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## **16. APPEAL AND GRIEVANCE RESOLUTION SYSTEM**

### **A. Appeal and Grievance Resolution Process for Members (Standard and Expedited)**

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#### **APPLIES TO:**

- A. This policy applies to all IEHP Medicare DualChoice (HMO SNP) 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 and 16-1b 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 concern 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 practitioner) and their affiliated Providers are required to have IEHP Member Appeal and Grievance Forms (see Attachments 16-1a and 16-1b in Section 16, "Attachments") readily available for distribution to Members upon request.
- D. All practitioners and their affiliated Providers are required to provide Members with assistance in filing their grievances and appeals. Practitioners and their affiliated Providers are informed annually regarding how to access current appeals and grievance resolution processes via the Provider Manual.
- E. 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. Expedited cases may be requested by the Member (or their authorized representative), or a physician (regardless of whether that physician is affiliated with IEHP). To be appointed by a Member, both the Member making the appointment and the

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representative accepting the appointment must sign, date, and complete a representative form (see Attachments 16-6a and 16-6b in Section 16, “Attachments”). If a form other than the Centers for Medicare and Medicaid Services (CMS) Form CMS-1696 is used, it must comply with all the requirements of the Form CMS-1696. The signed form or appropriate legal papers supporting an authorized representative’s status, must be included with each appeal. Unless revoked, an appointment is considered valid for one year from the date that the appointment is signed by both the Member and the representative. The representation is valid for the duration of the appeal, and photocopies may be included with future appeals up to one year. Upon notice to Member, Physicians and other prescribers may request reconsiderations and redeterminations on a Member’s behalf without having been appointed as the Member’s representative.

- F. 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 Appeal and Grievance Resolution Process, as described in the IEHP Medicare DualChoice (HMO SNP) Member Handbook/ Evidence of Coverage (EOC), Chapter 9.
- G. 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.
- H. A Member has the right to file a grievance for up to 60 calendar days following any incident or action that is the subject of dissatisfaction (see Attachment 16-7 in Section 16, “Attachments”).
- I. A Member has the right to file an appeal within 60 calendar days of receipt of organization determination, or later if the Member submits a written request for filing time extension, noting good cause for delay (see Attachment 16-9 in Section 16, “Attachments”).
- J. Grievances may be filed by telephone, in writing, by fax, in person, or online through IEHP’s website at [www.iehp.org](http://www.iehp.org), and may be withdrawn by notifying IEHP in writing. All standard appeals must be filed in writing. Expedited appeal requests may be submitted orally or in writing.
- K. Members may request an expedited (“fast”) appeal if they feel that following the routine timeframe would seriously jeopardize their life, health, or ability to regain maximum function. The IEHP Medical Director (or designee) will determine if CMS criteria are met for expediting the case. If expeditable criteria are not met, the appeal will be

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resolved within the standard timeframe. If a physician requests an expedited appeal, the request is expedited. The appeal decision is made as expeditiously as the Member's health condition requires, but no later than 72 hours from appeal receipt (or upon expiration of extension). If the decision is to overturn the denial, Members are notified verbally or in writing within 72 hours of appeal receipt. Verbal notice must be followed in writing within 3 calendar days. Providers are notified in writing within 72 hours of appeal receipt. If the decision is to uphold the denial, the appeal is sent to the CMS Independent Review Entity (IRE)/Maximus within 24 hours of the decision or within 72 hours of appeal receipt. For a Part D drug denial uphold, the Member is notified verbally and sent a Redetermination Letter within 72 hours, informing the Member how to contact Maximus (see Attachments 16-10 in Section 16, "Attachments").

- L. Members may request an expedited grievance when: (1) IEHP determines that a reconsideration/appeal request or organizational determination is not expeditable, (2) IEHP determines that Part D drug coverage determination or redetermination is not expeditable and the drug has not yet been received by the Member, or (3) IEHP is extending the expedited appeal or organizational determination timeframe. Expedited grievances are responded to within 24 hours of grievance receipt (see Attachment 16-8 in Section 16, "Attachments").
- M. Complaints categorized by CMS as "immediate action" are resolved within two (2) calendar days.
- N. Grievances are separate and distinct from appeals. Upon receiving a complaint, IEHP promptly determines, and informs the Member, whether the case is subject to IEHP's grievance or appeals/reconsideration process. If a case clearly has components of a grievance and an appeal, parallel cases will be processed to the extent possible.
- O. If a case is misclassified as a grievance or an appeal in error, the Member is notified in writing regarding the corrected resolution type. Case age is based on the original receipt date.
- P. IEHP resolves all grievances within 30 days, in accordance with regulatory guidelines. Response times for grievances are counted in calendar days.
- Q. IEHP provides Members with written responses to appeals and 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 appeal responses regarding non-covered benefits, IEHP includes in the response the provision in the contract that excludes the coverage, and references the IEHP's 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

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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 appeals and grievances to IEHP for resolution. Practitioners and Providers may contact IEHP Member Services at (800) 440-4347/TTY (800) 718-4347 to obtain further information regarding the IEHP Appeals and Grievance Resolution System.
- 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 and is available online through the IEHP web site, and is posted in common, public areas.
- T. Members with grievances 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 choose to delegate the appeal and/or 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. Delegated entities are responsible for establishing an appeal and/or grievance process in accordance with regulations. IEHP retains ultimate responsibility for ensuring that the delegated entity satisfies all requirements of the grievance and appeal process. Appeals and 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. Members have the right to file an appeal or grievance with the delegated entity or IEHP. Aggregate appeal and grievance data submitted to the Member upon request, includes information on the number of appeals and/or grievances IEHP receives per thousand (1000) Members, and the number of grievances related to quality of care in a specified time period.
- V. On an annual basis, IEHP evaluates delegate performance against IEHP, NCQA, and regulatory standards.
- W. IEHP maintains all Member appeals and grievances, including medical records, documents, evidence of coverage or other relevant information IEHP used to make the

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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.
- X. All Member correspondence is mailed via regular mail, unless the Member requests certified mail.
- Y. 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.
- Z. All appeals and grievances are responded to both verbally and in writing, including quality of care cases. Grievances received orally, not related to quality of care or denied services may be responded to orally only, unless the Member requests response in writing. All details of the oral case are documented in the electronic case tracking system. The complaint process available to the Member under the Quality Improvement Organization (QIO) is separate and distinct from IEHP's appeals and grievance process. Members have the right to file a written complaint with the QIO, IEHP, or both. IEHP cooperates fully with the QIO in the resolution process. Members are notified of the QIO process upon enrollment and annually thereafter.
- AA. 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 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

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- 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.
- BB. Grievances involving quality of care issues are reported to IEHP’s Quality Management Department upon resolution of the case, and Members are also notified of their right to file with their QIO. IEHP’s Chief Medical Officer or Medical Director is notified immediately upon receipt of a potential quality of care case (see Attachments 16-7 and 16-8 in Section 16, “Attachments”).
- CC. 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.
- DD. Members with expedited cases are notified of the shortened timeframe to submit documentation, or supporting evidence.
- EE. A Member may request a fourteen (14) day extension on their standard (routine) appeal or grievance case to allow time for submission of documents or evidence they feel is pertinent.
- FF. Any request for an urgent/expedited case submitted by a physician, with supporting evidence, will be processed as urgent.
- GG. IEHP staff is available on-call during non-business hours to process expedited cases and “immediate action” complaints.
- HH. IEHP does not discriminate against any Member for filing a grievance.

#### **PURPOSE:**

- A. To clearly define IEHP’s process for addressing IEHP Medicare DualChoice (HMO SNP) Member complaints, including grievances and appeals.

#### **REFERENCES:**

- A. Title 42, Code of Federal Regulations, § 422.560, 422.566(b)(3), 422.570
- B. IEHP Provider Manual Policies 16A1, “Urgent (Expedited Appeals,” 16B1, “Initial Appeal and Grievance Resolution,” 16B2, “Health Plan Appeals and Grievances,” and 16C, “Member Rights and Options.”
- C. Medicare Managed Care Manual, Chapter 13 and 18
- D. IEHP Medicare DualChoice (HMO SNP) Member Handbook/Evidence of Coverage (EOC)

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- E. Health Insurance Portability and Accountability Act (HIPAA) 45 CFR §§ 164.520, 164.528
- F. National Committee for Quality Assurance (NCQA) Standards for Health Plan Accreditation

#### **PROCEDURE:**

- A. Members who wish to file an appeal and/or grievance may contact IEHP's Member Services Department at (877) 273-4347 or (800) 718-4347 (TTY). Members may also submit their appeal or grievance to IEHP through IEHP's web site at [www.iehp.org](http://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

- B. IEHP mails an acknowledgment letter to the Member within five calendar days of receipt of grievance, with a copy to the involved practitioner and affiliated Provider. Grievances responded to orally only, and expedited cases do not require Acknowledgment letters.
- C. IEHP may contact the Member to obtain additional information within five calendar days of receipt of the grievance.
- D. Appeals and grievances received at IEHP are resolved as follows: IEHP Grievance Department staff triage 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 to the affiliated Provider's Medical Director, 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, 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.

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3. If a response is not received by the “Expected Response Date,” IEHP mails a due notice (see Attachment 16-2 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 Committee 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 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 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 completed 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 appeal in-house. IEHP works closely with the affiliated

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Provider in investigating and resolving appeals for denials of requested services.

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 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 an appeal regarding a denial or modification of health care services.
    - a. For 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. An appeal resolution letter is mailed to the Member. A copy of the letter is mailed to the involved practitioner and/or Provider. A case is considered resolved when IEHP resolves the Member's issue, takes appropriate action, or the Member withdraws the case. Additional appeal procedures are outlined in Policy 16A1, "Urgent (Expedited) Appeals," and Policy 16A2 "Standard Fast (Immediate), and Fast-Track Appeals."
- 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. 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 (877) 273-4347 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 Grievance Department at (909) 890-5748.
  2. If the Member submits an IEHP Appeal and Grievance Form and/or documentation regarding their complaint to the practitioner or Provider, the form and/or documentation is immediately faxed to IEHP Grievance Department at

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(909) 890-5748.

3. The practitioner or Provider must mail a hard copy of the IEHP Member Appeal and Grievance 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

- I. Upon receipt of an expedited case, Grievance Department staff contact the Member to verify the issues and obtain any needed information. Members are informed of their Rights and Options regarding the resolution process. A permanent electronic case is opened. All hard case files are maintained in the grievance file system for ten (10) years.

INLAND EMPIRE HEALTH PLAN		
<b>Chief Approval:</b> <i>Signature on file</i>	<b>Effective date:</b>	January 1, 2007
<b>Chief Title:</b> Chief Medical Officer	<b>Revised date:</b>	January 1, 2012

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## **16. APPEAL AND GRIEVANCE RESOLUTION SYSTEM**

- A. Appeal and Grievance Resolution Process for Members
    - 1. Urgent (Expedited) Appeals
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### **APPLIES TO:**

- A. This policy applies to all IEHP Medicare DualChoice (HMO SNP) Members.

### **POLICY:**

- A. IEHP defines an appeal as a review of an adverse organization determination on health care services a Member believes he or she is entitled to receive, including a delay in providing, arranging for, or approving such services, if such a delay would adversely affect the Member's health. A Member appeal may also include any money the Member must pay, as defined in Title 42, CFR Section 422.566 b.
- B. IEHP's Grievance Department has the responsibility of processing all expedited/urgent appeal cases.
- C. IEHP Members or their authorized representatives, who believe that the standard thirty (30) day appeal/reconsideration process could seriously jeopardize the life, health, or ability to regain maximum function, may request an expedited appeal.
- D. Appeals, including complaints regarding Part D coverage determinations, identified as urgent by the Chief Medical Officer or Medical Director are resolved within seventy-two (72) hours of receipt. 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 Chief Medical Officer 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. Refer to Policies 16C, "Member Rights and Options" and 22A, "Members' Rights and Responsibilities" for further details.
- E. IEHP's Chief Medical Officer or Medical Director reviews potentially urgent cases and makes a determination of the urgency of the response time, taking into consideration the Member's medical condition.
- F. For a request made or supported by a physician, IEHP provides an expedited reconsideration if the physician indicates that applying the standard timeframe for conducting a reconsideration could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.
- G. Upon receipt of an urgent case, IEHP's Grievance staff immediately informs the Member of the shortened timeframe to submit information related to their case.
- H. If a case is deemed non-urgent, it is transferred to the standard thirty (30) day appeal process. The 30-day period begins the day that IEHP received the request for expedited reconsideration. IEHP provides the Member and Provider with a prompt verbal notification of the resolution within seventy-two (72) hours from the receipt of the case,

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#### 1. Urgent (Expedited) Appeals

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and in writing within three (3) calendar days after the verbal notification with a letter that includes notification of the status of the case, the ability of a Provider to submit evidence in support of an expedited case, and the right to file an expedited grievance if the Member disagrees with IEHP's decision not to expedite the appeal. The Member is provided with instructions about the grievance process and its timeframes.

- I. Expedited appeal cases may be requested by the Member (or their authorized representative) or a physician, regardless of whether that physician is affiliated with IEHP (see Attachment 16-10 in Section 16, "Attachments").
- J. 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 reconsideration.
- K. The Member may file an expedited appeal by phone, by mail, by fax, in person, or through an IEHP Provider or via IEHP's web site at [www.iehp.org](http://www.iehp.org). All oral requests are documented in writing and maintained in the electronic case tracking system.
- L. IEHP maintains all Member files, including medical records, documents, evidence of coverage or other relevant information IEHP used to make the decision, in confidential electronic files for ten years.
- M. All Member correspondence is mailed via regular mail, unless the Member requests certified mail.
- N. IEHP complies with all regulations pertaining to Members' rights regarding appeals, grievances and confidentiality.
- O. IEHP provides Members with copies of their cases, including medical records and information used to make a decision, upon request.
- P. IEHP Members are informed of their right to an expedited appeal/reconsideration upon enrollment, and annually thereafter. The Member's request for an expedited appeal may be withdrawn in writing by the Member at any time.
- Q. IEHP staff is available on-call during non-business hours to process expedited cases.

#### **PURPOSE:**

- A. To clearly define IEHP's process for addressing IEHP Medicare DualChoice (HMO SNP) Member's Urgent (Expedited) Appeals/Reconsiderations.

#### **REFERENCES:**

- A. Medicare Managed Care Manual, Chapter 13 and 18

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#### 1. Urgent (Expedited) Appeals

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- B. Title 42, Code of Federal Regulations, Section 422.584
- C. National Committee for Quality Assurance (NCQA) Standards for Health Plan Accreditation

#### **PROCEDURE:**

- A. IEHP Members may request an expedited appeal after receiving an initial determination to deny, modify or terminate services or Part D drug coverage (see Attachment 16-10 in Section 16, “Attachments”).
- B. IEHP Members or their authorized representative may request (oral or written) an expedited reconsideration/appeal within sixty (60) calendar days from receipt of the initial adverse determination, or the Member may submit a written request for filing time extension, noting good cause for delay.
- C. IEHP Grievance staff enters the case into the electronic case tracking system and assigns the case to Appeals/Grievance staff.
- D. All Member urgent appeals 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 reconsideration. The case is expedited if the CMO (or designee) determines that applying the standard timeframe for reconsidering a determination could seriously jeopardize the life or health of the Member or the Member’s ability to regain maximum function. If the request is made or supported by a physician, IEHP will provide an expedited reconsideration if the physician indicates that applying the standard timeframe for conducting a reconsideration could seriously jeopardize the life or health of the Member or the Member’s ability to regain maximum function.
  - 2. If the case does not meet expedited criteria, the Member is given prompt oral notice, followed by written notice within three (3) calendar days, including transfer of the case to the standard appeal process (see Attachment 16-9 in Section 16, “Attachments”):
    - a. Members requesting a reconsideration of an adverse initial determination to deny, modify or terminate services are informed that the standard timeframe for processing an appeal is thirty (30) days.
    - b. Members requesting a reconsideration of an adverse initial determination to deny Part D drug coverage are informed that the standard timeframe for processing an appeal is seven (7) days.

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3. The Chief Medical Officer or Medical Director directs staff to investigate the issues, and resolves the case. The Chief Medical Officer or Medical Director follows through to ensure that urgent cases are resolved within the prescribed time constraints.
4. Part D medical information is requested within twenty-four (24) hours if necessary.
5. IEHP may request additional information or medical records from a practitioner or Provider, as necessary, such as copy of denial letter, including referral request, criteria applied and all supporting clinical documentation used in making the denial decision.
  - 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.
6. IEHP may extend the seventy (72) hour deadline for appeals related to service denials by up to fourteen (14) calendar days if the Member requests the extension or if IEHP justifies a need for additional information and how the delay is in the interest of the Member.
7. When IEHP extends the timeframe, it must notify the Member in writing of the reasons for the delay, and inform the Member of the right to file an expedited grievance if he or she disagrees with IEHP's decision to grant an extension.
8. IEHP must notify the Member of its determination as expeditiously as the Member's health condition requires but no later than seventy-two (72) hours from the appeal receipt, or upon expiration of the extension.
9. 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, or with expertise in the field of medicine that is appropriate for the services at issue.
10. If the denial is overturned, the Member is notified verbally or in writing within seventy-two (72) hours.
  - a. Verbal notice is followed in writing within three (3) calendar days.
  - b. The requesting Provider is notified in writing within seventy-two (72) hours of appeal receipt.
  - c. Services are authorized or provided within seventy-two (72) hours of

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- receipt of the case, or as soon as medically necessary, based on the Member's medical condition.
- d. IEHP works with the practitioner and/or Provider to obtain the approved authorization within the 72 hours, and to coordinate the Member's care as expeditiously as necessary related to the Member's medical condition.
11. If a non-Part D denial is upheld in whole or in part, the Member is notified verbally and in writing within seventy-two (72) hours of receipt of the case.
- a. The appeal is sent to The Centers for Medicare and Medicaid Services (CMS) contracted Independent Review Entity (IRE), Maximus within twenty-four (24) hours of the decision, or within seventy-two (72) hours of appeal receipt.
  - b. The Member and the Provider are concurrently notified in writing of the decision and of the case submission to Maximus.
  - c. Maximus will review the case and notify IEHP, the Member and CMS of their decision within seventy-two (72) hours of receipt.
  - d. If IEHP's decision is overturned by Maximus, IEHP will authorize or provide the requested services to the Member within seventy-two (72) hours of the IRE reversal notice.
  - e. IEHP informs Maximus that IEHP has effectuated the decision, via the Maximus Statement of Compliance Form.
  - f. A reconsidered determination is final and binding on all parties unless a party other than IEHP files a request for a hearing under the provisions of Title 42, CFR Section 422.602, or unless the reconsidered determination is revised under Title 42, CFR Section 422.616.
  - g. Further appeal rights available to the Member include an Administrative Law Judge (ALJ) hearing, Medicare Appeals Council hearing, or civil action as described in Policy 16A2, "Standard, Fast (Immediate), and Fast-Track Appeals." If an expedited appeal is overturned upon ALJ or higher review, IEHP will authorize or provide the service within sixty (60) days and notify Maximus this has been done.
12. If IEHP fails to reach a decision in the seventy-two (72) hour timeframe, the case will be forwarded to the IRE (Maximus) within twenty-four (24) hours of expiration of the required timeframe for expedited reconsideration.
- a. IEHP notifies the Member or their authorized representative.
  - b. The Member is notified of their right to submit evidence in support of their

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## 16. APPEAL AND GRIEVANCE RESOLUTION SYSTEM

### A. Appeal and Grievance Resolution Process for Members

#### 1. Urgent (Expedited) Appeals

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case to Maximus.

c. Information on how to contact Maximus is provided to the Member.

13. For favorable Part D determinations concerning payment (denial overturned), payment is authorized, and Member notified within 72 hours after receiving the request. Payment is mailed to the Member within 30 days after receiving the request, including out-of-network (OON) paper claims submitted by Members or their appointed representatives.
14. For a Part D appeal, if IEHP is unable to make a decision within the seventy-two (72) hour timeframe, the case is sent to Maximus Part D QIC within twenty-four (24) hours, per the process above with the appropriate Maximus Part D QIC forms. The Member is notified verbally within 24 hours of the timeframe adjudication, and in writing within 72 hours of receipt of the case.
15. For a Part D appeal, if IEHP upholds the denial in whole or in part, the Member is notified verbally and a Redetermination Letter is sent to the Member and Provider within seventy-two (72) hours of receipt of the case, informing the Member how to contact Maximus Part D QIC for reconsideration. The Member is provided with the Reconsideration Form as an attachment to the Redetermination Letter.
16. If Maximus Part D QIC overturns IEHP's denial, the same process above is followed, with the exception that the service (Part D drug) is authorized or provided within twenty-four (24) hours. IEHP informs Maximus Part D QIC that IEHP has effectuated the decision, via the Maximus Part D QIC Notice of Effectuation Form.

INLAND EMPIRE HEALTH PLAN		
<b>Chief Approval:</b> <i>Signature on file</i>	<b>Effective date:</b>	January 1, 2007
<b>Chief Title:</b> Chief Medical Officer	<b>Revised date:</b>	January 1, 2012

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## **16. APPEAL AND GRIEVANCE RESOLUTION SYSTEM**

- A. Appeal and Grievance Resolution Process for Members
    - 2. Standard, Fast (Immediate), and Fast-Track Appeals
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### **APPLIES TO:**

- A. This policy applies to all IEHP Medicare DualChoice (HMO SNP) Members.

### **POLICY:**

- A. IEHP defines an appeal as a review of an adverse organization determination of health care services a Member believes he or she is entitled to receive, including a delay in providing, arranging for, or approving such services, if such a delay would adversely affect the Member's health. A Member appeal may also include any money the Member must pay, as defined in Title 42, CFR Section 422.566 b.
- B. Grievances are separate and distinct from appeals and the appeal process. Upon receiving a complaint, IEHP promptly determines and informs the Member whether the case is subject to IEHP's grievance or appeals/reconsideration process. If a case clearly has components of a grievance and an appeal, parallel cases will be processed to the extent possible.
- C. IEHP's Grievance Department is responsible for the resolution of standard, fast (immediate), and fast-track Member appeal cases.
- D. 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.
- E. If utilizing the standard appeal process may present a threat to the Member's life, health, or ability to regain maximum function, the appeal may be processed as expedited. Expedited cases may be requested by the Member (or their authorized representative), or a physician, regardless of whether that physician is affiliated with IEHP. Refer to Policy 16A1, "Urgent (Expedited) Appeals" for more information.
- F. Physicians may not charge a Member to represent them in their case. IEHP ensures the party filing the case has the legal authority to do so.
- G. A Member, or their authorized representative, may request an appeal/reconsideration within sixty (60) calendar days of receipt of a denial letter/notice of adverse determination.
- H. IEHP processes standard service appeals/reconsiderations within thirty (30) calendar days, and Part D appeals within seven (7) calendar days of receipt. If IEHP is unable to provide a reconsideration within the required timeframe, IEHP will forward the request for reconsideration to Maximus within thirty (30) calendar days of receiving the appeal (or expiration of extension), and within twenty-four (24) hours for a Part D request.

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## 16. APPEAL AND GRIEVANCE RESOLUTION SYSTEM

### A. Appeal and Grievance Resolution Process for Members 2. Standard, Fast (Immediate), and Fast-Track Appeals

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- I. IEHP notifies Members of their right to appeal/reconsideration upon enrollment and annually thereafter. This information is contained in the Member Handbook, and periodically in Member Newsletters. All denial letters/adverse determination notices contain appeal information. The Member may also request information on the appeal/reconsideration process at any time.
- J. IEHP provides Members with the opportunity to present any facts or medical records or evidence related to the case, in person, or in writing.
- K. If a case is misclassified as a grievance or an appeal in error, the Member is notified in writing regarding the corrected resolution type. Case age is based on the original receipt date.
- L. A practitioner can appeal any adverse determination by an IPA or IEHP. Appeals/reconsiderations 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 16B3, "Provider Appeal of UM Decisions" for further details.
- M. 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 appeal/reconsideration, including a standard, expedited, fast (immediate), or fast-track review.
- N. The Member may file an expedited appeal by phone, by mail, by fax, in person, or through an IEHP Provider or via IEHP's web site at [www.iehp.org](http://www.iehp.org). All oral requests are documented in writing and maintained in the case file.
- O. All standard appeals must be filed in writing.
- P. IEHP maintains all Member files, including medical records, documents, evidence of coverage or other relevant information IEHP used to make the decision, in confidential electronic files for ten years.
- Q. All Member correspondence is mailed via regular mail, unless the Member requests certified mail.
- R. IEHP complies with all regulations pertaining to Members' rights regarding appeals, grievances and confidentiality.
- S. IEHP provides Members with copies of their cases, including medical records and information used to make a decision, upon request.
- T. The Member's request for a standard appeal, fast (immediate) review or fast-track appeal may be withdrawn in writing by the Member at any time.
- U. Payment appeals are subject to IEHP's appeal/reconsideration policies.

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## 16. APPEAL AND GRIEVANCE RESOLUTION SYSTEM

### A. Appeal and Grievance Resolution Process for Members

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- V. IEHP Members have the right to appeal a determination by IEHP or hospital that inpatient care is no longer necessary. The Member may request a “fast (immediate)” Quality Improvement Organization (QIO) review by Health Services Advisory Group (HSAG). In order to be considered timely, the request must be made no later than midnight of the day of discharge, may be in writing or by telephone, and must be requested before the Member leaves the hospital.
- W. If the Member fails to meet the QIO requirement of timely appeal submission after receiving the “Important Message from Medicare (IM),” the Member may request expedited reconsideration by IEHP.
- X. Members who do not request a review and remain in the hospital past the discharge date:
1. May request QIO review at any time.
  2. May be charged for any services provided after the discharge date.
  3. Will be refunded any funds collected, if the QIO finds for the patient.
- Y. Members who miss the deadline and leave the hospital continue to have the right to request a QIO review within 30 calendar days of the date of discharge.
- Z. Upon notice from the QIO that the Member has requested an immediate review, IEHP delivers a “Detailed Notice of Discharge” to the Member as soon as possible, but no later than noon of the day after the QIO's notification as outlined in Policy 14G, “Inpatient Review – Notice of Non-Coverage of Continued Inpatient Hospital, Skilled Nursing Facility, Home Health Agency, or Comprehensive Outpatient Rehabilitation Facility Services.”
- AA. IEHP denials related to Skilled Nursing Facilities (SNFs), Home Health Agencies (HHAs), or Comprehensive Outpatient Rehabilitation Facilities (CORFs) are forwarded to the Member using a Notice of Medicare Non-Coverage (NOMNC). The Member or their authorized representative may request a “fast-track” review by HSAG of the denial decision. If a fast track review is not requested timely (by noon the following calendar day of receipt, or by noon the calendar day prior to coverage ending if the NOMNC is received more than two (2) calendar days prior to the coverage ending), an expedited review may be requested. IEHP notifies Members of their right to a “fast-track” review upon enrollment and annually thereafter, as well as upon request. “Fast-track” reviews may be requested of HSAG in writing or verbally. IEHP forwards all “fast-track” appeal requests to HSAG for processing, and cooperates with them in case resolution. If a “fast-track” case is not presented to HSAG timely, the Member may still file an expedited appeal/reconsideration request with IEHP.
- BB. Upon notice by HSAG of a fast-track appeal, IEHP or the IPA will issue a Detailed Explanation of Non-Coverage (DENC) to the Member. IEHP will provide a copy to

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## 16. APPEAL AND GRIEVANCE RESOLUTION SYSTEM

### A. Appeal and Grievance Resolution Process for Members

#### 2. Standard, Fast (Immediate), and Fast-Track Appeals

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HSAG by the end of the business day it received the notice, or the close of one (1) business day prior to the end of coverage for the Member, whichever is later. Delivery is to be expeditious, and may include personal delivery, email, or fax.

1. The DENC shall include details related to the service not being medically necessary or no longer covered. The notice also contains a description of the coverage rule, regulation, policy, contract provision, or rationale applicable, how the Member may get a copy of criteria, guidelines, or regulations, from IEHP, and any other facts relating the decision specifically to the Member.
  2. IEHP provides any requested information within one (1) business day, and is liable for costs related to a delayed decision. A decision is received from HSAG within forty-eight (48) hours upon receipt of the case. If the case is upheld, the Member may appeal via the standard appeal options of Administrative Law Judge (ALJ), Medicare Appeals Council (MAC), or civil action. If the case is overturned, IEHP will authorize or provide services within seventy-two (72) hours of receipt of that decision by HSAG, and send a Notice to Member of QIO Compliance to the Member and HSAG.
  3. The Member does not incur additional financial responsibility for covered services if HSAG overturns IEHP's denial decision, or the Member stops receiving services no later than the date of the NOMNC. IEHP shall reimburse the Member for services already paid to the SNF, HHA, or CORF, if the denial is overturned.
  4. The Member may incur one (1) calendar day of financial responsibility if HSAG upholds IEHP's denial decision, or the Member continues to receive covered services until the calendar day after the effective date of the NOMNC. The Member also may incur financial responsibility for services received if HSAG upholds the denial, and they receive services after the effective date of the NOMNC.
- CC. If IEHP does not notify a Member of the resolution to their standard appeal case within the required timeframes, the case is considered an adverse determination, and must be forwarded to Maximus within twenty-four (24) hours of the expiration of the required timeframe.

#### **PURPOSE:**

- A. To clearly define IEHP's process for addressing IEHP Medicare DualChoice (HMO SNP) Members' Standard, Fast (Immediate), and Fast-Track Appeals/Reconsiderations.

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## **16. APPEAL AND GRIEVANCE RESOLUTION SYSTEM**

- A. Appeal and Grievance Resolution Process for Members
    - 2. Standard, Fast (Immediate), and Fast-Track Appeals
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### **REFERENCES:**

- A. Medicare Managed Care Manual, Chapter 13 and 18
- B. Title 20, Code of Federal Regulations, Section 404.911
- C. Title 42, Code of Federal Regulations, Sections 422.560, 422.578, 422.580, 422.582, 422.590, 422.592, 422.594, 422.596, 422.602, 422.608, 422.612, 422.618, 422.622, 422.624, 422.626
- D. Social Security Act, Section 205 (g)
- E. National Committee for Quality Assurance (NCQA) Standards for Health Plan Accreditation

### **PROCEDURE:**

- A. All Member standard appeals received by IEHP are resolved as follows (see Attachment 16-9 in Section 16, “Attachments”):
  - 1. IEHP Members may request a standard appeal after receiving an initial determination to deny, modify or terminate services or Part D drug coverage.
  - 2. IEHP Members or their authorized representative may request (oral or written) an expedited appeal/reconsideration within sixty (60) calendar days from receipt of the initial adverse determination, or the Member may submit a written request for filing time extension, noting good cause for delay. Standard appeals must be filed in writing.
  - 3. IEHP Grievance staff enters the case into the computer system and assigns the case to Appeals/Grievance staff.
  - 4. 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.
  - 5. IEHP Grievance staff mails an acknowledgment letter to the Member and Provider within five (5) calendar days. The letter informs the Member of his/her rights and refers the Member to the IEHP Medicare DualChoice (HMO SNP) Member Handbook/Evidence of Coverage (EOC) for additional information on the appeals and grievance process.
  - 6. IEHP mails a denial introduction letter to the Member’s primary care physician (PCP), along with a copy of the Member’s acknowledgment letter (if determined

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## 16. APPEAL AND GRIEVANCE RESOLUTION SYSTEM

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not expeditable). A copy of the letter is also mailed to the PCP's affiliated Provider. The letter informs the PCP that the Member filed a request for a reconsideration regarding a denial or modification of health care services (see Attachment 16-3 in Section 16, "Attachments").

7. For reconsiderations 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.
8. IEHP may request additional information or medical records from a practitioner or Provider, as necessary. 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.
9. IEHP may extend the deadline for appeal resolution up to fourteen (14) calendar days if the Member requests the extension or if IEHP justifies a need for additional information and how the delay is in the interest of the Member.
10. When IEHP extends the timeframe, it must notify the Member in writing of the reasons for the delay, and inform the Member of the right to file an expedited grievance if he or she disagrees with IEHP's decision to grant an extension.
11. 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.
12. IEHP must notify the Member of its determination as expeditiously as the Member's health condition requires but no later than thirty (30) calendar days for standard service requests or seven (7) days for Part D requests from the date of appeal receipt, or upon expiration of the extension.
13. If the denial is overturned, the Member is notified verbally or in writing within thirty (30) calendar days of standard appeal receipt (7 days for Part D).
  - a. Verbal notice is followed in writing within three (3) calendar days; not to exceed thirty (30) days from appeal receipt (7 days for Part D).
  - b. Upon notification of overturn, the Provider making the initial determination is required to issue the approved authorization within two (2) business days to Member. IEHP, Grievance staff, requesting Provider, and Provider of Service.
  - c. The requesting Provider is notified in writing within thirty (30) calendar days of appeal receipt for service requests. The Member and Provider are notified in writing within seven (7) days for Part D.

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## 16. APPEAL AND GRIEVANCE RESOLUTION SYSTEM

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#### 2. Standard, Fast (Immediate), and Fast-Track Appeals

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- d. Services are authorized or provided within thirty (30) days of receipt of the case (7 days for Part D), or upon expiration of extension, and as soon as medically necessary, based on the Member's medical condition.
  - e. IEHP works with the practitioner and/or Provider to coordinate the Member's care as expeditiously as necessary related to the Member's medical condition.
  - f. For appeal cases 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.
  - g. IEHP's Claims Department is notified, if applicable.
  - h. If the review indicates that case management would benefit the Member, the case is forwarded to Care Management staff to follow the Member's care coordination needs.
14. If IEHP upholds the contracted Provider's decision to deny, modify, or terminate the Member's referral, IEHP concurrently notifies the Member and Provider in writing of the decision within thirty (30) days of case receipt (7 days for Part D), or no later than expiration of extension; no later than twenty-four (24) hours from decision for Part D. For non-Part D appeals, the same notification informs the Member and Provider that the case has been submitted to Maximus.
- a. IEHP submits the case to Maximus within thirty (30) days of case receipt, or no later than expiration of extension.
  - b. Maximus reviews the case and notifies IEHP, the Member and CMS of their final determination within thirty (30) days of case receipt.
  - c. IEHP monitors the case status, and contacts Maximus to determine the final status, if notification is not received within the required timeframe.
  - d. For appeal cases 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.
  - e. If the IRE (Maximus) determines that the denial is to be overturned, IEHP authorizes or provides the service within seventy-two hours of IRE reversal notice. For ALJ or higher notice, the service is authorized or provided within sixty (60) days.
    - 1) IEHP informs Maximus that IEHP has effectuated the decision, via the Maximus Statement of Compliance Form.
    - 2) IEHP's Claims Department is notified, if applicable.

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## 16. APPEAL AND GRIEVANCE RESOLUTION SYSTEM

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- 3) If the review indicates that case management would benefit the Member, the case is forwarded to Care Management staff to follow the Member's care coordination needs.
- B. A Member or their representative may request a hearing before an Administrative Law Judge (ALJ), if the value of the service they are seeking is one-hundred-dollars (\$100), or more. An ALJ hearing may be requested by notifying IEHP or the CMS entity, in writing, within sixty (60) calendar days of notice of a final adverse determination. An extension of this timeframe may be granted to the Member or their representative due to good cause, as evidenced in writing.
1. IEHP does not have the right to request an ALJ hearing.
  2. IEHP forwards all Member requests for an ALJ hearing to the CMS entity.
  3. If the ALJ reverses IEHP's initial denial, in whole or in part, IEHP provides the services within sixty (60) calendar days of receiving notice of the overturn.
- C. The Member or IEHP may request a Medicare Appeals Council (MAC) review of the decision. IEHP does not provide the services until a decision is received from the MAC. IEHP notifies the CMS entity when the services are provided
1. MAC review must be requested in writing within sixty (60) calendar days of receipt of the ALJ decision.
  2. If IEHP receives a Member request for MAC review, a copy of the request, along with all available case information, is forwarded with a cover letter to MAC.
  3. IEHP notifies Members and Maximus when requesting a MAC review.
  4. If IEHP's denial is overturned in whole, or in part, IEHP provides the service in question within sixty (60) calendar days, and notifies Maximus when the decision is effectuated.
- D. Judicial review of an ALJ decision may be requested by the Member or IEHP if MAC denies a request for review, and the amount in question meets current criteria. The action must be filed as a civil action in a district court.
1. Judicial review of a MAC decision may be requested by the Member or IEHP if MAC denied a request for review, or it is the final decision, and the amount in question meets current criteria. The action must be filed as a civil action in a district court.
  2. IEHP notifies all parties involved in the reconsideration case prior to requesting a judicial review.
  3. If IEHP is reversed, IEHP will authorize the services and provide for the services within fourteen (14) days, or as expeditiously as the Member's medical condition

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## 16. APPEAL AND GRIEVANCE RESOLUTION SYSTEM

### A. Appeal and Grievance Resolution Process for Members 2. Standard, Fast (Immediate), and Fast-Track Appeals

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dictates. IEHP will notify the CMS entity of the action it has taken. If IEHP's denial decision is reversed by an ALJ or higher hearing, IEHP will provide the services in question within sixty (60) calendar days of receipt of notice from the judicial reviewer, or as expeditiously as the Member's medical condition dictates, and will notify Maximus when the decision is effectuated.

4. Judicial review is not an option until MAC has acted on the case.
- E. Any potential network problems, including a delay in the referral process or quality of care issues, are forwarded to the IEHP Quality Management Department.
- F. Members may receive a copy of their case file, other than Peer Review protected information, upon request.
- G. The Quality Management Committee receives quarterly reports from the Grievance Committee related to the tracking and trending of appeal data. Aggregate information is then forwarded to IEHP's governing board for review.
- H. All inpatient hospital care appeals received by IEHP are resolved as follows, and known as the "fast" appeals process:
1. When an IEHP Member disagrees with the discharge decision, or IEHP no longer intends to continue coverage of the inpatient stay, IEHP or its delegate (hospital) must provide an "Important Message from Medicare (IM)."
  2. IEHP or its delegate must deliver the IM within two (2) calendar days of admission or at preadmission, but not more than seven (7) calendar days before admission notification as outlined in Policy 14G, "Inpatient Review – Notice of Non-Coverage of Continued Inpatient Hospital, Skilled Nursing Facility, Home Health Agency, or Comprehensive Outpatient Rehabilitation Facility Services."
  3. The Member may request an immediate or "fast" review from the QIO (Health Services Advisory Group) no later than midnight of the day of discharge. If an untimely request is received by the QIO, the QIO sends the review request to IEHP.
    - a. The QIO notifies IEHP on the same date that the QIO received the Member's request. If the request is received by the QIO after the QIO's business hours, the QIO notifies IEHP immediately the next morning.
    - b. If the QIO call comes to the IEHP UM Department, or IEHP inpatient review nurse, the IEHP Grievance Department is notified immediately.
    - c. The Grievance Department creates an electronic case file and notifies the inpatient review nurse immediately for any information requested by the QIO.

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- d. The Grievance Department sends to the QIO all clinical information gathered from the inpatient review nurse and the hospital.
- e. Upon notification by the QIO of the Member's request for an immediate review, IEHP and the hospital must supply all information that the QIO needs to make its determination, including copies of both the IM and the Detailed Notices, as soon as possible, but no later than noon of the day after the QIO notifies the hospital of the request.
- f. In response to a request from IEHP, the hospital must supply all information that the QIO needs to make its determination, including copies of both the IM and the Detailed Notices (if applicable) as soon as possible, but no later than close of business of the day IEHP notifies the hospital of the request for information.
- g. At the request of the Member, IEHP must furnish the enrollee with a copy of, or access to, any documentation that it sends to the QIO, including written records of any information provided by telephone. IEHP may charge the enrollee a reasonable amount to cover the costs of duplicating the documentation and/or delivering it to the Member. IEHP must accommodate the request by no later than close of business of the first day after the material is requested.
- h. Timely request: If the Member's request is received timely, the QIO makes their determination and notifies the Member, hospital, physician, and IEHP within one calendar day after it receives all requested pertinent information.
- i. Grievance staff notifies the IEHP inpatient review nurse, and the Grievance staff or inpatient review nurse notifies the IPA, depending on the specific care coordination needs of the Member.
- j. IEHP is financially responsible until noon of the first calendar day after the QIO notifies the Member of the determination.
- k. Liability for further inpatient hospital services depends on the QIO decision:
  - 1) Unfavorable determination: If the QIO notifies the Member that the QIO did not agree with the Member, liability for continued services begins at noon of the day after the QIO notifies the enrollee that the QIO agreed with the hospital's discharge determination, or as otherwise determined by the QIO.
  - 2) Favorable determination: If the QIO notifies the Member that the

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## 16. APPEAL AND GRIEVANCE RESOLUTION SYSTEM

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QIO agreed with the Member, the Member is not financially responsible for continued care (other than applicable coinsurance and deductibles) until IEHP and the hospital once again determine that the Member no longer requires inpatient care, secure the concurrence of the physician responsible for the Member's care, and the hospital notifies the Member with a follow-up copy of the IM.

4. If the Member fails to submit a timely request (after midnight of the day of discharge), the Member may request a “fast” review from IEHP. This “fast” review is now called an expedited reconsideration/appeal.
  - a. If the QIO or Member’s call comes to the IEHP UM Department, or IEHP inpatient review nurse, the IEHP Grievance Department is notified immediately.
  - b. The Grievance Department creates an electronic case file and immediately requests clinical information from the inpatient review nurse and the hospital.
  - c. IEHP makes a decision within seventy-two (72) hours and notifies the Member, hospital, attending physician, and the IEHP inpatient review nurse.
  - d. The Member does not have financial protection and may be responsible for the cost of services beginning on the date of first non-covered day, if denial upheld.
  - e. The Member or IEHP may extend the review up to fourteen (14) extra calendar days if the Member requests the extension, or IEHP justifies that the extension is in the Member’s best interest. The Member does not have financial protection.
  - f. If the Member receives a favorable reconsideration, IEHP must continue covering the care and/or refund the Member for any expenses the Member incurred during the review.
- I. All appeals for termination of Provider services related to Home Health Agencies (HHAs), Skilled Nursing Facilities (SNFs), or Comprehensive Outpatient Rehabilitation Facilities (CORFs) are resolved as follows, and known as the “fast-track” appeals process:
  1. No later than two (2) days before termination of services, IEHP UM or IEHP’s delegate (facility or vendor) delivers a Notice of Medicare Non-Coverage (NOMNC). A NOMNC is not used for exhaustion of benefits.

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2. If the Member disagrees with the discharge notice, the Member or their authorized representative may request an immediate/expedited appeal from the QIO no later than noon of the day before the date that services will end (stated on the NOMNC). The QIO sends the request to IEHP if received later than noon.
  - a. The QIO immediately notifies IEHP that Member's request is received.
  - b. If the QIO call comes to the IEHP UM Department, or the IEHP inpatient review nurse, the IEHP Grievance Department is immediately notified.
  - c. Grievance Department staff creates an electronic case file and immediately notifies the inpatient review nurse.
  - d. No later than close of business on the day of notification from the QIO, or close of business on the day before discharge, whichever is later, the inpatient review nurse issues the Detailed Explanation of Non-Coverage (DENC) to the Member, with copy to the Grievance Department.
  - e. Grievance staff sends to the QIO all clinical info gathered from the inpatient review nurse, and Provider (facility or vendor).
  - f. No later than date of termination of services or close of business on day after the QIO receives all necessary information, the QIO makes their determination and notifies the Member and IEHP.
  - g. Grievance staff notifies the IEHP inpatient review nurse, and the Grievance staff or inpatient review nurse notifies the Provider, depending on the specific care coordination needs of the Member.
  - h. The Member does not have financial protection and may be responsible for the cost of services beginning on the date of the first non-covered day, if the denial is upheld by the QIO.
3. If the Member misses the QIO deadline of submission by noon of the day before the date that services will end (stated on the NOMNC), the Member may request a "fast-track" review from IEHP. This "fast-track" review is now called an expedited reconsideration/appeal.
  - a. If the QIO or Member's call comes to the IEHP UM Department, or IEHP inpatient review nurse, the IEHP Grievance Department is notified immediately.
  - b. Grievance staff creates an electronic case and the Chief Medical Officer or Medical Director determines if the case meets criteria for expedited review (standard timeframe could seriously jeopardize life, health or ability to regain maximum function).

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#### 2. Standard, Fast (Immediate), and Fast-Track Appeals

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- c. Grievance staff immediately notifies IEHP UM and/or the inpatient review nurse of appeal receipt and if expeditable; if not expedited, the standard appeals process will be followed.
- d. The Grievance Department creates an electronic case and immediately requests clinical information from IEHP UM or the inpatient review nurse and the Provider.
- e. If the case is expedited, IEHP makes the decision within seventy-two (72) hours and notifies the Member, Provider, attending physician, and UM and/or inpatient review nurse.
- f. If the case is not expedited, IEHP follows the standard appeal process and makes the decision within thirty (30) days.
- g. The Member does not have financial protection and may be responsible for the cost of services beginning on the date of the first non-covered day, if the denial is upheld.
- h. The Member or IEHP may extend the review up to fourteen (14) extra calendar days if the Member requests the extension, or IEHP justifies that the extension is in the Member's best interest. The Member does not have financial protection.

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## **16. APPEAL AND GRIEVANCE RESOLUTION SYSTEM**

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

### **APPLIES TO:**

- A. This policy applies to all IEHP Medicare DualChoice (HMO SNP) Providers.

### **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 appeals and/or grievances, including those involving claims, billing, capitation, enrollment, contracting or UM/medical necessity to IEHP for the initial appeal and grievance resolution process.
- C. All Provider appeals and/or grievances involving capitation, enrollment, contracting or UM/medical necessity must be submitted to the Payor within 30 calendar days of the last date of action on the issue requiring resolution.
- D. Contracted providers do not have claim payment appeal rights under this policy. Payment appeals received from contracted providers are handled in accordance with Medi-Cal Policy 20A1, “Provider Dispute Resolution Process – Initial Claims Disputes.”
- E. Payors must identify and acknowledge the receipt of all Provider appeals and/or grievances within 5 calendar days of receipt of a written appeal and/or grievance.
- F. Payors must resolve appeals and/or grievances and issue a written determination within 30 calendar days of receipt of an appeal and/or grievance.
- G. A Provider of service may submit an appeal regarding the outcome of a Payor’s appeal and grievance resolution to IEHP within 30 calendar days of receipt of the written appeal or grievance determination letter from the Payor.
- H. A Provider of service can appeal any adverse determination by IEHP. If the denial is upheld, the denial must then be forwarded to the IEHP Grievance Department as outlined in Policy 16B3, “Appeal and Grievance Resolution Process for Providers of Service: Provider Appeals of UM Decisions.”
- I. Payors must not discriminate against Providers of Service for filing appeals and/or grievances.
- J. A Provider of service may withdraw an appeal and/or grievance at any time by notifying the Payor in writing.

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## 16. APPEAL AND GRIEVANCE RESOLUTION SYSTEM

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

### **PROCEDURE:**

- A. Providers of service must submit all appeals and/or grievances, including capitation, enrollment, contracting issues, or those involving UM/medical necessity, in writing to the Payor within 30 calendar days of the last date of action on the issue requiring resolution. Justification and supporting documentation must be provided with the written appeal and/or grievance.
- B. Appeals and/or grievances are categorized as follows, for tracking and monitoring purposes:
  - 1. Claims Payment Determination – Payment appeals received from contracted providers are handled in accordance with Medi-Cal Policy 20A1, “Provider Dispute Resolution Process – Initial Claims Disputes.”
  - 2. Contract - any formal written disagreement concerning the interpretation, implementation, renewal or termination of a contractual agreement.
  - 3. UM/Medical Necessity - any formal written disagreement concerning the need, level or intensity of health care services provided to Members.
  - 4. Other – all other grievances/or appeals received by Payor including enrollment, capitation or other provider related issues
  - 5. If an appeal and/or grievance 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: Initial Claims Payment Appeals”, and sent to:

**Inland Empire Health Plan  
Claims Appeals  
P.O. Box 10276  
San Bernardino, CA 92423**
  - 6. If an appeal and/or grievance involves P4P reimbursements, the written request must be filed in accordance with the guidelines provided in Policy 19C, “Pay For Performance.”
  - 7. If the appeal and/or grievance is not about a claim payment determination, (i.e. capitation, enrollment, contracting, etc.) the written request must include a clear explanation of the issue and the appeal and/or grievance must be filed in accordance with the Payor’s appeal and grievance filing guidelines.
  - 8. If the appeal and/or grievance is filed on behalf of a Member, the appeal and/or grievance is considered a Member appeal and/or grievance, subject to the requirements of the Member Grievance Resolution process, as outlined in Policy

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## 16. APPEAL AND GRIEVANCE RESOLUTION SYSTEM

### B. Appeal and Grievance Resolution Process for Providers of Service

#### 1. Initial Appeal and Grievance Resolution

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16A, “Member Appeal and Grievance Resolution Process.”

- C. Payors must identify and acknowledge in writing the receipt of each appeal and/or grievance, whether or not complete, and disclose the recorded date of receipt within 5 calendar days of receipt (see Attachment 16-4a in Section 16, “Attachments”).
- D. If an appeal and/or grievance is incomplete, or if the information is in the possession of the Provider of service and not readily accessible to the Payor, the Payor may return the appeal and/or grievance with a clear explanation, in writing, of any information missing that is necessary to resolve the appeal and/or grievance. The Provider of service has 5 calendar days to resubmit an amended appeal and/or grievance with the missing information.
- E. Payors must make every effort to investigate and take into consideration all available information submitted and may further investigate and/or request additional information or discuss the issue with the involved Providers of service.
- F. Payors must send written notice of the resolution, including pertinent facts and an explanation of the reason for the determination, within 30 calendar days of the receipt of the appeal and/or grievance for decisions not involving claims payment.
- G. Providers of service dissatisfied with the resolution of any appeal and/or grievance **not** involving claims or billing (i.e. capitation, enrollment) may appeal to IEHP in writing, as outlined in Policy 16B2, “Appeal and Grievance Resolution Process for Providers of Service: Health Plan Appeals and Grievances.”
- H. Providers of service not satisfied with the initial determination by the Payor, **and** the determination is related to medical necessity or utilization management, have the right to appeal directly to IEHP within 30 calendar days of receipt of the written determination by submitting a written request for review as outlined in Policy 16B2, “Appeal and Grievance Resolution Process for Providers of Service: Health Plan Appeals and Grievances.”
- I. Furthermore, Providers of service dissatisfied with the outcome of an appeal and/or grievance originally filed with the Payor that involves pre-service referral denials or modifications may submit an appeal to IEHP in accordance with Policy 16B3, “Appeal and Grievance Resolution Process for Providers of Service: Provider Appeals of UM Decisions.”
- J. No retaliation can be made against a Provider of service who submits an appeal and/or grievance in good faith.
- K. Copies of all appeals and/or grievances from Providers of service, and related documentation, must be retained for at least ten years.

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## 16. APPEAL AND GRIEVANCE RESOLUTION SYSTEM

### B. Appeal and Grievance Resolution Process for Providers of Service

#### 1. Initial Appeal and Grievance Resolution

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

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## **16. APPEAL AND GRIEVANCE RESOLUTION SYSTEM**

- B. Appeal and Grievance Resolution Process for Providers of Service**
    - 2. Health Plan Appeals and Grievances**
- 

### **APPLIES TO:**

- A. This policy applies to all IEHP Medicare DualChoice (HMO SNP) Providers.

### **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 appeals and/or grievances to IEHP for the initial appeal and grievance resolution process.
- C. All initial appeals and/or grievances must be submitted to the Payor within 30 calendar days of the last date of action on the issue requiring resolution.
- D. Payors must resolve appeals and/or grievances within 30 calendar days of receipt of an appeal and/or grievance.
- E. A Provider of service may appeal the outcome of the Payor’s appeal and grievance resolution to IEHP within 30 calendar days of receipt of the written determination from the Payor. Providers of service have 30 calendar days from the date of determination to file an appeal to IEHP for appeal and/or grievance wherein the determination involves medical necessity or utilization management. IEHP maintains written policies and procedures for processing of Payor/Provider of service denial related appeals and/or grievances regarding UM decisions. IEHP makes final decisions on appeals of UM denials and UM related grievances within 30 days of receipt.
- F. A Provider of service can appeal to IEHP for any adverse determination by a Payor. Appeals of referral denials, or modifications, must be initially appealed to the appropriate Payor. 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.”
- G. IEHP does not discriminate against Providers of service for filing appeals and/or grievances.
- H. A Provider of service may withdraw an appeal and/or grievance at any time by notifying IEHP in writing.

### **PROCEDURE:**

- A. Providers of service must submit written appeals and/or grievances to the Payor within 30 calendar days of the last date of action on the issue requiring resolution as outlined in

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## 16. APPEAL AND GRIEVANCE RESOLUTION SYSTEM

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

Policy 16B1, “Appeal and Grievance Resolution Process for Providers of Service: Initial Appeal and Grievance Resolution.” Justification and supporting documentation must be provided with the written appeal and/or grievance. Payors must send written notice of the resolution of the appeal and/or grievance within 30 calendar days of receipt of the appeal and/or grievance.

- B. Providers of service may submit written appeals regarding payment or denial decisions on adjudicated claims, including payment denials for procedures, referrals or services by following the process outlined in Policy 20A1, “Claims Processing: Initial Claims Payment Appeals.”
- C. Providers of service dissatisfied with the written resolution of a grievance may appeal the decision to IEHP within 30 calendar days of receipt of the written determination from the Payor.
  - 1. A Provider of service must submit a written appeal to IEHP within 30 calendar days of receipt of resolution from the Payor regarding the initial appeal and/or grievance. Appeals and/or grievances should be sent to:

**Inland Empire Health Plan  
Attn: 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 30 calendar days, from receipt of the determination on the initial appeal and/or grievance, to submit a written appeal.
- b. The written appeal must include a copy of the initial grievance resolution being appealed and additional supporting documentation to justify the appeal.
- 2. All appeals and/or grievances must be identified and acknowledged in writing, whether or not complete, and disclose the recorded date of receipt within 5 calendar days of receipt (see Attachments 16-4, and 16-4a in Section 16, “Attachments”).
- 3. Grievances and/or appeals are defined as medical and non-medical. Medical and non-medical grievances are resolved separately:
  - a. Non-medical grievances 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

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## 16. APPEAL AND GRIEVANCE RESOLUTION SYSTEM

### B. Appeal and Grievance Resolution Process for Providers of Service

#### 2. Health Plan Appeals and Grievances

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- Issues or problems related to IEHP administrative and operational policies and procedures.
- b. Medical appeals and grievances are forwarded to IEHP's 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 medical policies and procedures.
- 4. Medical appeals and/or grievances involving current patient care are resolved according to the IEHP Grievance process, as outlined in Policy 16B3, "Appeal and Grievance Resolution Process for Providers of Service: Provider Appeals of UM Decisions", and the immediacy of the situation. Otherwise, medical and non-medical appeals and grievances are resolved within 30 calendar days. IEHP resolves the appeal and/or grievance by considering all 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 and/or grievance is resolved, IEHP mails a copy of the final disposition to the Provider of service within 30 calendar days of appeal or grievance receipt with a courtesy copy to the Payor (see Attachment 16-5 in Section 16, "Attachments").
- D. If the Provider of service is still not satisfied with the outcome of IEHP's appeal or grievance determination, the Provider of service may request that the IEHP Peer Review Committee (for medical decision) or IEHP's Chief Executive Officer and/or Governing Board (for non-medical decision) review the case. Requests for Peer Review must be received within 30 days from the date the Provider of service received the grievance or appeal resolution from IEHP. The IEHP Peer Review committee determines medical issues only. Decisions of the Peer Review committee or the IEHP Chief Executive Officer and/or Governing Board are final.
  - E. If IEHP receives an initial dispute directly from a Provider of service, IEHP will forward the appeal and/or grievance to the financially responsible Payor for resolution, as applicable and notify the Provider of service.
  - 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 (CMO) or designee reviews

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## 16. APPEAL AND GRIEVANCE RESOLUTION SYSTEM

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

the information, and makes a determination within 30 days. The Provider of service receives an acknowledgement letter, and a resolution letter notifying them of the final decision (see Attachments 16-4 and 16-5 in Section 16, “Attachments”).

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## 16. APPEAL AND GRIEVANCE RESOLUTION SYSTEM

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

### **APPLIES TO:**

- A. This policy applies to all IEHP Medicare DualChoice (HMO SNP) Practitioners/Providers of services 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. A Provider is automatically considered a Member’s representative when submitting an appeal for a denial of an urgent referral request. In this case, the appeal is considered a Member appeal, and processed in accordance with Policies 16A, “Appeal and Grievance Resolution Process for Members - Standard and Expedited,” 16A1 “Urgent (Expedited) Appeals,” and 16A2 “Standard, Fast (Immediate), and Fast-Track Appeals.” In addition, upon notice to Member, Physicians and other prescribers may request standard reconsiderations and redeterminations on a Member’s behalf without having been appointed as the representative.
- C. If a Provider 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.
- D. IEHP does not discriminate against Providers or practitioners for filing appeals.
- E. A Provider or practitioner may withdraw an appeal at any time by notifying IEHP in writing.
- F. 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.
- G. Provider appeals of adverse payment decisions are discussed in Provider Manual Policies 16B1, “Appeal and Grievance Resolution Process for Providers of Service – Initial Appeal and Grievance Resolution” and 16B2, “Appeal and Grievance Resolution Process for Providers of Service – Health Plan Appeals and Grievances.”
- H. Provider appeals filed on behalf of Members or as Member representative, are classified as Member appeals, and processed per Policies 16A, “Appeal and Grievance Resolution Process for Members,” 16A1, “Urgent (Expedited) Appeals, and 16A2 “Standard, Fast

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## **16. APPEAL AND GRIEVANCE RESOLUTION SYSTEM**

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

(Immediate), Fast-Track Appeals.”

### **PURPOSE:**

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

### **REFERENCES:**

- A. Medicare Managed Care Manual, Chapter 13
- B. Title 42, Code of Federal Regulations

### **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 in process, 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 16-4 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 is obtained as outlined in Policies 16A1, “Urgent (Expedited) Appeals” and 16A2 “Standard, Fast (Immediate), and Fast-Track Appeals.”
- E. A separate electronic case is maintained for each new Provider/practitioner appeal that is

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## 16. APPEAL AND GRIEVANCE RESOLUTION SYSTEM

### B. Appeal and Grievance Resolution Process for Providers of Service

#### 3. Provider Appeals of UM Decisions

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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:

- a. Section 1 of the file folder contains:
  - 1) Checklist
- b. Section 2 of the file folder contains:
  - 1) Printout of the Automated Eligibility Verification System (AEVS) form 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.

- F. 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.
- G. If a physician requests an urgent (expedited) review, IEHP must provide an expedited reconsideration if the physician indicates that applying the standard timeframe for conducting reconsideration could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function.
- H. If the 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 16A1, "Urgent (Expedited) Appeals."
- I. The Grievance Coordinator monitors the progress of the case.
- J. 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.
- K. 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

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## 16. APPEAL AND GRIEVANCE RESOLUTION SYSTEM

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

30 calendar days of receipt of the case. The decision of IEHP's CMO (or designee) is final.

- L. 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.
  - 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 16-5 in Section 16, "Attachments").
- M. 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 or Quality Management Committee.
- N. 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, "Appeal and Grievance Resolution Process for Members."

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## **16. APPEAL AND GRIEVANCE RESOLUTION SYSTEM**

### **B. Appeal and Grievance Resolution Process for Providers of Service**

#### **4. Provider (IPA, Hospital and Practitioner) Appeals and Grievances**

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##### **APPLIES TO:**

- A. This policy applies to all IEHP Medicare DualChoice (HMO SNP) Providers (IPAs, Hospitals and Practitioners).

##### **POLICY:**

- A. Providers (IPAs, Hospitals and Practitioners) must submit all appeals and/or grievances directly to IEHP.
- B. IEHP requires all Provider appeals and grievances to be submitted in writing within 30 calendar days of the last date of action on the issue requiring resolution.
- C. IEHP must identify and acknowledge the receipt of all appeals and grievances within five calendar days of receipt of a written appeal and/or grievance (see Attachment 16-4a in Section 16 “Attachments”).
- D. IEHP attempts to resolve all appeals and/or grievances within 30 calendar days of receipt.
- E. Providers may appeal the outcome of an appeal and/or grievance resolution to IEHP within 30 calendar days of receipt of the resolution letter from IEHP.
- F. IEHP does not discriminate against Providers for filing appeals and/or grievances.
- G. A Provider may withdraw an appeal and/or grievance at any time by notifying IEHP in writing.

##### **PROCEDURE:**

- A. Appeals and/or grievances requiring resolution must be initiated by the Provider and submitted to IEHP in writing within 30 calendar days of the last date of action on the issue requiring resolution. Justification and supporting documentation must be provided with the written appeal and/or grievance and sent to:

**Inland Empire Health Plan  
Attn: Provider Services  
P.O. Box 19026  
San Bernardino, CA 92423-9026**

- B. All written Provider appeals and grievances are reviewed and evaluated by IEHP to determine medical versus non-medical related status and distributed to appropriate staff accordingly.

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## 16. APPEAL AND GRIEVANCE RESOLUTION SYSTEM

### B. Appeal and Grievance Resolution Process for Providers of Service

#### 4. Provider (IPA, Hospital and Practitioner) Appeals and Grievances

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- 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 appeals and grievances must be identified and acknowledged in writing, whether or not complete, and disclose the recorded date of receipt within five calendar days of receipt of the appeal and/or grievance (see Attachment 16-4a, in Section 16 “Attachments”).
- E. IEHP must make a good faith attempt to resolve the issue within 30 calendar days of receipt of the appeal and/or grievance.
- F. If a grievance involves P4P reimbursements, the written request must be filed in accordance with the guidelines provided in Policy 19C, “Pay For Performance.”
- G. Claims related appeals are handled in accordance with Policy 20A1, “Claims Processing: Initial Claims Payment Appeals.”
- H. Non-medically related grievances are assessed and resolved by the IEHP Director of Provider Services. Non-medically related grievances from Contracted Providers may include but are not limited to credentialing issues, capitation issues, contractual issues, enrollment issues, IEHP Staff Member or Department issues or problems related to IEHP administrative and operational policies and procedures.
- I. Medically related appeals and grievances are assessed and resolved by the IEHP Chief Medical Officer (CMO) or designee. Medically related appeals and grievances from Providers may include quality management issues, case management issues, or problems related to medical IEHP Policies and Procedures.
- J. IEHP resolves the appeal and/or grievance by considering all available information and may request additional information or discuss the issue with the involved Provider(s).
- K. When appeals and grievances are resolved, IEHP mails a copy of the final disposition to the Provider within 30 calendar days of appeal or grievance receipt (see Attachment 16-12 in Section 16, “Attachments”).
- L. Providers dissatisfied with a resolution may appeal to IEHP within 30 calendar days of receipt of the appeal or grievance resolution from IEHP.
  - 1. Providers must submit a written appeal to IEHP within 30 calendar days of receipt of the final disposition of initial appeal or grievance. The written appeal must include a copy of the initial resolution being appealed, justification and supporting documentation for the appeal.
  - 2. Non-medical grievances are forwarded to the IEHP CEO for review.

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## 16. APPEAL AND GRIEVANCE RESOLUTION SYSTEM

### B. Appeal and Grievance Resolution Process for Providers of Service

#### 4. Provider (IPA, Hospital and Practitioner) Appeals and Grievances

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3. Medical grievances are forwarded to the Peer Review Subcommittee for review.
  4. The decision of IEHP's CEO or Peer Review Subcommittee is final.
  5. IEHP mails written notice of the appeal decision within 30 days of the decision.
  6. Refer to Policy 20A1, "Claims Processing: Initial Claims Payment Appeals," for appeals or grievances relating to payment or denial of adjudicated claims.
- M. 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 16-11, in Section 16, "Attachments"). The decision of the IEHP Governing Board is final.

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## 16. APPEAL AND GRIEVANCE RESOLUTION SYSTEM

### C. Member Rights and Options

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#### APPLIES TO:

- A. This policy applies to all IEHP Medicare DualChoice (HMO SNP) Members.

#### POLICY:

- A. During the resolution process, IEHP informs Members of their rights and options, in accordance with regulatory guidelines as described in the IEHP Medicare DualChoice (HMO SNP) Member Handbook/Evidence of Coverage (EOC), Chapter 8. Members receive information regarding their rights at enrollment, and annually thereafter.
- B. In addition to the standard rights and options available to Members, they have specific rights during the appeal and grievance process. These rights include:
1. The right to have a grievance between the Member and IEHP heard and resolved in a timely manner, and in accordance with Medicare guidelines;
  2. The right to request quality of care grievance data from IEHP;
  3. The right to appeal an adverse determination;
  4. The right to an expedited appeal (reconsideration) if there is potential for loss of life, health, or ability to regain maximum function;
  5. The right to request and receive appeal data from IEHP;
  6. The right to receive notice when an appeal is forwarded to the Independent Review Entity (IRE);
  7. The right to an automatic reconsideration by the Centers for Medicare and Medicaid Services (CMS) Independent Review Entity (IRE) if IEHP upholds its original adverse determination (denial) in whole or in part;
  8. The right to a hearing by an Administrative Law Judge (ALJ) if the IRE upholds the original adverse determination in whole or in part and the monetary amount in question meets current criteria;
  9. The right to a Departmental Appeals Board (DAB) review if the ALJ hearing decision is unfavorable to the Member in whole or in part;
  10. The right to a Medicare Appeals Council (MAC) review of the ALJ's decision;
  11. The right to judicial review in civil court if the ALJ hearing and/or DAB review is unfavorable to the Member in whole or in part and the monetary amount in question meets current criteria;
  12. The right to make a quality of care complaint under the Quality Improvement Organization (QIO) process;
  13. The right to request a QIO review of a determination of non-coverage of inpatient

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## 16. APPEAL AND GRIEVANCE RESOLUTION SYSTEM

### C. Member Rights and Options

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hospital care. See Policy 16A2, “Standard, Fast (Immediate), and Fast-Track Appeals” for further information;

14. The right to request a QIO review of a determination of non-coverage in skilled nursing facilities, home health agencies and comprehensive outpatient rehabilitation facilities. See Policy 16A2 “Standard, Fast (Immediate) and Fast-Track Appeals” for further information; and
  15. The right to request a timely copy of the Member’s case file, subject to federal and state law regarding confidentiality of patient information.
- C. Members have the right to register a grievance or expedited appeal with IEHP by phone, by mail, by fax, in person, online through IEHP’s web site at [www.iehp.org](http://www.iehp.org), or with the assistance of the involved practitioner or Provider. All standard appeals must be filed in writing.
- D. Members have the right to personally register a grievance or appeal, or designate either in writing or verbally, that a relative, representative, practitioner, Provider or attorney will represent them during the process (see Attachment 16-9 in Section 16, “Attachments”). IEHP allows Members sixty (60) calendar days to file their grievance following any incident or action that is the subject of the Member’s dissatisfaction. In addition, if the Member is a minor, or is incompetent or incapacitated, a grievance or appeal may be registered on behalf of the Member by the parent, guardian, conservator, relative, attorney, 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.
- E. For grievances related to confidentiality, Members have the right to file a grievance with the IEHP Chief Privacy Officer, or the Department of Health and Human Services (DHHS) Office of Civil Rights. This information is contained in the IEHP Notice of Privacy Practices (NPP).
- F. Members have the right to submit written comments, documents or other information relating to their case. This information is relayed to the Member during the triage of the case by a Grievance Nurse and in writing per the IEHP Medicare DualChoice (HMO SNP) Member Handbook/ Evidence of Coverage (EOC).
- G. Members have the right to file a grievance or appeal without discrimination from the Practitioner or Provider. Any case 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 immediately to the IEHP Grievance Department at (909) 890-5748. IEHP resolves discrimination grievances as outlined in the Grievance Resolution Process. See Policy 16A, “Appeal and Grievance Resolution Process for Members – Standard and Expedited” for more information.
- H. Members have the right to an expedited review and resolution of their urgent grievances

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## 16. APPEAL AND GRIEVANCE RESOLUTION SYSTEM

### C. Member Rights and Options

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within 24 hours if the Member has received notice that: (1) the reconsideration/appeal request or organizational determination is not expeditable, (2) the Part D drug coverage determination or redetermination is not expeditable and the drug has not yet been received, or (3) IEHP is extending the expedited appeal or organizational determination timeframe.

- I. Members have the right to an expedited review of their urgent appeal within 72 hours if their medical condition involves an imminent and serious threat to their health, including but not limited to, loss of life, health, or ability to regain maximum function. Refer to Policy 16A1, “Urgent (Expedited) Appeals.”

#### **PURPOSE:**

- A. To define the rights and options available to IEHP Medicare DualChoice (HMO SNP) 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 42, Code of Federal Regulations, Sections 422.110, 422.112, 422.562
- B. IEHP Medicare DualChoice (HMO SNP) Member Handbook/Evidence of Coverage (EOC)
- C. Medicare Contract
- D. Medicare Managed Care Manual, Chapter 13

#### **PROCEDURES:**

- A. Grievance Nurses inform Members of their right to submit written comments, documents or other information relating to their case during the triage of the case. In addition, these rights are submitted to Members in writing per the IEHP Medicare DualChoice Member (HMO SNP) Handbook/ Evidence of Coverage (EOC).
- B. IEHP processes appeal requests only after confirming that the requesting party is the Member, or the Member’s authorized representative, per federal regulations. IEHP recognizes the term authorized party to include: a Member (or authorized representative), an assignee that is non-contracted, but has provided services, and formally waives the right to payment from the Member, the legal representative of a Member’s estate, and any other Provider or entity, other than IEHP, having an interest in the case.
- C. If IEHP is unable to establish authorization to file a case, IEHP must submit the case to the CMS independent review entity (IRE) for resolution and approval for closure. The

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## 16. APPEAL AND GRIEVANCE RESOLUTION SYSTEM

### C. Member Rights and Options

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IRE will review IEHP's efforts to gain proof of authorization.

- D. If the Member or Provider subsequently submits documentation of authorized status, a new case is submitted to the IRE (Maximus); the old case is not reopened.
- E. If the Member is incapacitated or incompetent and cannot sign an appointment of legal representation, IEHP will gain legal counsel opinion to assure compliance in filing of the appeal case, and utilizes the *Medicare Managed Care Reconsideration Background Data Form*.
- F. Confidentiality (HIPAA Violation) Issues: All existing IEHP Members received notification of the IEHP Notice of Privacy Practices (NPP) by the effective regulatory date of April 14, 2003. All new IEHP Members are informed of the NPP upon enrollment. In addition, the NPP is made available to Members upon request and is available online through IEHP's web site.

INLAND EMPIRE HEALTH PLAN		
<b>Chief Approval:</b> <i>Signature on file</i>	<b>Effective date:</b>	January 1, 2007
<b>Chief Title:</b> Chief Medical Officer	<b>Revised date:</b>	January 1, 2012

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## 16. APPEAL AND GRIEVANCE RESOLUTION SYSTEM

### Attachments

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<u>ATTACHMENT</u>	<u>DESCRIPTION</u>	<u>POLICY CROSS REFERENCE</u>
16-1	IEHP Medicare Member Appeal & Grievance Form	
	a. English	16A
	b. Spanish	16A
16-2	First and Final Notice	16A
16-3	Denial Upheld Resolution Letter – PCP/Dentist	16A2
16-4	Provider Second Level Appeal of UM Decision – Acknowledgment Letter	16B3
16-4a	Provider Grievance Acknowledgement Letter	16B1, 16B2, 16B4
16-5	Provider Appeal of UM Decision Denial Resolution Letter	16B3
16-6	Appointment of Representative Statement - CMS Form 1696	
	a. English	16A
	b. Spanish	16A
16-7	Standard Grievance Process Flowchart	16A
16-8	Expedited Grievance Process Flowchart	16A
16-9	Standard Reconsideration/Appeal Process Flowchart	16A, 16A1, 16A2, 16C
16-10	Expedited Reconsideration/Appeal Process Flowchart	16A, 16A1
16-11	Provider Fair Hearing Process	16B4
16-12	Provider Grievance Resolution Letter	16B4



# California Medicare Advantage Plan Member Appeal & Grievance Form

(Non-Medicare Advantage IEHP members should use the "IEHP Member Complaint Form")

This form is for your use in making suggestions, filing a formal complaint, or appeal regarding any aspect of the care or service provided to you. IEHP Medicare DualChoice HMO SNP **is required by law** to respond to your complaints or appeals, and a detailed procedure exists for resolving these situations. If you have any questions, please feel free to call IEHP Member Services at 1-877-273-IEHP (4347) or 1-800-718-4347 (TTY), from 8:00 am to 8:00 pm (PST), 7 days a week, including holidays. IEHP's Member Services contact information may also be found on your IEHP card. 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.

**Please print or type the following information:**

Member Name (Last, first, middle initial) _____		IEHP I.D. CARD Number _____
Member Address _____		Home Phone number _____
City, State, Zip _____		Work or Message Phone number _____
Medicare Number _____	Male/Female _____	Date of Birth _____

*Authorized Representative: If the complaint is filed by someone other than the member, please review the section called "Who may file an Appeal" and provide the following information:*

Name: \_\_\_\_\_ Telephone # \_\_\_\_\_

Relationship to Member: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**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)/TIME(S)) \_\_\_\_\_

WHO WAS INVOLVED? \_\_\_\_\_

PLEASE DESCRIBE WHAT HAPPENED. (ATTACH COPIES OF ANY ADDITIONAL INFORMATION, IF NECESSARY)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Please sign and MAIL OR FAX THIS FORM TO:** INLAND EMPIRE HEALTH PLAN  
Attn: Appeal and Grievance Department, P.O. Box 19026, San Bernardino, CA 92423-9026  
Fax # (909) 890-5748; For Questions Call 1-877-273-IEHP (4347) or 1-800-718-4347 TTY, from 8:00 am to 8:00 pm (PST), 7 days a week, including holidays.

**Date** \_\_\_\_\_ **Member Signature** \_\_\_\_\_

**Date** \_\_\_\_\_ **Signature of Representative** \_\_\_\_\_

**Information for all Medicare Advantage Members (OMB Approval No. 0938-NEW Form No. HCFA-10003-NDMC (June 2001)):**

### **You may have the right to appeal.**

To exercise your appeal rights, file your appeal in writing within 60 calendar days after the date of your original denial notice. Your plan can give you more time if you have a good reason for missing the deadline.

### **Who May File An Appeal?**

You or someone you name to act for you (your **authorized representative**) may file an appeal. You can name a relative, friend, advocate, attorney, doctor, or someone else to act for you. Others, not previously mentioned may already be authorized under State law to act for you.

You can call us at: 1-877-273-IEHP (4347) to learn how to name your authorized representative. If you have a hearing or speech impairment, please call us at TTY/ TDD 1-800-718-4347, from 8:00 am to 8:00 pm (PST), 7 days a week, including holidays.

If you want someone to act for you, you and your authorized representative should sign, date, and send us page 1 of this form, which will serve as a statement naming that person to act for you.

### **IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS**

*For more information about your appeal rights, call your plan or see your Evidence of Coverage.*

#### **There Are Two Kinds of Appeals You Can File:**

**Standard (30 days)** - You can ask for a standard appeal. Your plan must give you a decision no later than 30 days after it gets your appeal. (Your plan may extend this time by up to 14 days if you request an extension, or if it needs additional information and the extension benefits you.)

**Fast (72-hour review)** - You can ask for a fast appeal if you or your doctor believe that your health could be seriously harmed by waiting too long for a decision. Your plan must decide on a fast appeal no later than 72 hours after it gets your appeal. (Your plan may extend this time by up to 14 days if you request an extension, or if your plan needs additional information and the extension benefits you.)

- If any doctor asks for a fast appeal for you, or supports you in asking for one, and the doctor indicates that waiting for 30 days could

seriously harm your health, your plan will automatically give you a fast appeal.

- If you ask for a fast appeal without support from a doctor, your plan will decide if your health requires a fast appeal. If your plan does not give you a fast appeal, your plan will decide your appeal within 30 days.

#### **What Do I Include With My Appeal?**

You should include: your name, address, Member ID number, reasons for appealing, and any evidence you wish to attach. You may send in supporting medical records, doctors' letters, or other information that explains why your plan should provide the service.

Call your doctor if you need this information to help you with your appeal. You may send in this information or present this information in person if you wish.

## How Do I File An Appeal?

**For a Standard Appeal:** You or your authorized representative should mail or deliver your written appeal to your health plan at the address indicated on the California Medicare Advantage Plan Member Appeal & Grievance Form.

**For a Fast Appeal:** You or your authorized representative should contact us by telephone or fax using the plan contact information indicated on the California Medicare Advantage Plan Member Appeal & Grievance Form.

**What Happens Next?** If you appeal, your plan will review our decision. After your plan review our decision, if any of the services you requested are still denied, Medicare will provide you with a new and impartial review of your case by a reviewer outside of your Medicare Advantage Organization. If you disagree with that decision, you will have further appeal rights. You will be notified of those appeal rights if this happens.

### Other Contact Information:

If you need information or help, call us at:

Toll Free: 1-877-273-IEHP (4347)

TTY: TTY (800) 718-4347

From 8:00 am to 8:00 pm (PST), 7 days a week, including holidays.

### Other Resources To Help You:

Medicare Rights Center:

Toll Free: 1-888-HMO-9050

TTY/TTD:

### Elder Care Locator

Toll Free: 1-800-677-1116

1-800-MEDICARE (1-800-633-4227)

TTY/TTD: 1-877-486-2048

24 hours a day, 7 days a week

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OMB Approval No. 0938-NEW Form No. HCFA-10003-NDMC (June 2001)



## Plan Medicare Advantage de California Formulario de Apelación y Queja

(Miembros de IEHP que no son Medicare Advantage deben usar el “Formulario de Quejas”)

Esta forma es para su uso para hacer sugerencias, presentar una queja formal, o apelar cualquier aspecto de su cuidado o servicios que se le proporcionaron. **Es requerido por ley** que IEHP Medicare DualChoice HMO SNP responda a sus quejas o apelaciones, un procedimiento detallado existe para resolver estas situaciones. Si usted tiene preguntas, por favor llame al Departamento de Servicios al Miembro de IEHP al 1-877-273-IEHP (4347) o al 1-800-718-4347 TTY, de 8am a 8pm (PST), 7 días a la semana, incluyendo días festivos. Puede encontrar información sobre como comunicarse con el departamento de Servicios al Miembro de IEHP en su tarjeta de IEHP. 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

**Por favor escriba en letra de molde o a maquina la siguiente información:**

Nombre del Miembro (Apellido, primer nombre, inicial)	Numero de ID. de IEHP	
Domicilio Del Miembro	Numero de Teléfono de Hogar	
Ciudad, Estado, Código Postal	Numero Teléfono de Trabajo o Mensaje	
Numero de Medicare	Hombre/Mujer	Fecha de Nacimiento

*Representante Autorizado: Si la queja es registrada por otra persona, no el Miembro, por favor lea la sección llamada “Quien puede registrar una Apelación,” e incluya la siguiente información:*

Nombre: \_\_\_\_\_ Teléfono # \_\_\_\_\_  
Relación al Miembro: \_\_\_\_\_  
Domicilio: \_\_\_\_\_  
Ciudad: \_\_\_\_\_ Estado: \_\_\_\_\_ Código Postal: \_\_\_\_\_

**Clase de Queja:**

¿DÓNDE PASO EL INCIDENTE? (NOMBRE DEL HOSPITAL, DOCTOR, OTRA LOCALIDAD)

¿CUÁNDO OCURRIÓ? (SI NO ESTA SEGURO, DEFECHA(S) APROXIMADAS)

¿QUIÉN ESTUBO IMPLICADO?

POR FAVOR DESCRIBA LO QUE PASO. (SI ES NECESARIO, ADJUNTE MAS HOJAS)

**Por favor firme y ENVIE O MANDE POR FAX ESTE FORMULARIO A:** INLAND EMPIRE HEALTH PLAN  
Attn: Appeal and Grievance Department, P.O. Box 19026, San Bernardino, CA 92423-9026  
Fax # (909) 890-5748; Para preguntas llame al 1-877-273-IEHP (4347) o 1-800-718-4347 TTY, de 8am a 8pm, 7 días a la semana, incluyendo días festivos.

Fecha \_\_\_\_\_ Firma del Miembro \_\_\_\_\_

Fecha \_\_\_\_\_ Firma del Representante \_\_\_\_\_

**Information for all Medicare Advantage Members (OMB Approval No. 0938-NEW Form No. HCFA-10003-NDMC (June 2001):  
Usted Puede Tener el Derecho de Apelar**

Para ejercitar sus derechos de apelación, registre su apelación por escrito dentro de 60 días después del día original de la notificación de negación. Su plan le puede extender el tiempo para registrar la queja si usted tiene buena razón por haber fallado a la fecha determinada.

**¿Quién Puede Registrar una Apelación?**

Usted o quien usted nombre para que actuase por usted (su representante autorizado) puede registrar la apelación. Usted puede nombrar a un familiar, amigo, defensor, abogado, doctor, u otra persona para que actuase por usted. Otros no mencionados pueden tener derecho de actuar por usted bajo leyes estatales.

Puede llamarnos al: 1-877-273-IEHP (4347) para información acerca de cómo nombrar a su representante autorizado. Si usted tiene impedimentos para escuchar o del habla, por favor llámenos al TTY/ TDD 1-800-718-4347, de 8am a 8pm, 7 días a la semana, incluyendo días festivos.

Si usted quiere que alguien actué por usted, usted y su representante autorizado deben firmar, fechar, y mandarnos una de estas formas, que servirá como declaración nombrando a la persona que actuara por usted.

**IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS**

*Para mas información sobre sus derechos de apelación, llame a su plan o vea su Evidencia de Cobertura.*

**Hay dos tipos de apelaciones que usted puede registrar:**

**Estándar (30 días)** – Usted puede pedir una apelación estándar. Su plan debe darle una decisión en no más de 30 días después de que recibió su apelación. (Su plan puede extender este tiempo hasta 14 días si usted pide una extensión, o si él necesita información adicional y la extensión lo beneficia a usted.)

• **Rápido (Revisión en 72-horas)** -

Usted puede pedir una apelación rápida si usted o su doctor consideran que su salud puede ser seriamente dañada por esperar largo tiempo para la decisión. Su plan debe decidir en una apelación rápida en no más de 72 horas después de recibir la apelación. Su plan puede extender este tiempo hasta 14 días si usted pide una extensión, o si él necesita información adicional y la extensión lo beneficia a usted.)

- Si su doctor pide una apelación rápida por usted, o lo apoya en pedir una apelación rápida y el doctor indica que esperar 30 días puede seriamente dañar su salud, su plan automáticamente le dará una apelación rápida.

**¿Que Incluyo Con Mi Apelación?**

Usted debe incluir: su nombre, domicilio, numero de Miembro, razón por la apelación, y cualquier otra evidencia que usted gusta añadir. Usted puede mandar documentos médicos, cartas de doctores, o otra información que explique porque su plan debe darle los servicios que pide. Llame a su doctor si usted necesita esta información para asistirle con su apelación. Usted puede mandar por correo esta información o presentara en persona.

## ¿Como Registro Una Apelación?

**Para una apelación estándar:** Usted o su representante autorizado debe enviar por correo o en persona su apelación pro escrito a su plan de salud al domicilio indicado en el Plan de Medicare Advantage de California Formulario de Apelación y Queja.

**Para una apelación rápida:** Usted o su representante autorizado debe comunicarse con nosotros por teléfono o fax usando la información indicada el Plan de Medicare Advantage de California Formulario de Apelación y Queja.

**¿Que sucede después?** Si usted registra una apelación su plan revisara la decisión, si algún (os) de los servicios que pidió son negados, Medicare le proporcionara con una nueva e imparcial revisión de su caso por un critico fuera de la Organización de Medicare Advantage. Si usted no esta de acuerdo con la decisión, usted tendrá mas derechos de apelación. Se le notificara de esos derechos si lo anterior ocurre.

### Otra Información de Contacto:

Si necesita ayuda llámenos al:

Sin costo al: 1-877-273-IEHP (4347)

TTY: TTY (800) 718-4347

De 8am a 8pm, 7 días a la semana,  
incluyendo días festivos.

### Otros Recursos para Ayudarlo:

Medicare Rights Center:

Sin costo: 1-888-HMO-9050

TTY/TTD:

### Localizador de Cuidado a Mayores:

Sin costo: 1-800-677-1116

1-800-MEDICARE (1-800-633-4227)

TTY/TTD: 1-877-486-2048

24 horas al día 7 días a la semana

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OMB Approval No. 0938-NEW Form No. HCFA-10003-NDMC (June 2001)

IEHP Medicare DualChoice HMO SNP  
(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 Centers for Medicare and Medicaid Services (CMS) 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

IEHP Medicare DualChoice HMO SNP  
DENIAL UPHELD RESOLUTION LETTER – PCP/DENTIST COVER LETTER

<<DATE>>

«Prov\_Name», MD or DO or DDS

«Prov\_Address\_1»

«Prov\_City», CA «PROV\_ZIP»

RE: «Member\_Name»  
Case # «CASE\_»

Via U.S. Regular Mail

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>.

The case has been forwarded to Maximus for review and final resolution per Medicare regulations.

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, or Dr. <IEHP's CMO/Medical Director's Name> at (909) <phone #>.

Sincerely,

<Grievance Coordinator's Name>

Grievance Coordinator

cc: «Gc\_Name», «Gc\_Title», «Ipa\_Name»  
Grievance e-File

IEHP Medicare DualChoice HMO SNP  
PROVIDER SECOND LEVEL APPEAL OF UM DECISION - ACKNOWLEDGEMENT  
LETTER

<Date>

«PROV\_NAME»  
«PROV\_ADDRESS\_2»  
«PROV\_CITY», CA «PROV\_ZIP»

RE: «Member\_Name»  
IEHP 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 may 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 8a.m. to 5p.m., at (909) 890-*<ext>*, or through IEHP Reception desk at (909) 890-2000, or through IEHP 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

cc: <PCP>  
«Gc\_Name», «Gc\_Title», «Ipa\_Name»

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 thirty (30) 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: NAME, Director of Provider Services, IEHP  
NAME, Provider Services Manager, IEHP  
File location (see policy and procedures PRO/GEN A1b and A1c) ex. F-120.a

IEHP Medicare DualChoice HMO SNP  
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

## APPOINTMENT OF REPRESENTATIVE

NAME OF PARTY	MEDICARE OR NATIONAL PROVIDER IDENTIFIER NUMBER
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### SECTION I: APPOINTMENT OF REPRESENTATIVE

**To be completed by the party seeking representation (i.e., the Medicare beneficiary, the provider or the supplier):**

I appoint this individual: \_\_\_\_\_ to act as my representative in connection with my claim or asserted right under Title XVIII of the Social Security Act (the "Act") and related provisions of Title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my appeal, wholly in my stead. I understand that personal medical information related to my appeal may be disclosed to the representative indicated below.

SIGNATURE OF PARTY SEEKING REPRESENTATION		DATE
STREET ADDRESS		PHONE NUMBER (with Area Code)
CITY	STATE	ZIP

### SECTION II: ACCEPTANCE OF APPOINTMENT

**To be completed by the representative:**

I, \_\_\_\_\_, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services; that I am not, as a current or former employee of the United States, disqualified from acting as the party's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a / an \_\_\_\_\_  
(PROFESSIONAL STATUS OR RELATIONSHIP TO THE PARTY, E.G. ATTORNEY, RELATIVE, ETC.)

SIGNATURE OF REPRESENTATIVE		DATE
STREET ADDRESS		PHONE NUMBER (with Area Code)
CITY	STATE	ZIP

### SECTION III: WAIVER OF FEE FOR REPRESENTATION

**Instructions: This section must be completed if the representative is required to, or chooses to waive their fee for representation.** (Note that providers or suppliers that are representing a beneficiary and furnished the items or services may not charge a fee for representation and **must** complete this section.)

I waive my right to charge and collect a fee for representing \_\_\_\_\_ before the Secretary of the Department of Health and Human Services.

SIGNATURE	DATE
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### SECTION IV: WAIVER OF PAYMENT FOR ITEMS OR SERVICES AT ISSUE

**Instructions: Providers or suppliers serving as a representative for a beneficiary to whom they provided items or services must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act.** (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, or could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.)

I waive my right to collect payment from the beneficiary for the items or services at issue in this appeal if a determination of liability under §1879(a)(2) of the Act is at issue.

SIGNATURE	DATE
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## **CHARGING OF FEES FOR REPRESENTING BENEFICIARIES BEFORE THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES**

An attorney, or other representative for a beneficiary, who wishes to charge a fee for services rendered in connection with an appeal before the Secretary of the Department of Health and Human Services (DHHS) (i.e., an Administrative Law Judge (ALJ) hearing, Medicare Appeals Council (MAC) review, or a proceeding before an ALJ or the MAC as a result of a remand from federal district court) is required to obtain approval of the fee in accordance with 42 CFR §405.910(f).

The form, "Petition to Obtain Representative Fee" elicits the information required for a fee petition. It should be completed by the representative and filed with the request for ALJ hearing or request for MAC review

Approval of a representative's fee is not required if (1) the appellant being represented is a provider or supplier; (2) the fee is for services rendered in an official capacity such as that of legal guardian, committee, or similar court appointed representative and the court has approved the fee in question; (3) the fee is for representation of a beneficiary in a proceeding in federal district court; or (4) the fee is for representation of a beneficiary in a redetermination or reconsideration. If the representative wishes to waive a fee, he or she may do so. Section III on the front of this form can be used for that purpose. In some instances, as indicated on the form, the fee must be waived for representation.

### **AUTHORIZATION OF FEE**

The requirement for the approval of fees ensures that a representative will receive fair value for the services performed before DHHS on behalf of a beneficiary, and provides the beneficiary with a measure of security that the fees are determined to be reasonable. In approving a requested fee, the ALJ or MAC considers the nature and type of services performed, the complexity of the case, the level of skill and competence required in rendition of the services, the amount of time spent on the case, the results achieved, the level of administrative review to which the representative carried the appeal and the amount of the fee requested by the representative.

### **CONFLICT OF INTEREST**

Sections 203, 205 and 207 of Title XVIII of the United States Code make it a criminal offense for certain officers, employees and former officers and employees of the United States to render certain services in matters affecting the Government or to aid or assist in the prosecution of claims against the United States. Individuals with a conflict of interest are excluded from being representatives of beneficiaries before DHHS.

### **WHERE TO SEND THIS FORM**

Send this form to the same location where you are sending (or have already sent) your appeal if you are filing an appeal, grievance if you are filing a grievance, initial determination or decision if you are requesting an initial determination or decision.

If additional help is needed, contact your Medicare plan or 1-800-MEDICARE (1-800-633-4227).

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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0950. The time required to prepare and distribute this collection is 15 minutes per notice, including the time to select the preprinted form, complete it and deliver it to the beneficiary. If you have comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to CMS, PRA Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

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## NOMBRAMIENTO DE REPRESENTANTE

NOMBRE DEL PARTICIPANTE	NÚMERO DE MEDICARE O DE IDENTIFICACIÓN DE PROVEEDOR NACIONAL
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### SECCIÓN I: NOMBRAMIENTO DEL REPRESENTANTE

**(Para ser completado por el participante que busca representación)** (es decir, el beneficiario de Medicare, el proveedor o suplidor):

Yo nombro a: \_\_\_\_\_ para actuar como representante en relación con mi reclamación o derecho en virtud del Título XVIII de la Ley del Seguro Social (la "Ley") y sus disposiciones relacionadas al Título XI de la Ley. Autorizo a este individuo a realizar cualquier solicitud; presentar u obtener información sobre apelaciones conseguir pruebas; obtener información sobre apelaciones y recibir toda notificación sobre mi apelación, completamente en mi representación. Entiendo que información médica personal sobre mi apelación podrá divulgarse al representante indicado a continuación.

FIRMA DEL PARTICIPANTE QUE BUSCA REPRESENTACIÓN	FECHA	
DIRECCIÓN	NÚMERO DE TELÉFONO (CÓDIGO DE ÁREA)	
CIUDAD	ESTADO	CÓDIGO POSTAL

### SECCIÓN II: ACEPTACIÓN DEL NOMBRAMIENTO

**Para ser completado por el representante:**

Yo, \_\_\_\_\_, acepto por la presente el nombramiento antes mencionado. Certifico que no he sido descalificado, suspendido o prohibido el desempeño profesional ante el Departamento de Salud y Servicios Humanos; que no estoy actuando en calidad de empleado al presente o el pasado de los Estados Unidos, descalificado para actuar como representante del participante; y que reconozco que todo honorario podría estar sujeto a revisión y aprobación por el Secretario(a).

Me desempeño como \_\_\_\_\_  
(SITUACIÓN PROFESIONAL O RELACIÓN CON LA PARTE, POR EJEMPLO, ABOGADO, PARIENTE, ETC.)

FIRMA DEL REPRESENTANTE	FECHA	
DIRECCIÓN	NÚMERO DE TELÉFONO (CÓDIGO DE ÁREA)	
CIUDAD	ESTADO	CÓDIGO POSTAL

### SECCIÓN III: RENUNCIA AL COBRO DE HONORARIOS POR REPRESENTACIÓN

**Instrucciones: Esta sección debe ser completada si se le requiere al representante a, o escoge renunciar al cobro de honorarios por representación.** (Obsérvese que los proveedores o suplidores que representan a un beneficiario y le proveyeron artículos o servicios no pueden cobrar honorarios por representación y **deben** completar esta sección).

Renuncio a mi derecho de cobrar un honorario por representar a \_\_\_\_\_ ante el Secretario(a) del Departamento de Salud y Servicios Humanos.

FIRMA	FECHA
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### SECCIÓN IV: RENUNCIA AL PAGO POR ARTÍCULOS O SERVICIOS EN CUESTIÓN

**Instrucciones: Proveedores o suplidores que sirven como representantes de beneficiarios a los cuales le prestaron artículos o servicios deben completar esta sección si la apelación es por un tema de responsabilidad en virtud de la sección 1879(a)(2) de la Ley.** (En la Sección 1879(a)(2) en general se aborda si un proveedor, suplidor o beneficiario no tenía conocimiento y no podía preverse razonablemente que tendría conocimiento que los artículos o servicios en cuestión no estarían cubiertos por Medicare).

Renuncio a mi derecho de cobrar al beneficiario un honorario por los artículos o servicios en cuestión en esta apelación si está pendiente una determinación de responsabilidad bajo la sección 1879(a)(2) de la Ley.

FIRMA	FECHA
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## **COBRO DE HONORARIOS POR REPRESENTACIÓN DE BENEFICIARIOS ANTE EL SECRETARIO(A) DEL DEPARTAMENTO DE SALUD Y SERVICIOS HUMANOS**

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Un abogado u otro representante de un beneficiario, que desee cobrar un honorario por los servicios prestados en relación con una apelación ante el Secretario(a) del Departamento de Salud y Servicios Humanos (DHHS, por sus siglas en inglés) (por ejemplo, una audiencia con un Juez de Derecho Administrativo (ALJ, por sus siglas en inglés), una revisión con el Consejo de Apelaciones de Medicare (MAC, por sus siglas en inglés) o un proceso ante un ALJ o el MAC como resultado de una orden de remisión de la Corte de Distrito Federal) debe, por ley obtener aprobación para recibir un honorario de acuerdo con 42 CFR §405.910(f).

Mediante este formulario, "Solicitud para obtener un honorario por concepto de representación" se recaba la información necesaria para solicitar el pago de honorario. Debe ser completado por el representante y presentado con la solicitud para audiencia con el ALJ o revisión del MAC.

La aprobación de honorarios para el representante no es necesaria si (1) el apelante es representado por un proveedor o suplidor; (2) prestados en calidad oficial como un tutor legal, comité o cargo similar representante designado por el tribunal y con la aprobación del tribunal del honorario en cuestión; (3) el honorario es por representación del beneficiario ante la Corte de Distrito Federal; o (4) el honorario es por representación del beneficiario en una redeterminación o reconsideración. Si el representante desea renunciar al cobro de un honorario, puede hacerlo. La Sección III en la primera página de este formulario puede usarse para ese propósito. En algunas instancias, según se indica en el formulario, no se cobrará el honorario por concepto de representación.

### **AUTORIZACIÓN DE HONORARIOS**

El requisito para la aprobación de honorarios garantiza que el representante recibirá un valor justo por los servicios prestados ante DHHS en nombre de un beneficiario y provee al beneficiario una medida de seguridad que los honorarios han sido determinados como razonables. Para la aprobación de un honorario solicitado, el ALJ o el MAC considera la naturaleza y el tipo de servicios prestados, la complejidad del caso, el nivel de pericia y capacidad necesaria para la prestación de servicios, la cantidad de tiempo dedicado al caso, los resultados alcanzados, el nivel de revisión administrativa al cual el representante llevó la apelación y el monto del honorario solicitado por el representante.

### **CONFLICTO DE INTERÉS**

Las Secciones 203, 205 y 207 del Título XVIII del Código de Estados Unidos estipulan el carácter de delito penal cuando ciertos funcionarios, empleados y antiguos funcionarios y empleados de los Estados Unidos prestan ciertos servicios en temas que afectan al Gobierno, ayudan o asisten en el procesamiento de reclamaciones contra los Estados Unidos. Los individuos con un conflicto de interés quedarán excluidos de ser representantes de los beneficiarios ante DHHS.

### **DÓNDE ENVIAR ESTE FORMULARIO**

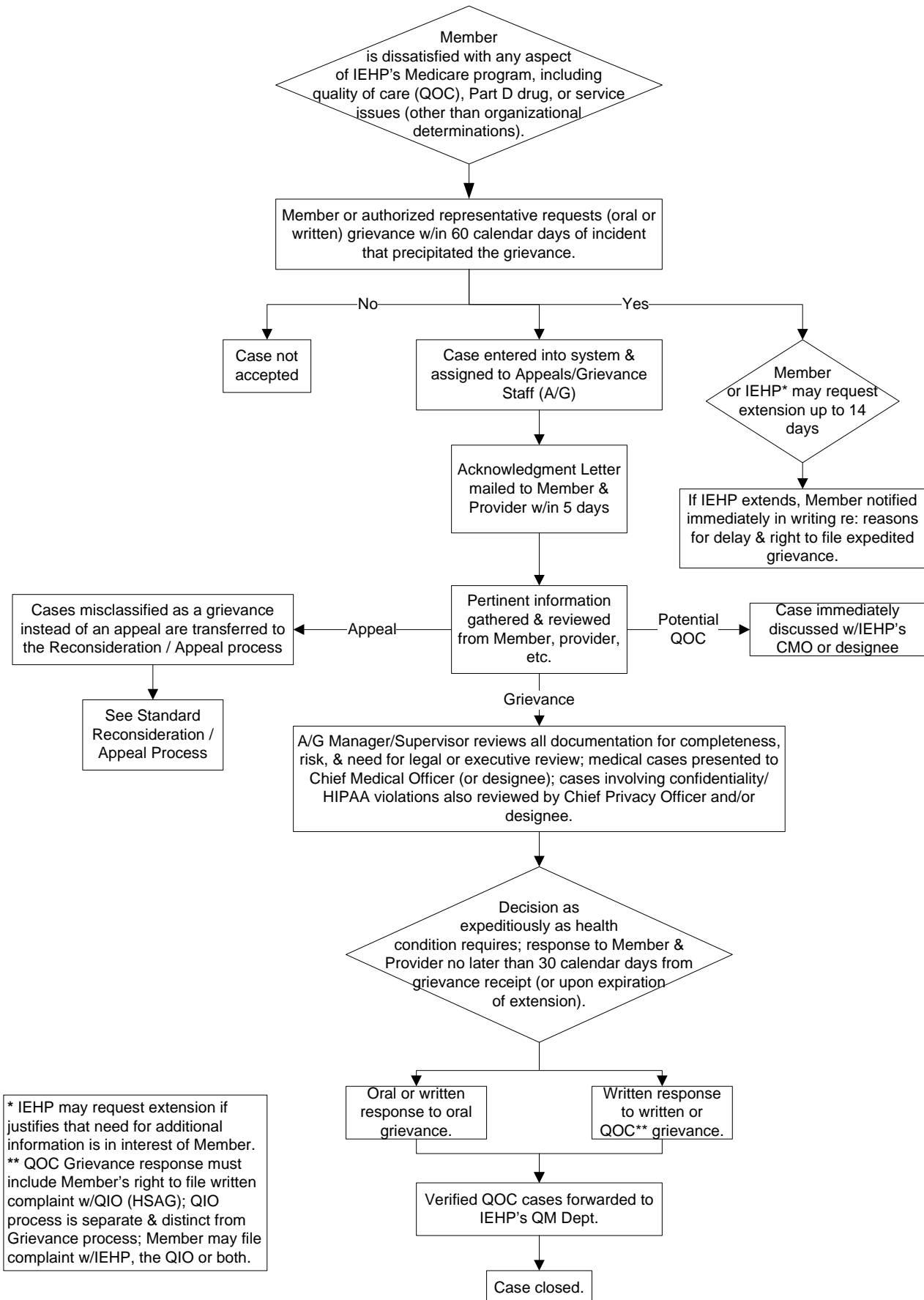
Envíe este formulario al mismo lugar que está enviando (o ha enviado) su: apelación si está solicitando una apelación, queja si está presentando una queja, determinación o decisión inicial si está solicitando una determinación inicial o decisión. Si necesita ayuda, comuníquese con su plan de Medicare o llame al 1-800-MEDICARE (1-800-633-4227).

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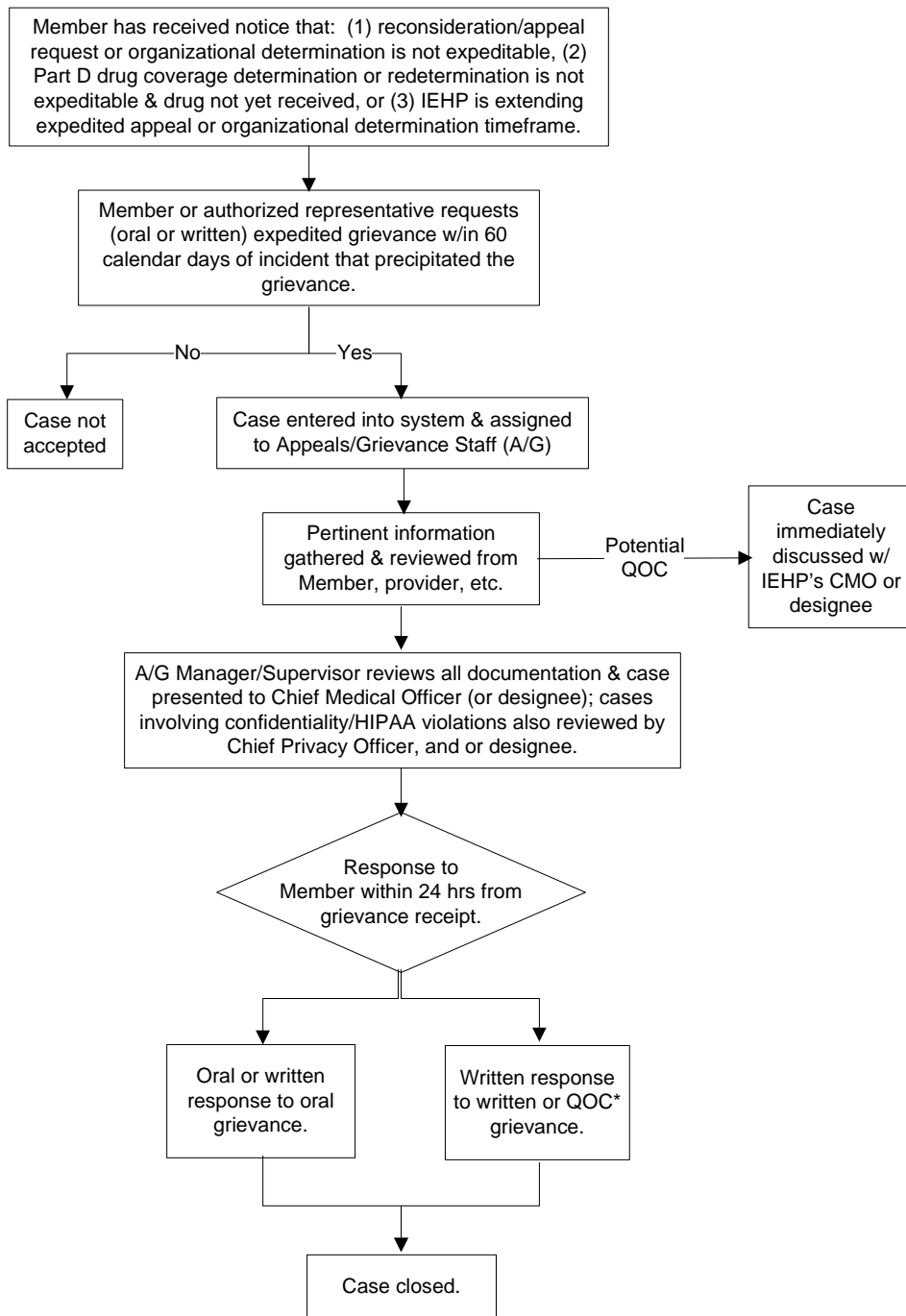
De acuerdo con la Ley de Reducción de Papeleo de 1995, no se le requiere a ninguna persona responder a una recopilación de información a menos de que presente un número de control válido de la Oficina de Administración de Personal y Presupuesto (OMB, por sus siglas en inglés). El número de control válido de OMB para esta recopilación es 09380950. El tiempo requerido para completar esta recopilación de información es de 15 minutos por notificación, incluyendo el tiempo necesario para seleccionar el formulario pre-impreso, completar y entregárselo al beneficiario. Si tiene comentarios sobre la precisión del tiempo estimado o sugerencias para mejorar este formulario, favor de escribir a: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, MD 21244.

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## IEHP Medicare DualChoice HMO SNP Member Standard Grievance Process

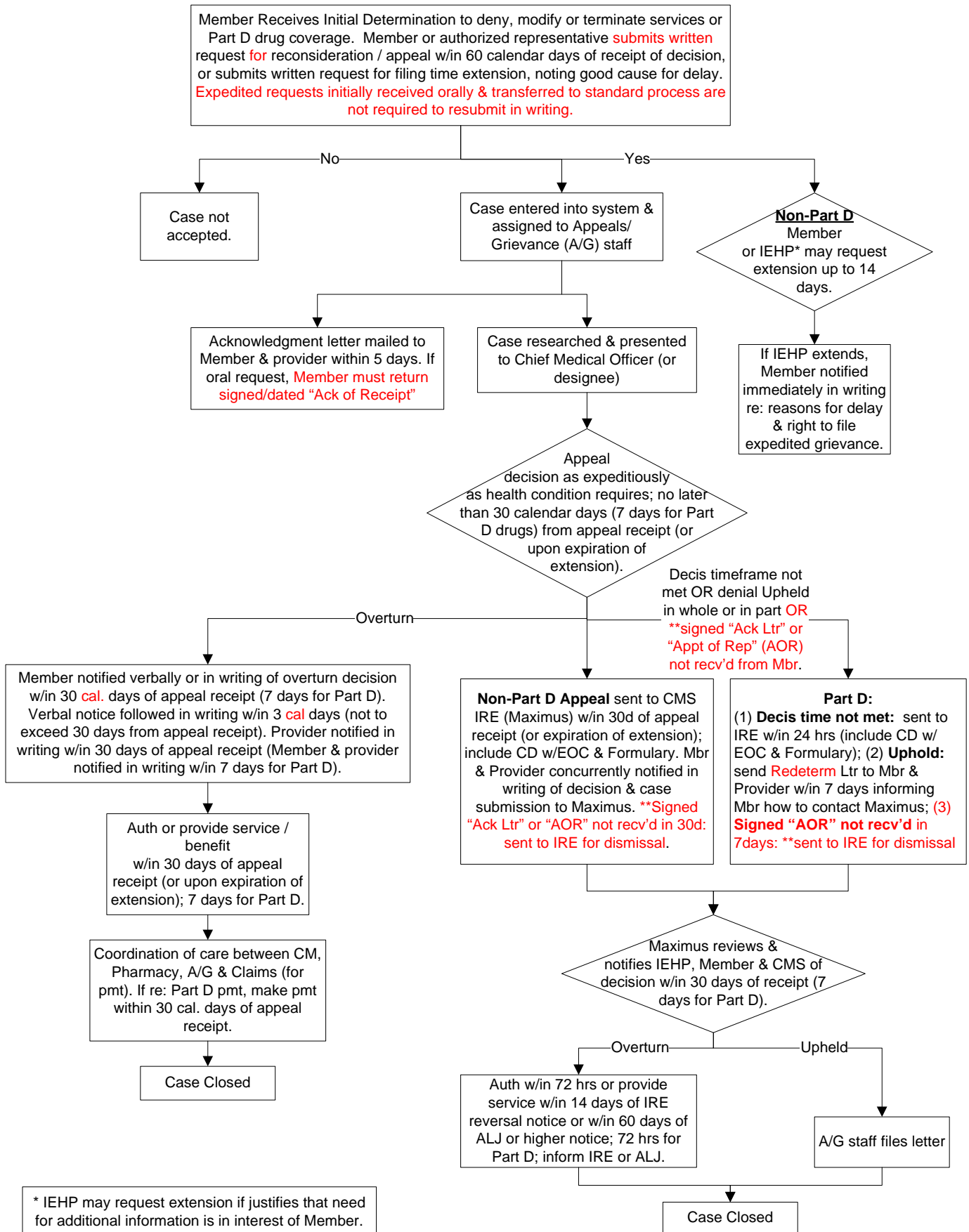


## IEHP Medicare DualChoice HMO SNP Member Expedited Grievance Process

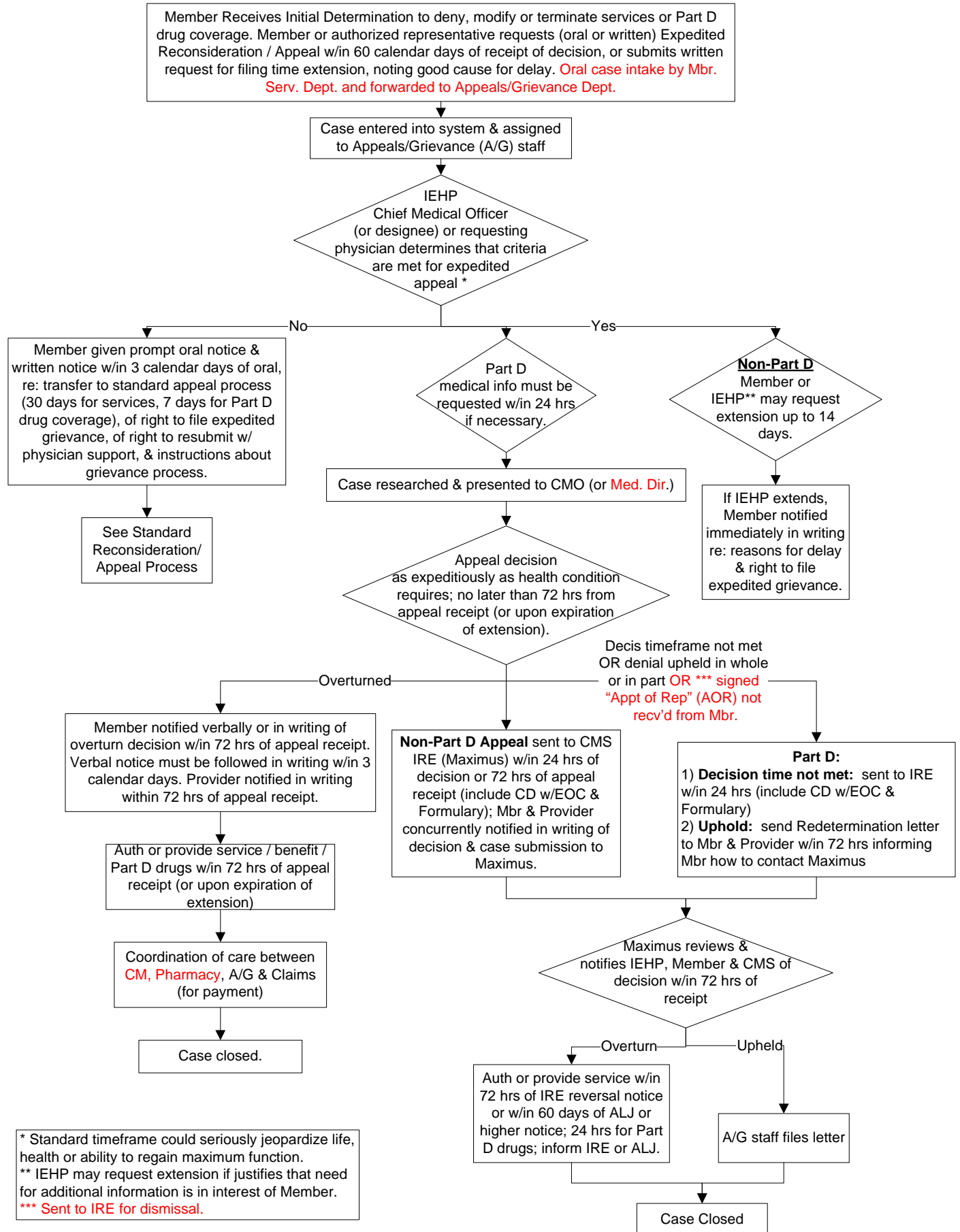


\* QOC Grievance response must include Member's right to file written complaint w/QIO (HSAG); QIO process is separate & distinct from Grievance process; Member may file complaint w/IEHP, the QIO or both.

## IEHP Medicare DualChoice HMO SNP Member Standard Reconsideration / Appeal Process



## IEHP Medicare DualChoice HMO SNP Member Expedited Reconsideration / Appeal Process



**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.

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:

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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