OREGON HEALTH PLAN

Managed Care Entities

Instructions for submitting

Grievance and Appeal Log

and Grievance System Report



**OREGON HEALTH PLAN**

**Coordinated Care Organizations**

Instructions for submitting Grievance and Appeal Log and

Grievance System Report as required by CCO contract Exhibit I

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Introduction

The instructions in this document are intended to provide technical assistance guidance to Managed Care Entities (MCEs) for reporting grievance and appeal information to the Oregon Health Authority (OHA). Use these instructions with the terms and conditions in Exhibit I of the MCE’s current contract with OHA, to fulfill grievance and appeal reporting requirements.

# Background

The current Oregon Health Plan 1115 Waiver requires OHA to submit quarterly reports about MCE grievances and appeals to the Centers for Medicare & Medicaid Services (CMS). OHA posts these reports on the OHA website at <https://www.oregon.gov/oha/HSD/Medicaid-Policy/Pages/2017-2022-Quarterly-Annual-Reports.aspx>.

Consistent and timely reporting of grievances and appeals is important to identify trends and implement interventions to address problem areas.

# Federal requirements

## 42 CFR §438.228 Grievance and appeal system

The State must ensure, through its contracts that each MCO, PIHP, and PAHP has in effect a grievance and appeal system that meets the requirements of subpart F.

## 42 CFR §438 Subpart F Grievance and appeal system

### §438.3 Recordkeeping requirements

(u) MCOs, PIHPs, and PAHPs must retain, and require subcontractors to retain, as applicable, the following information: enrollee grievance and appeal records in §438.416 […] for a period of no less than 10 years.

### §438.402 General requirements

The grievance and appeal system. Each MCO and PIHP and PAHP must have a grievance and appeal system in place for enrollees.

### §438.416 Recordkeeping requirements

(a) The State must require MCOs, PIHPs, and PAHPs to maintain records of grievances and appeals and must review the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the State quality strategy.

The CFR further states, “(c) the records “must be accurately maintained in a manner accessible to the state and available upon request to CMS.”

### §438.66  State monitoring requirements

(a) General requirement. The State agency must have in effect a monitoring system for all managed care programs.

(b) The State's system must address all aspects of the managed care program, including the performance of each MCO, PIHP, PAHP, and PCCM entity (if applicable) in at least the following areas:

(2) Appeal and grievance systems.

(c) The State must use data collected from its monitoring activities to improve the performance of its managed care program, including at a minimum:

(2) Member grievance and appeal logs.

# State requirements

## Oregon Administrative Rule (OAR) 410-141-3835, and 410-141-3875 through 410-141-3915

### OAR 410-141-3835

(11) Report to the Authority annual requests for prior authorization. The report shall include:

(a) The number of requests received;

(b) The number of requests that were initially denied and the reasons for the denials, including, but not limited to, lack of medical necessity or failure to provide additional clinical information request by the insurer;

(c) The number of requests that were initially approved; and

(d) The number of denials that were reversed by internal appeals or external reviews

### OAR 410-141-3875

(2) MCE’s shall establish and have an Authority-approved process and written procedures for compliance with grievance and appeals requirements . . .

(4) The MCE shall adopt and maintain compliance with grievances and appeals process timelines in 42 CFR §438.408(b) and these rules.

**OAR 410-141-3880**(2) For standard resolution of a grievance, the MCE shall resolve each grievance and provide notice of the disposition as expeditiously as the member’s health condition requires. The MCE shall:

(a) Within five business days from the date of the MCEs receipt of the grievance, notify the member in their preferred language that a decision on the grievance has been made and what that decision is; or

(b) Promptly, but in no event more than five business days after the date of the MCE’s receipt of the grievance, notify the member in their preferred language that there shall be a delay in the MCE’s decision of up to 30 days from the date on which the grievance was received by the MCE. The written notice shall specify why the additional time is necessary.

**OAR 410-141-3915**

(4) MCE’s shall submit for the Authority’s review of the Grievance and Appeals Log, samples of Notices of Adverse Benefit Determination, and other reports as required under the MCE contract.

## MCE contract Exhibit I

Contractor shall establish internal Grievance procedures under which Members, or Providers acting on their behalf, may challenge any action. Contractor shall maintain its Grievance System in accordance with this exhibit, OAR 410-141-3835, OAR 410-141-3875 through 410-141-3915 and 42 CFR 438.400 through 438.424.

Contractor’s Grievance and Appeal System shall be subject to review and approval by OHA.

9 (a) Contractor shall fully and timely comply with all records requests. Contractor shall fully and promptly comply with OHA monitoring and oversight.

9 (b) Contractor shall maintain records, in a central location accessible to OHA and available upon request to CMS, for each Grievance and Appeal.

10 (b) Within forty-five (45) days after the end of each calendar quarter, Contractor shall provide to OHA, via Administrative Notice, the following documentation (which shall include any and all documentation required to be held and maintained by the Contractor’s Subcontractors):

1. A Grievance and Appeal Log, which shall include the information about Prior Authorizations requests and denials required by Enrolled Oregon House Bill 2517 (2021) and specified in OAR 410-141-3835, in a format provided by OHA and available on the CCO/DCO Contract Forms Website;
2. Samples of NOABDs and corresponding Prior Authorization documentation. […] OHA will randomly select samples from Contractor’s Grievance and Appeal log for the corresponding quarter for review. […] Contractor shall submit records for the samples selected by OHA in the manner directed by OHA in its request no later than fourteen (14) days following receipt of OHA’s request.
3. All NOABDs for Applied Behavioral Analysis and Hepatitis C for the previous calendar quarter; and
4. Any other related documentation requested by OHA.

10 (c) Within forty-five (45) days after the end of each calendar quarter, Contractor shall provide its Grievance System Report to OHA via Administrative Notice. Such Grievance System Report shall be in a format provided by OHA which is available on the CCO/DCO Contract Forms Website. Contractor shall use data collected from its own and its Subcontractors’ Monitoring of Contractor’s Grievance and Appeal System, including the Grievance and Appeal data reported by Contractor and Subcontractors in their Grievance and Appeal logs to analyze such system. Contractor shall demonstrate how Contractor uses the data it has collected for itself and its Subcontractors to maintain an effective process for monitoring, evaluating, and improving the access, quality and appropriateness of services provided to Members.

# Definitions

| Term | Definition |
| --- | --- |
| Adverse Benefit Determination (ABD) | OAR 410-141-3875 (1)(b) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. The reduction, suspension, or termination of a previously authorized service; A denial, in whole or in part, of payment for a service. A payment denied solely because the claim does not meet the definition of a “clean claim” at CFR 447.45(b) is not an adverse benefit determination; The failure to provide services in a timely manner pursuant to 410-141-3515; The MCE’s failure to act within the timeframes provided in these rules regarding the standard resolution of grievances and appeals. See OAR 410-141-3885 for notifying a member enrolled in an MCE. |
| Appeal | 42 CFR §438.400(b)Appeal means a review by an MCO, PIHP, or PAHP of an adverse benefit determination.  OAR 410-141-3875 (1)(a): “Appeal” means a review by an MCE pursuant to OAR 410-141-3890 of an adverse benefit determination. |
| Contested Case Hearing | OAR 410-120-0000 (56) A proceeding before the Authority under the Administrative Procedures Act when any of the following contests an adverse determination, action, or as it relates to an MCE enrollee, an adverse benefit determination:  (a)A client or member or their representative;  (b)A member of an MCE after resolution of the MCEs appeal process;  (c)An MCE member’s provider; or  (d)An MCE. |
| Grievances/ Complaints | 42 CFR 438.400(b) Grievance means an expression of dissatisfaction about any matter other than an adverse benefit determination. |
| Grievance and Appeal System | OAR 410-141-3500 (35) The overall system that includes:  (a) Grievances to an MCE on matters other than adverse benefit determinations;  (b) Appeals to an MCE on adverse benefit determinations; and  (c) Contested case hearings through the Authority on adverse benefit determinations and other matters for which the member is given the right to a hearing by rule or statute. |
| Managed Care Entity (MCE)  (This term is being used in place of CCO/DCO) | OAR 410-141-3500 (49) As stated in 42 CFR 457.10, an entity that enters into a contract to provide services in a managed care delivery system including but not limited to managed care organizations, prepaid health plans, primary care case managers, Coordinated Care Organizations (CCOs) and Dental Care Organizations (DCOs). |
| Prior Authorization (PA) | OAR 410-120-0000 (202) Prior Authorization means payment authorization for specified medical services or items given by Authority staff or its contracted agencies prior to provision of the service. A physician referral is not a PA. |

# General information

Exhibit I of the current MCE contract lists all Grievance and Appeal reporting requirements. MCEs must email quarterly reports to the OHA Contract Administration Unit at: [CCO.MCODeliverableReports@odhsoha.oregon.gov](mailto:CCO.MCODeliverableReports@odhsoha.oregon.gov) ) no later than 45 calendar days from the end of each calendar quarter:

* Grievance and Appeal Log
* Grievance System Report

The report templates are at <http://www.oregon.gov/oha/HSD/OHP/Pages/CCO-Contract-Forms.aspx>.

State and federal rules have two main requirements for MCEs:

1 – Maintaining grievance and appeal records (recordkeeping) in a central location within the MCE;

2 – Reporting grievances and appeals to OHA.

# Recordkeeping requirements

## OAR 410-141-3915, MCE Contract Exhibit I (9) - Grievance and Appeals System Recordkeeping

**OAR 410-141-3915**

(1) Each MCE shall maintain records of grievances and appeals and shall review the information as part of its ongoing monitoring procedures. . .

(2) Consistent with record retention requirements in OAR 410-141-3520, MCE’s must maintain yearly logs of all appeals and grievances for 10 years, which must include information about the reasons for each grievance and appeal, as well as the resolution and supporting reasoning.

(3) The MCE must review the log monthly for completeness, accuracy, and compliance with required procedures.

(4) MCEs shall submit for the Authority’s review the Grievance and Appeals Log, samples of Notices of Adverse Benefit Determination, and other reports as required under the MCE contract.

**MCE Contract Exhibit I (9)**

1. Contractor shall document and maintain a record of all Member Grievances and Appeals in accordance with OAR 410-141-3890, OAR 410-141-3915, OAR 410-141-3875, and 42 CFR

§ 438.416. Contractor shall fully and timely comply with all records requests. Contractor shall fully and promptly comply with OHA Monitoring and oversight.

1. Contractor shall maintain records, in a central location accessible to OHA and available upon request to CMS, for each Grievance and Appeal. The records shall include, at a minimum:
2. A general description of the reason for the Appeal or Grievance and the supporting reasoning for its resolution;
3. The Member’s name and ID;
4. The date Contractor received the Grievance or Appeal filed by the Member, Subcontractor, or Provider;
5. The NOABD;
6. If filed in writing, the Appeal or Grievance;
7. If filed orally, documentation that the Grievance or Appeal was received orally;
8. Records of the review or investigation at each level of the Appeal, Grievance, or Contested Case Hearing;
9. Notice of resolution of the Grievance or Appeal, including dates of resolution at each level;
10. Copies of correspondence with the Member and all evidence, testimony, or additional documentation provided by the Member, the Member’s Representative, or the Member’s Provider as part of the Grievance, Appeal, or Contested Case Hearing process; and
11. All written decisions and copies of all correspondence with all parties to the Grievance, Appeal, or Contested Case Hearing.

# Reporting requirements

OHA does not ask MCEs to report all the information they must keep on record as described above in the Recordkeeping Requirements. Instead, MCEs must report grievances and appeals each quarter as required in the MCEs current contract with OHA in the Grievance and Appeal Log that is posted on the OHA Reporting website.

OHA reports grievance and appeal summary data to the Centers for Medicare and Medicaid Services (CMS) in the quarterly 1115 Waiver Report. The 1115 Waiver Report is a contractual agreement between the OHA and CMS. The specific data to be reported to CMS is detailed in the Waiver contract. OHA uses MCE reports to give CMS a “snapshot” of all complaints MCEs received and resolved in the quarter.

# Instructions for Grievance and Appeal Logs

Every quarter, each MCE must submit Grievance and Appeal Log information and one Grievance System Report.

Grievance and Appeal Log data files may be submitted in any of the following file formats:  
• ASCII text file\*

• Comma-separated values file (CSV)\*  
• Spreadsheet file (e.g., see MS Excel Grievance and Appeals Log 2023)  
• Other file types as coordinated with OHA

\*OHA prefers large data submissions via ASCII text file or Comma-separated values file (CSV).

If you have questions or concerns about how to complete the templates, or submitting to the OHA, please email [HSD.QualityAssurance@odhsoha.oregon.gov](mailto:HSD.QualityAssurance@odhsoha.oregon.gov)  for technical assistance.

# Grievance Log:

List all oral and written grievances/complaints received during the quarter. This includes all grievance/complaints collected from MCEs and their sub-contractors for all Medicaid members enrolled in a plan, regardless of other insurance coverage (Medicare, Private Insurance, etc.)

Record each grievance/complaint on separate lines that can be identified by a grievance type code. USE ‘Grievance System Code Tables’[[1]](#footnote-2) document to find the appropriate codes for the Grievance/Complaint Category, Type, and Service Type fields.

Reporting is based on the date the grievance/complaint was received.

“Resolved” means when all aspects of the complaint have been resolved and the member has been notified.

|  |  |  |  |
| --- | --- | --- | --- |
| **Data Field Name** | **Data Field Description** | **Date Field Instructions** | **Required** |
| **Client ID** | Member’s 8-digit alphanumeric Oregon Health ID number | Enter the Member’s 8-digit alphanumeric Oregon Health ID number.  Do not enter an MCE or Provider ID number.  **Format/Value:** 8-digit alphanumeric value (e.g., AZ19936X). | Yes |
| **Receipt Date** | Date Grievance/Complaint received | Enter date the MCE received the grievance/complaint (either orally or in writing)  **Format/Value:** MM/DD/YYYY (e.g., 01/01/2023). | Yes |
| **Category** | Category of Grievance/Complaint received | Enter the appropriate letter from the ‘Grievance’ tab of the ‘Grievance System Code Tables’ document, ‘Category’ column corresponding to the grievance/complaint received.  **Format/Value:** 1 to 2-digit alphabetic characters / present in ‘Grievance’ code table, ‘Category’ column. | Yes |
| **Grievance Type** | Type of Grievance/Complaint received | Enter the appropriate letter from the ‘Grievance’ tab of the ‘Grievance System Code Tables’ document, ‘Grievance Type’ column corresponding to the grievance/complaint received.  **Format/Value**: 1-digit alphabetic character / present in ‘Grievance’ code table, ‘Grievance Type’ column. | Yes |
| **Service Type** | Service Type for Grievance/Complaint received | Enter the appropriate number from the ‘Service Type’ tab of the ‘Grievance System Code Tables’ document, ‘Service Type’ column corresponding to the grievance/complaint received.  **Format/Value:** 1 to 2-digit numeric character / present ‘Service Type’ code table, ‘Service Type’ column. | Yes |
| **Resolved** | Resolution status of Complaint | Enter resolution status of Grievance/Complaint by indicating Yes (Y) if resolved or No (N) if not resolved.  **Format/Value**: 1-digit alphabetic character (Y or N). | Yes |
| **Date of Resolution** | Date the MCE resolved the Grievance/Complaint | Enter the date the MCE resolved the grievance/complaint.  **Format/Value:** MM/DD/YYYY (e.g., 01/01/2023)  **Null Value:** Blank – do not use NA, N/A or other conventions. | Yes, if Resolved=Y |
| **Provider** | Name of Provider | Enter the name of the Provider.  **Format/Value:** alphabetic characters, spaces, special characters associated with names.  **Null Value:** Blank – do not use NA, N/A, or other conventions. | Yes |
| **Clinic** | Name of Provider’s affiliated Group Practice, Clinic, or Facility name | Enter the name of the Provider’s affiliated Group Practice, Clinic, or Facility Name.  **Format/Value:** alphabetic characters, spaces, special characters associated with names  **Null Value:** Blank – do not use NA, N/A, or other conventions. | Yes |
| **Resolution** | Brief summary of Grievance/Complaint Resolution | Enter a brief summary of the Grievance/Complaint resolution.  **Format/Value:** alphabetic characters, spaces, special characters  **Null Value:** Blank – do not use NA, N/A, or other conventions. | Yes |

# Prior Authorization (PA) Log

MCEs must report each Prior Authorization (PA) received during the quarter, for all benefit types, including but not limited to medical, behavioral health, pharmacy, dental, and non-emergent medical transportation. This includes all PAs from MCEs and their sub-contractors for all Medicaid members enrolled in a plan, regardless of other insurance coverage (Medicare, Private Insurance, etc.)

Record each Prior Authorization on a separate line that can be identified by a Service Type code. USE ‘Grievance System Code Tables’[[2]](#footnote-3) document to find the appropriate codes for the Service Type field.

Reporting is based on the date the PA was received.

|  |  |  |  |
| --- | --- | --- | --- |
| **Data Field Name** | **Data Field Description** | **Date Field Instructions** | **Required** |
| PA ID | Prior Authorization Identification Number | Enter one of the following:   1. MCE unique internal identification number. Or; 2. Sequential number with “PA”, Year and Quarter listed in front such as: PA\_YYYYQ#\_#. (e.g., PA\_2023Q1\_1, PA\_2023Q1\_2, PA\_2023Q1\_3…)   Each quarter, the numbering will start over and begin with 1 again.  **Format/Value:** alphanumeric characters, spaces, special characters associated with ID #s. | Yes |
| Client ID | Member’s 8-digit alphanumeric Oregon Health ID number | Enter the Member’s 8-digit alphanumeric Oregon Health ID number.  Do not enter an MCE or Provider ID number.  **Format/Value:** 8-digit alphanumeric value (e.g., AZ19936X). | Yes |
| Date of Request | Date the PA request was made | Enter the date the MCE received the Prior Authorization request.  **Format/Value:** MM/DD/YYYY (e.g., 01/01/2023). | Yes |
| Outcome | Outcome of PA decision (Approved, Denied, Cancelled, Pending) | Enter outcome of PA decision using single letter identifier described below.  *Note re: cancellations: Report CCO cancellations only. Do not include provider cancellations.*  Partial Approvals/Denials: Please use same PA ID and report the Approved and Denied services on separate lines with corresponding procedure codes.  **Format/Value:** 1-digit alphabetic character / ‘A’ = Approved, ‘D’ = Denied,  ‘C’ = CCO Cancellation, ‘P’ = Pending. | Yes |
| Service Type | Service Type for PA received | Enter the appropriate number from the ‘Service Type’ tab of the ‘Grievance System Code Table’ document[[3]](#footnote-4), ‘Service Type’ column corresponding to the prior authorization request received.  **Format/Value:** 1 to 2-digit numeric character / present in ‘Service Type’ code table, ‘Service Type’ column. | Yes |
| Diagnosis Code(s) | Diagnosis code(s) submitted with PA request | Enter the Diagnosis (ICD-10) code(s) that are submitted with the PA request. If multiple codes, separate each with a semi-colon.  For Partial Approvals/Denials: Diagnosis codes associated with multiple outcomes (i.e., approved and denied) need to be duplicated across all rows associated with the same PA ID.  **Format/Value**: Alpha/Numeric characters with special characters associated with Diagnosis codes (e.g., R91.8).  **Null Value:** Blank – do not use NA, N/A, or other conventions. | Yes, when applicable |
| Procedure Code(s) | Procedure code(s) submitted with PA request | Enter the Procedure (CDT/CPT/HCPC) code(s) that are submitted with the PA request. If multiple codes, separate each with a comma.  **Format/Value:** 4-5 digit Alpha/Numeric characters associated with Procedure codes. (e.g., D3347 or 72148).  **Null Value:** Blank – do not use NA, N/A, or other conventions. | Yes, when applicable |

# Notices of Adverse Benefit Determination (NOABD) Log

MCEs must report the TOTAL number of NOABDs issued during the quarter. This means every time the MCE or a subcontractor sends an NOABD letter to a Medicaid member it must be included in the TOTAL for the quarter. This includes all NOABDs from MCEs and their sub-contractors for all Medicaid members enrolled in a plan, regardless of other insurance coverage (Medicare, Private Insurance, etc.) Report the following:

* All pre- and post-service notices,
* All notices for Hepatitis C Direct-Acting Antiviral (DAA) medication, and
* All notices for Applied Behavior Analysis.

List all NOABDs issued during the quarter.

|  |  |  |  |
| --- | --- | --- | --- |
| **Data Field Name** | **Data Field Description** | **Date Field Instructions** | **Required** |
| NOABD ID | Notice of Adverse Benefit Determination Identification Number | Enter one of the following:   1. MCE unique internal identification number. Or; 2. Sequential number with “NOABD”, Year and Quarter listed in front such as: NOABD\_YYYYQ#\_#. (e.g., NOABD\_2023Q1\_1, NOABD\_2023Q1\_2, NOABD\_2023Q1\_3…)   Each quarter, the numbering will start over and begin with 1 again.  **Format/Value:** alphanumeric characters, spaces, special characters associated with ID #s. | Yes |
| PA ID | Prior Authorization Identification Number | Enter one of the following:   1. MCE unique internal identification number. Or; 2. Corresponding ID from PA Log.   *Note: for instances where there is no PA associated with the service (i.e., dental services), leave this field blank.*  **Format/Value:** alphanumeric characters, spaces, special characters associated with ID #s.  **Null Value:** Blank – do not use NA, N/A, or other conventions. | Yes, when applicable |
| Claim ID | Claim Identification Number | Enter MCE unique internal identification number for single claim.  Do not enter multiple claims in a single cell. If multiple claims are associated with single NOABD, list each claim on separate line and repeat NOABD ID on each.  **Format/Value:** alphanumeric characters associated with claims.  **Null Value:** Blank – do not use NA, N/A, or other conventions. | Yes, when applicable |
| Client ID | Member’s 8-digit alphanumeric Oregon Health ID number | Enter the Member’s 8-digit alphanumeric Oregon Health ID number.  Do not enter an MCE or Provider ID number.  **Format/Value:** 8-digit alphanumeric value (e.g., AZ19936X). | Yes |
| Date Service Provided | Date Service Provided to Member | Enter the Date the service was provided to member. Note: This column pertains to claims only, not PAs.  **Format/Value:** MM/DD/YYYY (e.g., 01/01/2023). | Yes, for claims only |
| Date of NOABD | Date of the Notice of Adverse Benefit Determination (NOABD) | Enter the date of the NOABD.  **Format/Value:** MM/DD/YYYY (e.g., 01/01/2023). | Yes |
| Action Category | Action Category based on the denial reason | Enter the appropriate letter from the ‘Action Category’ tab of the ‘Grievance System Code Tables’ document[[4]](#footnote-5), ‘Action Category’ column to capture the denial reason.  **Format/Value**: 1-digit alphabetic character / present in ‘Action Category’ code table, ‘Action Category’ column. | Yes |
| Sub- Category | Sub-Category based on the denial reason | Note: Sub-Category is only required if Action Category = A, C, or F.  Enter the appropriate number from the ‘Sub- Category’ tab of the ‘Grievance System Code Tables’ document[[5]](#footnote-6), ‘Sub-Category’ column to capture the denial reason with additional detail.  **Format/Value**: 1-digit numeric character / present in ‘Sub-Category’ code table, ‘Sub- Category’ column. | Yes, if Action Category = A, C, or F |
| Service Type | Service Type for PA/Claim received | Enter the appropriate number from the ‘Service Type’ tab of the ‘Grievance System Code Table’ document[[6]](#footnote-7), ‘Service Type’ column corresponding to the prior authorization request/claim received.  **Format/Value:** 1 to 2-digit numeric character / present in ‘Service Type’ tab, ‘Service Type’ column, within the ‘Grievance System Code Tables’ document. | Yes |
| CCO Extension | Indicate if timeframe for CCO benefit determination was extended | Enter a ‘Y’ if there was an extension; or enter ‘N’ if there was not an extension.  **Format/Value:** 1-digit alphabetic character / ‘Y’ = Yes, ‘N’ = No. | Yes |
| Services Previously Authorized | Indicate if Services were Previously Authorized | Enter a ‘Y’ if services were previously authorized; Enter a ‘N’ if not.  Note: If Services were Previously Authorized this means a 10-day notice is required prior to services being reduced, terminated, or suspended.  **Format/Value:** 1-digit alphabetic character / ‘Y’ = Yes, ‘N’ = No. | Yes |
| Expedited Granted | Indicate whether the NOABD was Expedited | Enter a ‘Y’ if the NOABD was Expedited; Enter a ‘N’ if not.  **Format/Value:** 1-digit alphabetic character / ‘Y’ = Yes, ‘N’ = No. | Yes |

# Appeal Log

Enter all appeals that were received in the quarter and all NOABDs associated with the appeal. This means, the appeal dates in column G are dates within the current reporting quarter. The NOABDs listed in column C may have dates that are prior to the current reporting quarter.

|  |  |  |  |
| --- | --- | --- | --- |
| **Data Field Name** | **Data Field Description** | **Date Field Instructions** | **Required** |
| NOABD ID | Notice of Adverse Benefit Determination Identification Number | Enter one of the following:   1. MCE unique internal identification number. Or; 2. Corresponding ID from NOABD log.   **Format/Value:** alphanumeric characters, spaces, special characters associated with ID #s. | Yes |
| Client ID | Member’s 8-digit alphanumeric Oregon Health ID number | Enter the Member’s 8-digit alphanumeric Oregon Health ID number.  Do not enter an MCE or Provider ID number.  **Format/Value:** 8-digit alphanumeric value (e.g., AZ19936X). | Yes |
| Date of Appeal Request | Date of Appeal Request | Enter the date the appeal request was received.  **Format/Value:** MM/DD/YYYY (e.g., 01/01/2023). | Yes |
| CCO Extension | Indicate if timeframe for appeal was extended | Enter a ‘Y’ if the timeframe for this appeal was extended or enter ‘N’ if not.  **Format/Value:** 1-digit alphabetic character / ‘Y’ = Yes, ‘N’ = No. | Yes |
| Expedited Granted | Indicate if the request to expedite the appeal process was granted. | Enter a ‘Y’ if the request to expedite the appeal process was granted or enter ‘N’ if not.  **Format/Value:** 1-digit alphabetic character / ‘Y’ = Yes, ‘N’ = No. | Yes |
| Appeal Outcome | Indicate outcome of Appeal | Enter outcome of appeal using one of the following letters:  Enter ‘U’ for ‘Upheld’  Enter ‘O’ for ‘Overturned’  Enter ‘P’ for ‘Partially Approved/Denied’  Enter ‘W’ for ‘Withdrawn’  Enter ‘D’ for ‘Dismissed’  **Format/Value:** 1-digit alphabetic character – see list above. | Yes |
| Date Appeal Overturned | Date Appeal is Overturned | Enter date appeal is overturned during the appeal process.  **Format/Value:** MM/DD/YYYY (e.g., 01/01/2023)  **Null Value:** Blank – do not use NA, N/A, or other conventions. | Yes, when applicable |
| Time Appeal Overturned | Time Appeal is Overturned | Enter time appeal is overturned during the appeal process.  **Format/Value:** HH:MM AM/PM - alpha/numeric characters, special characters associated with time (e.g., 12:15 PM).  **Null Value:** Blank – do not use NA, N/A, or other conventions. | Yes, when applicable |
| Date Member Notified | Date Member Notified by CCO of Overturned Service Authorization | Enter date Member notified by CCO of overturned service authorization.  **Format/Value:** MM/DD/YYYY (e.g., 01/01/2023)  **Null Value:** Blank – do not use NA, N/A, or other conventions. | Yes, when applicable |
| Time Member Notified | Time Member Notified by CCO of Overturned Service Authorization | Enter time Member notified by CCO of overturned service authorization.  **Format/Value:** HH:MM AM/PM - (e.g., 12:15 PM)  **Null Value:** Blank – do not use NA, N/A, or other conventions. | Yes, when applicable |
| Date Provider Notified | Date Provider Notified by CCO of Overturned Service Authorization | Enter date Provider notified by CCO of overturned service authorization.  **Format/Value:** MM/DD/YYYY (e.g., 01/01/2023)  **Null Value:** Blank – do not use NA, N/A, or other conventions. | Yes, when applicable |
| Time Provider Notified | Time Provider Notified by CCO of Overturned Service Authorization | Enter time Provider notified by CCO of overturned service authorization.  **Format/Value:** HH:MM AM/PM - (e.g., 12:15 PM)  **Null Value:** Blank – do not use NA, N/A, or other conventions. | Yes, when applicable |
| Date Member Withdrew Appeal | Date the Member withdrew the appeal | Enter the date the Member withdrew the appeal.  **Format/Value:** MM/DD/YYYY (e.g., 01/01/2023)  **Null Value:** Blank – do not use NA, N/A, or other conventions. | Yes, when applicable |
| Dismissed Late Filing | Indicate if the appeal was dismissed due to the Member filing past the required timeframe | Enter a ‘Y’ if the appeal was dismissed due to the Member filing past the required timeframe.  **Format/Value:** 1-digit alphabetic character – ‘Y’.  **Null Value:** Blank – do not use NA, N/A, or other conventions. | Yes, when applicable |
| Invalid Waiver | Indicate if the Provider did not have the Member sign an approved Waiver | Enter a ‘Y’ if the Provider did not have the Member sign an approved Waiver, or agreement similar to form OHP 3165, as described in OAR 410-141-3540(6.b), 410-141-3565 (5) and 410-120-1280 (5.h).  **Format/Value:** 1-digit alphabetic character – ‘Y’.  **Null Value:** Blank – do not use NA, N/A, or other conventions. | Yes, when applicable |
| Continuing Benefits Provided | Indicate if benefits were continued during the appeal process | Enter a ‘Y’ if benefits were continued during the appeal process.  **Format/Value:** 1-digit alphabetic character – ‘Y’.  **Null Value:** Blank – do not use NA, N/A, or other conventions. | Yes, when applicable |
| Date of NOAR | Date of Notice of Appeal Resolution (NOAR) | Enter the date the Notice of Appeal Resolution was sent to the member. Leave blank if the appeal is outstanding at the end of the quarter.  **Format/Value:** MM/DD/YYYY (e.g., 01/01/2023)  **Null Value:** Blank – do not use NA, N/A, or other conventions. | Yes, when applicable |

# Grievance System Report

The Grievance System Report is a demonstration of how the MCE uses Grievance and Appeal System data to maintain an effective process for monitoring, evaluating, and improving the access, quality and appropriateness of services provided. MCEs must provide narrative that describes trends in the Grievance and Appeal System for the quarter, and interventions to address concerns identified during the quarter.

Use only the templates posted at <http://www.oregon.gov/oha/HSD/OHP/Pages/CCO-Contract-Forms.aspx>. MCEs may not change the templates or use different templates.

If you have questions or concerns about how to complete the templates, or submitting to the OHA, please email [HSD.QualityAssurance@odhsoha.oregon.gov](mailto:HSD.QualityAssurance@odhsoha.oregon.gov)  for technical assistance.

For the enrollment number, use the numbers from your MCE’s 834 information. The enrollment number is an average over the three months of the quarter.

1. ‘Grievance System Code Tables’ document located on the CCO Contract Forms webpage: https://www.oregon.gov/oha/HSD/OHP/Pages/CCO-Contract-Forms.aspx [↑](#footnote-ref-2)
2. ‘Grievance System Code Tables’ document located on the CCO Contract Forms webpage: https://www.oregon.gov/oha/HSD/OHP/Pages/CCO-Contract-Forms.aspx [↑](#footnote-ref-3)
3. ‘Grievance System Code Tables’ document located on the CCO Contract Forms webpage: https://www.oregon.gov/oha/HSD/OHP/Pages/CCO-Contract-Forms.aspx [↑](#footnote-ref-4)
4. ‘Grievance System Code Tables’ document located on the CCO Contract Forms webpage: https://www.oregon.gov/oha/HSD/OHP/Pages/CCO-Contract-Forms.aspx [↑](#footnote-ref-5)
5. ‘Grievance System Code Tables’ document located on the CCO Contract Forms webpage: https://www.oregon.gov/oha/HSD/OHP/Pages/CCO-Contract-Forms.aspx [↑](#footnote-ref-6)
6. ‘Grievance System Code Tables’ document located on the CCO Contract Forms webpage: https://www.oregon.gov/oha/HSD/OHP/Pages/CCO-Contract-Forms.aspx [↑](#footnote-ref-7)