POLICY AND PROCEDURE

DEPARTMENT: Provider Solutions	**DOCUMENT NAME:** Provider Complaints
PAGE: 1 of 8	**REPLACES DOCUMENT:**
APPROVED DATE: 9/11	**RETIRED:**
EFFECTIVE DATE: 1/12, 2/15	**REVIEWED/REVISED:** 01/14, 11/14, 3/15; 10/15, 10/16, 10/17, 10/18, 5/19, ~~2/20~~, 1/21
PRODUCT TYPE: Medicaid	**REFERENCE NUMBER:** LA.PRVR.03

SCOPE:
Louisiana Healthcare Connections (Plan) Quality, Provider Solutions, Network Accounts, and Medical Management departments

PURPOSE:
To have an established provider complaint system that ensures a provider complaint is resolved timely for both participating and non-participating providers.

POLICY:
For the purposes of this policy, a Provider Complaint is any verbal or written expression, originating from a provider and delivered to any employee of the Plan, voicing dissatisfaction with a policy, procedure, payment or any other communication or action by the Plan**, excluding request of reconsideration or appeal for specific individual claims. It does include general complaints about claim payment policies. Note that member grievances and appeals filed by providers on behalf of a member should be documented and processed in accordance with member grievance and appeals policies.**

Plan shall establish a Provider Complaint System with which to track the receipt and resolution of provider complaint from in-network and out-of-network providers. The provider complaint system will process provider complaints in accordance with all applicable State and Federal regulations and provider contracts. The system will be capable of identifying and tracking complaints received by phone, in writing, or in person, on any issue that expresses dissatisfaction with a policy, procedure, or any other communication or action by the Plan.

Plan shall track and trend provider inquiries/complaints/requests for information and take systemic actions as necessary and appropriate.

Plan will ensure that provider complaints are acknowledged with 3 business days of receipt; resolve and/or state the result communicated to the provider within 30 ~~**business**~~ **calendar** days of receipt (this included LDH referrals). ~~**If the plan is unable to resolve in 30 days, the plan must document why the issue goes unresolved; however, the issue must be resolved with 90 days.**~~

POLICY AND PROCEDURE

DEPARTMENT: Provider Solutions	**DOCUMENT NAME:** Provider Complaints
PAGE: 2 of 8	**REPLACES DOCUMENT:**
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Complaints regarding proposed utilization management (UM) or adverse actions are excluded from this policy and covered under LA.UM.08 – Appeal of UM Decisions.

~~**Provider complaints related to claim disputes and claim appeals will be received and addressed at Plan's Louisiana office utilizing the provider complaint system. The actual process for resolving and adjudicating claim disputes and claim appeals is completed at Centene Corporate (in collaboration with Plan).**~~

Providers may file complaints via phone by calling 1-866-595-8133 or via email at providercomplaints@louisianahealthconnect.com.

If a provider is unable to reach a satisfactory resolution or get a timely response through the provider complaints process, the provider may escalate to one of the management or executive level contacts below:

Candace Campbell, Director of Operation-Provider Solutions
Candace.H.Campbell@louisianahealthconnect.com

Joseph Tidwell, Vice President of Network and Contracting
jotidwell@centene.com

LDH has offered a direct contact email address as a final step. Providers may e-mail LDH staff at ProviderRelations@la.gov. LDH requests that providers be sure to include details on attempts to resolve the issue at the Health Plan level as well as contact information (contact name, provider name, e-mail and phone number) so that LDH staff can follow up with any questions.

For those decisions that are not a unique function of the Plan, the provider may file a complaint directly to the State of Louisiana Department of Health and Hospitals (LDH) and/or Medicaid Management Information Systems (MMIS).

PROCEDURE:

POLICY AND PROCEDURE

DEPARTMENT: Provider Solutions	**DOCUMENT NAME:** Provider Complaints
PAGE: 3 of 8	**REPLACES DOCUMENT:**
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1. Provider Complaints:

a. Plan has dedicated staff for providers to contact via telephone, electronic mail, surface mail, or in person, to ask questions, file provider complaints and resolve problems.

b. The Provider is allowed thirty (30) days from the date of the occurrence of the event that is the subject of the complaint, to file a complaint orally or in writing.

c. The Grievance and Appeal Coordinators (GAC) in the Provider Solutions Department serve as the designated staff to receive and process provider complaints. The Claim Liaisons (CL) in the Provider Solutions Department serves as the designated staff for initiating research and resolution on each complaint and collaborating with other internal departments, as appropriate.

d. The GAC and provider consulting staff receive hands-on training on Provider Complaints and Member Grievances as part of their training to ensure they can differentiate between the two and channel each through the appropriate process.

e. The GAC reviews the complaint at intake and provides an acknowledgment of receipt of the complaint within three (3) business days of receipt of the complaint in writing or in the same manner in which the complaint was received.

f. The GAC routes the case through the OMNI software to the CL, which collaborates on a daily basis with appropriate internal department staff (i.e. Medical Management, Quality Improvement, Network Accounts, Provider Consultants, etc.) to thoroughly investigate each provider complaint using applicable statutory, regulatory and state contractual provisions, collecting all pertinent facts from all parties and applying Plan written policies and procedures.

g. If providers call the provider hotline regarding the status of their request, Provider Service Representatives (PSRs) electronically access the status through the OMNI and respond to the provider's inquiry, usually on the same call.

~~h.~~ The Plan ~~sets a goal~~will ~~to~~ resolve every complaint and provide written notice to the provider of the Plan's resolution/decision within 30 calendar days from the date the complaint was received. ~~If the complaint is not resolved in 30 calendar days, the Plan will document the reason why the complaint has not been resolved and provide a written status letter to the provider; however, all complaints must be resolved within 90 calendar days of receiving the complaint.~~

h.

i. Using the OMNI tool, the GAC tracks and monitors timeliness of resolution of provider complaints and identifies in advance potential barriers to their timely and complete resolution.

j. The Provider Complaints System requires that complaint reports are provided to the Performance Improvement Team (PIT), which includes Plan executives with the authority to monitor and require corrective action plans when appropriate.

k. A report on provider complaints and their status will be submitted to LDH on a monthly basis.

l. Providers are allowed to consolidate complaints of multiple claims that cover similar issues such as payment or coverage regardless of the number of individual patients or payment claims included in the bundled complaint.

m. Providers are allowed to present their cases in-person if they so request.

2. Limited Delegation by Plan

a. Plan delegates authority to provider subcontractors only through written delegation agreements.

b. To the extent that Plan delegates utilization management or network management functions to provider subcontractors, Plan may delegate authority to the subcontractor to receive and determine requests for administrative review and provider appeals.

c. The delegated subcontractor must follow the same timelines, accountabilities and processes set forth in this Policy and Procedure; however, the delegated subcontractor may designate other position titles for their staff provided that the individual's qualifications and responsibilities are at least equivalent to those set forth in this Policy and Procedure.

d. Plan retains ultimate accountability for delegated services and conducts oversight of delegated vendors as outlined CC.QI.14 in Oversight of Delegated Vendors.

3. Appeal of Medical Necessity Adverse Action

Appeals of UM decisions, wherein the provider is acting on behalf of a member (with the member's written consent), may be filed in accordance with the medical necessity appeal process (see UM.08 Appeal of UM Decisions).

4. Description in Provider Manual

All information regarding this policy is described in the Plan's Provider Manual which all providers receive upon contracting with Plan. Provider complaint system policies and procedures are also available to out-of-network providers upon written or verbal request. Plan may distribute a summary of these policies and procedures if the summary includes information about how the provider may access the full policies and procedures on the Plan website. This summary shall also detail how the provider can request a hard copy from Plan at no charge to the provider.

REFERENCES:
LA.UM.08 Appeal of UM Decisions

POLICY AND PROCEDURE

DEPARTMENT: Provider Solutions	**DOCUMENT NAME:** Provider Complaints
PAGE: 6 of 8	**REPLACES DOCUMENT:**
APPROVED DATE: 9/11	**RETIRED:**
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CC.QI.14 Oversight of Delegated Vendors
Provider Manual
~~2014 Bayou~~Current Louisiana Department of Health Request for Proposals (RFP)

ATTACHMENTS

DEFINITIONS:

Action – For the purposes of this Policy and Procedure, an action is defined as:

- The denial or limited authorization of a requested service, including the type or level of service; or
- The reduction, suspension, or termination of a previously authorized service; or
- ~~The denial, in whole or in part, of payment for a service; or~~
- The failure to provide services in a timely manner, as defined by Section 7.3 and Section 7.5 of the ~~2014~~ 2020 ~~Bayou Health~~ RFP; or
- The failure of the MCO to act within the timeframes provided in Section ~~1~~3.7.110.6.5 **of the** ~~2014~~ 2020 ~~Bayou Health~~ RFP.

Adverse Action – Any decision by the Plan to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested. 42 CFR 438.214

Grievance and Appeal Coordinator (Provider Solutions Team) – The Plan staff who monitor and coordinate processing of provider complaints (but not requests for administrative review filed by a provider on behalf of a member and with the member's written consent; the latter are monitored and coordinated by the Appeals and Grievance Coordinator in Member Grievance Department).

Provider Complaint – Any verbal or written expression, originating from a provider and delivered to any employee of the Plan, voicing dissatisfaction with a policy, procedure, payment or any other communication or action by the Plan.

Claim Liaison (Provider Solutions Team) – The Plan staff who initiate research and resolution of complaints and coordinate with other departments.

POLICY AND PROCEDURE

DEPARTMENT: Provider Solutions	**DOCUMENT NAME:** Provider Complaints
PAGE: 7 of 8	**REPLACES DOCUMENT:**
APPROVED DATE: 9/11	**RETIRED:**
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REVISION LOG	**DATE**
Policy was revised according to DHH requirements and reporting	**04/13**
• Changes – Added RFP language to policy regarding DHH-decision items, adding PR staff to training, and complaint consolidation language. • RFP requirements – 10.6.2; 10.6.3; 10.6.4; 10.6.5	**11/14**
• Updates to reflect current structure and process of Provider Complaints System and LHCC departmental organization • Updates to comply with RFP	**03/15**
No revisions	**10/15**
• Changed DHH to LDH • Removed Provider Complaint Coordinator added Grievance and Appeal Coordinator in the Provider Solutions Department • Removed Resolution Team added Claim Liaison in the Provider Solutions Department • Updated PCC to GAC • Removed LA.QI.14 to CC.QI.14	**10/16**
• Changed DHH to LDH • Changed Provider Consultants to Provider Solutions	**10/17**
Changed CRM to Omni	**10/18**
Added the following language: Plan shall track and trend provider inquiries/complaints/requests for information and take systemic actions as necessary and appropriate. Plan will ensure that provider complaints are acknowledged with 3 business days of receipt; resolve and/or state the result communicated to the provider within 30 business days of receipt (this included LDH referrals). If the plan is unable to resolve in 30	**5/19**

POLICY AND PROCEDURE

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PAGE: 8 of 8	**REPLACES DOCUMENT:**
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days, the plan must document why the issue goes unresolved; however, the issue must be resolved with 90 days.	
Added the following language: **Excluding request of reconsideration or appeal for specific individual claims.** **Added how to contact the plan to file a complaint and the process to escalate** **Updated the Action definition by removing bullet #3 and changing RFP year to 2020.** **Changed the turn around time for provider complainst to 30 calendar days**	**1/21**

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in Archer GRC, Centene's P&P management software,
Is considered equivalent to an actual signature on paper.

Director Service Ops:_____Approval on file
Director of Contracting and Network Development.....Approval on file