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Section I: Provider Grievance System

Procedure: Processing Provider Inquires, Appeals and Complaints

A process has been established for providers to have their inquiries, appeals and complaints heard and evaluated.

I1: Definitions

Inquiry: A request by a Provider for clarification, or a request for additional information.

Appeal: An appeal is a request from a Provider to change a previous decision made by CenCal Health. Appeals by Providers are made to MedImpact regarding Medical Request Forms (MRFs).

Complaint: A complaint is an oral and/or written expression of dissatisfaction.

I2: Receipt and Resolution of a Provider Inquiry

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

I3: Pharmacy Claims Processing Decision

Providers may contact CenCal Health's Pharmacy Benefits Manager (PBM), MedImpact, regarding a pharmacy claims processing question, including a pharmacy claim denied for reasons other than lack of a MRF. Most of these inquiries are resolved at the initial contact and are not formally documented. The Provider may submit additional information to MedImpact to adjudicate the claim in question.

I4: Appeal of a Medical Request Form (MRF)

Providers may appeal denied or modified MRFs on behalf of the member by submitting the following documentation including written consent from the member to file on their behalf within sixty (60) calendar days from the date of the original decision:

A copy of the original or modified MRF;

- A copy of the original or modified MRF
- A letter stating why denial or modification should be overturned;
- Documentation to support overturning the original denial or modification.
- Written Consent from Member
- A new completed MRF

Providers/Members are notified of receipt of their appeals and the appeals process within five (5) working days.

The appeal decision shall be reviewed by the Medical Director or a qualified licensed Medical Director designee physician who may reverse the denial. The Provider will receive a written response within thirty(30) calendar days of receipt regarding the final determination of the appeal. If the service has not been provided, the provider may inform the member of his or her right to file an appeal by contacting CenCal Health's Member Service Department:

CenCal Health
Member Services Department
4050 Calle Real
Santa, Barbara, CA 93110
1-877-814-1861 (Toll-Free)

For the hearing impaired, use the California Relay Service at
711 or
TTY: 1-833-556-2560
8:00 a.m. to 5:00 p.m. - Monday through Friday

I5: Expedited Appeals

When the member's condition is such that the member faces an imminent and serious threat to his or her health including, but not limited to, the potential loss of life, limb or other major bodily function, or timeframe for the decision making process would be detrimental to the member's life or health or could jeopardize the member's ability to regain maximum function, decisions shall be made in a timely fashion not to exceed 72 hours after the CenCal Health's receipt of information necessary and requited to make the determination. Expedited appeals may be initiated by the member or by the provider acting on behalf of the member. Expedited appeals are performed by CenCal Health only

when, in the judgment of CenCal Health, a delay in decision making might seriously jeopardize the life or health of the member.

The provider will be notified in writing of the expedited appeal within twenty-four (24) hours of the decision. Written confirmation of the decision will be provided within two (2) working days if the initial decision was not in writing.
For additional information about MRF appeals, please call (805) 685-9525, extension 1661.

I6: Post Service Appeals

If a provider receives a letter of denial or modification of a MRF for a Post Service Request, the provider may contact the physician reviewer or licensed health care professional by calling or writing to the address and/or the telephone listed below:

CenCal Health
Pharmacy Services Department
4050 Calle Real
Santa Barbara, CA 93110
(805) 562-1639

If the service has not been provided, members are informed of their right to file an appeal. For additional information or assistance, members may contact CenCal Health's Member Services Department at:

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

1-877-814-1861 (Toll-Free) or
California Relay Service at 711 for the hearing impaired
or
TTY: 1-833-556-2560
8:00 a.m. to 5:00 p.m. Monday through Friday

I7: Receipt and Resolution of a Provider Complaint

The Provider Services Department is charged with the resolution of Provider Complaints. The Complaint may be related to: Member Issues, Another Provider's Care or Treatment, a Clinical or Quality of Care Issue, Aspects of CenCal Health's administration of its programs, or other issues. The Provider may file a complaint with the Provider Services Department via a telephone call, by fax or through other written means.

The Provider Services Representative (PSR) will determine whether the complaint involves an adverse or potentially adverse effect on a member's quality of care. Any complaints involving a clinical or quality of

care concern will be referred to the Supervisor, Clinical Practice Management, the Supervisor, Clinical Practice Management will attempt, under the direction of CenCal Health's Medical Director, or Designee, to respond to the issue as quickly as possible in a time frame appropriate to the member's medical condition. The Supervisor, Clinical Practice Management shall:

- Obtain Provider(s) perspective and/or medical records regarding complaints that are potentially clinical complaints.
- Present gathered information for review by the Medical Director or Designee, and/or the Credentials and Peer Review Committee, etc.
- Document the results of the investigation and resolution

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

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

I8: Provider Complaints Requiring Clinical Quality of Care Review

CenCal Health's Supervisor of Clinical Practice Management Nurse or Designee shall be responsible for reviewing clinical complaints when anyone has reported an adverse or potentially adverse effect on a member's health.

The Clinical Practice Management Nurse or Designee shall:
1. Obtain Provider(s) perspective and/or medical records regarding complaints that are potentially clinical complaints.

2. Present gathered information for review by the Chief Medical Officer or designee, and/or the Peer Review Committee, etc.

3. Document the results of the investigation and resolution.

I9: Disclosure to Providers and Members

Providers are informed of CenCal Health's Provider Grievance System through their Provider contract agreements or amendments, CenCal Health's website at **www.cencalhealth.org**, Provider Bulletins, and in Provider materials and manuals issued by CenCal Health and updated periodically. Additionally, denial of claims payment is indicated on the Provider's Explanation of Benefits (EOB).

All written communications to a physician or other health care provider of a denial, deferral, or modification of a MRF shall include the name and

direct phone number or extension of the health care professional responsible for the denial, deferral, or modification. The response will also include information as to how the member may file an appeal or complaint with CenCal Health, and in the case of Medi-Cal members when the service has not yet been provided, shall explain how to request an administrative hearing.

If CenCal Health, or a complaint has not satisfactorily resolved the Provider's complaint or appeal or appeal remains unresolved for more than thirty (30) days without written notice, the Provider may submit the complaint or appeal in writing to CenCal Health's Chief Executive Officer (or designee) who will determine whether it warrants review by the Board of Directors. If the Provider's request involves an exception to DHCS or DMHC regulations, the Provider must include justification for such an exception in order for it to be presented to the Board of Directors. CenCal Health's grievance system is in addition to any other dispute resolution procedures available to the Provider. The Provider's failure to use these procedures does not preclude the Provider's use of any other remedy provided by law.

CenCal Health's Deputy Executive Director should be notified immediately when a Provider's legal representative contacts CenCal Health regarding the pursuit of legal action to resolve a complaint or appeal.

I10: Confidentiality and Privacy Record Retention

All Provider complaints and appeals shall be placed in designated files and maintained by the PSQI Manager for at least five (5) years after the resolution; the files of the previous two (2) years shall be in an easily accessible place at CenCal Health's offices. Documents that are considered "confidential" and that are obtained during a clinical appeal or quality of care review will be maintained by the Health Services Department in appropriate files, folders, or binders.

I11: Monitoring the Process-Reports

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