



Policy #: 500-3011-F  
Title: Provider Grievance System  
Dept.: Provider Services  
Signature of CEO: \_\_\_\_\_  
Effective Date: 6/2002  
Revision Date: 6/25/2008

## **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**

It is the policy of CenCal Health to operate 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**

**Grievance (Dispute):** A term encompassing various types of provider inquiries, appeals, and complaints.

**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 MediCal)/Authorization Requests (ARs)(for all programs other than MediCal); 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) and to Provider Services (regarding RAFs, denied claims, and other non-claim management denials), as appropriate. Providers are encouraged to submit appeals in writing via a "Provider Grievance Form" (Attachment 1) to ensure that all information required for the processing of the appeal is included. This

form is available on the CenCal Health website ([www.cencalhealth.org](http://www.cencalhealth.org)) and is attached to this policy.

**Complaint:** A complaint is an oral and/or written expression of dissatisfaction, which is generally related to access, 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.

#### **IV. PROCEDURE**

##### **1) PROCESSING PROVIDER INQUIRIES, APPEALS, AND COMPLAINTS**

###### **A. Receipt and Resolution of a Provider Inquiry**

The appropriate department to address the inquiry, unless otherwise requested, shall review and respond by telephone to inquiries directed to CenCal Health's attention.

Providers may contact CenCal Health's Claims Department at (805) 562-1083 or (800) 421-2560, ext. 1083 regarding a claims processing question. 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 will be kept on file and may serve as documentation of the inquiry if the provider wishes to appeal the claims processing decision.

If the provider submits the inquiry in writing, or otherwise requests a formal response, the following procedure is followed:

- I. A standard "Provider Grievance Acknowledgment letter" (Attachment 2) is sent to the provider within 15 business days of the date the formal inquiry is received by a Claims staff person.
- II. A standard "Claims Inquiry Response letter" (Attachment 3) is sent to the provider within 45 business days of the date the formal inquiry was received. This letter provides information regarding the reason the claim(s) in question was denied or pended, as well as contact information for the Claims staff person responsible for the claim. For inquiries regarding claims denied or pended due to information that was required but was missing, providers must submit additional information as directed in the Claims Inquiry Response letter within 30 business days to adjudicate the claim. Providers will not be asked to resubmit previously submitted information, unless that information was not received by CenCal Health.

### **Claim Denial for No T/AR/MRF:**

If a claim is denied for “No T/AR”, the Claims Representative or the Provider Services QI (PSQI) Manager shall have the provider submit a T/AR, which will be directed to CenCal Health’s Health Services staff. The Health Services staff will review the T/AR and respond back to the appropriate staff. 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).

#### **B. 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-K.
- II. Reimbursement Appeals
  - a. 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 within 365 days of the decision date for services rendered to members of Knox Keene licensed plans. Regarding claims appeals for services rendered to SBHI and SLOHI members, *California Code of Regulations*, Title 22, Section 51015 states: “Providers must submit an appeal in writing within 90\_DAYS of the action/inaction precipitating the complaint”. The “action/inaction precipitating the complaint” is either 1) the date of notification by CenCal Health to the provider that the adjudication of the claim is upheld, or 2) the date the claim was last denied on an EOB, so long as the timeframe of attempts to adjudicate the claim at no time exceeded 6 months. Section 51008 (d) of Title 22 states “A request for adjustment or reconsideration of an adjudicated claim must be received by the fiscal intermediary not later than six months following the date of payment or denial of the claim by the fiscal intermediary”. Claims appeals submitted beyond these timeframes will not be considered. The mailing address is:

CenCal Health  
Claims Department  
4050 Calle Real  
Santa Barbara, CA 93110

- b. All claims appeals should be submitted via a "Provider Grievance Form" (Attachment 1), including all pertinent information and attachments (i.e. member name, ID#, DOS, Claims Control Number or CCN, reason the provider disagrees with the original claims decision, and any supporting documentation). Claims appeals lacking sufficient information to resolve the appeal, will be returned to the provider with a request for more information.
- c. If a provider wishes to submit multiple similar claims appeals (i.e. multiple DOS for one member, denial of same procedure code for multiple members), they may be submitted together provided all necessary information to resolve the appeal is included. The provider should include documentation to clarify that there are several claims involved and why they are being submitted together.
- d. If the Claims Department is able to resolve the issue, either by releasing the claim for payment due to additional information submitted, or by upholding the original claim decision, a "Claims Appeal Response Letter" (Attachment 4) is sent to the provider. This letter includes information explaining why the original decision has been upheld, if appropriate, and informs the provider of his option to appeal the claims decision further if he does not agree with said decision.
- e. If the Claims Department determines the appeal meets the criteria of a claims appeal (it represents a request to change a previous final claims decision), it is forwarded to the PSQI Manager for resolution.
- f. A standard "Claims Appeal Receipt Acknowledgment letter" (Attachment 2) is sent to the provider within 15 business days of the date the appeal is received by the PSQI Manager.
- g. The PSQI Manager shall gather all pertinent information, working with other departments as needed to research the claim. The PSQI Manager will contact the Claims Reimbursement Supervisor to determine if there have been inquiries through the Claims Department about the issue now being appealed, and will request any documentation that is available, if not already submitted with the appeal. The PSQI Manager will present the appeal and the accompanying Provider Claims Appeal Outcome Form to the Director of Provider Services for possible resolution. The Director of Provider Services may consult with additional staff prior to reaching a final determination.
- h. The Director of Provider Services may approve the payment of claims appeals with payable amounts less than \$1,500 per provider per benefit year, at her discretion. Reasons for approval may include, but are not limited to: one-time billing limitation/ timeliness of follow-up exception, demonstration of goodwill

(particularly when sensitive contractual issues are at stake), or provider diligently attempted to adjudicate claim (albeit unsuccessfully). Once approved, the PSQI Manager will forward the signed Provider Claims Appeal Outcome Form to the Claims Reimbursement Supervisor, authorizing payment of the claim(s). These paid claims appeals will be tracked in a spreadsheet.

- i. For claims appeals with payable amounts greater than \$1,500 per provider per benefit year, the Chief Financial Officer's approval and signature must also be obtained.
- j. In the event a negotiated settlement agreement is required to resolve a claims appeal (i.e. due to the complexity of the appeal or the reimbursement amount contested, for example) and the finding is in favor of the provider, CenCal Health will pay appropriate interest and penalties.
- k. Claims contested on the basis of a clinical issue, the necessity for treatment, or the type of treatment proposed or utilized, shall be referred to CenCal Health's Medical Director or designee, except for pharmacy, which are first reviewed by the PBM's clinical pharmacist. The Medical Director/designee shall review the appealed claim and if (s)he feels qualified to evaluate the specific clinical issues presented in the claim, shall make a determination on said claim. If the Medical Director/designee does not feel qualified to evaluate the specific clinical issues of the claim, prior to making a determination, (s)he shall consult with an appropriately licensed health care provider who is qualified to evaluate the specific clinical issues presented in the claim. The Medical Director/designee shall make the final determination as to whether the service provided was clinically warranted. The claim is then adjudicated against all other system edits. A request for additional information from the provider may be made if required by system edits. The Director of Provider Services shall make the final decision regarding payment of the claim.
- l. The PSQI Manager will send a written response regarding the final determination of the appeal to the provider within forty-five (45) business days of receipt of the appeal. The date this written response is postmarked shall be considered the "Date of Determination".
- m. Following resolution of the claims appeal with the provider, the PSQI Manager will enter all pertinent data into the Provider Complaint or Grievance System (PCOGS). All PCOGS records are assigned a unique identifying number for tracking purposes. Batch claims appeals submitted as one appeal will be considered as one PCOG record.

- n. If the final determination for a claims appeal for services rendered to a member of a Knox Keene licensed plan is in the provider's favor, CenCal Health will pay any monies due, including interest and penalties if applicable, within five (5) business days. Per Section 1300.71.38.g of Claims Settlement Practices, "Accrual of interest and penalties for the payment of these resolved provider disputes shall commence on the day following the expiration of "Time for Reimbursement" as set forth in section 1300.71(g)". Section 130071(g) defines "Time for Reimbursement" by stating "A plan...shall reimburse each complete claim, or portion thereof, whether in state or out of state, as soon as practical,...if the plan is a health maintenance organization, 45 working days after the date of receipt of the complete claim by the plan..., unless the complete claim or portion thereof is contested or denied, as provided in subdivision (h)". In other words, accrual of interest and penalties commences on day 46 after receipt of the claim by the plan.

**III.** Authorization Request/Treatment Authorization Request (T/AR) Appeals (Post Service)

- a. 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 at the following address:

CenCal Health  
Health Services Department  
4050 Calle Real, Santa Barbara, CA 93110

- b. Post-service appeals: Providers may appeal denied or modified post-service T/ARs by submitting the following documentation within 60 calendar days from the date of the original decision:
- A copy of the original T/AR or MRF
  - A copy of the denial/deferral/modification notification
  - A letter stating why denial or modification should be overturned
  - Documentation to support overturning the original denial or modification
- c. Providers are notified of receipt of their appeals and the appeals process within five working days.
- d. The provider will receive a written response within thirty (30) working days of receipt regarding the determination of the post-service appeal. If a decision cannot be reached within 30 working days, notice will be provided to the provider of the reason for the delay and a written decision will be issued within fifteen (15) additional days.

- e. If the service requested by the T/AR or MRF has not been provided, members, or a provider on behalf of a member, are informed of their right to file an appeal through the Member Grievance System. For additional information or assistance, members may contact CenCal Health's Member Services Department at:

CenCal Health

Member Services Department

4050 Calle Real, Santa Barbara, CA 93110

1-877-814-1861 (Toll-Free)

8:00 a.m. to 5:00 p.m.-Monday through Friday

**or**

805-685-4131 Telecommunications Device for the Hearing Impaired

8:00 a.m. to 5:00 p.m.-Monday through Friday

- f. The post-service appeal will be reviewed by a physician who was not involved in any previous decisions regarding the appeal.
- g. Following the final resolution of the post-service T/AR or MRF appeal, the appropriate CenCal Health staff shall log all pertinent data.
- h. For additional information about post-service T/AR or MRF appeals, call CenCal Health's Health Services UM Specialist at 805-562-1082.

## C. Receipt and Resolution of a Provider Complaint

### I. Provider Complaints

- a. The Provider Services Department is charged with the resolution of provider complaints. The complaint may be related to: access; 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; however, providers are encouraged to use the Provider Grievance Form (Attachment 1).
- b. Complaints related to any aspect of the pharmacy benefit must be submitted to the PSQI Manager in writing or by faxing it to 805-683-9203.
- c. A standard Complaint Receipt Acknowledgment Letter (Attachment 2) is sent to the provider within 15 business days of the date the complaint is received by the PSQI Manager.
- d. The Director of Provider Services assigns the investigation to the PSQI Manager, who works with the provider, the PBM (if applicable), and CenCal Health staff as indicated to respond to the complaint,

either by telephone or in writing within forty-five (45) business days of receipt of the complaint.

- e. The PSQI Manager shall consult with the Health Services Quality Management Specialist regarding a clinical or quality of care issue. The Quality Management Specialist will attempt, under the direction of CenCal Health's Medical Director, or designee, to respond to the issue as quickly as possible in a time frame appropriate to the member's medical condition.
- f. Following resolution of the complaint with the provider, the PSQI Manager will enter all pertinent data into the PCOGs. Complaints in which a provider has reported an adverse or potentially adverse effect on a member's quality of care will be referred to the Health Services Department for clinical quality of care review.

## II. Provider Complaints Requiring Clinical Quality of Care Review

- a. CenCal Health's Quality Management Specialist shall be responsible for reviewing clinical complaints in which a provider has reported an adverse or potentially adverse effect on a member's health.
- b. The Quality Management Specialist shall:
  - 1. Obtain provider(s) perspective and/or medical records regarding complaints that are potentially clinical complaints.
  - 2. Present gathered information for review by the Medical Director or designee, and/or the Peer Review Committee, etc.
  - 3. Document the results of the investigation and resolution.

## **2) DISCLOSURE TO PROVIDERS AND MEMBERS**

Providers are informed of CenCal Health's Provider Grievance System 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.

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 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 Deputy Executive Director 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 PSQI Manager 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 Health Services Department in appropriate files, folders, or binders.

### **4) MONITORING OF THE PROCESS**

#### **A. Reports**

The PSQI Manager will prepare a quarterly summary of PCOGs (Attachment 5) to be presented to CenCal Health's Provider Advisory Board, Network Management Committee, and Board of Directors. The PCOGs summary shall summarize the number and type of provider appeals and complaints, and will distinguish between those received for MediCal, and non-MediCal programs.

#### **B. Annual Review**

This policy will be reviewed and revised annually, approved by the Network Management Committee, and forwarded to the Healthcare Operations Committee.

**V. FORMS**

Provider Grievance Form  
Grievance Acknowledgement Letter  
Claim Inquiry Response Letter  
Appeal Response Letter

**VI. REFERENCE**

**REFERENCES:**

- CCR:** California Code of Regulations, Title 22, Chapter 3, Article 1.3, Section 51015, and Article 1.5, Sections 51014.1 & 51014.2, and 51008
- DHCS:** California Department of Health Care Services Contract 04-35904,  
Article 8, Section 8.14.1
- Knox-Keene:** Knox-Keene Health Care Service Plan Act Of 1975: Article 5, Sections 1367.01, 1368, 1370, 1370.1, 1370.2, 1371.1, 1371.2, 1371.22. California Code of Regulations Title 28, Division 1: Chapter 2, Article 8, Sections 1300.71, 1300.71.38.
- NCQA:** National Committee for Quality Assurance "Standards and Guidelines for the Accreditation of Managed Care Organizations 2008"
- POLICIES:** Member Grievance System, and Special Handling Requests.
- PROVIDER CONTRACT:** CenCal Health Health Care Provider Contract: All new Agreements, and updated Amendments, as necessary, reference policies and procedures. CenCal Health's Provider Manual, which is posted on CenCal Health's website, includes this policy in its entirety.