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SECTION 12: DISPUTE RESOLUTION

GRIEVANCES AND APPEALS

There are two ways to report or solve problems involving health care, treatment, or services for members. A complaint (or grievance) is when a member has a problem with HPSJ or a provider, or with the health care or treatment they got from a provider. An appeal is when there is disagreement with HPSJ's decision to change services or not to cover them.

Members have the right to file grievances and appeals with HPSJ to notify about the problem. This does not take away any of legal rights and remedies for members. Members should not be discriminated or retaliated against us for submitting a complaint. Solving member issues assists HPSJ to improve care for all members.

Members should always contact HPSJ first to notify of their problem. They may call between 8:00 a.m. to 5:00 p.m. at 1-888-936-PLAN (7526), TTY/TDD 711. If the grievance or appeal is still not resolved after 30 days, or they are unhappy with the result, members can call the California Department of Managed Health Care (DMHC) and ask them to review the complaint or conduct an Independent Medical Review. Members can call the DMHC at 1-888-466-2219 (TTY 1-877-688-9891 or 711) or visit the DMHC website for more information: https://www.dmhc.ca.gov. The California Department of Health Care Services (DHCS) Medi-Cal Managed Care Ombudsman can also help. They can help with problems joining, changing or leaving a health plan. They can also help if a member has moved and is having trouble getting their Medi-Cal transferred to your new county. The Ombudsman may be contacted Monday through Friday, between 8:00 a.m. and 5:00 p.m. at 1-888-452-8609. Members may also file a grievance with your county eligibility office about your Medi-Cal eligibility. If members are unsure who they can file your grievance with, they should call 1-888-936-PLAN (7526), TTY/TDD 711. To report incorrect information about additional health insurance, members may call call Medi-Cal Monday through Friday, between 8:00 a.m. and 5:00 p.m. at 1-800-541-5555.

Complaints

A complaint (or grievance) is when a member has a problem or is unhappy with the services they are receiving from HPSJ or a provider. There is no time limit to file a complaint. Members can file a complaint with HPSJ at any time by phone, in writing or online.

- By phone: Calling HPSJ at 1-888-936-PLAN (7526), TTY/TDD 711 between 8:00 a.m. - 5:00 p.m. Give your health plan ID number, your name and the reason for your complaint.
- By mail: Calling HPSJ at 1-888-936-PLAN (7526), TTY/TDD 711 and ask to have a form sent to them. When they receive the the form, they should fill it out. Ensure to include name, health plan ID number and the reason for your complaint. Tell HPSJ what happened and how we can assist.
- Mail the form to: Health Plan of San Joaquin Attention: Grievance and Appeal Department 7751 South Manthey Road French Camp, CA 95231. Provider offices should also make the complaint forms available for members.

- Online: Visit the HPSJ website. https://www.hpsj.com/member-grievance-form/
- By fax - Member, Member representative or Provider on behalf of member can fax Grievance form to 209-942-6355.
- By email - Member, member representative or Provider on behalf of the member can file grievance via email at Grievances@hpsj.com

If members need help filing their complaint, HPSJ can help. HPSJ can provide free language services. Members should call 1-888-936-PLAN (7526), TTY/TDD 711.

Within 5 calendar days of receiving a complaint, HPSJ will send a letter to confirm receipt. Within 30 days, HPSJ will send another letter to notify the member on how the problem was resolved. If the member calls HPSJ about a grievance that is not about health care coverage, medical necessity, or experimental or investigational treatment, and their grievance is resolved by the end of the next business day, they may not get a letter.

If the member has an urgent matter involving a serious health concern, HPSJ may start an expedited (fast) review and provide a decision to the member within 72 hours. To ask for an expedited review, members may call 1-888-936-PLAN (7526), TTY/TDD 711. Within 72 hours of receiving the complaint, HPSJ will make a decision about how to handle the complaint and whether to expedite. If HPSJ determines that they will not expedite the complaint, HPSJ will notify the member know that they will resolve the complaint within 30 days. Members may contact the DMHC directly for any reason, including if they believe their concern qualifies for an expedited review, or HPSJ does not respond within the 72-hour period.

Complaints related to Medi-Cal Rx pharmacy benefits are not subject to the HPSJ grievance process or eligible for Independent Medical Review. Members can submit complaints about Medi-Cal Rx pharmacy benefits by calling 800- 977-2273 (TTY 800-977-2273 and press 5 or 711) or going to https://medicalrx.dhcs.ca.gov/home/. However, complaints related to pharmacy benefits not subject to Medi-Cal Rx may be eligible for an Independent Medical Review. DMHC's toll-free telephone number is 1-888-466-2219 and the TTY line is 1-877-688-9891. Members can find the Independent Medical Review/Complaint form and instructions online at the DMHC's website: https://www.dmhc.ca.gov/.

Appeals

An appeal is different from a complaint. An appeal is a request for HPSJ review and change a decision made about the member's service(s). If we sent the member a Notice of Action (NOA) letter telling them that we are denying, delaying, changing or ending a service(s), and they do not agree with our decision, they can ask us for an appeal. The member's PCP or other provider can also ask us for an appeal on behalf of the member with their written permission. They may ask for an appeal within 60 days from the date on the NOA received from HPSJ. If HPSJ decided to reduce, suspend, or stop a service(s) the member is receiving now, the member can continue getting that service(s) while they wait for their appeal to be decided. This is called Aid Paid Pending. To receive Aid Paid Pending, the member must ask us for an appeal within 10 days from the date on the NOA or before the date the service(s) will stop, whichever is later. When an appeal is requested under these circumstances, the service(s) will continue.

SECTION 12: DISPUTE RESOLUTION

Members can file an appeal by phone, in writing or online:

- By phone: Calling HPSJ at 1-888-936-PLAN (7526), TTY/TDD 711 between 8:00 a.m. – 5:00 p.m. Give their name, health plan ID number and the service they are appealing.
- By mail: Calling HPSJ at 1-888-936-PLAN (7526), TTY/TDD 711 and ask to have a form sent to them. When they get the form, they should fill it out. Ensure to include their name, health plan ID number and the service they are appealing.
- Mail the form to: Health Plan of San Joaquin Attention: Grievance and Appeal Department 7751 South Manthey Road French Camp, CA 95231.Provider offices should also have appeal forms available.
- Online: Members can visit the HPSJ website by going to https://www.hpsj.com/grievances-appeals/If they need help asking for an appeal or with Aid Paid Pending, HPSJ can help. HPSJ can provide free language services by calling 1-888-936-PLAN (7526), TTY/TDD 711.
- By fax - Member, Member representative or Provider on behalf of member can fax Appeal form to 209-942-6355.
- By email - Member, member representative or Provider on behalf of the member can file Appeal via email at Grievances@hpsj.com

Within 5 days of receiving an appeal, HPSJ will send a letter to notify it has been Within 30 days, HPSJ notify of the appeal decision and send the member a Notice of Appeal Resolution (NAR) letter. If HPSJ does not provide you with our appeal decision within 30 days, members can request a State Hearing and an IMR with the DMHC. But if a State Hearing is requested first, and the hearing has already happened, members cannot ask for an IMR. In this case, the State Hearing has final say.

If a member or their doctor wants us to make a fast decision because the time it takes to decide an appeal would put a member's life, health or ability to function in danger, the member can ask for an expedited (fast) review. To ask for an expedited review, call 1-888-936-PLAN (7526), TTY/TDD 711. HPSJ will make a decision within 72 hours of receiving your appeal.

If a member requested an appeal and got a NAR letter telling them HPSJ did not change their decision, or member never got a NAR letter and it has been past 30 days, they can:

- Ask for a State Hearing from the California Department of Social Services (CDSS), and a judge will review their case.

- File an Independent Medical Review/Complaint form with the Department of Managed Health Care (DMHC) to have HPSJ's decision reviewed or ask for an Independent

  Medical Review (IMR) from the DMHC. During DMHC's IMR, an outside doctor who is not part of HPSJ will review the member's case. DMHC's toll-free telephone number is 1-888-466-2219 and the TTY line is 1- 877-688-9891. Members can find the Independent Medical Review/Complaint form and instructions online at the DMHC's website: https://www.dmhc.ca.gov.

Members will not have to pay for a State Hearing or an IMR.

Members are entitled to both a State Hearing and an IMR. But if a member asks for a State Hearing first, and the hearing has already happened, they cannot ask for an IMR. In this case, the State Hearing has the final say. The sections below have more information on how to ask for a State Hearing and an IMR. Complaints and appeals related to Medi-Cal Rx pharmacy benefits are not handled by HPSJ. Members can submit complaints and appeals about Medi-Cal Rx pharmacy benefits by calling 800-977-2273 (TTY 800-977-2273 and press 5 or 711). However, complaints and appeals related to pharmacy benefits not subject to Medi-Cal Rx may be eligible for an Independent Medical Review. If members do not agree with a decision related to their Medi-Cal Rx pharmacy benefit, they may ask for a State Hearing. Medi-Cal Rx pharmacy benefit decisions are not subject to the IMR process with the DMHC.

Complaints and Independent Medical Reviews (IMR) with the Department of Managed Health Care

An IMR is when an outside doctor who is not related to the member's health plan reviews their case. If the member wants an IMR, the member must first file an appeal with HPSJ. If the member does not hear from HPSJ within 30 calendar days, or if the member is unhappy with the health plan's decision, then they may request an IMR. The member must ask for an IMR within 6 months from the date on the notice of the appeal decision, but the member only has 120 days to request a State Hearing so if the member wants an IMR and a State hearing they must their complaint as soon as possible. If the member asks for a State Hearing first, and the hearing has already happened, the member cannot ask for an IMR. In this case, the State Hearing has the final say.

The member may be able to get an IMR right away without filing an appeal first. This is in cases where health concern is urgent, such as those involving a serious threat to your health.
If the member's complaint to DMHC does not qualify for an IMR, DMHC will still review the complaint to make sure HPSJ made the correct decision when the member appealed its denial of services. HPSJ has to comply with DMHC's IMR and review decisions.

Here is how to ask for an IMR:

The California Department of Managed Health Care is responsible for regulating health care service plans. If the member has a grievance against their health plan, the member should first telephone your health plan at 1-888-936-PLAN (7526), TTY/TDD 711 and use the health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to them. If they need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by

their health plan, or a grievance that has remained unresolved for more than 30 days, the member may call the department for assistance. The member may also be eligible for an Independent Medical Review (IMR). If they are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (1-888-466-2219) and a TDD line (1- 877-688-9891) for the

hearing and speech impaired. The department's internet website https://www.dmhc.ca.gov/ has complaint forms, IMR application forms and instructions online.

State Hearings

A State Hearing is a meeting with people from the California Department of Social Services (CDSS). A judge will help the member to resolve their problem or tell them that the health made the correct decision. The member has a right to ask for a State Hearing if they have already asked for an appeal with HPSJ and you are still not happy with the decision, or if the member does not get a decision on their appeal after 30 days.
The member must ask for a State Hearing within 120 days from the date on HPSJ's NAR letter. However, if HPSJ gave the member Aid Paid Pending during their appeal, and the member wants it to continue until there is a decision on their State Hearing, they must ask for a State Hearing within 10 days of HPSJ's NAR letter, or before the date specified their service(s) will stop, whichever is later. If the member needs help making sure Aid Paid Pending will continue until there is a final decision on their State Hearing, they may contact HPSJ between 8:00 a.m. – 5:00 p.m. by calling 1-888-936-PLAN (7526). If the member cannot hear or speak well, they may call TYY 711. The member's PCP can ask for a State Hearing on behalf of the member with their written permission.

In some instances the member can ask for a State Hearing without completing HPSJ's appeal process.
For example, the member can request a State Hearing without having to complete our appeal process, if we did not notify them correctly or on time about their service(s). This is called Deemed Exhaustion. Here are some examples of Deemed Exhaustion:

• The plan did not make a NOA letter available to the member in your preferred language.
• The plan made a mistake that affects any of member rights.
•The plan did not give the member a NOA letter.
• The plan made a mistake in our NAR letter.
• The plan did not decide the member appeal within 30 days. The plan decided the member's case was urgent but did not respond to their appeal within 72 hours.

Members ask for a State Hearing by phone or mail.

▪ By phone: Calling the CDSS Public Response Unit at 1-800-952-5253 (TTY 1-800-952-8349 or 711).
▪ By mail: Filling out the form provided with their appeals resolution notice and sending it to:

California Department of Social Services
State Hearings Division
P.O. Box 944243, MS 09-17-37
Sacramento, CA 94244-2430

If members need help asking for a State Hearing, HPSJ can help. HPSJ can provide free language services by calling 1-888-936-PLAN (7526), TTY/TDD 711.

At the hearing, the member and health plan can both provide information on the case. It could take up to 90 days for the judge to decide the member case. HPSJ must follow what the judge decides.

If a member wants the CDSS to make a fast decision because the time it takes to have a State Hearing would put the members life, health or ability to function fully in danger, the member or the member's PCP can contact the CDSS and ask for an expedited (fast) State Hearing. CDSS must make a decision no later than 3 business days after it gets the member's complete case file from HPSJ.

PROVIDER DISPUTE RESOLUTION (PDR)

HPSJ maintains a dispute resolution process to support the review and resolution of provider concerns including, but not limited to, disputes regarding claim payments and/or denials, utilization management decisions (authorizations) and recoupment requests.

Provider Dispute Resolution (PDR) request must be submitted as detailed below:

- **Contracted Providers** must submit a provider dispute online through the Provider Portal/Doctors Referral Express (DRE) https://provider.hpsj.com/dre/default.aspx
- **Non- Contracted Providers** must mail in provider disputes to the attention of the Claims Department at: Health Plan of San Joaquin P.O. Box 30490, Stockton, CA 95213-30490 with the appropriate **HPSJ Provider Dispute Resolution (PDR)** form. Located at: https://www.hpsj.com

Note*: Failure to submit the provider dispute through DRE or on the HPSJ PDR form will be returned for completion and may result in a delay of processing and potentially could fall outside of the dispute processing guidelines set by DMHC.*

TYPES OF DISPUTES

Provider Dispute Resolution (PDR) should only be submitted for the following reasons:

- **Contract Dispute**: Original claim did not pay per contracted or MCL rate.
- **Appeal of Medical Necessity/Utilization Management Decision**: Original claim denied because of a denied authorization or partially denied authorization and requires additional documentation to determine medical necessity.
- **Seeking Resolution of a Billing Determination**: Do not agree with claim or claim line denial.
- **Recovery Dispute**: A letter was received regarding an identified

overpayment and you do not agree with the determination.

- **Seeking Resolution of a Supplement Payment**: Do not agree with the amount supplemental and/or denial of supplemental payment.

Note: *Claim must be finalized before submitting a PDR*

REQUIREMENTS FOR A COMPLETE PDR

A **Complete PDR** is a detailed request form. The required information depends on the dispute type (see list above).

All PDR's require the following:

Provider Information

- Rendering Provider/Facility Name
- NPI
- Pay To Affiliate Name
- Provider Billing Address
- Contact Name & Phone Number

Member Information

- Patient Name
- HPSJ ID#
- Patient Date of Birth
- Patient Account Number

Claim Information

- HPSJ issued claim number

Additional information required by dispute type:

Appeal of Medical Necessity/Utilization Management Decision

- Authorization Number
- If Inpatient Claim: Denied Days and/or Level of Care Review
- If Outpatient Claim: Denied services with CPT Code and description
- Relevant clinical documentation to support disputed denial

Contract Dispute

- Contract Rate/Fee Schedule

- Claim/Claim Line(s) amount disputing
- Expected amount
- Type of Service (i.e. transportation)

Seeking Resolution of a Billing Determination

- Denial description identifying line(s) denied with justification for payment

Note: *If claim/claim line denied for additional documentation, submit via Correspondence.*

Recovery Request Dispute

- Recovery Request Number (RU#)
- Detailed reason for dispute (i.e. check/recoupment already applied)
- Supporting documentation
- Copy of Recovery Request Letter

PDR SUBMISSION TIMELINES

HPSJ's timely filing guidelines for PDR submissions is three hundred and sixty-five (365) days from the paid date of the claim. PDR's submitted electronically (through the provider portal) will be acknowledged within two (2) working days of receipt. PDR's submitted by mail will be acknowledged within fifteen (15) working days of receipt.

Note: *If the provider wishes to contest (**Recovery Request Dispute**) the notice of reimbursement of overpayment request it must be within thirty (30) working days.*

If additional information is required and requested through the dispute process the additional information requested must be received within thirty (30) working days of the notice date.

PDR DETERMINATION NOTIFICATION

Upon submission of a Complete PDR and/or receipt of additional information requested, HPSJ will resolve and issue a written determination within forty-five (45) working days.

Note: *Failure to submit complete and accurate information may result in a delay of processing and potentially could fall outside of the dispute processing guidelines set by DMHC.*

OTHER INFORMATION

If the provider is trying to submit corrections on a claim, follow the **Corrected Claim** submission guidelines.

If a claim or claim line was denied for lack of supporting documentation, submit such documentation as **Correspondence** with the requested information.

If a claim was denied as a duplicate and you feel it was denied in error, make sure it was submitted with the appropriate documentation, modifiers, or correct claim submission indicator before submitting a dispute.

Note: *Appeals filed by the provider on behalf of the beneficiary (member) require written consent from the beneficiary. See additional information under Grievances & Appeals* www.hpsj.com/grievances-appeals

If the provider is disputing a **Pre-Service Authorization Denial** an UM Appeal can be submitted via telephone, mail, fax or online through the Utilization Management Department. UM Appeals do not go through the claims dispute process. **See additional information under Utilization Management.*