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Section O: Provider Complaints and Grievances

O1: Provider Complaints and Grievances

CenCal Health has developed a process to address provider complaints and grievances efficiently and fairly. This policy provides an avenue for contracted and non-contracted providers to bring concerns or opportunities for improvement to CenCal Health's attention, and thus drive CenCal Health's operations and direction, as appropriate.

Definitions

Complaint: A complaint is a request for assistance, or an expression of dissatisfaction related to non-clinical member issues, aspects of CenCal Health's administration of its programs, or other issues.

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

Procedure

1. **Receipt of Provider Claims Inquiries, Disputes or Appeals; and Authorization Inquiries or Appeals**
   If a provider contacts Provider Services with issues outside their purview (claims inquires or appeals, authorization inquiries or appeals, clinical or quality of care concerns), the Provider Services Representative (PSR) will "warm transfer" the caller to the appropriate department. The appropriate department, to address the grievance, unless otherwise requested, shall review and respond as appropriate.

   A. *Receipt and Resolution of a Provider Complaint or Grievance:*
      I. The Provider Services Department is charged with the resolution of provider complaints and grievances. The complaint may be related to non-clinical member issues, 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, fax, e-mail, or handwritten letter.
      II. If a complaint has no clinical or quality of care aspect, the PSR determines whether the provider needs routine assistance or would like to file a formal grievance. Formal grievances must be submitted in writing, preferably on the provider's letterhead.
      III. Informal complaints and requests for routine assistance are addressed by the PSR, with assistance from other staff as needed. Formal written

acknowledgements or resolutions are generally not necessary for these matters

IV. 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 (5) business days.

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

2. Disclosure to Providers and Members

Providers are informed of their right to file complaints and grievances, and the availability of assistance in the filing process, in a variety of ways. This may include, but is not limited to, through their provider contract agreements or amendments, CenCal Health's website, Provider Bulletins, and in provider materials and manuals issued by CenCal Health and updated periodically.

CenCal Health's grievance system is in addition to any other dispute resolution procedures available to the provider. The provider's failure to use these procedures does not preclude the provider's use of any other remedy provided by law.

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

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

Grievances shall be received, handled, and resolved without charge to the provider. However, CenCal Health shall have no obligation to reimburse a provider for any costs incurred in connection with filing a complaint or grievance.

3. Confidentiality and Privacy Regarding Record Retention

All provider complaints and appeals shall be placed in designated files and maintained by the Provider Services Quality Liaison for at least ten (10) years after the resolution; the files of the previous two (2) years shall be in an easily accessible place at CenCal Health's offices.

4. Monitoring of the Process

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

O2: Member Grievance and Appeal Process

Providers or Authorized Representative can offer to help members file a grievance or an appeal. They can also file appeals on their behalf with their patient's consent. The following information explains the process for member grievance and appeal filing.

CenCal Health members have the right to file a grievance about their experiences with the Plan or its providers. While many providers have internal policies for resolving patient complaints/grievances, CenCal Health provides a Grievance and Appeal System for our members to express their dissatisfaction or to appeal a decision that they do not agree with. We do not delegate this activity to our provider network.

For appeals, members have 60 calendar days from the date of the Notice of Action Letter (NOA) or decision to submit an appeal. For Grievances, there is no longer a time limit to file. An appeal or grievance request can be made by the member, the authorized representative or by a provider on behalf of the member, with their consent.

Discrimination Grievances – These types of grievances are processed by a Discrimination Grievance Coordinator to ensure the health plan is in compliance with federal and State nondiscrimination requirements and investigating cases related to any action that would be prohibit by, or out of compliance with, federal and State.

If a member asks to file a grievance or an appeal with the provider, the provider's office staff should give him/her the appropriate forms and instructions. Forms are available in English and Spanish, and copies of these forms should be made readily available for CenCal Health members in your office, and are available at the following links:

Appeal Form: English or Spanish
Grievance Form: English or Spanish

HOW TO ASSIST MEMBERS IN FILING GRIEVANCES OR APPEALS

A grievance or an appeal can be filed by members or on behalf of members by any of the following methods:

- By calling CenCal Health's Member Service Department at our toll free number 1-877 -814-1861.
- In person, by visiting CenCal Health.
- By completing a Grievance/Appeal Form and/or submitting in writing to:

  CenCal Health
  Attn: Grievance & Appeals
  4050 Calle Real
  Santa Barbara, CA 93110
- Via website at this link: https://www.cencalhealth.org/members/file-complaint/

Standard and Expedited Review Processed

Standard - In most circumstances, grievance or appeal requests will be processed through the Standard Grievance/Appeal Review Process. This is a 30-day max timeframe for review. The timeframe may however be extended an additional 14 calendar days (for appeals only), if there is a need for additional information to make a decision and/or if the delayed decision is in the best interest to the member.

The standard process include a written resolution of the grievance or appeal within 30 calendar days of filing.

Expedited - An expedited review of a grievance or appeal can be requested in certain cases. This is a 72-hour allowed timeframe from the day it is received and consented from member, for review. This process supports resolution of the appeal within 72 hours when a delay in a decision using the 30-day standard process may seriously jeopardize the member's life, health, or the ability to attain, maintain or regain maximum function. A CenCal Health physician reviewer will determine if the appeal request meets expedited criteria for processing.

If the expedited process is granted, a physician reviewer who was not involved in the original decision will complete the review and resolution of that appeal is provided verbally to the requestor within the 72 hours of filing. Written notification is also provided within 72-hours in most cases, only delayed for translation needs.

If the CenCal Health Physician Reviewer determines the appeal does not meet expedited criteria for processing, the process will revert to the standard appeal process for resolution. Attempts will be made to verbally notify the member or authorized representative of this change to a standard 30-day process, and the verbal notification is also followed by a written Acknowledgement Letter initiating the standard grievance or appeal.

PROVIDER RESPONSIBILITIES

Providers must cooperate with CenCal Health in identifying, processing and resolving all member grievances and appeals.

Cooperation in this process includes, but is not limited to:

- Speaking with CenCal Health Grievance & Appeals Coordinators to assist with resolving the grievance or appeal in a reasonable manner.
- Having designated staff available for grievance and appeal investigation.
- Completing a provider response in writing, if requested. Providers may choose to respond in writing at any time as well and often provide written documentation of their requests when filing on a member's behalf.
- Responding to all information/documentation requests made by CenCal Health related to the grievance or appeal: medical record requests, provider's response to the complaint, scheduling documentation/ phone logs and/or other supporting documentation needed for CenCal Health's review.
- Responding to requests timely (within 7 business days at a maximum).

If providers would like to file a grievance or appeal on behalf of a member, providers must obtain written consent from members to do so. This signed consent should be submitted with your appeal request. CenCal Health is able to initiate a grievance or appeal filed by a provider for a member, with at the least, verbal authorization from the member. DHCS requires CenCal Health to request written consent even if verbal authorization is obtained, so it is best to obtain written authorization for submission when filing the grievance or appeal request.

CenCal Health's Grievance & Appeal Team is available to answer any questions you may have about this process at any time. Please contact us through the Member Services Call Center at 1-877-814-1861 and ask to speak with a Grievance Coordinator.