a provider in support of its dispute unless expressly agreed upon in advance in writing.
- II. Nature or Type of Provider Appeal
- A. Once Partners receives the completed Provider Appeal/Dispute Resolution Form from the provider, the Partners' provider network appeals specialist will perform an analysis of the nature or type of the dispute and assign it to the appropriate track described below. The provider network appeals specialist may confer with other departments as appropriate to assist with making this determination if needed.

Type I: Participating Provider Appeals:

- a. Finding of or recovery of an overpayment by the PIHP/PHP;
- b. Withhold or suspension of a payment related to fraud, waste or financial abuse concerns/
- c. Contract termination for cause of finding of contract violation;
- d. Corrective action by the PIHP/PHP;
- e. Determination to de-certify an AMH+ or CMA.

Type II: Out of Network Provider Appeals:

- a. Disputes regarding an out-of-network payment arrangement, such as a single-case agreement;
- b. Finding of fraud, waste or financial abuse by the PIHP/PHP;
- c. Finding of or recovery of an overpayment by the PIHP/PHP.

B. Exclusions: Not all parties and issues are subject to this participating provider appeals process.

- a. Parties: This process is limited to participating providers under an existing contract directly or indirectly, with Partners to provide Covered Services to Covered Persons, which has been approved for participation by Partners, and that is designated by Partners as a “participating provider” in the Tailored Plan network. Excluded include Applicants, credentialed but not contracted providers, employees of providers (including Relatives of Direct Support Employees (RDSE) and others not defined as participating providers below.
 - (i) If a participating provider has been issued a notice of dismissal or termination from the network, then the provider is considered participating for purposes of this dispute process up to and through the last day of participation as indicated on the notice, unless the notice is received on or after the last participation day, in which case, the provider will be given reasonable time to initiate the dispute mechanism. The timeframe is generally stated in the dismissal/termination notice.
- b. Medical Necessity and Other Enrollee Appeals: Medical necessity appeals, including disputes regarding resource allocation and Supports Intensity Scale (SIS) scores, are not included within the scope of this provider dispute process but are addressed as adverse benefit determinations by the Utilization Management department under separate policies and procedures for enrollees and beneficiaries.
 - (i) This provider dispute process does not include disputes primarily or exclusively belonging to the member, beneficiary, enrollee or their legally responsible person (LRP).
- c. Clear For-Cause Contract Violations: If the provider contract is explicit and breached, this provider dispute process is not required. For example, if a providers’ clinical license is revoked, if the provider is convicted of claims fraud or if the provider receives a failing fidelity score (TMACT), the provider loses its facility license, etc.
 - (i) For those violations described in the Integrated Payment and Reporting System (IPRS) (aka non-Medicaid) contract (the contract with providers who deliver state-funded services), Article IV, Term and Termination, the dispute resolution process is not available. Those violations include but are not limited to:
 - (a) Repeated non-performance of obligations without corrective action
 - (b) Violations of professional standards
 - (c) The commission of unlawful acts

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- d. Grievances: Disputes by individuals and entities not covered by this process may be eligible for the grievance/complaint process covered in Partners' Policy and Procedure 6.00U.
 - e. Untimely or Previously Adjudicated Disputes: Each dispute must be brought in a timely manner and cannot be brought again by the same participating provider regarding the same action or decision by Partners.

III. Panel Reviews by Provider Appeal Type

Partners' provider appeals process involves a two-level panel review process for all appeals. The panels follow the same process as described here.

A. All Panel Reviews

1. Unless otherwise specified, the provider network appeals specialist will consult with the appropriate Partners' staff to perform the duties associated with this provider appeals resolution process.
2. Providers initiate the provider appeals resolution process by submitting a Provider Appeals /Dispute Resolution Form generally included with the action or decision being disputed. A provider may also contact Partners by telephone or in-person, and the appropriate staff person will assist the provider with obtaining a copy of the Provider Appeals/Dispute Resolution Form and answer relevant questions on how to complete it. While the form is the preferred method for initiating this appeal process, other writings covering substantially the same information will be accepted.
3. The provider network appeals specialist will send an acknowledgment letter to the provider as soon as reasonable based on the urgency of the situation, but no later than five calendar days of receipt of the Provider Appeals/Dispute Resolution Form. The acknowledgment letter will include the following information, satisfied by enclosing a copy of this policy and procedure, if not already provided:
 - a. An explanation of the appeal resolution process and provider rights, including the right to request a second-level panel review if dissatisfied with the first-level panel resolution.
 - b. That at any time during the process, the provider may submit any supporting documentation and any additional written information to Partners for consideration.
 - c. An invitation for the provider to present arguments to the panel in person, by telephone or virtually.
4. The provider network appeals specialist ensures all pertinent information is gathered and organized in an orderly, confidential fashion, including:
 - a. Information collected from the provider, e.g.:
 - (i) Provider demographic information
 - (ii) Summary of problem/issue
 - (iii) Documents furnished by the provider during the dispute
 - (iv) Provider's view of the issue(s), including how to resolve it

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- b. All relevant information and documents from the appropriate Partners' staff making or supporting the decision or action, e.g., correspondence, research, contract(s), findings and summaries, as applicable.
 - c. If necessary, a Partners' staff person will investigate the matter further, which may involve a visit to the provider's office location.
 5. If reasonably feasible, the provider network appeals specialist may work closely with the provider to mediate and negotiate with the provider an amicable resolution in lieu of a panel review. The participating provider should submit, in writing, any decision or election to withdraw or stop the provider dispute process.
 6. Partners shall establish a committee (panel) to review and make decisions on provider Appeals. The committee must consist of at least three (3) qualified individuals who were not involved in the original decision, action, or inaction giving rise to the right to Appeal.
 7. None of the voting panelists may have a conflict of interest nor have been involved in the initial decision or action that is the subject of the dispute or a prior panel in the dispute. To the extent possible, panelists should be selected who are familiar with the issues, services and subjects raised by the provider or expected to arise in the panel review.
 8. Each panel meets as soon as reasonable, preferably prior to the effective date of the action or decision being disputed. First-level panels will meet no later than fifteen (15) business days following receipt by Partners of the completed Provider Appeals/Dispute Resolution Form. Second-level panels shall meet no later than fifteen (15) business days following receipt of the provider's request for a second-level panel review.
 9. The action or decision being disputed shall not pend or be extended during this dispute process unless expressly agreed in advance in writing by Partners. However, Partners will extend the timeframe by up to but not exceeding 30 calendar days for providers to request an appeal for good cause shown as determined by Partners. Partners will consider the voluminous nature of required evidence/supporting documentation, as good-cause reasons to extend the timeframe.
 10. While providers are invited to present to the panel, it is an accommodation and not a right. A provider's availability should not be permitted to delay the prompt and timely scheduling and holding of a panel review. If the provider has elected to present to the panel, the provider will be notified of the date and place of the panel review as far in advance as is feasible and prudent. This notification need not be in formal writing if time does not permit.
 11. Panel reviews shall be held at one of Partners' office locations or via an electronic in-person platform such as Zoom, if meeting in person is not feasible. Panelists must attend in person or via an electronic platform such as Zoom. The meeting location is at the sole discretion of Partners but will take into consideration, to the extent feasible, the availability and location of all panelists and participants, including any provider confirming an intent to present in person to the panel.
 12. Other than minimal information needed to check for conflicts, all panelists and participants in a panel review shall sign a confidentiality agreement prior to seeing the documents and hearing

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- the information gathered for the panel. Each panel will have the opportunity to carefully and thoroughly review and consider all information surrounding the case, including documents, information and presentation, if any, by the provider.
13. No formal chair of a panel is required. All procedures shall be facilitated by the provider network appeals specialist or other designated and qualified Partners' staff. A disputed decision or action by Partners is upheld unless a simple majority, or more, of the panel votes otherwise.
 14. Providers electing to present to the panel may do so for no more than 15 minutes. This time is intended to be a presentation and not a question-and-answer period. The provider is invited to use the time largely as it sees fit to persuade the panel to reconsider Partners' action or decision being disputed. The provider may not remain present for any other portion of the confidential panel review and reconsideration. A provider seeking to present must give Partners advance notice of who will be attending and speaking for the provider.
 15. Subject matter experts at Partners may be invited to attend the review to counsel and inform the panel, including appropriate Partners' clinicians as needed, regarding clinical matters or issues that are anticipated or raised. While Partners' Chief Legal Officer or other attorney for Partners may attend and also counsel and inform the panel, he or she will not attend during the presentation by the provider nor engage and ask questions of the provider, to the extent required by attorney codes of ethics and conduct. Partners may have an attorney present if the participating provider elects to have an attorney present. This provider appeal process is intended to be informal reconsideration by Partners of its decision or action; however, Partners shall allow providers to be represented by an attorney during the Appeals process.
 16. As necessary, the provider network appeals specialist will consult with relevant Partners' personnel, including the provider network director, the chief medical officer, the chief legal officer, chief operations officer (COO), or the chief executive officer (CEO).
 17. Following the presentation and review of all materials and information, panelists will deliberate among themselves with or without Partners' staff present to counsel and inform, as determined by the panel.
 18. Panels must limit their decisions to the facts, information, and controlling authorities before them. Panels may not reverse decisions made by the chief medical officer, or a committee chaired or membered by the chief medical officer, without the express consent of the chief medical officer. Any decision that reasonably contradicts controlling authorities must first be approved by the CEO in consult with the Chief Legal Officer.
 19. Once the panel decision has been made, written notification is sent within five business days, by trackable mail, to the provider regarding the outcome of the panel review.
 20. Any notes, minutes or other materials and information regarding the proceedings are kept and held in strictest confidence. This does not prohibit a provider from sharing the information with legal counsel or Partners' staff from sharing, as reasonably appropriate, internally.
- B. First-Level Type I (participating provider) or Type II (out of network provider) Panel Review:

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1. The appeals first level committee consists of at least three qualified individuals who were not involved in the original decision, action or inaction giving rise to the appeal; and at least one clinical peer who is not an employee of Partners or a Partners' committee member.
 2. These individuals review and make decisions on each appeal.
 3. The committee participants include those representing a variety of functional areas with expertise related to the appealed decision, action or inaction.
 4. The designated Partners' staff member compiles available information, including summaries of his/her own research, if applicable.
 5. The committee meets as soon as possible, but no later than fifteen (15) business days following receipt of the appeal.

Written Notice Regarding First Level Panel Review (Type I and II):

Once the decision has been made, written notification is sent to the provider within five business days regarding the outcome of the committee review, but no later than 30 calendar days of receipt of the appeal request or from the date the final evidence was received if an extension was granted, along with the notification of action or decision. The notice includes appeal rights.

C. Second Level Panel Review (Type I and II):

1. If the provider is dissatisfied with the first level committee's resolution and requests a second review, Partners will convene a second-level committee with at least three qualified individuals that were not involved in the original decision, action or inaction giving rise to the appeal, that did not participate on the first level committee.
2. This committee must include at least one clinical peer who is not an employee of Partners or a Partners' committee member.
3. The provider being reviewed may submit additional information that he/she deems important to support his/her case.
4. The designated Partners' staff member compiles all available information, including any summaries of his/her own research, if applicable.
5. The committee meets as soon as possible, but no later than fifteen (15) business days from receipt of the appeal to review the appeal, with special review and consideration of any additional information presented by the provider to support his/her case.

Written Notice Regarding Second Level Panel Review

Once the panel makes a decision, written notification is sent to the provider within five business days explaining the outcome of the committee review, but no later than 30 calendar days of receipt of the appeal request or from the date final evidence was received if an extension was granted, along with the notification of action or decision.

IV. Appeals to State

Partners has an Appeals process for providers to challenge certain Partners decisions and to receive information regarding access to a state level review through NCOAH or any other appropriate forum

provided by contract or law. A provider must exhaust Partners' internal appeals process before seeking recourse under any other process permitted by contract or law.

- A. Final Decision: A decision by Partners is not final until issued after completion of all the applicable portions of this appeals policy. The participating provider must exhaust the full provider dispute process afforded by Partners to appeal Partners' final decision to the State or otherwise seek recourse under any process permitted by contract or law. The potential for appealing and how to do so will be included in any final decision issued by Partners under this provider dispute process.
- B. Medicaid: Partners provider appeal decisions involving Medicaid funds or contracts, if appealable, are to the North Carolina Office of Administrative Hearings to the extent required by law.
- C. Non-Medicaid: Partners' provider appeal decisions involving non-Medicaid funds or contracts, if appealable, are to a North Carolina DMH/DD/SAS hearing officer, to the extent required by law.

V. Member Safety Mechanism

Partners' first priority is the well-being of its members. If the Partners' Chief Medical Officer or Chief Clinical Officer is of the opinion that the provider who is the subject of any dispute poses a significant risk to the health, welfare or safety of members, the provider may be immediately suspended pending the results of an investigation.

- A. A suspended participating provider will not receive funding or new referrals from Partners. Any suspension decisions must be made by the Partners Network Management Committee pursuant to LME/MCO/Tailored Plan Issued Sanctions Policy.
- B. Written notification of the intent to suspend the provider pending investigation is sent to the provider as soon as possible based on the urgency of the situation, but no later than five (5) calendar days of becoming aware of the issues. The notification includes the availability of the Appeal Process including the Appeal Resolution Form and the mechanism for initiation.
- C. In addition, Partners provides written notification to the appropriate entities, such as:
 - 1. Division of Health Service Regulation (DHSR)
 - 2. The Department of Social Services (DSS)
 - 3. The Division of Mental Health/Developmental Disability/Substance Abuse Services (DMH/DD/SAS) Program Integrity Unit
- D. As with any appeal, the provider may contact Partners' Provider Network Management department to share any information that they believe may bring about a favorable outcome.
- E. Partners makes every effort to achieve a final resolution to these kinds of cases ahead of the designated deadlines, given the provider has been suspended. However, Partners does not compromise the outcome to complete the case quickly.
- F. A first-level panel convenes once the information gathering and investigation is complete.
- G. All other steps to the panel review process are the same as outlined above, including the written notification and the right to a second-level panel review.

VI. Appeals Related to Provider Payment Withhold or Suspension: Partners shall notify the Department within ten (10) Business Days of a suspension or withhold of provider payment.

For administrative appeals related to payment withhold or suspension, Partners will resolve each appeal and issue a written decision within fifteen (15) business days. If the review of an appeal related to payment results in the determination that Partners did not have good cause for withholding or suspending payment, withheld or suspended payments will be made to the provider within five business days. Partners shall also pay interest and penalties, for overturned denials, underpayment, or findings it did not have good cause to suspend or withhold payment from the original Date of Payment, suspension, withhold or denial, to the extent required by law.

Partners shall offer the provider an in person, telephone, or virtual hearing when provider is Appealing whether Partners has good cause to withhold or suspend payment to the provider.

Partners will provide notice to NCDHHS of any provider appeal regarding the suspension or withhold of payment, finding or recovery of an overpayment by Partners, or any action related to a finding of fraud, waste, or financial abuse. Such notice must be provided within five business days of the appeal.

VII. Documentation

- A. Information pertaining to all appeals, administrative or clinical, is documented in the designated database. This information is also filed in the provider files maintained in the Provider Network Management department.
- B. Quarterly reports are created for presentation to the Quality Improvement Committee (QIC) and other appropriate committees for tracking and trending.
- C. The QIC will request an action plan to bring about improvements when patterns emerge.

Partners will notify NCDHHS if a provider has sued Partners in any administrative or general court of justice for actions related to Medicaid Managed Care. Such notice must be provided within five business days of being served.

Partners will submit the Provider Grievances and Appeals Policy to NCDHHS for review 120 days calendar after contract award. Partners will submit any significant policy changes to the NCDHHS for review at least 60 calendar days prior to implementing the changes.