Policy:	CMC.9005
Title:	**Payment Appeal**
Department:	Grievance and Appeals Resolution Services
Section:	Not Applicable
CEO Approval:	*/s/ Michael Hunn 08/18/2022*
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Applicable to:	☐ Medi-Cal ☐ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy outlines the process by which CalOptima shall ensure that Members have clear and reliable access to a Payment Appeal process for Medicare and Medi-Cal Covered Services that meet the requirements of the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS).

II. POLICY

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

1. Medi-Cal based Payment Appeals shall proceed pursuant to the laws and regulations governing Medi-Cal Appeals.

2. Medicare based Payment Appeals shall proceed pursuant to the laws and regulations governing Medicare Appeals.

3. Payment Appeals relating to benefits and services covered under both Medi-Cal and Medicare shall proceed pursuant to the laws and regulations governing Medi-Cal and Medicare Appeals.

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

C. Subject to the provisions of this Policy, the following parties have the right to request an Appeal in the timeframes set forth in this Policy, either orally or in writing:

1. Appealing Party for Medi-Cal based Payment Appeals: CalOptima shall assist the Appealing Party for Medi-Cal Appeal in confirming an oral Appeal in writing.

2. Appealing Party for Medicare based Payment Appeals: Such party shall have the right to request an Appeal of a Pre-Service Organization Determination.

3. Hereinafter, generic term "Appealing Party" will be used to collectively refer to appropriate parties to a Payment Appeal for both Medi-Cal and Medicare based Payment Appeals.

D. Subject to the provisions of this Policy, an Appealing Party may initiate a Payment Appeal.

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

F. Subject to the provisions of this Policy, CalOptima shall process a Medicare based Payment Appeal within sixty (60) calendar days after receipt of such Payment Appeal.

G. Subject to the provisions of this Policy, CalOptima shall process a Medi-Cal based Payment Appeal within thirty (30) calendar days after receipt of such Payment Appeal.

H. CalOptima shall notify a Member of the Payment Appeal process:

1. Upon initial enrollment and annually thereafter;

2. In the OneCare Connect Member Handbook and periodic Member newsletters;

3. In all Integrated Notices of Action; and

4. Upon the Member's request.

I. Upon request, CalOptima shall provide a Member with a copy of the contents of the Member's case file including, but not limited to, a copy of supporting Medical Records and information used to support CalOptima's decision. CalOptima shall provide records at no cost.

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

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

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

M. Notification of the Payment Appeal decision will include a single Integrated Notice of Action of Appeal rights, addressing the Member's rights under both Medicare and Medi-Cal.

N. CalOptima 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. CalOptima shall take all evidence into account when making its decision.

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

P. Payment Appeal decisions must be written in an easily understood language and format, be available in alternative formats, and in an appropriate manner that takes into consideration those with special needs. CalOptima must inform the Member that information is available in alternative formats and how to access those formats.

Q. CalOptima shall ensure that the individuals reviewing the Appeal were not involved in any previous level of review or decision-making and he or she is not a subordinate of any person involved in the initial determination.

R. Members shall have the right to request a State Hearing within one-hundred-twenty (120) calendar days from the Appeal for Medi-Cal Covered Services, in accordance with CalOptima Policy HH.1108: State Hearing Process and Procedures.

1. CalOptima shall provide the Member information about his or her right to call or write the State Department of Social Services to file a State Hearing for Medi-Cal Covered Services using any of the following methods:

a. By Mail to:

California Department of Social Services
State Hearings Division
P.O. Box 944243, MS 9-17-37
Sacramento, CA 94244-2430

b. By calling: 1-800-743-8525 or, for TDD only, 1-800-952-8349;

c. By Fax to: 1-916-309-3487;

d. By Email to: scopeofbenefits@dss.ca.gov

e. Online at www.cdss.ca.gov.

S. CalOptima and a Health Network shall inform a Member during the Appeal Process of his or her right to request a State Hearing after the internal Appeal Process has been exhausted or should have been exhausted, and of his or her right to Aid Paid Pending (i.e., continuation of benefits) for Medi-Cal covered Services, in accordance with CalOptima Policies HH.1108: State Hearings Process and Procedures and GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

T. If CalOptima fails to provide adequate notice to a Member with a visual impairment or other disabilities requiring the provision of written materials in alternative formats, within applicable federal or state timeframes, the member is deemed to have exhausted CalOptima's internal Appeal process and may immediately request a State Hearing, in accordance with CalOptima Policy HH.1108: State Hearings Process and Procedures.

U. Continuation of Benefits Pending an Appeal (i.e., Aid Paid Pending for Medi-Cal covered services).

1. Medicare covered services and benefits.

a. CalOptima shall continue providing all prior approved non-Part D Medicare covered services and benefits to Members pending completion of a Medicare based Appeal determination.

2. Medi-Cal covered services and benefits.

a. To receive continuing service on prior approved non-Part D Medi-Cal covered services that have been modified or terminated, the Appealing Party shall make the request within ten (10) calendar days after the mailing of the Integrated Notice of Action, or the last date on which the services were authorized under the immediately preceding authorization, whichever is later.

b. CalOptima shall grant Aid Paid Pending for Medi-Cal covered services while the State Hearing is pending if all of the following conditions are met:

   i. The Member filed their Appeal within the required timeframes set forth in 42 CFR 438.420;

   ii. The Appeal involves the termination, suspension, or reduction of previously authorized Covered Services;

   iii. The Covered Services were ordered by an authorized Provider;

   iv. The period covered by the original authorization has not expired; and

   v. The Member files for continuing Covered Services within ten (10) calendar days of when the NOA was sent, or before the intended effective date of the proposed adverse benefit determination.

c. CalOptima shall continue providing all prior approved Medi-Cal covered services and benefits to Members pending completion of a Medi-Cal based Appeal determination until one (1) of the following:

   i. Completion of the State Hearing process; or

   ii. Until the Member withdraws the Appeal request; or

   iii. Fails to timely request Aid Paid Pending within ten (10) calendar days of when the Integrated Notice of Action was sent off before the intended effective date of the proposed action.

d. CalOptima or a Health Network shall advise and assist the Member with the provision of Aid Paid Pending, regardless of whether the Member makes a separate request to CalOptima during the Appeal process for Medi-Cal covered services, if all of the following conditions are met:

   i. The Member filed their Appeal within the required timeframes (within ten (10) calendar days of when the Integrated Notice of Action was sent or before the intended effective date of the proposed action, whichever is later);

   ii. The Appeal involves the termination, suspension, or reduction of previously authorized Covered Services;

   iii. The Covered Services were ordered by an authorized Provider; and

   iv. The period covered by the original authorization has not expired.

V. CalOptima shall ensure that Members or a Member's Authorized Representative have equal access to, and can fully participate in, the Payment Appeal process by providing assistance to Members, or a Member's Authorized Representative, with limited English proficiency, vision disorders, or other communicative impairments by providing the following services in accordance with Policy CMC.4002: Cultural and Linguistic Services:

1. Translation of forms and responses;

2. Interpretation services;

3. Telephone relay systems;

4. Alternative formats (as set forth in DHCS All Plan Letter (APL) 21-004: Standards for Determining Threshold Languages, Nondiscrimination Requirements, And Language Assistance Services);

5. Other auxiliary aids or services; and

6. Other reasonable accommodations, as appropriate.

III. PROCEDURE

A. Parties to a Payment Appeal

1. An Appealing Party may file a Payment Appeal.

a. A Member or any individual (e.g., relative, friend, advocate, attorney) acting as the Member's 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:

i. Appropriate legal documents, or authority, supporting such appointment; or

ii. An Appointment of Representative Form, or equivalent written notice (Representative Form), signed by both the Member and the Member's Authorized Representative, except if an attorney acts as the Member'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 Member only.

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

i. Such Authorized Representative 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.

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

c. An Appealing Party for Medi-Cal based Payment Appeals may file an Authorization for Release of Protected Health Information (PHI) form, in lieu of any type of Representative Form.

2. A Provider shall not charge a fee to a Member to act as the Member's Authorized Representative.

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

B. Request for Payment Appeal

1. An Appealing Party may request a Payment Appeal by submitting a written, or verbal request to CalOptima within sixty (60) calendar days after the date of the Integrated Notice of Action.

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

      ii. 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 undergoing serious illness 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 Payment 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; or

i) The delay resulted from additional time required to produce Member documents in an accessible format pursuant to CalOptima Policy CMC.4002: Cultural and Linguistic Services.

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

   a. When any department within CalOptima 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 (or its designee);

   c. A faxed document is successfully transmitted to CalOptima, 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'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's website.

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

   a. If that party withdraws the Payment Appeal request verbally, CalOptima shall mail that party a written confirmation of the withdrawal to the party within three (3) calendar days from the date of the verbal request.

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

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

5. If a Member's request to file a Payment Appeal that is related to long-term services and support (LTSS) for which CalOptima is not responsible to process an Appeal, such as county authorized In Home Support Services (IHSS) or county authorized behavioral health services, CalOptima will assist the Member by providing contact information for their local social service agency. For IHSS Payment Appeals, the Member will be instructed to request to speak to their assigned IHSS Social Worker at 1-714-825-3000.

C. Payment Appeal Timeframe

1. Subject to the provisions of this Policy, CalOptima shall make a determination on a Medicare based Payment Appeal within sixty (60) calendar days after receipt of the request for such Appeal.

2. Subject to the provisions of this Policy, CalOptima shall make a determination on a Medi-Cal based Payment Appeal within thirty (30) calendar days after receipt of the request for such Appeal.

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

4. If CalOptima obtains information establishing good cause, the adjudication timeframe of the Payment Appeal request begins on the date CalOptima receives that information.

5. If CalOptima fails to provide an Appealing Party with an Appeal determination for services related to Medicare benefits within the timeframes specified in Section III.C.1. of this Policy:

    a. CalOptima shall consider such failure as an affirmation of the Adverse Benefits Determination; and

    b. CalOptima shall forward the complete case file of the Medicare based Payment Appeal request for Payment Appeal to the IRE within sixty (60) calendar days after receiving the request for Payment Appeal, in accordance with Section III.E.5.b-c.

    c. CalOptima GARS will notify the Appeal Party who requested the Medicare based Payment Appeal, in writing, that CalOptima forwarded the request to the IRE for final determination by using the model Notice of Appeal Status:

        i. Advise the Member of his or her rights to submit additional evidence that may be pertinent to the Member's case;

        ii. Direct the Member to submit such evidence to the IRE; and

        iii. Include information regarding how the Member may contact the IRE.

6. In most cases, a Member has one-hundred-twenty (120) calendar days to ask for a State Hearing (for Medi-Cal covered services) after the "Your Rights" notice is mailed to the Member. The timeframe is shorter (ten (10) calendar days) to ask for a hearing if a Member wants the benefits to be covered until the hearing decision is made.

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 Appeal, the Integrated Notice of Action, or a Health Network's, and all other correspondence.

2. If a Member 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 database.

b. GARS staff shall send an Acknowledgement Letter for verbal Appeal requests to the Member to confirm the facts and basis of the Payment Appeal to ensure the request is properly and accurately noted and addressed by CalOptima. Notice should advise the Member to contact CalOptima if the Acknowledgement Letter does not correctly capture the Member'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 a Member, a Member's Authorized Representative, or a Provider. If the requestor is not one of these parties GARS staff shall request, in writing, that the requestor submit documentation of the requestor's status as the Member'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.

      i. If CalOptima does not receive documentation of the requestor's status as the Member's Authorized Representative, GARS staff shall make at least two (2) telephone calls to the requestor in attempt to obtain the documentation.

      ii. If CalOptima does not receive documentation of the requestor's status as the Member's Authorized Representative within sixty (60) calendar days after CalOptima's receipt of the Payment Appeal,

         a) CalOptima shall dismiss the Appeal and notify the Member, in writing, that the request for Appeal shall be dismissed due to lack of the required documentation to process the request using the Notice of Dismissal of Appeal Request.

            1) The dismissal would be no sooner than and no later than sixty (60) calendar days.

            2) For Medicare based Appeals, the dismissal notice shall inform the Member of the process and his or her right to request a review of the dismissal by the IRE, and that such a request must be filed within sixty (60) calendar days from the date of receipt of CalOptima's written dismissal notice.

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

      i. If CalOptima, 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's claims processing and Organization Determination process.

      ii. If CalOptima, or a Health Network, did not deny the claim, GARS staff shall determine if the Member, or the Member's Authorized Representative, disputes a cost-sharing determination.

   c. GARS staff shall review the Integrated Notice of Action to verify that CalOptima received the request for Payment Appeal within sixty (60) calendar days after the date of the notice. If CalOptima received the request later than sixty (60) calendar days after the date of the

notice, GARS staff shall provide written notice, using the Appeal Received After 60 Days Letter to the Appealing Party. 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.b.i-ii. of this Policy.

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

5. If GARS staff identifies a potential quality of care issue, he or she shall forward a referral to the Quality Improvement Department, in accordance with CalOptima Policy GG.1611: Potential Quality Issue Process.

6. Upon verification that the request meets criteria for processing as a Payment 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 Payment Appeal after CalOptima receives such request.

7. 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 Payment Appeals which shall include:

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

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

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

        i. A copy of the Member's Medical Records from the corresponding hospital, or SNF;

        ii. A copy of utilization records related to admission and discharge; and

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

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

        i. A copy of the Member's home health records;

        ii. A copy of the Member's Medical Records from the Member's physician; and

        iii. A copy of the Member's discharge notification.

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

        i. A copy of all records considered at the time of denial; and

ii. A copy of the notice of Organization Determination.

e. Hospital discharge Appeals shall be processed in accordance with CalOptima Policy CMC.9007: Appeal Process for Member Discharge from Inpatient Facility.

8. 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 a Member'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 a Member.

b. If a Provider fails to respond to a request for a Member'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 Member's Medical Records within five (5) calendar days, the GARS staff shall present the Payment Appeal to the Medical Director without such Medical Records.

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

E. Payment Appeal Determination

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

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

a. Notify the Appealing Party of the decision, verbally, no later than one (1) business day from the decision date.

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

c. Notify the Claims Department, or the Health Network, of the decision to pay the appealed claim, in accordance with the Provider's contract, or Medicare Fee-for-Service rates;

d. Verify that payment has been made through the claims system, or that authorization, has been issued;

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

f. Ensure that the Member's case file includes documentation of payment and authorization; and

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

5. If, upon Appeal, CalOptima affirms, in whole, or in part, the adverse Organization Determination, CalOptima shall take the following actions:

   a. GARS staff shall notify the Appealing Party who requested the Appeal both verbally and in writing

      i. Verbally, within one (1) business day after CalOptima makes the Appeal determination; however,

         a) No more than sixty (60) calendar days after receipt of the request for a Medicare based Payment Appeal and;

         b) No more than thirty (30) calendar days after receipt of the request for a Medi-Cal based Payment Appeal.

      ii. In writing, within three (3) calendar days of the verbal notice. GARS will notify the Member upon forwarding the case to the IRE of the following by using the model Notice of Appeal Status:

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

         b) Direct the Member to submit such evidence to the IRE; and

         c) Include information regarding how the Member may contact the IRE.

   b. For Payment Appeals related to Medicare Covered Services, CalOptima will forward the Appeal to the IRE; and

      i. 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's Payment Appeal determination, within 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 Member, provider, and/or prescriber);

g) Representation documentation for representative Appeals;

h) A complete copy of the relevant EOC on a compact disc (CD) (if file is not submitted via IRE web portal); and

i) Dismissal Case File Data Form.

ii. 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 upon receipt of request for Payment Appeal.

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

c. For Payment Appeals related to Medi-Cal Covered Services, involving decisions not wholly in the Member's favor, CalOptima notice to Member shall at minimum include:

i. The Member's right to request a State Hearing;

ii. How to request a State Hearing;

iii. Right to continue to receive covered services and benefits pending a State Hearing;

iv. How to request Aid Paid Pending;

v. That Member may be liable for cost of any continued benefit if CalOptima's action is upheld on Appeal.

6. Upon an Appealing Party's request, CalOptima shall provide the Appealing Party with a copy of the contents of the Member's case file, including, but not limited to, a copy of supporting Medical Records and other pertinent information used to support CalOptima's decision. CalOptima shall provide records at no cost.

F. IRE Determination for Medicare Covered Services

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

2. The IRE may request additional information from CalOptima 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's adverse determination, it shall notify CalOptima and the Member, or the Member's Authorized Representative, of such decision in writing. Upon receipt of such notice, GARS staff shall place the notice in the Member's Appeal file and update the Appeal tracking system.

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

    a. Send a Notice of Compliance to Member or Provider

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

    c. Coordinate with the 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.

G. Administrative Law Judge (ALJ) Hearing

1. An Appealing Party foe Medicare based Appeals that provided Covered Services to a Member 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 for Medicare based Appeals shall request an ALJ hearing by submitting such request:

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

    b. Within sixty (60) calendar days after the notice from the IRE of its Appeal decision. The Appealing Party for Medicare based Appeal may request an extension to this timeframe for good cause by submitting a written request for such extension that includes the reason the Appealing Party for Medicare based Appeal cannot meet the timeframe in accordance with Title 20, Code of Federal Regulations, Section 404.911.

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

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

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

a. Pay the disputed claim within sixty (60) calendar days after the date it receives notice from the ALJ reversing the determination, unless it requests Medicare Appeals Council (MAC) review of the ALJ decision in accordance with Section III.H. of this policy. If CalOptima 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.

H. Medicare Appeals Council (MAC) Review

1. Any party that is dissatisfied with the ALJ hearing decision, including CalOptima, 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 receives an Appealing Party for Medicare based Appeal, request for a MAC review, it shall forward a copy of the Request for MAC Hearing, the Member's complete case file, and a cover letter to the MAC.

4. If CalOptima 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 Member of CalOptima's request by sending the Member a copy of the request and all information submitted to the MAC; and

c. Notify the IRE of CalOptima'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 shall notify all parties in writing of its decision to initiate such review.

6. If the MAC reverses CalOptima's adverse determination in whole, or in part, CalOptima shall:

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

b. Inform the IRE when it effectuates the decision.

I. Judicial Review

1. Any party, including CalOptima, 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 threshold amount specified in the Medicare Managed Care Manual.

2. Any party, including CalOptima, 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 threshold amount specified in the Medicare Managed Care Manual.

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

4. In order to obtain a 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 shall notify all other parties to an Appeal prior to requesting a judicial review.

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

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

   b. Inform the IRE when it effectuates the decision.

J. 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, Member satisfaction survey results, and disenrollment forms.

2. The QIC shall present aggregate information to the CalOptima Board of Directors with recommendations for interventions, as appropriate.
3. Notices, Records, and Reports

   a. CalOptima shall maintain written records of each Payment Appeal, including the date of receipt, date of resolution, Member's name, description of the problem, names of the CalOptima staff who received the Appeal and who is designated as the contact person, description of the action taken to investigate/resolve the problem, proposed resolution and all letters, for a minimum of ten (10) years from the final date of the contract period for CalOptima's contract with the CMS and/or DHCS from the date of completion of any audit, whichever is later.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Policy CMC.4002: Cultural and Linguistic Services
B. CalOptima Policy CMC.9001: Complaint Process
C. CalOptima Policy CMC.9007: Appeal Process for Member Discharge from Inpatient Facility

D. CalOptima Policy GG.1611: Potential Quality Issue Process
E. CalOptima Policy HH.1104: Complaints of Discrimination
F. CalOptima Policy HH.1108: State Hearing Process and Procedures
G. CalOptima Policy MA.9009: Non-Contracted Provider Payment Disputes
H. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
I. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-004: Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services
J. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-011: Grievance and Appeal Requirements, Notice and "Your Rights" Templates
K. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-002: Alternative Format Selection For Members With Visual Impairments
L. MAXIMUS Appendix: Reconsideration Case Form and Instructions
M. MAXIMUS Federal Medicare Health Plan Reconsideration Process Manual
N. Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance
O. Social Security Act, §205(g)
P. Title 20, Code of Federal Regulations (C.F.R.), §404.911
Q. Title 42, Code of Federal Regulations (C.F.R.), §422.560 et. seq.

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
07/01/2022	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	07/01/2015	CMC.9005	Payment Appeal	OneCare Connect
Revised	12/01/2016	CMC.9005	Payment Appeal	OneCare Connect
Revised	05/01/2017	CMC.9005	Payment Appeal	OneCare Connect
Revised	05/01/2022	CMC.9005	Payment Appeal	OneCare Connect

IX. GLOSSARY

Term	Definition
Aid Paid Pending	For purposes of this Policy; continuation of Medi-Cal Covered Services for a Member who has filed a timely request for a State Hearing as a result of a Notice of Adverse Benefit Determination of intent to terminate, suspend, or reduce an existing authorized service.
Appeal	In general, a Member's actions, both internal and external to CalOptima requesting review of CalOptima's denial, reduction or termination of benefits or services, from CalOptima. Appeals relating to Medi-Cal covered benefits and services shall proceed pursuant to the laws and regulations governing Medi-Cal Appeals. Appeals relating to Medicare covered benefits and services shall proceed pursuant to the laws and regulations governing Medicare Appeals. A Medi-Cal based Appeal is defined as review by CalOptima of an Adverse Benefit Determination.
Appealing Party for Medi-Cal based Payment Appeals	For purposes of this Policy, A Member, or a Provider or Authorized Representative acting on behalf of the Member, and with the Member's written consent.
Appealing Party for Medicare based Payment Appeals	For purposes of this Policy, this is a Member, a Member's Authorized Representative, or a Provider.
Authorized Representative	An individual either appointed by a Member or authorized under State or other applicable law to act on behalf of the Member in filing a Grievance, requesting a Prior Authorization request, or in dealing with any level of the Appeals process. Unless otherwise stated in Title 42 of the Code of Federal Regulations, Part 423, Subpart M, the representative has all of the rights and responsibilities of a Member in obtaining a Prior Authorization request or in dealing with any of the levels of the Appeals process, subject to the rules described in Part 422, Subpart M.
Complaint	A Complaint may be a Grievance or an Appeal, or a single Complaint could include both.
Centers for Medicare & Medicaid Services (CMS)	The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.
Covered Services	Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Three-Way contract with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS).
Department of Health Care Services (DHCS)	The state department in California responsible for administration of the federal Medicaid Program (referred to as Medi-Cal in California). DHCS is generally referred to as the state in this document.
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.

Term	Definition
Grievance	Any complaint or dispute, other than one that constitutes an organization determination under 42 C.F.R. § 422.566 or other than an Adverse Benefit Determination under 42 C.F.R. § 438.400, expressing dissatisfaction with any aspect of the CalOptima's or Provider's operations, activities, or behavior, regardless of whether remedial action is requested pursuant to 42 C.F.R. § 422.561. (Possible subjects for Grievances include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the Member's rights). Also called a "Complaint."
Health Network	A Physician Hospital Consortium (PHC), Physician Medical Group (PMG) under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Medi-Cal based Payment Appeals	For purposes of this Policy, Payment Appeals relating to Medi-Cal covered benefits and services.
Medical Necessity	Services must be provided in a way that provides all protections to the Member provided by Medicare and Medi-Cal. Per Medicare, services must be reasonable and necessary Covered Services for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. § 1395y. In accordance with Title XIX law and related regulations, and per Medi-Cal, medical necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury under WIC Section 14059.5.
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.
Medicare based Payment Appeals	For purposes of this Policy, Payment Appeals relating to Medicare covered benefits and services.
Member	A beneficiary enrolled in the CalOptima OneCare Connect program.
Non-Contracted Provider	A Provider that is not obligated by written contract to provide Covered Services to a Member on behalf of CalOptima or a Health Network.

Term	Definition
Organization Determination	Any determination made by OneCare Connect 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 Connect 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 OneCare Connect. 3. OneCare Connect'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 OneCare Connect; 4. Discontinuation of a service if the Member believes that continuation of the service is medically necessary; and 5. OneCare Connect'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.
Payment Appeal	An Appeal involving an Organization Determination regarding payment for services rendered to a Member.
Provider	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Health Network, physician group, or other person or institution who furnishes Covered Services.
Quality Improvement (QI) Committee	The CalOptima committee that is responsible for the Quality Improvement (QI) process.
Representative Form	For purposes of this Policy, a term used to collectively refer to an Appointment of Representative Form and/or equivalent written notice.
State Fair Hearing (State Hearing)	A quasi-judicial proceeding conducted by a judge, during which each hearing party may present arguments and evidence, including witness(es), and cross examine witness(es) against them, with respect to a decision regarding the availability or delivery of services or benefits.
Threshold Languages	As specified in annual guidance to Contractors on specific translation requirements for their service areas.