16. GRIEVANCE AND APPEAL RESOLUTION SYSTEM

A. Member Grievance Resolution Process

APPLIES TO:

A. This policy applies to all IEHP DualChoice Members.

POLICY:

A. IEHP has established and maintains written procedures for the submittal, processing, and resolution of all Member grievances and complaints.[1,2,3,4]

B. A Member has the right to file a grievance at any time following any incident or action that is the subject of dissatisfaction.[5]

PURPOSE:

A. To establish and maintain a timely and responsive procedure for submittal, process and resolution of all Member grievances and complaints.[6]

B. To identify and correct negative trends and potential problems regarding access to care, quality of care, denial of service, continuity of care, staff, confidentiality, or Provider network issues for quality improvement.

DEFINITIONS:

A. **Standard Grievance** - An oral or written expression of dissatisfaction regarding any matter other than one that constitutes an Organization Determination (OD), expressing dissatisfaction with any aspect of IEHP's, or its Providers' operations, activities, or behavior, regardless of whether remedial action is requested or can be taken.[7,8] Grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships, or failure to respect the Member's rights.[9,10] 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

[1] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 30
[2] Title 22, California Code of Regulations (CCR) § 53858(a)
[3] 28 CCR § 1300.68(a)
[4] California Health and Safety Code (Health & Saf. Code) § 1368(a)(1)
[5] Title 42 Code of Federal Regulation (CFR) § 438.402 (2)(i)
[6] 22 CCR § 53260
[7] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 10.1
[8] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 30
[9] 28 CCR § 1300.68(a)(1)
[10] 42 CFR § 438.400(b)

concerns regarding Member confidentiality in the Provider network and/or at IEHP made by a Member or the Member's representative. A complaint is the same as a Grievance.[11] If IEHP is unable to distinguish between a Grievance and an inquiry, it shall be considered a Grievance.[12]

B. **Expedited Grievance** – The Plan expedites grievances only when:[13]

1. It is related to IEHP's decision not to grant the Member's request to expedite an initial determination or appeal, and the Member has not yet obtained the drug; or
2. It involves IEHP's decision to extend a timeframe related to an organization determination or appeal.

C. **Exempt Grievance** - A type of grievance 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 orally. These grievances are exempt from the requirement to send written acknowledgment and response to Members. [14,15] This is also known as "orally resolved" grievances.

D. **Withdrawn Grievance** – A grievance that was rescinded or cancelled verbally or in writing.[16]

E. **Inquiry** – Any verbal or written request for information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other IEHP processes.[17,18]

F. **Quality of Care (QOC) Grievance** – A grievance category, wherein actions taken or not taken by the Member's Provider could result in potential harm to the Member or an adverse event that impacts the health of the patient.

G. **Potential Quality Incident (PQI)** - IEHP's Quality Management Department defines and establishes a process to review, monitor and report all PQIs.

H. **Authorized Representative** – This may include a relative, a representative, a Provider, or attorney, who may represent a Member during the grievance process. The authorized representative has all the rights and responsibilities of the Member.[19]

[11] 28 CCR § 1300.68(a)(2)
[12] 28 CCR § 1300.68(a)(1) and (2)
[13] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 30.2
[14] CA Health & Saf. Code § 1368(a)(4)(B)
[15] 28 CCR § 1300.68(d)(8)
[16] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 10.1
[17] Ibid.
[18] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 30.1
[19] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 10.1

16. GRIEVANCE AND APPEAL RESOLUTION SYSTEM

A. Member Grievance Resolution Process

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

PROCEDURES:

Member Rights and Options

A. The Member, Provider acting on behalf of the Member or the Member's authorized representative has the right to file a grievance at any time following any incident or action that is the subject of the Member's dissatisfaction via the following options:

1. By phone toll free at (877) 273-IEHP (4347) or (800) 718-4347 (TTY);[20,21]
2. By mail at P.O. Box 1800, Rancho Cucamonga, CA 91729-1800;
3. In person at 10801 Sixth St. Suite 120, Rancho Cucamonga, CA 91730-5987;
4. Via facsimile at (909) 890-5748;
5. Online through the IEHP website at www.iehp.org;
6. A complaint form obtained at an IPA, Hospital or Provider's (Primary Care, Specialty Care or Vision) office with their assistance.

   (See Attachment, "Member Appeal & Grievance Form – IEHP DualChoice" in threshold languages in Section 16).

B. The Member, Provider acting on behalf of the Member or the Member's authorized representative or Providers may call after-hours to file a grievance and leave a secured voicemail.[22]

C. Members have the right to appoint someone to file their grievance case and/or represent them.[23] The representative has all the rights and responsibilities of the Member in filing a grievance, obtaining an organization determination or in dealing with any of the levels of the appeals process.[24]

1. To be appointed by a Member, both the Member making the appointment and the representative accepting the appointment must sign, date, and complete a representative form (See Attachments, "Appointment of Representative – CMS Form 1696 – English" and "Appointment of Representative – CMS Form 1696 – Spanish" in Section 16).[25]

[20] Title 28 CCR § 1300.68(b)(4)
[21] CA HSC Health & Saf. Code § 1368.02(b)
[22] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 10.5.2
[23] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 20.1
[24] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 20.3
[25] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 20.1

2. If a form other than the CMS-1696 is used, it must comply with all the requirements of the CMS-1696 Form. The signed form or appropriate legal papers supporting an authorized representative's status must be included with each appeal.[26]
3. Unless revoked, an appointment is considered valid for one (1) year from the date that the appointment is signed by both the Member and the representative. The representation is valid for the duration of the case, and photocopies must be included with future cases for up to one (1) year.[27]

D. Members that are incapacitated or legally incompetent, a surrogate is not required to produce a representative form. Instead, the surrogate can produce the appropriate legal papers supporting their status as the Member's authorized representative.

E. Members are given reasonable opportunity to present evidence and testimony, and make legal factual arguments, in person as well as in writing, in support of their grievance.[28]

F. Members have the right to request translation services to file their grievance in their preferred language or format.

G. Members have the right to file a grievance if their cultural or linguistic needs are not met.

H. Members may request to withdraw their grievance in writing at any time before IEHP mails a resolution letter.[29]

I. Members have the right to obtain access to and copies of relevant grievance and appeal documents upon request by contacting Member Services.

J. Members who wish to file a grievance regarding dental services are referred to the appropriate dental Provider, as applicable.

K. IEHP has designated a Grievance and Appeals Manager as its Civil Rights Coordinator, who is responsible for ensuring compliance with federal and state non-discrimination requirements and investigating discrimination grievances.

L. Members with complaints regarding confidentiality, have the right to file a grievance to any of the following:[30]

1. IEHP Compliance Officer:
   a. By mail at P.O. Box 1800, Rancho Cucamonga, CA 91729-1800;
   b. By telephone at (866) 355-9038;
   c. By fax at (909) 477-8536; or

[26] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 20.2
[27] Ibid.
[28] 42 CFR § 438.406(b)(4)
[29] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 30.4
[30] 45 CFR §§ 164.520, 164.528

d. By email at Compliance@iehp.org; or

2. The Department of Health and Human Services Office of Civil Rights:

a. By mail at Attention: Regional Manager, 90 7th Street, Suite 4-100, San Francisco, CA 94103;

b. By phone at (800) 368-1019 or (800) 537-7697 TDD; or

c. By email to ocrmail@hhs.gov.

M. All IEHP staff and external IEHP committee members are required to sign a confidentiality statement agreeing not to disclose confidential information.[31] 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.

IEHP Responsibilities

A. IEHP sends its Members written information regarding the appeal and grievance process upon enrollment, involuntary disenrollment, annually, and upon request.[32]

B. IEHP does not discriminate on the basis of 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 information, marital status, or source of payment.[33,34,35,36]

C. IEHP has adopted an internal grievance procedure that provides for prompt and equitable resolution of complaints alleging any action prohibited by Section 1557 of the Affordable Care Act and its implementing regulations at 45 C.F.R. pt. 92, issued by the U.S. Department of Health and Human Services Section 1557 and its implementing regulations may be examined by the Regulatory Management Nurse whom, as Section 1557 Coordinator has been

[31] 45 CFR §§ 164.520, 164.528
[32] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 10.4.4
[33] 42 CFR § 422.110(a)
[34] 45 CFR Part 92
[35] CA Welfare and Institutions Code (Welf. & Inst. Code) § 14029.91
[36] CA Government Code (Gov. Code) § 11135(a)

designated to coordinate the efforts of IEHP to comply with Section 1557. Any person who believes someone has been subjected to discrimination on the basis of 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 information, marital status, or source of payment, may file a grievance under this procedure. It is against the law for IEHP to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance.[37,38]

D. IEHP does not discriminate against any Member for filing a grievance.[39]

E. IEHP ensures that Members with linguistic and cultural needs as well as Members with disabilities have access to and can fully participate in IEHP's grievance process by assisting those with limited English proficiency or with a visual or other communicative impairment.[40,41]

F. IEHP provides reasonable assistance throughout the compliant process which includes but not limited to, completing the forms, providing communication in threshold languages or in alternative format or languages upon request by the Member or Member's authorized representative, and access to interpreters for other languages, face-to-face, and/or telephonic translators.[42] IEHP staff may use the California Relay Services if necessary or requested by a Member with a hearing or speech disability.

G. IEHP provides a Telephone Typewriter line (TTY) (800) 718-4347 for Members with hearing or speech impairments. IEHP Member Services Representatives (MSRs) may use the California Relay Services, if necessary or requested by the Member. There are available MSRs, Grievance and Appeals Coordinators and Nurses that 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 and Appeals staff may request IEHP Member Services to arrange for face-to-face or telephonic translations, and sign language service for medical appointments.

H. The Compliance Officer for IEHP has the primary responsibility for oversight and direction of policies and procedures related to confidentiality and/or Health Insurance Portability and Accountability Act (HIPAA) violations. The Compliance Officer or their delegate is actively involved in the investigation and resolution of grievances related to confidentiality and/or HIPAA violations.[43]

1. All Members are informed of the Notice of Privacy Practices (NPP) upon enrollment. In addition, the NPP is made available in writing to Members upon request and is available

[37] Section 1557 of the Affordable Care Act (42 U.S.C. § 18116)
[38] 45 CFR § 92.101
[39] 28 CCR §1300.68(b)(8)
[40] 22 CCR § 53858(e)(6)
[41] 28 CCR § 1300.68(b)(3)
[42] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 10.4.4
[43] 45 CFR §§ 164.520, 164.528

online through the IEHP website, and is posted in common, public areas.

I. IEHP encourages Members to discuss any issues with their Provider to promote open communication and improve long-term Member and Provider relationships. If they are unable to resolve the issue, the Provider will assist the Member with contacting IEHP to initiate the grievance process.

J. IEHP does not reveal Provider, Member identity or personal information to any source other than for purposes of treatment, payment or IEHP operations, without the express written authorization of the Member or the Member's representative.[44]

K. IEHP ensures that only authorized representatives file cases on behalf of the Member, by determining that an individual filing on behalf of a Member is authorized to do so by the State.

L. IEHP ensures that the person making the final decision for the proposed resolution of grievances and appeals has neither participated in any prior decisions related to the grievance or appeal, nor is a subordinate of someone who has participated in a prior decision. Only qualified health care and licensed professionals with clinical expertise in treating a Member's condition or disease make the final determination for all clinical grievances.[45]

M. Fiscal and administrative concern shall not influence the independence of the medical decision-making process to resolve any medical dispute between Member and Provider of Service.

N. IEHP maintains all Member appeals and grievances, including medical records, documents, evidence of coverage or other information relevant to the grievance decision in confidential electronic case files for ten (10) years.

Provider Responsibilities

A. All Providers (e.g. Primary Care and Vision Providers) are required to have IEHP Member Appeal and Grievance Forms (See Attachment, "Member Appeal and Grievance Form – IEHP DualChoice" in threshold languages in Section 16) readily available for distribution to Members upon request.[46]

B. Providers who receive an IEHP Member Appeal and Grievance Form and/or documentation regarding a grievance must immediately fax them to IEHP's Grievance and Appeals Department at (909) 890-5748 (See Attachment, "Member Appeal and Grievance Form" in threshold languages in Section 16).

C. Any Provider contacted by a Member who wants to file a grievance must immediately assist the Member by contacting IEHP's Member Services Department at (877) 273-IEHP (4347) or (800) 718-4347 (TTY).

D. Providers and their staff must cooperate with IEHP in resolving Member grievances and

[44] 45 CFR § 164.502(a)(1)(ii)
[45] 42 CFR § 438.406(b)(2)
[46] 22 CCR, § 53858

comply with all final determinations of IEHP's grievance procedure.

E. Providers must ensure a Member's medical condition is at no time permitted to deteriorate because of delay in provision of care that a Provider disputes.

Member Grievance Notification Requirements

A. IEHP utilizes DHCS-approved templates when informing Members of a Grievance or Appeal resolution. All templates include the DHCS-approved "Your Rights" attachment. All Grievance and Appeals Member templates are submitted to DHCS for review and approval and are reviewed by IEHP Compliance department annually.

B. All Member grievance correspondence, Member Complaint Forms, and the IEHP Grievance Resolution Process handout are provided in threshold languages.

C. All grievances are responded to either verbally or in writing, including quality of care cases. Exempt grievances are exempt from the requirement to respond in writing.

Grievance Resolution Process

A. IEHP sends its Members written information regarding the appeal and grievance process upon enrollment, and annually thereafter.[47,48] Members are also informed of the appeal and grievance process upon request.

B. IEHP's Grievance and Appeals Department is responsible for the resolution of Member complaints, including grievances and appeals (reconsiderations/redeterminations). Grievance records include the following information:[49,50]

1. Dates of receipt and closure by IEHP;
2. Member's name and identification number;
3. IEHP staff person responsible for the case;
4. A description of the grievance;
5. A description of the resolution; and
6. Copies of relevant information used in the case.

C. IEHP ensures grievances are resolved as quickly as the Member's health condition requires and not to exceed these regulatory timeframes:[51]

1. Standard grievances are resolved within thirty (30) calendar days of receiving the

[47] CA Welf. & Inst. Code §14450
[48] CA Health & Saf. Code (HSC) § 1368(a)(2)
[49] CCI Three-Way Contract September 2019, Section 2.14
[50] CA Health & Saf. Code 1368(a)(4)B)
[51] 28 CCR § 1300.68

grievance.[52,53,54] In the event a resolution is not reached within thirty (30) calendar days of receiving the grievance, the Member is notified in writing of the status of the grievance.[55] All cases are resolved as expeditiously as the Member's health condition requires.[56]

2. Expedited grievances are resolved within twenty-four (24) hours from the receipt date. IEHP expedites the grievance if:[57]
   a. It is related to IEHP's decision not to grant the Member's request to expedite an initial determination or appeal, and the Member has not yet obtained the drug; or
   b. It involves IEHP's decision to extend a timeframe related to an organization determination or appeal.
3. A grievance case may be extended by fourteen (14) calendar days in either of these scenarios:[58]
   a. The Member requests for the extension; or
   b. IEHP justifies a need for additional information and documents how the extension is in the best interest of the Member.
4. Complaints categorized by CMS as "immediate action" are resolved within two (2) calendar days of receipt.

D. An acknowledgment letter is mailed to the Member within five (5) calendar days of receipt of standard grievance, which includes:[59,60]
   1. The grievance receipt date;
   2. Name of the IEHP representative who may be contacted regarding the grievance;
   3. The toll-free telephone number, and address of the IEHP representative who may be contacted about the grievance;
   4. How to initiate the complaint process through the Department of Managed Health Care (DMHC), as applicable; and
   5. The Member's right to appoint a representative to act on his/her behalf during the

[52] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 30.2
[53] 22 CCR § 53858(g)(1)
[54] 28 CCR § 1300.68(d)(3)
[55] 22 CCR §53858(g)(2)
[56] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 10.4.1
[57] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 30.2
[58] Ibid.
[59] CA Health & Saf. Code § 1368(a)(4)(A)
[60] 28 CCR § 1300.68(d)(1)

grievance process.

E. Expedited grievance cases do not require Acknowledgement Letters, as initial notification is provided verbally within twenty-four (24) hours of receipt of the grievance, followed by written resolution within three (3) calendar days of verbal notification.[61]

F. IEHP makes good faith efforts to obtain input from a party involved in the grievance, when this is necessary to resolve the Member's complaint. Parties to a grievance may include but are not limited to Provider, Delegates, and Hospitals; hereinafter referred to as "Respondent." When necessary, IEHP faxes or emails a Grievance Summary Form (GSF) or request for medical records to the Respondent containing the substance of the grievance, identified issues to be addressed by the Respondent and a request for pertinent documents (i.e., medical records, call notes, policies) that may aid in the investigation.

1. Responses are due to IEHP by the due date specified on the GSF or medical record request. For expedited grievances, the due date may be in less than 24 hours from the time the GSF or medical record request is sent to the Respondent.
2. Respondents must procure and assemble all requested information upon receipt of the GSF or medical record request.
3. Once a response is received, IEHP reviews the information to ensure all Member issues were addressed. If Member issues are not completely addressed, IEHP notifies the Respondent that additional information is needed.
4. IEHP makes good faith efforts to obtain a complete and timely response to the GSF or medical record request:
    a. If not received by the due date, IEHP will follow-up with the Respondent telephonically and in writing.
    b. If IEHP remains unsuccessful in obtaining a response, the grievance is resolved to address the Member's needs based on the available information.
    c. Continued failure to respond timely to grievance requests may result in a Corrective Action Plan (CAP), freezing to new Member assignments, or further disciplinary action, up to and including termination of contract.

G. IEHP takes into account all comments, documents, records, and other information submitted by the Member or their representative, without regard to whether such information was submitted or considered in the initial action.[62]

H. A Member may request to withdraw a grievance in writing at any time before IEHP mails a resolution letter. If the Member withdraws a quality of care grievance, IEHP will continue to

[61] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 30.2.1
[62] 42 CFR § 438.406(b)(2)(iii)

its investigation but is not required to notify the Member of the outcome.[63]

I. Once the grievance is resolved, IEHP mails the Member a resolution letter within thirty (30) calendar days from receipt of a standard grievance and provides verbal resolution within twenty-four (24) hours from receipt of an expedited grievance.[64] In the case of expedited grievances, a copy of the resolution letter is also sent to DMHC. Providers may obtain a copy of the resolution, upon request.

J. Grievances involving quality of care issues may be reported to IEHP's Quality Management Team upon resolution of the case. IEHP's Medical Director is notified immediately upon receipt of a potential quality of care case.[65]

K. After case investigation, the IEHP Grievance and Appeals staff determines and assigns a level to the case as follows:

1. Level 0 – No substantiated issue identified.
2. Level 1 – Provider non-response to GSF. Unable to determine if Member grievance was substantiated due to lack of information, documentation and/or evidence.
3. Level 2 – Substantiated grievance with information, documentation, and/or evidence that has not resulted in any harm to the Member.
4. Level 3 – Substantiated grievance with information, documentation, and/or evidence that has resulted in some harm to the Member.
5. Level 4 – Substantiated grievance with information, documentation, and/or evidence that has resulted in significant harm to the Member.

Monitoring and Oversight

A. Grievances related to Provider's office site quality issues are referred to Quality Management for assessment of: physical accessibility, physical appearance, adequacy of waiting-room and examination-room space, appointment availability, and adequacy of treatment record-keeping.

B. If a Corrective Action Plan (CAP) or education for a substantiated QOC Grievance is required, it is sent to the Provider by direction of the IEHP Medical Director.

C. 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).[66] Timeliness rates are based on the initial expected response due date and date a completed response is

[63] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 30.4
[64] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 30.2.1
[65] 22 CCR § 53858(e)(2)
[66] 28 CCR § 1300.68(b)(5)

received, addressing all alleged issues.[67] 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 CAP from IEHP.

D. IEHP may choose to delegate the appeal and/or grievance resolution process to organizations that are accredited by the National Committee for Quality Assurance (NCQA) and with written agreement between IEHP and the Delegates.

1. Members may choose to directly address grievances to IEHP. IEHP will forward those grievances to the delegated organization for investigation only. Results must be returned by the due date. IEHP manages the grievance process and responds to Members.
2. The Delegate is responsible for establishing a grievance process in accordance with regulations mandated by CMS, DMHC, DHCS, and NCQA.
3. 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 IEHP committees as indicated.
4. IEHP retains ultimate responsibility for ensuring that the delegated entity satisfies all requirements of the grievance and appeal process.
5. On a periodic basis, IEHP evaluates delegate performance against IEHP, CMS, NCQA, and regulatory standards.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	January 1, 2007
Chief Title: Chief Medical Officer	**Revision Date:**	January 1, 2023

[67] 22 CCR § 53260

16. GRIEVANCE AND APPEALS RESOLUTION SYSTEM

B. Member Appeal Resolution Process
1. Part C Reconsiderations

APPLIES TO:

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

POLICY:

A. IEHP has established and maintains written procedures for the submittal, processing, and resolution of all Member appeals.[1]

B. A Member has the right to request an appeal within sixty (60) calendar days of the date on the Integrated Notice of Action.[2]

PURPOSE:

A. To establish and maintain a timely and responsive procedure for submittal, process and resolution of all Member appeals.

DEFINITIONS:

A. **Appeal:** An Appeal is defined as the review of an adverse initial determination to mean any of the following actions taken by IEHP or its IPA:[3]

1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
2. The reduction, suspension, or termination of a previously authorized service;
3. The denial, in whole or in part, of payment for a service;
4. The failure to provide services in a timely manner;
5. The failure to act within the required timeframes for standard and expedited resolution of Appeals;
6. For a resident of a rural area with IEHP as the only Health Plan, the denial of the Member's request to obtain services outside of the network; and
7. The denial of a Member's request to dispute financial liability.

B. **Expedited Appeal** – A request in which there is an imminent and serious threat to a Member's health, including but not limited to severe pain, potential loss of life, limb, or other major bodily function, or lack of timeliness that could seriously jeopardize the Member's life,

[1] Title 28, California Code of Regulations (CCR) § 1300.68(a)
[2] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 50.2.1
[3] Title 42, Code of Federal Regulations (CFR) § 438.400(b)

physical or mental health, or ability to attain, maintain, or regain maximum function.[4] This includes all requests concerning admissions, continued stay or other health care services for a Member who has received emergency services but has not been discharged from a facility.

C. **Integrated Notice of Action** – A formal letter informing the Member of an Adverse Benefit Determination.

D. **Reconsideration** – Under Part C, the first level in the Part C appeal process, which involves the review of adverse organization determination.[5]

E. **Authorized Representative –** An individual appointed by a Member or other party authorized under State or other applicable law, to act on their behalf in a grievance, organization or coverage determination, or appeal. This individual will have all of the rights and responsibilities of a Member.[6,7]

PROCEDURES:

Member Rights and Options

A. The Member, a Provider acting on behalf of the Member, or the Member's authorized representative may request an appeal within sixty (60) calendar days of the date on the Integrated Notice of Action via the following options:[8]

1. By phone toll free at (877) 273-IEHP (4347) or (800) 718-4347 (TTY);[9]
2. By mail at P.O. Box 1800, Rancho Cucamonga, CA 91729-1800;
3. In person at 10801 Sixth St., Suite 120, Rancho Cucamonga, CA 91730-5987;
4. Via facsimile at (909) 890-5748; or
5. Online through the IEHP website at www.iehp.org;

B. A provider who is providing treatment to the Member may file an appeal on behalf of the Member. The provider must give the Member notice of filing the appeal.[10]

C. If a Member is incapacitated or legally incompetent, a surrogate is not required to produce a representative form. Instead, he or she can produce the appropriate legal papers supporting his or her status as the Member's authorized representative. The representative has all the rights

[4] 42 CFR § 438.410(a)
[5] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 10.1
[6] Ibid.
[7] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 20.3
[8] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Sections 50.1 & 50.2.1
[9] 28 CCR § 1300.68(b)(4)
[10] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Sections 50.1

and responsibilities of the Member in filing a grievance, obtaining an organization determination or in dealing with any of the levels of the appeals process.

1. To be appointed by a Member, both the Member making the appointment and the representative accepting the appointment must sign, date, and complete a representative form (See "Attachments/Appointment of Representative – CMS Form 1696 – English" and "Appointment of Representative – CMS Form 1696 – Spanish" in Section 16).[11]
2. If a form other than the Centers for Medicare and Medicaid Services (CMS) Form CMS-1696 is used, it must comply with all the requirements of the Form CMS-1696. The signed form or appropriate legal papers supporting an authorized representative's status must be included with each appeal.[12]
3. Unless revoked, an appointment is considered valid for one (1) year from the date that the appointment is signed by both the Member and the representative. The representation is valid for the duration of the appeal, and photocopies may be included with future appeals up to one (1) year.[13]

D. Members have the right to have a grievance heard and resolved in a timely manner, the right to a timely organization and coverage determination, and the right to appeal.[14] Members are given reasonable opportunity to present evidence and testimony, and make legal or factual arguments, in person as well as in writing, in support of their grievance or appeal.[15]

E. The party who files a request for appeal may withdraw the request in writing at any time before an appeal decision is mailed by IEHP.[16]

F. Members have the right to request translation services to request their appeal in their preferred language or alternative format.

1. Alternative formats must also be provided to a family member, friend, associate, or authorized representative with a visual impairment or disability, if requested by the Member, in compliance with the Americans with Disabilities Act (ADA) effective communication requirements.[17]

G. Members have the right to obtain access to and copies of relevant appeal documents, free of charge, upon request by contacting Member Services.[18,19]

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[11] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 20.2
[12] Ibid.
[13] Ibid.
[14] 42 C.F.R. §§ 422.562(b)
[15] 42 CFR § 438.406(b)(4)
[16] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 50.4
[17] DHCS APL 22-002 "Alternative Format Selection for Members with Visual Impairments
[18] Ibid.
[19] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 50.5.2

H. The Member, a Provider acting on behalf of the Member, or the Member's authorized representative may request a State Hearing in either of these situations:[20]

1. Member received a Notice of Appeal Resolution stating that the initial adverse benefit determination has been upheld, and the request is made within one hundred twenty (120) calendar days from the date on the Notice of Appeal Resolution; or
2. Member has exhausted IEHP's appeal process due to the health plan's failure to adhere to the appeal notice and timing requirements; or
3. Member has exhausted IEHP's appeal process due to the health plan's failure to provide adequate notice in a selected alternative format to the Member, their family member, friend, associate, or authorized representative, if required by the ADA.[21]

The State must reach its decision within ninety (90) calendar days of the date of the request for standard State Hearing or within three (3) business days of the date of the request for expedited State Hearing.

I. Members have the right to request from DMHC an Independent Medical Review (IMR) of determinations based on lack of medical necessity, experimental/investigation or emergency service.[22,23] Members shall not be required to participate in the Appeal process for more than thirty (30) calendar days before applying for an IMR.

J. 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:[24]

1. For the direct provision of care or treatment of the patient;
2. For payment transactions, or health care operations, 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.

IEHP Responsibilities

A. IEHP sends its Members written information regarding the appeal and grievance process upon enrollment, annually thereafter, upon request, and upon notification of an adverse initial

[20] 42 CFR § 438.408(f)
[21] DHCS APL 22-002
[22] Ibid.
[23] California Health and Safety Code (Health & Saf. Code) § 1374.30(j)(1)
[24] 45 CFR § 164.502(a)(1)(ii)

determination.[25,26]

B. IEHP accepts appeal requests after the sixty (60)-day timeframe if a filing party shows good cause.[27] If information is obtained to establish good cause, the adjudication timeframe begins on the date the plan receives the information. If IEHP denies a request for a good cause extension, the party may file a grievance with the plan. Please refer to Policy 16A, "Member Grievance Resolution Process" for more information.

C. IEHP does not discriminate on the basis of sex, race, color, religion, ancestry, national origin, ethnicity, ethnic group identification, , language, , 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 information, marital status, or source of payment.[28,29,30,31]

D. IEHP does not discriminate against any Member for filing a grievance or appeal.[32] IEHP does not discriminate, take, or threaten to take any punitive action against a Provider acting on behalf of or in support of a Member in requesting an expedited appeal.[33,34]

E. IEHP ensures that Members with linguistic and cultural needs as well as Members with disabilities have access to and can fully participate in IEHP's appeal process by assisting those with limited English proficiency or with a visual or other communicative impairment.[35]

F. IEHP provides reasonable assistance throughout the complaint process which includes but not limited to, completing the forms, providing communication in threshold languages or in alternative format or languages upon request by the Member or Member's authorized representative, and access to interpreters for other languages, face-to-face, and/or telephonic translators.[36] IEHP staff may use the California Relay Services if necessary or requested by a Member with a hearing or speech disability.

G. IEHP shall continue to cover disputed services if the Member received these while the appeal or State Hearing was pending.[37] Continuation of benefits shall not be provided unless the Plan

[25] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 10.4.4
[26] 28 CCR § 1300.68(b)(2)
[27] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 50.3
[28] 42 CFR § 422.110(a)
[29] 45 CFR Part 92
[30] CA Welfare and Institutions Code (Welf. & Inst. Code) § 14029.91
[31] CA Government Code (Gov. Code) § 11135(a)
[32] 28 CCR § 1300.68(b)(8)
[33] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 50.2.2
[34] 42 CFR § 438.40(b)
[35] 28 CCR § 1300.68(b)(3)
[36] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 10.4.4
[37] 42 CFR § 438.420(b)

receives written consent from the Member authorizing continuation of benefits. For the service or item to continue, the Member must make the continuation request by the later of the following: within ten (10) calendar days after the applicable integrated plan sends the notice of its integrated organization determination or the intended effective date of the integrated organization determination.[38]

H. IEHP ensures that the person making the final decision for the proposed resolution of an appeal has neither participated in any prior decisions related to the appeal, nor is a subordinate of someone who has participated in a prior decision. Only qualified health care and licensed professionals with clinical expertise in treating a Member's condition or disease make the final determinations for a denial of an appeal based on lack of medical necessity; a grievance regarding denial of expedited resolution of an appeal; or any appeal involving clinical issues.[39,40]

I. In the event that the Member pursues the appeal in multiple forums, and receives conflicting decisions, IEHP is bound by the decision favorable to the Member or the decision closest to the Member's relief requested on appeal.

J. 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.[41]

K. IEHP maintains all Member appeal requests, including medical records, documents, evidence of coverage or other information relevant to the appeal resolution in confidential electronic case files for ten (10) years.

Provider Responsibilities

A. IPAs and Providers must ensure a Member's medical condition is at no time permitted to deteriorate because of delay in provision of care that a Provider disputes.

B. IPAs and Providers must respond to requests for medical records within forty-eight (48) hours for standard appeals and by the specified due date for expedited appeals. Any delay caused by the Provider or IPA's failure to submit the requested information to IEHP may result in disciplinary actions against the Provider or IPA.

Member Appeal Notification Requirements

A. IEHP utilizes Department of Health Care Services (DHCS)-approved templates when informing Members of an Appeal resolution. All templates include the DHCS-approved

[38] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 50.3.b
[39] 42 CFR § 438.406(b)(2)
[40] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 50.5.2
[41] CA Health & Saf. Code § 1367(g)

"Your Rights" attachment. All Grievance and Appeals Member templates are submitted to DHCS for review and approval and are reviewed by IEHP Compliance department annually.

B. All Member appeal correspondence, Member Appeal Forms, and the IEHP Appeal Resolution Process handout meet all language and accessibility standards.[42] This includes providing the Notice of Appeal Resolution (NAR) and clinical rationale for the health plan's decision, in the Member or authorized representative's selected language or alternative format.

C. For Appeals not resolved wholly in favor of the Member, IEHP includes in its written response the reasons for its determination.[43]

Appeal Resolution Process

A. Appeal records include the following information:

1. Name of the covered person for whom the appeal was field.
2. Name of the IEHP staff recording the appeal
3. A general description of the reason for the appeal;
4. The date the appeal was received;
5. The date of each review or review meeting (if applicable);
6. Description of the resolution; and
7. Date of resolution

B. IEHP ensures appeals are resolved as quickly as the Member's health condition requires and do not exceed these regulatory timeframes:

1. Standard appeals are resolved within thirty (30) calendar days of the appeal request being received by the IEHP Grievance & Appeals department.[44,45,46]
2. Expedited appeals are resolved no later than seventy-two (72) hours of the IEHP Grievance & Appeals department receiving the appeal.[47,48,49]
3. D-SNP may not extend timeframes for integrated reconsiderations of Medicare and

[42] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 10.4.4
[43] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 50.10.1
[44] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 50.2.1
[45] 28 CCR § 1300.68(a)
[46] 42 CFR § 438.408(b)(2)
[47] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 50.2.1
[48] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 50.2.2
[49] 42 CFR § 438.408(b)(3)

Medicaid services.[50] .

C. An acknowledgment letter is mailed to the Member within five (5) calendar days of receipt of the appeal.

D. Expedited appeals do not require Acknowledgement Letters, as these are resolved within seventy-two (72) hours. Oral notice of resolution of an expedited appeal is provided within seventy-two (72) hours.[51]

1. Within two (2) calendar days of receiving the appeal, IEHP notifies the Member whether or not the appeal met the criteria for expedited review, as defined in this policy. If criteria is met, the Member is informed of the shortened timeframe to submit information related to their appeal.[52]

2. If the appeal does not meet the criteria for expedited review, IEHP informs the Member orally within twenty-four (24) hours of appeal receipt, followed by a written notice within two (2) calendar days of receiving the appeal. Both oral and written notices include notification of transfer to the standard thirty (30) day appeal process, the Member's right to file an expedited grievance if they disagree with the plan's decision not to expedited, and the Member's right to resubmit a request for an expedited appeal with physician's supporting documentation. [53,54]

E. If the case involves a decision that is not within the IEHP Medical Director's expertise, an additional opinion is obtained from an independent physician reviewer in the appropriate specialty prior to review by an IEHP Medical Director. IEHP ensures that practitioners or subordinates of the practitioners involved in a denial decision are not involved in the resolution of an Appeal involving the prior decision, although the practitioner who made the initial adverse determination may review the case and overturn the previous decision.

F. IEHP may request additional information or medical records from a Provider or IPA, as necessary, including but not limited to: copy of denial letter, referral request, criteria applied and all supporting clinical documentation used in making the initial determination.

G. The Appeal determination will either uphold or overturn the NOA.

1. If a denial is upheld, the Member is notified of their right to request a State Hearing within one-hundred twenty (120) calendar days from the date of Notice of Appeal Resolution (NAR); right to request and receive continuation of benefits while State Hearing is pending; and right to request an Independent Medical Review (IMR) from DMHC for determinations based on lack of medical necessity, experimental/investigation or

[50] CalAIM Dual Eligible Special Needs Plans Policy Guide 2023
[51] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 40.5.4
[52] Ibid.
[53] 42 CFR § 438.410(c)
[54] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 50.2.2

emergency service.[55]

a. IEHP forwards the case file to the Independent Review Entity within twenty-four (24) hours of the denial being upheld.[56]

2. If a denial is overturned, services are authorized as expeditiously as the Member's health condition requires and no later than seventy-two (72) hours from the date of the Notice of Appeal Resolution.[57,58]

3. If IEHP fails to provide the Member with its decision within the timeframes for standard and expedited appeals, such failure constitutes an adverse decision. In this case, IEHP will forward the case to the IRE for review.[59]

H. Upon notification that DHCS, through a State Hearing, has reversed IEHP's appeal determination, services are authorized as expeditiously as the Member's health condition requires and no later than seventy-two (72) hours from the date the health plan receives notice reversing the determination.

I. Upon notification that DMHC, through the IMR process, has ruled a disputed health care service as medically necessary: IEHP immediately contacts the Member and arranges to authorize the services as expeditiously as the Member's health condition requires and no later than five (5) business days of receiving written decision from DMHC.[60]

J. Upon notification that the IRE has reversed IEHP's appeal determination, services are authorized as expeditiously as the Member's health condition requires and no later than seventy-two (72) hours of receiving written decision from the IRE.

K. IEHP dismisses reconsideration requests under any of the following circumstances:[61]

1. An individual requests a reconsideration on behalf of a Member but a properly executed appointment of representative form has not been filed and there is no other documentation to show that the individual is legally authorized to act on the Member's behalf;

2. The Member or other party fails to file the reconsideration within sixty (60) calendar days of the date on the Integrated Notice of Action and good cause for late filing has not been established;

3. IEHP becomes aware that the Member has obtained the service before the health plan

[55] CA Health & Saf. Code § 1374.30(j)(1)
[56] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 50.2.2
[57] Ibid.
[58] 42 CFR § 438.424
[59] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 50.7.2
[60] CA Health & Saf. Code § 1374.34(a)
[61] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 50.9

completes its pre-service reconsideration; or

4. Any other circumstance, where IEHP may lack jurisdiction to review the case.

Monitoring and Oversight

A. IEHP may choose to delegate the Member appeal resolution process to organizations that are accredited by the National Committee for Quality Assurance (NCQA) and with written agreement between IEHP and the Delegates.[62]

1. The Delegate is responsible for establishing an appeal resolution process in accordance with regulations mandated by DMHC, DHCS, and NCQA.
2. IEHP retains ultimate responsibility for ensuring that the Delegate satisfies all requirements of the grievance and appeal process.
3. On a periodic basis, IEHP evaluates delegate performance against IEHP, NCQA, and regulatory standards.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on File*	**Original Effective Date:**	January 1, 2022
Chief Title: Chief Medical Officer	**Revision Date:**	January 1, 2023

[62] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 10.4.3

16. GRIEVANCE AND APPEALS RESOLUTION SYSTEM

B. Member Appeal Resolution Process
2. Part B & Part D Redeterminations

APPLIES TO:

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

POLICY:

A. IEHP has established and maintains written procedures for the submittal, processing, and resolution of all Member appeals.[1]

B. A Member has the right to request an appeal within sixty (60) calendar days of the date on the Integrated Notice of Action.[2,3,4]

PURPOSE:

A. To establish and maintain a timely and responsive procedure for submittal, process, and resolution of all Member appeals.

DEFINITIONS:

A. **Appeal:** An appeal is defined as the review of an adverse coverage determination made by IEHP on Part B drugs & Part D benefits that the Member believes they are entitled to receive, including delay in providing or approving the drug coverage, or on any amounts the Member must pay for the drug coverage.[5]

B. **Expedited Appeal** – A request in which there is an imminent and serious threat to a Member's health, including but not limited to severe pain, potential loss of life, limb, or other major bodily function, or lack of timeliness that could seriously jeopardize the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function.[6,7] This includes all requests concerning admissions, continued stay or other health care services for a Member who has received emergency services but has not been discharged from a facility.

C. **Integrated Notice of Action** – A formal letter informing the Member of an Adverse Benefit Determination.

D. **Coverage Determination –** Any decision made by IEHP regarding:[8]

1. Receipt of or payment for a prescription drug that a Member believes may be covered;

[1] Title 42 Code of Federal Regulations (CFR) § 423.562(a)(1)(iv)
[2] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 50.2.1
[3] 42 CFR § 423.562(b)(4)
[4] 42 CFR § 423.580
[5] 42 CFR § 423.560
[6] 42 CFR § 423.584(c)(2)
[7] 42 CFR § 438.410(a)
[8] https://www.cms.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev/CoverageDeterminations-

2. A tiering or formulary exception request;
3. The amount that the health plan requires a Member to pay for a Part D prescription drug;
4. A limit on the quantity or dose of a requested drug;
5. A requirement that a Member try another drug before the health plan pays for the requested drug; or
6. A decision whether a Member has or has not satisfied prior authorization or other utilization management requirement.

E. **Redetermination** – The first level in the Part D appeal process in which the health plan reviews adverse Part D coverage determination, including the findings upon which the decision was based, and any other evidence submitted or obtained.[9]

F. **Authorized Representative –** An individual appointed by a Member or other party authorized under State or other applicable law, to act on their behalf in a grievance, organization or coverage determination, or appeal. This individual will have all of the rights and responsibilities of a Member.[10,11]

PROCEDURES:

Member Rights and Options

A. The Member, a prescribing physician or other prescriber acting on behalf of the Member, or the Member's authorized representative may request an appeal within sixty (60) calendar days of the date on the Integrated Notice of Action via the following options:[12,13,14]
   1. By phone toll free at (877) 273-IEHP (4347) or (800) 718-4347 (TTY);[15]
   2. By mail at P.O. Box 1800, Rancho Cucamonga, CA 91729-1800;
   3. In person at 10801 Sixth St., Suite 120, Rancho Cucamonga, CA 91730-5987;
   4. Via facsimile at (909) 890-5748;
   5. Online through the IEHP website at www.iehp.org; or
   6. A prescribing physician or other prescriber may file an appeal by contacting IEHP

[9] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 10.1
[10] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 20.3
[11] 42 CFR § 423.560
[12] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Sections 50.1 & 50.2.1
[13] 42 CFR § 423.582(b)
[14] 42 CFR § 423.582(a)
[15] 28 CCR § 1300.68(b)(4)

Provider Services at (866) 223-4347 and may leave a secure voice message after-hours.

B. A provider who is providing treatment to the Member may file an appeal on behalf of the Member. The provider must give the Member notice of filing the appeal.[16]

C. If a Member is incapacitated or legally incompetent, a surrogate is not required to produce a representative form. Instead, he or she can produce the appropriate legal papers supporting his or her status as the Member's authorized representative. The representative has all the rights and responsibilities of the Member in filing a grievance, obtaining an organization determination or in dealing with any of the levels of the appeals process.[17]

1. While a prescribing physician or other prescriber may file an appeal request on behalf of the Member, they do not have all of the rights and responsibilities of the Member, unless appointed by the Member as their representative.
2. To be appointed by a Member, both the Member making the appointment and the representative accepting the appointment must sign, date, and complete a representative form (See Attachments, "Appointment of Representative – CMS Form 1696 – English" and "Appointment of Representative – CMS Form 1696 – Spanish" in Section 16).[18]
3. If a form other than the Centers for Medicare and Medicaid Services (CMS) Form CMS-1696 is used, it must comply with all the requirements of Form CMS-1696. The signed form or appropriate legal papers supporting an authorized representative's status must be included with each appeal.[19]
4. Unless revoked, an appointment is considered valid for one (1) year from the date that the appointment is signed by both the Member and the representative. The representation is valid for the duration of the appeal, and photocopies may be included with future appeals up to one (1) year.[20]

D. Members have the right to have a grievance heard and resolved in a timely manner, the right to a timely organization and coverage determination, and the right to appeal.[21] Members are given reasonable opportunity to present evidence and testimony, and make legal or factual arguments, in person as well as in writing, in support of their grievance or appeal.[22]

[16] Addendum to Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance for Applicable Integrated Plans Sections 50.1.a
[17] 42 CFR § 423.560
[18] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 20.2
[19] Ibid.
[20] Ibid.
[21] 42 CFR § 423.562
[22] 42 CFR § 423.586

E. The party who files a request for appeal may withdraw the request verbally or in writing at any time before an appeal decision is mailed by IEHP.[23,24]

F. Members have the right to request translation services to request their appeal in their preferred language or alternative format.

1. Alternative formats must also be provided to a family member, friend, associate, or authorized representative with a visual impairment or disability, if requested by the Member, in compliance with the Americans with Disabilities Act (ADA) effective communication requirements.

G. Members have the right to obtain access to and copies of relevant appeal documents, free of charge, by contacting Member Services.[25]

H. The Member, a Provider acting on behalf of and with written consent from the Member, or the Member's authorized representative may request a State Hearing in either of these situations:[26]

1. Member received a Notice of Appeal Resolution stating that the initial adverse benefit determination has been upheld, and the request is made within one hundred twenty (120) calendar days from the date on the Notice of Appeal Resolution; or
2. Member has exhausted IEHP's appeal process due to the health plan's failure to adhere to the appeal notice and timing requirements; or
3. Member has exhausted IEHP's appeal process due to the health plan's failure to provide adequate notice in a selected alternative format to the Member, their family member, friend, associate, or authorized representative, if required by the ADA.

The State must reach its decision within ninety (90) calendar days of the date of the request for standard State Hearing or within three (3) business days of the date of the request for expedited State Hearing.

I. Members have the right to request from the Department of Managed Health Care (DMHC) an Independent Medical Review (IMR) of determinations based on lack of medical necessity, experimental/investigation, or emergency service.[27] Members shall not be required to participate in the appeal process for more than thirty (30) calendar days before applying for an IMR.

J. 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

[23] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 50.4
[24] 42 CFR § 423.582(d)
[25] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 50.5.2
[26] 42 CFR § 438.408(f)
[27] California Health and Safety Code (Health & Saf. Code) § 1374.30(j)(1)

disclose a Member's individually identifiable health information without a Member's authorization as follows:[28]

1. For the direct provision of care or treatment of the patient;
2. For payment transactions or health care operations, 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.

IEHP Responsibilities

A. IEHP sends its Members written information regarding the appeal and grievance process upon enrollment, annually thereafter, upon request, and upon notification of an adverse initial determination.[29,30]

B. IEHP accepts appeal requests after the sixty (60)-day timeframe if a filing party shows good cause. Examples of circumstances where good cause may exist include but are not limited to:[31,32]

1. The party did not receive the notice for the adverse initial determination, or they received it late;
2. The party was seriously ill, which prevented a timely appeal;
3. There was a death or serious illness in the party's immediate family;
4. An accident (e.g., a natural or man-made disaster) caused important records to be destroyed;
5. Documentation was difficult to locate within the time limits;
6. The party had incorrect or incomplete information concerning the appeal process;
7. The party lacked capacity to understand the timeframe for filing an appeal; or
8. The party sent the request to an incorrect address, in good faith, within the time limit and the request did not reach the plan until after the time period had expired.

[28] 45 CFR § 164.502(a)(1)(ii)
[29] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 10.4.4
[30] 28 CCR § 1300.68(b)(2)
[31] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 50.3
[32] 42 CFR § 423.582(c)(1)

9. The delay is a result of the additional time required to produce enrollee documents in an accessible format (for example, large print or Braille). The delay is the result of an individual having sought and received help from an auxiliary resource (such as a State Health Insurance Assistance Program (SHIP) or senior center), on account of their disability, in order to be able to file the appeal.

If information is obtained to establish good cause, the adjudication timeframe begins on the date the plan receives the information. If IEHP denies a request for a good cause extension, the party may file a grievance with the plan but does not have the right to appeal IEHP's denial of the good-cause extension.[33] Please refer to Policy 16A, "Member Grievance Resolution Process" for more information.

C. IEHP does not discriminate on the basis of race, color, national origin, sex, age, mental or physical disability or medical condition, ethnicity, ethnic group identification, ancestry, language, religion, gender, gender identity, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), genetic information, marital status, or source of payment.[34,35,36,37]

D. IEHP does not discriminate against any Member for filing a grievance or appeal.[38] IEHP does not discriminate, take, or threaten to take any punitive action against a Provider acting on behalf of or in support of a Member in requesting an expedited appeal.[39,40]

E. IEHP ensures that Members with linguistic and cultural needs as well as Members with disabilities have access to and can fully participate in IEHP's appeal process by assisting those with limited English proficiency or with a visual or other communicative impairment.[41]

F. IEHP provides reasonable assistance throughout the complaint process, which includes but not limited to, completing the forms, providing communication in threshold languages or in alternative format or languages upon request by the Member or Member's authorized representative, and access to interpreters for other languages, face-to-face, and/or telephonic translators.[42] IEHP staff may use the California Relay Services if necessary or requested by a Member with a hearing or speech disability.

G. IEHP ensures staff is available during non-business hours to process expedited cases.

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[33] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 60.5
[34] 42 CFR § 422.110(a)
[35] 45 CFR Part 92
[36] CA Welfare and Institutions Code (Welf. & Inst. Code) § 14029.91(e)(2)
[37] CA Government Code (Gov. Code) § 11135(a)
[38] 28 CCR § 1300.68(b)(8)
[39] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 50.2.2
[40] 42 CFR § 438.40(b)
[41] 28 CCR § 1300.68(b)(3)
[42] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 10.4.4

H. IEHP shall continue to cover disputed services if the Member received these while the appeal or State Hearing was pending.[43] IEHP ensures that the person making the final decision for the proposed resolution of an appeal has neither participated in any prior decisions related to the appeal, nor is a subordinate of someone who has participated in a prior decision.[44] Only qualified health care and licensed professionals with clinical expertise in treating a Member's condition or disease make the final determinations for a denial of an appeal based on lack of medical necessity; a grievance regarding denial of expedited resolution of an appeal; or any appeal involving clinical issues.[45,46]

I. In the event that the Member pursues the appeal in multiple forums, and receives conflicting decisions, IEHP is bound by the decision favorable to the Member or the decision closest to the Member's relief requested on appeal.

J. 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.

K. IEHP maintains all Member appeal requests, including medical records, documents, evidence of coverage or other information relevant to the appeal resolution in confidential electronic case files for ten (10) years.

Provider Responsibilities

A. IPAs and Providers must ensure a Member's medical condition is at no time permitted to deteriorate because of delay in provision of care that a Provider disputes.

B. IPAs and Providers must respond to requests for medical records within forty-eight (48) hours for standard appeals and by the specified due date for expedited appeals. Any delay caused by the Provider or IPA's failure to submit the requested information to IEHP may result in disciplinary actions against the Provider or IPA.

Member Appeal Notification Requirements

A. IEHP utilizes Department of Health Care Services (DHCS)-approved templates when informing Members of an appeal resolution. All templates include the DHCS-approved "Your Rights" attachment. All Grievance and Appeals Member templates are submitted to DHCS for review and approval and are reviewed by IEHP Compliance department annually.

B. All Member appeal correspondence, Member Appeal Forms, and the IEHP Appeal Resolution Process handout are provided in threshold languages.[47]

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[43] 42 CFR § 438.420(b)
[44] 42 CFR § 423.590(f)
[45] 42 CFR § 438.406(b)(2)
[46] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 50.5.2
[47] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 10.4.4

C. For appeals not resolved wholly in favor of the Member, IEHP includes in its written response the reasons for its determination.[48]

Appeal Resolution Process

A. Appeal records include the following information:

1. Name of the covered person for whom the appeal was filed;
2. Name of the IEHP staff recording the appeal;
3. A general description of the reason for the appeal;
4. The date the appeal was received;
5. The date of each review or review meeting (if applicable);
6. Description of the resolution; and
7. Date of resolution.

B. IEHP ensures appeals are resolved as quickly as the Member's health condition requires and do not exceed these regulatory timeframes:

1. Standard appeals for Part B & D drugs are resolved within seven (7) calendar days of the appeal request being received by the IEHP Grievance & Appeals department.[49,50,51,52]
2. Expedited appeals for Part B and D drugs are resolved no later than seventy-two (72) hours of the appeal being received by the IEHP Grievance & Appeals department.[53,54,55,56]
3. Except for Part B drug appeals, these timeframes may be extended by fourteen (14) calendar days if any of these conditions apply:[57,58]
    a. The Member requests the extension in writing; or
    b. The extension is justified and in the Member's interest due to the need for additional

[48] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 50.10.1
[49] 42 CFR § 423.590(a)
[50] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 50.2.1
[51] 28 CCR § 1300.68(a)
[52] 42 CFR § 438.408(b)(2)
[53] 42 CFR § 423.590(d)(1)
[54] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 50.2.1
[55] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 50.2.2
[56] 42 CFR § 438.408(b)(3)
[57] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 50.2.2
[58] 42 CFR § 438.408(c)(1)

information from a non-contracted provider; or

c. The extension is justified due to extraordinary, exigent or other non-routine circumstances and is in the Member's interest.

C. An acknowledgment letter is mailed to the Member within five (5) calendar days of receipt of the appeal.[59] Expedited appeals do not require Acknowledgement Letters, as these are resolved within seventy-two (72) hours.

D. Requests for expedited appeals are processed as follows:

1. If the Member's request for expedited appeal meets the criteria for expedited review, IEHP informs the Member of this determination orally within twenty-four (24) hours of receiving their appeal. The Member is informed at this time of the shortened timeframe to submit information related to their appeal. Oral notice of resolution of an expedited appeal is provided within seventy-two (72) hours.[60]

2. If the Member's request for expedited appeal does not meet the criteria for expedited review, IEHP informs the Member of this determination orally within twenty-four (24) hours of receiving their appeal, followed by a written notice within two (2) calendar days of the oral notice. Both oral and written notices inform the Member that their appeal will be transferred to the standard seven (7) day appeal process, and their rights to file an expedited grievance if they disagree with the plan's decision not to expedite, and to resubmit a request for an expedited appeal with prescribing physician or other prescriber's supporting documentation.[61,62]

E. If the case involves a decision that is not within the IEHP Medical Director's expertise, an additional opinion is obtained from an independent physician reviewer in the appropriate specialty prior to review by an IEHP Medical Director.

F. IEHP may request additional information or medical records from a Provider or IPA, as necessary, including but not limited to a copy of denial letter, referral request, criteria applied and all supporting clinical documentation used in making the initial determination.

G. The appeal determination will either uphold or overturn the adverse benefit determination.

1. If a denial is upheld, the Member is notified of their rights to request a State Hearing within one-hundred twenty (120) calendar days from the date of Notice of Appeal Resolution; to request and receive continuation of benefits while State Hearing is pending; and to request an Independent Medical Review (IMR) from DMHC for determinations based on lack of medical necessity, experimental/investigation or

[59] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 50.2.1.a
[60] 42 CFR § 423.590(d)(1)
[61] 42 CFR § 423.584(d)
[62] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 50.2.2

emergency service.[63]

a. Upon request from the Independent Review Entity (IRE), IEHP forwards the case file to the IRE and notifies the Member accordingly.[64,65]

2. If an expedited Part D redetermination results in an upheld denial, in whole or in part, the Member is notified verbally and by mail within three (3) calendar days of oral notification. Both notifications inform the Member of how to contact the Part D Qualified Independent Contract (QIC) for reconsideration.

3. If a denial is overturned, services are authorized as expeditiously as the Member's health condition requires and no later than seventy-two (72) hours from the date of the Notice of Appeal Resolution.[66,67]

4. If IEHP fails to provide the Member with its decision within the timeframes for standard and expedited appeals, such failure constitutes an adverse decision. In this case, IEHP will forward the case to the IRE for review within 24 hours of the expiration of the decision timeframe.[68,69,70]

H. Upon notification that DHCS, through a State Hearing, has reversed IEHP's appeal determination, services are authorized as expeditiously as the Member's health condition requires and no later than seventy (72) hours from the date the health plan receives notice reversing the determination.

I. Upon notification that DMHC, through the IMR process, has ruled a disputed health care service as medically necessary, IEHP immediately contacts the Member and arranges to authorize the services as expeditiously as the Member's health condition requires and no later than five (5) business days from the date the health plan receives the written decision from DMHC.[71]

J. Upon notification that the IRE has reversed IEHP's appeal determination, services are authorized as expeditiously as the Member's health condition requires and no later than seventy-two (72) hours from the date the health plan receives the written decision from the IRE.

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[63] CA Health & Saf. Code § 1374.30(j)(1)
[64] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 50.2.2
[65] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 50.7.2
[66] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 50.2.2
[67] 42 CFR § 438.424
[68] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 50.7.2
[69] 42 CFR § 423.590(c)
[70] 42 CFR § 423.590(e)
[71] CA Health & Saf. Code § 1374.34(a)

K. Upon notification that the Part D QIC has reversed IEHP's appeal determination, services are authorized as expeditiously as the Member's health condition requires and no later than twenty-four (24) hours of the date the health plan receives the written decision from the Part D QIC.

L. IEHP dismisses redetermination requests under any of the following circumstances:[72]

1. An individual requests a reconsideration on behalf of a Member but a properly executed appointment of representative form has not been filed and there is no other documentation to show that the individual is legally authorized to act on the Member's behalf;
2. The Member or other party fails to file the reconsideration within sixty (60) calendar days of the date on the Integrated Notice of Action and good cause for late filing has not been established;
3. The Member expires while the request is pending and the Member's surviving spouse or estate has no remaining financial interest in the case; and the Member's representative, if any, does not wish to pursue the request for coverage; or
4. The Member or other party withdraws their redetermination request timely.

Monitoring and Oversight

A. IEHP may choose to delegate the Member appeal resolution process to organizations that are accredited by the National Committee for Quality Assurance (NCQA) and with written agreement between IEHP and the Delegates.[73]

1. The Delegate is responsible for establishing an appeal resolution process in accordance with regulations mandated by DMHC, DHCS, and NCQA.
2. IEHP retains ultimate responsibility for ensuring that the Delegate satisfies all requirements of the grievance and appeal process.
3. On a periodic basis, IEHP evaluates delegate performance against IEHP, NCQA, and regulatory standards.

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[72] 42 CFR § 423.582(e)
[73] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 10.4.3

16. GRIEVANCE AND APPEAL RESOLUTION SYSTEM

C. Grievance and Appeal Resolution Process for Providers
1. Initial

APPLIES TO:

A. This policy applies to all IEHP DualChoice Providers.

POLICY:

A. Appeals and/or Grievances 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, Prop56 or other Provider related issues.

B. Providers of Service must submit all appeals and/or grievances, including those involving claims, billing, capitation, enrollment, contracting or UM/medical necessity to IEHP for the initial appeal and grievance resolution process.

C. All Provider appeals and/or grievances involving capitation, enrollment, contracting or UM/medical necessity must be submitted to the Payor within thirty (30) calendar days of the last date of action on the issue requiring resolution.

D. Payors must identify and acknowledge the receipt of all Provider appeals and/or grievances within five (5) calendar days of receipt of a written appeal and/or grievance.

E. Payors must resolve appeals and/or grievances and issue a written determination within thirty (30) calendar days of receipt of an appeal and/or grievance.

F. A Provider of Service may submit an appeal regarding the outcome of a Payor's appeal and grievance resolution to IEHP within thirty (30) calendar days of receipt of the written appeal or grievance determination letter from the Payor.

G. A Provider of Service can appeal any adverse determination by IEHP. If the denial is upheld, the denial must then be forwarded to the IEHP Grievance and Appeals Department as outlined in Policy 16B3, "Appeal and Grievance Resolution Process for Providers – UM Decisions."

H. Payors must not discriminate against Providers of Service for filing appeals and/or grievances.

I. A Provider of Service may withdraw an appeal and/or grievance at any time by notifying the Payor in writing.

DEFINITION:

16. GRIEVANCE AND APPEAL RESOLUTION SYSTEM

C. Grievance and Appeal Resolution Process for Providers
1. Initial

A. **Provider of Service** – 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:

A. Providers of Service must submit all appeals and/or grievances, including those involving claims, billing, capitation, enrollment, contracting issues, or those involving UM/medical necessity, in writing to the Payor within thirty (30) calendar days of the last date of action on the issue requiring resolution. Justification and supporting documentation must be provided with the written appeal and/or grievance.

1. If an appeal and/or grievance involves P4P reimbursements, the written request must be filed in accordance with the guidelines provided in Policy 19C, "Pay For Performance (P4P)."
2. If the appeal and/or grievance is not about a claim payment determination, (i.e. capitation, enrollment, contracting, etc.) the written request must include a clear explanation of the issue and the appeal and/or grievance must be filed in accordance with the Payor's appeal and grievance filing guidelines.
3. If the appeal and/or grievance is filed on behalf of a Member, the appeal and/or grievance is considered a Member appeal and/or grievance, subject to the requirements of the Member Grievance Resolution process, as outlined in Policy 16A, "Member Grievance Resolution Process."

B. Payors must identify and acknowledge in writing the receipt of each appeal and/or grievance, whether or not complete, and disclose the recorded date of receipt within five (5) calendar days of receipt (See Attachment, "Provider Grievance Acknowledgment Letter" in Section 16).

C. If an appeal and/or grievance is incomplete, or if the information is in the possession of the Provider of Service and not readily accessible to the Payor, the Payor may return the appeal and/or grievance with a clear explanation, in writing, of any information missing that is necessary to resolve the appeal and/or grievance. The Provider of Service has five (5) calendar days to resubmit an amended appeal and/or grievance with the missing information.

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 appeal and/or grievance for decisions not involving claims payment.

F. Providers of Service dissatisfied with the resolution of any appeal and/or grievance not involving claims or billing (i.e. capitation, enrollment) may appeal to IEHP in writing, as outlined in Policy 16C2, "Grievance and Appeal Resolution Process for Providers - Health Plan."

G. Providers of Service not satisfied with the initial determination by the Payor, and the determination is related to medical necessity or utilization management, have the right to appeal directly to IEHP within thirty (30) calendar days of receipt of the written determination by submitting a written request for review as outlined in Policy 16C2, "Grievance and Appeal Resolution for Providers - Health Plan."

H. Furthermore, Providers of Service dissatisfied with the outcome of an appeal and/or grievance originally filed with the Payor that involves pre-service referral denials or modifications may submit an appeal to IEHP.

I. No retaliation can be made against a Provider of Service who submits an appeal and/or grievance in good faith.

J. Copies of all appeals and/or grievances from Providers of Service, and related documentation, must be retained for at least ten (10) years.

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16. GRIEVANCE AND APPEAL RESOLUTION SYSTEM

C. Grievance and Appeal Resolution Process for Providers
2. Health Plan

APPLIES TO:

A. This policy applies to all IEHP DualChoice Providers.

POLICY:

A. Providers of Service must submit all appeals and/or grievances to IEHP for the initial appeal and grievance resolution process.

B. All initial appeals and/or grievances must be submitted to the Payor within thirty (30) calendar days of the last date of action on the issue requiring resolution.

C. Payors must resolve appeals and/or grievances within thirty (30) calendar days of receipt of an appeal and/or grievance.

D. A Provider of Service may appeal the outcome of the Payor's appeal and grievance resolution to IEHP within thirty (30) calendar days of receipt of the written determination from the Payor. Providers of Service have thirty (30) calendar days from the date of determination to file an appeal to IEHP for appeal and/or grievance wherein the determination involves medical necessity or utilization management. IEHP maintains written policies and procedures for processing of Payor/Provider of Service denial related appeals and/or grievances regarding utilization management (UM) decisions. IEHP makes final decisions on appeals of UM denials and UM related grievances within thirty (30) calendar days of receipt.

E. A Provider of Service can appeal to IEHP for any adverse determination by a Payor. Appeals of referral denials, or modifications, must be initially appealed to the appropriate Payor. If the denial is upheld, the denial must then be forwarded to the IEHP Grievance Department.

F. IEHP does not discriminate against Providers of Service for filing appeals and/or grievances.

G. A Provider of Service may withdraw an appeal and/or grievance at any time by notifying IEHP in writing.

DEFINITION:

A. **Provider of Service** – Any Practitioner or professional person, acute care hospital organization, health facility, ancillary Provider, or other person or institution licensed by the State to deliver or furnish health care services directly to the Member.

B. **Grievance** – An oral or written expression of dissatisfaction experienced by a Member or Provider regarding IEHP Staff, policies or processes, contracted Providers staff, processes or actions, or any other aspect of health care delivery through IEHP, including quality of care or services provided, aspects of interpersonal relationships, appeals of adverse grievance decisions made by IEHP and the beneficiary's right to dispute an extension of time proposed by IEHP to make an authorization decision, If IEHP is unable to distinguish between a Grievance and an inquiry, it shall be considered a Grievance.

C. **Appeal –** A review of an adverse benefit determination such as:

1. The denial or limited authorization of a requested service, including determination based on the type of level of service, medical necessity, appropriateness, setting of effectiveness of a covered benefit.
2. The reduction, suspension, or termination of a previously authorized service.
3. The denial, in whole or in part, of payment for a service.
4. The failure to provide services in a timely manner.
5. The failure to act within the required timeframes for standard resolution of Grievances and Appeals.
6. For a resident of a rural area, the denial of the beneficiary's request to obtain services outside the network.
7. The denial of a beneficiary's request to dispute financial liability.

D. **Complaint or Dispute** – Any expression of dissatisfaction to a Medicare health plan or Part D sponsor, Provider, Facility or Quality Improvement Organizations (QIO) by a Member made orally or in writing. A complaint may involve a grievance or appeal, or a single complaint could include elements of both. A grievance is always a complaint.

PROCEDURES:

A. Providers of Service dissatisfied with the written resolution of a grievance may appeal the decision to IEHP within thirty (30) calendar days of receipt of the written determination from the Payor.

1. A Provider of Service must submit a written appeal to IEHP within thirty (30) calendar days of receipt of resolution from the Payor regarding the initial appeal and/or grievance. Appeals and/or grievances should be sent to:

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

   a. If the determination involves medical necessity or utilization management, the Provider of Service has thirty (30) calendar days, from receipt of the determination on the initial appeal and/or grievance, to submit a written appeal.

   b. The written appeal must include a copy of the initial grievance resolution being appealed and additional supporting documentation to justify the appeal.

2. All appeals and/or grievances must be identified and acknowledged in writing, whether or not complete, and disclose the recorded date of receipt within five (5) calendar days of receipt (See Attachments, "Appeal of UM Decision – Member – Provider Acknowledgment – IEHP DualChoice Part C and D" and "Provider Grievance Acknowledgment Letter" in Section 16).

3. Grievances and/or appeals are defined as medical and non-medical. Medical and non-medical grievances are resolved separately:

   a. Non-medical grievances are forwarded to the IEHP Director of Provider Relations and may include but are not limited to credentialing issues, contractual issues, enrollment issues, EDI issues, IEHP Team Member or Department Issues or problems related to IEHP administrative and operational policies and procedures.

      1) Refer to Policy 5A6, "Credentialing Standards – Notification to Authorities and Practitioner Appeals Rights", for appeals or grievance related to adverse credentialing decisions.

   b. Medical appeals and grievances are forwarded to IEHP's Medical Director or designee and may include but are not limited to quality management issues, case management issues, or problems related to IEHP medical policies and procedures related to delivery of health care services.

      1) Medical appeals and/or grievances involving current patient care are resolved and the immediacy of the situation. Otherwise, medical and non-medical appeals and grievances are resolved within thirty (30) calendar days. IEHP resolves the appeal and/or grievance by considering all available information and may request additional information, discuss the issue with the involved Provider of Service and/or Payor, or present the issue to the Peer Review Subcommittee or QM Committee for input. The Provider of Service is notified if the resolution will be delayed beyond established timeframes.

      2) 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, "Grievance 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) calendar days. The Provider of Service receives an acknowledgement letter, and a resolution letter notifying them of the final decision (See Attachments, "Appeal of UM Decision – Member - Provider Acknowledgement – IEHP DualChoice Part C and D" and "Appeal of UM Decision Uphold – Member - Provider Resolution – IEHP DualChoice Part C and D" in Section 16).

4. When the appeal and/or grievance is resolved, IEHP mails a copy of the final disposition to the Provider of Service within thirty (30) calendar days of appeal or grievance receipt with a courtesy copy to the Payor (See Attachment, "Appeal of UM Decision Uphold – Member - Provider Resolution - IEHP DualChoice Part C and D" in Section 16).

B. If the Provider of Service is still not satisfied with the outcome of IEHP's appeal or grievance determination, the Provider of Service may request that the IEHP Peer Review Committee (for medical decision) or IEHP's Chief Executive Officer (CEO) and/or Governing Board (for

non-medical decision) review the case. Requests for Peer Review must be received within thirty (30) calendar days from the date the Provider of Service received the grievance or appeal resolution from IEHP. The IEHP Peer Review committee determines medical issues only. Decisions of the Peer Review committee or the IEHP CEO and/or Governing Board are final.

C. If IEHP receives an initial dispute directly from a Provider of Service, IEHP will forward the appeal and/or grievance to the financially responsible Payor for resolution, as applicable and notify the Provider of Service.

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16. GRIEVANCE AND APPEAL RESOLUTION SYSTEM

C. Grievance and Appeal Resolution Process for Providers
3. IPA, Hospital and Practitioner

APPLIES TO:

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

POLICY:

A. Providers (IPAs, Hospitals and Practitioners) must submit all appeals and/or grievances directly to IEHP.

B. IEHP does not discriminate against Providers for filing appeals and/or grievances.

C. A Provider may withdraw an appeal and/or grievance at any time by notifying IEHP in writing.

D. Non-medically related grievances are assessed and resolved by the IEHP Director of Provider Relations. Non-medically related grievances from Contracted Providers may include but are not limited to credentialing issues, capitation issues, contractual issues, enrollment issues, IEHP staff or department issues, or problems related to IEHP administrative and operational policies and procedures.

I. Medically related appeals and grievances are assessed and resolved by the IEHP Medical Director or designee. Medically related appeals and grievances from Providers may include quality management issues, case management issues, or problems related to medical IEHP Policies and Procedures.

PROCEDURES:

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

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

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

C. All other written Provider Grievances not relevant to IEHP are reviewed and triaged for appropriateness and are referred to the sponsoring organization as applicable.

D. All Provider appeals and grievances must be identified and acknowledged in writing, whether or not complete, and disclose the recorded date of receipt within five (5) calendar days of

receipt of the appeal and/or grievance (See Attachment, "Provider Grievance Acknowledgement Letter" in Section 16).

E. IEHP must make a good faith attempt to resolve the issue within thirty (30) calendar days of receipt of the appeal and/or grievance.

F. If a grievance involves P4P reimbursements, the written request must be filed in accordance with the guidelines provided in Policy 19C, "Pay For Performance (P4P)."

G. Claims related appeals are handled in accordance with Policy 20A1, "Claims Processing - Claims Appeals – Denied Claims."

H. IEHP resolves the appeal and/or grievance by considering all available information and may request additional information or discuss the issue with the involved Provider(s).

I. When appeals and grievances are resolved, IEHP mails a copy of the final disposition to the Provider within thirty (30) calendar days of appeal or grievance receipt (See Attachment, "Provider Grievance Resolution Letter" in Section 16).

J. Providers dissatisfied with a resolution may appeal to IEHP within thirty (30) calendar days of receipt of the appeal or grievance resolution from IEHP.

1. Providers must submit a written appeal to IEHP within thirty (30) calendar days of receipt of the final disposition of initial appeal or grievance. The written appeal must include a copy of the initial resolution being appealed, justification and supporting documentation for the appeal.
2. Non-medical grievances are forwarded to the IEHP Chief Executive Officer (CEO) for review.
3. Medical grievances are forwarded to the Peer Review Subcommittee for review.
4. The decision of IEHP's CEO or Peer Review Subcommittee is final.
5. IEHP mails written notice of the appeal decision within thirty (30) calendar days of the decision.
6. Refer to Policy 20A1, "Claims Processing - Claims Appeals – Denied Claims" for appeals or grievances relating to payment or denial of adjudicated claims.

K. IPA or hospital appealing the termination or non-renewal of their IEHP Agreement may appeal to the IEHP Governing Board and request a Fair Hearing (See Attachment, "Provider Fair Hearing Process" in Section 16). The decision of the IEHP Governing Board is final.

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16. GRIEVANCE AND APPEALS RESOLUTION SYSTEM

Attachments

DESCRIPTION	POLICY CROSS REFERENCE
Appointment of Representative - CMS Form 1696 – English	16A, 16B
Appointment of Representative - CMS Form 1696 – Spanish	16A, 16B
Member Appeal and Grievance Form - IEHP DualChoice - English	16A
Member Appeal and Grievance Form - IEHP DualChoice - Spanish	16A
Member Appeal and Grievance Form - IEHP DualChoice – Chinese	16A
Member Appeal and Grievance Form - IEHP DualChoice - Vietnamese	16A
Provider Fair Hearing Process	16C3
Provider Grievance Acknowledgment Letter	16C1, 16C2, 16C3
Provider Grievance Resolution Letter	16C3

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0950

APPOINTMENT OF REPRESENTATIVE

Name of Party	Medicare Number (beneficiary as party) or National Provider Identifier Number (provider as party)

Section 1: Appointment of Representative

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

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

Signature of Party Seeking Representation		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code

Section 2: Acceptance of Appointment

To be completed by the representative:

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

I am a / an _____
(Professional status or relationship to the party, e.g. attorney, relative, etc.)

Signature of Representative		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code

Section 3: Waiver of Fee for Representation

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

I waive my right to charge and collect a fee for representing _____ before the Secretary of DHHS.

Signature	Date

Section 4: Waiver of Payment for Items or Services at Issue

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

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

Signature	Date

Charging of Fees for Representing Beneficiaries before the Secretary of DHHS

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

The form, "Petition to Obtain Representative Fee" elicits the information required for a fee petition. It should be completed by the representative and filed with the request for ALJ hearing or request for Medicare Appeals Council review. Approval of a representative's fee is not required if: (1) the appellant being represented is a provider or supplier; (2) the fee is for services rendered in an official capacity such as that of legal guardian, committee, or similar court appointed representative and the court has approved the fee in question; (3) the fee is for representation of a beneficiary in a proceeding in federal district court; or (4) the fee is for representation of a beneficiary in a redetermination or reconsideration. If the representative wishes to waive a fee, he or she may do so. Section III on the front of this form can be used for that purpose. In some instances, as indicated on the form, the fee must be waived for representation.

Approval of Fee

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

Conflict of Interest

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

Where to Send This Form

Send this form to the same location where you are sending (or have already sent) your: appeal if you are filing an appeal, grievance if you are filing a grievance, initial determination or decision if you are requesting an initial determination or decision. If additional help is needed, contact your Medicare plan or 1-800-MEDICARE (1-800-633-4227). TTY users please call 1-877-486-2048.

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: **AltFormatRequest@cms.hhs.gov**.

DEPARTAMENTO DE SALUD Y SERVICIOS HUMANOS
CENTROS DE SERVICIOS DE MEDICARE Y MEDICAID

Formulario aprobado
OMB No. 0938-0950

NOMBRAMIENTO DE UN REPRESENTANTE

Nombre de la Parte	Numero de Medicare (beneficiario como parte) o Identificador Nacional del Proveedor (proveedor como parte)

SECCIÓN 1: NOMBRAMIENTO DE UN REPRESENTANTE

Para ser completado por la parte que busca representación (i.e., el beneficiario de Medicare, el proveedor o suplidor):

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

Firma dela Parte Solicitando Representación		Fecha
Dirección		Número de Teléfono (Con Código de Area)
Ciudad	Estado	Código Postal

SECCIÓN 2: ACEPTACIÓN DEL NOMBRAMIENTO

Para ser completado por el representante:

Yo,_____, acepto por la presente el nombramiento antes mencionado. Certifico que no se me ha descalificado, suspendido o prohibido mi desempeño profesional ante el Departamento de Salud y Servicios Humanos (DHHS en inglés); que no estoy en calidad de empleado actual o anteriormente de los Estados Unidos, descalificado para actuar como representante del participante; y que reconozco que todo honorario podría estar sujeto a revisión y aprobación de la Secretaría.

Me desempeño como _____
(Situación profesional o relación con la parte, por ejemplo, abogado, pariente, etc.)

Firma del Representante		Fecha
Dirección		Número de Teléfono (Con Código de Area)
Ciudad	Estado	Código postal

SECCIÓN 3: RENUNCIA AL COBRO DE HONORARIOS POR REPRESENTACIÓN

Instrucciones: El representante debe completar esta sección si se lo requieren o si renuncia al cobro de honorarios por representación. (Los proveedores o suplidores que representen a un beneficiario y le hayan brindado artículos o servicios no pueden cobrar honorarios por representación y deben completar esta sección).

Renuncio a mi derecho de cobrar un honorario por representar a _____ ante el Secretario(a) del DHHS.

Firma	Fecha

SECCIÓN 4: RENUNCIA AL PAGO POR ARTÍCULOS O SERVICIOS EN CUESTIÓN

Instrucciones: Los proveedores o suplidores que actúan como representantes de beneficiarios a los que les brindaron artículos o servicios deben completar esta sección si la apelación involucra un tema de responsabilidad en virtud de la sección 1879(a)(2) de la Ley. (La sección 1879(a)(2) en general se aborda si un proveedor, suplidor o beneficiario no tenía conocimiento o no se podía esperar razonablemente que supiera que los artículos o servicios en cuestión no estarían cubiertos por Medicare).

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

Firma	Fecha

Cobro de Honorarios por Representación de Beneficiarios ante El Secretario(a) del DHHS
Un abogado u otro representante de un beneficiario, que desee cobrar un honorario por los servicios prestados en relación con una apelación ante el Secretario(a) del DHHS (i.e., una audiencia con un Juez de Derecho Administrativo (ALJ en inglés), una revisión con el Consejo de Apelaciones de Medicare o un proceso ante un ALJ o el Consejo de Apelaciones de Medicare como resultado de una orden de remisión de la Corte de Distrito Federal) debe, por ley obtener aprobación para recibir un honorario de acuerdo con 42 CFR §405.910(f).

Mediante este formulario, "Solicitud para obtener un honorario por concepto de representación" se obtiene la información necesaria para solicitar el pago de honorario. Debe ser completado por el representante y presentado con la solicitud para audiencia con el ALJ o revisión del Consejo de Apelaciones de Medicare. La aprobación de honorarios para el representante no es necesaria si: (1) el apelante es representado por un proveedor o suplidor; (2) prestados en calidad oficial como un tutor legal, comité o cargo similar representante designado por el tribunal y con la aprobación del tribunal del honorario en cuestión; (3) el honorario es por representación del beneficiario ante la corte de distrito federal; o (4) el honorario es por representación del beneficiario en una redeterminación o reconsideración. Si el representante desea renunciar al cobro de un honorario, puede hacerlo. La sección 3 en la primera página de este formulario puede usarse para ese propósito. En algunas instancias, según se indica en el formulario, no se cobrará el honorario por concepto de representación.

Aprobación de Honorarios
El requisito para la aprobación de honorarios garantiza que el representante recibirá una remuneración justa por los servicios prestados ante DHHS en nombre de un beneficiario y brinda al beneficiario la seguridad de que los honorarios sean razonables. Para la aprobación de un honorario solicitado, el ALJ o el Consejo de Apelaciones de Medicare considera la clase y el tipo de servicios prestados, la complejidad del caso, el nivel de pericia y capacidad necesaria para la prestación de servicios, la cantidad de tiempo dedicado al caso, los resultados alcanzados, el nivel de revisión administrativa al cual el representante llevó la apelación y el monto del honorario solicitado por el representante.

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

Dónde enviar este Formulario
Envíe este formulario al mismo lugar que está enviando (o ha enviado) su: apelación si está solicitando una apelación, queja si está solicitando una queja, o determinación o decisión inicial si está solicitando una determinación o decisión inicial. Si necesita ayuda, comuníquese con su plan de Medicare o llame al 1-800-MEDICARE (1-800-633-4227). Usuarios TTY debe llamar al 1-877-486-2048.

CMS no discrimina en sus programas o actividades. Para solicitar una esta publicación en un formato alterno, llame al 1-800-MEDICARE (TTY 1-877-486-2048) o envíe un correo electrónico a: AltFormatRequest@cms.hhs.gov.

IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan)

Appeal & Grievance Form

This form is for your use in making suggestions, filing a formal complaint, or appeal regarding any aspect of the care or service provided to you. IEHP DualChoice **is required by law** to respond to your complaints or appeals, and a detailed procedure exists for resolving these situations. If you have any questions, please feel free to call IEHP DualChoice Member Services at **1-877-273-IEHP (4347)** or **1-800-718-4347 (TTY),** from 8:00 am to 8:00 pm (PST), 7 days a week, including holidays. IEHP's DualChoice Member Services contact information may also be found on your IEHP DualChoice card. As a Member of IEHP DualChoice, you have the right to file a complaint against IEHP DualChoice or its providers without fear of negative action by IEHP DualChoice, your Doctor, or any other provider.

Please print or type the following information:

_____ _____

Member Name (Last, First, Middle Initial) IEHP I.D. CARD Number

_____ _____

Member Address Home Phone Number

_____ _____

City, State, Zip Work or Message Phone Number

_____ _____ _____

Medicare Number Male/Female Date of Birth

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

Name: _____ Telephone : _____

Relationship to Member: _____

Address: _____

City: _____ State: _____ Zip: _____

Nature of complaint:

WHERE DID THE INCIDENT HAPPEN? *(NAME OF HOSPITAL, DOCTOR, OR OTHER LOCATION)*

_____

WHEN DID THIS HAPPEN? *(IF UNSURE, GIVE APPROXIMATE DATE(S)/TIME(S))*

_____

WHO WAS INVOLVED?

_____

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

_____

_____

_____

Please sign and MAIL OR FAX THIS FORM TO: IEHP DUALCHOICE
Attn: Appeal and Grievance Department, P.O. Box 1800, Rancho Cucamonga, CA 91729-1800
Fax**: (909) 890-5748**; For Questions Call **1-877-273-IEHP (4347)** or **1-800-718-4347 TTY**, from 8:00 am to 8:00 pm (PST), 7 days a week, including holidays.

Date_____ **Member Signature**_____

Date_____ **Signature of Representative**_____

You may have the right to appeal.

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

Who May File An Appeal?

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

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

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

IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS

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

There Are Two Kinds of Appeals You Can File:

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

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

- If any doctor asks for a fast appeal for you, or supports you in asking for one, and the doctor indicates that waiting for 30 days could seriously harm your health**,** your plan will automatically give you a fast appeal.
- If you ask for a fast appeal without support from a doctor, your plan will decide if your health requires a fast appeal. If your plan does not give you a fast appeal, your plan will decide your appeal within 30 days.

What Do I Include With My Appeal?

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

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

How Do I File An Appeal?

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

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

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

Other Contact Information:

If you need information or help, call us at:

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

TTY: **1-800-718-4347**

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

Other Resources To Help You:

Medicare Rights Center Toll Free: **1-888-HMO-9050**

Elder Care Locator: Toll Free: **1-800-677-1116**

1-800-MEDICARE (1-800-633-4227) TTY/TTD: **1-877-486-2048**

24 hours a day, 7 days a week

IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) is a Health Plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees.

IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan)
Appeal & Grievance Form

Este formulario debe usarse para hacer sugerencias, presentar una queja formal o una apelación relacionada con cualquier aspecto de la atención o el servicio que se le proporcionó. La **ley exige a** IEHP DualChoice que responda a sus quejas o apelaciones y existe un procedimiento detallado para resolver estas situaciones. Si tiene alguna pregunta, por favor no dude en llamar a Servicios para Miembros de IEHP DualChoice al **1-877-273-IEHP (4347)** o al **1-800-718-4347** (TTY), de 8am-8pm (Hora Estándar del Pacífico), los 7 días de la semana, incluidos los días festivos. También puede encontrar la información de contacto de Servicios para Miembros de IEHP DualChoice en su tarjeta de IEHP DualChoice. Como Miembro de IEHP DualChoice, usted tiene derecho a presentar una queja en contra de IEHP DualChoice o sus proveedores sin temor a que exista una acción negativa por parte de IEHP DualChoice, su Doctor o cualquier otro proveedor.

Por favor escriba a mano o a máquina la siguiente información:

_____ _____
Nombre del Miembro (Apellido, Primer Nombre e Inicial del Segundo Nombre) | Número de TARJETA de IDENTIFICACIÓN de IEHP

_____ _____
Domicilio del Miembro | Número de Teléfono de Casa

_____ _____
Ciudad, Estado, Código Postal | Número de Teléfono del Trabajo o para Mensajes

_____ _____ _____
Número de Medicare | Masculino/Femenino | Fecha de Nacimiento

Representante Autorizado: Si la queja es presentada por alguien que no es el Miembro, por favor, consulte la sección titulada "Quién puede presentar una Apelación" y proporcione la siguiente información:

Nombre: _____ Teléfono: _____

Relación con el Miembro: _____

Domicilio: _____

Ciudad: _____Estado: _____ Código Postal: _____

Naturaleza de la queja:
¿DÓNDE OCURRIÓ EL INCIDENTE? *(NOMBRE DEL HOSPITAL, DOCTOR U OTRA UBICACIÓN)*

_____
¿CUÁNDO SUCEDIÓ ESTO? *(SI NO ESTÁ SEGURO, DÉ LAS FECHAS/HORAS APROXIMADAS)*

_____
¿QUIÉN ESTUVO INVOLUCRADO?

_____
POR FAVOR DESCRIBA LO QUE SUCEDIÓ. *(ADJUNTE COPIAS DE CUALQUIER INFORMACIÓN ADICIONAL, SI ES NECESARIO)*

_____

_____

_____

Por favor firme y ENVÍE ESTE FORMULARIO POR CORREO O POR FAX A: IEHP DUALCHOICE
Attn: Appeal and Grievance Department, P.O. Box 1800, Rancho Cucamonga, CA 91729-1800
Fax: **(909) 890-5748**. Si tiene Preguntas, llame al **1-877-273-IEHP (4347)** o al **1-800-718-4347 para usuarios de TTY**, de 8am-8pm (Hora Estándar del Pacífico), los 7 días de la semana, incluidos los días festivos.

Fecha_____ **Firma del Miembro**_____

Fecha_____ **Firma del Representante**_____

Es posible que usted tenga el derecho a presentar una apelación.

Para ejercer sus derechos de apelación, presente su apelación por escrito en un plazo de 60 días naturales después de la fecha de su aviso de denegación original. Es posible que su plan le dé más tiempo si tiene una buena razón para no cumplir el plazo.

¿Quién Puede Presentar Una Apelación?

Usted o alguien que usted designe para actuar en su representación (su **representante autorizado**), puede presentar una apelación. Puede designar a un familiar, amigo, abogado, Doctor o cualquier otra persona para que lo represente. Es probable que otras personas, que no se mencionaron anteriormente, ya estén autorizadas para representarlo según la ley Estatal.

Puede llamarnos al **1-877-273-IEHP (4347)** para obtener información sobre cómo designar a un representante autorizado. Si tiene deficiencia auditiva o del habla, puede llamar a la Línea TTY/TDD al **1-800-718-4347**, de 8am-8pm (Hora Estándar del Pacífico), los 7 días de la semana, incluidos los días festivos.

Si desea que alguien lo represente, usted y su representante autorizado deben firmar, poner la fecha y enviarnos la página 1 de este formulario, que servirá como una declaración en la que se designa a la persona que lo representará.

INFORMACIÓN IMPORTANTE ACERCA DE SUS DERECHOS DE APELACIÓN

Para obtener más información sobre sus derechos de apelación, llame a su plan o consulte su Evidencia de Cobertura.

Existen Dos Tipos de Apelaciones que Puede Presentar:

Estándar (30 días): Usted puede solicitar una apelación estándar. Su plan debe informarle su decisión a más tardar 30 días después de recibir su apelación. (Es probable que su plan extienda este tiempo hasta 14 días si usted solicita una extensión o si el plan necesita información adicional y la extensión lo beneficia a usted).

Rápida (revisión en 72 horas): Usted puede solicitar una apelación rápida si usted o su Doctor consideran que su salud podría sufrir un daño grave si espera demasiado para obtener una decisión. Su plan debe tomar una decisión respecto a una apelación rápida en un plazo no mayor de 72 horas después de recibir su apelación. (Es probable que su plan extienda este tiempo hasta 14 días si usted solicita una extensión o si el plan necesita información adicional y la extensión lo beneficia a usted).

- Si algún Doctor solicita una apelación rápida para usted, o lo respalda para solicitar una, y el Doctor indica que esperar 30 días podría dañar gravemente su salud, su plan le autorizará una apelación rápida automáticamente.
- Si usted solicita una apelación rápida sin el respaldo de un Doctor, su plan decidirá si su salud requiere una apelación rápida. Si su plan no le autoriza una apelación rápida, su plan tomará una decisión respecto a su apelación en un periodo de 30 días.

¿Qué Debo Incluir En Mi Apelación?

Debe incluir: su nombre, su domicilio, su número de Identificación de Miembro, los motivos por los que solicita la apelación y cualquier evidencia que desee adjuntar. Puede enviar los registros médicos, las cartas del Doctor u otra información de respaldo que explique por qué su plan debe proporcionar el servicio.

Llame a su Doctor si necesita esta información para ayudarle con su apelación. Puede enviar o presentar esta información personalmente, si lo desea.

¿Cómo Presento Una Apelación?

Para una Apelación Estándar: Usted o su representante autorizado, debe enviar por correo o entregar su apelación por escrito a su plan de salud en el domicilio que se indica en el Formulario de Apelaciones y Quejas del Miembro del Plan de Medicare Advantage de California.

Para una Apelación Rápida: Usted o su representante autorizado debe contactarnos por teléfono o fax usando la información de contacto del plan que se indica en el Formulario de Apelaciones y Quejas del Miembro del Plan de Medicare Advantage de California.

¿Qué Sigue? Si presenta una apelación, su plan revisará nuestra decisión. Después de que su plan revise nuestra decisión, y si aún son denegados algunos de los servicios que solicitó, Medicare le proporcionará una revisión nueva e imparcial de su caso, por medio de un revisor que no pertenezca a su Organización de Medicare Advantage. Si no está de acuerdo con esa decisión, tendrá otros derechos de apelación. Si esto sucede, se le notificarán estos derechos de apelación**.**

Otra Información de Contacto:

Si necesita información o ayuda, llámenos a:

Línea Gratuita: **1-877-273-IEHP (4347)**

TTY: **1-800-718-4347**

De 8am-8pm (Hora Estándar del Pacífico), los 7 días de la semana, incluidos los días festivos.

Otros Recursos que le Pueden Ayudar:

Línea Gratuita del Medicare Rights Center: **1-888-HMO-9050**

Servicio de Localización de Cuidados para Adultos Mayores: Línea Gratuita: **1-800-677-1116**

1-800-MEDICARE (**1-800-633-4227**) Línea TTY/TTD: **1-877-486-2048**

Las 24 horas del día, los 7 días de la semana

IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) es un Plan de Salud que tiene contratos con Medicare y Medi-Cal para proporcionar los beneficios de ambos programas a los afiliados.

IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan)

上訴與申訴表

本表格供您用於針對提供給您之照護或服務的任何方面提出建議、正式投訴或上訴。**根據法律規定**，IEHP DualChoice **必須**回覆您的投訴或上訴， 且**必須**要有詳細程序用於解決這些情況。如果您有任何疑問，請隨時致電 **1-877-273-IEHP (4347)** 或 **1-800-718-4347 (TTY 使用者專線)** 與 IEHP DualChoice 會員服務部聯絡，服務時間為每週 7 天 (包括假日)，上午 8 時至晚上 8 時 (太平洋標準時間 (PST))。您也可在您的 IEHP DualChoice 卡上找到 IEHP DualChoice 的會員服務部聯絡資訊。因為您是 IEHP DualChoice 會員，所以您有權對 IEHP DualChoice 或其醫療服務提供者提出投訴，不用害怕 IEHP DualChoice、您的醫生或任何其他醫療服務提供者會採取對您不利的行動。

請以正楷填寫或打字輸入下列資訊：

會員姓名 (姓氏、名字、中間名首字母)　　IEHP 會員卡號碼

會員地址　　住家電話號碼

城市、州、郵遞區號　　工作或簡訊電話號碼

Medicare 號碼　　男性 / 女性　　出生日期

授權代理人：如果投訴是由會員以外的人士提出，請檢閱「誰可提出上訴」部分並提供下列資訊：

姓名：_____ 電話：_____

與會員的關係：_____

地址：_____

城市：_____ 州：_____ 郵遞區號：_____

投訴性質：

事件發生地點？(*醫院名稱、醫生名稱或其他地點名稱)*

此事件發生時間？*(如果不確定，請提供大約的日期 / 時間)*

相關人士？

請說明事發經過。*(必要時請隨附任何額外資訊的副本)*

請簽名並將本表格郵寄或傳真至： IEHP DUALCHOICE
Attn: Appeal and Grievance Department, P.O. Box 1800, Rancho Cucamonga, CA 91729-1800
傳真：**(909) 890-5748**；如有疑問，請致電 **1-877-273-IEHP (4347)** 或 **TTY** 使用者專線 **1-800-718-4347**，服務時間為每週 7 天 (包括假日)，上午 8 時至晚上 8 時 (太平洋標準時間 (PST))。

日期_____ **會員簽名**_____

日期_____ **代理人簽名**_____

您可能有權提出上訴。

如欲行使您的上訴權，請在原始拒保通知日期後的 60 個曆日內透過書面方式提出上訴。如果您有錯過截止期限的正當理由，您的計畫可以給您更多時間。

誰可提出上訴？

您本人或您指定代您行事的人士 (您的**授權代理人**) 均可提出上訴。您可指定一名親戚、朋友、辯護人、律師、醫生或其他人代您行事。前文未提及的其他人士可能已獲得州法律的授權可代您行事。

您可致電 **1-877-273-IEHP (4347)** 與我們聯絡，以瞭解如何指定授權代理人。如果您有聽力或言語障礙，請致電 TTY/TDD 使用者專線 **1-800-718-4347** 與我們聯絡，服務時間為每週 7 天 (包括假日)，上午 8 時至晚上 8 時 (太平洋標準時間 (PST))。。

如果您想請人代您行事，您和您的授權代理人皆應簽署本表格的第 1 頁、註明日期並將其寄給我們，該頁面將可作為您指定該人士代您行事的聲明。

與您上訴權利有關的重要資訊

如需與您上訴權利有關的進一步資訊，請致電與您的計畫聯絡或參閱您的承保範圍證明。

您可提出兩種類型的上訴:

標準上訴 (30 天) - 您可提出標準上訴要求。您的計畫必須在收到您上訴後的 30 天內告知您決定。(如果您要求延期，或者您的計畫需要額外資訊且延期對您有利，您的計畫可能會延長此期限最多 14 天的時間。)

快速上訴 (72 小時審查) - 如果您或您的醫生認為等候決定過長時間可能會嚴重損害您的健康，您可提出快速上訴要求。您的計畫必須在收到您上訴後的 72 小時內針對快速上訴作出決定。(如果您要求延期，或者您的計畫需要額外資訊且延期對您有利，您的計畫可能會延長此期限最多 14 天的時間。)

- 如果您的醫生替您提出快速上訴要求，或者為您的要求提供佐證，且醫生表示等候 30 天的時間可能會嚴重損害您的健康，您的計畫將會自動為您進行快速上訴。
- 如果您提出快速上訴要求，但沒有醫生的佐證，您的計畫將會判定您的健康狀況是否需要進行快速上訴。如果您的計畫沒有為您進行快速上訴，您的計畫將會在 30 天內針對您的上訴作出決定。

我該在上訴中包含哪些資訊？

您應包含：您的姓名、地址、會員卡號碼、上訴理由以及您希望附上的任何證明。您可寄送佐證病歷、醫生信函或是可說明為何您計畫應提供該服務的其他資訊。

如果您需要上述資訊以協助您提出上訴，請致電與醫生聯絡。您可寄送這些資訊，或者如果您希望的話，您可親自呈遞這些資訊。

我該如何提出上訴？

如欲要求標準上訴：您或您的授權代理人應將您的書面上訴郵寄或遞交至加州 Medicare Advantage 計畫會員上訴與申訴表上所示的地址給您的健保計畫。

如欲要求快速上訴：您或您的授權代理人應使用加州 Medicare Advantage 計畫會員上訴與申訴表上所示的計畫聯絡資訊透過電話或傳真與我們聯絡。

接下來呢？如果您提出上訴，您的計畫將會審查我們的決定。在您的計畫審查完我們的決定之後，如果您所要求的任何服務仍遭到拒絕，Medicare 將會請 Medicare Advantage 組織外的審查人員針對您的個案進行全新且公正的審查。如果您對該決定有異議，您將享有再次上訴的權利。如果發生該情況，您將會接獲有關該等上訴權利的通知。

其他聯絡資訊：

如果您需要資訊或協助，請致電下列電話號碼與我們聯絡：

免付費電話：**1-877-273-IEHP (4347)**

TTY 使用者專線：**1-800-718-4347**

服務時間為每週 7 天 (包括假日)，上午 8 時至晚上 8 時 (太平洋標準時間 (PST))。

可協助您的其他資源：

Medicare 權利中心免付費電話：**1-888-HMO-9050**

年長者照護查詢機構：免付費電話：**1-800-677-1116**

1-800-MEDICARE (1-800-633-4227) TTY/TTD 使用者專線：**1-877-486-2048**

服務時間為每週 7 天，每天 24 小時

IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) 是與 Medicare 和 Medi-Cal 均簽有合約的健保計畫，為計畫參加者提供兩種方案的福利。

Chương trình IEHP DualChoice Cal MediConnect (Chương trình Medicare-Medicaid)

Mẫu đơn Kháng nghị và Khiếu nại

Mẫu đơn này được sử dụng để quý vị đưa ra các gợi ý, nộp đơn khiếu nại chính thức, hoặc kháng nghị về bất kỳ một khía cạnh nào của sự chăm sóc hoặc dịch vụ được cung cấp cho quý vị. **Luật pháp yêu cầu** IEHP DualChoice hồi đáp lại đơn khiếu nại hoặc đơn kháng nghị của quý vị và chúng tôi có một quy trình chi tiết để giải quyết những tình huống này. Nếu quý vị có bất kỳ thắc mắc nào, xin vui lòng gọi tới Ban Dịch Vụ Hội Viên IEHP DualChoice theo số **1-877-273-IEHP (4347)** hoặc **1-800-718-4347 (TTY)**, từ 8:00 sáng tới 8:00 tối (Múi giờ PST). 7 ngày một tuần, kể cả ngày lễ. Thông tin liên lạc của Ban Dịch Vụ Hội Viên IEHP DualChoice cũng có trên thẻ IEHP DualChoice của quý vị. Với tư cách là Hội viên IEHP DualChoice, quý vị có quyền nộp đơn khiếu nại chống lại IEHP DualChoice hoặc nhà cung cấp của họ mà không phải lo sợ hành động tiêu cực của IEHP DualChoice, Bác sĩ của quý vị hoặc bất kỳ nhà cung cấp nào khác.

Vui lòng viết in hoa hoặc đánh máy các thông tin sau:

_____ _____

Họ tên Hội viên (Họ, Tên, Chữ cái đầu của Tên đệm) Mã Số IEHP Số THẺ

_____ _____

Địa chỉ của Hội viên Số Điện thoại Nhà

_____ _____

Thành phố, Tiểu bang, mã Zip Số Điện thoại Nơi làm việc hay Số để Nhắn tin

_____ _____ _____

Số Medicare Nam/Nữ Ngày sinh

Đại diện được Ủy quyền: Nếu đơn khiếu nại được nộp bởi ai khác không phải là hội viên, vui lòng xem xét mục "Ai có thể nộp đơn Kháng nghị" và cung cấp các thông tin sau:

Họ tên: _____ Điện thoại: _____

Mối quan hệ với Hội viên: _____

Địa chỉ: _____

Thành phố: _____ Tiểu bang: _____ Mã Zip: _____

Bản chất của đơn khiếu nại:

VỤ VIỆC DIỄN RA Ở ĐÂU? *(GHI TÊN BỆNH VIỆN, BÁC SĨ HOẶC ĐỊA ĐIỂM KHÁC)*

_____

VIỆC NÀY ĐÃ XẢY RA KHI NÀO? *(GHI GẦN ĐÚNG NGÀY/GIỜ NẾU QUÝ VỊ KHÔNG CHẮC CHẮN)*

_____

NHỮNG NGƯỜI CÓ LIÊN QUAN ĐẾN VỤ VIỆC LÀ AI?

_____

VUI LÒNG MÔ TẢ NHỮNG GÌ ĐÃ XẢY RA. *(ĐÍNH KÈM BẢN SAO CỦA BẤT KỲ THÔNG TIN BỔ SUNG NÀO NẾU CẦN THIẾT)*

_____

_____

Vui lòng ký tên và GỬI THƯ HOẶC FAX ĐƠN NÀY TỚI: IEHP DUALCHOICE
Attn: Appeal and Grievance Department, P.O. Box 1800, Rancho Cucamonga, CA 91729-1800
Fax: **(909) 890-5748**; Nếu Quý vị Có Thắc mắc, Hãy Gọi **1-877-273-IEHP (4347)** hoặc

1-800-718-4347 TTY, từ 8:00 sáng tới 8:00 tối (Múi giờ PST), 7 ngày một tuần, kể cả ngày lễ.

Ngày_____ Chữ ký Hội viên_____

Ngày_____ Chữ ký Người đại diện_____

Quý vị có thể có quyền kháng nghị.

Để thực thi quyền kháng nghị của mình, hãy nộp đơn kháng nghị bằng văn bản của quý vị trong vòng 60 ngày sau ngày quý vị nhận được thông báo quyết định từ chối ban đầu. Chương trình của quý vị có thể cho quý vị thêm thời gian nếu quý vị có lý do chính đáng cho việc bị quá hạn.

Ai Có thể Gửi đơn Kháng nghị?

Quý vị hoặc người được quý vị chỉ định đại diện cho quý vị (**người đại diện được ủy quyền** của quý vị) có thể nộp đơn kháng nghị. Quý vị có thể chỉ định một người thân, bạn bè, người bảo vệ quyền lợi, luật sư, bác sĩ, hoặc ai đó đại diện cho quý vị. Những người khác, không được nhắc tới trước đó có thể đã được ủy quyền theo luật pháp Tiểu bang để đại diện cho quý vị.

Quý vị có thể gọi cho chúng tôi theo số **1-877-273-IEHP (4347)** để biết cách chỉ định người đại diện được ủy quyền của quý vị. Nếu quý vị bị khiếm thính hoặc khiếm ngôn, vui lòng gọi cho chúng tôi theo số TTY/ TDD **1-800-718-4347**, từ 8:00 sáng tới 8:00 tối (Múi giờ PST), 7 ngày một tuần, kể cả ngày lễ.

Nếu quý vị muốn ai đó đại diện cho quý vị, quý vị và người đại diện được ủy quyền của mình nên ký tên, ghi ngày và gửi cho chúng tôi trang 1 của mẫu đơn này, và trang đó sẽ là tuyên bố chỉ định người đại diện cho quý vị.

THÔNG TIN QUAN TRỌNG VỀ QUYỀN KHÁNG NGHỊ CỦA QUÝ VỊ

Để biết thêm thông tin về quyền kháng nghị của quý vị, hãy gọi cho chương trình của quý vị hoặc xem Chứng từ Bảo hiểm của quý vị.

Có Hai Kiểu Kháng nghị Quý vị Có thể Nộp:

Tiêu chuẩn (30 ngày) - Quý vị có thể yêu cầu kháng nghị tiêu chuẩn. Chương trình của quý vị phải đưa ra một quyết định cho quý vị không muộn hơn 30 ngày sau khi nhận được đơn kháng nghị của quý vị. (Chương trình có thể tăng thời gian này lên tới 14 ngày nếu quý vị yêu cầu kéo dài thời gian hoặc nếu chương trình cần thêm thông tin và việc kéo dài có lợi cho quý vị.)

Khẩn (xem xét trong 72 giờ) - Quý vị có thể yêu cầu kháng nghị khẩn nếu quý vị hoặc bác sĩ của quý vị cho rằng sức khỏe của quý vị có thể bị ảnh hưởng nghiêm trọng nếu phải đợi quyết định quá lâu. Chương trình của quý vị phải đưa ra quyết định cho kháng nghị khẩn không muộn hơn 72 giờ sau khi nhận được đơn kháng nghị của quý vị. (Chương trình có thể tăng thời gian này lên tới 14 ngày nếu quý vị yêu cầu kéo dài thời gian hoặc nếu chương trình cần thêm thông tin và việc kéo dài có lợi cho quý vị.)

- Nếu bất kỳ bác sĩ nào yêu cầu kháng nghị khẩn cho quý vị, hoặc hỗ trợ quý vị thực hiện yêu cầu và bác sĩ cho biết rằng chờ đợi 30 ngày có thể ảnh hưởng nghiêm trọng tới sức khỏe của quý vị, chương trình của quý vị sẽ tự động cho quý vị kháng nghị khẩn.
- Nếu quý vị yêu cầu kháng nghị khẩn mà không có sự ủng hộ của một bác sĩ, chương trình sẽ quyết định liệu sức khỏe của quý vị có cần một kháng nghị khẩn hay không. Nếu chương trình của quý vị không cho quý vị kháng nghị khẩn, chương trình sẽ đưa ra quyết định trong vòng 30 ngày.

Tôi Nên Gửi Kèm Những gì với Đơn Kháng nghị của Mình?

Quý vị nên ghi đầy đủ: họ tên, địa chỉ, số ID Hội viên, lý do kháng nghị của quý vị và bất kỳ bằng chứng nào quý vị muốn đính kèm. Quý vị có thể gửi hồ sơ bệnh án hỗ trợ, thư của bác sĩ, hoặc thông tin khác có thể giải thích tại sao chương trình nên cung cấp dịch vụ.

Gọi cho bác sĩ của quý vị nếu quý vị cần thông tin này để hỗ trợ quý với đơn kháng nghị của mình. Quý vị có thể gửi thông tin này hoặc đích thân cung cấp thông tin này nếu muốn.

Làm thế nào Để Tôi Nộp Đơn Kháng nghị?

Đối với Kháng nghị Tiêu chuẩn: Quý vị hoặc người đại diện được ủy quyền của mình nên gửi hoặc chuyển đơn kháng nghị bằng văn bản tới chương trình bảo hiểm y tế của quý vị theo địa chỉ được ghi ở Mẫu Đơn Kháng nghị và Khiếu nại của Hội viên Chương trình Medicare Advantage California.

Đối với Kháng nghị Khẩn: Quý vị hoặc người đại diện được ủy quyền của mình nên liên lạc với chúng tôi bằng điện thoại hoặc fax sử dụng thông tin liên hệ được ghi ở Đơn Kháng nghị và Khiếu nại của Hội viên Chương trình Medicare Advantage California.

Điều gì sẽ Xảy ra Tiếp theo? Nếu quý vị kháng nghị, chương trình của quý vị sẽ xem xét quyết định của chúng tôi. Sau khi chương trình xem xét quyết định của chúng tôi, nếu bất kỳ dịch vụ nào quý vị yêu cầu vẫn bị từ chối, Medicare sẽ cung cấp cho quý vị một đợt xem xét mới và khách quan về vụ việc của quý vị do một người đánh giá không thuộc Tổ chức Medicare Advantage của quý vị thực hiện. Nếu quý vị không đồng ý với quyết định đó, quý vị sẽ có quyền tiếp tục kháng nghị. Quý vị sẽ được thông báo về các quyền kháng nghị đó nếu điều này xảy ra.

Thông tin Liên hệ Khác:

Nếu quý vị cần thông tin hoặc giúp đỡ, hãy gọi cho chúng tôi theo số:

Số Điện thoại Miễn phí: **1-877-273-IEHP (4347)**

TTY: **1-800-718-4347**

Từ 8:00 sáng tới 8:00 tối (Múi giờ PST), 7 ngày một tuần, kể cả ngày lễ.

Các Nguồn Trợ giúp Khác Dành cho Quý vị:

Số Điện thoại Miễn phí của Trung tâm Quyền Medicare: **1-888-HM0-9050**

Công cụ Định vị Dịch vụ Chăm sóc Người Cao niên: Số Điện thoại Miễn phí: **1-800-677-1116**

1-800-MEDICARE (1-800-633-4227) TTY/TTD: **1-877-486-2048**

24 giờ mỗi ngày, 7 ngày một tuần

Chương trình IEHP DualChoice Cal MediConnect (Chương trình Medicare-Medicaid) là Chương Trình Bảo Hiểm Y Tế có hợp đồng với cả Medicare và Medi-Cal để cung cấp quyền lợi của cả hai chương trình cho những người ghi danh.

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 Dr. [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 (909) 890-XXXX.

Sincerely,

[Director Name]
Director of Provider Relations, IEHP

cc:
Manager Name, Manager of Provider Relations, IEHP
PSR Name, Provider Services Representative, IEHP
File location (see policy and procedures PRO/GEN 03) ex. F-120.a

[DATE]

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

Re: Grievance _____

Dear Dr. [Provider Name]:

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

_____

_____

_____

_____

_____

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

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

Sincerely,

[Director Name]
Director of Provider Relations, IEHP

cc: Manager Name, Manager of Provider Relations, IEHP
PSR Name, Provider Services Representative, IEHP
PCP
IPA
File location (see policy and procedure PRO/GEN 03) ex. F-120.a