Policy #: 500-3011-G
Title: Provider Grievance System
Dept.: Provider Services
Effective Date: December 20, 2016

I. PURPOSE

To establish a process for CenCal Health's contracted and non-contracted providers to have their inquiries, appeals, and complaints heard and evaluated.

II. POLICY

CenCal Health operates a uniform system across all of CenCal Health's programs to address provider appeals and complaints to encourage resolution of any dispute as informally as possible. This policy provides several levels of review to ensure a fair and appropriate adjudication of issues, and allows providers access to all levels of CenCal Health's decision-making process.

III. DEFINITIONS

Inquiry: A request by a provider for clarification, or a request for additional information. Inquiries may be made regarding (but are not limited to) the following: Referral Authorization Forms (RAFs); Treatment Authorizations Requests (TARs)(for Medi-Cal)/Authorization Requests (ARs)(for all programs other than Medi-Cal); Medications Request Forms (MRFs); the processing, suspension, or denial of a particular claim or series of claims; or other issues not related to utilization or claims. The majority of claims inquiries are requests for assistance in interpreting the Explanation of Benefits (EOB). Inquiries may be made orally or submitted in writing.

Appeal: An appeal is a request from a provider to change a previous decision made by CenCal Health. Appeals by providers are made to CenCal Health's Utilization Management Unit (regarding post-service T/ARs) and (post-service MRFs), to Claims (regarding claims disputes and appeals) and to Provider Services (regarding operational issues), as appropriate. Providers are encouraged to submit appeals in writing to

ensure that all information required for the processing of the appeal is included. A form is available on the CenCal Health website (www.cencalhealth.org) specifically for the submittal of claims disputes and appeals.

Complaint: A complaint is an expression of dissatisfaction that is generally related to member issues, another provider's care or treatment, a clinical or quality of care issue, aspects of CenCal Health's administration of its programs, or other issues.

Grievance: A formal written expression of dissatisfaction by a provider with any aspect of CenCal Health's operations, or another provider's or member's activities or behavior- with the exception of CenCal Health decisions regarding claims or service authorizations- regardless of whether any remedial action is requested or can be taken.

IV. PROCEDURE

1) PROCESSING PROVIDER INQUIRIES, APPEALS, AND COMPLAINTS

If a provider contacts Provider Services with issues outside their purview (claims inquires or appeals, TAR/MRF inquiries or appeals), the Provider Services Customer Representative will "warm transfer" the caller to the appropriate department. The appropriate department to address the grievance, unless otherwise requested, shall review and respond as appropriate.

A. Receipt and Resolution of a Provider Claims Inquiry

Providers may contact CenCal Health's Claims Department at (805) 685-9525 or (800) 421-2560. A Claims Representative and/or Senior Claims Analyst will research the issue and inform the provider of the resolution. Most claims inquiries are resolved at the initial contact and are not formally documented. The provider may submit additional information to the Claims Department to adjudicate the claim in question. This additional information is kept on file and may serve as documentation of the inquiry if the provider wishes to appeal the claims processing decision.

B. Claim Denial for No T/AR/MRF:

If a provider's inquiry is regarding a claim denied for "No T/AR", the provider is directed to the Health Services Department to

submit a T/AR. The Health Services staff will review the T/AR and if the T/AR is approved, the claim is processed according to CenCal Health guidelines. Likewise, for pharmacy claims denied for "No MRF", CenCal Health's PBM will have the provider submit a MRF. PBM staff will review the MRF and if the MRF is approved, the claim will be processed by the PBM. If the T/AR/MRF is denied, the provider receives the PROVIDER/MEMBER T/AR/MRF APPEAL PROCESS information sheet containing appeal instructions (the appeal process is described below).

C. Receipt and Resolution of a Provider Appeal

I. MRF (Medication Request Form) Appeals: If the original pharmacy initial determination for medication is a denial issued through CenCal Health's PBM, the provider may file a pre-authorization appeal on behalf of the member through the Member Grievance System. Please refer to Policy number 300-1000.

II. Reimbursement Appeals: If the outcome of the adjudication of the original claim is upheld, the provider may file an appeal of a claim decision in writing to the Claims Department. Please see policy 800-3000 Provider Dispute Resolution Process.

III. Authorization Request/Treatment Authorization Request (T/AR) Appeals: If a provider receives a letter of denial, deferral, or modification of a post-service T/AR/MRF, the provider may appeal the denial or modification in writing to the Health Services Department. Please see Policy 400-4420 Provider/Member Treatment Authorization Request Appeals Process. b. Preservice appeals: If the service requested by the T/AR or MRF has not been provided, the member, or a provider on behalf of the member, is informed of their right to file an appeal with the Member Services Department. Please see Policy 300-1000 Member Grievance System (Complaints and Appeals).

IV. Receipt and Resolution of a Provider Complaint:

a. The Provider Services Department is charged with the resolution of provider complaints. The complaint may be related to: member issues, another provider's care or treatment, a clinical or quality of care issue, aspects of CenCal Health's administration of its programs, or other issues. The provider may file a complaint with the Provider Services

Department via a telephone call, by fax, or through other written means.

b. The provider's Provider Services Representative (PSR) will determine whether the complaint involves an adverse or potentially adverse effect on a member's quality of care. Any complaints involving a clinical or quality of care concern will be referred to the Supervisor, Clinical Practice Management. The Supervisor, Clinical Practice Management will attempt, under the direction of CenCal Health's Medical Director, or designee, to respond to the issue as quickly as possible in a timeframe appropriate to the member's medical condition. The Supervisor, Clinical Practice Management shall:
   - Obtain provider(s) perspective and/or medical records regarding complaints that are potentially clinical complaints.
   - Present gathered information for review by the Medical Director or designee, and/or the Credentials and Peer Review Committee, etc.
   - Document the results of the investigation and resolution

c. If a complaint has no clinical or quality of care aspect, the PSR determines whether the provider needs routine assistance or would like to file a formal grievance. Formal grievances must be submitted in writing.

d. If the provider submits a written formal grievance, the PSR will notify the Provider Services Quality Liaison, who will send a receipt acknowledgment letter within five business days.

e. The PSR will collaborate with other staff as needed to investigate and resolve the provider's grievance. Following resolution of the complaint, the PSR will document the case and the outcome, and the Quality Liaison will send a resolution letter. All grievances are resolved within 45 business days.

2) DISCLOSURE TO PROVIDERS AND MEMBERS

Providers are informed of their right to file grievances and appeals, and the availability of assistance in the filing process through their provider contract agreements or amendments, CenCal Health's website, on their Explanation of Benefits (EOB) (which directs them to CenCal Health's website), Provider Bulletins, and in provider materials and manuals issued by CenCal Health and updated periodically. Additionally, denial of

claims payment is indicated on the provider's EOB, along with a statement informing the provider of his options in requesting assistance with claims inquiries and appeals. This serves as notification to non-contracted providers for accessing CenCal Health's Provider Grievance System. The requirements and timeframes for filing a grievance or appeal may vary depending on the type, and are outlined in this policy or those referenced herein.

All written communications to a physician or other health care provider of a denial, deferral, or modification of a T/AR or MRF, including post-service T/ARs and MRFs, shall include the name and direct phone number or extension of the health care professional responsible for the denial, deferral, or modification. The response will also include information as to how the member may file an appeal or complaint with CenCal Health, and in the case of Medi-Cal members when the service has not yet been provided, shall explain how to request an administrative hearing. If the member requests a State fair hearing, any services or benefits in dispute will continue at the member's request, pending the outcome of the hearing; however the member may be required to pay the cost of those services if the final decision is adverse to the member.

If the provider's complaint or appeal has not been satisfactorily resolved by CenCal Health, or a complaint or appeal remains unresolved for more than 45 days without written notice, the provider may present the complaint or appeal to the Board for assistance. CenCal Health's grievance system is in addition to any other dispute resolution procedures available to the provider. The provider's failure to use these procedures does not preclude the provider's use of any other remedy provided by law.

CenCal Health's Chief Operating Officer should be notified immediately when a provider's legal representative contacts CenCal Health regarding the pursuit of legal action to resolve a complaint or appeal.

CenCal Health will not discriminate or retaliate in any manner, including but not limited to the cancellation of the provider's contract, against a provider who files a grievance.

Grievances shall be received, handled, and resolved without charge to the provider. However, CenCal Health shall have no obligation to reimburse a provider for any costs incurred in connection with utilizing the Provider Grievance System.

3) Confidentiality and Privacy Regarding Record Retention

All provider complaints and appeals shall be placed in designated files and maintained by the Provider Services Quality Liaison for at least seven (7) years after the resolution; the files of the previous two (2) years

shall be in an easily accessible place at CenCal Health's offices. Documents that are considered "confidential" and that are obtained during a clinical appeal or quality of care review will be maintained by the Supervisor, Clinical Practice Management in appropriate files, folders, or binders.

4) MONITORING OF THE PROCESS

Reports

The Provider Services Manager will prepare a quarterly summary of provider complaints and grievances to be presented to CenCal Health's Network Management Committee and Board of Directors. The summary shall summarize the number and type of provider complaints, grievances and appeals.