Policy:	MA.9005
Title:	**Payment Appeal**
Department:	Grievance and Appeals Resolution Services
Section:	Not Applicable
CEO Approval:	*/s/ Michael Hunn 12/21/2022*
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Applicable to:	☐ Medi-Cal ☒ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines the procedures by which CalOptima Health shall ensure that an Enrollee has clear and reliable access to a Payment Appeal process that meets the requirements of the Centers for Medicare & Medicaid Services (CMS.

II. POLICY

A. CalOptima Health shall establish and maintain a process that addresses the receipt, handling, and disposition of a Payment Appeal, in accordance with applicable statutes, regulations, contractual requirements, and the terms and conditions of this Policy.

B. CalOptima Health shall notify an Enrollee of the Payment Appeal process:

1. Upon initial enrollment, and annually thereafter;

2. In the OneCare Evidence of Coverage and periodic member newsletters;

3. In all notices of adverse Organization Determination; and

4. Upon the Enrollee's request.

C. Grievance and Appeals Resolution Services (GARS) staff shall accept, track, and report all Payment Appeals.

D. Subject to the provisions of this Policy, an Appealing Party (an Enrollee; an Enrollee's representative; a non-contracted provider (with WOL); the legal representative of a deceased Enrollee's estate or any other provider or entity determined to have an appealable interest in the proceeding) may initiate a Payment Appeal.

1. When filing a Payment Appeal on behalf of an Enrollee, a Provider may not charge a fee to the Enrollee for doing so.

E. An Enrollee shall have the right to an attorney, or other representation, in the Payment Appeal process.

F. If a Payment Appeal involves multiple issues, CalOptima Health shall process each issue separately and simultaneously under the appropriate process.

G. Subject to the provisions of this Policy, CalOptima Health shall process a Payment Appeal within sixty (60) calendar days after receipt of such Payment Appeal through December 31, 2022. Thereafter, payment appeals must be adjudicated within 30 days or 44 days with an extension..

H. The processing timeframe for a Payment Appeal shall begin when any unit within CalOptima Health, or a delegated entity (including those not responsible for processing the request) received a Payment Appeal request.

I. Upon an Enrollee's request for a copy of the contents of the case file at any point of the Appeals process, CalOptima Health shall:

1. Provide an Enrollee with a copy of the contents of the Enrollee's case file, including, but not limited to, a copy of supporting Medical Records, any new or additional evidence considered, relied upon, or generated, and other pertinent documents, records, or information used in connection with the Appeal and to support CalOptima Health's Payment Appeal decision. Where an Enrollee has an alternate format preference, the case file contents must be provided in that format.

2. Make every reasonable effort to accommodate an Enrollee request for case file material (e.g., allowing the enrollee or authorized representative to obtain the material at CalOptima Health's location or mailing the material to any address specified by the Enrollee or Authorized Representative) and provide such material in advance of making the Payment Appeal decision.

3. Abide by all applicable federal and state laws regarding confidentiality and disclosure for mental health records, medical records, or other health information (Under Title 45 Code of Federal Regulations (C.F.R.) 164 Subpart E, regarding the privacy of individual identifiable health information)

4. CalOptima Health shall provide records at no cost.

J. All CalOptima Health departments shall respond promptly, within designated timeframes, to any inquiry related to a Payment Appeal.

K. CalOptima Health shall provide all parties to a Payment Appeal with reasonable opportunity to present evidence, or allegations of fact or law, related to the issue in dispute, in person, or in writing (e.g., by telephone, fax, or hand delivered to CalOptima Health's physical location). CalOptima Health shall take all evidence into account when making its decision.

L. CalOptima Health shall ensure that there is no discrimination against an Enrollee on the grounds that such Enrollee filed a Payment Appeal, in accordance with CalOptima Health Policy HH.1104: Complaints of Discrimination.

M. CalOptima Health shall ensure that Enrollees have equal access to, and can fully participate in, the Payment Appeal process by providing assistance to Enrollees with Limited English Proficiency (LEP), vision disorders, or other communicative impairments and ensuring such Enrollees have the same level of access to CalOptima Health representatives and information regarding Appeals as

Enrollees who are proficient in English, in accordance with CalOptima Health Policy MA.4002: Cultural and Linguistic Services, as follows:

1. Translation of forms and responses;

2. Interpretation services;

3. Telephone relay systems; and

4. Other reasonable accommodations, as appropriate.

III. PROCEDURE

A. Parties to a Payment Appeal

1. An individual appointed by the Enrollee (e.g., relative, friend, advocate, attorney) as his or her Authorized Representative may file a Payment Appeal. If an Authorized Representative files a Payment Appeal, he or she shall submit documentation of such appointment, as follows:

    a. Appropriate legal documents or authority supporting such appointment; or

    b. An Appointment of Representative Form or equivalent written notice (i.e., Representative Form) signed by both the Enrollee and the Enrollee's Authorized Representative, except if an attorney acts as the Enrollee's Authorized Representative. If an attorney acts as the Authorized Representative, the Authorized Representative may submit a Request for Appointment of Representative Form or equivalent written notice signed by the Enrollee only.

2. A court acting in accordance with state or other applicable laws can authorize an individual to act on behalf of the Enrollee in filing a Payment Appeal.

    a. Authorized Representatives could include, but is not limited to a court appointed guardian, individual with durable power of attorney, a health care proxy, a person designated under a health care consent statute, executor of an estate.

    b. The Authorized Representative shall produce and submit appropriate legal papers supporting his or her appointment under state law (a Representative Form is not required).

3. A Non-Contracted Provider, on his, her, or its own behalf, may file an Appeal for a denied claim, in accordance with CalOptima Health Policy MA.9009: Non-Contracted Provider Payment Appeals, if such Non-Contracted Provider:

    a. Furnished a Covered Service to an Enrollee; and

    b. Completes a Waiver of Liability (WOL) statement that states that the Non-Contracted Provider shall not bill the Enrollee for the Covered Service, regardless of the outcome of the Payment Appeal.

B. Request for a Payment Appeal (Level 1 Appeal)

1. Timely Filing Requirements: An Appealing Party may request a Payment Appeal verbally, by telephone, in-person with the Customer Service Department, or in writing to CalOptima Health within sixty (60) calendar days from the date of the receipt of notice of an adverse Organization Determination, or an Explanation of Benefits (EOB).

    a. CalOptima Health may accept a request for Payment Appeal filed after the sixty (60) calendar day limit if the Appealing Party submits a written request for an extension of the timeframe for good cause.

        i. In its request for an extension, the Appealing Party must include a statement explaining why the request for Payment Appeal was not filed on time.

        ii. If the request for an extension submitted does not include an explanation as to why the request for Payment Appeal was not filed on time, CalOptima Health may attempt to obtain information supporting good cause for the late filing.

        iii. In making its determination, CalOptima Health should consider the circumstance that kept the party from making the request on time and whether any organization actions may have misled the party.

        iv. CalOptima Health shall ensure that there is no discrimination against a Enrollee in the determination of good cause justification when a Payment Appeal request is outside the sixty (60) calendar day limit, in accordance with CalOptima Health Policy HH.1104: Complaints of Discrimination.

        v. Instances where good cause may exist include, but are not limited to:

            a) The Appealing Party either not personally receiving the notice for the adverse initial determination or receiving it late;

            b) The Appealing Party was seriously ill which prevented a timely Payment Appeal;

            c) Death or serious illness in the Appealing Party's immediate family;

            d) An accident causing important records to be destroyed;

            e) Difficulty in locating and/or receiving necessary documents within the established time limits;

            f) Incomplete or incorrect information regarding the Payment Appeal process;

            g) The Appealing Party's lack of capacity to understand the Payment Appeal filing timeframe;

            h) The Appealing Party sent the request to an incorrect address, in good faith, within the established time limit;

            i) The delay resulted from additional time required to produce Enrollee documents in an accessible format pursuant to CalOptima Health Policy MA.4002: Cultural and Linguistic Services; or

j) The delay resulted from the Appealing Party having sought and received help from an auxiliary resource (such as a State Health Insurance Assistance Program or senior center), on account of his or her disability, in order to be able to file the Payment Appeal.

vi. If CalOptima Health denies the Appealing Party's request for good cause extension, CalOptima Health must dismiss such request in accordance with Section III.D.5. of this policy and the Appealing Party may file a Grievance in accordance with CalOptima Health Policy MA.9002: Enrollee Grievance Process.

2. A Payment Appeal request shall be considered received on the date and time:

   a. When any department within CalOptima Health initially stamps a document received by regular mail;

   b. A delivery service (that has the ability to track when a shipment is delivered) delivers the document to CalOptima Health (or its designee);

   c. A faxed document is successfully transmitted to CalOptima Health, as indicated on the fax transmission report;

   d. A verbal request is made by telephone with Customer Service;

   e. A message is left on CalOptima Health's voicemail system (if a voicemail system is utilized to accept the Appeal request or supporting statements after normal business hours); or

   f. A Payment Appeal request is received through CalOptima Health's website.

3. Withdrawal of a Payment Appeal Request: An Appealing Party who requests a Payment Appeal may withdraw the request at any time before CalOptima Health renders a decision by notifying CalOptima Health of such withdrawal, verbally or in writing.

   a. If the request to withdraw is filed with CalOptima Health as appropriate, CalOptima Health shall dismiss the Appeal request in accordance with Section III.D.5. of this policy.

   b. The request to withdraw the Appeal must be filed by the Appealing Party who initially requested the Appeal.

   c. If that party withdraws the Payment Appeal request verbally, CalOptima Health shall:

      i. Clearly document the date and reason why the Appealing Party chose not to proceed with the Appeal.

      ii. Mail all parties a written confirmation of the withdrawal to the party within three (3) calendar days from the date of the verbal request using the Notice of Dismissal of Appeal Request as detailed in Section III.D.5.g. of this policy.

   d. If the withdrawal request is received after CalOptima Health has forwarded the case file to the Independent Review Entity (IRE), then CalOptima Health must forward the withdrawal request to the IRE for processing.

4. Any unit within CalOptima Health or a delegated entity not responsible for processing Payment Appeals that incorrectly receives a Payment Appeal request, shall submit such request to the CalOptima Health Grievance and Appeals Resolution Services email inbox: grievancemailbox@CalOptima.org, as expeditiously as possible for requests submitted in writing, or transfer to the CalOptima Health Customer Service Department for verbal requests.

C. Payment Appeal Timeframe (Level 1 Appeal)

1. Subject to the provisions of this Policy, CalOptima Health shall make a determination on a Payment Appeal no later than sixty (60) calendar days after receipt of the request for Appeal.

    a. The Payment Appeal processing timeframe begins when CalOptima Health, any unit within CalOptima Health, or a delegated entity (including those not responsible for processing the request) receives a Payment Appeal request. If such CalOptima Health unit or delegated entity incorrectly receives a Payment Appeal request, the party shall handle that request in accordance with Section III.B.4. of this policy.

    b. If CalOptima Health obtains information establishing good cause for filing the Payment Appeal after the 60-day timely filing limit, the adjudication timeframe of the Payment Appeal request begins on the date CalOptima Health receives that information.

D. Appeal Processing

1. Upon receipt of a request for Appeal, GARS staff shall:

    a. Date stamp, and code the request with the appropriate categorization in the database; and

    b. Prepare a case file that contains the original request for a Payment Appeal, notice of CalOptima Health's or a Health Network's adverse Organization Determination, and all other correspondence.

2. If an Enrollee makes a verbal Payment Appeal, GARS staff shall request confirmation of such as follows:

    a. GARS staff shall confirm with the party receiving the verbal Payment Appeal that he or she verified with the Appealing Party the facts and basis of the request for Payment Appeal. The validated verbal acknowledgement shall be documented in the CalOptima Health database.

    b. GARS staff shall send an Acknowledgement Letter for verbal Payment Appeal requests to the Enrollee to confirm the facts and basis of the Payment Appeal to ensure the request is properly and accurately noted and addressed by CalOptima Health. Notice should advise the Enrollee to contact CalOptima Health if the Acknowledgement Letter does not correctly capture the Enrollee's request.

3. GARS staff shall verify that the request meets criteria for processing as a Payment Appeal:

    a. GARS staff shall verify that the requestor is an Enrollee an Enrollee's Authorized Representative, or a Provider. If the requestor is not one of these parties, GARS staff shall make the following attempts to secure the missing documentation:

i. Written Attempt: If CalOptima Health does not receive documentation of the requestor's status as the Enrollee's Authorized Representative, GARS staff shall request in writing, that the requestor submit documentation of the requestor's status as the Enrollee's Authorized Representative. Included with the request, staff shall send an Appointment of Representative Form and an Authorization for Use and Disclosure of Protected Health Information Form to avoid delays for a Payment Appeal determination.

ii. Verbal Attempt: If CalOptima Health does not receive documentation of the requestor's status as the Enrollee's Authorized Representative, GARS staff shall:

a) Make and document at least two (2) telephone calls to the requestor in an attempt to obtain documentation.

b) Inform the Enrollee and purported representative, in writing, that CalOptima Health will not issue a decision for the Payment Appeal request until valid documentation is provided.

iii. If CalOptima Health does not receive documentation (i.e., any type of Representative Form) of the requestor's status as the Enrollee's Authorized Representative no later than sixty (60) calendar days after CalOptima Health's receipt of the Payment Appeal, CalOptima Health shall dismiss the Payment Appeal as detailed in Section III.D.5. of this policy due to lack of the required documentation to process the request:

b. GARS staff shall verify if CalOptima Health or a Health Network denied a claim for payment.

i. If CalOptima Health or a Health Network did not process the claim, GARS staff shall transmit the claim to the Claims Department or the Health Network for processing and shall notify the Appealing Party who requested the Appeal, of CalOptima Health's claims processing and Organization Determination process.

ii. If CalOptima Health or a Health Network did not deny the claim, GARS staff shall determine if the Enrollee disputes a cost-sharing determination, or if the Provider who requests an Appeal disputes the payment amount.

c. GARS staff shall review the notice of adverse Organization Determination to verify that CalOptima Health received the request for Appeal within sixty (60) calendar days after the date of notice. If CalOptima Health received the request later than sixty (60) calendar days after the date of notice, GARS staff shall provide written notice, using the over sixty (60) Days Letter, to the Appealing Party who requested the Appeal. The notice shall inform the Appealing Party that the request does not meet criteria for Appeal unless the requesting party provides good cause for an extension, in accordance with Section III.B.1.a.5).a)-j). of this policy.

4. If GARS staff identifies a potential quality of care issue, he or she shall forward a referral to the Quality Improvement (QI) Department, in accordance with CalOptima Health Policy MA.9002: Enrollee Grievance Process.

5. Dismissal of Appeal Request

a. CalOptima Health shall dismiss a Payment Appeal request under any of the following circumstances:

i. If an individual who requests an Appeal is not a proper party to the Appeal and a properly executed Representative Form or required documentation has not been filed (and there is no other documentation to show that the requestor is legally authorized to act on the Enrollee's behalf) within sixty (60) calendar days.

ii. If the Appealing Party fails to file the Appeal within sixty (60) calendar days and does not provide written request for an extension for good cause, and/or CalOptima Health denies the Appealing Party's request for good cause extension in accordance with Section III.B.1. of this policy.

iii. If the Enrollee becomes deceased while the Appeal is pending, and the Enrollee's spouse or estate has no remaining financial interest in the case and no other individual or entity with a financial interest in the case wishes to pursue the Appeal request.

iv. When the Appealing Party submits a timely written request to withdraw their request for an Appeal.

v. If CalOptima Health is unable to obtain the information necessary to process a payment request.

a) CalOptima Health shall send a written Notice of Dismissal of Appeal Request form to the Enrollee or Enrollee's Authorized Representative at their last known address at the conclusion of the applicable adjudication timeframe.

b) The dismissal is not considered an adverse determination; however, the dismissal notice must state the reason for the dismissal and explain the Enrollee's right to request IRE review of the dismissal, which must be filed within sixty (60) calendar days from the date of receipt of CalOptima Health's written dismissal notice.

b. CalOptima Health's dismissal of an Appeal request shall be binding unless:

i. The Enrollee or other Appealing party requests review by the IRE or the dismissal is vacated by CalOptima Health under the applicable regulation.

ii. The Appeal is modified or reversed by CalOptima Health, as applicable, upon reconsideration or vacated.

iii. A party meets the amount in controversy threshold requirements necessary for the right to a review by an Administrative Law Judge (ALJ) or attorney adjudicator and the party files a proper request for review with the Office of Medicare Hearings and Appeals.

iv. A party submits a request to vacate a dismissal and the request contains sufficient evidence or other documentation that supports good cause for vacating.

a) If CalOptima Health makes a favorable good cause determination, it shall vacate its prior dismissal action and process the appeal within sixty (60) calendar days if an extension is applied, of vacating the dismissal.

b) CalOptima Health shall document the good cause determination in the case file.

c. If CalOptima Health does not find good cause to vacate a dismissal request, the dismissal shall remain in effect.

i. CalOptima Health shall notify the Enrollee, in writing (not Notice of Dismissal), explaining that good cause has not been established and the dismissal cannot be vacated.

ii. CalOptima Health shall explain in clear language, why the information submitted with the request to vacate the dismissal does not establish good cause to vacate the dismissal action.

d. If CalOptima Health or the IRE establish good cause for vacating an issued dismissal of an Appeal within six (6) months of the date of the dismissal, the dismissal may be vacated.

e. If the IRE requests to review CalOptima Health's dismissal of an Appeal request by obtaining a case file, CalOptima Health GARS shall:

i. Assemble and forward the case file (in accordance with Section III.F.5.b. of this policy, as appropriate) to the IRE via mail or submit through the IRE Quality Independent Contractor (QIC) Appeals web portal within twenty-four (24) hours of receipt of the IRE's case file request.

f. If the IRE vacates the dismissal and remands the case to CalOptima Health for appeal processing:

i. CalOptima Health GARS shall document the appeal case with the notice and requested action ensuring processing of the appeal within sixty (60) calendar days of receipt of the IRE's remand order.

ii. The adjudication timeframe begins when any department within CalOptima Health receives the IRE's remand order vacating CalOptima Health's dismissal of appeal request.

iii. The IRE's decision regarding CalOptima Health's dismissal of an appeal request is binding and not subject to further review.

g. Dismissal Notice: If CalOptima Health dismisses an Appeal request, CalOptima Health shall mail or otherwise transmit a written notice of the dismissal to the appropriate parties at their last known address no later than sixty (60) calendar days using the Notice of Dismissal of Appeal Request. The notice shall state the following:

i. The reason for the dismissal.

ii. The right to request that CalOptima Health vacate the dismissal action; and

iii. The right to request review of the dismissal by the IRE and that such request must be filed with the IRE within sixty (60) calendar days from the date of CalOptima Health's dismissal notice.

6. GARS staff shall prepare the case file with appropriate information and documents that include, but are not limited to, the following:

a. A copy of the Enrollee's eligibility status.

b. If the Payment Appeal involves a denied hospital claim, including emergency room claims:

i. A copy of the Enrollee's Medical Records;

ii. A copy of the notification of admission; and

A copy of the notice of Organization Determination.

c. If the Payment Appeal involves a denied ambulance claim:

i. A copy of the transport record;

ii. A copy of the Enrollee's Medical Records relating to the ambulance trip, including records from the triage or medical departments, as applicable; and

iii. A copy of the notice of Organization Determination.

d. If the Payment Appeal involves co-payment charges or co-payment reimbursement:

i. A copy of the Enrollee's Medical Records from the corresponding hospital, emergency room, or Provider office;

ii. A copy of utilization records, if the Enrollee was admitted;

iii. A copy of the notification of emergency room visit or admission; and

iv. A copy of the notice of Organization Determination.

7. GARS staff shall request necessary Medical Records using an Authorization for Use or Disclosure of Protected Health Information Form, an Appeal Information Request Form, or Medical Records Request Form.

a. GARS staff may request an Enrollee's Medical Records from any Provider by submitting an Authorization for Use or Disclosure of Protected Health Information Form, or Medical Records Request Form, to such Provider by facsimile labeled with "ENROLLEE SIGNATURE ON FILE," which shall suffice to obtain records for an Enrollee.

b. If a Provider fails to respond to a request for an Enrollee's Medical Records within five (5) calendar days after such request, GARS staff shall notify the Provider Relations Department. If the Provider Relations Department is unable to obtain the Enrollee's Medical Records within five (5) calendar days, the GARS staff shall present the Payment Appeal to the reviewer, as set forth in Section III.E. of this policy, without such Medical Records.

c. If CalOptima Health cannot obtain all relevant documentation, it shall make a decision based on the material available.

E. Upon verification that the request meets criteria for processing as a Payment Appeal, GARS staff shall send an Acknowledgement Letter, an Authorization for Use and Disclosure of Protected Health Information, and a self-addressed stamped envelope to the Appealing Party who submitted the request for Appeal within five (5) business days after CalOptima Health receives such request.

F. Payment Appeal Determination (Level 1 Appeal)

1. CalOptima Health shall designate an individual, involved in making the initial Organization Determination, to review a request for Payment Appeal.

    a. If CalOptima Health based the original denial on a lack of Medical Necessity, a physician with expertise in the field of medicine that is appropriate for the requested service, shall review the request for Appeal. The reviewing physician shall possess the appropriate level of training and expertise to evaluate the necessity of the service, but need not have the same specialty, or subspecialty, as the treating physician.

    b. If the request for Appeal involves emergency services, CalOptima Health shall apply the prudent layperson standard when making the Appeal determination.

2. GARS staff shall present the Payment Appeal to the appropriate reviewer for decision.

3. GARS staff shall document the decision made by the reviewer, including the rationale for the decision.

4. Favorable Decisions

    a. If, upon Payment Appeal, CalOptima Health completely reverses the adverse Organization Determination, GARS staff shall conduct the following:

        i. Verbal Notification: Notify the Appealing Party of the decision, verbally, no later than one (1) business day from the decision date; and.

        ii. Written Notification: Notify the Appealing Party of the decision, in writing, no later than three (3) calendar days of the verbal notice

        iii. Effectuation: Notify the Claims Department, or the Health Network, of the decision to pay the appealed claim, in accordance with the Provider's contract or the Medicare Fee for Service rates for Providers:

            a) Verify that payment has been made through the claims system, or that authorization has been issued;

            b) Ensure that CalOptima Health or the Health Network adjusts the claim for payment within sixty (60) calendar days after the date of receipt of the request for Appeal.

        iv. Ensure that the Enrollee's case file includes documentation of payment and authorization; and

        v. Note the Payment Appeal as "closed" in the Appeals database.

5. Partially Favorable, Adverse, or Untimely Decisions

    a. Partially Favorable or Adverse Decisions: If, upon Appeal, CalOptima Health affirms, in whole, or in part, the adverse Organization Determination, CalOptima Health GARS shall take the following actions:

i. Verbal Notification: Notify the Appealing Party who requested the Payment Appeal within one (1) business day after CalOptima Health makes the Appeal determination, but not more than sixty (60) calendar days after receipt of the request for Payment Appeal, and

ii. Written Notification: Notify the Appealing Party, in writing, within three (3) calendar days of the verbal notice. GARS will notify the Enrollee upon forwarding the case to the IRE of the following by using the Appeal Decision Letter:

a) Notice shall explain the resolution of and basis for the Integrated Appeal

b) Include the date it was completed; and

c) Additional information outlined in the following Section III.F.5.c. of this Policy

b. Untimely Decisions: If CalOptima Health fails to provide an Appealing Party with an Appeal determination within the timeframes specified in Sections III.C.1.-3. Of this Policy:

i. Such failure shall constitute an adverse Organization Determination; and

6. GARS staff shall mail or submit through the IRE Quality Independent Contractor (QIC) Appeals web portal, a copy of the case file to the IRE, following receipt of CalOptima Health's Payment Appeal determination, or no later than sixty (60) calendar days after receipt of the request for Appeal. The following should be included in the case file forwarded to the IRE:

a. Appeal Case File Cover Sheet;

b. Reconsideration Background Date Form (not required if submitting via IRE web portal);

c. Case Narrative;

d. Copy of the initial Adverse Organization Determination Request and Notice;

e. Copy of the Appeal Request and Notice;

f. Copy of information used to make Appeal decision, including supporting documentation (e.g., medical records, or evidence submitted by the Enrollee, provider, and/or prescriber);

g. Representation documentation for representative Appeals;

h. A complete copy of the relevant EOC on a universal digital storage device (e.g., USB flash drive (if file is not submitted via IRE web portal); and

i. Dismissal Case File Data Form.

i. If GARS staff is unable to upload the case files through the IRE QIC Appeals Portal, GARS staff may submit such case files to the IRE by standard mail no later than sixty (60) calendar days after receipt of request for Payment Appeal.

ii. Within ten (10) business days of CalOptima Health's case file submission of a Payment Appeal to the IRE, the GARS Manager or his or her designee shall review such case file to determine if CalOptima Health received an IRE Acknowledgment Letter to the Enrollee or Provider. If CalOptima Health did not receive such a letter, GARS staff shall send a letter to the IRE requesting acknowledgment of receipt of the case file using the Letter to the IRE for Acknowledgement of Receipt upon identifying no receipt of the IRE Acknowledgement Letter from the IRE.

H. IRE Determination (Level 2 Appeal of Medicare covered services)

1. The IRE will make a decision on an Appeal, in accordance with its CMS contracted timeframe.

2. The IRE may request additional information from CalOptima Health within a specified timeframe using the IRE Request for Additional Information Form. Upon receipt of such request, GARS staff shall make every effort to provide the requested information within the specified timeframe, using the Request for Information Response Cover Sheet and Request for information Response Letter to IRE.

3. If the IRE upholds CalOptima Health's adverse Organization Determination, it will notify CalOptima Health and the Enrollee or the Provider of such decision, in writing. Upon receipt of such notice, GARS staff shall place the notice in the Enrollee's Appeal file and update the Appeal tracking system.

4. If the IRE reverses, or partially reverses, CalOptima Health's determination, GARS staff shall:

   a. Send a Notice of Compliance to the Enrollee or Provider;

   b. If applicable, notify the Enrollee's Provider of the IRE's decision;

   c. Effectuation: Coordinate with the CalOptima Health's Claims Department, or the Health Network, to arrange for the payment or adjustment of the Appealed claim no later than thirty (30) calendar days after notice from the IRE;

   d. Send a notice of compliance to the IRE, using the Statement of Compliance Form within fourteen (14) calendar days after authorization, or provision of the disputed service; and

   e. Document all activities in the Appeal tracking system.

I. Administrative Law Judge (ALJ) Hearing

1. An Appealing Party that provided Covered Services to an Enrollee has the right to a hearing before an ALJ if the projected value of the disputed service meets the appropriate threshold requirement, as set forth in the Medicare Managed Care Manual.

2. An Appealing Party shall request an ALJ hearing by submitting such request:

   a. In writing to CalOptima Health, or the IRE; and

   b. Within sixty (60) calendar days after the notice from the IRE of its Appeal decision. The Appealing Party may request an extension to this timeframe for good cause by submitting a written request for such extension that includes the reason the Enrollee, the Enrollee's Authorized Representative, or a Provider cannot meet the timeframe, in accordance with Title 20, C.F.R. § 404.911.

3. If CalOptima Health receives a request for an ALJ hearing from an Appealing Party, GARS staff shall forward the request for an ALJ Hearing to the IRE. The IRE shall compile and forward the Enrollee's file to the ALJ.

4. CalOptima Health shall not have the right to request an ALJ hearing, but may remain a party to the hearing.

5. If the ALJ reverses CalOptima Health's adverse Organization Determination, in whole, or in part, CalOptima shall:

    a. Effectuation: Pay the disputed claim within sixty (60) calendar days after the date it receives notice from the ALJ reversing the Organization Determination, unless it requests Medicare Appeals Council (MAC) review of the ALJ decision, in accordance with Section III.J. of this Policy. If CalOptima Health requests MAC review of the ALJ decision, it may wait for the MAC's decision before it authorizes, or provides, the disputed service; and

    b. Inform the IRE when it effectuates the decision.

J. Medicare Appeals Council (MAC) Review

1. Any party, including CalOptima Health, that is dissatisfied with the ALJ hearing decision, including CalOptima Health, may request a MAC review of the ALJ decision or dismissal.

2. A party requesting a MAC review shall submit such request:

    a. In writing directly to the MAC; and

    b. Within sixty (60) calendar days after the date of receipt of the ALJ hearing decision or dismissal. The MAC may grant an extension if the requesting party demonstrates good cause.

3. If CalOptima Health receives an Enrollee's, an Enrollee's Authorized Representative's, or a Provider's request for a MAC review, it shall forward a copy of the request for a MAC Hearing, the Enrollee's complete case file, and a cover letter to the MAC.

4. If CalOptima Health requests a MAC Review, it shall:

    a. Submit a request for a MAC Hearing and a complete case file to the MAC;

    b. Concurrently notify the Enrollee or the Provider of CalOptima Health's request by sending the Enrollee or the Provider a copy of the request and all information submitted to the MAC; and

    c. Notify the IRE of CalOptima Health's request.

5. The MAC may initiate a review on its motion within sixty (60) calendar days after the date of an ALJ hearing decision, or dismissal. The MAC will notify all parties, in writing, of its decision to initiate such review.

6. If the MAC reverses CalOptima Health's initial adverse Organization Determination, in whole, or in part, CalOptima Health shall:

a. Effectuation: Pay the disputed claim within sixty (60) calendar days after the date it receives notice from the MAC reversing the adverse Organization Determination; and

b. Inform the IRE when it effectuates the decision.

K. Judicial Review

1. Any party, including CalOptima Health, may request judicial review of an ALJ decision if:

a. The MAC denied the party's request for review; and

b. The amount in controversy meets the threshold amount specified in the Medicare Managed Care Manual.

2. Any party, including CalOptima Health, may request judicial review of a MAC decision if:

a. The MAC denied the party's request for review; or

b. It is the final decision of CMS; and

c. The amount in controversy meets the threshold amount specified in the Medicare Managed Care Manual.

3. A party may not obtain judicial review unless the MAC has acted on the case.

4. In order to obtain judicial review, a party shall file a civil action in a district court of the United States, in accordance with Section 205(g) of the Social Security Act.

5. CalOptima Health shall notify all other parties to an Appeal prior to requesting a judicial review.

6. If the judicial review reverses CalOptima Health's adverse Organization Determination, in whole, or in part, CalOptima Health shall:

a. Effectuation: Pay the disputed claim as directed by the Court, or within sixty (60) calendar days after the date it receives notice from the judicial review reversing the Organization Determination if the Court does not specify a time for performance; and

b. Inform the IRE when it effectuates the decision.

L. Appeals Data

1. The Quality Improvement Committee (QIC) shall track, trend, and analyze Appeals data, taking into account information from other sources, including, but not limited to, Grievances, Enrollee satisfaction survey results, and disenrollment forms.

2. The QIC shall present aggregate information to the CalOptima Health Board of Directors, with recommendations for interventions, as appropriate.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Health Policy HH.1104: Complaints of Discrimination
C. CalOptima Health Policy MA.4002: Cultural and Linguistic Services
D. CalOptima Health Policy MA.9004: Expedited Pre-Service Appeal
E. Health Plan Management System (HPMS) Notice September 10, 2013, Change in Part C Reconsideration Dismissal Procedures
F. MAXIMUS Appendix: Reconsideration Case Forms and Instructions
G. MAXIMUS Federal Medicare Health Plan Reconsideration Process Manual
H. Medicare Managed Care Manual, Chapter 13
I. Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance
J. Social Security Act, §205(g)
K. Title 20, Code of Federal Regulations (C.F.R.), §404.911
L. Title 42, Code of Federal Regulations (C.F.R.), §422.560 et. seq.

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting	Action
05/05/2022	Regular Meeting of the CalOptima Board of Directors	Ratified Post-CEO Approval

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	08/01/2005	MA.9005	Payment Appeal	OneCare
Revised	10/01/2012	MA.9005	Payment Appeal	OneCare
Revised	01/01/2014	MA.9005	Payment Appeal	OneCare
Revised	12/01/2016	MA.9005	Payment Appeal	OneCare
Revised	05/01/2017	MA.9005	Payment Appeal	OneCare
Revised	04/01/2022	MA.9005	Payment Appeal	OneCare
Revised	12/01/2022	MA.9005	Payment Appeal	OneCare

IX. GLOSSARY

Term	Definition
Appeal	Any of the procedures that deal with the review of an adverse initial organization determination made by CalOptima Health on health care services or benefits under Part C the Enrollee believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the Enrollee), or on any amounts the Enrollee must pay for a service or drug defined in CFR §422.566(b) and §423.566(b). These procedures include reconsideration by, an independent review entity (IRE), adjudication by an Administrative Law Judges (ALJs), or attorney adjudicator, review by the Medicare Appeals Council (MAC), and judicial review. A reconsideration (Part C) consists of a review of an adverse initial determination, the evidence and finding upon which it was based, and any other evidence that the parties submit or that is obtained by the plan.
Appealing Party	For purposes of this Policy, this is an Enrollee, an Enrollee's Authorized Representative, or a Provider (hereinafter "Appealing Party).
Authorized Representative	An individual who is the legal representative or otherwise legally able to act on behalf of an enrollee, as the law of the State in which the beneficiary resides may allow, in order to execute an enrollment or disenrollment request; e.g., court appointed legal guardians, persons having durable power of attorney for health care decisions, or individuals authorized to make health care decisions under state surrogate consent laws, provided they have the authority to act for the beneficiary in this capacity (see §40.2.1). Form CMS-1696 may not be used to appoint an authorized representative for the purposes of enrollment and disenrollment. This form is solely for use in the claims adjudication or claim appeals process, and does not provide broad legal authority to make another individual's healthcare decisions
Covered Services	Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract.
Dismissal	A decision not to review a request for a grievance, initial determination, or appeal because it is considered invalid or does not otherwise meet Medicare Advantage or Part D requirements.
Effectuation	Authorization or provision of a benefit that a plan has approved, payment of a claim or compliance with a complete or partial reversal of a plan's original adverse determination.
Enrollee	For purposes of this policy, the term "Enrollee" will be applied both synonymously and/or in lieu of the term "Member" to reflect regulatory and/or contractual language of the Centers for Medicare and Medicaid Services (CMS). An eligible individual who has elected a Medicare Advantage, Prescription Drug, or cost plan or health care prepayment plan (HCPP).
Explanation of Benefits (EOB)	An ad hoc communication that provides Enrollees with clear and timely information about their medical claims to support informed decisions about their healthcare options.

Term	Definition
Grievance	An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. A grievance does not include, and is distinct from, a dispute of the appeal of an organization determination or coverage determination or an LEP determination.
Independent Review Entity (IRE)	For purposes of this policy, an independent entity contracted by the Centers for Medicare & Medicaid Services (CMS) to review adverse level 1 Appeal decisions made by the plan. Under Part C, an IRE can review plan dismissals
Medical Records	A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.
Enrollee	A beneficiary enrolled in the CalOptima Health OneCare program.
Non-Contracted Provider	A Provider that is not obligated by written contract to provide Covered Services to a Enrollee on behalf of CalOptima Health or a Health Network.
Organization Determination	Any determination made by OneCare with respect to any of the following: 1. Payment for temporarily Out-of-Area renal dialysis services, Emergency Services, post-stabilization care, or urgently needed services; 2. Payment for any other health services furnished by a Provider other than OneCare that the Enrollee believes: a. Are covered under Medicare; or b. If not covered under Medicare, should have been furnished, arranged for, or reimbursed by OneCare. 3. OneCare's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the Enrollee believes should be furnished or arranged for by OneCare; 4. Discontinuation of a service if the Enrollee believes that continuation of the service is medically necessary; and/or 5. OneCare's failure to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the Enrollee with timely notice of an adverse determination, such that a delay would adversely affect the Enrollee's health.
Payment Appeal	An Appeal involving an Organization Determination regarding payment for services rendered to a Enrollee.
Provider	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, or other person or institution who furnishes Covered Services.

Term	Definition
Reconsideration	For purposes of this policy, Under Part C, the first level in the appeals process which involves a review of an adverse organization determination by an MA plan, the evidence and findings upon which it was based, and any other evidence submitted by a party to the organization determination, the MA plan or CMS. Under Part D, the second level in the appeals process which involves a review of an adverse coverage determination by an independent review entity (IRE), the evidence and findings upon which it was based, and any other evidence the enrollee submits, or the IRE obtains. As used in this guidance, the term may refer to the first level in the Part C appeals process in which the MA plan reviews an adverse Part C organization determination or the second level of appeal in both the Part C and Part D appeals process in which an independent review entity reviews an adverse plan decision.
Representative	For purposes of this policy under Part C, as defined in §422.561, an individual appointed by an enrollee or other party, or authorized under state or other applicable law, to act on behalf of an enrollee or other party involved in a grievance, organization determination, or appeal. Under Part D §423.560 *defines "representative" as* an individual either appointed by an enrollee or authorized under state or other applicable law to act on behalf of the enrollee in filing a grievance, obtaining a coverage determination, or in dealing with any of the levels of the appeals process. For both Part C & Part D, *unless otherwise provided in the applicable law,* the representative will have all of the rights and responsibilities of an enrollee or other party, as applicable.
Representative Form	For purposes of this Policy, a term used to collectively refer to an Appointment of Representative Form or equivalent written notice.
Withdrawal	A voluntary verbal or written request to rescind or cancel a pending grievance, initial determination, or appeal request submitted by the same party.