
16. GRIEVANCE RESOLUTION SYSTEM

A. Member Grievance Resolution Process

APPLIES TO:

- A. This policy applies to all IEHP Healthy Families and Healthy Kids Members.

POLICY:

- A. IEHP's Grievance Department is responsible for the resolution of Member complaints, including grievances and appeals.
- B. IEHP Members receive written information regarding the appeal and grievance process upon enrollment, and annually thereafter. Members are also informed of the appeal and grievance process upon request (see Attachments 16-1a, 16-1b, 16-2a, and 16-2b in Section 16, "Attachments").
- C. All Members are encouraged to bring up any concerns or issues with their practitioner, in order to promote open communication and a positive Member and practitioner relationship. This open communication between a Member and his/her practitioner is discussed in the IEHP Member Handbook issued to all new Members at enrollment and in annual updates to existing heads of household. IEHP's Member Services Department and/or Grievance Department also encourage Members to communicate with their practitioners at the time issues arise.
- D. All Practitioners, their affiliated Providers and staff are required to cooperate with IEHP in resolving Member Grievances and comply with all final determinations of IEHP's grievance procedure. At no time shall a Member's medical condition be permitted to deteriorate because of delay in provision of care that Provider disputes. Fiscal and administrative concerns shall not influence the independence of the medical decision-making process to resolve any medical dispute between Member and Provider of service.
- E. All practitioners (e.g., primary care physicians and vision practitioners) and their affiliated Providers are required to have IEHP Member Complaint Forms and a copy of the IEHP Grievance Resolution Process readily available for distribution to Members upon request (see Attachments 16-1a, 16-1b, 16-2a, and 16-2b in Section 16, "Attachments").
- F. Members who wish to file a grievance regarding behavioral health services are referred as follows:
1. Healthy Kids Members who reside in Riverside County are referred to the Riverside County Behavioral Health Plan's Quality Improvement Committee at (909) 352-1612, extension 244 or Patients' Rights at (800) 350-0519 or (909) 358-4600.
 2. Healthy Kids Members who reside in San Bernardino County are referred to IEHP Member Services at (800) 440-4347/ TTY (800) 718-4347. Behavioral health is provided through IEHP Direct Behavioral Health Program. All behavioral health

16. GRIEVANCE RESOLUTION SYSTEM

A. Member Grievance Resolution Process

care related grievances for San Bernardino County Healthy Kids Members are resolved by IEHP.

3. Healthy Families Members are referred to IEHP Member Services at (800) 440-4347/TTY (800) 718-4347. Behavioral health is provided through IEHP Direct Behavioral Health Program. All behavioral health care related grievances for Healthy Families Members are resolved by IEHP.
- G. Healthy Families Members who wish to file a grievance regarding dental services are referred to the appropriate dental provider, as applicable. All dental related grievances for Healthy Kids Members are resolved by IEHP.
- H. All practitioners and their affiliated Providers are required to provide Members with assistance in filing their grievances. Practitioners and their affiliated Providers are informed annually regarding how to access current appeals and grievance resolution processes via the Provider Manual.
- I. Members have the right to appoint someone to file their grievance or represent them during the grievance process. Members (or their representatives), any Provider that furnishes or intends to furnish services to the Member, or the legal representative of a Member's estate, may file a case with IEHP. In addition, if the Member is a minor, or is incompetent or incapacitated, a grievance may be registered on behalf of the Member by the parent, guardian, conservator, relative, practitioner, Provider, attorney, or other designee of the Member, either in writing or verbally, as appropriate. IEHP recognizes the term relative to include a parent, stepparent, spouse, adult son or daughter, grandparent, brother, sister, uncle, or aunt of the Member. Expedited cases may be requested by the Member (or their authorized representative), or a physician (regardless of whether that physician is affiliated with IEHP).
- J. Grievances filed by a practitioner or Provider on behalf of a Member or regarding a Member appeal are subject to the requirements of the IEHP Member Grievance Resolution Process.
- K. IEHP provides a Telephone Typewriter line (TTY) (800) 718-4347 for Members with hearing or speech impairments. IEHP Member Services Representatives (MSRs) may use the California Relay Services, if necessary or requested by the Member. MSRs and Grievance Coordinators are proficient in Spanish to assist Spanish-speaking Members. Access to interpreters for up to 140 other languages is obtained through IEHP's contracted interpretation services. If necessary, IEHP Grievance staff may arrange for face-to-face or telephonic translations, and sign language services for medical appointments.
- L. A Member has the right to file a grievance for at least 180 days following any incident or action that is the subject of the Member's dissatisfaction.
- M. Grievances and appeals may be filed by telephone, in writing, by mail, by fax, in person,

16. GRIEVANCE RESOLUTION SYSTEM

A. Member Grievance Resolution Process

- or online through IEHP's web site at www.iehp.org, and may be withdrawn by notifying IEHP.
- N. IEHP resolves all grievances within 30 days, in accordance with state and federal regulatory guidelines. Response times for grievances are counted in calendar days. Urgent grievances requiring expedited review are resolved within 72 hours in accordance with Policy 16A2, "Member Urgent Medical Grievances."
- O. During the grievance process and notification to the Member of the grievance disposition, IEHP Members are informed of their right to further appeal a decision if they are not satisfied with IEHP's resolution to their grievance. Members may appeal an adverse IEHP grievance resolution arising out of a complaint (not appeal of coverage decision), within thirty (30) calendar days of receipt of the grievance. For complaint appeals (non-coverage disputes), both levels of grievance resolution/appeal must be completed within the 30 days, according to California Code of Regulations (CCR), Title 28, section 1300.68 (a)(4)(A). After 30 days, Members are directed to the Department of Managed Health Care (DMHC) and/or the Department of Health Care Services (DHCS), as applicable, for the next level of grievance resolution. All grievance correspondence informs Members of their right to contact DMHC or DHCS, as applicable, for assistance after completing the IEHP grievance resolution process or participating in the process for 30 days. This requirement may be waived if DMHC determines that an earlier review is necessary.
- P. Grievances received by telephone, which are not denial related or related to quality to care, and that are resolved by the close of the next business day, are exempt from the requirement to send written acknowledgment and response to Members.
- Q. IEHP provides Members with written responses to grievances, including a clear and concise explanation of the reasons for IEHP's response. For explanations regarding denials, modifications, terminations of health care service, or investigational or experimental therapies, IEHP includes the criteria, clinical guidelines and/or medical policies used for the decision, including those related to medical necessity. For grievance responses regarding non-covered benefits, IEHP includes in the response the provision in the contract that excludes the coverage, and references the IEHP Member Handbook (Evidence of Coverage), identifying the specific section or sections that excludes the proposed service or benefit as not covered under the terms of the contract. The response either identifies the document and page where the provision is found, directs the Member to the applicable section of the contract containing the provision, or provides a copy of the provision and explains in clear and concise language how the exclusion applies to the specific health care service or benefit requested by the Member.
- R. All practitioners and Providers are required to immediately forward grievances to IEHP for resolution. Practitioners and Providers may contact IEHP Member Services at (800) 440-4347 to obtain further information regarding the IEHP Grievance Resolution System.

16. GRIEVANCE RESOLUTION SYSTEM

A. Member Grievance Resolution Process

- S. All Members are informed of the Notice of Privacy Practices (NPP) upon enrollment. In addition, the NPP is made available in writing to Members upon request, is available online through the IEHP web site, and is posted in common, public areas.
- T. Members with complaints regarding confidentiality, have the right to file a grievance as follows:
1. IEHP Chief Privacy Officer by mail at P.O. Box 19026, San Bernardino, CA 92423-9026 or by telephone at (909) 890-2000, or
 2. Department of Health and Human Services Office of Civil Rights, Attention: Regional Manager at 50 United Nations Plaza, Room 322, San Francisco, CA 94102. For additional information, Members may call (800) 368-1019 or U.S. Office for Civil Rights at (866) OCR-PRIV (866-627-7748) or (866) 788-4989 TTY.
- U. IEHP may chose to delegate the Member grievance resolution process to organizations that are accredited by the National Committee for Quality Assurance (NCQA) and with written agreement between IEHP and the delegated organization. However, Members may choose to directly address grievances to IEHP and those grievances are forwarded to the delegated organization for investigation only and the results returned to IEHP within 14 calendar days. IEHP manages the grievance process and responds to Members. IEHP forwards a copy of the Member resolution letter to the delegated organization. The delegated organization is responsible for establishing a grievance process in accordance with regulations mandated by DMHC and NCQA. Grievances received directly by the delegated entity are reported to IEHP on a quarterly basis, reviewed by the Grievance Committee, and forwarded to other committees as indicated. IEHP retains ultimate responsibility for ensuring that the delegated entity satisfies all requirements of the grievance and appeal process.
- V. On an annual basis, IEHP evaluates delegate performance against IEHP, NCQA, and regulatory standards.
- W. IEHP informs Members of their right to contact DMHC after completing IEHP's grievance process or after having participated in the grievance process for 30 days. This requirement may be waived if DMHC determines that an earlier review is necessary.
- X. Members are informed of their right to request Independent Medical Review (IMR) with DMHC if IEHP upholds a Provider's decision to deny, modify or terminate a Member's referral because the service is not considered medically necessary. DMHC makes the final decision regarding the qualification of coverage decisions for the IMR process.
- Y. Members with life-threatening or seriously debilitating medical conditions that have received a Provider's decision to deny, modify or terminate experimental or investigational treatment or therapy, are not required to participate in IEHP's grievance process prior to submitting their request for IMR with DMHC. Life-threatening medical

16. GRIEVANCE RESOLUTION SYSTEM

A. Member Grievance Resolution Process

conditions are those diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted, or diseases or conditions with potential outcomes where the end point of clinical intervention is survival. Seriously debilitating medical conditions are diseases or conditions that cause major irreversible morbidity.

- Z. IEHP maintains all Member grievances, including medical records, documents, evidence of coverage or other relevant information IEHP used to make the grievance decision or resolve the case, in confidential electronic case files for ten years. The record will include the following information:
1. Dates of receipt and closure by IEHP;
 2. Member's name;
 3. IEHP staff person responsible for the case;
 4. A description of the case; and
 5. Copies of relevant information used in the case.
- AA. All Member correspondence is mailed via regular mail, unless the Member requests certified mail.
- BB. IEHP does not reveal practitioner, Member identity or personal information to unauthorized sources. All IEHP staff and external IEHP committee members are required to sign a confidentiality statement agreeing not to disclose confidential information. However, IEHP may use or disclose a Member's individually identifiable health information without a Member's authorization as follows:
1. For the direct provision of care or treatment of the patient;
 2. For payment transactions, including billing for Member care;
 3. For IEHP operational activities, including quality review;
 4. If the request originates with a healthcare provider who is involved in the treatment of the Member such as a pharmacy or a laboratory;
 5. If the request is made to provide care to an inmate of a correctional facility;
 6. If the request is made by a representative of an accredited body.
- CC. All appeals and grievances are responded to both verbally and in writing, including quality of care cases (see Attachments 16-4, 16-6, and 16-7, in Section 16, "Attachments"). Grievances received orally not related to quality of care or denied services, and resolved in one (1) business day, are exempt from the requirement to respond in writing. All details of the oral case are documented in the electronic case tracking system.
- DD. The cultural and linguistic needs, and disabilities of Members, are considered in the appeal and grievance process. IEHP Grievance staff receives an annual in-service that

16. GRIEVANCE RESOLUTION SYSTEM

A. Member Grievance Resolution Process

addresses cultural and linguistic service requirements. Every effort is made to meet the special needs of Members in a competent manner, including those Members with limited English proficiency and reading skills, or diverse cultural or ethnic backgrounds. IEHP Members have the right to file a grievance if their cultural or linguistic needs are not met.

- EE. Grievances involving quality of care issues are reported to IEHP's Quality Management Department upon resolution of the case. IEHP's Chief Medical Officer or Medical Director is notified immediately upon receipt of a potential quality of care case.
- FF. Grievances related to Practitioner office site quality issues are referred to Quality Management for assessment of: Physical accessibility, Physical appearance, adequacy of waiting-room and examination-room space, appointment availability, and adequacy of treatment record-keeping.
- GG. IEHP does not discriminate against any Member for filing a grievance.

PURPOSE:

- A. To clearly define IEHP's process for addressing Member complaints, including grievances and appeals.

REFERENCE:

- A. Health and Safety Code §§ 1368, 1368.01, 1368.015, 1368.02, 1368.03, 1374.30
- B. Health Insurance Portability and Accountability Act (HIPAA) 45 CFR §§ 164.520, 164.528
- C. National Committee for Quality Assurance (NCQA) Standards for Health Plan Accreditation
- D. IEHP Healthy Families and Healthy Kids Member Handbook/Evidence of Coverage (EOC)

PROCEDURE:

- A. Members who wish to file a grievance may contact IEHP's Member Services Department at (800) 440-4347 or (800) 718-4347 (TTY). Members may also submit their grievance to IEHP through IEHP's web site at www.iehp.org, in person at 303 E. Vanderbilt Way, Suite 100, San Bernardino, CA 92408, or by mail/fax to the following address:

Inland Empire Health Plan
Attn: Grievance Department
P.O. Box 19026
San Bernardino, CA 92423-9026
Fax (909) 890-5748

16. GRIEVANCE RESOLUTION SYSTEM

A. Member Grievance Resolution Process

- B. IEHP mails an acknowledgment letter to the Member within five calendar days of receipt of the grievance, with a copy to the involved practitioner and affiliated Provider.
- C. IEHP may contact the Member to obtain additional information within five calendar days of receipt of the grievance.
- D. Grievances received at IEHP are resolved as follows: IEHP grievance staff triages the grievance to determine if the issue(s) can be resolved at the Plan Level. If a grievance does not require investigation by the contracted Provider, IEHP resolves the grievance, in accordance with IEHP's Policies and Procedures.
 - 1. IEHP mails an in-house grievance summary and a copy of the Member's grievance resolution letter to the Provider grievance contact. The letter informs the Provider of the Member's concerns and the results of IEHP's investigation.
- E. If a grievance requires investigation and proposed resolution by the involved practitioner's Provider (IPA or Hospital), IEHP faxes an IEHP Grievance Summary Form to the affiliated Provider. The grievance is handled in the following manner:
 - 1. An "Expected Response Date" is set at 14 calendar days from the date the Grievance Summary Form is faxed to the affiliated Provider.
 - 2. Once the response has been obtained by the affiliated Provider, a typed copy of the response must be forwarded to IEHP.
 - 3. If a response is not received by the "Expected Response Date," IEHP mails a due notice (see Attachment 16-3 in Section 16, "Attachments") to the Provider. The Provider is then granted two additional business days to provide IEHP with a typed response.
 - 4. If the Provider fails to provide a response within two days following the due notice, IEHP directly resolves the grievance without any further input from the practitioner or Provider. However, further action by IEHP may include an Education Letter, specific Corrective Action Plan (CAP) related to non-response or referral to Peer Review Subcommittee as indicated.
 - 5. If the Provider is unable to submit a response in the designated 14-day timeframe, the Provider may request an extension to the "Expected Response Date" by providing a written update with a new "Expected Response Date" to IEHP.
 - a. If the extension is granted, IEHP notifies the Provider within one day. The Provider must then respond to the grievance on the new "Expected Response Date." If the Provider fails to provide a response by the expected date, IEHP directly resolves the grievance with no further input from the Provider, and with possible follow-up actions as stated above.
 - b. If IEHP does not approve the request for extension, IEHP notifies the Provider within one day. If the Provider fails to provide a response by the

16. GRIEVANCE RESOLUTION SYSTEM

A. Member Grievance Resolution Process

- expected date, IEHP directly resolves the grievance with no further input from the Provider.
- c. IEHP monitors the rate of Extension Requests and overall grievance response timeliness for further action, including referral to Peer Review as indicated for medical issues, or Provider Services for non-medical issues. The rate of grievance response timeliness is reported to IPA Providers monthly, and included in the annual Provider Evaluation Tool (PET). Timeliness rates are based on the initial expected response due date and date a complete response is received, addressing all alleged issues.
 6. Once a response is received, IEHP reviews the information to ensure all Member issues were addressed. If the Member issues are not addressed, IEHP notifies the Provider that additional information is needed. If a Corrective Action Plan (CAP) is required, IEHP faxes and mails a letter to the Provider.
 7. Once the grievance is resolved, IEHP mails the Member a resolution letter within 30 calendar days of receipt of the grievance. A copy of the resolution letter is mailed to the involved practitioner and/or Provider.
- F. If the complaint is regarding a denial or modification of health care services, IEHP investigates and resolves the grievance (appeal) in-house. IEHP works closely with the affiliated Provider in investigating and resolving denial-related grievances.
1. IEHP Grievance staff initially informs Provider of appeal via telephone or email. Upon notification, Provider is required to submit copy of denial letter to Grievance staff within two (2) business days, including referral request, criteria applied, and all supporting clinical documentation used in making the denial decision.
 2. IEHP mails a denial-related grievance introduction letter to the Member's primary care physician (PCP), along with a copy of the Member's appeal acknowledgment letter. A copy of the letter is mailed to the PCP's affiliated Provider. The letter informs the PCP that the Member filed a grievance (appeal) regarding a denial or modification of health care services.
 - a. For grievances (appeals) filed by the practitioner or Provider on behalf of a Member, the correspondence is mailed to the practitioner or Provider and a copy is mailed to the Member.
 3. Necessary medical records are requested from Providers and practitioners associated with the service request. Provider and practitioners must provide the requested medical records to IEHP Grievance staff within two (2) business days of request.
 4. If IEHP upholds the contracted Provider's decision to deny, modify, or terminate the Member's referral, IEHP mails a resolution letter to the Member. The letter

16. GRIEVANCE RESOLUTION SYSTEM

A. Member Grievance Resolution Process

informs the Member of his/her right to request an Independent Medical Review (IMR) with DMHC regarding IEHP's determination to uphold the Provider's decision. The resolution includes an IMR application form, instructions on how to request an IMR, and a self-addressed envelope with the DMHC's IMR Unit address.

- a. A second letter is mailed to the Member's PCP (see Attachment 16-4 in Section 16, "Attachments"), along with a copy of the Member's resolution letter. The letter informs the PCP that the denial was upheld and the reasons for the decision.
 - b. For grievances (appeals) filed by the practitioner or Provider on behalf of a Member, the correspondence is mailed to the practitioner or Provider and a copy is mailed to the Member.
5. If IEHP overturns the denial, IEHP contacts the affiliated Provider, via telephone, and/or email, to inform the Provider of the decision, and begin coordination of care for the Member, as necessary.
- a. Upon notification of overturn, the Provider making the initial denial determination is required to issue the approved authorization within two (2) business days to Member, IEHP Grievance staff, requesting Provider, and Provider of Service.
 - b. A grievance (appeal) resolution letter is mailed to the Member. A copy of the letter is mailed to the involved practitioner and/or Provider.
- G. Any potential network problems including a delay in the referral process, recurrent issues, or quality of care issues, are forwarded to the IEHP Quality Management Department upon the resolution of the case.
- H. Members may apply for an IMR when all of the following conditions are met:
1. The Member's practitioner has recommended a health care service as medically necessary; or
 - a. The Member has received urgent care or emergency services that a practitioner determined was medically necessary; or
 - b. The Member was seen by a Provider within the IEHP network for the diagnosis or treatment of the medical condition for which the Member seeks independent review. The Provider may be an out-of-network Provider when DMHC finds that the Member's decision to secure services outside IEHP's network was reasonable under the circumstances and the disputed health care services were a covered benefit under the terms and conditions of IEHP's contract;
 2. The disputed health care service has been denied, modified or terminated by IEHP

16. GRIEVANCE RESOLUTION SYSTEM

A. Member Grievance Resolution Process

- or one of its contracting Providers, based in whole or in part on a decision that the health care service is not medically necessary;
3. The Member has filed a grievance with IEHP, and the disputed decision is upheld or the grievance remains unresolved after 30 days. Members are not required to participate in IEHP's Grievance Process for more than 30 days. If the grievance requires expedited review, Members are not required to participate in IEHP's Grievance Process for more than 72 hours.
- I. If DMHC determines that the request qualifies for IMR, DMHC designates an IMR organization to review the case. DMHC notifies IEHP that the Member has requested an IMR.
1. Within two business days from the receipt of the notification that an IEHP Member has requested an IMR, IEHP completes a Request for Health Plan Information form and submits the form to the IMR organization, along with the following documentation:
 - a. A copy of the Member's medical records in IEHP's possession, which must include the Member's medical condition, the health care services being provided by IEHP and its affiliated Providers, and the disputed health care service requested by the Member.
 - b. Any newly developed or discovered relevant medical records in possession of IEHP or its affiliated Providers.
 - c. A copy of all the information provided to the Member by IEHP and any of its affiliated Providers regarding the Member's condition and care, and a copy of any materials the Member or the Member's practitioner submitted to IEHP or its affiliated Provider in support of the Member's request.
 - d. A copy of all other relevant documents or information used by IEHP or its affiliated Providers in determining whether the disputed health care services should have been provided, and any statements by IEHP or its affiliated Provider explaining the reasons for the decision to deny or modify the disputed health care service.
 2. If the IMR organization determines that the health care service is medically necessary, IEHP contacts the Member and authorizes the services within five working days of receipt of the written decision from DMHC's Director, or sooner if appropriate for the nature of the Member's medical condition.
 3. IEHP informs the Member, the practitioner and the affiliated Provider of the authorization in writing within two business days. Approved decisions pertaining to care that is underway are communicated within 24 hours.
 4. Affiliated Providers are responsible for payment of health care services pertaining to DMHC's IMR decisions that overturn the Provider's original denial decision.

16. GRIEVANCE RESOLUTION SYSTEM

A. Member Grievance Resolution Process

J. Grievances Received by an IEHP Practitioner or Provider:

1. If the Member contacts the practitioner or Provider via telephone to file a grievance, he/she is immediately referred to IEHP's Member Services Department at (800) 440-4347 or (800) 718-4347 (TTY). However, if the Member wishes to file his/her grievance with the practitioner or Provider, the grievance documentation must be immediately faxed to IEHP's Grievance Department at (909) 890-5748.
2. If the Member submits an IEHP Complaint Form and/or documentation regarding their grievance to the practitioner or Provider, the form and/or documentation is immediately faxed to IEHP's Grievance Department at (909) 890-5748.
3. The practitioner or Provider must mail a hard copy of the IEHP Member Complaint form (see Attachments 16-1a and 16-1b in Section 16, "Attachments") and/or documentation to:

Inland Empire Health Plan
Attn: Grievance Department
P.O. Box 19026
San Bernardino, CA 92423-9026

INLAND EMPIRE HEALTH PLAN		
Chief Approval: <i>Signature on file</i>	Effective date:	September 1, 1996
Chief Title: Chief Executive Officer	Revised date:	January 1, 2012

16. GRIEVANCE RESOLUTION SYSTEM

A. Member Grievance Resolution Process

1. Member Rights and Options

APPLIES TO:

- A. This policy applies to all IEHP Healthy Families and Healthy Kids Members.

POLICY:

- A. During the grievance resolution process, IEHP informs Members of their rights and options, in accordance with state and federal regulatory guidelines and NCQA standards (see Attachments 16-2a and 16-2b in Section 16, “Attachments”). Members receive information regarding their rights at enrollment, and annually thereafter.
- B. Members have the right to register grievances with IEHP by phone, by mail, by fax, in person, online through IEHP’s web site at www.iehp.org, or with the assistance of the involved practitioner or Provider.
- C. **Authorized Representative:** Members have the right to personally register a grievance, or designate either in writing or verbally, that a relative, a representative, practitioner, Provider, or attorney will represent them during the grievance process. In addition, if the Member is a minor, or is incompetent or incapacitated, a grievance may be registered on behalf of the Member by the parent, guardian, conservator, relative, or other designee of the Member, as appropriate. IEHP recognizes the term “relative” to include a parent, stepparent, spouse, adult son or daughter, grandparent, brother, sister, uncle, or aunt of the Member. IEHP allows Members at least 180 days to file their grievance following any incident or action that is the subject of the Member’s dissatisfaction.
- D. **Confidentiality:** Members have the right to file a grievance with IEHP’s Chief Privacy Officer, or the Department of Health and Human Services (DHHS) Office of Civil Rights if the Member believes their right to confidentiality has been violated (HIPAA violation). This information is contained in the IEHP Notice of Privacy Practices.
- E. **Submission of Additional Information:** Members have the right to submit written comments, documents or other information relating to their grievance. This information is relayed to the Member during the triage of the grievance by a Grievance Nurse and in writing through the denial-related grievance (appeal) acknowledgment letter.
- F. **Discrimination:** Members have the right to file a grievance without discrimination from the Practitioner or Provider. Any grievance alleging discrimination against any Member, because of race, color, creed, gender, religion, language, age, national origin, ancestry, marital status, sexual orientation, health status, or disability must be faxed to IEHP immediately at (909) 890-5748. Discrimination grievances are resolved in accordance with the Grievance Resolution Process.
- G. **Linguistic Needs:** IEHP Members have the right to file a grievance if their linguistic needs are not met when seeking medical care.

16. GRIEVANCE RESOLUTION SYSTEM

A. Member Grievance Resolution Process

1. Member Rights and Options

- H. **Expedited Review:** Members have the right to an expedited review and resolution of their urgent grievance within 72 hours, if their medical condition involves an imminent and serious threat to the health of the patient, including but not limited to, severe pain, potential loss of life, limb, or major bodily function. See Policy 16A2, “Member Urgent Medical Grievances,” for more information.
- I. The Member and/or a practitioner acting on behalf of the Member may initiate an expedited grievance.
- J. **Change of Provider:** Members have the right to request a change of their Primary Care Physician (PCP) once a month.
- K. **Right to Disenroll:** Members have the right to disenroll from IEHP at any time without giving a reason.
- L. **Voluntary Mediation:** Either a Member or the Member’s designated representative may request voluntary mediation with IEHP prior to exercising the right to submit a grievance to the Department of Managed Health Care (DMHC).
- M. **Request for Assistance:** Members have the right to contact DMHC for assistance and/or to request an Independent Medical Review (IMR).
- N. **Independent Medical Review:** A Member may request an Independent Medical Review (IMR) of disputed health care services from DMHC if he/she believes that health care services have been improperly denied or modified by IEHP or one of its contracted providers, in whole or in part because the service is not medically necessary, or related to experimental and investigational therapies.
- O. **Access to Grievance Documents:** For denial-related grievances (appeals), Members have the right to obtain access to and copies of relevant grievance documents upon request by contacting Member Services at (800) 440-4347. This information is included in the proposed grievance resolution letter mailed to the Member. IEHP maintains electronic copies of medical records for ten years.

PURPOSE:

- A. To define the rights and options available to Members filing a grievance or appeal.
- B. To ensure there is no discrimination against a Member, including cancellation of the contract, solely on the grounds of filing a grievance or appeal.

REFERENCES:

- A. Title 28, California Code of Regulations, §§ 1300.68, 1300.68.01
- B. Title 42, Code of Federal Regulations, § 438

16. GRIEVANCE RESOLUTION SYSTEM

A. Member Grievance Resolution Process

1. Member Rights and Options

PROCEDURE:

A. Members are informed of the following rights and options during the Grievance Resolution Process:

1. The Right to Contact DMHC

a. **The following statement is included in all Member grievance correspondence:**

“The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-800-440-4347** or **TTY 1-800-718-4347** and use your 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 you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to 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-HMO-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department’s Internet Web site <http://www.hmohelp.ca.gov> has complaint application forms and instructions online.”

b. DMHC may require Members to participate in IEHP’s Grievance Resolution Process for up to 30 days prior to pursuing a grievance with DMHC, unless it is determined that an earlier review is warranted.

2. Expedited Review

a. Upon receipt of the urgent grievance, Members are immediately informed verbally of their right to notify DMHC of their grievance.

b. The Member and DMHC are informed of the resolution to the Member’s grievance no later than 72 hours from receipt of the grievance.

3. Voluntary Mediation

a. Members, or the Member’s representative, may request voluntary mediation with IEHP prior to exercising the right to submit a grievance to

16. GRIEVANCE RESOLUTION SYSTEM

A. Member Grievance Resolution Process

1. Member Rights and Options

DMHC. The use of mediation services does not preclude the right of the Member to submit a grievance to DMHC upon completion of mediation.

- b. In order to initiate mediation, the Member, or the Member's representative, and IEHP must voluntarily agree to mediation.
- c. Expenses for mediation are borne equally by IEHP and the Member.

4. Independent Medical Review

- a. Members may request Independent Medical Review (IMR) of disputed health care services from DMHC if a Member believes that health care services have been improperly denied or modified by IEHP or one of its contracting providers. A disputed health care service is any health care service eligible for coverage and payment under the subscriber contract that has been denied, modified, or terminated by IEHP or its contracting Providers, in whole or in part because the service is not medically necessary. Members may request an IMR when the following criteria has been met:
 - 1) The Member's Doctor recommended a health care service as medically necessary;
 - 2) The Member has received urgent care or emergency services that a provider determined was medically necessary;
 - 3) The Member has seen a provider within the IEHP network for the diagnosis or treatment of the medical condition for which the Member seeks independent review. The Provider may be an out-of-network Provider when DMHC finds that the Member's decision to secure services outside IEHP's network was reasonable under the circumstances and the disputed health care services were a covered benefit under the terms and conditions of IEHP's contract;
 - 4) The disputed health care service has been denied, modified or terminated by IEHP or one of its contracting Providers, based in whole or in part on a decision that the health care service is not medically necessary; or
 - 5) The Member has filed a grievance with IEHP and IEHP has determined to agree with the denial decision or the grievance remains unresolved for 30 days. If the grievance requires expedited review, the Member may immediately submit the request for IMR to DMHC.

16. GRIEVANCE RESOLUTION SYSTEM

A. Member Grievance Resolution Process

1. Member Rights and Options

- b. The Member may apply to DMHC for an IMR within six months after a grievance was filed with IEHP and the disputed decision is upheld or the case remains unresolved more than 30 days. If the case requires expedited review, Members are not required to file a grievance with IEHP prior to submitting the request for an IMR with DMHC.
- c. Members may contact IEHP for additional information regarding how to request an IMR or to request an IMR application form at (800) 440-4347 or TTY (800) 718-4347.

INLAND EMPIRE HEALTH PLAN		
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Chief Title: Chief Medical Officer	Revised date:	January 1, 2011

16. GRIEVANCE RESOLUTION SYSTEM

- A. Grievance Resolution Process
 - 2. Member Urgent Medical Grievances
-

APPLIES TO:

- A. This policy applies to all IEHP Healthy Families and Healthy Kids Members.

POLICY:

- A. IEHP's Grievance Department has the responsibility for processing all expedited/urgent grievance cases.
- B. The IEHP Chief Medical Officer (CMO) or Medical Director reviews potentially urgent grievances and makes a determination regarding the urgency of the grievance response time, taking into consideration the Member's medical condition.
- C. Grievances (including appeals) identified as urgent by the CMO or Medical Director, are resolved within 72 hours of receipt. To be considered urgent, there must be evidence of an imminent and serious threat to a Member's health, including but not limited to severe pain, the potential loss of life, limb, or major bodily function.
- D. In such cases, decisions and notification of decisions to practitioners are completed in a timely fashion, not to exceed 72 hours after receipt of the request. IEHP's CMO or Medical Director expedites the review and decides with the requesting physician, if applicable, which course of action is necessary based on the medical circumstances. See Policies 16A1, "Member Rights and Options" and 22A, "Members' Rights and Responsibilities," for further details.
- E. Upon receipt of an urgent grievance, IEHP's Grievance staff immediately informs the Member of the shortened timeframe to submit information related to their case, and of their right to notify the Department of Managed Health Care (DMHC) of their grievance.
- F. IEHP provides the Member, practitioner and DMHC with a written notification of the resolution within 72 hours from receipt of the grievance.
- G. Members have a right to appoint someone to file their grievance or represent them during the grievance process. In addition, if the Member is a minor, or is incompetent or incapacitated, a grievance may be registered on behalf of the Member by an attorney, a physician, a parent, guardian, conservator, relative, or other designee of the Member, either in writing or verbally, as appropriate. IEHP recognizes the term relative to include a parent, stepparent, spouse, adult son or daughter, grandparent, brother, sister, uncle, or aunt of the Member.
- H. IEHP does not discriminate, take or threaten to take any punitive action against a Member or physician acting on behalf of or in support of a Member in requesting an expedited grievance.

16. GRIEVANCE RESOLUTION SYSTEM

A. Grievance Resolution Process

2. Member Urgent Medical Grievances

- I. The Member may file a grievance by phone, by mail, by fax, in person, through an IEHP provider, or via IEHP's web site at www.iehp.org. All oral requests are documented in writing and maintained in the electronic case file.
- J. IEHP maintains all Member grievances, including medical records, documents, evidence of coverage or other relevant information IEHP used to make the grievance decision, in confidential electronic files for ten years.
- K. All Member correspondence is mailed via regular mail, unless the Member requests certified mail.
- L. IEHP complies with all federal and state regulations pertaining to Members' rights regarding grievances and confidentiality.
- M. IEHP provides Members with copies of their cases, including medical records and information used to make a decision, upon request.
- N. IEHP Members are informed of their right to an expedited grievance upon enrollment, and annually thereafter.
- O. The Member's request for an expedited grievance may be withdrawn by the Member at any time.
- P. IEHP staff is available on-call during non-business hours to process expedited cases.

PURPOSE:

- A. To ensure a timely and responsive process for addressing and resolving IEHP Members' urgent medical grievances.
- B. To identify and correct potential problems regarding access, quality, continuity of care, staff, or provider network issues.

REFERENCE:

- A. Health and Safety Code §§ 1368, 1368.01, 1368.02, 1368.015
- B. Title 28 CCR §§ 1300.68, 1300.68.01
- C. Health Insurance Portability and Accountability Act (HIPAA) §164.520, 164.528
- D. National Committee for Quality Assurance (NCQA) Standards for Health Plan Accreditation

16. GRIEVANCE RESOLUTION SYSTEM

- A. Grievance Resolution Process
 - 2. Member Urgent Medical Grievances
-

PROCEDURE:

- A. IEHP Grievance staff enters the case into the computer system and assigns the case to Appeals/Grievance staff.
- B. All Member urgent medical grievances received by IEHP are resolved as follows:
 - 1. IEHP's Chief Medical Officer (CMO) or Medical Director evaluates the case for urgency, considering the Member's medical condition. The CMO or Medical Director determines if criteria are met to expedite the review. The case is expedited if the CMO (or designee) determines that applying the standard timeframe for review could cause an imminent and serious threat to a Member's health, including but not limited to severe pain, the potential loss of life, limb, or major bodily function.
 - 2. The Member is notified telephonically within twenty-four (24) hours if criteria are met or not met to expedite the review. The Member is informed of the right to notify DMHC of the grievance.
 - 3. If the case does not meet expedited criteria, a written Acknowledgement letter is mailed to the Member within three (3) calendar days of case receipt, including transfer of the case to the standard grievance process. The Member is informed that the standard timeframe for processing the grievance is within thirty (30) days. The Member is informed of his/her rights, including the right to notify DMHC of the grievance.
 - 4. As an enclosure to the Acknowledgement letter, the Member is provided with instructions about the grievance process and its timeframes (see Attachments 16-2a and 16-2b in Section 16, "Attachments").
 - 5. The CMO or Medical Director directs the medical grievance staff to investigate the issues, and resolves the case. The CMO or Medical Director follows through to ensure that urgent grievances are resolved within the prescribed time constraints.
 - 6. IEHP may request additional information or medical records from a practitioner or Provider, as necessary.
 - a. The affiliated practitioner or Provider must submit this information to IEHP within one (1) calendar day of receipt of IEHP's request.
 - b. Any delay caused by the practitioner, or Provider's failure to submit the requested information to IEHP, may result in negative actions by IEHP against the practitioner or Provider.
 - 7. If the grievance is regarding a denial or modification or termination of health care

16. GRIEVANCE RESOLUTION SYSTEM

A. Grievance Resolution Process

2. Member Urgent Medical Grievances

services, the case is reviewed by someone other than the person making the initial determination, and must be reviewed by a Provider with the same specialty or sub-specialty as the requesting Provider.

8. IEHP contacts the Member with decision information as expeditiously as the Member's health condition requires, but no later than seventy-two (72) hours from receipt of the urgent grievance. IEHP works with the practitioner and/or Provider to coordinate the Member's care, if necessary.
 9. IEHP mails a resolution letter to the Member within 72 hours of receipt of the grievance, with a copy of the letter to the practitioner, the Provider and DMHC.
 10. If the grievance is regarding a denial or modification or termination of health care services that have been upheld by IEHP, the resolution letter informs the Member of his/her right to submit a request for Independent Medical Review (IMR) to DMHC. The letter includes an IMR Application Form, instructions on how to request an IMR, and a self-addressed envelope with DMHC's IMR Unit address.
- C. A Member may submit a grievance to DMHC for review, after completing IEHP's grievance process or after having participated in IEHP's grievance system for 30 days; however, this requirement may be waived if DMHC determines that an earlier review is necessary. Upon receipt of such grievance, DMHC notifies IEHP and requests the information used by IEHP to resolve the Member's grievance.
- D. DMHC may request additional information or medical records from IEHP. Should additional information be requested by DMHC, IEHP requests such information from the affiliated practitioner or Provider, as necessary.
1. The affiliated practitioner or Provider must submit this information to IEHP within one (1) calendar day of the receipt of IEHP's request.
 2. Any delay caused by the practitioner or Provider's failure to submit the requested information to IEHP may result in negative actions by IEHP against the practitioner or Provider.
- E. All Member urgent medical grievances received by a practitioner or Provider are handled in the following manner:
1. The practitioner or Provider immediately directs Members to contact IEHP at (800) 440-4347 or TTY (800) 718-4347, to file their urgent grievance.
 2. IEHP resolves all Member urgent medical grievances referred by practitioner and Providers, in accordance with the guidelines outlined in Procedures A through E.

16. GRIEVANCE RESOLUTION SYSTEM

- A. Grievance Resolution Process
 - 2. Member Urgent Medical Grievances
-

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16. GRIEVANCE RESOLUTION SYSTEM

- B. Dispute and Appeal Resolution Process for Providers of Service
 - 1. Initial Dispute Resolution
-

APPLIES TO:

- A. This policy applies to all IEHP Healthy Families and Healthy Kids Providers of Service.

POLICY:

- A. “Provider of Service” means any practitioner or professional person, acute care hospital organization, health facility, ancillary provider, or other person or institution licensed by the State to deliver or furnish health care services directly to the Member.
- B. Providers of service must submit all disputes, including those involving claims, billing, capitation, enrollment, contracting or UM/medical necessity to the financially responsible Payor (contracted IPAs/Hospitals or IEHP) for the initial dispute resolution process.
- C. All disputes must be submitted to the Payor within 365 days of the last date of action on the issue requiring resolution.
- D. Payors must identify and acknowledge the receipt of all disputes within two working days if the dispute was received electronically or 15 working days of receipt of a written dispute.
- E. Payors must resolve disputes and issue a written determination within 45 working days of receipt of a dispute.
- F. A provider of service may submit an appeal regarding the outcome of a Payor’s dispute resolution to IEHP within six months of receipt of the written dispute determination letter from the Payor.
- G. A practitioner can appeal any adverse determination by an IPA or IEHP. Appeals of referral denials, or modifications, must be initially appealed to the appropriate IPA. If the denial is upheld, the denial must then be forwarded to the IEHP Grievance Department (refer to Policy 16B2, “Dispute and Appeal Resolution Process for Providers of Service: Health Plan Appeals”).

PROCEDURE:

- A. Providers of service must submit all disputes, including claims payment or denial, billing, capitation, enrollment, contracting issues, or those involving UM/medical necessity, in writing to the Payor within 365 days of the last date of action on the issue requiring resolution. Justification and supporting documentation must be provided with the written dispute.

16. GRIEVANCE RESOLUTION SYSTEM

B. Dispute and Appeal Resolution Process for Providers of Service

1. Initial Dispute Resolution

1. Disputes are categorized as follows, for tracking and monitoring purposes:
 - a. Claims/Billing - any formal written disagreement involving the payment, denial, adjustment or contesting of a claim, including overpayments, payment rates, billing issues or other claim reimbursement decisions.
 - b. Contract - any formal written disagreement concerning the interpretation, implementation, renewal or termination of a contractual agreement.
 - c. UM/Medical Necessity - any formal written disagreement concerning the need, level or intensity of health care services provided to Members.
 - d. Other – all other disputes received by Payor including enrollment, capitation or other provider related issues.
2. If a dispute concerns a claim involving IEHP as a payor, the written request must be filed in accordance with the guidelines provided in Policy 20A1, “Claims Processing Provider Dispute Resolution Process-Initial Claims Disputes” and sent to:

IEHP - Claims Disputes

P.O. Box 10276

San Bernardino, CA 92423

3. If a dispute involves a claim related matter in which one of IEHP’s Capitated Providers is the payor, the dispute must be filed with the payor in accordance with the payor’s dispute filing guidelines.
 4. If a dispute involves P4P reimbursements, the written request must be filed in accordance with the guidelines provided in Policy 19C, “Pay For Performance.”
 5. If the dispute is not about a claim/billing, (i.e. capitation, enrollment, contracting, etc.) the written request must include a clear explanation of the issue and the dispute must be filed in accordance with the payor’s dispute filing guidelines.
 6. If the dispute is filed on behalf of a Member, the dispute is considered a Member grievance, subject to the requirements of the Member Grievance Resolution process, as outlined in Policy 16A, “Member Grievance Resolution Process.”
- B. Payors must identify and acknowledge in writing the receipt of each dispute, whether or not complete, and disclose the recorded date of receipt for provider disputes not impacting Member’s financial risk as follows:
1. If the dispute was received electronically, acknowledgment must be provided within two working days of receipt of the dispute; or

16. GRIEVANCE RESOLUTION SYSTEM

B. Dispute and Appeal Resolution Process for Providers of Service

1. Initial Dispute Resolution

2. If the dispute was a paper dispute, acknowledgement must be provided within 15 working days of receipt of the dispute.
- C. If a dispute is incomplete, or if the information is in the possession of the practitioner and not readily accessible to the Payor, the Payor may return the dispute with a clear explanation, in writing, of any information missing that is necessary to resolve the dispute. The provider of service has 30 working days to resubmit an amended dispute with the missing information.
- D. Payors must make every effort to investigate and take into consideration all available information and may further investigate and/or request additional information or discuss the issue with the involved providers of service.
- E. Payors must send written notice of the resolution, including pertinent facts and an explanation of the reason for the determination, within 45 working days of the receipt of the dispute.
- F. Providers of service dissatisfied with the resolution of any dispute **not** involving claims or billing (i.e. capitation, enrollment) may appeal to IEHP in writing, as outlined in Policy 16B2, "Dispute and Appeal Resolution Process for Providers of Service: Health Plan Appeals."
- G. Providers of service dissatisfied with the initial resolution and written determination by the Payor that involves payment or denial decisions on adjudicated claims or billing, including denials for procedures, referrals or services may submit a written appeal of the Payor's determination to IEHP by following the process outlined in Policy 20A2, "Claims Processing: Health Plan Claims Appeals."
- H. Providers of service not satisfied with the initial determination by the Payor, **and** the determination is related to medical necessity or utilization management, the provider of service has "de novo" right to appeal directly to IEHP within 60 working days of receipt of the written determination by submitting a written request for review as outlined in Policy 16B2, "Dispute and Appeal Resolution Process for Providers of Service: Health Plan Appeals."
- I. Furthermore, providers dissatisfied with the outcome of a dispute originally filed with the Payor that involves pre-service referral denials or modifications may submit an appeal to IEHP in accordance with Policy 16B3, "Dispute and Appeal Resolution Process for Providers of Service: Provider Appeals of UM Decisions."
- J. No retaliation can be made against a provider of service who submits a dispute in good faith.
- K. Copies of all disputes from providers of service, and related documentation, must be

16. GRIEVANCE RESOLUTION SYSTEM

- B. Dispute and Appeal Resolution Process for Providers of Service
 - 1. Initial Dispute Resolution

retained for at least ten years. A minimum of the last two years must be easily accessible and available within five days of request from IEHP or regulatory agency.

- L. Payors must track and report all disputes received and submit monthly summary reports to IEHP in accordance with Policy 20H, "Claims and Provider Dispute Reporting." A principal officer of the entity must be assigned responsibility for the Dispute Resolution Process.

INLAND EMPIRE HEALTH PLAN		
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16. GRIEVANCE RESOLUTION SYSTEM

- B. Dispute and Appeal Resolution Process for Providers of Service
 - 2. Health Plan Appeals
-

APPLIES TO:

- A. This policy applies to all IEHP Healthy Families and Healthy Kids Providers of Service.

POLICY:

- A. “Provider of Service” means any practitioner or professional person, acute care hospital organization, health facility, ancillary provider, or other person or institution licensed by the State to deliver or furnish health care services directly to the Member.
- B. Providers of service with disputes must go through the financially responsible Payor (contracted IPAs/Hospitals or IEHP) for the initial dispute resolution process.
- C. All initial disputes must be submitted to the Payor within 365 days of the development of an issue requiring resolution.
- D. Payors must resolve disputes within 45 working days of receipt.
- E. A provider of service may appeal the outcome of the Payors dispute resolution to IEHP within six months of receipt of the written determination. Providers of service have 60 working days from the date of determination to file an appeal to IEHP for disputes wherein the determination involves medical necessity or utilization management. IEHP maintains written policies and procedures for processing of Provider/practitioner denial-related grievances regarding UM decisions. IEHP makes final decisions on UM denial-related grievance appeals within 30 days of receipt.
- F. A practitioner can appeal any adverse determination by an IPA or IEHP. Appeals of referral denials, or modifications, must be initially appealed to the appropriate IPA. If the denial is upheld, the denial must then be forwarded to the IEHP Grievance Department as outlined in Policy 16B3, “Provider Appeals of UM Decisions.”

PROCEDURE:

- A. Providers of service must submit written disputes to the Payor within 365 days of the development of an issue requiring resolution as outlined in Policy 16B1, “Dispute and Appeal Resolution Process for Providers of Service: Initial Dispute Resolution.” Justification and supporting documentation must be provided with the written dispute. Payors must send written notice of the resolution of the dispute within 45 working days of receipt of the dispute.
- B. Providers of service may submit written disputes regarding payment or denial decisions on adjudicated claims, including payment denials for procedures, referrals or services by

16. GRIEVANCE RESOLUTION SYSTEM

- B. Dispute and Appeal Resolution Process for Providers of Service
 - 2. Health Plan Appeals
-

following the process outlined in Policy 20A1, "Claims Processing: Provider Dispute Resolution Process – Initial Claims Disputes."

- C. Providers of service dissatisfied with the written resolution of a grievance or dispute may appeal the decision to IEHP within six months of receipt of the written determination from the Payor.
 - 1. A provider of service must submit a written appeal to IEHP within six months of receipt of resolution of initial disputes. Appeals should be sent to:
 - IEHP – Provider Services
 - P.O. Box 19026
 - San Bernardino, CA 92423-9026
 - a. If the determination involves medical necessity or utilization management, the provider of service has the "de novo" right to appeal directly to IEHP within 60 working days from receipt of the determination on the initial dispute, by submitting a written appeal.
 - b. The written appeal must include a copy of the initial dispute resolution being appealed and additional supporting documentation to justify the appeal.
- 2. Claims related dispute appeals are handled in accordance with Policy 20A2, "Claims Processing: Health Plan Claim Appeals."
- 3. Initial appeals are defined as medical and non-medical. Medical and non-medical dispute appeals are resolved separately:
 - a. Non-medical dispute appeals are forwarded to the IEHP Director of Provider Services, and may include, but are not limited to credentialing issues, contractual issues, enrollment issues, IEHP Team Member or Department issues or problems related to IEHP policies and procedures.
 - b. Medical dispute appeals are forwarded to the IEHP Chief Medical Officer (CMO) or designee, and may include but are not limited to quality management issues, case management issues or problems related to IEHP policies and procedures.
- 4. Medical disputes involving current patient care are resolved according to the IEHP Grievance process outlined in Policy 16B3, "Dispute and Appeal Resolution Process for Providers of Service: Provider Appeals of UM Decisions", and the immediacy of the situation. Otherwise, medical and non-medical dispute appeals are resolved within 45 working days. IEHP resolves the appeal by considering all

16. GRIEVANCE RESOLUTION SYSTEM

- B. Dispute and Appeal Resolution Process for Providers of Service
 - 2. Health Plan Appeals
-

available information and may request additional information, discuss the issue with the involved Provider of Service and/or Payor, or present the issue to the Peer Review Subcommittee or QM Committee for input. The Provider of Service is notified if the resolution will be delayed beyond established timeframes.

- 5. When the appeal is resolved, IEHP mails a copy of the final appeal disposition to the provider of service within 45 working days of resolution with a courtesy copy to the Payor.
- D. If the provider of service is still not satisfied with the outcome of IEHP’s appeal determination, the provider of service may request that the IEHP Peer Review Committee (for medical decision) or IEHP CEO and/or Governing Board review (for non-medical decision) the appeal. Appeals for Peer Review must be received within 30 days of receipt of the decision concerning the appeal to IEHP. The IEHP Peer Review committee determines medical issues only. Decisions of the Peer Review committee or the IEHP CEO and/or Governing Board, are final.
- E. If IEHP receives an initial dispute directly from a provider of service, IEHP will forward the dispute to the financially responsible Payor for resolution, as applicable and notify the provider of service, except as stated for “de novo” rights (Procedure C1a).
- F. Refer to Policy 5G, “Credentialing Appeals Process for Practitioners Denied Participation with IEHP”, for appeals or grievance related to adverse credentialing decisions.
- G. UM denial appeals from a Provider of service that do not involve a claims issue are forwarded to IEHP’s Grievance Department as outlined in Policy 16B3, “Provider Appeals of UM Decisions.” IEHP’s Chief Medical Officer reviews the information, and makes a determination within 30 days. The practitioner receives an acknowledgement letter, and a resolution letter notifying them of the final decision.

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16. GRIEVANCE RESOLUTION SYSTEM

- B. Dispute and Appeal Resolution Process for Providers of Service
 - 3. Provider Appeals of UM Decisions
-

APPLIES TO:

- A. This policy applies to all IEHP Healthy Families and Healthy Kids Practitioners/Providers of service filing an appeal due to a UM denial decision.

POLICY:

- A. A practitioner or Provider may appeal any adverse determination by an IPA or IEHP. Practitioner appeals (request for reconsideration) of referral denials or modifications must be initially appealed to the appropriate IPA as an “opportunity to discuss” within seventy-two (72) hours of initial denial determination. If the initial denial determination is upheld by the IPA, the Provider (practitioner) may request a formal appeal by directing the request to the IEHP Grievance Department.
- B. If a Provider/practitioner appeal involves a potential quality of care issue, the case is immediately discussed with the Chief Medical Officer (or Medical Director), and referred to the Quality Management Department upon resolution, if a quality of care issue is identified.
- C. IEHP does not discriminate against Providers or practitioners for filing denial-related grievances (appeals).
- D. A Provider or practitioner may withdraw a denial-related grievance (appeal) at any time by notifying IEHP in writing.
- E. If a claim has been adjudicated, or in the process of adjudication, the Provider appeal is forwarded to the Claims Department for the Provider dispute resolution process.
- F. Provider appeals of adverse payment decisions are discussed in Provider Manual Policies 16B1, “Dispute and Appeal Resolution Process for Providers of Service – Initial Dispute Resolution,” and 16B2, “Dispute and Appeal Resolution Process for Providers of Service – Health Plan Appeals.”
- G. Provider denial-related grievances (appeals) filed on behalf of Members or as Member representative, are classified as Member appeals, and processed per Policies 16A, “Member Grievance Resolution Process” and 16A2, “Member Urgent Medical Grievances.” A Practitioner is automatically considered a Member’s representative when submitting an appeal for a denial of an urgent referral request, or for any referral request with Member impact, such as a pre-service request without initiation of claim adjudication.

16. GRIEVANCE RESOLUTION SYSTEM

- B. Dispute and Appeal Resolution Process for Providers of Service
 - 3. Provider Appeals of UM Decisions
-

PURPOSE:

- A. To ensure a timely and responsive process for addressing and resolving Provider and practitioner denial-related grievances (appeals) of UM decisions.
- B. To identify potential problem areas regarding denials or modifications of health service requests.

REFERENCES:

- A. Title 28, California Code of Regulations, § 1300.68.01

PROCEDURE:

- A. IEHP Grievance staff conducts an initial review of the Provider appeal request to determine if a Provider/practitioner claim is in process, or the Provider has first appealed through the affiliated IPA. If the Provider has not yet appealed through the IPA and a claim is not in process, the Provider is directed to the IPA for initial appeal. An IEHP appeal case is not opened until the Provider has appealed through the IPA and the IPA has upheld the denial.
- B. If a claim has been received and in process, the appeal is routed to the IEHP Claims Department for processing.
- C. Upon confirmation that the IPA has upheld the denial, and claim adjudication has not been initiated, IEHP Grievance staff open a case and document any action taken in the appeal. The case is coded as a Provider Appeal for tracking, trending, and reporting purposes. The case is coded as a Member Appeal, if pre-service with Member impact. In this case, the Provider/practitioner is noted as the Member's representative.
- D. Upon receipt of the appeal by IEHP Grievance Department, an acknowledgement letter is sent to the Provider/practitioner within five (5) calendar days from appeal receipt (see Attachment 16-6 in Section 16, "Attachments"). The letter is copied to the Member if the decision will impact the Member. The initial denial letter, referral criteria and all supporting documentation are obtained as outlined in Policy 16A, "Member Grievance Resolution Process."
 - 1. A separate electronic case is maintained for each new Provider/practitioner appeal that is filed. Any hard copy practitioner appeal files are stored in the Grievance Department locked filing cabinets. The file folder contains all documentation pertaining to the case, including, but not limited to the following:

16. GRIEVANCE RESOLUTION SYSTEM

B. Dispute and Appeal Resolution Process for Providers of Service

3. Provider Appeals of UM Decisions

- a. Section 1 of the file folder contains:
 - 1) Checklist
 - b. Section 2 of the file folder contains:
 - 1) Printout of the electronic system Member detail screens reflecting Member's current eligibility, if applicable;
 - 2) IEHP's electronic case tracking system notes;
 - 3) Member Detail Screen, including address and eligibility;
 - 4) Member's Plan Detail Screen; and
 - 5) Member Provider Screen.
 - c. Section 3 of the file folder contains: all IEHP correspondence mailed to the practitioner.
- E. The Grievance Nurse prepares the case for review by the Chief Medical Officer (CMO) or Medical Director, ensuring all necessary medical information has been received.
- F. If a physician requests an urgent (expedited) review, IEHP must provide an expedited review if the physician indicates that applying the standard timeframe for conducting a review could cause imminent and serious threat to the health of the Member, including, but not limited to, severe pain, potential loss of life, limb or major bodily function.
- G. If the CMO or Medical Director determines that the practitioner appeal is urgent and requires an expedited review, it is resolved as quickly as the medical condition warrants, but no later than 72 hours after receipt of the appeal, to ensure that the Member's health and welfare are not at risk, as outlined in Policy 16A2, "Member Urgent Medical Grievances."
- H. The Grievance Coordinator monitors the progress of the case.
- I. IEHP's CMO (or designee) reviews all practitioner appeals, and with the assistance of the Grievance Department, obtains all necessary pertinent medical information to review the previous denial decision.
- J. After review of pertinent medical information, the CMO (or designee) may discuss the case with the practitioner if necessary. The CMO (or designee) makes a decision within 30 calendar days of receipt of the case. The decision of IEHP's CMO (or designee) is final.
- K. A notification letter is sent to the practitioner informing them of the outcome of the appeal, including the criteria, applicable benefit coverage, and regulations used in making the decision.

16. GRIEVANCE RESOLUTION SYSTEM

- B. Dispute and Appeal Resolution Process for Providers of Service
 - 3. Provider Appeals of UM Decisions
-

- 1. The Grievance Coordinator prepares a resolution letter informing the practitioner of the resolution, within thirty (30) calendar days from case receipt, and closes the case (see Attachment 16-7 in Section 16, “Attachments”).
- L. Practitioner appeals are tracked and trended by the Grievance Manager and reported to the Grievance Committee if negative patterns are identified. After investigation of the case or after discussion at Grievance Committee, cases may be forwarded to Peer Review Subcommittee or Quality Management Committee.
- M. A practitioner filing an appeal on behalf of a Member is directed to the Grievance Department for processing of the issue according to regulations and standards for Member appeals, as outlined in Policy 16A, “Member Grievance Resolution Process.”

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16. GRIEVANCE RESOLUTION SYSTEM

C. Provider (IPA, Hospital and Practitioner) Grievance and Appeal Resolution Process

APPLIES TO:

- A. This policy applies to all IEHP Healthy Families and Healthy Kids Providers (IPA, Hospital and Practitioners).

POLICY:

- A. Providers (IPAs, Hospitals and Practitioners) must submit their grievances directly to IEHP.
- B. IEHP requires all Provider grievances to be submitted in writing within 365 days of the development of an issue requiring resolution.
- C. IEHP must identify and acknowledge the receipt of all grievances within two working days if the grievance was received electronically or within fifteen working days of receipt of a written grievance and/or appeal (see Attachment 16-12 in Section 16, "Attachments").
- D. IEHP attempts to resolve all grievances within 45 working days after the date or receipt of the provider dispute or the amended provider dispute.
- E. Providers may appeal a grievance resolution to IEHP within 30 working days of receipt of the grievance resolution letter from IEHP.

PROCEDURE:

- A. Grievances requiring resolution must be initiated by the Provider and submitted to IEHP in writing within 365 days of the development of the issue. Justification and supporting documentation must be provided with the written grievance and sent to:

IEHP-Provider Services
P.O. Box 19026
San Bernardino, CA 92423-9026

- B. All written Provider Grievances are reviewed and evaluated by IEHP to determine medical vs. non-medical related grievances and distributed to appropriate staff accordingly.
- C. All other written Provider Grievances not relevant to IEHP are reviewed and triaged for appropriateness and are referred to the sponsoring organization as applicable.
- D. All Provider Grievances must be identified and acknowledged in writing upon receipt, whether or not complete and disclose the recorded date of receipt as follows:

16. GRIEVANCE RESOLUTION SYSTEM

C. Provider (IPA, Hospital and Practitioner) Grievance and Appeal Resolution Process

1. If the grievance was received electronically, acknowledgment must be provided within two working days of receipt of the dispute; or
 2. If the grievance was received in writing, acknowledgment must be provided within fifteen working days of receipt of the dispute.
- E. IEHP must make a good faith attempt to resolve the issue within 45 working days of receipt of the grievance.
- F. Providers are notified in writing if the resolution will be delayed beyond IEHP's established timeframes.
- G. If a grievance involves P4P reimbursements, the written request must be filed in accordance with the guidelines provided in Policy 19C, "Pay For Performance."
- H. Claims related grievance appeals are handled in accordance with Policy 20A2, "Claims Processing: Health Plan Claims Appeals."
- I. Non-medically related grievances are assessed and resolved by the IEHP Director of Provider Services. Non-medically related grievances from Providers may include credentialing issues, capitation issues, contractual issues, enrollment issues, IEHP Team Member or Department issues or problems related to IEHP policies and procedures.
- J. Medically related grievances are assessed and resolved by the IEHP Chief Medical Officer (CMO) or designee. Medically related grievances from Providers may include quality management issues, case management issues, or problems related to IEHP Policies and Procedures.
- K. IEHP resolves the grievance by considering all available information and may request additional information or discuss the issue with the involved provider(s).
- L. When grievances are resolved, IEHP mails a copy of the final disposition to the Provider within 45 working days of resolution (see Attachment 16-13 in Section 16, Attachments").
- M. Providers dissatisfied with a resolution may appeal to IEHP within 30 working days of receipt of the grievance resolution from IEHP.
1. Providers must submit a written appeal to IEHP within 30 working days of receipt of the final disposition of initial grievance. The written appeal must include a copy of the initial resolution being appealed, justification and supporting documentation for the appeal.
 2. Non-medical grievance appeals are forwarded to the IEHP CEO for review.
 3. Medical grievance appeals are forwarded to the Peer Review Subcommittee for review.
 4. The decision of the IEHP CEO or Peer Review Subcommittee is final.

16. GRIEVANCE RESOLUTION SYSTEM

C. Provider (IPA, Hospital and Practitioner) Grievance and Appeal Resolution Process

5. IEHP mails written notice of the appeal decision within 30 working days of the decision.
 6. Refer to Policy 20A2, "Claims Processing: Health Plan Claims Appeals," for appeals or grievances relating to payment or denial of adjudicated claims.
- N. Providers appealing the termination or non-renewal of their IEHP Agreement may appeal to the IEHP Governing Board and request a Fair Hearing (see Attachment 16-5 in Section 16, "Attachments"). The decision of the IEHP Governing Board is final.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: <i>Signature on file</i>	Effective Date:	September 1, 1996
Chief Title: Chief Medical Officer	Revised Date:	January 1, 2011

16. GRIEVANCE RESOLUTION SYSTEM

Attachments

<u>ATTACHMENT</u>	<u>DESCRIPTION</u>	<u>POLICY CROSS REFERENCE</u>
16-1	IEHP Member Complaint Form	
	a. English	16A
	b. Spanish	16A
16-2	IEHP Grievance Resolution Process	
	a. English	16A, 16A1, 16A2
	b. Spanish	16A, 16A1, 16A2
16-3	First and Final Notice	16A
16-4	Denial Upheld Cover Letter – PCP/Dentist	16A
16-5	Provider Fair Hearing Process	16C
16-6	Provider Second Level Appeal of UM Decision– Acknowledgement Letter	16A, 16B3
16-7	Provider Second Appeal of UM Decision– Resolution Letter	16A, 16B3
16-8	Provider Grievance– Acknowledgement Letter	16C
16-9	Provider Grievance – Resolution Letter	16C

Inland Empire Health Plan
 Attn: Grievance Department
 P.O. Box 19026
 San Bernardino, CA 92423-9026
 Fax # (909) 890-5748



Attachment 16-1a
 IEHP Member Complaint Form - English

For Questions Call
 1-800-440-4347 or TTY
 1-800-718-4347

MEMBER COMPLAINT FORM
 (HEALTHY FAMILIES / HEALTHY KIDS)

Please complete the following form and return it to IEHP Grievance Department at the address above.

MEMBER INFORMATION

FIRST NAME	M.I.	LAST NAME	SOCIAL SECURITY # - -
MEMBER ADDRESS:			IEHP MEMBER ID #
			TELEPHONE # () -

PERSON MAKING THE COMPLAINT (You have the right to appoint someone to file your grievance or represent you during the grievance process. In addition, grievances can be filed by parents, guardians, conservator, relative or other designee, if the Member is a minor or an adult who is incapacitated).

NAME _____
RELATIONSHIP <input type="checkbox"/> SELF <input type="checkbox"/> MOTHER <input type="checkbox"/> FATHER <input type="checkbox"/> GRANDPARENT <input type="checkbox"/> GUARDIAN <input type="checkbox"/> OTHER _____

NATURE OF COMPLAINT

WHERE DID THE INCIDENT HAPPEN? (NAME OF HOSPITAL, DOCTOR OR OTHER LOCATION)
WHEN DID THIS HAPPEN? (IF UNSURE, GIVE APPROXIMATE DATE(S))
WHO WAS INVOLVED?
PLEASE DESCRIBE WHAT HAPPENED. (ATTACH ADDITIONAL PAGES, IF NECESSARY)

As a Member of IEHP, you have the right to file a complaint against IEHP or its providers without fear of negative action by IEHP, your Doctor, or any other provider. You can make a complaint/grievance to the Department of Managed Health Care, which regulates health plans. If you have any questions, please call 1-800-440-4347, or 1-800-718-4347 (TTY).

MEMBER'S SIGNATURE _____

DATE _____

SIGNATURE OF PARENT OR LEGAL GUARDIAN
 (IF THE MEMBER IS A MINOR OR INCOMPETENT) _____

DATE _____

Department of Managed Health Care:

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-800-440-4347**, or **1-800-718-4347 TTY** and use your 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 you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you 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-HMO-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department's Internet Web site <http://www.hmohelp.ca.gov> has complaint forms, IMR application forms and instructions online.

The above services are available to IEHP Members at no cost.

Inland Empire Health Plan
Attn: Grievance Unit
P.O. Box 19026
San Bernardino, CA 92423-9026
Fax # (909) 890-5748



Para preguntas llame a
1-800-4347 o TTY
1-800-718-4347

FORMULARIO DE QUEJAS
(HEALTHY FAMILIES / HEALTHY KIDS)

Favor de completar el formulario y regréselo al Departamento de Quejas de IEHP al domicilio escrito arriba.

INFORMACION DEL MIEMBRO

NOMBRE	INICIAL	APELLIDO	IDENFICACION DE IEHP
DOMICILIO DEL MIEMBRO:			TELÉFONO
			() -
			TELEFONO PARA MENSAJES
			() -

PERSONA QUE ESTA HACIENDO LA QUEJA (Usted tiene el derecho de designar a cualquier persona que usted escoja para que presente y/o lo represente durante el proceso de su queja. También las quejas pueden ser sometidas por un padre, tutor, pariente, u otra persona cual usted a escogido, si el Miembro es menor de edad o está incapacitado)

NOMBRE _____
RELACION <input type="checkbox"/> MADRE <input type="checkbox"/> PADRE <input type="checkbox"/> ABUELO <input type="checkbox"/> TUTOR <input type="checkbox"/> OTRO _____

CLASE DE QUEJA

¿DÓNDE PASO EL INCIDENTE? (<i>NOMBRE DEL HOSPITAL, DOCTOR, OTRA LOCALIDAD</i>)
¿CUÁNDO OCURRIÓ? (<i>SI NO ESTA SEGURO, DE FECHA(S) APROXIMADAS</i>)
¿QUIÉN ESTUBO IMPLICADO?
POR FAVOR DESCRIBA LO QUE PASO. (<i>SI ES NECESARIO, ADJUNTE MAS HOJAS</i>)

Como Miembro de IEHP, Ud. tiene derecho a registrar una queja en contra de IEHP o sus proveedores sin tener que preocuparse de alguna acción negativa de parte de IEHP, su Doctor, o cualquier otro proveedor. Ud. también tiene derecho a solicitar una queja con el Departamento de Administración de Cuidados Médicos, el cual regula planes de salud. Todos los miembros, si tiene preguntas, por favor llame al 1-800-440-4347, o 1-800-718-4347 (TTY).

FIRMA DEL MIEMBRO

FECHA

FIRMA DEL PADRE O TUTOR LEGAL
(*SI EL MIEMBRO ES UN MENOR O ES INCOMPETENTE*)

FECHA

Departamento de Administración de Cuidados Médicos:

El Departamento de Administración de Cuidado Médico es responsable de regular los planes de servicio de cuidado de salud. Si tiene una queja contra su plan de salud, debe de llamar a su plan primero (**1-800-440-4347** o **1-800-718-4347** (TTY) y usar su proceso de resolución de quejas antes de comunicarse con el Departamento. Utilizando el proceso de quejas del plan no le previene el uso de cualquier otro remedio provisto por la ley. Si tiene una queja que envuelve una emergencia, una queja que no ha sido resuelta satisfactoriamente por el plan, o su queja sigue sin resolución por mas de 30 días, usted puede llamar al Departamento para asistencia. También pueda que usted sea elegible para una Revisión Medica Independiente. Si su caso es elegible para una Revisión Medica Independiente, el proceso proveerá una revisión imparcial de las decisiones medicas hechas por un plan de salud relacionado con el servicio o tratamiento propuesto para él cuidado medico que sé esta necesitado, las decisiones de cobertura para terapia o tratamiento experimental o de investigación y aclarara el conflicto financiero para servicios urgentes o de emergencia. El Departamento tiene un número de teléfono gratuito (**1-888-HMO-2219**) y para las personas con impedimentos auditivos y del habla pueden usar el (**1-877-688-9891**) para comunicarse con el Departamento. La red del Internet del Departamento <http://www.hmohelp.ca.gov> tiene los formularios de quejas y las instrucciones disponibles en línea.

Los servicios mencionados arriba son servicios gratuitos para Miembros de IEHP.



INLAND EMPIRE HEALTH PLAN

GRIEVANCE RESOLUTION PROCESS **(HEALTHY FAMILIES / HEALTHY KIDS)**

HOW CAN I FILE A GRIEVANCE?

1. IEHP Members have the right to file a grievance against IEHP or its practitioners without fear of recrimination. You may file your grievance directly with IEHP by taking one of the following actions:
 - a) Call IEHP's Member Services Department at (800) 440-4347, or at (800) 718-4347 (TTY) and file your grievance with a Member Services Representative.
 - b) Fax your grievance to IEHP's Grievance Department at (909) 890-5748.
 - c) Submit your grievance online through the IEHP web site at www.iehp.org.
 - d) You may choose to file your grievance in person at the following address:

Inland Empire Health Plan
Grievance Department
303 East Vanderbilt Way
San Bernardino, CA 92408
IEHP's Business Hours: 8:00AM to 5:00PM
Monday through Friday
 - e) You may also file your grievance by mail at P.O. Box 19026, San Bernardino, CA 92423-9026
2. IEHP Complaint Forms are readily available at all IEHP practitioner and their Contracting Organization locations. A patient advocate should be available to assist you with this process.

WHAT HAPPENS AFTER I FILE MY GRIEVANCE?

1. You will receive an acknowledgment letter informing you of the receipt of your grievance within five (5) days from the date IEHP receives your grievance. The letter will provide you with the name and telephone number of a Grievance Representative, who will assist you with your grievance. Please inform the Grievance Representative if your address or telephone number has changed.
2. The entire process will be resolved within 30 days. IEHP will send you a letter with the resolution within this time.
3. If your grievance involves a serious threat to your health (we call these urgent), we will resolve it within 72 hours. We will notify you of the decision immediately and send you a letter explaining our resolution within 72 hours from the date that we received your grievance. Urgent grievances involve

an imminent and serious threat to your health, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function.

YOUR GRIEVANCE RIGHTS

1. You have the right to have your urgent grievance resolved within 72 hours. You have the right to immediately contact the Department of Managed Health Care (DMHC) regarding your urgent grievance at 1-888-HMO-2219, or TDD line 1-877-688-9891, or at their web site: <http://www.hmohelp.ca.gov>. All other grievances are resolved within 30 days.
2. You have the right to ask IEHP to help you work with your Provider or anyone else to fix your problem.
3. You have the right to change your Providers.
4. You have the right to appoint a representative to help you file your grievance and represent you during the grievance process. In addition, grievances can be registered or filed by Attorneys, Physicians, Parents, Guardians, Conservators, Relative, or other Designee if the Member is a minor or an adult who is otherwise incapacitated. Relatives include Parents, Stepparents, Spouse, Adult Son or Daughter, Grandparents, Brother, Sister, Uncle or Aunt.
5. You have the right to disenroll from IEHP at any time without giving a reason.
6. You have the right to request voluntary mediation. You will be responsible for half of the costs of mediation.
7. You have the right to submit written comments, documents or other information in support of your grievance.
8. You have the right to file a grievance if your linguistic needs are not met
9. You may contact other State Agencies for help.

IF YOU ARE STILL UNHAPPY OR YOU HAVE AN URGENT GRIEVANCE YOU MAY:

1. Appeal the grievance decision by calling IEHP Member Services at 1-800-440-IEHP (4347)/TTY 1-800-718-4347 within 30 days of when you first filed your grievance; or
2. Contact the Department of Managed Health Care 30 days after you filed a grievance at **1-888-HMO-2219**, or for TDD line **1-877-688-9891** for the hearing and speech impaired. The department's Internet Web site <http://www.hmohelp.ca.gov> has complaint forms, Independent Medical Review (IMR) Application forms and instructions online. You may contact them immediately if you have an "Urgent Grievance", as discussed above.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-800-440-4347** or **1-800-718-4347 TTY** and use your 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 you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to 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-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department's Internet Web site <http://www.hmohelp.ca.gov> has complaint application forms and instructions online.

INDEPENDENT MEDICAL REVIEW

An Independent Medical Review (IMR) is when the Department of Managed Health Care (DMHC) reviews a Health Plan's decision to deny, terminate, or modify a service your Doctor requests. There is no cost for this service and a determination will be made in writing within 30 days of DMHC's receipt of your completed application or less if determined that an expedited review is necessary. If your request concerns an imminent and serious threat to your health, including, but not limited to serious pain, potential loss of life, limb, or major bodily function or immediate and serious deterioration of your health, you will get results within 3 days. "Subject to the approval of the department, the deadlines for analysis and determination involving both regular and expedited reviews may be extended by the Department of Managed Health Care up to three days in extraordinary circumstances or for good cause."

You may request an IMR of disputed health care services from DMHC if you believe that health care services have been improperly denied, modified, or terminated. A "disputed health care service" is any health care service that has been denied, modified, terminated or delayed, in whole or in part because the service is not medically necessary.

The IMR is in addition to any other procedures or remedies available to you. You pay no application or processing fees of any kind for an IMR. You have the right to provide information in support of the request for an IMR. IEHP must provide you with an IMR application form and or information on how to file an IMR with any grievance disposition letter that denies, modifies, or delays health care services. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against IEHP regarding the disputed health care service. You are not required to participate in the IEHP's Grievance Process before filing an IMR for experimental or investigational therapy or treatment. For more information about an Independent Medical Review, contact IEHP Member Services at 1-800-440-4347/TTY 1-800-718-4347.



INLAND EMPIRE HEALTH PLAN

PROCESO DE RESOLUCION DE QUEJAS **(HEALTHY FAMILIES / HEALTHY KIDS)**

¿CÓMO PUEDO REGISTRAR UNA QUEJA?

1. Los Miembros de IEHP tienen el derecho de registrar una queja contra IEHP o sus proveedores sin tener que preocuparse de alguna acción negativa de parte de IEHP, su Doctor o cualquier otro proveedor. Ud. puede registrar su queja directamente con IEHP si toma una de las siguientes acciones:

- a) Llame al Departamento de Servicios para Miembros de IEHP al (800) 440-4347, o al (800) 718-4347 (TTY) y registre sus queja con un Representante de Servicios para Miembros.
- b) Envíe su queja al Personal de Quejas de IEHP por medio de fax al (909) 890-5748.
- c) Registre su queja a través de la red de Internet de IEHP al www.iehp.org.
- d) Puede registrar su queja en persona a la siguiente dirección:

Inland Empire Health Plan
Departamento De Quejas
303 East Vanderbilt Way
San Bernardino, CA 92408

Horarios de Negocio de IEHP: 8:00AM a 5:00PM
lunes a viernes

- e) También puede registrar su queja por correo al P. O. Box 19026, San Bernardino, CA 92423 -9026.

2. Los Formularios de Quejas de IEHP están disponibles en todas las oficinas de los doctores de IEHP y las Organizaciones Contratantes. Un asesor de pacientes estará disponible para asistirle con este proceso.

¿QUE SUCEDE DESPUES DE QUE REGISTRE MI QUEJA?

1. Entre los primeros 5 días de la fecha en que IEHP recibió su queja, Ud. recibirá una carta de reconocimiento informándole que su queja fue recibida. La carta le proveerá a Ud. con el nombre y el número de teléfono de un Representante de Quejas, que le asistirá con su queja. Por favor infórmele al Representante de Quejas si su domicilio o número de teléfono ha cambiado.
2. Todo el proceso será resuelto dentro de 30 días. IEHP le mandará una carta con la resolución de su dentro de ese tiempo.

3. Las quejas que involucran una amenaza seria a su salud serán marcadas urgentes, serán resueltas dentro de 72 horas. Nosotros le notificaremos inmediatamente de la decisión y le enviaremos una carta explicando nuestra resolución dentro de 72 horas del día en que nosotros recibimos su queja. Quejas urgentes incluyen una inminente y seria amenaza a su salud, incluyendo, pero no limitado a, dolor severo, el potencial de pérdida de vida, extremidad, o una función del cuerpo.

SUS DERECHOS

1. Usted tiene derecho a que su queja urgente sea resuelta dentro de 72 horas. Usted también tiene derecho de comunicarse con el Departamento de Administración del Cuidado de la Salud acerca de su queja al 1-888-HMO-2219 o para las personas con impedimentos auditivos y del habla pueden usar el 1-877-688-9891 o en la red de Internet <http://www.hmohelp.ca.gov>. Todas otras quejas serán resueltas dentro de 30 días.
2. Usted tiene el derecho de pedirle a IEHP que lo ayude a trabajar con su proveedor, o cualquier otra persona, para tratar de solucionar su problema.
3. Usted tiene el derecho de cambiar de proveedor.
4. Usted tiene el derecho de designar una persona que lo represente durante el proceso de su queja. También, si el Miembro es un menor de edad, o adulto que no goza de sus facultades, o está incapacitado, se puede presentar una queja a favor del Miembro por parte de un abogado, un doctor, padre, tutor, pariente, u otra persona designada por el Miembro, con consideración a lo apropiado. Un pariente puede incluir: un padre, padrastro, esposo, hijos adultos, abuelo, hermano (a), o tío (a), del Miembro.
5. Usted tiene derecho de cancelar su participación como Miembro de IEHP en cualquier momento y por cualquier razón.
6. Usted tiene derecho de solicitar mediación voluntaria. Usted será responsable por la mitad de los costos para la mediación.
7. Usted tiene derecho de enviar a IEHP información, documentos, u otra información escrita para respaldar su queja.
8. Usted tiene el derecho de presentar una queja si sus necesidades lingüísticas no son cumplidas.
9. Puede comunicarse con otras Agencias Estatales para ayuda.

SI AUN ESTA DESCONTENTO USTED PUEDE:

1. Puede apelar esta decisión de su queja llamando al Servicio de Miembros de IEHP al 1-800-440-IEHP (4347)/TTY 1-800-718-4347 dentro los primeros 30 días que usted entablo su queja, o
2. Comuníquese con el Departamento de Administración del Cuidado a la Salud 30 días después que haya presentado su queja al 1-888-HMO-2219 o para las personas con impedimentos auditivos y del habla pueden usar el TDD 1-877-688-9891. La red del Internet del departamento <http://www.hmohelp.ca.gov> tiene formas para quejas, Aplicaciones para una Revisión Medica Independiente. Usted puede comunicares inmediatamente con ellos si tiene una “Queja Urgente” como se menciona arriba.

El Departamento de Administración de Cuidado Médico es responsable de regular los planes de servicio de cuidado de salud. Si tiene una queja contra su plan de salud, debe de llamar a su plan primero

al **1-800-440-4347**, o **1-800-718-4347** TTY y usar su proceso de resolución de quejas antes de comunicarse con el Departamento. Utilizando el proceso de quejas del plan no le previene el uso de cualquier otro remedio provisto por la ley. Si tiene una queja que envuelve una emergencia, una queja que no ha sido resuelta satisfactoriamente por el plan, o su queja sigue sin resolución por mas de 30 días, usted puede llamar al Departamento para asistencia. También pueda que usted sea elegible para una Revisión Medica Independiente. Si su caso es elegible para una Revisión Medica Independiente, el proceso proveerá una revisión imparcial de las decisiones medicas hechas por un plan de salud relacionado con el servicio o tratamiento propuesto para él ciudad medico que sé esta necesitado, las decisiones de cobertura para terapia o tratamiento experimental o de investigación y aclarara el conflicto financiero para servicios urgentes o de emergencia. El Departamento tiene un número de teléfono gratuito (**1-888-HMO-2219**) y para las personas con impedimentos auditivos y del habla pueden usar el (**1-877-688-9891**) para comunicarse con el Departamento. La red del Internet del Departamento (**<http://www.hmohelp.ca.gov>**) tiene los formularios de quejas y las instrucciones disponibles en línea.

REVISION MEDICA INDEPENDIENTE

Una Revisión Medica Independiente (IMR – siglas en inglés) es cuando el Departamento de Administración de Cuidados Médicos (DMHC – siglas en inglés) repasa la decisión del Plan de seguro medico de negar, atrasar, o modificar un servicio solicitado por su Doctor. No hay ningún cobro por este servicio, y sé hará una determinación por escrito dentro de 30 días de que DMHC reciba su solicitud completa, o más pronto si se decide que una revisión acelerada es necesaria. Si su solicitud se trata de una amenaza seria e inminente a sus salud, incluyendo pero no limitado a dolor fuerte, o perdida potencial de vida, miembro o función mayor del cuerpo, o una seria e inmediata deterioración del cuerpo, usted recibirá los resultado dentro de 3 días. “Sujeto a la aprobación del departamento, el plazo de tiempo por análisis y determinación de revisión de casos regulares tanto como aceleradas puede ser extendido hasta 3 días por el Departamento de Administración de Cuidados Médicos, en circunstancias extraordinarias, si hay causa debida.”

Usted puede solicitar una IMR para disputar los tratamientos del cuidado de salud a través del DMHC si usted cree que sus tratamientos de cuidado de salud han sido indebidamente negados, modificados o demorados. Una “disputa del tratamiento de cuidado de salud” es cualquier servicio de cuidado de salud elegible bajo la cobertura y pago que haga sido negado, modificado o demorado, todo o en parte porque el tratamiento no es medicamento necesario.

El IMR es una adición aparte de cualquier otro procedimiento o remedio disponible para usted. Usted no paga cuota alguna de solicitud o procesamiento por un IMR. Usted tiene el derecho de proveer información que respalde la solicitud de un IMR. IEHP debe proveerle una solicitud para un IMR con cualquier carta de resolución de un queja que le niegue, modifique, o demore algún tratamiento de cuidado de salud. La decisión de no participar en el proceso IMR podría provocar que usted pierda su derecho reglamentario en proseguir con una acción legal en contra de IEHP referente al tratamiento de cuidado de salud en disputa. Para mas información acerca de una Revisión Medica Independiente, llame al Departamento de Servicios para Miembros de IEHP al 1-800-440-4347, o 1-800-718-4347 TTY).

(FIRST and FINAL NOTICE)

<DATE>

<NAME OF MEDICAL DIRECTOR>

<NAME OF IPA>

<ADDRESS>

Re: Case # <number>

<Member Name>

Via Fax <PROVIDER'S MEDICAL
DIRECTOR FAX NUMBER> and U.S. Mail

Dear Dr. <LAST NAME>:

On <DATE, <NAME OF PROVIDER ORGANIZATION, PROVIDER, OR FACILITY> was faxed an IEHP Grievance Summary Form with an expected resolution date of <DATE>. A copy of this form is enclosed for your review.

As of the date of this letter, we have not received any written communication from <NAME OF PROVIDER ORGANIZATION, PROVIDER OR FACILITY> regarding the above-referenced grievance.

Please fax a typewritten resolution to IEHP by <DATE in 2 business days>, at (909) 890-5748. Due to regulatory requirements from the Department of Health Care Services and Department of Managed Health Care regarding resolution of grievances within 30 days, if we do not receive information from <NAME OF PROVIDER ORGANIZATION, PROVIDER, OR FACILITY> by <DATE>, IEHP will resolve the grievance.

Please note that IEHP monitors response submission timeliness for further action, including referral to Peer Review as indicated for medical issues or Provider Services for non-medical issues.

If you have any questions regarding this letter, please contact me at <IEHP GRIEVANCE CONTACT'S PHONE NUMBER>, or through IEHP Reception desk at (909)890-2000, or through IEHP Member Services at 1-800-440-IEHP (4347). Thank you for your cooperation in this matter.

Sincerely,

<NAME OF GRIEVANCE CONTACT>/<TITLE>

Inland Empire Health Plan

Enclosures

cc: <NAME OF PROVIDER GRIEVANCE CONTACT>
Grievance e-file

DENIAL UPHELD RESOLUTION LETTER – PCP/DENTIST COVER LETTER

<Date>

«PROV_NAME», MD
«PROV_ADDRESS_1»
«PROV_ADDRESS_2»
«PROV_CITY», «PROV_STATE» «PROV_ZIP»

Via U.S. Regular Mail

RE: «Member_Name»
Case # «CASE_»

Dear Dr. «PROV_NAME»:

Enclosed is a copy of the resolution letter that was mailed to the above-mentioned IEHP Member. As you will note, IEHP's Medical Director, <Name, DO or MD>, has agreed with <your Medical or Dental Group's or IEHP's> decision to deny the Member's request for «PROCEDURE, SERVICE OR TREATMENT_REQ», based on the «Criteria» and the opinion of the Independent Physician Reviewer, a Specialist Board Certified in <enter specialty>. «ProposedAlternative»

We hope this information will assist you in coordinating care for this Member. However, if you disagree with this decision, you may contact <Medical Director's Name> at <phone #>, or you may send a letter of appeal to us at: Inland Empire Health Plan, Attn. Grievance Department, 303 East Vanderbilt Way, Suite 100, San Bernardino, CA 92408.

We appreciate the high quality care and service you provide to IEHP Members, and understand the demands of a busy practice. If we can be of any assistance, please do not hesitate to contact IEHP's Grievance Nurse at (909) 890-2000.

Sincerely,

<Name>

Grievance Coordinator

cc: «gc_Name», «gc_Title», «ipa_name»
Grievance e-File

FAIR HEARING PROCESS

FOR THE AWARD OF CONTRACTS

FOR PARTICIPATION IN

THE PROVIDER NETWORK

OF

INLAND EMPIRE HEALTH PLAN

(Adopted September 11, 1995 and Revised September 11, 2006)

**FAIR HEARING PROCESS
FOR THE AWARD OF CONTRACTS
FOR PARTICIPATION IN THE PROVIDER NETWORK
OF INLAND EMPIRE HEALTH PLAN**

Providers of medical services who wish to be included in the provider network of the Inland Empire Health Plan (IEHP), and who have not been offered a contract to participate, including those providers whose contract has expired, or whose contract has been terminated by IEHP shall follow the procedure outlined below in seeking to be included or for continued participation in the IEHP provider network:

Section 1 **Right of Fair Hearing Before the Board of IEHP**

- a. Any provider who has received a written response from the Chief Executive Officer, or his designee, rejecting the request to be included or to continue participation in the provider network for IEHP shall have the right to a Fair Hearing before the Board of IEHP regarding the decision of the Chief Executive Officer, or his designee.
- b. The written response from IEHP, rejecting the request of a provider to be included or to continue participation in the provider network of IEHP shall inform the provider of the right to a Fair Hearing before the Board of IEHP regarding the decision of the Chief Executive Officer, or his designee.
- c. The provider shall be given ten (10) working days from the date of mailing of the response from IEHP to request a Fair Hearing before the Board of IEHP. Such request for a Fair Hearing shall be made by written response from the provider to the Chief Executive Officer, or his designee.
- d. Providers failing to request a Fair Hearing before the Board of IEHP within ten (10) working days relinquish their right to a Fair Hearing and any other judicial review.
- e. The Fair Hearing before the Board of IEHP shall be set on a regular agenda within sixty (60) calendar days, for which proper notice pursuant to the Brown Act can be given.
- f. The Chief Executive Officer shall set the Fair Hearing on the agenda of a regular Board meeting of IEHP pursuant to the provisions of section 1 e. herein, and shall give written notice to the provider, of the date, time, and place of the Fair Hearing. The notice shall include a statement that exhaustion of the administrative remedies, as set forth herein is required prior to seeking judicial review.

Section 2 Fair Hearing Position Statements

- a. If the provider has requested a Fair Hearing, counsel for IEHP shall provide written notice to both parties requesting written statements that outline their position to be served to IEHP counsel and opposing party by a specified date and time.
- b. Failure by provider to provide requested documentation in the timeframes indicated may be deemed that the provider has waived the right to a Fair Hearing and any other judicial review. Such decision shall be made at the sole discretion of the Board of IEHP.

Section 3 Fair Hearing Before the Board of IEHP

- a. At the time, and date specified in the written response of the Chief Executive Officer, the Board of IEHP shall conduct a hearing, and shall receive evidence, including testimony from the Chief Executive Officer of IEHP, his designee, other employees of IEHP if necessary, and the provider. The Board of IEHP may receive evidence, including testimony from any other concerned parties who desire to present evidence to the Board of IEHP regarding the request of the provider to be included or to continue participation in the provider network for the operations of IEHP.
- b. **Any party wishing to speak on this matter must state for the record any contribution in excess of \$250 made in the past twelve (12) months to any IEHP Board member, the name of the Board member receiving the contribution.**
- c. The Board of IEHP shall not be limited by the technical rules of evidence in conducting the Fair Hearing.
- d. The Fair Hearing shall be conducted in open session during the regular meeting of the Board of IEHP.
- e. If the provider fails to appear at the Board meeting for the Fair Hearing, after receiving written notice of the date, time and place of the hearing from the Chief Executive Officer, or his designee, and without requesting a continuance, in writing, directed to the Chief Executive Officer, such writing to be received prior to the date of the Fair Hearing, the provider shall be deemed to have waived the right to a Fair Hearing.
- f. The decision of whether a continuance of the Fair Hearing is granted, when requested by a provider at the date and time of the Fair Hearing, shall be in the sole discretion of the Board of IEHP. The Board may, in its sole discretion, decide to deny the request for the provider for a continuance, and proceed with the Fair Hearing.

Section 4 Actions of the Board after the Fair Hearing

- a. The Board of IEHP, after the completion of the evidentiary portion of the Fair Hearing may take any of the following actions without further notice:
 - i. Grant the request of the provider to be included in the provider network wholly, partially, or conditionally. The Board may direct the Chief Executive Officer, or designee, to negotiate and reach contractual terms and conditions, subject to Board approval, provided that the provider meets the provider participation standards for inclusion, as approved by the Board.
 - ii. Grant the request of the provider to continue participation in the provider network wholly, partially or conditionally. The Board may direct the Chief Executive Officer to negotiate and reach new or renewed contractual terms and conditions, subject to Board approval, provided that the provider meets the provider participation standards for continued inclusion in the provider network of IEHP, as approved by the Board.
 - iii. Deny the request of the provider wholly, partially, or conditionally to be included or to continue participation in the provider network of IEHP.
 - iv. Continue the matter to the next regularly scheduled Board meeting, at which time the decision of the Board will be rendered.

Section 5 Exhaustion of Administrative Remedies

- a. A provider seeking to be included in the IEHP provider network shall be required to exhaust the administrative remedies herein prior to seeking judicial review of the actions of IEHP, and the Board of IEHP.
- b. A provider seeking to continue participation in the provider network for the operations of IEHP upon termination or contract expiration shall be required to exhaust the administrative remedies herein prior to seeking judicial review of the actions of IEHP, and the Board of IEHP.
- c. The Notice of the Fair Hearing shall contain a statement that exhaustion of administrative remedies, as set forth herein, is required prior to seeking judicial review.

Section 6 Finality of the Decision of the Board

The decision of the Board of the Inland Empire Health Plan shall be final as to the request of the provider to be included or to continue participation in the provider network for the operation of IEHP.

PROVIDER SECOND LEVEL APPEAL OF UM DECISION – ACKNOWLEDGEMENT
LETTER

<DATE>

<<PROV_NAME>>
<<PROV_ADDRESS_2>>
<<PROV_CITY>>, CA <<PROV_ZIP>>

RE: <<Member Name>>
Case # <<CASE_>>

Via U.S. Regular Mail

Dear Dr. <<PROV_NAME>>:

Thank you for taking the time to let us know of your request for a review of the denial by <<Grievance_Against>> for <treatment/service> for the above-mentioned Member. Your appeal arrived on <<RECEIVED>>. IEHP's Medical Director will review this case so that you will have an answer within thirty (30) days from when we received your appeal.

Please send us any additional information you think is important to this case, such as written comments or other documents. You can also have a copy of all the documents from IEHP that will be used to make a decision regarding your appeal. Just send us your request in writing.

Thank you for sharing your concerns. Your feedback is important to maintaining and improving the Member's quality of care. If you have any questions or want to know the status of this case, please give me a call Monday – Friday 8am to 5pm, at (909) 890-~~<ext>~~, or through IEHP Reception Desk at (909) 980-2000, or Member Services at 1-800-440-IEHP (4347). Please refer to your IEHP Provider Manual for additional information regarding the appeals and grievance process.

Sincerely,
<Name>/Your Appeals and Grievance Team
Inland Empire Health Plan

Enclosed: Grievance Resolution Process

cc: <PCP>
<<Gc_Name>>, <<Gc_Title>>, <<Ipa_Name>>
Grievance e-File

PROVIDER SECOND LEVEL APPEAL OF UM DECISION – RESOLUTION LETTER

<DATE>

<PROVIDER NAME>

<ADDRESS>

<ADDRESS>

Via U.S. Regular Mail

RE: <MEMBER NAME>
IEHP Case # <NUMBER>

Dear Dr. <PROVIDER NAME>:

This letter is in response to your request for a second level appeal received by IEHP on <DATE>, regarding a UM denial for the above-mentioned Member for <service>.

After further review, I have made a decision to <uphold/overturn> the denial for the <service>. The decision was based on <criteria or regulation>. <Documentation supporting the uphold>.

Per your conversation with IEHP's Grievance nurse on <Date>, you were informed of the appeal determination <insert any additional information>.

We hope this information will assist you in coordinating care for this Member.

We appreciate the high quality care and service you provide to IEHP Members. If you have any questions, please contact me at (909) 890-5642 <or 2155 for Dr. Thomazin>

Sincerely,

Kenneth Smith, MD <or name of reviewing Physician>
Medical Director

KS/your initials

cc: <PCP name, if applicable>
<IPA CONTACT>
Grievance e-File

[DATE]

[PROVIDER NAME]
[CLINIC NAME]
[STREET ADDRESS]
[CITY, STATE ZIP]

SUBJECT: _____ GRIEVANCE

Dear [DOCTOR NAME]:

On [DATE], IEHP received your grievance against [MEMBER, IPA, HOSPITAL OR IEHP]. Thank you for bringing this matter to our attention, your concerns are important to us.

IEHP is currently taking the necessary steps to immediately resolve your grievance. You will be contacted if we have any further questions. IEHP's Director of Provider Services will resolve your grievance within forty-five (45) days.

If you have any questions or concerns regarding the status of your grievance, please call me at [PSR phone number].

Sincerely,

[PSR NAME]
Provider Services Representative

cc: Susie White, Director of Provider Services, IEHP
Esther Iverson, Provider Services Manager, IEHP
File location (see policy and procedures PRO/GEN A1b and A1c) ex. F-120.a

DATE

Dr. PROVIDER NAME

Address

City, State ZIP

Re: Grievance _____

Dear Dr. [Provider Name]:

IEHP has concluded its review of your provider grievance filed [Date] regarding [state reason here.....] and has determined the following:

Thank you again for bringing your concerns to IEHP's attention so that we may best serve the needs of our providers and Members.

Please contact me at (909) 890-XXXX if you have any further questions or concerns.

Sincerely,

Susie White

Director of Provider Services, IEHP

cc: Esther Iverson, Provider Services Manager, IEHP
PSR Name, Provider Services Representative, IEHP
PCP
IPA
File