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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 Health Plan or a Provider, or with the health care or treatment they got from a Provider. An appeal is when there is disagreement with Health Plan's decision to change services or not to cover them.

Members have the right to file grievances and appeals with Health Plan 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 Health Plan to improve care for all Members.

Members should always contact Health Plan first to notify them 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. The California Department of Managed Health Care is responsible for regulating health care service plans. If Members have a grievance against your Health Plan, they should first telephone your Health Plan at (209-942-6320) and use 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 the Member. If they need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by Health Plan, or a grievance that has remained unresolved for more than 30 days, they may call the department for assistance. They 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 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 www.dmhc.ca.gov has complaint forms, IMR application forms, and instructions online."

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 their county eligibility office about their Medi-Cal eligibility. If Members are unsure who they can file their grievance with, they should call 1-888-936-PLAN (7526), TTY/TDD 711. To report incorrect information about additional health insurance, Members may 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 Health Plan or a Provider. There is no time limit to file a complaint. Grievances may be submitted to Health Plan in person, by mail, fax, telephone or electronically through HPSJ's website, or at any contracted Provider's office

- By phone: Calling Health Plan at 1-888-936-PLAN (7526), TTY/TDD 711 between 8:00 a.m. - 5:00 p.m. Give their health plan ID number, their name and the reason for their complaint.
- By mail: Calling Health Plan at 1-888-936-PLAN (7526), TTY/TDD 711 and ask to have a form sent to them. When they receive the form, they should fill it out. Be sure to include name, health plan ID number and the reason for the complaint. Tell Health Plan 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 Health Plan website at 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, Health Plan can help. Health Plan can provide free language services. Members should call 1-888-936-PLAN (7526), TTY/TDD 711.

Within 5 calendar days of receiving a complaint, Health Plan will send a letter to confirm receipt. Within 30 days, Health Plan will send another letter to notify the Member on how the problem was resolved. If the Member calls Health Plan 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, Health Plan 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, Health Plan will make a decision about how to handle the complaint and whether to expedite. If Health Plan determines that they will not expedite the complaint, Health Plan 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 Health Plan does not respond within the 72-hour period.

Complaints related to Medi-Cal Rx pharmacy benefits are not subject to the Health Plan 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: .

Failure on the part of the Provider to respond to grievances from the grievance team may result in the case being resolved in Member's favor based upon the available records.
Health Plan Providers may not dismiss, discriminate, or retaliate against a Member because they filed a Grievance.

Health Plan complies with all non-discrimination policies set forth by State and Federal Law as described in APL 21-004. Members will not be required to file discrimination grievances with Health Plan prior to filing directly with DHCS' Office of Civil Rights (OCR) or with the Department of Health and Human Services' (HHS) OCR.

All grievances alleging discrimination will be forwarded timely to DHCS. This includes, and not limited to the following: language access complaints, failure to reasonably accommodate a Member under the requirements of the American Disability Act (ADA), and discrimination based on sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, creed, health status, or identification with any other persons or groups (see CA Penal Code section 422.56).

Provider grievances which are not related to Member or enrollee must go through Provider services inquiry process.

All standard Grievances are acknowledged in writing and postmarked within five (5) calendar days of receiving the Grievance. Any grievance deemed urgent/expedited by a clinical staff Member is acknowledged within 24 hours from receipt of the grievance in writing, over the phone, or another method. A grievance letter is sent to the Provider outlining the grievance, any requests for medical records, and/or a written response. The Grievance Coordinator/QI Nurses gather information and investigate the grievances. After completion of the investigation, the case is forwarded to the Medical Director or Peer Physician Reviewer for severity coding, leveling, and final resolution. All grievances are fully investigated and resolved before closing them with the severity level and point values.

Grievance Corrective Action Plan (CAP): CAPs allow the Provider office the opportunity to work collaboratively with HPSJ in order to improve areas of concerns.

CAPs based on meeting threshold: Grievances related to Access, Quality of Care, and Quality of Service remain the highest reported categories. There are thresholds for these categories: Access (3 per 1000), Quality of Care (3 per 1000), Quality of Service (5 per 1000). If a Provider meets any of the above listed category's threshold, a Corrective Action Plan (CAP) will be issued to the Provider and/or presented at Peer Review & Credentialing Committee (PR&CC).

CAPs based on meeting severity points: All the grievances are reviewed and closed with the severity level and point values. The accumulation of grievance cases by any Provider with severity levels points or any combination of cases totaling 16 points or more during a rolling 12 months will be subject to case presentation at the PR&CC except for cases closed with either C0 or S0. Providers with 48 or more cases in this category in a rolling 12 months will be subject to

presentation at the Grievance Committee for possible CAP and/or review at PR&CC.

48 cases with a level of C-0 and S-0
12 cases with a leveling of C-1 and S-1
6 cases with a leveling of C-2
1 case with a leveling of C-3 or C-4 (automatic referral to the applicable Peer Review Committee)
C-0 and S-0 are 0 points. C1 and S1-1 point, C2- 2 points, C3-3 points, C4- 4

Educational Letters will be issued to any cases leveled C-1 and above and S-1 at the discretion of the Medical Director. 3 letters per 6 months for the same issue will be subject to a CAP.

At the discretion of Medical Director, a CAP can be issued based on the severity of the case.

Appeals

An appeal is different from a complaint. An appeal is a request for Health Plan to 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 Health Plan. If Health Plan decides to reduce, suspend, or stop service(s) the Member is receiving now, the Member can continue getting 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.

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

- By phone: Calling Health Plan 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 Health Plan 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. Be sure to include their name, health plan ID number and the service they are appealing.
- Mail the form to: Health Plan of San Joaquin/Mountain Valley Health Plan, 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 Health Plan website by going to www.hpsj.com/grievances-appeals/ if they need help asking for an appeal or with Aid Paid Pending, Health Plan can help. Health Plan 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, Health Plan will send a letter to notify it has been within 30 days, Health Plan notify of the appeal decision and send the Member a Notice of Appeal Resolution (NAR) letter. If Health Plan 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. Health Plan will make a decision within 72 hours of receiving the appeal.

If a Member requested an appeal and got a NAR letter telling them Health Plan 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 Health Plan 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 Health Plan. 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 Health Plan. If the Member does not hear from Health Plan 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 Health Plan made the correct decision when the Member appealed its denial of services. Health Plan 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 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 plan made the correct decision. The Member has a right to ask for a State Hearing if they have already asked for an appeal with Health Plan and they 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 Health Plan'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 Health Plan 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, Health Plan can help. Health Plan 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. Health Plan 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.

SECTION 12: DISPUTE RESOLUTION

PROVIDER DISPUTE RESOLUTION (PDR)

Health Plan 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) 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/Mountain Valley Health Plan, P.O. Box 30490, Stockton, CA 95213-30490 with the appropriate **HPSJ Provider Dispute Resolution (PDR)** form. Located at www.hpsj-mvhp.org

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
- Health Plan ID#
- Patient Date of Birth
- Patient Account Number

Claim Information

- Health Plan-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

Health Plan'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, Health Plan 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.*