



GRIEVANCE & APPEAL TRAINING-

PREPARED FOR VENDORS AND FIRST-TIER,
DOWNSTREAM, AND RELATED ENTITIES (FDRS)

Advantage DSNP (Part C)



Training Objectives - Grievances

Properly identify and submit grievance to Health Plan same day

Respond to member

Transmit grievances to HPSJ/MVHP

Understand Health Plan grievance process

Understand vendor/FDR responsibilities in grievance process



Identify a grievance

WHAT IS A GRIEVANCE?

Any complaint or dispute expressing dissatisfaction with any aspect of the operations, activities, or behavior of a plan, provider, or facility regardless of whether remedial action is requested.

WHEN CAN A GRIEVANCE BE SUBMITTED?

A grievance may be filed at any time.

WHO CAN SUBMIT A GRIEVANCE?

The enrollee, enrollee's representative or a provider the enrollee designates as their representative.

HOW CAN A GRIEVANCE BE SUBMITTED?

A grievance may be submitted verbally or in writing.



Grievance Examples

"My doctor said I need this service, and you denied it. I want it approved."

"I asked for 10 physical therapy visits and HPSJ only approved 6. I need at least 12."

"HPSJ denied my reimbursement request. I need that money asap."

"The doctor is billing me for <services>. HPSJ should be paying this. I need HPSJ to pay this provider."

"I was told I'm being discharged from the hospital. I need more time to recover."



Document the grievance

- Vendor/FDR name, FDR representative -name receiving the grievance from the enrollee/authorized representative.
- How the enrollee filed the grievance with the vendor/FDR --- verbal or in writing.
- Enrollee name and id number or authorized representative name and contact phone number and address.
- Confirm enrollee contact information is accurate and if not, document current contact info
- Date and time of call or face-to-face interaction or written grievance received
- When incident occurred – Date and time
- Where incident occurred – doctor’s office, lab, call to plan, etc.
- Who was involved – provider/staff names, representative, contact information if available
- What happened – Narrative description of the grievance as stated by the member or authorized representative



Respond to the enrollee

Empathize – ‘I see you are frustrated.’

Confirm understanding –‘Let’s make sure I have all the details.’ Repeat issue to ensure accuracy and document.

Inform enrollee - ‘I will share your concern with the Health Plan who will investigate and provide a response to you. Please be aware they may call you to obtain more details and notify you of the outcome. Would you prefer the plan respond to you in writing? You may also contact the Health Plan directly at the Customer Service number on the back of your card or by mail (provide address).’

NOTE: Send the grievance to the Health Plan even if the enrollee indicates they do not need a response.

Forward to Plan - Send to Grievance & Appeals Department on the same day vendor/FDR receives the grievance.



Transmit the grievance to Health Plan Grievance & Appeals Department

Grievances must be sent to Health Plan the same day they are received to ensure regulatory timeframes are met.

Enrollees and Vendor/FDR may submit grievances by:

Method	Part C (including Part B drugs) and Part D
Secure Email	Grievances@hpsj.com
Fax	1-209-942-6355
Phone	1-888-361-PLAN (7526) or TTY 711
Online	https://www.hpsj.com
Mail (for enrollees only)*	Health Plan of San Joaquin 7751 South Manthey French Camp, CA 95231-9802



** Due to timeframe requirements vendors/FDRs may not mail grievances to the Health Plan*

Understand the grievance process at Health Plan

Categorize grievances as expedited or standard –

A grievance may be expedited only when:

- It is related to a decision not to grant an enrollee's request to expedite an initial determination or appeal, and
- for Part D only - the enrollee has not yet obtained the drug

Resolution timeframe is based on categorization and as expeditiously as the case requires, based on the enrollee's health status, but no later than:

Expedited - 24 hours

Standard - 30 calendar days



Understand the grievance process at Health Plan, continued...

Transfer information received from vendor/FDR into Health Plan grievance tracking system

Acknowledge receipt of grievance with enrollee

Investigate details of case

- May contact member for additional context, information
- Outreach to provider, vendor, or FDR by Request for Response letter
 - Includes a summary of the grievance
 - Asks probing questions for additional detail
 - Requests response by a date specified
 - Identifies how to return responses – fax or email
- Outreach to internal departments as needed to obtain additional information.
- Complete investigation phase

Prepare and document resolution

Deliver resolution based on submission method (verbal or written) or written if requested by enrollee.



Understand provider responsibilities for responding to a grievance

Receive and promptly review request for response letter

Provide a summary of your understanding of the situation and add context:

Who provided information to the enrollee in this situation?

What information was shared with enrollee by provider?

What alternatives if any were offered?

What was the outcome of the situation from your point of view?

Respond to detailed questions included in the request for response letter.

Include any attachments which may help clarify the situation or resolve the issue for member.

Return response within the requested timeframe.

NOTE: The Grievance & Appeals staff may outreach to provider via phone for expedited grievances.



Quick Reference

GRIEVANCES – Send to HPSJ/MVHP same day received by Vendor/FDR

Category	Request type	Who can request	Submission method	Resolution Timeframe	Response method
Expedited	Part C (includes Part B drugs)&Part D	Enrollee, Enrollee's authorized representative, provider on behalf of enrollee	Verbal or written	24 hours	Verbal and written if submitted in writing or requested by member
Standard				30 calendar days	Same as submission method or in writing if requested by member



Training Objectives - Appeals

Properly identify

- appeal
- organization determination
- coverage determination

Respond to enrollee

Transmit appeals to responsible party

Understand Health Plan appeals process

Understand vendor/FDR responsibilities in appeals process



Identify an appeal

WHAT IS AN APPEAL?

A request to reconsider a previous plan decision to deny, reduce or partially approve a service or payment request. An enrollee may appeal only after an organization determination, coverage determination, notice of discharge from an inpatient facility, or reduction in service from skilled nursing or a rehabilitation facility has been issued by the Health Plan.

A reconsideration is the first level of appeal.

WHEN MAY AN APPEAL BE SUBMITTED?

A reconsideration must be filed within 65 calendar days from the date of the notice of the initial determination unless good cause can be established.

Good cause may include:

- Enrollee did not receive notice or received notice late
- Enrollee was seriously ill
- An accident resulting in destruction of records

WHO CAN SUBMIT AN APPEAL?

An enrollee, enrollee's authorized representative, or provider

HOW CAN AN APPEAL BE SUBMITTED?

An appeal may be submitted verbally or in writing.



Appeals examples

"My doctor said I need this service and you denied it. I want it approved."

"I asked for 10 physical therapy visits and HPSJ only approved 6. I need at least 12."

"HPSJ denied my reimbursement request. I need that money asap."

"The doctor is billing me for <services>. HPSJ should be paying this. I need HPSJ to pay this provider."

"I was told I'm being discharged from the hospital. I need more time to recover."



Document the appeal request

- Vendor/FDR name, representative name receiving the appeal request from the enrollee/authorized representative.
- How the enrollee filed the appeal with the vendor/FDR --- verbal or in writing.
- Enrollee name and id number or authorized representative name and contact phone number and address.
- Confirm enrollee contact information is accurate and if not, document current contact info
- Date and time of call or face-to-face interaction or written appeal received
- Prior authorization number, claim number, or notice indicating the partially favorable, denial, or reduction in services.
- What services, supplies or medications were partially favorable, denied, or reduced?
- What does the enrollee expect to happen? – Fully approved, extended stay, more visits, paid by Health Plan, etc.
- Was this requested as a matter of urgency, i.e. expedited?



Respond to the enrollee

Empathize – ‘I understand you are asking the Health Plan to reconsider the decision to deny or reduce the <service, procedure, drug>.’

Confirm understanding –‘Let’s make sure I have all the details.’ Repeat issue to ensure accuracy and document.

Inform enrollee - ‘I will send your request for reconsideration to the Health Plan (or MedImpact for Part D) who will investigate and provide a response to you. Please be aware they may call you to obtain more details and notify you of the outcome. You may also contact the Health Plan (or MedImpact for Part D) directly using one of these methods.’ See next slide for transmission methods.

Forward to Health Plan or MedImpact -Send to Grievance & Appeals Department of the responsible party on the same day vendor/FDR receives the appeal.



Transmit the appeal request to Health Plan Grievance & Appeals Department

Grievances must be sent to Health Plan or MedImpact the same day they are received to ensure regulatory timeframes are met.

Enrollees and Vendor/FDR may submit appeals by:

Method	Part C (including Part B drugs)	Part D
Email	Grievances@hpsj.com	
Fax	1-209-942-6355	1-858-790-6060
Phone	1-888-361-PLAN (7526) or TTY 711	1-833-546-0796 or TTY 711
Online	https://www.hpsj-mvjp.org	https://www.hpsj-mvjp.org
Mail (for enrollees only)*	Health Plan of San Joaquin 7751 South Manthey French Camp, CA 95231-9802	



** Due to timeframe requirements vendors/FDRs may not mail grievances to the Health Plan or MedImpact*

Understand the appeals process at Health Plan & Med Impact

Categorize appeal request as expedited or standard –

An appeal will be expedited when:

A physician makes a request or supports an enrollee's request for an expedited appeal and indicates that applying the standard timeframe could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function (the physician does not have to use these exact words).

An expedited appeal requested by the enrollee/enrollee's representative may be downgraded to standard. Enrollee/enrollee's representative will be notified if the appeal is downgraded by Health Plan or MedImpact.

Resolution timeframe is based on categorization and the type of request: Part B drugs, Part C, or Part D.



Understand the appeals process at Health Plan & MedImpact, continued...

Transfer information received from vendor/FDR into Health Plan/MedImpact appeals tracking system

Acknowledge receipt of appeal with enrollee/enrollee's representative

Investigate details of case

- May contact enrollee for additional context, information
- Outreach to provider, vendor, or FDR by Request for Response letter
 - Includes a summary of the appeal including reference to organization determination or coverage determination
 - Asks probing questions for additional detail
 - Requests response by a date specified
 - Identifies how to return responses – fax or email
- Outreach to internal departments as needed to obtain additional information.
- Complete investigation phase

Prepare and document resolution

Deliver written resolution to enrollee. To meet timeframes, resolution may be provided verbally in addition to the written notice.



Understand provider responsibilities for responding to an appeal

Receive and promptly review request for response letter **back to Health Plan within the due date**

Provide a summary of your understanding of the situation and add context:

Who provided information to the enrollee in this situation?

What information was shared with enrollee by provider?

What alternatives if any were offered?

What was the outcome of the situation from your point of view?

Respond to detailed questions included in the request for response letter.

Include any attachments which may help clarify the situation or resolve the issue for member.

Return response within the requested timeframe.

NOTE: The Grievance & Appeals staff may outreach to provider via phone for expedited appeals.



Quick Reference

APPEALS – Send Part B Drugs & Part C to HPSJ/MVHP. Send Part D to MedImpact.					
Category	Request type	Who can request	Submission method	Resolution Timeframe	Response method
Expedited	Part C (includes Part B drugs) & Part D	Enrollee, Enrollee's authorized representative, provider on behalf of enrollee, or provider	Verbal or written	72 hours	Verbal and written
Standard	Part B Drugs or Part D			7 calendar days	Written
Standard	Part C			30 calendar days	Written



Regulatory references

[42 CFR §§ 422.629-634](#)

<https://www.ecfr.gov/current/title-42/section-422.630>

Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance:

[2024-medicare-managed-care-and-part-d-appeals-guidance-update_508-112024.pdf](#)

[D-SNPs: Integration & Unified Appeals & Grievance Requirements | CMS](#)

Addendum to the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance:

<https://www.cms.gov/files/document/dsnppartscdgrievancesdeterminationsappealsguidanceaddendum.pdf>



THANK YOU!

Health Plan 
of San Joaquin

 Mountain Valley
Health Plan

www.hpsj-mvhp-org | 1-888-936-PLAN (7526)



San Joaquin

HPSJ/MVHP Headquarters
7751 South Manthey Road
French Camp, CA 95231



Stanislaus

1025 J Street
Modesto, CA 95354



El Dorado

4237 Golden Circle Drive
Placerville, CA 95667