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## 16. GRIEVANCE AND APPEALS RESOLUTION SYSTEM

### A. Member Grievance and Appeals Resolution Process

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#### **APPLIES TO:**

- A. This policy applies to all IEHP Medi-Cal Members.

#### **POLICY:**

- A. IEHP defines a grievance (complaint) as an oral or written expression of dissatisfaction regarding IEHP staff, policies or processes, our contracted Providers' staff,<sup>1</sup> processes or actions, or any other aspect of health care delivery through IEHP, including quality of care concerns. Where IEHP is unable to distinguish between a grievance and an inquiry, the case shall be considered a grievance. Grievances include, but are not limited to, complaints about waiting times for appointments, disputes, timely assignment to a Provider, issues related to cultural or linguistic access or sensitivity, difficulty accessing specialists or other services, delays and denials of care, requests for treatment, administration and delivery of medical benefits, continuity of care, staff, facility, or other medical care problems, and concerns regarding Member confidentiality in the Provider network and/or at IEHP made by a Member or the Member's representative. A "complaint" is categorized as a "grievance." A request for reconsideration, defined as a grievance appealing a denial, or partial approval (modification) in the referral process, is outlined in this policy.
- B. IEHP's Grievance and Appeals Department is responsible for the resolution of Member complaints, including grievances and appeals.
- C. IEHP Members receive written information regarding the appeal and grievance process<sup>2</sup> upon enrollment, and annually thereafter. Members are also informed of the appeal and grievance process upon request
- D. All Members are encouraged to bring up any concerns or issues with their Provider in order to promote open communication and a positive Member and Provider relationship. This open communication between a Member and his/her Provider is discussed in the IEHP Member Handbook. IEHP's Member Services Department and/or Grievance and Appeals Department also encourage Members to communicate with their Providers at the time issues arise.
- E. All 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 a Provider or Delegate disputes. At no time shall a Member be retaliated against for initiating a grievance.<sup>3</sup> Fiscal and administrative concerns shall not influence the independence of the medical decision-making process to resolve any medical dispute between Member and Provider of service.

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1 CA Health & Safety. Code (HSC), §§ 1374.30(i)

2 DHCS IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 13, Member Services

3 Section 1557 of the Affordable Care Act (42 U.S.C. § 18116)

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- F. All Providers (e.g., Primary Care Physicians and Vision Providers) are required to have IEHP Member Complaint Forms and a copy of the IEHP Grievance Resolution Process readily available for distribution to Members upon request (See Attachments, “Member Complaint Form – Medi-Cal - English,” “Member Complaint Form – Medi-Cal – Spanish,” “Grievance Resolution Process – Medi-Cal – English,” and “Grievance Resolution Process – Medi-Cal – Spanish” in Section 16).
- G. All Providers are required to provide Members with assistance in filing their grievances. Providers are informed annually through IEHP’s Provider Manual regarding how to access current appeals and grievance resolution processes.
- H. IEHP will not take punitive action against a Provider who either requests an expedited resolution or supports a Members’ Grievance and/or Appeal
- I. Members who wish to file a grievance regarding County behavioral health services are referred as follows:
1. Medi-Cal Members who reside in Riverside County are referred to the Riverside County University Health Department’s Quality Management at (951) 955-7320 for outpatient or at (951) 358-6031 for inpatient.
  2. Medi-Cal Members who reside in San Bernardino County are referred to the San Bernardino County Department of Mental Health Department’s Quality Management at (909) 386-8227.
- J. Members who wish to file a grievance regarding dental services are referred to the appropriate dental Provider, as applicable.
- K. Members have the right to appoint someone to file their grievance or represent them during the grievance process. Members (or their representatives), any Provider that furnishes or intends to furnish services to the Member, or the legal representative of the Member’s estate and/or deceased Member, may file a case with IEHP. In addition, if the Member is a minor, or is incompetent or incapacitated, a grievance may be registered on behalf of the Member by the parent, guardian, conservator, relative, Practitioner, Provider, attorney, or other designee of the Member, either in writing or verbally, as appropriate. IEHP recognizes the term “relative” to include a parent, stepparent, spouse, adult son or daughter, grandparent, brother, sister, uncle, or aunt of the Member. Expedited cases may be requested by the Member (or their authorized representative), or a physician (regardless of whether that physician is affiliated with IEHP).
- L. Grievances or an application for Independent Medical Review (IMR) filed by a Provider on behalf of a Member or regarding a Member appeal are subject to the requirements of the IEHP Member Grievance Resolution Process and only if the State permits the Provider to act as the enrollee’s authorized representative. Written consent from the Member must be obtained from the Provider to proceed with an appeal by the Provider on behalf of the

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Member<sup>4,5</sup>

- M. 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. Bilingual MSRs and Grievance Coordinators are proficient in Spanish to assist Spanish-speaking Members. Access to interpreters for other languages is obtained through IEHP's contracted interpretation services. If necessary, IEHP Grievance staff may request IEHP Member Services to arrange for face-to-face or telephonic translations, and sign language services for medical appointments.
- N. A Member has the right to file a grievance at any time following any incident or action that is the subject of the Member's dissatisfaction.<sup>6</sup> According to Title 42 of the Code of Federal Regulations (CFR). Medi-Cal Members have up to sixty (60) calendar days from the date on the Notice of Adverse Benefit Determination (NABD) to file an appeal with IEHP.<sup>7,8</sup>
- O. Services previously authorized will continue while the grievance or appeal is being resolved.<sup>9</sup>
- P. Grievances and appeals may be filed by telephone, in writing, by mail, by fax, in person, or online through IEHP's web site at [www.iehp.org](http://www.iehp.org), and may be withdrawn by notifying IEHP. (See Attachments "Appeal Resolution Process – Medi-Cal – English," "Appeal Resolution Process – Medi-Cal – Spanish," "Grievance Resolution Process – Medi-Cal – English," and "Grievance Resolution Process – Medi-Cal – Spanish" in Section 16).
- Q. IEHP resolves all standard grievances within thirty (30) calendar days, in accordance with state and federal regulatory guidelines. Response times for grievances are counted in calendar days. Urgent grievances requiring expedited review are resolved within seventy-two (72) hours. See Policy 16A2, "Grievance Resolution Process - Member Urgent Medical Grievances" for further details<sup>10</sup>
- R. During the grievance process and notification to the Member of the grievance disposition, IEHP Members are informed of their right to further appeal a decision if they are not satisfied with IEHP's resolution to their grievance. Members may appeal an adverse IEHP grievance resolution arising out of a complaint (not appeal of coverage decision), within thirty (30) calendar days of receipt of the original grievance. For complaint appeals (non-coverage disputes), both levels of grievance resolution/appeal must be completed within the thirty (30) calendar days, according to Title 28 of the California Code of Regulations

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4 Department of Health Care Services (DHCS) All Plan Letter (APL) 17-006, Supersedes APL 04-006 and 05-005 and PL 09-006, Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" attachments

5 Title 28, California Code of Regulations (CCR), § 1300.68

6 Title 42, Code of Federal Regulation (CFR) § 438.402 (2)(i)

7 Title 42 CFR. § 438.402(2)(ii)

8 California code of regulations Title 22, §§ 53894(a)

9 Coordinated Care Initiative (CCI) Three-Way Contract January 2019, Section 2.15

10 DHCS APL 17-006

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(CCR). After thirty (30) calendar days, Members are directed to the Department of Managed Health Care (DMHC) for the next level of grievance resolution. All grievance correspondence informs Members of their right to contact DMHC for assistance after completing the IEHP grievance resolution process<sup>11,12</sup> or participating in the process for thirty (30) days. This requirement may be waived if DMHC determines that an earlier review is necessary.

- S. Grievances received by telephone, which are not coverage disputes or disputed health services involving medical necessity, experimental and/or investigational treatments or related to quality of care, and that are resolved by the close of the next business day, are exempt from the requirement to send written acknowledgment and response to Members.
- T. IEHP provides Members with written responses to grievances, including a clear and concise explanation of the reasons for IEHP's response. For explanations regarding denials, partial approvals (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.
- U. All Providers are required to immediately forward grievances to IEHP for resolution. Providers may contact IEHP Member Services or Provider Relations Team to obtain further information regarding the IEHP Grievance Resolution System.
- V. All Members are informed of the Notice of Privacy Practices (NPP) upon enrollment. In addition, the NPP is made available in writing to Members upon request, is available online through the IEHP web site, and is posted in common, public areas.
- W. Members with complaints regarding confidentiality, have the right to file a grievance as follows:
  - 1. IEHP Compliance Officer by mail at: P.O. Box 1800, Rancho Cucamonga, CA 91729-1800 or by telephone at (866) 355-9038;
  - 2. The California Department of Health Care Services Privacy Officer c/o Office of HIPAA Compliance: Information Protection Unit at CA Department of Health Care Services, P.O. Box 997413 MS0010, Sacramento, CA 95899-7413 or by telephone at (916) 445-4646 or (866) 866-0602 TTY/TDD or by email [privacyofficer@dhcs.co.gov](mailto:privacyofficer@dhcs.co.gov) ; or
  - 3. Department of Health and Human Services Office of Civil Rights, Attention: Regional Manager at 90 7th Street, Suite 4-100, San Francisco, CA 94103. For additional information, Members may call (800) 368-1019 or (800) 537-7697 TDD or by email to [ocrmail@hhs.gov](mailto:ocrmail@hhs.gov) .
- X. IEHP may choose to delegate the Member grievance resolution process to organizations that are accredited by the National Committee for Quality Assurance (NCQA) and with written agreement between IEHP and the Delegates. However, Members may choose to

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<sup>11</sup> Section 1557 of the Affordable Care Act (42 U.S.C. § 18116)

<sup>12</sup> DHCS APL 17-006

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directly address grievances to IEHP and those grievances are forwarded to the delegated organization for investigation only and the results returned to IEHP within fourteen (14) calendar days. IEHP manages the grievance process and responds to Members. IEHP forwards a summary of the cases to the Delegate. The Delegate is responsible for establishing a grievance process in accordance with regulations mandated by DMHC, DHCS, and NCQA. Grievances received directly by the delegated entity are reported to IEHP on a quarterly basis, reviewed by the Grievance and Appeals Review Committee, and forwarded to other committees as indicated. IEHP retains ultimate responsibility for ensuring that the delegated entity satisfies all requirements of the grievance and appeal process.

- Y. On an annual basis, IEHP evaluates delegate performance against IEHP, NCQA, and regulatory standards.
- Z. IEHP informs Members of their right to contact DMHC after completing IEHP's grievance process or after having participated in the grievance process for thirty (30) calendar days. This requirement may be waived if DMHC determines that an earlier review is necessary.
- AA. Members are informed of their right to request Independent Medical Review (IMR)<sup>13</sup> with DMHC if IEHP upholds a Provider's decision to deny, partially approve (modify) or terminate a Member's referral because the service is not considered medically necessary.<sup>14</sup> DMHC makes the final decision regarding the qualification of coverage decisions for the IMR process.
- BB. Members with life-threatening or seriously debilitating medical conditions that have received a Provider's decision to deny, partially approve (modify) or terminate experimental or investigational treatment or therapy,<sup>15</sup> are not required to participate in IEHP's grievance process prior to submitting their request for IMR with DMHC. Life-threatening medical conditions are those diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted, or diseases or conditions with potential outcomes, where the end point of clinical intervention is survival. Seriously debilitating medical conditions are diseases or conditions that cause major irreversible morbidity.
- CC. IEHP maintains all Member grievances, including medical records, documents, evidence of coverage or other relevant information IEHP used to make the grievance decision or resolve the case, in confidential electronic case files for ten (10) 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;

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<sup>13</sup> HSC, § 1374.30

<sup>14</sup> Title 28, CCR, § 1300.74.30 (f)(1)retaliateagainst th

<sup>15</sup> Title 28, CCR, § 1300.74.30(a)

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4. A description of the case; and
  5. Copies of relevant information used in the case.
- DD. All Member correspondence is mailed via regular mail, unless the Member requests certified mail.
- EE. IEHP does not reveal Provider, 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; or
  6. If the request is made by a representative of an accredited body.
- FF. All appeals and grievances are responded to either verbally or in writing, including quality of care cases. Grievances received orally not related to quality of care or denied services and resolved by the end of the following business day are exempt from the requirement to respond in writing. All details of the oral case are documented in the electronic case tracking system.
- GG. The cultural and linguistic needs, and disabilities of Members, are considered in the appeal and grievance process. IEHP Grievance and Appeals 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 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.
- HH. Grievances involving quality of care issues may be reported to IEHP's Potential Quality Incident (PQI) Team upon resolution of the case. IEHP's Medical Director is notified immediately upon receipt of a potential quality of care case.
- II. Grievances related to Provider office site quality issues are tracked by Quality Systems for assessment of physical accessibility, physical appearance, adequacy of waiting-room and examination-room space, appointment availability, and adequacy of treatment record-keeping.
- JJ. Medi-Cal Members, their authorized representative or representative of a deceased Member's estate have the right to request a Medi-Cal Fair Hearing within one hundred and

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twenty (120) calendar days from the date of the Notice of Appeal Resolution (NAR).<sup>16,17</sup>

- KK. Medi-Cal Members have the right to continued medical assistance, and benefits, including continuation of services previously authorized, pending a Fair Hearing decision if the Member appeals in writing to the Department of Health Care Services for a hearing:
1. Within ten (10) calendar days of the mailing or personal delivery of the NABD to reduce or terminate authorization for a medical service; or
  2. Before the effective date of action (22 CCR § 51014.1, 51014.2).
- LL. IEHP does not discriminate against any Member for filing a grievance.<sup>18</sup>
- MM. During the appeal process a Member can have their benefits continued if requested within ten (10) calendar days of the Plan mailing the NABD or before the intended effective date of the proposed action. The appeal must involve the termination, suspension, or reduction of a previously authorized course of treatment ordered by an authorized Provider. In addition, the original period covered by the original authorization has not expired and the Member requested the extension of benefits. If the plan continues or reinstates the benefits while the appeal is pending, the benefits will continue until one (1) of the following occurs:
1. The Member withdraws the appeal;
  2. Ten (10) calendar days pass after IEHP mails the notice providing the resolution of the appeal against the Member, unless the Member (within the ten (10) calendar day timeframe) has requested an IMR with continuation of benefits until an IMR decision is reached, the IMR office issues a decision adverse to the Member or the time period or service limits of a previously authorized service has been met;
  3. If the final resolution of the appeal is adverse to the Member, that is, upholds IEHP's action, IEHP may recover the cost of the services furnished to the Member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section.

#### **DEFINITION:**

- A. Delegate – For the purpose of this policy, this is defined as a Physician, medical group, Health Plan, IPA, or any contracted organization delegated to provide services.

#### **PURPOSE:**

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

#### **PROCEDURES:**

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16 Title 22, CCR, § 50951

17 Welfare & Institution Code (WIC), § 10951

18 45 Code of Federal Regulation (CFR), § 92.101

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- A. Members who wish to file a grievance may contact IEHP's Member Services Department at (800) 440-IEHP (4347) or (800) 718-4347 (TTY). Members may also submit their grievance to IEHP through IEHP's web site at [www.iehp.org](http://www.iehp.org), in person at 10801 Sixth St., Suite 120, Rancho Cucamonga, CA 91730, or by mail/fax to the following address:

Inland Empire Health Plan  
Attn: Grievance Department  
P.O. Box 1800  
Rancho Cucamonga, CA 91729-1800  
Fax (909) 890-5748

(See Attachments, "Member Complaint Form – Medi-Cal English," and "Member Complaint Form – Medi-Cal – Spanish).

- B. IEHP mails an acknowledgment letter to the Member within five (5) calendar days of receipt of the grievance.
- C. IEHP may contact the Member to obtain additional information. Grievances received at IEHP are resolved as follows:
1. IEHP Grievance and Appeals staff triages the grievance to determine if the issue(s) can be resolved at the Plan level.
  2. If a grievance does not require investigation by the contracted Providers, IEHP resolves the grievance in accordance with IEHP's Policies and Procedures.
- D. IEHP faxes a copy of the Member's grievance resolution letter to the Providers. The letter informs the Providers of the Member's concerns and the results of IEHP's investigation
- E. If a grievance requires investigation and proposed resolution by the involved Provider and Delegate, IEHP faxes or emails an IEHP Grievance Summary Form (GSF) to the affiliated Provider. The grievance is handled in the following manner:
1. Delegates are required to procure and assemble all information requested in the GSF upon receipt. The "Expected Response Date" for Providers is set at fourteen (14) calendar days from the date the GSF is faxed and/or emailed to the affiliated Provider. Delegates should provide the response as expeditiously as possible but no later than fourteen (14) calendar days from the date the GSF is received by the Provider or Delegate.
  2. The "Expected Response Date" for Providers and Delegates for expedited grievance cases is as expeditiously as the Member's health condition requires but not to exceed twenty-four (24) hours from the time the GSF is faxed and/or emailed to the affiliated Provider.
  3. Once the response has been obtained by the affiliated Provider, a typed copy of the response must be forwarded to IEHP.
  4. Prior to the due date, a Final Notice will be sent to remind the Provider of the Expected Response Date (See Attachment, "Final Notice" in Section 16).

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5. If the Provider fails to provide a response by day thirty (30) of case receipt, IEHP directly resolves the grievance without any further input from the Practitioner or Provider. Failure to respond to grievance requests may result in disciplinary action, up to and including termination of contract.
  6. IEHP monitors the rate of overall grievance response timeliness for further action, including but not limited to; referral to Grievance and Appeals Review Committee, and/or Provider Services for non-medical issues. The rate of grievance response timeliness is reported to Delegates monthly and included in the annual Provider Evaluation Tool (PET). Timeliness rates are based on the initial expected response due date and date a complete response is received, addressing all alleged issues. Providers who fail to respond to a grievance three (3) times within a year period will be referred to the Director of Grievance and Appeals for follow up and potential escalation. Delegates that do not meet Grievance response timeliness for two (2) consecutive months will be issued a Corrective Action Plan (CAP) from IEHP.
  7. 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) or education is required, IEHP mails a letter to the Provider or Delegate.
  8. After case investigation, the Grievance staff determines and assigns a level to the case based on the outcome. The case assignments are as follows:
    - a. Level 0 – No substantiated issue.
    - b. Level 1 – Provider non-response to Grievance Summary Form.
    - c. Level 2 – Substantiated issue that has not resulted in any harm to the Member.
    - d. Level 3 – Substantiated issue that has resulted in some (temporary) harm to the Member.
    - e. Level 4 – Substantiated issue that has resulted in significant (permanent or death) harm to the Member.
  9. Once the grievance is resolved, IEHP mails the Member a resolution letter within thirty (30) calendar days of receipt of a standard grievance and within seventy-two (72) hours of receipt of an expedited grievance. A copy of the resolution letter is mailed to the involved Provider and Delegate.
- F. If the complaint is regarding a denial or partial approval (modification) of health care services, IEHP investigates and resolves the appeal. IEHP works closely with the Provider and Delegates in investigating and resolving denial-related appeals.
1. IEHP initially informs Practitioner/Provider of appeal via telephone, fax or email. Upon notification, Practitioner/Provider is required to submit a copy of denial letter to Grievance and Appeals staff within two (2) business days including the referral request, criteria applied and all supporting clinical documentation used in making the denial decision.
  2. A copy of the Acknowledgement letter is mailed to the affiliated Provider. The

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letter informs the Provider that the Member filed a grievance (appeal) regarding a denial or partial approval (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 associated with the service request. Provider must provide the requested medical records to IEHP within two (2) business days of request.
4. If IEHP upholds the decision to deny, partially approve (modify), or terminate the Member's referral, IEHP mails a resolution letter to the Member. The letter informs the Member of his/her right to request an Independent Medical Review (IMR) with DMHC19 and right to file a State Fair Hearing with DHCS regarding IEHP's determination to uphold the initial decision. The resolution includes an IMR application form, instructions on how to request an IMR, and a self-addressed envelope with the DMHC's IMR Unit address.
  - a. A copy of the Member's resolution letter is sent to the requesting Provider. The letter informs the requesting Provider that the denial was upheld and the reasons for the decision.
  - b. For appeals filed by the Provider on behalf of a Member, the correspondence is mailed to the Provider and a copy is mailed to the Member.
5. Members may not request an IMR if a State Fair Hearing has already been held on the issue.
6. If IEHP overturns the denial, IEHP contacts the Delegate, via telephone, fax and/or email, to inform the Provider of the decision and begin coordination of care for the Member, as necessary.
  - a. Upon notification of overturn, the IPA making the initial denial determination is required to issue the approved authorization within two (2) business days to Member, IEHP Grievance and Appeals Staff and requesting Provider. For expedited cases, the IPA is required to issue the approved authorization by the end of business day.
  - b. An appeal resolution letter is mailed to the Member. A copy of the letter is mailed to the involved Provider.
  - c. IEHP or Delegate must pay for disputed services if the Member received services while the appeal was pending.
- G. Any potential network problems including a delay in the referral process, recurrent issues, or quality of care issues, may be forwarded to the IEHP Quality Systems Department for

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19 Title 28, CCR, § 1300.74.30 (f)(1)

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further action.

H. Members may apply for an IMR when the following conditions are met:

1. The Member's Provider has recommended a health care service as medically necessary;
2. The Member has received urgent care or emergency services that a Provider determined was medically necessary;
3. The Member was seen by a Provider within the IEHP network for the diagnosis or treatment of the medical condition for which the Member seeks independent review. The Practitioner may be an out-of-network Practitioner when DMHC finds that the Member's decision to secure services outside IEHP's network was reasonable under the circumstances and the disputed health care services were a covered benefit under the terms and conditions of IEHP's contract;
4. The disputed health care service has been denied, partially approved (modified) or terminated by IEHP or one of its contracting Providers, based in whole or in part on a decision that the health care service is not medically necessary; or
5. The Member has filed an appeal with IEHP, and the disputed decision is upheld or the appeal remains unresolved after thirty (30) calendar days. Members are not required to participate in IEHP's Grievance Process for more than thirty (30) calendar days before applying for an IMR. If the grievance requires expedited review, Members are not required to participate in IEHP's Grievance Process for more than seventy-two (72) hours.
6. If IEHP denies a Member request for expedited resolution of an appeal, IEHP will transfer to the standard timeframe of thirty (30) calendar day appeal process.

I. If DMHC determines that the request qualifies for IMR, DMHC designates an IMR organization to review the case. DMHC notifies IEHP that the Member has requested an IMR.

1. As expeditiously as possible, but no greater than two (2) business days from the receipt of the notification that an IEHP Member has requested an IMR, IEHP completes a Request for Health Plan Information form and submits the form to the IMR organization, along with the following documentation:
  - a. A copy of the Member's medical records in IEHP's possession, which must include the Member's medical condition, the health care services being provided by IEHP and its Delegates, and the disputed health care service requested by the Member;
  - b. Any newly developed or discovered relevant medical records in possession of IEHP or its affiliated Providers;
  - c. A copy of all the information provided to the Member by IEHP and any of its Delegates regarding the Member's condition and care, and a copy of any

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materials the Member or the Member's Provider submitted to IEHP or its affiliated Provider in support of the Member's request; and

- d. A copy of all other relevant documents or information used by IEHP or its Delegates in determining whether the disputed health care services should have been provided, and any statements by IEHP or its Delegates explaining the reasons for the decision to deny or partially approve (modify) the disputed health care service.
2. If the IMR organization determines that the health care service is medically necessary, IEHP contacts the Member and authorizes the services within five (5) business days of receipt of the written decision from DMHC's Director, or sooner if appropriate for the nature of the Member's medical condition.
    - a. Members may apply for an IMR without first participating in IEHP's Internal Appeal process in extraordinary and compelling cases, as determined by DMHC, and in cases where Member's request for an experimental treatment was denied. Members are notified in writing of the opportunity to request an IMR of a decision denying experimental within five (5) business days of the decision to deny coverage.
  3. IEHP informs the Member, Provider and Delegates of the authorization in writing within two (2) business days. Approved decisions pertaining to care that are underway are communicated within twenty-four (24) hours. Payment must be processed by close of business on same day of notification of overturn.
  4. Delegates are responsible for payment of health care services pertaining to DMHC's IMR decisions that overturn the Delegate's original denial decision.
- J. Grievances Received by an IEHP Provider:
1. If the Member contacts the Provider via telephone to file a grievance, he/she is immediately referred to IEHP's Member Services Department at (800) 440-IEHP (4347) or (800) 718-4347 (TTY). However, if the Member wishes to file his/her grievance with the Provider, the grievance documentation must be immediately faxed to IEHP's Grievance and Appeals Department at (909) 890-5748.
  2. If the Member submits an IEHP Member Complaint Form and/or documentation regarding their grievance to the Provider, the form and/or documentation is immediately faxed to IEHP's Grievance and Appeals Department at (909) 890-5748 (See Attachments, "Member Complaint Form – Medi-Cal – English" and "Member Complaint Form – Medi-Cal – Spanish" in Section 16).
- K. The IEHP Compliance Department reports to the Department of Health Care Services any substantiated grievance alleging discrimination against Members or eligible beneficiaries because of race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual orientation, or physical or mental handicap:
1. IEHP resolves discrimination-related grievances according to Section 1557 of the

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Affordable Care Act (ACA) and copies of all substantiated case written correspondence are forwarded to DHCS via IEHP's Compliance Department.

2. DHCS reviews and takes appropriate action on all discrimination-related grievances.
- L. All Medi-Cal Members are informed of their right to the State Fair Hearing process. The following statement is included in all Member Notice of Appeal Resolution correspondence:

“If you want a State Hearing, you must ask for one within one hundred twenty **(120) days** from the date of the Notice of Appeal Resolution letter. But, if you are currently getting treatment and you want to continue getting treatment, you must ask for a State Hearing within ten **(10) calendar days** from the date this letter was postmarked or delivered to you, or before the date your health plan says services will stop. You must say that you want to keep getting your treatment going when you ask for the State Fair Hearing.

You can ask for a State Hearing over the phone or in writing:

1. By phone, call **1-800-743-8525**. This number can be very busy, so you may get a message to call back later. If you cannot speak or hear well, call **TTY/TDD 1-800-952-8349**.
2. In writing, you will need to fill out a State Hearing form or send a letter to:

**California Department of Social Services  
State Hearings Division  
P.O. Box 944243, Mail Station 9-17-37  
Sacramento, CA 94244-2430**

A State Hearing form is included with this letter. Be sure to include your name, address, telephone number, Social Security Number, and the reason you want a State Hearing. If someone is helping you ask for a State Hearing, add their name, address, and telephone number to the form or letter. If you need an interpreter, you will not have to pay for an interpreter tell us what language you speak, and we will provide one.

After you ask for a State Hearing, it could take up to ninety (90) days to decide your case and send you an answer. If you think waiting that long will hurt your health, you might be able to get an answer within seventy-two (72) hours. Ask your doctor or health plan to write a letter for you. The letter must explain in detail how waiting for up to ninety (90) days for your case to be decided will seriously harm your life, your health, or your ability to attain, maintain, or regain maximum function. Then, ask for an **“expedited hearing,”** and provide the letter with your request for a hearing.

You may speak at the State Hearing yourself. Or someone like a relative, friend, advocate, doctor, or attorney can speak for you. If you want another person to speak for you, then you must tell the State Hearing office that the person is allowed to speak for you. This person is called an “authorized representative.”

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## 16. GRIEVANCE AND APPEALS RESOLUTION SYSTEM

### A. Member Grievance and Appeals Resolution Process

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#### **LEGAL HELP**

- A. You may be able to get free legal help. Call the *California Department of Consumer Affairs* at 1-800-952-5210. You may also call the local Legal Aid Society in your county at 1-888-804-3536.

#### **REFERENCES:**

- A. CA Health & Safety. Code (HSC), §§ 1374.30(i)
- B. DHCS IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 13, Member Services
- C. Section 1557 of the Affordable Care Act (42 U.S.C. § 18116)
- D. Department of Health Care Services (DHCS) All Plan Letter (APL) 17-006, Supersedes APL 04-006 and 05-005 and PL 09-006, Grievance and Appeal Requirements and Revised Notice Templates and “Your Rights” attachments
- E. Title 28, California Code of Regulations (CCR), § 1300.68
- F. Title 42, Code of Federal Regulation (CFR) § 438.402 (2)(i)
- G. Title 42 CFR. § 438.402(2)(ii)
- H. California code of regulations Title 22, §§ 53894(a)
- I. Coordinated Care Initiative (CCI) Three-Way Contract January 2019, Section 2.15
- J. DHCS APL 17-006
- K. Section 1557 of the Affordable Care Act (42 U.S.C. § 18116)
- L. DHCS APL 17-006
- M. HSC, § 1374.30
- N. Title 28, CCR, § 1300.74.30 (f)
- O. Title 28, CCR, § 1300.74.30(a)
- P. Title 22, CCR, § 50951
- Q. Welfare & Institution Code (WIC), § 10951
- R. 45 Code of Federal Regulation (CFR), § 92.101
- S. Title 28, CCR, § 1300.74.30 (f)(1)

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## 16. GRIEVANCE AND APPEALS RESOLUTION SYSTEM

### A. Member Grievance and Appeals Resolution Process

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INLAND EMPIRE HEALTH PLAN		
<b>Chief Approval:</b> <i>Signature on File</i>	<b>Original Effective Date:</b>	September 1, 1996
<b>Chief Title:</b> Chief Medical Officer	<b>Revision Date:</b>	January 1, 2019

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## 16. GRIEVANCE AND APPEALS RESOLUTION SYSTEM

### A. Member Grievance and Appeals Resolution

#### 1. Member Rights and Options

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#### **APPLIES TO:**

A. This policy applies to all IEHP Medi-Cal Members.

#### **POLICY:**

A. IEHP informs Members of their rights and options in accordance with state and federal regulatory guidelines and National Committee for Quality Assurance (NCQA) standards. This information is provided at enrollment and annually thereafter through the IEHP Medi-Cal Member Handbook/Evidence of Coverage (EOC), as well as during the grievance and appeal resolution process.<sup>1</sup>

#### **DEFINITION:**

A. Delegate – For the purpose of this policy, this is defined as a Physician, medical group, Health Plan, IPA, or any contracted organization delegated to provide services on behalf of IEHP.

#### **PURPOSE:**

- A. To define the rights and options available to Members filing a grievance or appeal.
- B. To ensure there is no discrimination against a Member, including cancellation of the contract, solely on the grounds of filing a grievance or appeal.<sup>2</sup>

#### **PROCEDURES:**

A. **Grievances:** Members, their authorized representative or a Provider acting on behalf of a Member and with the Member's consent, may file a grievance at any time following any incident or action that is the subject of the Member's dissatisfaction.<sup>3</sup> Grievances may be filed with IEHP by phone, mail, fax, in person, online through IEHP's website at [www.iehp.org](http://www.iehp.org), or with the assistance of the involved Provider.<sup>4,5,6,7</sup>

Members have the right to personally register a grievance, or designate, either in writing or

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<sup>1</sup> Department of Health Care Services (DHCS)-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 13, Provision 4, Written Member Information.

<sup>2</sup> DHCS All Plan Letter (APL) 17-006 Supersedes APL 04-006 and 05-005 and Policy Letter (PL) 09-006, "Grievance and Appeal Requirements and Revised Notice Templates and 'Your Rights' Attachments".

<sup>3</sup> DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 13, Provision 2, Grievance Process.

<sup>4</sup> DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 13, Provision 1, Members' Rights and Responsibilities.

<sup>5</sup> DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 14, Provisions 1, Member Grievance and Appeal System.

<sup>6</sup> DHCS APL 17-006.

<sup>7</sup> Title 42, Code of Federal Regulations (CFR) § 438.402.

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## 16. GRIEVANCE AND APPEALS RESOLUTION SYSTEM

### A. Member Grievance and Appeals Resolution

#### 1. Member Rights and Options

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verbally that a relative, a representative, Practitioner, Provider or attorney will represent them during the grievance process. In addition, if the Member is a minor, or is incompetent or incapacitated, a grievance may be registered on behalf of the Member by the parent, guardian, conservator, relative, or other designee of the Member, as appropriate. IEHP recognizes the term “relative” to include a parent, stepparent, spouse, adult son or daughter, grandparent, brother, sister, uncle, or aunt of the Member.<sup>8</sup> Please see Policy 16A1, “Member Grievance Resolution Process” for more information.

- B. **Appeals:** Members, their authorized representative or a Provider acting on behalf of a Member and with Member’s written consent, have up to sixty (60) calendar days from the date on the Notice of Adverse Benefit Determination (NABD) to file an appeal with IEHP either orally or in writing.<sup>9,10</sup> Members have the right to request continuation of benefits during an appeal.<sup>11</sup> Please see Policy 16A2, “Member Appeals Resolution Process” for more information.
- C. **Confidentiality:** Members have the right to confidentiality of medical information.<sup>12</sup> Members have the right to file a grievance with the IEHP Chief Compliance Officer, the California Department of Health Care Services (DHCS) Privacy Officer, or the Department of Health and Human Services (DHHS) Office of Civil Rights if the Member believes their right to confidentiality has been violated (HIPAA violation). This information is contained in the IEHP Notice of Privacy Practices.
- D. **Submission of Additional Information:** Members have the right to submit written comments, documents or other information relating to their grievance.<sup>13</sup> This information is relayed to the Member during the triage of the grievance by IEHP and in writing through the denial-related grievance (appeal) acknowledgment letter.
- E. **Discrimination:** All Members have the right to receive access to all covered services without restriction based on race, color, ethnicity, ethnic group identification, national origin, ancestry, language, religion, sex, age, mental or physical disability or medical condition, gender, gender identity, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), genetic

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<sup>8</sup> Knox-Keene Health Care Service Plan Act of 1975, § 1368.

<sup>9</sup> DHCS APL 17-006.

<sup>10</sup> 42 CFR § 438.402.

<sup>11</sup> National Committee for Quality Assurance (NCQA), 2020 Health Plan Standards and Guidelines, UM 8, Element A, Factor 16.

<sup>12</sup> DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 13, Provision 1, Members’ Rights and Responsibilities.

<sup>13</sup> NCQA, 2020 HP Standards and Guidelines, UM 8, Element A, Factor 4.

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## 16. GRIEVANCE AND APPEALS RESOLUTION SYSTEM

### A. Member Grievance and Appeals Resolution

#### 1. Member Rights and Options

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information, marital status, or source of payment.<sup>14,15,16,17,18</sup> IEHP also assures that there is no discrimination against a Member on the grounds that the complainant filed a grievance.<sup>19,20</sup>

Any grievance alleging discrimination against the Member must be filed by email, fax to (909) 890-5748, phone, web, or in person to IEHP immediately. Discrimination grievances are resolved in accordance with the Section 1557 of the Affordable Care Act (ACA). All substantiated cases alleging discrimination against Members or eligible beneficiaries are forwarded to DHCS for review.<sup>21</sup> Please see Policy 9H3, “Cultural and Linguistic Services – Non-Discrimination.”

- F. **Change of Provider:** Members have the right to request a change of their Primary Care Provider (PCP) at any time.<sup>22</sup>
- G. **Right to Disenroll:** Members have the right to disenroll from IEHP at any time without giving a reason.<sup>23</sup>
- H. **Linguistic Needs:** IEHP Members have the right to file a grievance if their linguistic needs are not met when seeking medical care.<sup>24</sup>
- I. **Request for Assistance:** Members have the right to contact DMHC for assistance and/or to request an Independent Medical Review (IMR).
- J. Members are informed of the following rights and options during the Appeals Resolution Process:<sup>25</sup>
  - 1. The Medi-Cal Fair Hearing
    - a. Medi-Cal Members, their authorized representative or a Provider acting on behalf of the Members and with the Member’s written consent, or representative of a deceased Member’s estate have the right to request a Medi-Cal Fair Hearing orally or in writing after IEHP completes review of appeal and issues a Notice of Appeal Resolution

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<sup>14</sup> 42 CFR § 422.110(a).

<sup>15</sup> 45 CFR Part 92.

<sup>16</sup> California Welfare and Institutions Code (Welf. & Inst. Code) § 14029.91.

<sup>17</sup> CA Government Code (Gov. Code) § 11135(a).

<sup>18</sup> DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit E, Attachment 2, Provision 28, Discrimination Prohibition.

<sup>19</sup> DHCS APL 17-006.

<sup>20</sup> Title 28, California Code of Regulations (CCR) § 1300.68(b)(8).

<sup>21</sup> DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit E, Attachment 2, Provision 28, Discrimination Prohibitions.

<sup>22</sup> DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 13, Provision 1, Members’ Rights and Responsibilities

<sup>23</sup> Ibid.

<sup>24</sup> DHCS PL 99-03, “Linguistic Services”.

<sup>25</sup> NCQA, 2020 HP Standards and Guidelines, UM 8, Element A, Factor 10.

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## 16. GRIEVANCE AND APPEALS RESOLUTION SYSTEM

### A. Member Grievance and Appeals Resolution

#### 1. Member Rights and Options

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(NAR).<sup>26,27,28</sup>

- c. Medi-Cal Members have the right to continued medical assistance and benefits, including continuation of services previously authorized, pending a Fair Hearing decision if the Member appeals in writing to the Department of Health Care Services for a hearing:
  - 1) within ten (10) calendar days of the mailing or personal delivery of the NAR to reduce or terminate authorization for a medical service; or
  - 2) before the effective date of action.
- 2. The Right to Contact DMHC

- a. The following statement is included in all Member grievance correspondence:<sup>29</sup>

“If you want an IMR, you must ask for one within one hundred-eighty (180) calendar days from the date of this “Notice of Appeal Resolution” letter. The paragraph below will provide you with information on how to request an IMR. Note that the term “grievance” is talking about both “complaints” and “appeals.”

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-800-440-4347** or **TTY 1-800-718-4347** and use your health plan’s grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than thirty (30) calendar days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for an IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number (**1-888-HMO-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The Department’s Internet Website (<http://www.hmohelp.ca.gov>) has complaint forms, IMR application forms, and instructions online.”

- b. DMHC may require Members to participate in IEHP’s Grievance Resolution Process for up to thirty (30) calendar days prior to pursuing a grievance with DMHC, unless it

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<sup>26</sup> DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 14, Provision 7, State Fair Hearings and Independent Medical Reviews.

<sup>27</sup> DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 16, Provision 3, Disenrollment

<sup>28</sup> DHCS APL 17-006.

<sup>29</sup> KKA, § 1368.02(b).

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## 16. GRIEVANCE AND APPEALS RESOLUTION SYSTEM

### A. Member Grievance and Appeals Resolution

#### 1. Member Rights and Options

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is determined that an earlier review is warranted.

#### 3. Expedited Review

- a. Members have the right to an expedited review and resolution of their urgent grievance within seventy-two (72) hours, if their medical condition involves an imminent and serious threat to the health of the patient, including but not limited to, severe pain, and potential loss of life, limb, or major bodily function.<sup>30,31,32</sup> See Policy 16A2, “Grievance Resolution Process - Member Urgent Medical Grievances” for more information.

#### 4. Voluntary Mediation<sup>33</sup>

- a. Members or their authorized representative may request voluntary mediation with IEHP prior to exercising the right to submit a grievance to DMHC. The use of mediation services does not preclude the right of the Member to submit a grievance to DMHC upon completion of mediation.
- b. In order to initiate mediation, the Member or his/her authorized representative and IEHP must voluntarily agree to mediation.
- c. Expenses for mediation are borne equally by IEHP and the Member.

#### 5. Independent Medical Review (IMR)

- a. A Member may request an IMR of disputed health care services from DMHC if he/she believes that health care services have been improperly denied or partially approved (modified) by IEHP or one of its Delegates, in whole or in part because the service is not medically necessary, or related to experimental and investigational therapies.<sup>34</sup> A disputed health care service is any health care service eligible for coverage and payment under the subscriber contract that has been denied, partially approved (modified), or terminated by IEHP or its contracting Providers, in whole or in part because the service is not medically necessary.<sup>35</sup>
  - 1) Members whose appeal requires expedited review shall not be required to participate in the IEHP’s Internal Grievance process for more than three (3) calendar days before applying for an IMR.
  - 2) If DMHC determines that Member is not eligible for an IMR, the Member’s case will be reviewed through DMHC’s consumer complaint process.

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<sup>30</sup> KKA, § 1368.015.

<sup>31</sup> 28 CCR § 1300.68.01(a).

<sup>32</sup> DHCS APL 17-006.

<sup>33</sup> KKA, § 1368.

<sup>34</sup> CA Health & Saf. Code § 1374.30(i).

<sup>35</sup> KKA, § 1374.30.

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## 16. GRIEVANCE AND APPEALS RESOLUTION SYSTEM

### A. Member Grievance and Appeals Resolution

#### 1. Member Rights and Options

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- 3) Members may not request an IMR if a State Fair Hearing has already been held on the issue.
  - b. Members may apply for an IMR without first participating in IEHP's internal Appeal process in extraordinary and compelling cases, as determined by DMHC, and in cases where Member's request for an experimental treatment was denied. Members are notified in writing of the opportunity to request an IMR of a decision denying an experimental therapy within five (5) business days of the decision to deny coverage.
  - c. Members may request an IMR when the following criteria has been met:<sup>36</sup>
    - 1) The Member's Doctor recommended a health care service as medically necessary;
    - 2) The Member has received urgent care or emergency services that a Provider determined was medically necessary;
    - 3) The Member has seen a Provider within the IEHP network for the diagnosis or treatment of the medical condition for which the Member seeks IMR. The Provider may be an out-of-network Provider when DMHC finds that the Member's decision to secure services outside IEHP's network was reasonable under the circumstances and the disputed health care services were a covered benefit under the terms and conditions of IEHP's contract;
    - 4) The disputed health care service has been denied, partially approved (modified) or terminated by IEHP or one of its Delegates, based in whole or in part on a decision that the health care service is not medically necessary; or
    - 5) The Member has filed a grievance with IEHP and IEHP has determined to agree with the denial decision or the grievance remains unresolved for thirty (30) calendar days. If the grievance requires expedited review, the Member may immediately submit the request for IMR to DMHC.
  - d. The Member may apply to DMHC for an IMR within six (6) months after an appeal was filed with IEHP and the disputed decision is upheld, in whole or in part, that the service is not medically necessary or the case remains unresolved more than thirty (30) calendar days. If the case requires expedited review, Members are not required to file an appeal with IEHP prior to submitting the request for an IMR with DMHC.
  - e. Members may contact IEHP for additional information regarding how to request an IMR or to request an IMR application form at (800) 440-4347 or TTY (800) 718-4347.
- L. **Access to Grievance Documents:** For denial-related appeals, Members have the right to obtain access to and copies of relevant grievance documents upon request and at no cost to

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<sup>36</sup> KKA, § 1374.30.

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## 16. GRIEVANCE AND APPEALS RESOLUTION SYSTEM

- A. Member Grievance and Appeals Resolution
    - 1. Member Rights and Options
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them by contacting Member Services at (800) 440-4347.<sup>37</sup> This information is included in the NAR and grievance resolution letter mailed to the Member. IEHP maintains electronic copies of medical records for ten (10) years.<sup>38,39</sup>

INLAND EMPIRE HEALTH PLAN		
<b>Chief Approval:</b> <i>Signature on file</i>	<b>Original Effective Date:</b>	September 1, 1996
<b>Chief Title:</b> Chief Medical Officer	<b>Revision Date:</b>	January 1, 2021

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<sup>37</sup> NCQA, 2020 Health Plan Standards and Guidelines, UM 8, Element A, Factor 12.

<sup>38</sup> DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit E, Attachment 2, Provision 19, Audit.

<sup>39</sup> KKA, § 1300.68.

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## 16. GRIEVANCE AND APPEAL RESOLUTION SYSTEM

- A. Grievance Resolution Process
    - 2. Member Urgent Medical Grievances
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### **APPLIES TO:**

- A. This policy applies to all IEHP Medi-Cal Members.

### **POLICY:**

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

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## 16. GRIEVANCE AND APPEAL RESOLUTION SYSTEM

### A. Grievance Resolution Process

#### 2. Member Urgent Medical Grievances

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

#### **PURPOSE:**

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

#### **PROCEDURES:**

- A. IEHP Grievance and Appeals department enters the case into the medical management system and assigns the case to Grievance and Appeals staff.
- B. All Member urgent medical grievances received by IEHP are resolved as follows:
  - 1. IEHP's Medical Director evaluates the case for urgency, considering the Member's medical condition. The Medical Director determines if criteria are met to expedite the review. The case is expedited if the Medical Director determines that applying the standard timeframe for review could cause an imminent and serious threat to a Member's health, including but not limited to severe pain, the potential loss of life, limb, or major bodily function, or lack of timeliness that could seriously jeopardize the Member's life, health, or ability to attain, maintain, or regain maximum

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## 16. GRIEVANCE AND APPEAL RESOLUTION SYSTEM

### A. Grievance Resolution Process

#### 2. Member Urgent Medical Grievances

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function.

2. The Member is notified telephonically within twenty-four (24) hours of receiving the grievance if criteria are met (or not) to expedite the review. The Member is informed of the right to notify DMHC of the grievance.
3. If the case does not meet expedited criteria, a written Acknowledgement letter is mailed to the Member within three (3) calendar days of case receipt, including transfer of the case to the standard grievance process. The Member is informed that the standard timeframe for processing the grievance is within thirty (30) calendar days. The Member is informed of his/her rights, including the right to notify DMHC of the grievance.
4. As an enclosure to the Acknowledgement letter, the Member is provided with instructions about the grievance process and its timeframes (See Attachments, “Grievance Resolution Process – Medi-Cal – English” and “Grievance Resolution Process – Medi-Cal – Spanish” in Section 16).
5. The Grievance and Appeals staff investigate the issues and resolve the case. The clinical staff follows through to ensure that urgent grievances are resolved within the prescribed time constraints.
6. IEHP may request additional information or medical records from a Provider, as necessary.
  - a. The affiliated 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 Provider.
7. If the grievance is regarding a denial or partial approval (modification) or termination of health care services, the case is reviewed by someone other than the person making the initial determination and must be reviewed by a Provider with the same specialty or sub-specialty as the requesting Provider.
8. IEHP verbally contacts the Member with decision information as expeditiously as the Member's health condition requires, but no later than seventy-two (72) hours from receipt of the urgent grievance. IEHP works with the Provider to coordinate the Member’s care, if necessary.
9. IEHP mails a resolution letter to the Member within seventy-two (72) hours of receipt of the grievance, with a copy of the letter to the Provider and DMHC.
10. If the grievance is regarding a denial or partial approval (modification) or termination of health care services that have been upheld by IEHP, the resolution letter informs the Member of his/her right to submit a request for Independent

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## 16. GRIEVANCE AND APPEAL RESOLUTION SYSTEM

### A. Grievance Resolution Process

#### 2. Member Urgent Medical Grievances

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Medical Review (IMR) to DMHC. The letter includes an IMR Application Form, instructions on how to request an IMR, and a self-addressed envelope with DMHC's IMR Unit address.

- C. A Member may submit a grievance to DMHC for review, after completing IEHP's grievance process or after having participated in IEHP's grievance system for thirty (30) calendar days; however, this requirement may be waived if DMHC determines that an earlier review is necessary. Upon receipt of such grievance, DMHC notifies IEHP and requests the information used by IEHP to resolve the Member's grievance.
- D. DMHC may request additional information or medical records from IEHP. Should additional information be requested by DMHC, IEHP requests such information from the affiliated Provider, as necessary.
1. The affiliated Provider must submit this information to IEHP within one (1) calendar day of the receipt of IEHP's request.
  2. Any delay caused by the Provider's failure to submit the requested information to IEHP may result in negative actions by IEHP against the Provider.
- E. All Member urgent medical grievances received by a Provider are handled in the following manner:
1. The Provider immediately directs Members to contact IEHP at (800) 440-4347 or TTY (800) 718-4347, to file their urgent grievance.
  2. IEHP resolves all Member urgent medical grievances referred by Providers, in accordance with the guidelines outlined in Procedures A through E.

#### **REFERENCES:**

- A. Title 42 Code of Federal Regulations §438.402, 406 and 408.
- B. Health and Safety Code §§1368, 1368.01, 1368.02, 1368.015.
- C. Title 28, California Code of Regulations §§1300.68, 1300.68.01.
- D. Title 22, California Code of Regulations §§53260, 53858.
- E. Health Insurance Portability and Accountability Act (HIPAA) §§164.520, 164.528.
- F. Department of Health Care Services (DHCS) All Plan Letter 17-006 Supersedes APL 04-006 and 05-005 and Policy Letter (PL) 09-006, "Grievance and Appeal Requirements and Revised Notice Templates and 'Your Rights' Attachments".
- G. NCQA, 2019 HP Standards and Guidelines, Members' Rights and Responsibilities (RR) 2.
- H. DMHC Technical Assistance Guide, Grievance and Appeals – GA-005.

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## 16. GRIEVANCE AND APPEAL RESOLUTION SYSTEM

- A. Grievance Resolution Process
    - 2. Member Urgent Medical Grievances
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- I. DHCS Final Rule Contract Amendment January 2018, Exhibit A, Attachment 14, Member Grievance and Appeal System.

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## 16. GRIEVANCE AND APPEALS RESOLUTION SYSTEM

### B. Dispute and Appeal Resolution Process for Providers

#### 1. Initial

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#### **APPLIES TO:**

A. This policy applies to all IEHP Medi-Cal Providers of Service.

#### **POLICY:**

- A. Disputes are categorized as follows, for tracking and monitoring purposes:
1. Claims/Billing - any formal written disagreement involving the payment, denial, adjustment or contesting of a claim, including overpayments, payment rates, billing issues or other claim reimbursement decisions.
  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 disputes received by Payor including enrollment, capitation or other Provider related issues.
- B. Providers of Service must submit all disputes, including those involving claims, billing, capitation, enrollment, contracting or UM/medical necessity to the financially responsible Payor (contracted IPAs/Hospitals or IEHP) for the initial dispute resolution process.
- C. All disputes must be submitted to the Payor within three hundred and sixty-five (365) days of the last date of action on the issue requiring resolution.<sup>1</sup>
- D. Payors must identify and acknowledge the receipt of all disputes within two (2) working days if the dispute was received electronically or fifteen (15) working days of receipt of a written dispute.<sup>2</sup>
- E. Payors must resolve disputes and issue a written determination within thirty (30) calendar days of receipt of a dispute.
- F. A Provider of Service may submit an appeal regarding the outcome of a Payor's dispute resolution to IEHP within six (6) months of receipt of the written dispute determination letter from the Payor.
- G. A Provider can appeal any adverse determination by a IPA or IEHP. Appeals of referrals denials, or modifications, must be appealed to IEHP. If the denial is upheld, the denial must then be forwarded to the IEHP Grievance and Appeals Department as outlined in Policy 16B2, "Dispute and Appeal Resolution Process for Providers - Health Plan."

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<sup>1</sup> Title 28 California Code of Regulation (CCR) § 1300.71.38.

<sup>2</sup> Ibid.

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## 16. GRIEVANCE AND APPEALS RESOLUTION SYSTEM

### B. Dispute and Appeal Resolution Process for Providers

#### 1. Initial

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#### **DEFINITION:**

- 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.

#### **PROCEDURES:**<sup>3</sup>

- A. Providers of Service must submit all disputes, including those involving claims, billing, capitation, enrollment, contracting or UM/medical necessity to the financially responsible Payor (contracted IPAs/Hospitals or IEHP) for the initial dispute resolution process.
1. If a dispute concerns a claim involving IEHP as a Payor, the written request must be filed in accordance with the guidelines provided in Policy 20A1, “Claims Processing - Provider Dispute Resolution Process - Initial Claims Disputes”.
  2. If a dispute involves a claim related matter in which one of IEHP’s Capitated Providers is the Payor, the dispute must be filed with the Payor in accordance with the Payor’s dispute filing guidelines.<sup>4</sup>
  3. If a dispute involves P4P reimbursements, the written request must be filed in accordance with the guidelines provided in Policy 19C, “Pay For Performance (P4P).”
  4. If the dispute is not about a claim, (i.e. capitation, enrollment, contracting, etc.) the written request must include a clear explanation of the issue and the dispute must be filed in accordance with the Payor’s dispute filing guidelines.<sup>5</sup>
  5. If the dispute is filed on behalf of a Member, the dispute is considered a Member grievance, subject to the requirements of the Member Grievance Resolution process, as outlined in Policy 16A, “Member Grievance Resolution Process.”
- B. Payors must identify and acknowledge in writing the receipt of each dispute, whether complete or not, and disclose the recorded date of receipt for Provider disputes not impacting Member financial risk as follows:<sup>6</sup>
1. If the dispute was received electronically, acknowledgment must be provided within two (2) working days of receipt of the dispute; or
  2. If the dispute was a paper dispute, acknowledgment must be provided within fifteen

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<sup>3</sup> Department of Health Care Services (DHCS) IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 7, Provision 2, Provider Grievance.

<sup>4</sup> 28 CCR § 1300.71.38.

<sup>5</sup> Ibid.

<sup>6</sup> Ibid.

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## 16. GRIEVANCE AND APPEALS RESOLUTION SYSTEM

### B. Dispute and Appeal Resolution Process for Providers

#### 1. Initial

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(15) working days of receipt of the dispute.<sup>7</sup>

- C. If a dispute is incomplete, or if the information is in the possession of the Practitioner and not readily accessible to the Payor, the Payor may return the dispute with a clear explanation, in writing, of any information missing that is necessary to resolve the dispute. The Provider of Service has thirty (30) calendar days to resubmit an amended dispute with the missing information.<sup>8</sup>
- D. 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.
- E. Payors must send written notice of the resolution, including pertinent facts and an explanation of the reason for the determination, within thirty (30) calendar days of the receipt of the dispute.
- F. Providers of Service dissatisfied with the resolution of any dispute **not** involving claims or billing (i.e. capitation, enrollment) may appeal to IEHP in writing, as outlined in Policy 16B2, “Dispute and Appeal Resolution Process for Providers - Health Plan.”
- G. Providers of Service dissatisfied with the initial resolution and written determination by the Payor that involves payment or denial decisions on adjudicated claims or billing, including denials for procedures, referrals or services may submit a written appeal of the Payor’s determination to IEHP by following the process outlined in Policy 20A2, “Claims Processing - Health Plan Claims Appeals.”
- H. Providers of Service not satisfied with the initial determination by the Payor, and the determination is related to medical necessity or utilization management, the Provider of service has the “de novo” right to appeal directly to IEHP within sixty (60) calendar days of receipt of the written determination by submitting a written request for review as outlined in Policy 16B2, “Dispute and Appeal Resolution Process for Providers - Health Plan.”
- I. Furthermore, Providers dissatisfied with the outcome of a dispute originally filed with the Payor that involves pre-service referral denials or modifications may submit an appeal to IEHP in accordance with Policy 16B3, “Dispute and Appeal Resolution Process for Providers – UM Decisions.”
- J. No retaliation can be made against a Provider of Service who submits a dispute in good faith.
- K. Copies of all disputes from Providers of Service, and related documentation, must be retained for at least ten (10) years. A minimum of the last two (2) years must be easily accessible and available within five (5) days of request from IEHP or regulatory agency.

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<sup>7</sup> 28 CCR § 1300.71.38.

<sup>8</sup> Ibid.

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## 16. GRIEVANCE AND APPEALS RESOLUTION SYSTEM

- B. Dispute and Appeal Resolution Process for Providers
    - 1. Initial
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## 16. GRIEVANCE AND APPEALS RESOLUTION SYSTEM

### B. Dispute and Appeal Resolution Process for Providers 2. Health Plan

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#### **APPLIES TO:**

A. This policy applies to all IEHP Medi-Cal Providers of Service.

#### **DEFINITION:**

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.

#### **POLICY:**

A. Providers of Service with disputes must go through the financially responsible Payor (contracted IPAs/Hospitals or IEHP) for the initial dispute resolution process within three hundred and sixty-five (365) days of the development of an issue requiring resolution. Payors must resolve disputes within thirty (30) calendar days of receipt.

B. A Provider of Service may appeal the outcome of the Payor's dispute resolution to IEHP:

1. Within six (6) months of receipt of the written determination; or
2. Within sixty (60) calendar days from the date of written determination for disputes that involve medical necessity or utilization management.

C. IEHP maintains written policies and procedures for processing of Provider/Practitioner denial related grievances regarding UM decisions. IEHP makes final decisions on UM denial related grievance appeals within thirty (30) calendar days of receipt for standard cases or seventy-two (72) hours for expedited cases.

#### **PROCEDURES:**<sup>1</sup>

A. Providers of Service dissatisfied with the written resolution of a grievance or dispute may appeal the decision to IEHP within six (6) months of receipt of the written determination from the Payor.

1. A Provider of Service must submit a written appeal to IEHP within six (6) months of receipt of resolution of initial disputes. Appeals should be sent to:

**Inland Empire Health Plan  
Attn: Provider Services  
P.O. Box 1800  
Rancho Cucamonga, CA 91729-1800**

- a. If the determination involves medical necessity or utilization management, the Provider of Service has the "de novo" right to appeal directly to IEHP within sixty

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<sup>1</sup> Department of Health Care Services (DHCS) IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 7, Provision2, Provider Grievance.

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## 16. GRIEVANCE AND APPEALS RESOLUTION SYSTEM

### B. Dispute and Appeal Resolution Process for Providers

#### 2. Health Plan

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- (60) calendar days from receipt of the determination on the initial dispute, by submitting a written appeal.
- b. The written appeal must include a copy of the initial dispute resolution being appealed and additional supporting documentation to justify the appeal.
2. Dispute appeals are defined as medical and non-medical. Medical and non-medical dispute appeals are resolved separately:
- a. Non-medical dispute appeals are forwarded to the IEHP Director of Provider Relations and may include but are not limited to credentialing issues, contractual issues, enrollment issues, IEHP Team Member or Department issues or problems related to IEHP policies and procedures.
    - 1) Claims related dispute appeals are handled in accordance with Policy 20A2, “Claims Processing - Health Plan Claim Appeals.”
    - 2) Refer to Policy 5A6, “Credentialing Standards – Notifications to Authorities and Practitioners Appeal Rights” for appeals or grievance related to adverse credentialing decisions.
  - b. Medical dispute appeals are forwarded to IEHP Medical Director or designee and may include but are not limited to quality management issues, case management issues, or problems related to IEHP policies and procedures related to delivery of health care services.
    - 1) Medical disputes involving current patient care are resolved according to the IEHP Grievance process, as outlined in Policy 16B3, “Dispute and Appeal Resolution Process for Providers – Utilization Management Decisions,” and the immediacy of the situation. Otherwise, medical and non-medical dispute appeals are resolved within thirty (30) calendar days. IEHP resolves the appeal 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.
    - 2) Utilization Management (UM) denial appeals from a Provider of Service that do not involve a claims issue are forwarded to IEHP’s Grievance and Appeal Department as outlined in Policy 16B3, “Dispute and Appeal Resolution Process for Providers – Utilization Management Decisions.” IEHP’s Medical Director or designee reviews the information and makes a determination within thirty (30) days. The Provider receives an acknowledgement letter, and a resolution letter notifying them of the final decision.
    - 3) When the appeal is resolved, IEHP mails a copy of the final appeal disposition

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## 16. GRIEVANCE AND APPEALS RESOLUTION SYSTEM

### B. Dispute and Appeal Resolution Process for Providers 2. Health Plan

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to the Provider of Service within thirty (30) calendar days of resolution with a courtesy copy to the Payor.

- B. If the Provider of Service is still not satisfied with the outcome of IEHP's appeal determination, the Provider of Service may request IEHP Chief Executive Officer (CEO) reviews (for non-medical decision) the appeal. Appeals for IEHP CEO must be received within thirty (30) calendar days of receipt of the decision concerning the appeal to IEHP. Decisions on the health plan appeal by IEHP CEO are final.
- C. If IEHP receives an initial dispute directly from a Provider of Service, IEHP will forward the dispute to the financially responsible Payor for resolution, as applicable and notify the Provider of Service, except as stated for "de novo" rights (Procedure A.1.a).

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## 16. GRIEVANCE AND APPEAL RESOLUTION SYSTEM

### B. Dispute and Appeal Resolution Process for Providers

#### 3. Utilization Management Decisions

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#### **APPLIES TO:**

- A. This policy applies to all IEHP Medi-Cal Providers filing an appeal due to a utilization management (UM) denial or partial approval (modification) decision.

#### **POLICY:**

- A. A Provider may appeal any adverse determination (denial or partial approval) by a Delegate or IEHP. Provider appeals (request for reconsideration) of referral denials or partial approvals (modifications) must be initially submitted to the appropriate Delegate as an “opportunity to discuss” within seventy-two (72) hours of initial denial determination. If the initial denial determination is upheld by the Delegate, the Provider may request a formal appeal by directing the request to the IEHP Grievance and Appeals 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, “Member Grievance and Appeals Resolution Process,” 16A1, “Grievance and Appeals Resolution Process - Member Rights and Options,” and 16A2, “Grievance Resolution Process - Member Urgent Medical Grievances.” 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 (QOC) issue, the case is discussed with the Medical Director, and may be referred to the Potential Quality Incident (PQI) Team upon resolution, if a QOC issue is identified.
- D. IEHP does not discriminate against Providers for filing denial-related appeals.
- E. A Provider may withdraw a denial-related 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, “Dispute and Appeal Resolution Process for Providers – Initial” and 16B2, “Dispute and Appeal Resolution Process for Providers – Health Plan.”
- H. Provider denial-related grievances (appeals) filed on behalf of Members or as Member representative, are classified as Member appeals and processed per Policies 16A, “Member Grievance and Appeals Resolution Process” and 16A2, “Grievance Resolution Process - Member Urgent Medical Grievances.” A Provider is automatically considered a Member’s representative when submitting an appeal for a denial of an urgent referral request, or for any referral request with Member impact, such as a pre-service request without initiation of claim adjudication.

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## 16. GRIEVANCE AND APPEAL RESOLUTION SYSTEM

### B. Dispute and Appeal Resolution Process for Providers

#### 3. Utilization Management Decisions

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#### **PURPOSE:**

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

#### **DEFINITION:**

- A. Delegate – For the purpose of this policy, this is defined as a medical group, Delegated IPA, or any contracted organization delegated to provide utilization management (UM) services.

#### **PROCEDURES:**

- A. IEHP Grievance and Appeals staff conducts an initial review of the Provider appeal request to determine if a Provider claim is in process, or the Provider has first appealed through the Delegate. The Provider will be directed to the Delegate for an initial appeal only if the adverse determination was made within the last seventy-two (72) hours. If the determination was made over seventy-two (72) hours, IEHP will open an appeal.
- B. If a claim has been received and is in process, the appeal is routed to the IEHP Claims Department for processing.
- C. Upon confirmation of the denial and if claim adjudication has not been initiated; IEHP Grievance and Appeals staff will open an appeal 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 is noted as the Member's representative.
- D. An acknowledgement letter is sent to the Provider by IEHP Grievance and Appeals Department within five (5) calendar days from appeal receipt. The letter is copied to the Member. The initial denial letter, referral criteria, and all supporting documentation are obtained as outlined in Policy 16A, "Member Grievance and Appeals Resolution Process."
- E. A separate electronic case is maintained for each new Provider appeal that is filed.
- F. The Grievance and Appeals Nurse prepares the case for review by the Medical Director, ensuring all necessary medical information has been received.
- G. If a Provider requests an urgent (expedited) review, IEHP must provide an expedited review if the Provider indicates that applying the standard timeframe for conducting a review could cause an imminent and serious threat to the health of the Member, including, but not limited to, severe pain, potential loss of life, limb or major bodily function; or lack of timeliness that could seriously jeopardize the Member's life, health, or ability to attain, maintain, or regain maximum function.

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## 16. GRIEVANCE AND APPEAL RESOLUTION SYSTEM

### B. Dispute and Appeal Resolution Process for Providers 3. Utilization Management Decisions

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- 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 seventy-two (72) hours after receipt of the appeal, to ensure that the Member's health and welfare are not at risk as outlined in Policy 16A2, "Grievance Resolution Process - Member Urgent Medical Grievances."
- I. The Grievance and Appeals Coordinator and/or Nurse monitors the progress of the case.
- J. IEHP's Medical Director reviews all Provider/ appeals, and with the assistance of the Grievance and Appeals Department, obtains all necessary pertinent medical information to review the previous denial decision.
- K. After review of pertinent medical information, the Medical Director may discuss the case with the Provider if necessary. The Medical Director makes a decision within thirty (30) calendar days of receipt of the standard case. The decision of IEHP's Medical Director is final.
- L. A notification letter is sent to the Provider informing them of the outcome of the appeal, including the criteria, applicable benefit coverage, and regulations used in making the decision.
- M. Provider appeals are tracked and trended by the Grievance and Appeals Department and reported to the Quality Management Committee if negative patterns are identified.
- N. A Provider filing an appeal on behalf of a Member is directed to the Grievance and Appeals Department for processing of the issue according to regulations and standards for Member appeals, as outlined in Policy 16A, "Member Grievance and Appeals Resolution Process."

#### **REFERENCES:**

- A. Title 22, California Code of Regulations §53859.
- B. Title 28, California Code of Regulations §1300.68.01.
- C. Department of Health Care Services (DHCS) All Plan Letter (APL) 17-006 Supersedes APL 04-006 and 05-005 and Policy Letter (PL) 09-006, "Grievance and Appeal Requirements and Revised Notice Templates and 'Your Rights' Attachments".
- D. NCQA, 2019 HP Standards and Guidelines, Members' Rights and Responsibilities (RR) 2.
- E. DHCS Final Rule Contract Amendment January 2018, Exhibit A, Attachment 14, Member Grievance and Appeal System.

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## 16. GRIEVANCE AND APPEALS RESOLUTION SYSTEM

### C. IPA, Hospital and Practitioner Grievance and Appeal Resolution Process

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#### **APPLIES TO:**

- A. This policy applies to all IEHP Medi-Cal Providers (IPA, Hospital and Practitioners).

#### **POLICY:**

- A. Providers (IPAs, Hospitals and Practitioners) must submit their grievances directly to IEHP.
- B. IEHP requires all Provider grievances to be submitted in writing within three hundred sixty-five (365) days of the development of an issue requiring resolution.
- C. IEHP must identify and acknowledge the receipt of all grievances within two (2) working days if the grievance was received electronically or within fifteen (15) working days of receipt of a written grievance and/or appeal (See Attachment, “Provider Grievance Acknowledgment Letter” in Section 16).
- D. IEHP attempts to resolve all grievances within thirty (30) calendar days after the date of receipt of the Provider dispute or the amended Provider dispute.
- E. Providers may appeal a grievance resolution to IEHP within thirty (30) calendar days of receipt of the grievance resolution letter from IEHP.
- F. Non-medically related grievances are assessed and resolved by the IEHP Director of Provider Relations. Non-medically related grievances from Providers may include credentialing issues, capitation issues, contractual issues, enrollment issues, IEHP Team Member or Department issues or problems related to IEHP policies and procedures.
- G. Medically related grievances are assessed and resolved by the IEHP Medical Director or designee. Medically related grievances from Providers may include quality management issues, case management issues, or problems related to IEHP Policies and Procedures.

#### **PROCEDURES:**

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

**Inland Empire Health Plan  
Attn: Provider Services  
P.O. Box 1800  
Rancho Cucamonga, CA 91729-1800**

- B. All written Provider Grievances are reviewed and evaluated by IEHP to determine medical vs. non-medical related grievances and distributed to appropriate staff accordingly.
- C. All other written Provider Grievances not relevant to IEHP are reviewed and triaged for appropriateness and are referred to the sponsoring organization as applicable.

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## 16. GRIEVANCE AND APPEALS RESOLUTION SYSTEM

### C. IPA, Hospital and Practitioner Grievance and Appeal Resolution Process

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- D. All Provider Grievances must be identified and acknowledged in writing upon receipt, whether complete or not, and disclose the recorded date of receipt as follows:
1. If the grievance was received electronically, acknowledgment must be provided within two (2) working days of receipt of the dispute; or
  2. If the grievance was received in writing, acknowledgment must be provided within fifteen (15) working days of receipt of the dispute.
- E. IEHP must make a good faith attempt to resolve the issue within thirty (30) calendar days of receipt of the grievance.
- F. Providers are notified in writing if the resolution will be delayed beyond IEHP's established timeframes.
- G. If a grievance involves P4P reimbursements, the written request must be filed in accordance with the guidelines provided in Policy 19C, "Pay For Performance (P4P)."
- H. Claims related grievance appeals are handled in accordance with Policy 20A2, "Claims Processing - Health Plan Claims Appeals."
- I. IEHP resolves the grievance by considering all available information and may request additional information or discuss the issue with the involved Provider(s).
- J. When grievances are resolved, IEHP mails a copy of the final disposition to the Provider within thirty (30) calendar days of resolution (See Attachment, "Provider Grievance Resolution Letter" in Section 16).
- K. Providers dissatisfied with a resolution may appeal to IEHP within thirty (30) calendar days of receipt of the grievance resolution from IEHP (See Attachment, "Provider Fair Hearing Process" in Section 16).
1. Providers must submit a written appeal to IEHP within thirty (30) calendar days of receipt of the final disposition of initial grievance. The written appeal must include a copy of the initial resolution being appealed, justification and supporting documentation for the appeal.
  2. Non-medical grievance appeals are forwarded to the IEHP Chief Executive Officer (CEO) for review.
  3. Medical grievance appeals are forwarded to the Peer Review Subcommittee for review.
  4. The decision of the IEHP CEO or Peer Review Subcommittee is final.
  5. IEHP mails written notice of the appeal decision within thirty (30) calendar days of the decision.
  6. Refer to Policy 20A2, "Claims Processing - Health Plan Claims Appeals" for appeals or grievances relating to payment or denial of adjudicated claims.

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## 16. GRIEVANCE AND APPEALS RESOLUTION SYSTEM

### C. IPA, Hospital and Practitioner Grievance and Appeal Resolution Process

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- L. Providers appealing the termination or non-renewal of their IEHP Agreement may appeal to the Peer Review Subcommittee (See Attachment, “IEHP Peer Review Level I and Credentialing Appeal” in Section 5).

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## 16. GRIEVANCE AND APPEALS RESOLUTION SYSTEM

### Attachments

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<u>DESCRIPTION</u>	<u>POLICY CROSS REFERENCE</u>
Appeal Resolution Process – Medi-Cal – English	16A1
Appeal Resolution Process – Medi-Cal – Spanish	16A1
Grievance Resolution Process – Medi-Cal - Spanish	16A1, 16A2
Grievance Resolution Process – Medi-Cal - English	16A1, 16A2
Member Complaint Form – Medi-Cal - English	16A1
Member Complaint Form – Medi-Cal - Spanish	16A1
Provider Fair Hearing Process	16B4, 16C
Provider Grievance Acknowledgment Letter	16C
Provider Grievance Resolution Letter	16C



## **APPEAL RESOLUTION PROCESS** **(MEDI-CAL)**

### **HOW CAN I FILE AN APPEAL?**

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

Inland Empire Health Plan  
Grievance and Appeals Department  
10801 6<sup>th</sup> St., Suite 120  
Rancho Cucamonga CA 91730-5987  
IEHP's Business Hours: 8:00AM to 5:00PM  
Monday through Friday
  - e) You may also file your appeal by mail at P.O. Box 1800, Rancho Cucamonga, CA 91729-1800.
2. IEHP Complaint Forms are readily available at all IEHP Provider and their Contracting Organization locations. A patient advocate should be available to assist you with this process.

### **WHAT HAPPENS AFTER I FILE MY APPEAL?**

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

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

4. Services previously authorized by IEHP will continue while the appeal is being resolved.

### **YOUR APPEAL RIGHTS**

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



## **PROCESO DE RESOLUCIÓN DE APELACIONES** **(MEDI-CAL)**

### **¿CÓMO PUEDO PRESENTAR UNA APELACIÓN?**

1. Los Miembros de IEHP tienen derecho a presentar una apelación sin temor a recriminación. Para presentar su apelación directamente ante IEHP, puede hacer una de las siguientes acciones:
  - a) Llame al Departamento de Servicios para Miembros de IEHP al (800) 440-4347 o al (800) 718-4347 (TTY) y presente su apelación con un Representante de Servicios para Miembros.
  - b) Envíe su apelación al Departamento de Apelaciones y Quejas Formales de IEHP por fax al (909) 890-5748.
  - c) Presente su apelación a través del sitio web de IEHP en [www.iehp.org](http://www.iehp.org).
  - d) Puede elegir presentar su apelación personalmente en la siguiente dirección:

Inland Empire Health Plan  
Grievance and Appeals Department  
10801 6<sup>th</sup> St., Suite 120  
Rancho Cucamonga CA 91730-5987  
Horas Laborables de IEHP: De 8am a 5pm  
De lunes a viernes

- e) También puede presentar su apelación por correo en P.O. Box 1800, Rancho Cucamonga, CA 91729-1800.
2. Los Formularios de Quejas de IEHP están disponibles en todas las ubicaciones de los profesionales de IEHP y sus Organizaciones Contratantes. Un defensor del paciente debe estar a su disposición para ayudarle con este proceso.

### **¿QUÉ SUCEDE DESPUÉS DE QUE PRESENTE MI APELACIÓN?**

1. Recibirá una carta de acuse de recibo en la que se le informará la recepción de su apelación dentro de los cinco (5) días a partir de la fecha en que IEHP reciba su apelación. La carta le proporcionará el nombre y el número de teléfono de un Representante de Apelaciones, quien le ayudará con su apelación. Informe al Representante de Apelaciones si su dirección o número de teléfono ha cambiado.
2. Todo el proceso se resolverá en un plazo de 30 días. IEHP le enviará una carta con la resolución dentro de este plazo.

3. Si su apelación implica una amenaza grave para su salud (lo que denominamos apelación urgente), la resolveremos dentro de un plazo de 72 horas. Le notificaremos la decisión de inmediato y le enviaremos una carta para explicarle nuestra resolución dentro de las 72 horas a partir de la fecha en que recibamos su apelación. Las apelaciones urgentes implican una amenaza inminente y grave para su salud, incluyendo, pero sin limitarse a, dolor severo, la posible pérdida de la vida, una extremidad o una función corporal importante.
4. Los servicios autorizados previamente por IEHP continuarán mientras se resuelve la apelación.

### **SUS DERECHOS RELATIVOS A UNA APELACIÓN**

1. Tiene derecho a que se resuelva su apelación urgente dentro de un plazo de 72 horas. Tiene derecho a comunicarse de inmediato con el Department of Managed Health Care, DMHC en relación con su apelación urgente al 1-888-HMO-2219, o a la línea TDD al 1-877-688-9891, o bien, a través del sitio web: <http://www.hmohelp.ca.gov>. Todas las demás apelaciones se resuelven dentro de un plazo de 30 días.
2. Tiene derecho a solicitar a IEHP que le ayude a trabajar con su Proveedor o cualquier otra persona para solucionar su problema.
3. Tiene derecho a cambiar de Proveedor.
4. Tiene derecho a designar a un representante para que le ayude a presentar su apelación y le represente durante el proceso de apelaciones. Además, las apelaciones pueden ser registradas o presentadas por Abogados, Médicos, Padres, Tutores, Custodios, Parientes u otra Persona Designada, si el Miembro es menor de edad o un adulto incapacitado. Los Parientes incluyen Padre o Madre, Padrastro o Madrastra, Cónyuge, Hijo o Hija Adultos, Abuelo o Abuela, Hermano o Hermana, Tío o Tía.
5. Tiene derecho a cancelar su inscripción en IEHP en cualquier momento sin proporcionar un motivo.
6. Tiene derecho a solicitar una mediación voluntaria. Usted será responsable de la mitad de los costos de la mediación.
7. Tiene derecho a presentar comentarios escritos, documentos u otro tipo de información que respalde su apelación.
8. Tiene derecho a presentar una queja formal si no se satisfacen sus necesidades lingüísticas.
9. Puede comunicarse con otras Agencias Estatales para solicitar ayuda.



## **GRIEVANCE RESOLUTION PROCESS** **(MEDI-CAL)**

### **HOW CAN I FILE A GRIEVANCE?**

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

Inland Empire Health Plan  
Grievance and Appeals Department  
10801 6<sup>th</sup> St., Suite 120  
Rancho Cucamonga CA 91730-5987  
IEHP's Business Hours: 8:00AM to 5:00PM  
Monday through Friday

- e) You may also file your grievance by mail at P.O. Box 1800, Rancho Cucamonga, CA 91729-1800.
2. IEHP Complaint Forms are readily available at all IEHP Practitioner and their Contracting Organization locations. A patient advocate should be available to assist you with this process.

### **WHAT HAPPENS AFTER I FILE MY GRIEVANCE?**

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

including, but not limited to, severe pain, potential loss of life, limb, or major bodily function.

4. Services previously authorized by IEHP will continue while the grievance is being resolved.

### **YOUR GRIEVANCE RIGHTS**

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

### **IF YOU ARE STILL UNHAPPY YOU MAY:**

1. Appeal the grievance decision by calling IEHP Member Services at 1-800-440-IEHP (4347)/TTY 1-800-718-4347 within 30 days of when you first filed your grievance.



Inland Empire Health Plan

## **PROCESO DE RESOLUCIÓN DE QUEJAS FORMALES** **(MEDI-CAL)**

### **¿CÓMO PUEDO PRESENTAR UNA QUEJA FORMAL?**

1. Los Miembros de IEHP tienen derecho a presentar una queja formal contra IEHP o sus profesionales sin temor a recriminación. Para presentar su queja formal directamente ante IEHP, puede hacer una de las siguientes acciones:
  - a) Llame al Departamento de Servicios para Miembros de IEHP al (800) 440-4347 o al (800) 718-4347 (TTY) y presente su queja formal ante un Representante de Servicios para Miembros.
  - b) Envíe su queja formal al Departamento de Quejas Formales de IEHP por fax al (909) 890-5748.
  - c) Presente su queja formal a través del sitio web de IEHP en [www.iehp.org](http://www.iehp.org).
  - d) Puede elegir presentar su queja formal personalmente en la siguiente dirección:

Inland Empire Health Plan  
Grievance and Appeals Department  
10801 6<sup>th</sup> St., Suite 120  
Rancho Cucamonga CA 91730-5987  
Horas Laborables de IEHP: De 8am a 5pm  
De lunes a viernes
  - e) También puede presentar su queja formal por correo en P.O. Box 1800, Rancho Cucamonga, CA 91729-1800.
2. Los Formularios de Quejas de IEHP están disponibles en todas las ubicaciones de los profesionales de IEHP y sus Organizaciones Contratantes. Un defensor del paciente debe estar a su disposición para ayudarle con este proceso.

### **¿QUÉ SUCEDE DESPUÉS DE QUE PRESENTE MI QUEJA FORMAL?**

1. Recibirá una carta de acuse de recibo en la que se le informará la recepción de su queja formal dentro de los cinco (5) días a partir de la fecha en que IEHP reciba su queja formal. La carta le proporcionará el nombre y el número de teléfono de un Representante de Quejas Formales, quien le ayudará con su queja formal. Informe al Representante de Quejas Formales si su dirección o número de teléfono ha cambiado.
2. Todo el proceso se resolverá en un plazo de 30 días. IEHP le enviará una carta con la resolución dentro de este plazo.
3. Si su queja formal implica una amenaza grave para su salud (lo que denominamos queja formal urgente), la resolveremos dentro de un plazo de 72 horas. Le notificaremos la

decisión de inmediato y le enviaremos una carta para explicarle nuestra resolución dentro de las 72 horas a partir de la fecha en que recibamos su queja formal. Las quejas formales urgentes implican una amenaza inminente y grave para su salud, incluyendo, pero sin limitarse a, dolor severo, la posible pérdida de la vida, una extremidad o una función corporal importante.

4. Los servicios autorizados previamente por IEHP continuarán mientras se resuelve la queja formal.

### **SUS DERECHOS RELATIVOS A UNA QUEJA FORMAL**

1. Tiene derecho a que se resuelva su queja formal urgente dentro de un plazo de 72 horas. Tiene derecho a comunicarse de inmediato con el Department of Managed Health Care, DMHC, en relación con su queja formal urgente al 1-888-HMO-2219, o a la línea TDD 1-877-688-9891, o bien, a través del sitio web: <http://www.hmohelp.ca.gov>. Todas las demás quejas formales se resuelven dentro de un plazo de 30 días.
2. Tiene derecho a solicitar a IEHP que le ayude a trabajar con su Proveedor o cualquier otra persona para solucionar su problema.
3. Tiene derecho a cambiar de Proveedor.
4. Tiene derecho a designar a un representante para que le ayude a presentar su queja formal y le represente durante el proceso de quejas formales. Además, las quejas formales pueden ser registradas o presentadas por Abogados, Doctores, Padres, Tutores, Custodios, Parientes u otra Persona Designada, si el Miembro es menor de edad o un adulto incapacitado. Los Parientes incluyen Padre o Madre, Padrastro o Madrastra, Cónyuge, Hijo o Hija Adultos, Abuelo o Abuela, Hermano o Hermana, Tío o Tía.
5. Tiene derecho a cancelar su inscripción en IEHP en cualquier momento sin proporcionar un motivo.
6. Tiene derecho a solicitar una mediación voluntaria. Usted será responsable de la mitad de los costos de la mediación.
7. Tiene derecho a presentar comentarios escritos, documentos u otro tipo de información que respalde su queja formal.
8. Tiene derecho a presentar una queja formal si no se satisfacen sus necesidades lingüísticas.
9. Puede comunicarse con otras Agencias Estatales para solicitar ayuda.

### **SI AÚN NO ESTÁ CONFORME, ADEMÁS PUEDE:**

1. Apelar la decisión sobre la queja formal llamando a Servicios para Miembros de IEHP al 1-800-440-IEHP (4347)/TTY 1-800-718-4347 dentro de los 30 días a partir del día en que presentó su queja formal por primera vez.

Inland Empire Health Plan  
 Attn: Grievance Department  
 P.O. Box 1800  
 Rancho Cucamonga, CA 91729-1800  
 Fax # (909) 890-5748



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

Inland Empire Health Plan  
**MEMBER COMPLAINT FORM**  
**(MEDI-CAL)**

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

**MEMBER INFORMATION**

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

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

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

**NATURE OF COMPLAINT**

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

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

\_\_\_\_\_  
**MEMBER'S SIGNATURE** \_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**SIGNATURE OF PARENT OR LEGAL GUARDIAN**  
*(IF THE MEMBER IS A MINOR OR INCOMPETENT)* \_\_\_\_\_  
**DATE**

**Department of Managed Health Care:**

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-800-440-4347**, or **1-800-718-4347 TTY** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (**1-888-HMO-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department's Internet Web site <http://www.hmohelp.ca.gov> has complaint forms, IMR application forms and instructions online.

You can get this information for free in other languages. You can ask for this in other formats, such as large print, Braille or audio. Call 1-800-440-IEHP (4347), Monday through Friday, from 8am to 5pm (PST), . TTY/TDD users should call 1-800-718-4347. The call is free.

The above services are available to IEHP Member's at no cost.

Inland Empire Health Plan  
 Attn: Grievance Department  
 P.O. Box 1800  
 Rancho Cucamonga, CA 91729-1800  
 Fax # (909) 890-5748



Inland Empire Health Plan  
**FORMULARIO DE QUEJAS**  
**(MEDI-CAL)**

Si tiene alguna pregunta  
 llame al:  
 1-800-440-4347  
 1-800-718-4347 (TTY)

**Por favor responda este formulario y reenvíelo al Departamento de Quejas de IEHP (IEHP Grievance Department) al domicilio indicado en la parte superior.**

**INFORMACIÓN DEL MIEMBRO**

NOMBRE	INICIAL	APELLIDO	
DOMICILIO DEL MIEMBRO:			# DE IDENTIFICACIÓN DEL MIEMBRO DE IEHP
			# DE TELÉFONO ( ) -

**PERSONA QUE ESTÁ PRESENTANDO LA QUEJA** (Usted tiene el derecho de designar a cualquier persona a su libre elección para que presente su queja (queja formal) o para que lo represente durante el proceso de queja. También, las quejas pueden ser presentadas por un padre, tutor, custodio, familiar, u otra persona designada, si el Miembro es menor de edad o es un adulto incapacitado).

NOMBRE _____
RELACIÓN <input type="checkbox"/> UNO MISMO <input type="checkbox"/> MADRE <input type="checkbox"/> PADRE <input type="checkbox"/> ABUELO <input type="checkbox"/> TUTOR <input type="checkbox"/> OTRO _____

**TIPO DE QUEJA**

¿DÓNDE SUCEDIÓ EL INCIDENTE? ( <i>NOMBRE DEL HOSPITAL, DOCTOR, OTRO LUGAR</i> ).
¿CUÁNDO SUCEDIÓ? ( <i>SI NO RECUERDA CON EXACTITUD, INDIQUE FECHAS APROXIMADAS</i> ).
¿QUIÉN ESTUVO IMPLICADO O QUIÉNES PARTICIPARON EN EL INCIDENTE?
POR FAVOR DESCRIBA QUÉ SUCEDIÓ. ( <i>SI ES NECESARIO, ADJUNTE HOJAS ADICIONALES PARA DETALLAR SU DECLARACIÓN</i> ).

Como Miembro de IEHP, usted tiene derecho a presentar una queja en contra de IEHP o de sus proveedores, sin temor a sufrir alguna acción negativa por parte de IEHP, su Doctor, o cualquier otro proveedor. También tiene derecho a presentar una queja/queja formal ante el Departamento de Atención Médica Administrada (*Department of Managed Health Care*), el cual regula los planes de salud. Si tiene alguna pregunta, por favor llame al 1-800-440-4347 o al 1-800-718-4347 (TTY).

\_\_\_\_\_  
**FIRMA DEL MIEMBRO**

\_\_\_\_\_  
**FECHA**

\_\_\_\_\_  
**FIRMA DEL PADRE O TUTOR LEGAL**  
 (*SI EL MIEMBRO ES UN MENOR O ESTÁ INCAPACITADO*)

\_\_\_\_\_  
**FECHA**

**Departamento de Atención Médica Administrada:**

El Departamento de Atención Médica Administrada de California es responsable de regular los planes que ofrecen servicios de atención médica. Si tiene una queja formal relacionada con su plan de salud, debe de llamar primero a su plan de salud al **1-800-440-4347** o al **1-800-718-4347 TTY** y seguir el proceso de resolución de quejas de su plan de salud antes de comunicarse con el departamento. Utilizar este proceso de quejas no le impide el uso de cualquier otro derecho o recurso legal potencial disponible para usted. Si necesita ayuda con una queja que involucra una emergencia, una queja que no ha sido resuelta satisfactoriamente por su plan de salud, o que continúa sin resolución por más de 30 días, puede llamar al departamento para recibir asistencia. También es posible que usted sea elegible para una Revisión Médica Independiente (*Independent Medical Review, IMR*). Si es elegible para una IMR, el proceso de IMR proveerá una revisión imparcial de las decisiones médicas determinadas por un plan de salud en relación a la necesidad médica de un servicio o tratamiento propuesto, las decisiones de cobertura para tratamientos experimentales o de investigación y conflictos financieros por servicios médicos urgentes o de emergencia. El departamento tiene un número de teléfono gratuito (**1-888-HMO-2219**) y una línea TDD (**1-877-688-9891**) para las personas con dificultades auditivas y del habla. El sitio web del departamento <http://www.hmohelp.ca.gov> cuenta con formularios para presentar quejas, solicitudes para IMR e instrucciones disponibles en línea.

Usted puede obtener esta información en otros idiomas de manera gratuita. Puede solicitar esta información en formatos alternativos, como impresión con letra grande, en Braille o audio. Llame al 1-800-440-IEHP (4347), de 8am a 5pm (Hora del Pacífico), de lunes a viernes. Los usuarios de TTY/TDD deben llamar al 1-800-718-4347. La llamada es gratuita.

Los servicios mencionados anteriormente están disponibles sin costo para Miembros de IEHP.

**PROVIDER FAIR HEARING PROCESS**

**FOR PARTICIPATION IN**

**THE PROVIDER NETWORK**

**OF**

**INLAND EMPIRE HEALTH PLAN**

(Adopted September 11, 1995; Revised September 11, 2006, August 10, 2009, and July, 2015)

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

Independent Physician Associations (“IPA) and Hospital Providers (hereinafter, collectively referred to as “Provider”) 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 (IPA) 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 (IPA) to be included or to continue participation in the provider network of IEHP shall inform the Provider(IPA) of the reason(s) for rejection and 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 (IPA) 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. “Date of mailing” shall be defined as the date response is deposited to the postal service and postmarked; or such other documented date of deposit to a nationally recognized express transportation company. Such request for a Fair Hearing shall be made by written response from the Provider (IPA) to the Chief Executive Officer, or his designee.
- d. Providers (IPA) failing to request a Fair Hearing before the Board of IEHP within ten (10) working days from the date of mailing 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 (IPA) 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 (IPA) 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 (IPA) to provide requested documentation in the timeframes indicated may be considered waiver of Provider (IPA)'s 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 (IPA). 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 (IPA) 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 (IPA) 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 (IPA) 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 (IPA) 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 (IPA) 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 (IPA) 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 (IPA) meets the Provider participation standards for inclusion, as approved by the Board.
  - ii. Grant the request of the Provider (IPA) 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 (IPA) 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 (IPA) 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 (IPA) seeking to be included in the IEHP provider network shall be required to exhaust the administrative remedies, as set forth herein, prior to seeking judicial review of the actions of IEHP, and the Board of IEHP.
- b. A Provider (IPA) 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, as set forth 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 (IPA) to be included or to continue participation in the provider network of IEHP.



[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 Relations will resolve your grievance, within thirty (30) calendar 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:

Kenneth Scott, Director of Provider Relations, IEHP  
Justin Bottger, Manager of Provider Relations  
File location (see policy and procedures PRO/GEN 03) ex. F-120.a



DATE

Dr. PROVIDER NAME  
Address  
City, State ZIP

**Re: Grievance** \_\_\_\_\_

Dear Dr. [Provider Name]:

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

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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,

Kenneth Scott  
Director of Provider Relations, IEHP

cc: Justin Bottger, Manager of Provider Relations, IEHP  
PSR Name, Provider Services Representative, IEHP  
PCP

File location (see policy and procedures PRO/GEN 03) ex. F-120.a