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SECTION 12: DISPUTE RESOLUTION

GRIEVANCES, APPEALS and PROVIDER DISPUTES

Enrollees may address concerns to the Health Plan Advantage D-SNP through a grievance or a request for reconsideration (appeal).

Providers may request a reconsideration or file a provider dispute resolution request depending on the type of concern.

Enrollee Assistance

The Enrollee can name a relative, friend, advocate, attorney, doctor, or someone else to act on his/her behalf; in some cases, others authorized under state law may act on behalf of the Enrollee. Representatives acting on behalf of the Enrollee must complete an Appointment of Representative (AOR), or equivalent, to file a grievance.

If the Enrollee needs help filing his/her grievance or appeal, Health Plan Advantage D-SNP can help and provide free language services.

Enrollees may file a grievance or appeal by contacting the Health Plan Advantage D-SNP using any of the methods below:

In person: Visit any of Health Plan Advantage D-SNP's locations in French Camp, Modesto, or Placerville

- **By Phone**: 1-888-361-7526 (TTY 711)
- **By Mail:**

  Health Plan Advantage D-SNP

  Attention: Grievance and Appeal Department

  7751 South Manthey Road French Camp, CA 95231
- **Online:** Visit Health Plan Advantage D-SNP's website at www.hpsj-mvhp.org/grievances-appeals
- **By Fax:** 1-209-942-6355
- **By email:** grievances@hpsj.com

Enrollees can also submit complaints externally to the following entities:

- Medicare: 1-800-MEDICARE (1-800-633-4227, TTY 1-877-486-2048)
- DHCS: Medi-Cal Managed Care Ombudsman: (1-888-452-8609, TTY 711)
- Department of Managed Health Care (DMHC): (1-888-466-2219, TTY 1-877-688-9891)
- OCR: (1-800-368-1019, TTY 1-800-537-7697)

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Enrollee Grievances

A grievance (dispute or complaint) may occur when the Enrollee is not satisfied with Health Plan Advantage D-SNP or Providers. A grievance may include:

- Concerns about the operations of Provider Health Plan Advantage D-SNP
- Concerns about the health care or treatment received from a Provider or one of its network pharmacies
- Concerns about the quality of care provided by a Provider or at a pharmacy.

Health Plan Advantage D-SNP complies with all non-discrimination policies set forth by State and Federal Law as described in APL 21-004. Enrollees will not be required to file discrimination grievances with Health Plan Advantage D-SNP 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 in a timely manner to the Department of Health Care Services (DHCS). This includes, and is not limited to, the following: language access grievances, failure to reasonably accommodate a Enrollee 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).

Use the table below as a quick-reference to understand how the Centers for Medicare and Medicaid (CMS) expects Health Plans to classify and process standard and expedited grievances for Part C (medical services) and Part D (prescription drugs).

Description	**Standard**	**Expedited:** If member disagrees with health plan decision: • NOT to expedite an organization determination (OD) or reconsideration (RD); or • requesting an extension on an OD or RD
Filing deadline**	None – Grievances may be submitted any time	
Method of request?	Verbally or in writing	
Who may file?	• Enrollee	• Enrollee • Assignee for Enrollee (Authorized

	• Assignee for Enrollee (Authorized Representative;/good for one year)* • Representative authorized by the Court (Surrogate; must provide documentation)	Representative;/good for one year) • Representative authorized by the Court (Surrogate; must provide documentation)
How can I confirm receipt?	The Health Plan Advantage D-SNP will send written notification confirming receipt within 5 calendar days for standard grievances. See 'Timeframe for resolution' below for expedited grievance confirmation.	
Who can Review?**	Someone other than the person involved, or a subordinate of the person involved with the initial determination. If medical necessity is involved, a physician with expertise in the field must review.	
Extension?	Yes. May extend 14 calendar days if appropriate	No
Timeframe for resolution	30 calendar days	24 hours If oral notification is delivered initially, written confirmation must be sent within 3 calendar days of the verbal notification.
Timeframe for notification	Must send notification within the timeframe indicated above.	
Notification Requirements	When submitted in writing, response must be in writing	

*Make effort obtain documentation. If not received, dismiss request. And ask to resubmit upon receipt of form.
**For Integrated Plans, requirements do not apply to Part D grievances

Provider Role in Resolving a Grievance

Providers may not dismiss, discriminate, or retaliate against the Enrollee for filing a grievance.

Provider may receive a letter outlining the grievance, requesting medical records and/or requesting a written response indicating a timeframe to respond and address to submit the requested documentation. Health Plan Advantage D-SNP resources may contact the Provider during the investigation to clarify information received or ask additional questions.

A corrective action plan (CAP) will be issued to the Provider and/or presented at Peer Review & Credentialing Committee (PRCC) when a Provider exceeds the thresholds for grievances related to access, quality of care and quality of service. The Medical Director may also issue a CAP at their discretion based on the severity of the case.

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Enrollee Appeals (Reconsiderations)

An appeal is when there is disagreement with Health Plan Advantage D-SNP's decision to change services or not to cover them.

The Enrollee has a right to appeal if the Enrollee believes that:

- Health Plan Advantage D-SNP has not paid for emergency, post-stabilization, or urgently needed services
- Health Plan Advantage D-SNP has not paid a bill in full
- A non-contracted medical Provider or facility or supplier furnished health services that should have been provided by, arranged for, or reimbursed by Health Plan Advantage D-SNP.
- Health Plan Advantage D-SNP has not provided or paid for services for which the Health Plan Advantage D-SNP is responsible
- A previously authorized ongoing course of treatment has been reduced or prematurely discontinued and the services are still medically necessary.
- An organization determination has not been made within the appropriate time frames.
- A non-covered service should have been provided, arranged, or reimbursed.
- Health Plan Advantage D-SNP does not to cover a drug, vaccine, or other Part D benefit
- Health Plan Advantage D-SNP did not reimburse the Enrollee for a Part D drug
- Health Plan Advantage D-SNP made a payment for a Part D drug with which the Enrollee disagrees
- Health Plan Advantage D-SNP denied the Enrollee's exception request
- Health Plan Advantage D-SNP made a coverage determination with which the Enrollee disagrees

Submitting a Part D reconsideration request

Part D appeals for Health Plan Advantage D-SNP are handled through its Pharmacy Benefit Manager (PBM), MedImpact.

Enrollees, Enrollee representatives or Providers on behalf of Enrollees may submit a Part D appeal to PBM via the following:

- Phone: 1-833-546-0796
- Fax: 1- 858-790-6060
- Mail: MedImpact Healthcare Systems, Inc.

For a description of the Part D exception request process, please see the Pharmacy section of this manual.

The Enrollee or the Enrollee's representative may provide additional information to Health Plan Advantage D-SNP, either in person or in writing, including evidence and allegations of fact or law related to the issue in dispute.

If Enrollee or the Enrollee's Provider believes an expedited appeal is required because a delay would significantly increase risk to the Enrollee's health, the Enrollee or the Enrollee's appointed representative may request an expedited appeal. Health Plan Advantage D-SNP may reclassify Enrollee's expedited request for reconsideration and must notify Enrollee of its decision. If Provider requests or supports the Enrollee's request for an expedited appeal, Health Plan Advantage D-SNP will expedite the review.

The Enrollee's Provider can also request an expedited appeal if the denial was made during a concurrent review (request for extension of services beyond the time or quantity currently authorized).

Health Plan Advantage D-SNP will make reasonable efforts to request clinical documentation to substantiate services that are needed expeditiously if the information is not submitted with the initial request. Providers should understand that delays or failure to submit necessary clinical information may jeopardize the Enrollee's health.

Provider Role in Resolving a Reconsideration

Providers may not dismiss, discriminate, or retaliate against the Enrollee for filing a reconsideration.

Provider may receive a letter outlining the reconsideration, requesting clinical medical records and/or requesting a written response indicating a timeframe to respond and address to submit the requested documentation. Health Plan Advantage D-SNP resources may contact the Provider during the investigation to clarify information received or ask additional questions.

Any additional information requested can be faxed to the Appeals and Grievances Department at 1-209-942-6355.

Use the tables below as a quick reference to understand how the Centers for Medicare and Medicaid (CMS) expect Health Plans to classify and process standard and expedited grievances for Part C (medical services) and Part D (prescription drugs).

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PART C Reconsiderations

Description	Standard Payment/Claim Direct Member Reimbursement (DMR)	Expedited Payment/Claim (DMR)	Standard Pre-Service (Prior Authorization)	Expedited Pre-Service (Prior Authorization)	Standard Part B Drug	Expedited Part B Drug
Filing deadline	Reconsideration must be filed within 65 days of receipt of initial determination. If beyond the timeframe, good cause must be established.					
Method of request?	In writing	In writing	In writing or orally			
Who may file?	• Enrollee • Assignee of the Enrollee (Authorized Representative (good for one year) • Representative authorized by the Court (Surrogate; must provide documentation) • Non-Contracted provider with appeal rights (Must execute waiver of liability)	• Enrollee • Assignee of the Enrollee (Authorized Representative (good for one year)* • Representative authorized by the Court (Surrogate; must provide documentation)	• Enrollee • Assignee of the Enrollee (Authorized Representative (good for one year)* • Representative authorized by the Court (Surrogate; must provide documentation) • Provider treating the enrollee (Must notify Enrollee)	• Enrollee • Assignee of the Enrollee (Authorized Representative (good for one year)* • Representative authorized by the Court (Surrogate; must provide documentation) • Physician, regardless of whether or not he/she is contracted with the Plan (Must notify Enrollee)	• Enrollee • Assignee of the Enrollee (Authorized Representative (good for one year)* • Representative authorized by the Court (Surrogate; must provide documentation) • Provider treating the enrollee (Must notify Enrollee)	• Enrollee • Assignee of the Enrollee (Authorized Representative (good for one year)* • Representative authorized by the Court (Surrogate; must provide documentation) • Provider treating the enrollee (Must notify Enrollee)
Who can Review?	Someone other than the person involved with the initial determination. If medical necessity is involved, physician with expertise in the field must be appointed.					
Extension?	No	No	Yes. May extend 14 days if	Yes. May extend 14 days if	No	No

Description	Standard Payment/Claim Direct Member Reimbursement (DMR)	Expedited Payment/Claim (DMR)	Standard Pre-Service (Prior Authorization)	Expedited Pre-Service (Prior Authorization)	Standard Part B Drug	Expedited Part B Drug
			appropriate and with appropriate notice.	appropriate and with appropriate notice.		
Timeframe for determination	Within 30 calendar days of receipt by the organization.	Within 72 hours of receipt in the A&G department.	Within 30 calendar days of receipt by the organization.	Within 72 hours of receipt in the A&G department.	Within 7 calendar days of receipt by the organization.	Within 72 hours of receipt in the A&G department.
Timeframe for notification	Within 30 calendar days of receipt by the organization.	Within 72 hours of receipt in the A&G department (orally). Must send written notification within 3 calendar days of oral notification.	Within 30 calendar days of receipt by the organization.	Within 72 hours of receipt in the A&G department (orally). Must send written notification within 3 calendar days of oral notification.	Within 7 calendar days of receipt by the organization.	Within 72 hours of receipt in the A&G department.
Timeframe to provide if overturned	Must effectuate no later than the earlier of 72 hours of making its decision (standard) or 72 hours of receipt of the request (expedited) or within the timeframes indicated above.					
Denial/ partial denials/untimely decisions	Forward to the IRE within the timeframe indicated on following page.					

PART D Table

Type	Timeframe
Standard Grievance	30 calendar days
Expedited Grievance	24 hours
Standard Appeal (Service)	7 calendar days
Expedited Appeal	72 hours
Standard Appeal (Payment)	14 calendar days (30 calendar days to issue payment)

Part C - Second Level Appeals

If Health Plan Advantage D-SNP says no to all or part of the Enrollee's initial reconsideration/appeal, the case is automatically forwarded to the Independent Review Entity (IRE), not affiliated with Health Plan Advantage D-SNP, for the second level appeal process. If the appeal decision was untimely, the case is also automatically forwarded to the IRE. If the Enrollee is not satisfied with the decision at the Level 2 appeal, there may be additional levels of appeal available to him/her.

PROVIDER GRIEVANCES AND APPEALS

Provider grievances not related to the Enrollee are processed as an inquiry. Provider appeals related to payment are processed through the Provider Dispute Resolution process.

Part C Non-Contract Provider Payment Appeals (Reconsiderations)

Non-contract Providers may submit a written request to have Health Plan Advantage D-SNP review a claim denial or partial denial. Reconsideration requests for an amount paid which is different than what Provider would have been paid under Original Medicare will be handled as a provider dispute (See Provider Disputes below).

Description	Standard Payment/Claim Direct Member Reimbursement (DMR)
Filing deadline	Reconsideration must be filed within 65 calendar days of receipt of initial determination. If beyond the timeframe, good cause (must be established).
Method of request?	In writing - with all pertinent documentation, such as a copy of original claim, remit showing the denial,

Description	Standard Payment/Claim Direct Member Reimbursement (DMR)
	records, or any other documentation that would support the request for review
Required documentation	The Waiver of Liability (WOL) form must be completed and submitted with reconsideration request. The WOL is available online at https://www.cms.gov/medicare/appeals-grievances/managed-care/notices-forms
Who may file?	Non-Contract provider with appeal rights (Must execute waiver of liability)
Who can Review?	Someone other than the person involved with the initial determination. If medical necessity is involved, physician with expertise in the field must be appointed.
Extension?	No
Timeframe for determination	Within 30 calendar days of receipt by the organization.
Timeframe for notification	Within 30 calendar days of receipt by the organization.
Timeframe to provide if overturned	Within 30 calendar days of receipt by the organization.
Denial/ partial denials/untimely decisions	Forward to the IRE within the timeframe indicated on following page.

*Circumstances for good cause may include:

- Provider sent the request to an incorrect address, in good faith, within the time limit
- Provider did not receive the adverse initial determination, or it was received late, documentation was difficult to locate within the time limit.

PROVIDER DISPUTE RESOLUTION (PDR)

Health Plan Advantage D-SNP 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:

- **Contract Providers** must submit a Provider dispute online through the Provider Portal/Doctors Referral Express (DRE) <provider.hpsj.com/dre/default.aspx>
- **Non- Contract Providers** must mail Provider disputes to the attention of the Claims Department at: < Health Plan Advantage D-SNP, P.O. Box 30490, Stockton, CA 95213-30490> with the appropriate **Health Plan Provider Dispute Resolution** form, located at www.hpsj.com/provider-dispute-resolution.

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***Note**: Failure to submit the Provider dispute through DRE or on Health Plan Advantage D-SNP's PDR form will result in return of form for completion and may result in a delay of processing and potentially falling outside of the dispute processing guidelines established by DMHC.*

TYPES OF DISPUTES

A PDR request should only be submitted for the following reasons:

Contract Providers

- **Contract dispute**: Original claim did not pay per contracted rate.
- **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.

Non-Contract Providers

- **Amount different than Original Medicare**: Do not agree with the amount paid is the same as what would have been paid under Original Medicare.

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

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Enrollee Information

- Enrollee name
- Health Plan Advantage D-SNP ID#
- Enrollee date of birth
- Enrollee account number

Claim Information

- Health Plan Advantage D-SNP issued claim number

Contract Dispute

- Expected payment amount per contract or 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

Recovery Request Dispute

- Recovery request number (RU#)
- Detailed reason for dispute (i.e. check/recoupment already applied)
- Supporting documentation
- Copy of recovery request letter

Amount different that Original Medicare

- Evidence of the amount calculated under Original Medicare including but not limited to, pricer software results showing all details, Medicare Physician Fee Schedule rate for the geographic locality, or other Medicare pricing tool results supporting the requested amount.

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PDR SUBMISSION TIMELINES

Health Plan Advantage D-SNP's timely filing guideline for PDR submissions is 120 calendar days from the paid date of the claim. PDRs submitted electronically (through the Provider portal) will be acknowledged within two working days of receipt. PDR's submitted by mail will be acknowledged within 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 30 calendar days.

If additional information is required and requested through the dispute process the additional information requested must be received within 30 calendar days of the receipt of the dispute request.

PDR DETERMINATION NOTIFICATION

Upon submission of a complete PDR request and/or receipt of additional information requested, Health Plan Advantage D-SNP will resolve and issue a written determination within 30 calendar days.

Note: Failure to submit complete and accurate information may result in a delay of processing and potentially falling 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 the Provider feels 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 (Enrollee) require written consent from the beneficiary. See additional information under Grievances & Appeals <www.hpsj-mvhp.org/grievances-appeals>