16. GRIEVANCE AND APPEALS RESOLUTION SYSTEM

A. Member Grievance Resolution Process

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal 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 the Member's dissatisfaction.[5,6,7]

PURPOSE:

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

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 an Adverse Benefit Determination/Notice of Action (NOA). Grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships, and the Member's right to dispute an extension of time proposed by IEHP to make an authorization decision.[8,9,10,11] Grievances include, but are not limited to, complaints about waiting times for appointments, disputes, timely assignment to a Provider, issues related to cultural or linguistic access or sensitivity, difficulty accessing specialists or other services, delays and denials of care, requests for treatment, administration and delivery of medical benefits, continuity of care, staff, facility, or other medical care problems, and concerns

[1] Title 22, California Code of Regulations (CCR) § 53858(a)
[2] 22 CCR § 53260
[3] 28 CCR § 1300.68(a)
[4] California Health and Safety Code (Health & Saf. Code) § 1368(a)(1)
[5] Department of Health Care Services (DHCS)-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 14, Provision 2, Grievance Process
[6] DHCS All Plan Letter (APL) 21-011 Supersedes APL 17-006 and 04-006, "Grievance and Appeal Requirements, Notice and 'Your Rights' Templates
[7] Title 42 Code of Federal Regulation (CFR) § 438.402(c)(2)(i)
[8] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 14, Provision 2, Grievance Process
[9] DHCS APL 21-011
[10] 28 CCR § 1300.68(a)(1)
[11] 42 CFR § 438.400(b)

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.[12] The term "grievance" need not be used for a complaint to be captured as an expression of dissatisfaction and processed as a grievance.[13] If IEHP is unable to distinguish between a Grievance and an inquiry, it shall be considered a Grievance.[14]

Grievances that involve the delay, modification, or denial of services based on medical necessity or a determination that the requested service is not a covered benefit, are treated as appeals.[15]

B. **Expedited Grievance** – A type of grievance that IEHP considers to be urgent if the Member's medical condition involves an imminent and serious threat to the health of the Member, including but not limited to severe pain, potential loss of life, limb or major bodily function, or lack of timeliness that could seriously jeopardize the Member's life, health, or ability to attain, maintain, or regain maximum function.[16,17,18]

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 by the close of the next business day. Exempt Grievances are exempt from the requirement to send written acknowledgment and response to Members,[19,20,21] and are incorporated into the quarterly grievance and appeal report that is submitted to DHCS.

D. **Inquiry** - A 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. If the Member expressly declines to file a grievance, the complaint is still categorized as a grievance and not an inquiry. [22]

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

F. **Grievance Resolution –** For the purpose of this policy, a resolved grievance means that a final conclusion has been reached with respect to the Member's submitted grievance.[23]

[12] 28 CCR § 1300.68(a)(2)
[13] DHCS APL 21-011
[14] 28 CCR § 1300.68(a)(1)
[15] 28 CCR § 1300.68(d)(4)-(5)
[16] DHCS APL 21-011
[17] CA Health & Saf. Code 1368.01(b)
[18] 22 CCR § 53858(e)(7)
[19] DHCS APL 17-00621-011
[20] CA Health & Saf. Code § 1368(a)(4)(B)(i)
[21] 28 CCR § 1300.68(d)(8)
[22] DHCS APL 21-011
[23] 28 CCR § 1300.68(a)(4)

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

H. **Authorized Representative** – This may include a relative, a representative, a Provider, or attorney, who may represent a Member during the grievance process.

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, a Provider acting on behalf of and with written consent from 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: [24,25,26]

1. By phone toll free at (800) 440-IEHP (4347) or (800) 718-4347 (TTY);[27,28]
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.[29,30,31]

(See Attachments, "Member Complaint Form – Medi-Cal English," and "Member Complaint Form – Medi-Cal – Spanish" in Section 16).

B. Members that are minors, incompetent or incapacitated, may have a grievance filed on their behalf by the parent, guardian, conservator, relative, or other representative of the Member, as appropriate.[32]

C. Members are given reasonable opportunity to present evidence and testimony, and make legal

[24] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 14, Provision 1, Member Grievance and Appeal System
[25] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 14, Provision 2, Grievance Process
[26] DHCS APL 21-011
[27] 28 CCR § 1300.68(b)(4)
[28] 22 CCR § 53858(b)
[29] DHCS APL 21-011
[30] 28 CCR § 1300.68(b)(7)
[31] 22 CCR § 53858(f)
[32] CA Health & Saf. Code § 1368(b)(2)

or factual arguments, in person as well as in writing, in support of their grievance.[33,34,35]

D. Members have the right to request translation services to file their grievance in their preferred language or format.[36,37]

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

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

G. Members who wish to file a grievance regarding County behavioral health services are referred as follows:

1. Medi-Cal Members who reside in Riverside County are referred to the Riverside County University Health Department's Quality Management at (951) 955-7320 for outpatient or at (951) 358-6031 for inpatient.

2. Medi-Cal Members who reside in San Bernardino County are referred to the San Bernardino County Department of Mental Health Department's Quality Management at (909) 386-8227.

H. Members contacting IEHP to file a grievance regarding dental services are referred to Denti-Cal, the State Dental Program dependent upon State dental benefit coverage.

J. Members and potential Members have the right to file a discrimination grievance with IEHP before filing with the California Department of Health Care Services (DHCS) Office of Civil Rights (OCR) or the United States Department of Health and Human Services Office of Civil Rights.[38]

1. 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.

2. All cases alleging discrimination against Members or eligible beneficiaries are forwarded to DHCS OCR for review within ten (10) days of mailing a discrimination grievance resolution letter. Please see Policy 9H3, "Cultural and Linguistic Services – Non-Discrimination."

K. Members with complaints regarding confidentiality, have the right to file a grievance to any

[33] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 14, Provision 1, Member Grievance and Appeal System
[34] DHCS APL 21-011
[35] 42 CFR § 438.406(b)(4)
[36] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 14, Provision 1, Member Grievance and Appeal System
[37] National Committee for Quality Assurance (NCQA), 2022 Health Plan (HP) Standards and Guidelines, ME 7, Element A, Factor 5
[38] DHCS APL 21-004, "Standards for Determining Threshold Languages, Non-Discrimination Requirements, and Language Assistance Services."

of the following:

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 e-mail at Compliance@iehp.org; or
2. The California Department of Health Care Services Privacy Officer:
    a. By mail at: DHCS Privacy Officer, P.O. Box 997413 MS0010, Sacramento, CA 95899-7413;
    b. By telephone at (916) 445-4646 or (866) 866-0602 TTY/TDD; or
    c. By email at PrivacyOfficer@dhcs.ca.gov; or
3. 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 at ocrmail@hhs.gov.

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

1. For the direct provision of care or treatment of the patient;
2. For payment transactions, including billing for Member care;
3. For IEHP operational activities, including quality review;
4. If the request originates with a healthcare Provider who is involved in the treatment of the Member such as a pharmacy or a laboratory;
5. If the request is made to provide care to an inmate of a correctional facility; or
6. If the request is made by a representative of an accredited body.

IEHP Responsibilities

A. IEHP sends its Members written information regarding the appeal and grievance process upon

enrollment, and annually thereafter and upon request. [39,40,41,42,43] Please see Policy 16B, "Member Appeal Resolution Process," for information on the Member appeal resolution process.

B. IEHP does not discriminate on the basis of race, color, ethnicity, ethnic group identification, national origin, ancestry, language, religion, sex, age, mental or physical disability or medical condition, gender, gender identity, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), genetic information, marital status, or source of payment.[44,45,46,47,48]

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. IEHP has designated a Grievance and Appeals Manager as its Section 1557 Coordinator, who is responsible for ensuring compliance with federal and state non-discrimination requirements and investigating discrimination grievances. [49] 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.[50]

D. IEHP neither discourages the filing of grievance nor discriminates against any Member for filing a grievance or appeal.[51,52]

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

[39] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 13, Provision 4, Written Member Information
[40] DHCS APL 21-011
[41] CA Health & Saf. Code § 1368(a)(2)
[42] 28 CCR § 1300.68(b)(2)
[43] 22 CCR § 53858(a)(2)
[44] 42 CFR § 422.110(a)
[45] 45 CFR Part 92
[46] CA Welfare and Institutions Code (Welf. & Inst. Code) § 14029.91
[47] CA Government Code (Gov. Code) § 11135(a)
[48] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit E, Attachment 2, Provision 28, Discrimination Prohibition
[49] DHCS APL 21-004
[50] Title 42 United States Code (USC) § 18116
[51] DHCS APL 21-011
[52] 28 CCR § 1300.68(b)(8)

impairment.[53,54,55, 56]

F. IEHP provides reasonable assistance throughout the grievance and appeals process, which includes but is not limited to, providing and completing the forms, navigating the health plan's website, 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.[57,58] 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 Typewrite (TTY) line (800) 718-4347 for Members with hearing or speech impairments. IEHP Member Services Representatives (MSRs) may use the California Relay Services, if necessary or requested by the Member. Bilingual MSRs and Grievance Coordinators are proficient in Spanish to assist Spanish-speaking Members. Access to interpreters for other languages is obtained through IEHP's contracted interpretation services. If necessary, IEHP Grievance staff may request IEHP Member Services to arrange for face-to-face or telephonic translations, and sign language services for medical appointments.

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.

   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, is available online through the IEHP web site, 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 or 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.[59]

K. IEHP shall continue to provide previously authorized services to the Member while the

[53] DHCS APL 21-011
[54] 22 CCR § 53858(e)(6)
[55] 28 CCR § 1300.68(b)(3)
[56] 45 CFR § 92.101
[57] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 14, Provision 1, Member Grievance and Appeal System
[58] NCQA, 2022 HP Standards and Guidelines, ME 7, Element A, Factor 5
[59] 45 CFR § 164.502(a)(1)(ii)

grievance is being resolved.

L. 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.

M. IEHP ensures that the person making the final decision for the proposed resolution of grievances and appeals has neither participated in any prior decisions related to the grievance or appeal, nor is a subordinate of someone who has participated in a prior decision. Only qualified health care and licensed professionals with clinical expertise in treating a Member's condition or disease make the final determination for all clinical grievances, including those regarding denial of a request for expedited resolution of an appeal.[60,61,62]

N. 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.[63]

O. IEHP maintains all Member 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.[64]

Provider Responsibilities

A. All Providers (e.g., Primary Care, Specialty Care and Vision) are required to have IEHP Member Complaint Forms and copies of the IEHP Grievance Resolution Process readily available for Members who wish to file a grievance (See Attachments, "Member Complaint Form – Medi-Cal - English," "Member Complaint Form – Medi-Cal – Spanish," "Grievance Resolution Process – Medi-Cal – English," and "Grievance Resolution Process – Medi-Cal – Spanish" in Section 16).[65,66,67]

B. Providers who receive an IEHP Member Complaint Form and/or documentation regarding a grievance must immediately fax them to IEHP's Grievance and Appeals Department at (909) 890-5748 (See Attachments, "Member Complaint Form – Medi-Cal – English" and "Member Complaint Form – Medi-Cal – Spanish" in Section 16).

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 (800) 440-IEHP (4347) or (800) 718-4347 (TTY).

D. Providers and Delegates, who are party to a grievance must respond to requests received from

[60] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 14, Provision 1, Member Grievance and Appeal System
[61] DHCS APL 21-011
[62] 42 CFR § 438.406(b)(2)
[63] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 1, Provision 5, Medical Decisions
[64] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit E, Attachment 2, Provision 19, Audit
[65] DHCS APL 21-011
[66] 28 CCR § 1300.68(b)(7)
[67] 22 CCR § 53858(f)

IEHP as expeditiously as possible but not to exceed the specified due date. Failure to do so may result in disciplinary action up to and including termination of contract.

E. Providers and their staff must cooperate with IEHP in resolving Member grievances and comply with all final determinations of IEHP's grievance process.

F. 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, language assistance taglines and Non-Discrimination Notice. All Grievance and Appeals Member templates are submitted to DHCS for review and approval and are reviewed by IEHP Compliance department annually.[68]

B. All Member grievance correspondence, Member Complaint Forms, and the IEHP Grievance Resolution Process handouts meet all language and accessibility standards. This includes fully translating the correspondence in the Member's required language.[69]

C. For partially translated grievance correspondence mailed during the implementation period, IEHP is required to meet the requirements, including but not limited to inserting a sentence that informs the Member, in their required language, how to obtain oral interpretation of the clinical rationale on an expedited basis, as well as, mailing a fully translated correspondence, with a fully translated clinical rationale, as soon as possible but not later than 30 calendar days from the date the partially translated notice was sent.[70]

D. 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's Grievance and Appeals Department is responsible for the resolution of Member complaints, including grievances and appeals. Grievance records include the following information:[71,72,73]

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;

[68] DHCS APL 21-011
[69] DHCS APL 21-011
[70] Ibid.
[71] Ibid.
[72] 28 CCR § 1300.68(b)(5)
[73] NCQA, 2022 HP Standards and Guidelines, ME 7, Element A, Factor 1

5. A description of the action taken to investigate and resolve the grievance;
6. A description of the resolution;
7. Date of resolution notice; and
8. Copies of relevant information used in the case.

B. IEHP ensures grievances are resolved as quickly as the Member's health condition requires and not to exceed these regulatory timeframes:[74]

1. Standard grievances are resolved within 30 calendar days of receiving the grievance.[75,76,77,78,79,80] In the event a resolution is not reached within 30 calendar days of receiving the grievance, the Member is notified in writing of the status of the grievance and the estimated date of resolution.[81,82] All cases are resolved based on clinical urgency of the Member's condition.
2. Expedited grievances are resolved no later than 72 hours from the receipt date and time.[83,84]

C. An acknowledgment letter is provided to the Member that is dated and postmarked within five (5) calendar days of receipt of the standard grievance, which includes:[85,86,87]

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. [88]

[74] NCQA, 2022 HP Standards and Guidelines, ME 7, Element A, Factor 4
[75] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 14, Provision 1, Member Grievance and Appeal System
[76] DHCS APL 21-011
[77] NCQA, 2022 HP Standards and Guidelines, ME 7, Element A, Factor 4
[78] CA Health & Saf. Code § 1368.01(a)
[79] 22 CCR § 53858(g)(1)
[80] 28 CCR § 1300.68(d)(3)
[81] DHCS APL21-011
[82] 22 CCR §53858(g)(2)
[83] DHCS APL 21-011
[84] 42 CFR § 438.408(b)(3)
[85] DHCS APL 21-011
[86] CA Health & Saf. Code § 1368(a)(4)(A)
[87] 28 CCR § 1300.68(d)(1)
[88] DHCS APL 21-011

D. Expedited grievance cases do not require Acknowledgement Letters, as the Resolution Letter is mailed within seventy-two (72) hours.[89,90] Oral notice of resolution of an expedited grievance is provided within seventy-two (72) hours.[91,92,93]

1. Within twenty-four (24) hours of receiving the grievance, IEHP notifies the Member whether or not the grievance met the criteria for expedited review, as defined in this policy. If criteria are met, the Member is informed of the shortened timeframe to submit information related to their case, and of their right to notify DMHC of their grievance.
2. If the grievance does not meet the criteria for expedited review, IEHP informs the Member by mail within three (3) calendar days of receiving their grievance that this will be processed as a standard grievance.

E. 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 Providers, Delegates, and Hospitals; hereinafter referred to as "Respondent." When necessary, IEHP faxes or emails a Grievance Summary Form (GSF) or request for medical records to the Respondent, containing the substance of the grievance, identified issues to be addressed by the Respondent, and a request for pertinent documents (i.e., medical records, call notes, policies) that may aid in the investigation.

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

[89] Ibid.
[90] NCQA, 2022 HP Standards and Guidelines, ME 7, Element A, Factor 4
[91] DHCS APL 21-011
[92] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 14, Provision 1, Member Grievance and Appeal System
[93] NCQA, 2022 HP Standards and Guidelines, ME 7, Element A, Factor 3

up to and including termination of contract.

F. 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.[94,95,96,97]

G. 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.

H. Once the grievance is resolved, IEHP mails the Member a resolution letter within thirty (30) calendar days of receipt of a standard grievance and within seventy-two (72) hours of receipt of an expedited grievance.[98,99] Resolution letters shall contain a clear and concise explanation of IEHP's decision.[100,101,102] 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.

I. 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.[103,104,105]

J. After case review, the IEHP Grievance & Appeals staff determines and assigns a level to the case as follows:

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

[94] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 14, Provision 1, Member Grievance and Appeal System
[95] NCQA, 2022 HP Standards and Guidelines, ME 7, Element A, Factor 2
[96] DHCS APL 21-011
[97] 42 CFR § 438.406(b)(2)(iii)
[98] DHCS APL 21-011
[99] NCQA, 2022 HP Standards and Guidelines, ME 7, Element A, Factor 3
[100] DHCS APL 21-011
[101] CA Health & Saf. Code § 1368(a)(5)
[102] 28 CCR § 1300.68(d)(3)
[103] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 14, Provision 2, Grievance Process
[104] DHCS APL 21-011
[105] 22 CCR § 53858(e)(2)

16. GRIEVANCE AND APPEALS RESOLUTION SYSTEM

A. Member Grievance Resolution Process

Monitoring and Oversight

A. The Director of Grievance and Appeals is the designated Officer of the plan who has the primary responsibility for the maintenance of the IEHP Grievance Resolution System.[106]

B. Review and analysis of recorded grievances and appeals related to access to care, quality of care and denial of services, is presented to the Quality Management Committee on at least a quarterly basis. IEHP takes appropriate action to remedy any problems identified.[107]

C. 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.

D. Substantiated QOC grievances may result in the issuance of a CAP or education at the direction of the IEHP Medical Director.

E. IEHP monitors the rate of overall grievance response timeliness and reports findings to the Delegation Oversight Committee.

   1. The rate of grievance response timeliness is reported to Delegates monthly. Timeliness rates are based on the initial expected response due date and date a complete response is received, addressing all alleged issues.

   2. IEHP issues a CAP for Delegates that do not meet grievance response timeliness for two (2) consecutive months.

   3. The grievance response timeliness rate and number of CAPs issued for the year are used to score Providers annually on the Provider Evaluation Tool (PET).

F. Respondents who meet established thresholds for non-response are referred to the Provider Relations Department for follow-up and potential escalation, including issuance of Corrective Action Plan (CAP), freezing new Member assignments, or further disciplinary action up to and including termination of contract.

   1. Respondents that are issued a CAP must submit by the specified due date a completed CAP.

   2. IEHP will review the CAP to ensure that all findings are addressed, and all pertinent information is included. IEHP will either deny or approve the CAP.

   3. Respondents that do not submit a complete CAP by the specified due date are escalated up to the Director of Provider Relations.

   4. The Director of Provider Relations will outreach to the Respondent regarding their CAP, and determine further disciplinary action, which may include freezing new Member assignments until a complete CAP is submitted.

   5. Continued non-response to or failure to submit a complete CAP could result in further

[106] DHCS APL 21-011
[107] 22 CCR § 53858(e)(3) and (4)

disciplinary action up to and including termination of contract.

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

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 DMHC, DHCS, and NCQA.
3. Grievances received directly by the delegated entity are reported to IEHP on a quarterly basis, reviewed by the Quality Management Committee, and forwarded to other IEHP committees as indicated.
4. IEHP retains ultimate responsibility for ensuring that the delegated entity satisfies all requirements of the grievance and appeal process.
5. On a periodic basis, IEHP evaluates delegate performance against IEHP, NCQA, and regulatory standards.

16. GRIEVANCE AND APPEALS RESOLUTION SYSTEM

B. Member Appeal Resolution Process

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal 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 Notice of Action.[2,3]

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 Benefit Determination to mean any of the following actions taken by IEHP or its IPA:[4,5]

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 grievances and 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.

[1] Title 28, California Code of Regulations (CCR) § 1300.68(a)
[2] Department of Health Care Services (DHCS)-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 14, Provision 5, Appeal Process
[3] DHCS All Plan Letter (APL) 21-011 Supersedes APL 17-006, "Grievance and Appeal Requirements and Revised Notice Templates and 'Your Rights' Attachments"
[4] Ibid.
[5] Title 42, Code of Federal Regulations (CFR) § 438.400(b)

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. **Notice of Action (NOA)** – An NOA is formal letter informing the Member of an Adverse Benefit Determination.[8]

D. **Notice of Appeal Resolution (NAR) –** An NAR is a formal letter informing the Member of the outcome of the appeal of an Adverse Benefit Determination. The NAR informs the Member whether the Adverse Benefit Determination was overturned or upheld.[9]

PROCEDURES:

Member Rights and Options

A. The Member, a Provider acting on behalf of and with written consent from the Member, or the Member's authorized representative[10] may request an appeal within sixty (60) calendar days of the date on the Notice of Action via the following options:[11,12,13]

1. By phone toll free at (800) 440-IEHP (4347) or (800) 718-4347 (TTY);[14]
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. Members that are minors, incompetent or incapacitated, may have an appeal requested on their behalf by the parent, guardian, conservator, relative, or other representative of the Member, as appropriate.[15]

[6] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 14, Provision 6, Responsibilities in Expedited Appeals
[7] 42 CFR § 438.410(a)
[8] DHCS APL 21-011
[9] 42 CFR § 438.408(d)(2)
[10] National Committee for Quality Assurance (NCQA), 2022 Health Plan Standards and Guidelines, UM 8, Element A, Factor 14
[11] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 14, Provision 1, Member Grievance and Appeal System
[12] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 14, Provision 5, Appeal Process
[13] DHCS APL 21-011
[14] 28 CCR § 1300.68(b)(4)
[15] California Health and Safety (Health & Saf.) Code § 1368(b)(2)

C. 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.[16,17,18]

D. Members have the right to request translation services to request their appeal in their preferred language or alternative format.[19]

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.[20]

E. Members have the opportunity before and during their appeals process to examine their case file, including medical records and any other documents and records considered during the appeals process. These are provided, free of charge, upon the Member's request by contacting Member Services.[21,22]

F. 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:[23,24]

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;[25] including failure to provide a fully translated notice; or[26]

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,

[16] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 14, Provision 1, Member Grievance and Appeal System
[17] NCQA, 2022 HP Standards and Guidelines, UM 8, Element A, Factor 4
[18] 42 CFR § 438.406(b)(4)
[19] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 14, Provision 1, Member Grievance and Appeal System
[20] DHCS APL 22-002 "Alternative Format Selection for Members with Visual Impairments
[21] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 14, Provision 5, Appeal Process
[22] NCQA, 2022 HP Standards and Guidelines, UM 8, Element A, Factor 12
[23] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 14, Provision 7, State Fair Hearing and Independent Medical Reviews
[24] 42 CFR § 438.408(f)
[25] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 14, Provision 5, Appeal Process
[26] DHCS APL 21-011

friend, associate, or authorized representative, if required by the ADA.[27]

IEHP notifies its Members that 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.

G. 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. The Member is not required to request an IMR before, or use one as a deterrent to, requesting a State Hearing [28,29] The request for an IMR must however, be submitted before there is a final State Hearing decision.[30]

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

1. For the direct provision of care or treatment of the patient;
2. For payment transactions, including billing for Member care;
3. For IEHP operational activities, including quality review;
4. If the request originates with a healthcare Provider who is involved in the treatment of the Member such as a pharmacy or a laboratory;
5. If the request is made to provide care to an inmate of a correctional facility; or
6. If the request is made by a representative of an accredited body.

IEHP Responsibilities

A. IEHP sends its Members written information regarding the appeal and grievance process upon enrollment, and annually thereafter and upon request.[31]

B. IEHP must assist Members requesting an appeal orally to prepare a written and signed appeal. However, IEHP must neither dismiss nor delay resolution of the oral appeal request for which a written and signed appeal was not received.[32,33] The date of the oral appeal establishes the filing date for the appeal.[34]

C. IEHP does not discriminate on the basis of race, color, ethnicity, ethnic group identification,

[27] DHCS APL 22-004
[28] DHCS APL 21-011
[29] CA Health & Saf. Code § 1374.30(j)(1)
[30] DHCS APL 21-011
[31] 28 CCR § 1300.68(b)(2)
[32] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 14, Provision 5, Appeal Process
[33] DHCS APL 21-011
[34] 42 CFR § 438.406(b)(3)

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.

D. IEHP does not discriminate against any Member for filing a grievance or appeal.[35] IEHP does not discriminate, take or threaten to take any punitive action against a Provider, who requests an expedited resolution or supports a Member's appeal.[36,37]

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.[38,39]

F. IEHP provides reasonable assistance throughout the appeal process which includes but is not limited to, providing and completing the forms, navigating the health plan's website, 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.[40] IEHP staff may use the California Relay Services if necessary or requested by a Member with a hearing or speech disability.

G. IEHP provides Aid Paid Pending regardless of whether the Member makes a separate request when the Member timely files an appeal or State Hearing of a decision to terminate, suspend or reduce services. IEHP ensures that the Member is not billed for the continued services even if the State Hearing or IMR finds the disputed services were not medically necessary.[41,42,43,44]

H. IEHP will assist Members with preparing for State Hearing by providing the Member or the Member's representative with the Member's case file, including medical records, other documents and records, guidelines, clinical criteria, and any new or additional evidence that

[35] 28 CCR § 1300.68(b)(8)
[36] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 14, Provision 6, Responsibilities in Expedited Appeals
[37] 42 CFR § 438.40(b)
[38] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 14, Provision 1, Member Grievance and Appeal System
[39] 28 CCR § 1300.68(b)(3)
[40] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 14, Provision 1, Member Grievance and Appeal System
[41] 42 CFR § 438.420
[42] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 14, Provision 5, Appeal Process
[43] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 14, Provision 7, State Fair Hearing and Independent Medical Reviews
[44] NCQA, 2022 HP Standards and Guidelines, UM 8, Element A, Factor 16

the Plan relied on for its initial denial and anything the Plan considered during its internal appeal process.

I. 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 determination for all appeals.[46,47,48]

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.[49]

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.[50]

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.

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, language assistance taglines and Non-Discrimination Notice. All Grievance and Appeals Member templates are submitted to DHCS for review and approval and are reviewed by IEHP Compliance department annually.[51]

B. All Member appeal correspondence, Member Appeal Forms, and the IEHP Appeal Resolution Process handouts meet all language and accessibility standards. This includes fully translating the NAR, including the clinical rationale for the health plan's decision, in the Member's required language.[52]

[45] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 14, Provision 1, Member Grievance and Appeal System
[46] Ibid.
[47] NCQA, 2022 HP Standards and Guidelines, UM 8, Element A, Factor 5
[48] 42 CFR § 438.406(b)(2)
[49] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 1, Provision 5, Medical Decisions
[50] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit E, Attachment 2, Provision 19, Audit
[51] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 14, Provision 1, Member Grievance and Appeal System
[52] DHCS APL 21-011

C. For partially translated appeal correspondence mailed during the implementation period, IEHP is required to meet the requirements, including but not limited to inserting a sentence that informs the Member, in their required language, how to obtain oral interpretation of the clinical rationale on an expedited basis, as well as, mailing a fully translated correspondence, with a fully translated clinical rationale, as soon as possible but not later than 30 calendar days from the date the partially translated notice was sent.[53]

D. For Appeals not resolved wholly in favor of the Member, IEHP includes in its written response the reasons for its determination, including:[54]

1. For determinations based on medical necessity, the criteria, clinical guidelines or medical policies used in reaching the determination; or
2. For determinations based on the requested service not being a covered benefit, the provision in the DHCS Contract, Evidence of Coverage or Member Handbook that excludes the service.

E. For Appeals resolved in favor of the Member, IEHP includes a clear and concise explanation of why the decision was overturned.[55]

Appeal Resolution Process

A. IEHP has a one level Appeal process,[56,57,58] for which IEHP's Grievance and Appeals Department is responsible (see Attachments, "Appeal Resolution Process – Medi-Cal – English" and "Appeal Resolution Process – Medi-Cal – Spanish" in Section 16).[59]

B. IEHP's Grievance and Appeals Department is responsible for the resolution of Member complaints, including grievances and appeals. Appeal records include the following information:[60,61]

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 appeal;

[53] DHCS APL 21-011
[54] Ibid.
[55] Ibid.
[56] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 14, Provision 1, Member Grievance and Appeal System
[57] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 14, Provision 5, Appeal Process
[58] 42 CFR § 438.402(b)
[59] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 14, Provision 5, Appeal Process
[60] DHCS APL 21-011
[61] 28 CCR § 1300.68(b)(5)

5. A description of the action taken to investigate and resolve the appeal;
6. A description of the resolution;
7. Date of resolution notice; and
8. Copies of relevant information used in the case.

C. 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 receiving the appeal.[62,63,64,65,66]
2. Expedited appeals are resolved no later than seventy-two (72) hours of receiving the appeal.[67,68,69]
3. These timeframes may be extended by fourteen (14) calendar days if either of the two conditions apply:[70,71,72,73]
   a. The Member requests the extension; or
   b. IEHP demonstrates, to the satisfaction of DHCS upon request, that there is a need for additional information and how the delay is in the Member's best interest.

D. An acknowledgment letter to the Member within five (5) calendar days of receipt of the appeal,[74] which includes:[75]

1. The appeal receipt date;
2. Name of the IEHP representative who may be contacted regarding the appeal; and
3. The toll-free telephone number, and address of the IEHP representative who may be

[62] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 14, Provision 1, Member Grievance and Appeal System
[63] DHCS APL 21-011
[64] NCQA, 2022 HP Standards and Guidelines, UM 8, Element A, Factor 7
[65] 28 CCR § 1300.68(a)
[66] 42 CFR § 438.408(b)(2)
[67] DHCS APL 21-011
[68] NCQA, 2022 HP Standards and Guidelines, UM 8, Element A, Factor 9
[69] 42 CFR § 438.408(b)(3)
[70] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 14, Provision 5, Appeal Process
[71] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 14, Provision 6, Responsibilities in Expedited Appeals
[72] DHCS APL 21-011
[73] 42 CFR § 438.408(c)(1)
[74] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 14, Provision 1, Member Grievance and Appeal System
[75] DHCS APL 21-011

contacted about the appeal.

E. 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.[76,77,78]

1. Within twenty-four (24) hours 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, and of their right to notify the Department of Managed Health Care (DMHC) of their appeal.[79,80]

2. If the appeal does not meet the criteria for expedited review, IEHP informs the Member orally within seventy-two (72) hours of appeal receipt, followed by a written notice. Both oral and written notices include notification of transfer to the standard thirty (30) day appeal process,[81] and the Member's right to notify DMHC of the expedited review request.

F. 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.

G. The Appeal determination will either be to 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.[82,83]

2. If a denial is overturned, services are authorized as expeditiously as the Member's health

[76] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 14, Provision 1, Member Grievance and Appeal System
[77] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 14, Provision 6, Responsibilities in Expedited Appeals
[78] DHCS APL 21-011
[79] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 14, Provision 5, Appeal Process
[80] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 14, Provision 6, Responsibilities in Expedited Appeals
[81] 42 CFR § 438.410(c)
[82] DHCS APL 21-011
[83] CA Health & Saf. Code § 1374.30(j)(1)

condition requires and no later than seventy-two (72) hours from the date of the Notice of Appeal Resolution.[84,85,86]

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 72 hours from the date the health plan receives notice reversing the determination.[87]

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.[88]

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.

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

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

[84] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 14, Provision 5, Appeal Process
[85] DHCS APL 21-011
[86] 42 CFR § 438.424
[87] DHCS APL 21-011
[88] CA Health & Saf. Code § 1374.34(a)

16. GRIEVANCE AND APPEALS RESOLUTION SYSTEM

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

APPLIES TO:

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

POLICY:

A. Disputes are categorized as follows, for tracking and monitoring purposes:
   1. Claims/Billing - any formal written disagreement involving the payment, denial, adjustment or contesting of a claim, including overpayments, payment rates, billing issues or other claim reimbursement decisions.
   2. Contract - any formal written disagreement concerning the interpretation, implementation, renewal or termination of a contractual agreement.
   3. UM/Medical Necessity - any formal written disagreement concerning the need, level or intensity of health care services provided to Members.
   4. Other – all other disputes received by Payor including enrollment, capitation, Prop56 or other Provider related issues.

B. Providers of Service must submit all disputes, including those involving claims, billing, capitation, enrollment, contracting or UM/medical necessity to the financially responsible Payor (contracted IPAs/Hospitals or IEHP) for the initial dispute resolution process.

C. All disputes must be submitted to the Payor within three hundred and sixty-five (365) days of the last date of action on the issue requiring resolution.[1]

D. Payors must identify and acknowledge the receipt of all disputes within two (2) working days if the dispute was received electronically or fifteen (15) working days of receipt of a written dispute.[2]

E. Payors must resolve disputes and issue a written determination within thirty (30) calendar days of receipt of a dispute.

F. A Provider of Service may submit an appeal regarding the outcome of a Payor's dispute resolution to IEHP within six (6) months of receipt of the written dispute determination letter from the Payor.

G. A Provider can appeal any adverse determination by an IPA or IEHP. Appeals of referrals denials, or modifications, must be appealed to IEHP. If the denial is upheld, the denial must then be forwarded to the IEHP Grievance and Appeals Department as outlined in Policy 16B2, "Dispute and Appeal Resolution Process for Providers - Health Plan."

[1] Title 28 California Code of Regulation (CCR) § 1300.71.38
[2] Ibid.

16. GRIEVANCE AND APPEALS RESOLUTION SYSTEM

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

DEFINITION:

A. "Provider of Service" means any Practitioner or professional person, Acute Care Hospital Organization, Health Facility, Ancillary Provider, or other person or institution licensed by the State to deliver or furnish health care services directly to the Member.

PROCEDURES:[3]

A. Providers of Service must submit all disputes, including those involving claims, billing, capitation, enrollment, contracting or UM/medical necessity to the financially responsible Payor (contracted IPAs/Hospitals or IEHP) for the initial dispute resolution process.

1. If a dispute concerns a claim involving IEHP as a Payor, the written request must be filed in accordance with the guidelines provided in Policy 20A1, "Claims Processing - Provider Dispute Resolution Process - Initial Claims Disputes".
2. If a dispute involves a claim related matter in which one of IEHP's Capitated Providers is the Payor, the dispute must be filed with the Payor in accordance with the Payor's dispute filing guidelines.[4]
3. If a dispute involves P4P reimbursements, the written request must be filed in accordance with the guidelines provided in Policy 19C, "Pay For Performance (P4P)."
4. If the dispute is not about a claim, (i.e. capitation, enrollment, contracting, etc.) the written request must include a clear explanation of the issue and the dispute must be filed in accordance with the Payor's dispute filing guidelines.[5]
5. If the dispute is filed on behalf of a Member, the dispute is considered a Member grievance, subject to the requirements of the Member Grievance Resolution process, as outlined in Policy 16A, "Member Grievance Resolution Process."

B. Payors must identify and acknowledge in writing the receipt of each dispute, whether complete or not, and disclose the recorded date of receipt for Provider disputes not impacting Member financial risk as follows:[6]

1. If the dispute was received electronically, acknowledgment must be provided within two (2) working days of receipt of the dispute; or
2. If the dispute was a paper dispute, acknowledgement must be provided within fifteen

[3] Department of Health Care Services (DHCS) IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 7, Provision 2, Provider Grievance.
[4] 28 CCR § 1300.71.38
[5] Ibid.
[6] Ibid.

(15) working days of receipt of the dispute.[7]

C. If a dispute is incomplete, or if the information is in the possession of the Provider of Services and not readily accessible to the Payor, the Payor may return the dispute with a clear explanation, in writing, of any information missing that is necessary to resolve the dispute. The Provider of Service has thirty (30) calendar days to resubmit an amended dispute with the missing information.[8]

D. Payors must make every effort to investigate and take into consideration all available information submitted and may further investigate and/or request additional information or discuss the issue with the involved Providers of Service.

E. Payors must send written notice of the resolution, including pertinent facts and an explanation of the reason for the determination, within thirty (30) calendar days of the receipt of the dispute.

F. Providers of Service dissatisfied with the resolution of any dispute **not** involving claims or billing (i.e. capitation, enrollment) may appeal to IEHP in writing, as outlined in Policy 16B2, "Dispute and Appeal Resolution Process for Providers - Health Plan."

G. Providers of Service dissatisfied with the initial resolution and written determination by the Payor that involves payment or denial decisions on adjudicated claims or billing, including denials for procedures, referrals or services may submit a written appeal of the Payor's determination to IEHP by following the process outlined in Policy 20A2, "Claims Processing - Health Plan Claims Appeals."

H. Providers of Service not satisfied with the initial determination by the Payor, and the determination is related to medical necessity or utilization management, the Provider of service has the right to appeal directly to IEHP within sixty (60) calendar days of receipt of the written determination by submitting a written request for review as outlined in Policy 16B2, "Dispute and Appeal Resolution Process for Providers - Health Plan."

I. Furthermore, Providers dissatisfied with the outcome of a dispute originally filed with the Payor that involves pre-service referral denials or modifications may submit an appeal to IEHP in accordance with Policy 16B3, "Dispute and Appeal Resolution Process for Providers – UM Decisions."

J. No retaliation can be made against a Provider of Service who submits a dispute in good faith.

K. Copies of all disputes from Providers of Service, and related documentation, must be retained for at least ten (10) years. A minimum of the last two (2) years must be easily accessible and available within five (5) days of request from IEHP or regulatory agency.

[7] 28 CCR § 1300.71.38
[8] Ibid.

16. GRIEVANCE AND APPEALS RESOLUTION SYSTEM

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

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	February 1, 2004
Chief Title: Chief Operating Officer	**Revision Date:**	January 1, 2022

16. GRIEVANCE AND APPEALS RESOLUTION SYSTEM

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

APPLIES TO:

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

POLICY:

A. Providers of Service with disputes must go through the financially responsible Payor (contracted IPAs/Hospitals or IEHP) for the initial dispute resolution process within three hundred and sixty-five (365) days of the development of an issue requiring resolution. Payors must resolve disputes within thirty (30) calendar days of receipt.[1]

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

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

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

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

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

DEFINITION:

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

A. "Grievance" is 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.

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

B. "Appeals" - Under the new federal regulations, an appeal is defined as a review of an adverse benefit determination such as:[2]

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.

C. 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:[3]

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

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

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

a. If the determination involves medical necessity or utilization management, the Provider of Service has the right to appeal directly to IEHP within sixty (60) calendar days from receipt of the determination on the initial dispute, by submitting a written

[2] DHCS APL 17-006
[3] Department of Health Care Services (DHCS) IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 7, Provision2, Provider Grievance

appeal.[4]

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

2. Dispute appeals are defined as medical and non-medical. Medical and non-medical dispute appeals are resolved separately:

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

      1) Claims related dispute appeals are handled in accordance with Policy 20A2, "Claims Processing - Health Plan Claim Appeals."

      2) Refer to Policy 5A6, "Credentialing Standards – Notifications to Authorities and Practitioners Appeal Rights" for appeals or grievance related to adverse credentialing decisions.

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

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

      2) Utilization Management (UM) denial appeals from a Provider of Service that do not involve a claims issue are forwarded to IEHP's Grievance and Appeal Department. IEHP's Medical Director or designee reviews the information and makes a determination within thirty (30) days. The Provider receives an acknowledgement letter, and a resolution letter notifying them of the final decision.

      3) When the appeal is resolved, IEHP mails a copy of the final appeal disposition to the Provider of Service within thirty (30) calendar days of resolution with a courtesy copy to the Payor.

[4] DHCS APL 17-006

B. If the Provider of Service is still not satisfied with the outcome of IEHP's appeal determination, the Provider of Service may request IEHP Chief Executive Officer (CEO) reviews (for non-medical decision) the appeal. Appeals for IEHP CEO must be received within thirty (30) calendar days of receipt of the decision concerning the appeal to IEHP. Decisions on the health plan appeal by IEHP CEO are final.

C. If IEHP receives an initial dispute directly from a Provider of Service, IEHP will forward the dispute to the financially responsible Payor for resolution, as applicable and notify the Provider of Service, except as stated for "de novo" rights (Procedure A.1.a).

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Chief Approval: *Signature on file*	**Original effective Date:**	September 1, 1996
Chief Title: Chief Operating Officer	**Revision Date:**	January 1, 2022

16. GRIEVANCE AND APPEALS RESOLUTION SYSTEM

D. IPA, Hospital and Practitioner Grievance and Appeal Resolution Process

APPLIES TO:

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

POLICY:

A. Providers (IPAs, Hospitals and Practitioners) must submit their grievances directly to IEHP.

B. IEHP requires all Provider grievances to be submitted in writing within three hundred sixty-five (365) days of the development of an issue requiring resolution.

C. IEHP must identify and acknowledge the receipt of all grievances within two (2) working days if the grievance was received electronically or within fifteen (15) working days of receipt of a written grievance and/or appeal (See Attachment, "Provider Grievance Acknowledgment Letter" in Section 16).

D. IEHP attempts to resolve all grievances within thirty (30) calendar days after the date of receipt of the Provider dispute or the amended Provider dispute.

E. Providers may appeal a grievance resolution to IEHP within thirty (30) calendar days of receipt of the grievance resolution letter from IEHP.

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

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

H. Non-medically related grievances are assessed and resolved by the IEHP Director of Provider Relations. Non-medically related grievances from Providers may include credentialing issues, capitation issues, contractual issues, enrollment issues, IEHP Team Member or Department issues or problems related to IEHP policies and procedures.

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

PROCEDURES:

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

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

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

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

D. All Provider Grievances must be identified and acknowledged in writing upon receipt, whether complete or not, and disclose the recorded date of receipt as follows:

1. If the grievance was received electronically, acknowledgment must be provided within two (2) working days of receipt of the dispute; or
2. If the grievance was received in writing, acknowledgment must be provided within fifteen (15) working days of receipt of the dispute.

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

F. Providers are notified in writing if the resolution will be delayed beyond IEHP's established timeframes.

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

H. Claims related grievance appeals are handled in accordance with Policy 20A2, "Claims Processing - Health Plan Claims Appeals."

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

J. When grievances are resolved, IEHP mails a copy of the final disposition to the Provider within thirty (30) calendar days of resolution (See Attachment, "Provider Grievance Resolution Letter" in Section 16).

K. Providers dissatisfied with a resolution may appeal to IEHP within thirty (30) calendar days of receipt of the grievance resolution from IEHP (See Attachment, "Provider Fair Hearing Process" in Section 16).

1. Providers must submit a written appeal to IEHP within thirty (30) calendar days of receipt of the final disposition of initial grievance. The written appeal must include a copy of the initial resolution being appealed, justification and supporting documentation for the appeal.
2. Non-medical grievance appeals are forwarded to the IEHP Chief Executive Officer (CEO) for review.
3. Medical grievance appeals are forwarded to the Peer Review Subcommittee for review.
4. The decision of the IEHP CEO or Peer Review Subcommittee is final.

5. IEHP mails written notice of the appeal decision within thirty (30) calendar days of the decision.
6. Refer to Policy 20A2, "Claims Processing - Health Plan Claims Appeals" for appeals or grievances relating to payment or denial of adjudicated claims.

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

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Chief Approval: *Signature on file*	**Original Effective Date:**	September 1, 1996
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16. GRIEVANCE AND APPEALS RESOLUTION SYSTEM

Attachments

DESCRIPTION	POLICY CROSS REFERENCE
Appeal Resolution Process – Medi-Cal – English	16B
Appeal Resolution Process – Medi-Cal – Spanish	16B
Grievance Resolution Process – Medi-Cal - Spanish	16A
Grievance Resolution Process – Medi-Cal - English	16A
Member Complaint Form – Medi-Cal - English	16A
Member Complaint Form – Medi-Cal - Spanish	16A
Provider Fair Hearing Process	16D
Provider Grievance Acknowledgment Letter	16D
Provider Grievance Resolution Letter	16D

APPEAL RESOLUTION PROCESS
(MEDI-CAL)

HOW CAN I FILE AN APPEAL?

1. IEHP Members have the right to file an appeal without fear of recrimination. You may file your appeal directly with IEHP by taking one of the following actions:

   a) Call IEHP's Member Services Department at (800) 440-4347, or at (800) 718-4347 (TTY) and file your appeal with a Member Services Representative.
   b) Fax your appeal to IEHP's Grievance and Appeals Department at (909) 890-5748.
   c) Submit your appeal online through the IEHP web site at www.iehp.org.
   d) You may choose to file your appeal in person at the following address:

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

   e) You may also file your appeal by mail at P.O. Box 1800, Rancho Cucamonga, CA 91729-1800.

2. IEHP Complaint Forms are readily available at all IEHP Provider and their Contracting Organization locations. A patient advocate should be available to assist you with this process.

WHAT HAPPENS AFTER I FILE MY APPEAL?

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

appeals involve an imminent and serious threat to your health, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function.
4. Services previously authorized by IEHP will continue while the appeal is being resolved.

YOUR APPEAL RIGHTS

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

PROCESO DE RESOLUCIÓN DE APELACIONES
(MEDI-CAL)

¿CÓMO PUEDO PRESENTAR UNA APELACIÓN?

1. Los Miembros de IEHP tienen derecho a presentar una apelación sin temor a recriminación. Para presentar su apelación directamente ante IEHP, puede hacer una de las siguientes acciones:

   a) Llame al Departamento de Servicios para Miembros de IEHP al (800) 440-4347 o al (800) 718-4347 (TTY) y presente su apelación con un Representante de Servicios para Miembros.
   b) Envíe su apelación al Departamento de Apelaciones y Quejas Formales de IEHP por fax al (909) 890-5748.
   c) Presente su apelación a través del sitio web de IEHP en www.iehp.org.
   d) Puede elegir presentar su apelación personalmente en la siguiente dirección:

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

   e) También puede presentar su apelación por correo en P.O. Box 1800, Rancho Cucamonga, CA 91729-1800.

2. Los Formularios de Quejas de IEHP están disponibles en todas las ubicaciones de los profesionales de IEHP y sus Organizaciones Contratantes. Un defensor del paciente debe estar a su disposición para ayudarle con este proceso.

¿QUÉ SUCEDE DESPUÉS DE QUE PRESENTE MI APELACIÓN?

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

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

SUS DERECHOS RELATIVOS A UNA APELACIÓN

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

Inland Empire Health Plan

GRIEVANCE RESOLUTION PROCESS
(MEDI-CAL)

HOW CAN I FILE A GRIEVANCE?

1. IEHP Members have the right to file a grievance against IEHP or its Practitioners without fear of recrimination. You may file your grievance directly with IEHP by taking one of the following actions:

    a) Call IEHP's Member Services Department at (800) 440-4347, or at (800) 718-4347 (TTY) and file your grievance with a Member Services Representative.
    b) Fax your grievance to IEHP's Grievance Department at (909) 890-5748.
    c) Submit your grievance online through the IEHP web site at www.iehp.org.
    d) You may choose to file your grievance in person at the following address:

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

    e) You may also file your grievance by mail at P.O. Box 1800, Rancho Cucamonga, CA 91729-1800.

2. IEHP Complaint Forms are readily available at all IEHP Practitioner and their Contracting Organization locations. A patient advocate should be available to assist you with this process.

WHAT HAPPENS AFTER I FILE MY GRIEVANCE?

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

including, but not limited to, severe pain, potential loss of life, limb, or major bodily function.
4. Services previously authorized by IEHP will continue while the grievance is being resolved.

YOUR GRIEVANCE RIGHTS

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

IF YOU ARE STILL UNHAPPY YOU MAY:

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

Entidad Pública
Inland Empire Health Plan

PROCESO DE RESOLUCIÓN DE QUEJAS FORMALES
(MEDI-CAL)

¿CÓMO PUEDO PRESENTAR UNA QUEJA FORMAL?

1. Los Miembros de IEHP tienen derecho a presentar una queja formal contra IEHP o sus profesionales sin temor a recriminación. Para presentar su queja formal directamente ante IEHP, puede hacer una de las siguientes acciones:

    a) Llame al Departamento de Servicios para Miembros de IEHP al (800) 440-4347 o al (800) 718-4347 (TTY) y presente su queja formal ante un Representante de Servicios para Miembros.
    b) Envíe su queja formal al Departamento de Quejas Formales de IEHP por fax al (909) 890-5748.
    c) Presente su queja formal a través del sitio web de IEHP en www.iehp.org.
    d) Puede elegir presentar su queja formal personalmente en la siguiente dirección:

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

    e) También puede presentar su queja formal por correo en P.O. Box 1800, Rancho Cucamonga, CA 91729-1800.

2. Los Formularios de Quejas de IEHP están disponibles en todas las ubicaciones de los profesionales de IEHP y sus Organizaciones Contratantes. Un defensor del paciente debe estar a su disposición para ayudarle con este proceso.

¿QUÉ SUCEDE DESPUÉS DE QUE PRESENTE MI QUEJA FORMAL?

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

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

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

SUS DERECHOS RELATIVOS A UNA QUEJA FORMAL

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

SI AÚN NO ESTÁ CONFORME, ADEMÁS PUEDE:

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

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

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

MEMBER COMPLAINT FORM (MEDI-CAL)

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

MEMBER INFORMATION

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

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

NAME_____

RELATIONSHIP ☐ SELF ☐ MOTHER ☐ FATHER ☐ GRANDPARENT ☐ GUARDIAN ☐ OTHER _____

NATURE OF COMPLAINT

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

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

MEMBER'S SIGNATURE _____ **DATE** _____

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

Department of Managed Health Care:

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

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

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

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

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

Inland Empire Health Plan

FORMULARIO DE QUEJAS (MEDI-CAL)

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

INFORMACIÓN DEL MIEMBRO

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

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

NOMBRE_____

RELACIÓN ☐UNO MISMO ☐ MADRE ☐ PADRE ☐ ABUELO ☐ TUTOR ☐ OTRO _____

TIPO DE QUEJA

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

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

FIRMA DEL MIEMBRO _____ **FECHA** _____

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

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

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

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

PROVIDER FAIR HEARING PROCESS

FOR PARTICIPATION IN

THE PROVIDER NETWORK

OF

INLAND EMPIRE HEALTH PLAN

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

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

Independent Physician Associations ("IPA) and Hospital Providers (hereinafter, collectively referred to as "Provider") of medical services who wish to be included in the provider network of the Inland Empire Health Plan ("IEHP"), and who have not been offered a contract to participate, including those providers whose contract has expired, or whose contract has been terminated by IEHP shall follow the procedure outlined below in seeking to be included or for continued participation in the IEHP provider network:

Section 1 Right of Fair Hearing Before the Board of IEHP

a. Any Provider (IPA) who has received a written response from the Chief Executive Officer, or his designee, rejecting the request to be included or to continue participation in the provider network for IEHP shall have the right to a Fair Hearing before the Board of IEHP regarding the decision of the Chief Executive Officer, or his designee.

b. The written response from IEHP, rejecting the request of a Provider (IPA) to be included or to continue participation in the provider network of IEHP shall inform the Provider(IPA) of the reason(s) for rejection and the right to a Fair Hearing before the Board of IEHP regarding the decision of the Chief Executive Officer, or his designee.

c. The Provider (IPA) shall be given ten (10) working days from the date of mailing of the response from IEHP to request a Fair Hearing before the Board of IEHP. "Date of mailing" shall be defined as the date response is deposited to the postal service and postmarked; or such other documented date of deposit to a nationally recognized express transportation company. Such request for a Fair Hearing shall be made by written response from the Provider (IPA) to the Chief Executive Officer, or his designee.

d. Providers (IPA) failing to request a Fair Hearing before the Board of IEHP within ten (10) working days from the date of mailing relinquish their right to a Fair Hearing and any other judicial review.

e. The Fair Hearing before the Board of IEHP shall be set on a regular agenda within sixty (60) calendar days, for which proper notice pursuant to the Brown Act can be given.

f. The Chief Executive Officer shall set the Fair Hearing on the agenda of a regular Board meeting of IEHP pursuant to the provisions of section 1 e. herein, and shall give written notice to the Provider (IPA) of the date, time, and place of the Fair

Hearing. The notice shall include a statement that exhaustion of the administrative remedies, as set forth herein is required prior to seeking judicial review.

Section 2 Fair Hearing Position Statements

a. If the Provider (IPA) has requested a Fair Hearing, counsel for IEHP shall provide written notice to both parties requesting written statements that outline their position to be served to IEHP counsel and opposing party by a specified date and time.

b. Failure by Provider (IPA) to provide requested documentation in the timeframes indicated may be considered waiver of Provider (IPA)'s right to a Fair Hearing and any other judicial review. Such decision shall be made at the sole discretion of the Board of IEHP.

Section 3 Fair Hearing Before the Board of IEHP

a. At the time and date specified in the written response of the Chief Executive Officer, the Board of IEHP shall conduct a hearing, and shall receive evidence, including testimony from the Chief Executive Officer of IEHP, his designee, other employees of IEHP if necessary, and the Provider (IPA). The Board of IEHP may receive evidence, including testimony from any other concerned parties who desire to present evidence to the Board of IEHP regarding the request of the Provider (IPA) to be included or to continue participation in the provider network for the operations of IEHP.

b. **Any party wishing to speak on this matter must state for the record any contribution in excess of $250 made in the past twelve (12) months to any IEHP Board member, the name of the Board member receiving the contribution**.

c. The Board of IEHP shall not be limited by the technical rules of evidence in conducting the Fair Hearing.

d. The Fair Hearing shall be conducted in open session during the regular meeting of the Board of IEHP.

e. If the Provider (IPA) fails to appear at the Board meeting for the Fair Hearing, after receiving written notice of the date, time and place of the hearing from the Chief Executive Officer, or his designee, and without requesting a continuance, in writing, directed to the Chief Executive Officer, such writing to be received prior to the date of the Fair Hearing, the Provider (IPA) shall be deemed to have waived the right to a Fair Hearing.

f. The decision of whether a continuance of the Fair Hearing is granted, when requested by a Provider (IPA) at the date and time of the Fair Hearing, shall be in the sole discretion of the Board of IEHP. The Board may, in its sole discretion, decide to deny the request for the Provider (IPA) for a continuance, and proceed with the Fair Hearing.

Section 4 Actions of the Board after the Fair Hearing

a. The Board of IEHP, after the completion of the evidentiary portion of the Fair Hearing may take any of the following actions without further notice:

i. Grant the request of the Provider (IPA) to be included in the provider network wholly, partially, or conditionally. The Board may direct the Chief Executive Officer, or designee, to negotiate and reach contractual terms and conditions, subject to Board approval, provided that the Provider (IPA) meets the Provider participation standards for inclusion, as approved by the Board.

ii. Grant the request of the Provider (IPA) to continue participation in the provider network wholly, partially or conditionally. The Board may direct the Chief Executive Officer to negotiate and reach new or renewed contractual terms and conditions, subject to Board approval, provided that the Provider (IPA) meets the Provider participation standards for continued inclusion in the provider network of IEHP, as approved by the Board.

iii. Deny the request of the provider (IPA) wholly, partially, or conditionally to be included or to continue participation in the provider network of IEHP.

iv. Continue the matter to the next regularly scheduled Board meeting, at which time the decision of the Board will be rendered.

Section 5 Exhaustion of Administrative Remedies

a. A Provider (IPA) seeking to be included in the IEHP provider network shall be required to exhaust the administrative remedies, as set forth herein, prior to seeking judicial review of the actions of IEHP, and the Board of IEHP.

b. A Provider (IPA) seeking to continue participation in the provider network for the operations of IEHP upon termination or contract expiration shall be required to exhaust the administrative remedies, as set forth herein, prior to seeking judicial review of the actions of IEHP, and the Board of IEHP.

c. The Notice of the Fair Hearing shall contain a statement that exhaustion of administrative remedies, as set forth herein, is required prior to seeking judicial review.

Section 6 Finality of the Decision of the Board

The decision of the Board of the Inland Empire Health Plan shall be final as to the request of the Provider (IPA) to be included or to continue participation in the provider network of IEHP.

[DATE]

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

SUBJECT: _____ GRIEVANCE

Dear Dr. [Provider Name]:

On [DATE], IEHP received your grievance against [MEMBER, IPA, HOSPITAL OR IEHP]. Thank you for bringing this matter to our attention, your concerns are important to us.

IEHP is currently taking the necessary steps to immediately resolve your grievance. You will be contacted if we have any further questions. IEHP's Director of Provider Relations will resolve your grievance, within thirty (30) calendar days.

If you have any questions or concerns regarding the status of your grievance, please call me at (909) 890-XXXX.

Sincerely,

[Director Name]
Director of Provider Relations, IEHP

cc:

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

[DATE]

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

Re: Grievance _____

Dear Dr. [Provider Name]:

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

_____

_____

_____

_____

_____

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

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

Sincerely,

[Director Name]
Director of Provider Relations, IEHP

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