Policy:	MA.9015
Title:	**Standard Integrated Appeals**
Department:	Grievance and Appeals Resolution Services
Section:	Not Applicable
CEO Approval:	*/s/ Michael Hunn 02/21/2025*
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Applicable to:	☐ Medi-Cal ☒ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy addresses Part C Appeals and describes the procedures specific to a standard process for Integrated Appeals involving Medi-Cal and Medicare Covered Services and benefits, consistent with the Centers for Medicare & Medicaid Services (CMS) and Department of Health Care Services (DHCS) requirements.

II. POLICY

A. CalOptima Health shall establish and maintain a process that addresses the receipt, handling, and disposition of a Part C Integrated Appeal (hereinafter, Appeal) involving Medi-Cal and/or Medicare Covered Services and benefits, in accordance with applicable statutes, regulations, contractual requirements, and the terms and conditions of this policy.

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

C. Subject to the provisions of this policy, an Appealing Party has the right to request an Appeal of:

1. A Pre-Service Organization Determination; or

2. An Organization Determination regarding payment for services rendered to an Enrollee.

    a. If a Provider files an appeal regarding payment for services rendered on behalf of an Enrollee, the Provider may not charge a fee to the Member for doing so.

D. A Member shall have the right to an attorney, or other representation, in the Appeal process.

E. Subject to the provisions of this policy, CalOptima Health shall process an Appeal within thirty (30) calendar days, after receipt of the Appeal.

F. Subject to the provisions of this policy, CalOptima Health shall process an Appeal involving Part B drugs within seven (7) calendar days after receipt of such Appeal type.

1. Part B drug cases do not apply to Appeals regarding payment for services already rendered to an Enrollee.

2. Part B drug timeframes cannot be extended.

G. If an Appeal involves multiple issues, CalOptima Health shall process each issue separately and simultaneously under the appropriate process.

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

I. If the Appealing Party believes that CalOptima Health's thirty (30) calendar day Appeal process for Appeals of a Pre-Service Organization Determination may seriously jeopardize the Enrollee's life, health, or ability to regain maximum function, the Enrollee, the Enrollee's Authorized Representative, or physician may request an expedited Appeal, in accordance with CalOptima Health Policy MA.9004: Expedited Pre-Service Integrated Appeal.

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

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

L. CalOptima Health shall ensure that Enrollees have equal access to, and can fully participate in, the 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 DD.2002: 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.

M. CalOptima Health shall provide all parties to an 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.

1. CalOptima Health shall inform the party of their right to request a fourteen (14) day extension if the party feels they will need additional time to submit such evidence.

N. Upon an Enrollee's request for a copy of the contents of the case file, at any point during 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 decision. Where an Enrollee has an alternate format preference, the case file contents must be provided in that format.

a. Make every reasonable effort to accommodate an Enrollee's 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 Appeal decision.

b. 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 (CFR) 164 Subpart E, regarding the privacy of individual identifiable health information).

c. CalOptima Health shall provide records at no cost.

O. CalOptima Health shall notify Enrollees about any changes to its Appeals procedures thirty (30) days in advance of the effective date of change.

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

1. Upon initial enrollment, and annually thereafter;

2. In the OneCare Evidence of Coverage (EOC) and periodic Enrollee newsletters;

3. In all notices of adverse Organization Determination;

4. Upon involuntary disenrollment; and

5. Upon the Enrollee's request.

Q. Non-contracted Provider Appeal requests related to claim disputes shall be processed in accordance with CalOptima Health Policy MA.9009: Non-Contract Provider Payment Appeals.

R. Any potential quality of care issues shall be referred to the Quality Improvement (QI) Department in accordance with CalOptima Health Policy GG.1611: Potential Quality Issue Review Process.

S. Continuation of Benefits While Pending an Appeal

1. An Enrollee or an Enrollee's Authorized Representative or treating Provider, may request that the Enrollee continue to receive the previously authorized service or item while the Appeal is pending if:

a. The request for continuation was submitted by the later of the following: within ten (10) calendar days after CalOptima Health send the notice of its integrated Organization Determination, or the intended effective date of the integrated Organization Determination;

b. The Appeal was timely submitted;

c. The services meet the continuation of coverage standards;

d. The Appeal involves the termination, suspension, or reduction of previously authorized services; and

d. The period covering the initial authorization has not yet expired.

2. If the Provider requests that the benefits continue while the Appeal is pending, pursuant to Title 42 CFR §422.632 and consistent with state law or other applicable laws, the Provider must obtain the written consent of the Enrollee to request the Appeal on behalf of the Enrollee.

    a. If the Provider does not provide the Enrollee's written consent to continue benefits at the time the request is made, but the Appeal is otherwise valid, CalOptima Health should begin processing the Appeal.

    b. The consent must state that the Enrollee has given the Provider permission to request that the service or item continue while the Appeal is pending.

    c. CalOptima Health shall not provide continuation of benefits unless it receives the Enrollee's written consent (delivered either via the Provider or directly from the Enrollee or their Authorized Representative requesting continuation of benefits).

    d. Such request must be received in accordance with the timeframes outlined in Section II.S.1. of this policy.

3. If the request to continue the service or items meets the requirements listed in Section II.S.1. of this Policy, CalOptima Health must continue to provide the service or item, at the previously authorized level until:

    a. The Enrollee withdraws the request for the Appeal,

    b. CalOptima Health issues an Appeal determination that is unfavorable to the Enrollee,

    c. For Medi-Cal Covered Services and items only:

        i. The Enrollee fails to file a request for a State Fair Hearing and continuation of benefits, within ten (10) calendar days after CalOptima Health sends the notice of the Appeal;

        ii. The Enrollee withdraws the Appeal or request for a State Fair Hearing; or

        iii. A State Fair Hearing Officer issues a hearing decision adverse to the Enrollee.

4. If CalOptima Health or the State Fair Hearing entity issues a decision that is adverse to the Enrollee, CalOptima Health or the State agency may not pursue recovery for costs of services furnished CalOptima Health while the Integrated Appeal was pending if the services were furnished solely under the requirements of Title 42 CFR §422.632.

5. If, after the Appeal decision is final, an Enrollee requests that Medi-Cal Covered Services continue until a State Fair Hearing decision is made, state rules on recovery costs, in accordance with the requirements of Title 42 CFR §438.420(d), apply for costs incurred for items and services provided the Enrollee after the date that the Appeal decision was made.

T. CalOptima Health is responsible for reaching out to and engaging Members who are identified to be eligible for Enhanced Care Management (ECM), in accordance with CalOptima Health Policy GG.1353: CalAIM Enhanced Care Management Service Delivery.

III. PROCEDURE

A. Parties to a Standard Appeal

1. An Enrollee, an individual appointed by the Enrollee (e.g., relative, friend, advocate, attorney), or any person authorized under State law acting as the Enrollee's Authorized Representative may file an Appeal. If an Authorized Representative files an Appeal, he or she shall submit documentation of such appointment, as follows:

    a. Appropriate legal documents, or authority, supporting such appointment, or another form that meets state and Medicare requirements (as applicable to the Covered Service or benefit); or

    b. 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.

    c. For cases only involving a Medi-Cal covered benefit, CalOptima Health may accept a written authorization from an Enrollee that complies with state Medi-Cal requirements (even if such authorization does not contain every element described under Section 20.2 of the CMS Grievance and Appeals Guidance).

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 an 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 Policy MA.9009: Non-Contracted Provider Payment Appeals, if such Non-Contracted Provider:

    a. Furnished a Covered Service to a Member; and

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

4. A Provider who is providing treatment to the Enrollee may file an Appeal on behalf of the Enrollee. The Provider must give the Enrollee notice of filing the Appeal.

    a. A Provider who is providing treatment to the Member may, upon providing notice to the Member, file a standard Appeal on behalf of the Member, but may not file an expedited Appeal related to a payment request on behalf of the Member, in accordance with this policy.

b. If the Enrollee's records indicate that he or she has not previously visited the requesting Provider, CalOptima Health shall undertake reasonable efforts to confirm that the Enrollee has received the appropriate notification of the Appeal request.

c. A Provider shall not charge an Enrollee to act as the Enrollee's Authorized Representative.

5. Any other Provider or entity (other than CalOptima) determined to have an appealable interest.

B. Request for an Appeal (Level 1 Appeal)

1. Timely Filing Requirements: An Appealing Party may request an Appeal verbally, by telephone, in-person with the Customer Service Department, or in writing to CalOptima Health within sixty-five (65) calendar days from the date of the receipt of notice of an initial adverse Organization Determination, or an Explanation of Benefits (EOB).

a. CalOptima Health may accept a request for an Appeal filed after the sixty-five (65) 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 written statement explaining why the request for 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 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 an Enrollee in the determination of good cause justification when an Appeal request is outside the sixty-five (65) 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 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 Appeal process;

g) The Appealing Party's lack of capacity to understand the 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 DD.2002: 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 a senior center), on account of his or her disability, in order to be able to file the Appeal.

b. 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. An 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. An Appeal request is received through CalOptima Health's website.

3. Withdrawal of an Appeal Request: An Appealing Party 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 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 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.h. 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 Appeals that incorrectly receives an 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.

5. An Appealing Party may request an expedited Appeal for Appeals of a Pre-Service Organization Determination, in accordance with CalOptima Health Policy MA.9004: Expedited Pre-Service Integrated Appeal.

C. Standard Appeal Timeframe (Level 1 Appeal)

1. Subject to the provisions of this Policy, CalOptima Health shall make an Appeal determination, as expeditiously as the Enrollee's case requires, based on the Enrollee's health status, but not later than thirty (30) calendar days upon receipt of a request for an Appeal for items and services. Part B drug timeframes cannot be extended, and a decision will be rendered within seven (7) calendar days of receipt.

2. CalOptima Health may extend the timeframe for an Appeal determination for items and services up to fourteen (14) calendar days upon the Enrollee's request (except for Part B drugs); or if CalOptima Health needs additional information to make a determination and there is a reasonable likelihood that receipt of such information would lead to approval of the request if received, and such extension is justified and in the Enrollee's interest due to the need for additional medical evidence from a non-contracted Provider that may change CalOptima Health's decision to deny an item or service; or it is the Enrollee's best interest due to extraordinary, exigent, or other non-routine circumstances, such as a natural disaster. If CalOptima Health extends the timeframe for an Appeal determination, it shall notify the Enrollee as follows:

a. Verbal Notification: Notify the Appealing Party and all involved parties of the decision to extend the timeframe for an Appeal determination, verbally, no later than one (1) business day from such decision; and

b. Written Notification: Notify the Enrollee of the decision, in writing, no later than two (2) calendar days of the verbal notice and include:

i. The reason for the extension; and

ii. The Enrollee's right to file an expedited Grievance, in accordance with CalOptima Health Policy MA.9002: Enrollee Grievance Process, if he or she disagrees with CalOptima Health's decision to extend the timeframe.

D. Standard Appeal Processing (Level 1 Appeal)

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 Appeal, notice of CalOptima Health's or the Health Network's adverse Organization Determination, and all other correspondence.

2. If after a standard Appeal request is initiated and a Provider indicates that the Enrollee's health requires an expedited decision, the Provider may request to change the review priority (i.e., from standard to expedited).

    a. CalOptima Health shall begin the applicable expedited review period at the time CalOptima Health receives the Provider's request to expedite the decision.

    b. Change of review priority does not allow for extra review time.

    c. If the remaining standard review period is less than the applicable expedited review period, the original standard deadline shall still apply.

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

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

    b. GARS staff shall send an acknowledgement letter for verbal Appeal requests to the Enrollee to confirm the facts and basis of the 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.

4. GARS staff shall verify that the request meets criteria for processing as an Appeal:

    a. GARS staff shall verify that the requestor is an Enrollee, the Enrollee's Authorized Representative, treating physician acting on behalf of the Enrollee, or staff of physician's office acting on said physician's behalf or working under the direction of the physician. 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 an 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 make and document at least two (2) telephone calls to the requestor in an attempt to obtain documentation.

        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 within thirty (30) calendar days after CalOptima Health's receipt of the Appeal, CalOptima

Health shall dismiss the Appeal as detailed in Section III.D.5. of this Policy due to lack of the required documentation to process the request.

iv. A valid request, in accordance with Title 42 §§ 422.582(a) and 423.582(a), includes sufficient information to identify the Enrollee to allow CalOptima Health to adjudicate the request (or, at a minimum, make contact with the Enrollee to clarify the request), including a full name or Member ID number or at least one (1) means of contact (e.g., address, telephone number, email).

5. The list of circumstances (taken from the applicable regulations) under which CalOptima Health must dismiss a request for a level 1 Appeal is exhaustive. CalOptima Health may not deem a request invalid or dismiss a request for a level 1 Appeal for any reason not explicitly included in Title 42 CFR §§ 422.582(f) and 423.582(e), as applicable

   a. GARS staff shall verify whether:

      i. CalOptima Health or a Health Network denied a service.

         a) If CalOptima Health or a Health Network did not deny a service, GARS staff shall contact the Appealing Party to determine the purpose of the request for Appeal.

      ii. CalOptima Health or a Health Network denied a claim for payment.

         a) If CalOptima Health or a Health Network did not process the claim, GARS staff shall transmit the claim to the CalOptima Health 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.

         b) If CalOptima Health or a Health Network did not deny the claim, GARS staff shall determine if the Member 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-five (65) days after the date of notice. If CalOptima Health received the request later than sixty-five (65) days after the date of notice, GARS staff shall provide the over sixty-five (65) day letter to the Appealing Party, indicating that the request does not meet criteria for Appeal unless the Appealing Party provides good cause for an extension, in accordance with Section III.B.1.a.5). of this policy.

   d. If CalOptima Health determines an Enrollee's Appeal was misclassified as a Grievance and later discovers the error, CalOptima Health shall notify the Enrollee, in writing, of the misclassified Appeal, and immediately process the reclassified Appeal through the Appeal process in accordance with this Policy. CalOptima Health shall consider the date of receipt of the original request as the date of receipt of the Appeal and not the date the misclassification was discovered.

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

5. Dismissal of Appeal Request

    a. CalOptima Health shall dismiss an 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 thirty (30) calendar days.

        ii. If the Appealing Party fails to file the Appeal within sixty-five (65) 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 (e.g., receipt from Enrollee; Provider claim) to process an Appeal of an Organization Determination regarding payment for services rendered to an Enrollee (i.e., a payment request).

            a) CalOptima Health shall send a written Notice of Dismissal of Appeal Request form to the Member or Member'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 Member'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 thirty (30) calendar days 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 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 thirty (30) 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 thirty (30) calendar days using the Notice of Dismissal of Appeal Request. The notice shall state the following:

i. The reason for the Dismissal.

Note: The circumstances (taken from the applicable regulations) under which the IRE must dismiss a level 2 Appeal is exhaustive. The IRE may not deem a request invalid or dismiss a level 2 Appeal for any reason not explicitly included in Title 42 CFR §§ 422.592(d) and 423.600(g), as applicable.

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. The case file for all Appeals which shall include:

      i. A copy of the Enrollee's eligibility status; and

      ii. A copy of the Appealing Party's request for Appeal.

   b. The case file for Appeals of a Pre-Service Organization Determination:

      i. If the Appeal involves non-coverage of a hospital or Skilled Nursing Facility (SNF) stay, the case file shall include:

         a) A copy of the Enrollee's Medical Records from the corresponding hospital, or SNF;

         b) A copy of utilization records related to admission and discharge; and

         c) A copy of a signed non-coverage letter to the Enrollee, or his or her Authorized Representative, or a copy of the certified mail receipt.

      ii. If the Appeal involves non-coverage of home health care, the case file shall include:

         a) A copy of the Enrollee's home health records;

         b) A copy of the Enrollee's Medical Records from the Enrollee's physician; and

         c) A copy of the Enrollee's discharge notification.

      iii. If the Appeal involves a pre-service denial or non-authorization, the case file shall include:

         a) A copy of all records considered at the time of denial;

         b) A copy of the notice of Organization Determination; and

         c) Any additional Medical Records mentioned by the Enrollee, or Provider.

      iv. If the Appeal involves a Covered Service that does not meet criteria, the case file shall include:

         a) A copy of all records considered at the time of denial; and

         b) A copy of the notice of Organization Determination.

   c. The case file for Appeals of an Organization Determination regarding payment for services rendered to an Enrollee:

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

a) A copy of the Enrollee's Medical Records;

b) A copy of the notification of admission; and

c) A copy of the notice of Organization Determination.

ii. If the Appeal involves a denied ambulance claim:

a) A copy of the transport record;

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

c) A copy of the notice of Organization Determination.

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

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

b) A copy of utilization records if the Enrollee was admitted;

c) A copy of the notification of emergency room visit or admission; and

d) A copy of the notice of Organization Determination.

7. GARS staff shall request necessary Medical Records using an Authorization for Use and 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 and Disclosure of Protected Health Information Form to such Provider by facsimile labeled with "MEMBER 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 Appeal to the Medical Director without such Medical Records.

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

8. Upon verification that the request meets criteria for processing as an Appeal, GARS staff shall send an Acknowledgment 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.

E. Standard Appeal Determination (Level 1 Appeal)

1. CalOptima Health shall designate an individual, who was neither involved in any previous levels of review or decision-making nor a subordinate of any such individual making the initial Organization Determination, to review a request for Appeal.

    a. If CalOptima Health based the original denial on a lack of Medical Necessity, a physician or other appropriate health care professional with clinical 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, in treating the Enrollee's condition or disease and knowledge of Medicare and Medi-Cal coverage criteria 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.

    c. For Medicare Covered Services and Items only:

        i. If CalOptima Health identifies that the Enrollee has received the requested benefit (i.e., item, service, Part B drug) before CalOptima Health completes its Appeal determination.

        ii. CalOptima Health shall finish adjudicating the Appeal request and issue a substantive decision consistent with the applicable requirements. If applicable, CalOptima Health will separately process and issue a decision on any related claim or reimbursement request.

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

3. GARS staff shall document the decision and the rationale for the decision in CalOptima Health's database.

4. Favorable Decisions

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

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

        ii. Written Notification: Notify the Enrollee of the decision, in writing, no later than two (2) calendar days of the verbal notice and no later than (30) thirty calendar days.

        iii. Effectuation.

            a) Standard Appeals

                i) Appeals of Pre-Service Organization Determinations: Coordinate with CalOptima Health's Utilization Management (UM) Department or the Enrollee's Health Network to authorize or provide the disputed service.

                ii) Appeals of an Organization Determination regarding payment for services rendered to an Enrollee: Notify the Claims Department, or the Health Network,

of the decision to pay the appeals claim, in accordance with the Provider's contract or the Medicare Fee for Service rates for Providers.

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

2) The payment does not need to be in the hands of the requestor to be considered effectuated; authorization of the payment is sufficient.

iii) Ensure that CalOptima Health or the Health Network authorized or provides the disputed service or adjusts the claim payment as expeditiously as the Enrollee's health condition requires, but

1) No later than the earlier of seventy-two (72) hours from the Integrated Appeal decision date (i.e., CalOptima Health's decision); or receipt of the notice of a decision (i.e., for a State Fair Hearing decision); or

2) No later than thirty (30) calendar days after CalOptima Health's receipt of the request for Appeal.

b) Standard Part B Drug Appeals: No later than the earlier of seven (7) calendar days after the date CalOptima Health receives the request for the Appeal.

iv. Notify the Enrollee's requesting Provider of CalOptima Health's decision.

v. Ensure that the Enrollee's case file includes documentation of the authorization or provision; and

vi. Note the 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 of CalOptima Health's decision, verbally, within one (1) business day after CalOptima Health makes the Appeal determination, but not later than thirty (30) calendar days after receipt of the request for Appeal; and

ii. Written Notification: Notify the Appealing Party, in writing, within two (2) calendar days of the verbal notice and no later than thirty (30) calendar days. GARS will notify the Enrollee upon forwarding the case to the IRE of the following by using the model Appeal Decision Letter:

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

b) Include the date it was completed; and

c) Additional information outlined in the following Section III.E.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. Of this policy:

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

   ii. CalOptima Health shall send a notice to the Enrollee using the Appeal Decision Letter, providing the information outlined in the following Section III.E.5.c. of this policy.

c. Partially Favorable, Adverse, and Untimely Decisions:

   i. CalOptima Health shall identify, where appropriate, whether the benefit(s) at issue are covered by Medicare or Medi-Cal or potentially both.

   ii. CalOptima Health shall send a notice (i.e., using the Appeal Decision Letter) to the Enrollee that is written in plain language and available in a language and format that is accessible to the Enrollee. The Notice shall explain the following:

      a) The next level of both the Medi-Cal and Medicare Appeals process,

      b) The steps the Enrollee needs to take to make the next level Appeal under each program.

         i) Medicare Appeal cases: CalOptima Health shall auto forward the case to the IRE the complete case file of the Appeal request to the IRE, no later than thirty (30) calendar days after receiving the request for Appeal, in accordance with Section III.E.6. of this Policy (Enrollee does not need to take any action).

         ii) Medi-Cal Appeal cases: The Enrollee may choose to file for a State Fair Hearing or, if applicable, a Medi-Cal external medical review (in accordance with 42 CFR § 438.402I(1)(i)(B)).

      c) Provide information on how the Enrollee can obtain assistance in pursuing the next level of Appeal under each program, and

      d) Next level Appeal rights for both Medicare and Medi-Cal Covered Services and benefits.

         i) Medicare covered benefits:

            1) Notice must include that CalOptima Health has forwarded the case to the IRE;

            2) Advise the Enrollee of his or her rights to submit additional evidence that may be pertinent to the Enrollee's case;

            3) Direct the Enrollee to submit such evidence to the IRE; and

            4) Include information regarding how the Enrollee may contact the IRE.

         ii) Medi-Cal covered benefits:

1) Notice must include information that Enrollee can have the benefits continue while the Appeal is pending with a State Fair Hearing; and

2) How the Enrollee should make such request (if applicable);

iii) Medicare and Medi-Cal covered benefits:

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1) The notice to the Enrollee shall advise that the case has been forwarded to the IRE; and

2) The Enrollee shall be informed of the right to a State Fair Hearing under there Medi-Cal Appeal rights

6. GARS staff shall mail or submit through the IRE QIC Appeals web portal, a copy of the case file to the IRE, following receipt of CalOptima Health's Appeal determination as follows:

   a. Standard Appeal: As expeditiously as the Enrollee's health condition requires, or no later than thirty (30) calendar days after receipt of the request for Appeal; or

   b. Part B Drug Appeals: Within twenty-four (24) hours of CalOptima Health's Appeal determination.

   c. If GARS staff is unable to upload the case files (standard Appeal or standard Part B Drug Appeal) through the IRE QIC Appeals Portal, GARS staff shall submit such case files to the IRE by overnight mail/next day delivery, within twenty-four (24) hours after the decision is rendered.

   d. The following should be included in the case file forwarded to the IRE:

      i. Appeal Case File Cover Sheet;

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

      iii. Case Narrative;

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

      v. Copy of the Appeal Request and Notice;

      vi. 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);

      vii. Representation documentation for representative Appeals;

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

      ix. Dismissal Case File Data Form.

7. Within ten (10) business days of CalOptima Health's case file submission of a standard 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 Member. 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 CalOptima Health Letter to IRE for acknowledgement of receipt upon identifying no receipt of the IRE Acknowledgement Letter from the IRE.

F. State Fair Hearing (Level 2 Appeal of Medi-Cal Covered Services)

1. For cases involving Medi-Cal Covered Services, the appropriate Appealing Parties have the right to access the State Fair Hearing process in accordance with CalOptima Health Policy HH.1108: State Hearing Process and Procedures.

2. If a State Fair Hearing Officer reverses CalOptima Health's integrated Appeal decision to deny, limit, or delay a Medi-Cal Covered Service or benefit that was not furnished while the Appeal was pending:

    a. Effectuation: CalOptima Health GARS must coordinate with the appropriate CalOptima departments or the Enrollee's Health Network to either authorize or provide the disputed item or service or adjust the claim payment promptly and as expeditiously as the Enrollee's health condition required, but no later than seventy-two (72) hours from the date it receives notice to reverse the determination.

G. IRE Determination (Level 2 Appeal Request of Medicare Covered Services)

1. The IRE will make a decision on an Appeal request as quickly as the Enrollee's health requires, but no later than 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 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 adverse Organization Determination, GARS staff shall conduct the following:

    a. Send a Notice of Compliance letter to the Enrollee;

    b. Notify the Enrollee's Provider of the IRE's decision;

    c. Effectuation: CalOptima Health GARS must coordinate with the appropriate CalOptima departments or the Enrollee's Health Network to either authorize or provide the disputed item or service or adjust the claim payment, promptly and as expeditiously as the Enrollee's health condition required:

        i. But not later than fourteen (14) calendar days after notice of such reversal from the IRE; or

ii. Within seventy-two (72) hours after notice of such reversal 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.

H. Administrative Law Judge (ALJ) Hearing

1. An Appealing Party has the right to a hearing before an ALJ if the projected value of the disputed service is within the threshold amount set by CMS.

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

a. In writing to CalOptima Health, or to 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 or the Enrollee's Authorized Representative cannot meet the timeframe, in accordance with Title 20 CFR § 404.911.

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

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

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

a. Effectuation: Coordinate with the appropriate CalOptima departments or the Enrollee's Health Network to either authorize or provide the disputed item or service or adjust the claim payment, as expeditiously as the Enrollee's health condition requires, but no later than sixty (60) calendar days after the date it receives notice from the ALJ reversing the determination, unless CalOptima Health requests Medicare Appeals Council (MAC) review of the ALJ decision, in accordance with Section III.I. of this policy. If CalOptima Health requests a 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, in writing, when it effectuates the decision.

I. Medicare Appeals Council (MAC) Review

1. Any party 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 Appealing Party's request for a MAC review, it shall forward a copy of the Enrollee's request for MAC review, 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 written request to the MAC;

   b. Concurrently notify the Enrollee of CalOptima Health's request by sending the Enrollee 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 own 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 adverse Organization Determination, in whole or in part, CalOptima Health shall:

   a. Effectuation: Coordinate with the appropriate CalOptima Health departments or the Enrollee's Health Network to either authorize or provide the disputed item or service or adjust the claim payment, as expeditiously as the Enrollee's health condition requires, but no later than sixty (60) calendar days after the date it receives notice from the MAC reversing the adverse Organization Determination; and

   b. Inform the IRE, in writing, when it effectuates the decision.

J. Judicial Review

1. Any party, including CalOptima Health, may request a 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 CMS designated amount for judicial review.

2. Any party, including CalOptima Health, may request a 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 CMS designated amount for judicial reviews.

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 judicial review.

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

    a. Effectuation: Coordinate with the appropriate CalOptima departments or the Enrollee's Health Network to either authorize or provide the disputed item or service or adjust the claim payment, as expeditiously as the Enrollee's health condition requires, but no later than sixty (60) calendar days after the date it receives notice from the judicial review reversing the Organization Determination; and

    b. Inform the IRE, in writing, when it effectuates the decision.

K. 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.

3. GARS shall present to the Quality Improvement Health Equity Committee (QIHEC) on a quarterly basis any trends identified including those related to health inequities, implicit bias, and discrimination. GARS will update the QIHEC on any actions taken by the GARS Committee.

4. The written record of Appeals shall be reviewed periodically by CalOptima Health's Governing Board, the Member Advisory Committee (MAC), Provider Advisory Committee (PAC), and the Chief Operations Officer (COO) or designee, all who have the authority to require corrective action. The review and recommendations of such shall be thoroughly documented.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Health Policy DD.2002: Cultural and Linguistic Services
C. CalOptima Health Policy GG.1353 CalAIM Enhanced Care Management Service Delivery
D. CalOptima Health Policy HH.1104: Complaints of Discrimination.
E. CalOptima Health Policy HH.1108: State Hearing Process and Procedures
F. CalOptima Health Policy MA.9002: Enrollee Grievance Process
G. CalOptima Health Policy MA.9004: Expedited Pre-Service Integrated Appeals
H. CalOptima Health Policy MA.9009: Non-Contracted Provider Payment Disputes
I. Health Plan Management System (HPMS) Notice September 10, 2013, Change in Part C Reconsideration Dismissal Procedures
J. MAXIMUS Appendix: Reconsideration Case Forms and Instructions
K. MAXIMUS Federal Medicare Health Plan Reconsideration Process Manual

L. Medicare Managed Care Manual, Chapter 13, Medicare Managed Care Beneficiary Grievances, Organization Determinations, and Appeals Applicable to Medicare Advantage Plans, Cost Plans, and Health Care Prepayment Plans (HCPPs)
M. Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance, Effective November 18, 2024
N. Reason Codes
O. Social Security Act, §205(g)
P. Title 20, Code of Federal Regulations (CFR), §404.911
Q. Title 42, Code of Federal Regulations (CFR), §§ 422.113(b)(1)(i), 422.2267(e)(31), 422.560, 422.582(a), 422.582(f), 422.592(d), 422.632, 422.633, 423.582(a), 423.582(e), 423.600(g), 438.420(d), et seq.

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
03/02/2023	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2023	MA.9015	Standard Integrated Appeals	OneCare
Revised	02/01/2025	MA.9015	Standard Integrated Appeals	OneCare

IX. GLOSSARY

Term	Definition
Acknowledgement Letter	A written statement acknowledging receipt of an Appeal.
Appeal	As defined at 42 CFR §422.561 and §423.560, the procedures that deal with the review of adverse initial determinations made by the plan on health care services or benefits under Part C or D 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 as defined in 42 CFR §422.566(b) and §423.566(b). These appeal procedures include a plan reconsideration or redetermination (also referred to as a level 1 appeal), a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (Council), and judicial review.
Appealing Party	For purposes of this Policy, a Member, a Member's Authorized Representative, treating physician acting on behalf of the Member, or staff of physician's office acting on said physician's behalf or working under the direction of the physician.
Authorized Representative	For purposes of this policy, an individual appointed by a Member, or a Member's parent, guardian or other party, or authorized under State or other applicable law, to act on behalf of a Member involved in an Appeal or Grievance.
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.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Dismissal	Includes a decision not to review a request for an integrated grievance, integrated appeal, or integrated organization determination because it is considered invalid or does not otherwise meet the requirements for a request for integrated grievance, integrated appeal, or integrated organization determination. Subject to the guidance in this Addendum (see, for example, Section 20.2.a and Section 50.9.1.a), wherever the Part C & D Guidance refers to a "Dismissal," the statements and guidance apply equally to integrated grievances, integrated appeals, and integrated organization determinations for applicable integrated plans.
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).

Term	Definition
Expedited Appeal	A Service Appeal in which the thirty (30) calendar day process could seriously jeopardize the Member's life, health, or ability to regain maximum function.
Governing Board	CalOptima Health's board of directors or a similar body, and/or its executive management, that has the authority to manage and direct CalOptima Health's affairs and activities, including, but not limited to, approving initiatives and establishing CalOptima Health's policies and procedures.
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
Integrated Appeal	The procedures that deal with, or result from, adverse integrated organization determinations by an applicable integrated plan on the benefits both under Part C and under state Medicaid rules the enrollee believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the enrollee), or on any amounts the enrollee must pay for a service. See 42 CFR § 422.561. Integrated appeals do not include appeals related to Part D benefits.
Integrated Grievance	A dispute or complaint that would be defined and covered, for grievances filed by an enrollee in non-applicable integrated plans, under § 422.564 or §§ 438.400 through 438.416 of this chapter. Integrated grievances do not include appeals procedures and QIO complaints, as described in § 422.564(b) and (c). An integrated grievance made by an enrollee in an applicable integrated plan is subject to the integrated grievance procedures in §§ 422.629 and 422.630. Integrated grievances do not include grievances related to Part D benefits.
Medically Necessary or Medical Necessity	The services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
Medical Record	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.
Member	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 Member on behalf of CalOptima Health or a Health Network.
Provider	Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B.

Term	Definition
Organization Determination	Any determination made by CalOptima Health 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 that the Member believes: a. Are covered under Medicare; or b. If not covered under Medicare, should have been furnished, arranged for, or reimbursed by CalOptima Health. 3. CalOptima Health's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the Member believes should be furnished or arranged for by CalOptima Health; 4. Reduction or premature discontinuation of a previously authorized service; or 5. CalOptima Health's failure to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the Member with timely notice of an adverse determination, such that a delay would adversely affect the Member's health.
Pre-Service	Review of any case or service that requires approval by OneCare or a Health Network, in whole or in part, in advance of the Member obtaining medical care or services. Pre-authorization and precertification are pre-service decisions.
Quality Improvement Committee	CalOptima Health committee that is responsible for the Quality Improvement (QI) process.
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 CalOptima Health, the evidence and findings upon which it was based, and any other evidence submitted by a party to the organization determination, CalOptima Health 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 CalOptima Health 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.
Redetermination	For purposes of this policy, first level in the Part D appeal process in which CalOptima Health reviews an adverse Part D coverage determination, including the findings upon which the decision was based, and any other evidence submitted or obtained.

Term	Definition
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 and/or equivalent written notice.
Threshold Languages	A threshold language is defined by CMS as the native language of a group who compromises five percent (5%) or more of the people served by the CMS Program.
Withdrawal	A voluntary verbal or written request to rescind or cancel a pending grievance, initial determination, or appeal request submitted by the same party.