

Rule No. 560-X-45-.07 Complaints and Grievances

- (1) Each Primary Contractor shall implement an approved written grievance and a one level appeal system that meets the requirements of 42 CFR §438.42-CFR 431.201 including, but not limited to:
 - (a) Designation of a responsible Grievance Committee with appropriate clinical expertise.
 - (b) Two levels of review for the resolution of grievances. The time frame for these reviews shall be based on the nature of the grievance and the immediacy or urgency of the health care needs of the Medicaid recipient.
 - (c) The primary entry level for complaints shall be a designated responsible representative of each Primary Contractor.
 - (d) Resolution of grievances of an immediate or urgent nature (life threatening situations, perceived harm, etc.) shall not exceed a forty-eight hour review within the Primary Contractor's review process, which includes subcontractor's review. The Grievance Committee's decision shall be binding unless the Medicaid recipient files a written appeal.
 - (e) If the Medicaid recipient is not satisfied with the findings of the Grievance Committee, the Medicaid recipient may appeal to the Medicaid Agency for an administrative fair hearing.
 - (f) All grievances shall be maintained in a log as specified in the Maternity Care Program (MCP) Operational Manual.

- (2) Handling of Grievance and Appeals. The Primary Contractor must dispose of each grievance and resolve each appeal, and provide notice, as expeditiously as the enrollee's health condition requires, within State established timeframes and as specified in CFR 438.408, 438.410, 438.416, 438.420 and 438.424, including but not limited to:
 - (a) General Requirements. In handling grievances and appeals, the following requirements must be met:
 1. Give enrollees any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing numbers that have adequate TTY/TTD and interpreter capability.
 2. Acknowledge receipt of each grievance and appeal.
 3. Ensure that the individuals who make decisions on grievances and appeals are individuals-
 - (i) Who were not involved in any previous level of review or decision making; and
 - (ii) Who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease.
 - (I) An appeal of a denial that is based on lack of medical necessity.
 - (II) A grievance regarding denial of expedited resolution of an appeal.
 - (III) A grievance or appeal that involves clinical issues.

- (b) Special requirements for appeals. The process for appeals must:
 - 1. Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the enrollee or the provider requests expedited resolution.
 - 2. Provide the enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The Primary Contractor must inform the enrollee of the limited time available for this in the case of expedited resolution.)
 - 3. Provide the enrollee and his or her representative opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeals process.
 - 4. Include, as parties to the appeal-
 - (i) The enrollee and his or her representative; or
 - (ii) The legal representative of a deceased enrollee's estate.
- (3) Service Authorizations and Notice of Action
 - (a) An action is defined as the Primary Contractor
 - 1. denying or limiting authorization of a requested service including the type or level of service;
 - 2. reduction, suspension or termination of a previously authorized service;
 - 3. the denial, in whole or part, of payment for a service;
 - 4. the failure to provide services in a timely manner;
 - 5. the failure to act within specified timeframes
 - (b) Adverse actions taken by the Primary Contractor must meet the requirements of 42 CFR 438.10, 438.12, 438.404 and 438.210-214.
 - (c) A service authorization is defined as an enrollee's request for the provision of a service.
 - (d) Authorization of services. For the processing of requests for initial and continuing authorizations of services, each contract must meet the requirements of 42 CFR 438.210.

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Statutory Authority: Section 1932 of the Balanced Budget Act of 1997; Section 1905(t)(3) of the Social Security Act; 42 CFR Section 438; Alabama Medicaid Agency State Plan and approved 1915 (b) Waiver.

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