16. GRIEVANCE AND APPEAL RESOLUTION SYSTEM

A. Member Grievance Resolution Process

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 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 voluntary verbal or written request to rescind or cancel a pending grievance.[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 related to whether the quality of covered services provided by a plan or provider meets professionally recognized standards of health care, including whether appropriate health care services have been provided or have been provided in appropriate settings.[19]

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

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[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

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.[20]

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);[21,22]
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"[23] in threshold languages in found on the IEHP website).

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.[24]

C. Members have the right to appoint someone to file their grievance case and/or represent them.[25] 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.[26]

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[20] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 10.1
[21] Title 28 CCR § 1300.68(b)(4)
[22] CA HSC Health & Saf. Code § 1368.02(b)
[23] https://www.iehp.org/en/providers/provider-resources?target=forms
[24] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 10.5.2
[25] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 20.1
[26] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 20.3

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"[27] in found on the IEHP website).[28]
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.[29]
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.[30]

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.[31]

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.[32]

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.

1. 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. The Civil Rights Coordinator

[27] https://www.iehp.org/en/providers/provider-resources?target=forms
[28] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 20.1
[29] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 20.2
[30] Ibid.
[31] 42 CFR § 438.406(b)(4)
[32] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 30.4

must be available to:[33]

a. Answer questions and provide appropriate assistance to IEHP staff and Members regarding the Plan's state and federal non-discrimination legal obligations;

b. Advise the Plan about non-discrimination best practices and accommodating persons with disabilities; and

Investigate and process any ADA, Section 504, Section 1557, and/or Government Code Section 11135 grievances received by the Plan.

~~K.~~c. ~~Grievances alleging discrimination must be submitted to IEHP's Section 1557 Coordinator for review within 180 calendar days of the date the person filing the grievance becomes aware of the alleged discriminatory action. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought. All cases alleging discrimination against Members or eligible beneficiaries are forwarded to DHCS OCR for review with ten (10) days of mailing a discrimination grievance resolution letter. Please see Policy 9H3, "Cultural and Linguistic Services – Non-Discrimination."~~

~~L.~~K. Members with complaints regarding confidentiality, have the right to file a grievance to any of the following:[34]

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
   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.~~L. All IEHP staff and external IEHP committee members are required to sign a confidentiality statement agreeing not to disclose confidential information.[35] However, IEHP may use or disclose a Member's individually identifiable health information without a Member's authorization as follows:[36]

[33] DHCS APL 21-004
[34] 45 CFR §§ 164.520, 164.528
[35] 45 CFR §§ 164.520, 164.528
[36] 45 CFR § 164.502(a)(1)(ii)

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, involuntary disenrollment, annually, and upon request.[37]

B. 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.[38,39,40,41]

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 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.[42,43]

D. IEHP does not discriminate against any Member for filing a grievance.[44]

E. IEHP ensures that Members with linguistic and cultural needs as well as Members with

[37] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 10.4.4
[38] 42 CFR § 422.110(a)
[39] 45 CFR Part 92
[40] CA Welfare and Institutions Code (Welf. & Inst. Code) § 14029.91
[41] CA Government Code (Gov. Code) § 11135(a)
[42] Section 1557 of the Affordable Care Act (42 U.S.C. § 18116)
[43] 45 CFR § 92.101
[44] 28 CCR §1300.68(b)(8)

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.[45,46]

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.[47] 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.[48]

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 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.[49]

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

[45] 22 CCR § 53858(e)(6)
[46] 28 CCR § 1300.68(b)(3)
[47] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 10.4.4
[48] 45 CFR §§ 164.520, 164.528
[49] 45 CFR § 164.502(a)(1)(ii)

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.[50]

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" [51] in threshold languages on the IEHP website) readily available for distribution to Members upon request.[52]

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"[53] in threshold languages on the IEHP website).

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 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.

[50] 42 CFR § 438.406(b)(2)
[51] https://www.iehp.org/en/providers/provider-resources?target=forms
[52] 22 CCR, § 53858
[53] https://www.iehp.org/en/providers/provider-resources?target=forms

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.[54,55] 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:[56,57]

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:[58]

1. Standard grievances are resolved within thirty (30) calendar days of receiving the grievance.[59,60,61] 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.[62] All cases are resolved as expeditiously as the Member's health condition requires.[63]
2. Expedited grievances are resolved within twenty-four (24) hours from the receipt date. IEHP expedites the grievance if:[64]

[54] CA Welf. & Inst. Code §14450
[55] CA Health & Saf. Code (HSC) § 1368(a)(2)
[56] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 30
[57] CA Health & Saf. Code 1368(a)(4)B)
[58] 28 CCR § 1300.68
[59] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 30.2
[60] 22 CCR § 53858(g)(1)
[61] 28 CCR § 1300.68(d)(3)
[62] 22 CCR §53858(g)(2)
[63] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 10.4.1
[64] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 30.2

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:[65]

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: [66,67]

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 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.[68]

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

[65] Ibid.
[66] CA Health & Saf. Code § 1368(a)(4)(A)
[67] 28 CCR § 1300.68(d)(1)
[68] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 30.2.1

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.[69]

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 its investigation but is not required to notify the Member of the outcome.[70]

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.[71] 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.[72]

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

[69] 42 CFR § 438.406(b)(2)(iii)
[70] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 30.4
[71] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 30.2.1
[72] 22 CCR § 53858(e)(2)

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).[73] Timeliness rates are based on the initial expected response due date and date a completed response is received, addressing all alleged issues.[74] 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

[73] 28 CCR § 1300.68(b)(5)
[74] 22 CCR § 53260

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.

16. GRIEVANCE AND APPEAL RESOLUTION SYSTEM

A. Member Grievance Resolution Process

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☐ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	January 1, 2007	
Revision Effective Date:	January 1, 2023	

~~INLAND EMPIRE HEALTH PLAN~~		
~~**Regulatory/ Accreditation Agencies:**~~	☐ ~~DHCS~~	☐ ~~CMS~~
	☐ ~~DMHC~~	☐ ~~NCQA~~
~~**Original Effective Date:**~~	~~January 1, 2007~~	
~~**Revision Effective Date:**~~	~~January 1, 2023~~	

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.~~ ~~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)

~~These timeframes may be extended by fourteen (14) calendar days if any of these conditions apply:~~[50,51]

~~a. The Member requests the extension; or~~

~~b. The extension is justified and in the Member's interest due to the need for additional 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.~~

3. Medicaid services.

C. An ~~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.[52]

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.[53]

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. [54,55]

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.

~~[50] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 50.2.2~~

~~[51] 42 CFR § 438.408(c)(1)~~

[52] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 40.5.4

[53] Ibid.

[54] 42 CFR § 438.410(c)

[55] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 50.2.2

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 emergency service.[56]

    a. IEHP forwards the case file to the Independent Review Entity within twenty-four (24) hours of the denial being upheld.[57]

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.[58,59]

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.[60]

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.[61]

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.

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

K. IEHP dismisses reconsideration requests under any of the following circumstances:[62]

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 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.[63]

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.

[62] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 50.9
[63] 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

1. Part C Reconsiderations

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☐ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	January 1, 2022	
Revision Effective Date:	January 1, 2023	

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"-[18] found on the IEHP website~~in Section 16IEHP Portal~~).[19]

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.[20]

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.[21]

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.[22] 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.[23]

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[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] https://www.iehp.org/en/providers/provider-resources?target=forms

[19] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 20.2

[20] Ibid.

[21] Ibid.

[22] 42 CFR § 423.562

[23] 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.[24,25]

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.[26]

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:[27]

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.[28] 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

[24] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 50.4
[25] 42 CFR § 423.582(d)
[26] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 50.5.2
[27] 42 CFR § 438.408(f)
[28] 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:[29]

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.[30,31]

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:[32,33]

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.

[29] 45 CFR § 164.502(a)(1)(ii)
[30] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 10.4.4
[31] 28 CCR § 1300.68(b)(2)
[32] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 50.3
[33] 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.[34] 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.[35,36,37,38]

D. IEHP does not discriminate against any Member for filing a grievance or appeal.[39] 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.[40,41]

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.[42]

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.[43] 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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[34] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 60.5
[35] 42 CFR § 422.110(a)
[36] 45 CFR Part 92
[37] CA Welfare and Institutions Code (Welf. & Inst. Code) § 14029.91(e)(2)
[38] CA Government Code (Gov. Code) § 11135(a)
[39] 28 CCR § 1300.68(b)(8)
[40] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 50.2.2
[41] 42 CFR § 438.40(b)
[42] 28 CCR § 1300.68(b)(3)
[43] 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.[44]

~~I.~~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.[45] 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.[46,47]

~~J.~~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.

~~K.~~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.

~~L.~~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.

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

B. All Member appeal correspondence, Member Appeal Forms, and the IEHP Appeal Resolution Process handout are provided in threshold languages.[48]

C. For appeals not resolved wholly in favor of the Member, IEHP includes in its written response the reasons for its determination.[49]

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.[50,51,52,53]
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.[54,55,56,57]
3. Except for Part B drug appeals, these timeframes may be extended by fourteen (14)

[48] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 10.4.4
[49] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 50.10.1
[50] 42 CFR § 423.590(a)
[51] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 50.2.1
[52] 28 CCR § 1300.68(a)
[53] 42 CFR § 438.408(b)(2)
[54] 42 CFR § 423.590(d)(1)
[55] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 50.2.1
[56] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 50.2.2
[57] 42 CFR § 438.408(b)(3)

calendar days if any of these conditions apply:[58,59]

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 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.[60] 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.[61]

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.[62,63]

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.

[58] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 50.2.2
[59] 42 CFR § 438.408(c)(1)
[60] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 50.2.1.a
[61] 42 CFR § 423.590(d)(1)
[62] 42 CFR § 423.584(d)
[63] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 50.2.2

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 emergency service.[64]

    a. Upon request from the Independent Review Entity (IRE), IEHP forwards the case file to the IRE and notifies the Member accordingly.[65,66]

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.[67,68]

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.[69,70,71]

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

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

DMHC.[72]

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.

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:[73]

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.[74]

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.

[72] CA Health & Saf. Code § 1374.34(a)
[73] 42 CFR § 423.582(e)
[74] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 10.4.3

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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 (HMO D-SNP) 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"[1] ~~in Section 16IEHP Portal~~found on the IEHP website[2]).

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

[1] ~~https://www.iehp.org/en/providers/provider-resources?target=forms~~
[2] https://www.iehp.org/en/providers/provider-resources?target=forms

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 (HMO D-SNP) 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"-[1] ~~in Section 16~~~~IEHP Portal~~found on the IEHP website [2]).

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"[3] ~~in~~ found on the IEHP ~~Portal~~website ~~Section 16~~[4]).

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

[1] ~~https://www.iehp.org/en/providers/provider-resources?target=forms~~
[2] https://www.iehp.org/en/providers/provider-resources?target=forms
[3] ~~Ibid.~~
[4] Ibid.

with a courtesy copy to the Payor (See Attachment, "Appeal of UM Decision Uphold – Member - Provider Resolution - IEHP DualChoice Part C and D"[5] ~~in~~ found on the ~~Section 16~~IEHP ~~Portal~~website [6]).

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.

[5] ~~https://www.iehp.org/en/providers/provider-resources?target=forms~~
[6] https://www.iehp.org/en/providers/provider-resources?target=forms

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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 (HMO D-SNP) Providers (IPAs, Hospitals and Practitioners).

POLICY:

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

B. IEHP 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" [1] ~~in Section 16).IEHP Portal~~found on the IEHP website [2]).

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" [3] ~~in IEHP Portal Section 16~~found on the IEHP website [4]).

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

[1] ~~https://www.iehp.org/en/providers/provider-resources?target=forms~~
[2] https://www.iehp.org/en/providers/provider-resources?target=forms
[3] ~~Ibid.~~
[4] Ibid.

Fair Hearing Process"[5] ~~in IEHP Portal Section 16~~found on the IEHP website [6]). The decision of the IEHP Governing Board is final.

[5] ~~Ibid.~~
[6] https://www.iehp.org/en/providers/provider-resources?target=forms

16. GRIEVANCE AND APPEAL RESOLUTION SYSTEM

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

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☐ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	January 1, 2007	
Revision Effective Date:	January 1, 2023	

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