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## 16. GRIEVANCE AND APPEALS RESOLUTION SYSTEM

### A. Member Grievance and Appeals Resolution

#### 1. Member Rights and Options

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#### **APPLIES TO:**

A. This policy applies to all IEHP Medi-Cal Members.

#### **POLICY:**

A. IEHP informs Members of their rights and options in accordance with state and federal regulatory guidelines and National Committee for Quality Assurance (NCQA) standards. This information is provided at enrollment and annually thereafter through the IEHP Medi-Cal Member Handbook/Evidence of Coverage (EOC), as well as during the grievance and appeal resolution process.<sup>1</sup>

#### **DEFINITION:**

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

#### **PURPOSE:**

- A. To define the rights and options available to Members filing a grievance or appeal.
- B. To ensure there is no discrimination against a Member, including cancellation of the contract, solely on the grounds of filing a grievance or appeal.<sup>2</sup>

#### **PROCEDURES:**

A. **Grievances:** Members, their authorized representative or a Provider acting on behalf of a Member and with the Member's consent, may file a grievance at any time following any incident or action that is the subject of the Member's dissatisfaction.<sup>3</sup> Grievances may be filed with IEHP by phone, mail, fax, in person, online through IEHP's website at [www.iehp.org](http://www.iehp.org), or with the assistance of the involved Provider.<sup>4,5,6,7</sup>

Members have the right to personally register a grievance, or designate, either in writing or

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<sup>1</sup> Department of Health Care Services (DHCS)-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 13, Provision 4, Written Member Information.

<sup>2</sup> 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".

<sup>3</sup> DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 13, Provision 2, Grievance Process.

<sup>4</sup> DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 13, Provision 1, Members' Rights and Responsibilities.

<sup>5</sup> DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 14, Provisions 1, Member Grievance and Appeal System.

<sup>6</sup> DHCS APL 17-006.

<sup>7</sup> Title 42, Code of Federal Regulations (CFR) § 438.402.

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## 16. GRIEVANCE AND APPEALS RESOLUTION SYSTEM

### A. Member Grievance and Appeals Resolution

#### 1. Member Rights and Options

---

verbally that a relative, a representative, Practitioner, Provider or attorney will represent them during the grievance process. In addition, if the Member is a minor, or is incompetent or incapacitated, a grievance may be registered on behalf of the Member by the parent, guardian, conservator, relative, or other designee of the Member, as appropriate. IEHP recognizes the term “relative” to include a parent, stepparent, spouse, adult son or daughter, grandparent, brother, sister, uncle, or aunt of the Member.<sup>8</sup> Please see Policy 16A1, “Member Grievance Resolution Process” for more information.

- B. **Appeals:** Members, their authorized representative or a Provider acting on behalf of a Member and with Member’s written consent, have up to sixty (60) calendar days from the date on the Notice of Adverse Benefit Determination (NABD) to file an appeal with IEHP either orally or in writing.<sup>9,10</sup> Members have the right to request continuation of benefits during an appeal.<sup>11</sup> Please see Policy 16A2, “Member Appeals Resolution Process” for more information.
- C. **Confidentiality:** Members have the right to confidentiality of medical information.<sup>12</sup> Members have the right to file a grievance with the IEHP Chief Compliance Officer, the California Department of Health Care Services (DHCS) Privacy Officer, or the Department of Health and Human Services (DHHS) Office of Civil Rights if the Member believes their right to confidentiality has been violated (HIPAA violation). This information is contained in the IEHP Notice of Privacy Practices.
- D. **Submission of Additional Information:** Members have the right to submit written comments, documents or other information relating to their grievance.<sup>13</sup> This information is relayed to the Member during the triage of the grievance by IEHP and in writing through the denial-related grievance (appeal) acknowledgment letter.
- E. **Discrimination:** All Members have the right to receive access to all covered services without restriction based on 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

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<sup>8</sup> Knox-Keene Health Care Service Plan Act of 1975, § 1368.

<sup>9</sup> DHCS APL 17-006.

<sup>10</sup> 42 CFR § 438.402.

<sup>11</sup> National Committee for Quality Assurance (NCQA), 2020 Health Plan Standards and Guidelines, UM 8, Element A, Factor 16.

<sup>12</sup> DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 13, Provision 1, Members’ Rights and Responsibilities.

<sup>13</sup> NCQA, 2020 HP Standards and Guidelines, UM 8, Element A, Factor 4.

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## 16. GRIEVANCE AND APPEALS RESOLUTION SYSTEM

### A. Member Grievance and Appeals Resolution

#### 1. Member Rights and Options

---

information, marital status, or source of payment.<sup>14,15,16,17,18</sup> IEHP also assures that there is no discrimination against a Member on the grounds that the complainant filed a grievance.<sup>19,20</sup>

Any grievance alleging discrimination against the Member must be filed by email, fax to (909) 890-5748, phone, web, or in person to IEHP immediately. Discrimination grievances are resolved in accordance with the Section 1557 of the Affordable Care Act (ACA). All substantiated cases alleging discrimination against Members or eligible beneficiaries are forwarded to DHCS for review.<sup>21</sup> Please see Policy 9H3, “Cultural and Linguistic Services – Non-Discrimination.”

- F. **Change of Provider:** Members have the right to request a change of their Primary Care Provider (PCP) at any time.<sup>22</sup>
- G. **Right to Disenroll:** Members have the right to disenroll from IEHP at any time without giving a reason.<sup>23</sup>
- H. **Linguistic Needs:** IEHP Members have the right to file a grievance if their linguistic needs are not met when seeking medical care.<sup>24</sup>
- I. **Request for Assistance:** Members have the right to contact DMHC for assistance and/or to request an Independent Medical Review (IMR).
- J. Members are informed of the following rights and options during the Appeals Resolution Process:<sup>25</sup>
  - 1. The Medi-Cal Fair Hearing
    - a. Medi-Cal Members, their authorized representative or a Provider acting on behalf of the Members and with the Member’s written consent, or representative of a deceased Member’s estate have the right to request a Medi-Cal Fair Hearing orally or in writing after IEHP completes review of appeal and issues a Notice of Appeal Resolution

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<sup>14</sup> 42 CFR § 422.110(a).

<sup>15</sup> 45 CFR Part 92.

<sup>16</sup> California Welfare and Institutions Code (Welf. & Inst. Code) § 14029.91.

<sup>17</sup> CA Government Code (Gov. Code) § 11135(a).

<sup>18</sup> DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit E, Attachment 2, Provision 28, Discrimination Prohibition.

<sup>19</sup> DHCS APL 17-006.

<sup>20</sup> Title 28, California Code of Regulations (CCR) § 1300.68(b)(8).

<sup>21</sup> DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit E, Attachment 2, Provision 28, Discrimination Prohibitions.

<sup>22</sup> DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 13, Provision 1, Members’ Rights and Responsibilities

<sup>23</sup> Ibid.

<sup>24</sup> DHCS PL 99-03, “Linguistic Services”.

<sup>25</sup> NCQA, 2020 HP Standards and Guidelines, UM 8, Element A, Factor 10.

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## 16. GRIEVANCE AND APPEALS RESOLUTION SYSTEM

### A. Member Grievance and Appeals Resolution

#### 1. Member Rights and Options

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(NAR).<sup>26,27,28</sup>

- c. Medi-Cal Members have the right to continued medical assistance and benefits, including continuation of services previously authorized, pending a Fair Hearing decision if the Member appeals in writing to the Department of Health Care Services for a hearing:
  - 1) within ten (10) calendar days of the mailing or personal delivery of the NAR to reduce or terminate authorization for a medical service; or
  - 2) before the effective date of action.
- 2. The Right to Contact DMHC

- a. The following statement is included in all Member grievance correspondence:<sup>29</sup>

“If you want an IMR, you must ask for one within one hundred-eighty (180) calendar days from the date of this “Notice of Appeal Resolution” letter. The paragraph below will provide you with information on how to request an IMR. Note that the term “grievance” is talking about both “complaints” and “appeals.”

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 **TTY 1-800-718-4347** 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 thirty (30) calendar days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for an 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 Website (<http://www.hmohelp.ca.gov>) has complaint forms, IMR application forms, and instructions online.”

- b. DMHC may require Members to participate in IEHP’s Grievance Resolution Process for up to thirty (30) calendar days prior to pursuing a grievance with DMHC, unless it

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<sup>26</sup> DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 14, Provision 7, State Fair Hearings and Independent Medical Reviews.

<sup>27</sup> DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 16, Provision 3, Disenrollment

<sup>28</sup> DHCS APL 17-006.

<sup>29</sup> KKA, § 1368.02(b).

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## 16. GRIEVANCE AND APPEALS RESOLUTION SYSTEM

### A. Member Grievance and Appeals Resolution

#### 1. Member Rights and Options

---

is determined that an earlier review is warranted.

#### 3. Expedited Review

- a. Members have the right to an expedited review and resolution of their urgent grievance within seventy-two (72) hours, if their medical condition involves an imminent and serious threat to the health of the patient, including but not limited to, severe pain, and potential loss of life, limb, or major bodily function.<sup>30,31,32</sup> See Policy 16A2, “Grievance Resolution Process - Member Urgent Medical Grievances” for more information.

#### 4. Voluntary Mediation<sup>33</sup>

- a. Members or their authorized representative may request voluntary mediation with IEHP prior to exercising the right to submit a grievance to DMHC. The use of mediation services does not preclude the right of the Member to submit a grievance to DMHC upon completion of mediation.
- b. In order to initiate mediation, the Member or his/her authorized representative and IEHP must voluntarily agree to mediation.
- c. Expenses for mediation are borne equally by IEHP and the Member.

#### 5. Independent Medical Review (IMR)

- a. A Member may request an IMR of disputed health care services from DMHC if he/she believes that health care services have been improperly denied or partially approved (modified) by IEHP or one of its Delegates, in whole or in part because the service is not medically necessary, or related to experimental and investigational therapies.<sup>34</sup> A disputed health care service is any health care service eligible for coverage and payment under the subscriber contract that has been denied, partially approved (modified), or terminated by IEHP or its contracting Providers, in whole or in part because the service is not medically necessary.<sup>35</sup>
  - 1) Members whose appeal requires expedited review shall not be required to participate in the IEHP’s Internal Grievance process for more than three (3) calendar days before applying for an IMR.
  - 2) If DMHC determines that Member is not eligible for an IMR, the Member’s case will be reviewed through DMHC’s consumer complaint process.

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<sup>30</sup> KKA, § 1368.015.

<sup>31</sup> 28 CCR § 1300.68.01(a).

<sup>32</sup> DHCS APL 17-006.

<sup>33</sup> KKA, § 1368.

<sup>34</sup> CA Health & Saf. Code § 1374.30(i).

<sup>35</sup> KKA, § 1374.30.

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## 16. GRIEVANCE AND APPEALS RESOLUTION SYSTEM

### A. Member Grievance and Appeals Resolution

#### 1. Member Rights and Options

---

- 3) Members may not request an IMR if a State Fair Hearing has already been held on the issue.
  - b. Members may apply for an IMR without first participating in IEHP's internal Appeal process in extraordinary and compelling cases, as determined by DMHC, and in cases where Member's request for an experimental treatment was denied. Members are notified in writing of the opportunity to request an IMR of a decision denying an experimental therapy within five (5) business days of the decision to deny coverage.
  - c. Members may request an IMR when the following criteria has been met:<sup>36</sup>
    - 1) The Member's Doctor recommended a health care service as medically necessary;
    - 2) The Member has received urgent care or emergency services that a Provider determined was medically necessary;
    - 3) The Member has seen a Provider within the IEHP network for the diagnosis or treatment of the medical condition for which the Member seeks IMR. The Provider may be an out-of-network Provider when DMHC finds that the Member's decision to secure services outside IEHP's network was reasonable under the circumstances and the disputed health care services were a covered benefit under the terms and conditions of IEHP's contract;
    - 4) The disputed health care service has been denied, partially approved (modified) or terminated by IEHP or one of its Delegates, based in whole or in part on a decision that the health care service is not medically necessary; or
    - 5) The Member has filed a grievance with IEHP and IEHP has determined to agree with the denial decision or the grievance remains unresolved for thirty (30) calendar days. If the grievance requires expedited review, the Member may immediately submit the request for IMR to DMHC.
  - d. The Member may apply to DMHC for an IMR within six (6) months after an appeal was filed with IEHP and the disputed decision is upheld, in whole or in part, that the service is not medically necessary or the case remains unresolved more than thirty (30) calendar days. If the case requires expedited review, Members are not required to file an appeal with IEHP prior to submitting the request for an IMR with DMHC.
  - e. Members may contact IEHP for additional information regarding how to request an IMR or to request an IMR application form at (800) 440-4347 or TTY (800) 718-4347.
- L. **Access to Grievance Documents:** For denial-related appeals, Members have the right to obtain access to and copies of relevant grievance documents upon request and at no cost to

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<sup>36</sup> KKA, § 1374.30.

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## 16. GRIEVANCE AND APPEALS RESOLUTION SYSTEM

- A. Member Grievance and Appeals Resolution
1. Member Rights and Options
- 

them by contacting Member Services at (800) 440-4347.<sup>37</sup> This information is included in the NAR and grievance resolution letter mailed to the Member. IEHP maintains electronic copies of medical records for ten (10) years.<sup>38,39</sup>

INLAND EMPIRE HEALTH PLAN		
<b>Chief Approval:</b> <i>Signature on file</i>	<b>Original Effective Date:</b>	September 1, 1996
<b>Chief Title:</b> Chief Medical Officer	<b>Revision Date:</b>	January 1, 2021

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<sup>37</sup> NCQA, 2020 Health Plan Standards and Guidelines, UM 8, Element A, Factor 12.

<sup>38</sup> DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit E, Attachment 2, Provision 19, Audit.

<sup>39</sup> KKA, § 1300.68.

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## **16. GRIEVANCE AND APPEALS RESOLUTION SYSTEM**

- A. Member Grievance and Appeals Resolution
    - 1. Member Rights and Options
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