Policy:	MA.9004
Title:	**Expedited Pre-Service Integrated Appeal**
Department:	Grievance and Appeals Resolution Services
Section:	Not Applicable
CEO Approval:	*/s/ Michael Hunn 02/21/2025*
Effective Date:	10/01/2005
Revised Date:	02/01/2025
Applicable to:	☐ Medi-Cal ☒ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This Policy addresses Part C Appeals and describes the procedures by which CalOptima Health ensures that Enrollees have clear and reliable access to an expedited process for Appeals and Integrated Appeals of Pre-Service Organization Determinations involving Medi-Cal and Medicare covered services and benefits, consistent with Centers for Medicare & Medicaid Services (CMS) and Department of Health Care Services (DHCS) requirements.

II. POLICY

A. If an Appealing Party believes that CalOptima Health's thirty (30) calendar day standard Appeal process could seriously jeopardize the Enrollee's life, health, or ability to regain maximum function, the Appealing Party may request an expedited Appeal, in accordance with the terms and conditions of this Policy.

B. Subject to the requirements in the Addendum Guidance for Applicable Integrated Plans effective January 1, 2023, understanding that wherever the Part C & D Guidance refers to an "expedited Appeal," the statements and guidance apply equally to expedited Integrated Appeals for CalOptima Health. Therefore, the term expedited Appeals in this policy respectfully applies, where/when appropriate, to the expedited Integrated Appeals also.

C. CalOptima Health shall process an expedited Appeal within seventy-two (72) hours after receiving the request for an expedited Appeal.

D. The processing timeframe for an expedited Appeal shall begin when the appropriate department within CalOptima Health receives the request.

E. If CalOptima Health denies a request for an expedited Appeal, it shall process the request as a standard Appeal, in accordance with CalOptima Health Policy MA.9003: Standard Pre-Service Integrated Appeal.

F. If a physician makes, or supports, a request for an expedited Appeal, CalOptima Health shall grant such request, and shall process the request as an expedited Appeal.

G. An Enrollee shall have the right to be represented by an attorney or other representative in the expedited Appeal process.

H. Grievance and Appeal Resolution Services (GARS) Department staff shall be responsible for tracking and reporting all expedited Appeals.

I. CalOptima Health's Utilization Management Department shall be responsible for designating, training, and monitoring a clinical on-call nurse to accept and initiate the expedited Appeal process.

J. CalOptima Health or the Enrollee's Health Network shall notify the Enrollee of the expedited Appeal process:

1. Upon initial enrollment, and annually thereafter;

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

3. In all notices of adverse Organization Determination and non-coverage;

4. Upon involuntary disenrollment; and

5. Upon an Enrollee's request.

K. 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 generate, and other pertinent documents, records, or information used in connection with the Appeal and to support CalOptima Health's decision. Where a Enrollee has an alternate format preference, the case file contents must be provided in that format.

2. Make every reasonable effort to accommodate an Enrollee'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.

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

4. CalOptima Health shall provide records at no cost.

L. CalOptima Health shall provide all parties to an expedited 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. The opportunity to submit evidence is limited by the expedited Appeal timeframe requirement (i.e., seventy-two (72) hours upon receipt of request for an expedited appeal). CalOptima Health shall inform the requesting party of the conditions for submitting the evidence:

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

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

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

O. CalOptima Health shall ensure that Enrollees have equal access to, and can fully participate in, the expedited Appeal process by providing assistance to Enrollees with limited English proficiency, 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.

P. 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 CalOptima Health Policy MA.9002: Enrollee Grievance Process.

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

R. Continuation of Benefits While Pending an expedited Integrated Appeal

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

a. The request for continuation and the Integrated Appeal are both submitted within timely filing requirements.

i. Continuation Request: For the service or item to continue, the Enrollee must make the request for continuation,

a) Within ten (10) calendar days after CalOptima Health sends the notice of its integrated Organization Determination; or

b) The intended effective date of the integrated Organization Determination.

ii. Integrated Appeal Request: For the service or item to continue, the Enrollee must make the request for Integrated Appeal timely, in accordance with Section III.B.1. of this Policy.

b. The service or item was ordered by an authorized Provider.

i. If the Provider requests that the benefits continue while the Integrated Appeal is pending, pursuant to Title 42 CFR §422.632 and consistent with State law, the Provider must obtain the written consent of the Enrollee to request the Integrated 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 within the timeframes outlined in Section II.Q.1.a.1). of this Policy.

c. The Integrated 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 request to continue the service or items meets the requirements listed in Section II.Q.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 Integrated Appeal,

b. CalOptima Health issues an Integrated 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 Integrated 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.

3. 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.

4. If, after the Integrated 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 Integrated Appeal decision was made.

S. 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 an Expedited Pre-Service Appeal

1. An Enrollee or 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 expedited Appeal. If an Authorized Representative files an expedited 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 Forms) signed by both the Enrollee and the Authorized Representative, except if an attorney acts as the Authorized Representative. If an attorney acts as the Authorized Representative, the Authorized Representative may submit an Appointment of Representative Form, or equivalent written notice, signed by the Enrollee only.

    b. For cases involving only a Medi-Cal covered service or benefit, CalOptima Health may accept a written authorization from an Enrollee that complies with state Medi-Cal requirements.

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 expedited Appeal.

    a. Authorized Representatives could include, but are 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 must produce and submit appropriate legal papers supporting his or her appointment under state law (a Representative Form is not required).

3. 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 Enrollee may, upon providing notice to the Enrollee, file a standard Integrated Appeal on behalf of the Enrollee but may not file an Expedited Integrated Appeal related to a payment request on behalf of the Enrollee, in accordance with CalOptima Health Policy MA.9005: Payment Appeals and/or CalOptima Health Policy MA.9015: Standard Integrated Appeals.

    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 in accordance with Section III.A. of this Policy.

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

B. Request for an Expedited Pre-Service Appeal (Level 1 Appeal)

1. Timely Filing Requirements: If an Appealing Party believes that CalOptima Health's thirty (30) calendar day standard Appeal process may seriously jeopardize the Enrollee's life, health, or ability to regain maximum function, the Appealing Party may request an expedited Appeal verbally, by telephone, or in person with the Customer Service Department, or in writing to CalOptima Health within sixty-five (65) calendar days from the date of the notice of the initial adverse Organization Determination.

    a. CalOptima Health may accept a request for an expedited 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 an expedited 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 an expedited 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 expedited 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 being seriously ill, which prevented a timely expedited 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 expedited Appeal process;

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

            h) The Appealing Party sending 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 senior center), on account of his or her disability, in order to be able to file the expedited 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.8. and the Appealing Party may file a Grievance in accordance with CalOptima Health Policy MA.9002: Enrollee Grievance Process.

2. An expedited Appeal request shall be considered received on the date and time:

   a. When the appropriate 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 and the appropriate department within CalOptima Health receives such document;

   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 expedited Appeal request or supporting statements after normal business hours); or

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

3. Withdrawal of an expedited Appeal Request: An Appealing Party who requests an expedited Appeal, may withdraw such 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.8. 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 expedited Appeal request verbally, CalOptima Health shall

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

      ii. Mail all parties a written confirmation of the withdrawal to the party within three (3) calendar days from the date of the verbal request using the Notice of Dismissal of Appeal Request as detailed in Section III.D.8.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 expedited Appeal request, shall submit such request to the CalOptima Health Grievance and Appeals Resolution Services email inbox: grievancemailbox@caloptima.org, as expeditiously as possible for requests submitted in writing, or transfer to the CalOptima Health Customer Service Department for verbal requests.

C. Expedited Pre-Service Appeal Timeframe (Level 1 Appeal)

1. Subject to the provisions of this Policy, CalOptima Health shall make an expedited Appeal determination, as expeditiously as the Enrollee's case requires, based on the Enrollee's health status, but not later than seventy-two (72) hours after receipt of a request for such expedited Appeal for items and services, unless a fourteen (14) calendar day extension has been granted. Part B drug timeframes cannot be extended.

    a. The expedited Appeal processing timeframe begins when the appropriate CalOptima Health department receives an expedited Appeal request.

    b. If CalOptima Health obtains information establishing good cause for late filing, the adjudication timeframe of the expedited Appeal request begins on the date CalOptima Health receives that information.

    c. CalOptima Health shall inform the Enrollee or Enrollee's Authorized Representative of the right to request a fourteen (14) calendar day extension if additional time is needed to submit evidence related to an expedited Appeal.

2. CalOptima Health may extend the timeframe for an expedited Appeal determination for items and services by up to fourteen (14) additional 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 best 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. If CalOptima Health extends the timeframe for an expedited 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;

        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; and

        iii. Information that the Enrollee may resubmit the request for an expedited Appeal, and that CalOptima Health shall expedite a request for expedited Appeal that is supported by a physician.

3. Subject to the provisions of this Policy, CalOptima Health shall make an expedited Appeal determination for Part B drugs, as expeditiously as the Enrollee's case requires, based on the

Enrollee's health status, but not later than seventy-two (72) hours after receipt of a request for such Appeal type. Part B drugs timeframes cannot be extended.

D. Expedited Pre-Service Appeal Processing (Level 1 Appeal)

1. CalOptima Health shall route a request for an expedited Service Appeal as follows:

Contact Type	Monday–Friday **08:00–17:30**	Evenings **17:31–07:59**	Weekends **Friday 17:31–Monday 07:59**	Holidays **24 hrs./day**
Telephone	Route to GARS	On-call answering service directs call to the on-call nurse	On-call answering service directs call to the on-call nurse	On-call answering service directs call to the on-call nurse
Facsimile	Take to GARS immediately	N/A	N/A	N/A

2. A GARS staff member shall administer each request for expedited Appeal.

3. For expedited Appeals received by CalOptima Health after hours during the evening, or on weekends or holidays an on-call nurse shall initiate the process for such Appeal request by:

   a. Forwarding notice of CalOptima Health's or the Health Network's adverse Organization Determination and the Enrollee's Medical Records to CalOptima Health's on-call Medical Director for clinical review, to determine whether such request meets medical criteria for an expedited Appeal.

   b. Notifying the Appealing Party verbally, whether request meets medical criteria for an expedited Appeal.

      i. If request does not meet criteria, the Appeal shall be processed in accordance with Sections III.D.9.a-c. of this Policy.

      ii. If the request meets criteria, CalOptima Health's on-call Medical Director shall make a determination, as expeditiously as the Enrollee's case requires, but no later than seventy-two (72) hours after receipt of a request for such expedited Appeal.

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

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

   a. GARS staff shall confirm with the party receiving the verbal expedited Appeal that he or she verified with the Appealing Party the facts and basis of the request for expedited Appeal. The validated verbal acknowledgement 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 expedited 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.

6. If after an expedited Appeal request is initiated, the Provider may also request to change the review priority (i.e., from expedited to standard).

   a. CalOptima Health shall begin the applicable standard review period at the time CalOptima Health receives the Provider's request to change the review priority of the decision.

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

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

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

   a. GARS staff shall verify that the requestor is the 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 expedited Appeal determination.

      ii. Verbal Attempt: If CalOptima Health does not receive documentation of the requestor's status as the Enrollee's Authorized Representative, 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 seventy-two (72) hours or no later than the end of the fourteen (14) calendar day extension if CalOptima Health extended the timeframe, after CalOptima Health's receipt of the expedited Appeal, CalOptima Health shall dismiss the expedited Appeal as detailed in Section III.D.8. of this Policy due to lack of required documentation to process the request.

      iv. A valid request, in accordance with §§ 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 means of contact (e.g., address, telephone number, email).

         a) 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 Code of Federal Regulations (CFR) §§ 422.582(f) and 423.582(e), as applicable.

b. GARS staff shall determine if the Enrollee received the notice of an adverse Organization Determination, and request a copy of such notice by facsimile, or email, from the Enrollee's Health Network. If the Enrollee did not receive notice of an adverse Organization Determination, staff shall submit the request to CalOptima Health's Utilization Management Department or the Health Network to make an Organization Determination.

c. GARS staff shall review the notice of adverse Organization Determination to verify that CalOptima Health received the request for expedited 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 expedited Appeal unless the Appealing Party provides good cause for an extension, in accordance with Sections III.B.1.a.5). of this Policy.

d. If CalOptima Health determines an Enrollee's expedited Appeal was misclassified as an expedited Grievance and later discovers the error, CalOptima Health shall notify the Enrollee, in writing, of the misclassified expedited Appeal, and immediately process the reclassified expedited Appeal through the expedited 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 expedited Appeal and not as the date the misclassification was discovered.

e. Medical criteria determination for an expedited Appeal:

i. CalOptima Health's Medical Director shall determine if the request meets medical criteria for an expedited Appeal when the Appeal request is made by the Enrollee or an Enrollee's Authorized Representative.

ii. If an Enrollee's treating physician acting on behalf of the Enrollee makes or supports a request for an expedited Appeal, the request is presumed to meet medical criteria for an expedited Appeal, and CalOptima Health Medical Director review is not required.

8. Dismissal of an expedited Appeal Request

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

i. If an individual who requests an expedited Appeal is not a proper party to the expedited 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 seventy-two (72) hours or no later than the end of a fourteen (14) calendar day extension.

ii. If the Appealing Party fails to file the expedited 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 expedited 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 expedited Appeal request.

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

b. CalOptima Health's dismissal of an expedited 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 expedited 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 expedited appeal within seventy-two (72) hours or no later than the end of a fourteen (14) calendar day extension 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 expedited 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 expedited Appeal request by obtaining a case file, CalOptima Health GARS shall:

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

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

i. CalOptima Health GARS shall document the expedited appeal case with the notice and requested action ensuring processing of the expedited appeal within seventy-two (72) hours (or no later than the end of a fourteen (14) calendar day extension) of receipt of the IRE's remand order.

ii. The adjudication timeframe begins when the appropriate 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. 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:

i. For Medicare Covered Services and Items only:

a) 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.

ii. For Medi-Cal Covered Services and Items only:

a) CalOptima Health shall process the request as a request for payment in accordance with CalOptima Health Policy MA.9005: Payment Appeal, if it is able to obtain the information necessary to process a payment request (i.e., receipt from, Enrollee; provider claim); or

iii. CalOptima Health shall dismiss the Appeal request if it is unable to obtain the information necessary to process a payment request.

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

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

iv. If CalOptima Health denies payment after processing the request in accordance with CalOptima Health Policy MA.9005: Payment Appeal, CalOptima Health GARS must send the case to the IRE for reconsideration.

h. 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 seventy-two (72) hours or no later than the end of a fourteen (14) calendar day extension 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.

9. If the Enrollee's physician or CalOptima Health's Medical Director determines that the request does not meet criteria for an expedited Appeal, staff shall refer the request to the standard Appeal process, in accordance with CalOptima Health Policy MA.9003: Standard Pre-Service Integrated Appeal.

   a. Staff shall notify the Enrollee verbally no later than seventy-two (72) hours after receipt of the request for Appeal, and in writing no later than two 2) calendar days after the verbal notification with a letter that includes:

      i. Notice that CalOptima Health shall automatically transfer and process the request as a standard Appeal;

      ii. Notice that CalOptima Health shall expedite any request for Appeal in which a physician indicates that applying the standard timeframe for making a determination may seriously jeopardize the Enrollee's life, health, or ability to regain maximum function; and

      iii. The Enrollee's right to file an expedited Grievance or fast complaint, in accordance with CalOptima Health Policy MA.9002: Enrollee Grievance Process, and Grievance instructions and timeframes.

   b. If the expedited Appeal request is instead determined as a standard Appeal request, the timeframe for the Appeal determination shall begin the day CalOptima Health receives the request for expedited Appeal.

   c. If the Enrollee disagrees with CalOptima Health's decision to process the request as a standard Appeal, the Enrollee has the right to request an expedited Grievance or fast complaint, in accordance with CalOptima Health Policy MA.9002: Enrollee Grievance Process.

10. Staff shall complete the case file with appropriate information and documents that include, but are not limited to:

    a. Documentation of the Enrollee's Medicare eligibility status;

    b. The Enrollee's request for expedited Appeal;

    c. A copy of corresponding facility, home health, or physician's records;

    d. A copy of utilization records related to the Enrollee's admission and discharge;

e. A copy of a Detailed Explanation of Non-coverage (DENC), Notice of Medicare Non-Coverage (NOMNC), or other notice of non-coverage provided to the Enrollee, or Authorized Representative;

f. A copy of all records considered for the initial Organization Determination;

g. A copy of the notice of the Organization Determination; and

h. Any additional records mentioned by the Enrollee, or physician.

11. If CalOptima Health needs additional information from a Provider to make a determination, it shall request such information within twenty-four (24) hours of receipt of the request for an expedited Appeal.

E. Expedited Pre-Service 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 expedited 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 item, service, or drug in question, shall review the request for expedited 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 item, service, or drug in question, but need not be of the same specialty, or subspecialty, as the treating physician.

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

2. GARS staff shall present the expedited 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 expedited Appeal, CalOptima Health completely reverses the adverse Organization Determination, staff shall conduct the following:

i. Verbal Notification: Notify the Appealing Party who requested the expedited Appeal and all involved parties of the decision, verbally, no later than seventy-two (72) hours after CalOptima Health's receipt of the request for expedited Appeal;

ii. Written Notification: Notify the Appealing Party of the decision, in writing, no later than two (2) calendar days of the verbal notification.

iii. Effectuation: Coordinate with CalOptima Health's Utilization Management Department, or the Enrollee's Health Network, to arrange for the ordered service or continuation of services as soon as medically indicated, but not later than seventy-two (72) hours or no later than the fourteen (14) calendar day extension if CalOptima Health

extended the timeframe, after CalOptima Health receives the request for expedited 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 expedited Appeal as "closed" in the Appeal database.

5. Partially Favorable, Adverse, or Untimely Decisions

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

i. GARS staff shall notify the Appealing Party who requested the expedited Appeal of CalOptima Health's decision, verbally, no later than seventy-two (72) hours after receipt of the request for expedited Appeal, or no later than the fourteen (14) calendar day extension if CalOptima Health extended the timeframe; and

ii. Notify the Appealing Party, in writing, no later than two (2) calendar days after the verbal notification. GARS will notify the Enrollee upon forwarding the case to the IRE of the following by using the Appeal Decision Letter:

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

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

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

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

i. CalOptima Health shall consider such failure as an affirmation of the adverse Organization Determination;

ii. CalOptima Health shall forward the complete case file of the expedited Appeal request to the IRE no later than twenty-four (24) hours after the expedited Appeal decision, or no later than the fourteen (14) calendar day extension from receipt of the expedited Appeal request if CalOptima Health extended the timeframe, in accordance with Section III.E.5.b-c. of this Policy;

c. Both Partially Favorable or 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.

a) Translate the notice and include a Multi-Language Insert (MLI)

b) Notice shall comply with any applicable state Medi-Cal reading level requirement.

iii. CalOptima Health shall send the notice which explains 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.

1) 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, or no later than forty-four (44) calendar days if CalOptima Health extended the timeframe, in accordance with Section III.E.6.b. of this Policy (Enrollee does not need to take any action).

2) 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.

1) Medicare covered benefits:

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

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

(c) Direct the Enrollee to submit such evidence to the IRE; and

(d) Include information regarding how the Enrollee may contact the IRE.

2) Medi-Cal covered benefits:

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

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

3) Medicare and Medi-Cal covered benefits:

(a) The case shall be forwarded to the IRE.

(b) The Enrollee shall be informed of Medi-Cal Appeal rights.

6. GARS staff shall mail or submit through the IRE Quality Independent Contractor (QIC) Appeals web portal, a copy of the case file, following receipt of CalOptima Health's expedited Appeal determination, within twenty-four (24) hours of the expedited Appeal decision (both expedited Appeals and Part B Drug Appeals). The following should be included in the case file forwarded to the IRE:

    a. Appeal Case File Cover Sheet;

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

    c. Case Narrative;

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

    e. Copy of the Appeal Request and Notice;

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

    g. Representation documentation for representative Appeals;

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

    i. Dismissal Case File Data Form.

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

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 Integrated Appeal was pending:

    a. Effectuation: CalOptima Health must authorize or provide the disputed services 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 reversing the determination.

3. If the State has established an external medical review process, the requirements and conditions set forth under Title 42 §438.402I(1)(i)(B) and §422.633(b) apply to CalOptima Health.

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

1. The IRE will make a decision on an expedited Appeal within seventy-two (72) hours after receipt of the request from CalOptima Health.

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 initial adverse Organization Determination, the IRE shall 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 overturns or partially overturns CalOptima Health's initial 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: Coordinate with CalOptima Health' Utilization Management Department or the Enrollee's Health Network to arrange for the ordered service or continuation of services, as soon as medically indicated, but not later than seventy-two (72) hours after the 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.

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 meets 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 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 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. Although CalOptima Health does not have a right to request an ALJ hearing, it may be a party to the hearing.

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

    a. Effectuation: Authorize or provide the service under dispute 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 Organization Determination, unless CalOptima Health requests Medicare Appeals Council (MAC) review of the ALJ decision, in accordance with Section III.G. of this Policy. If CalOptima Health requests MAC review of the ALJ decision, it may wait for the MAC's decision before it authorizes, or provides, the disputed service; and

b. Inform the IRE when it effectuates the decision.

I. MAC Review

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

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 can demonstrate 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 letter requesting such 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 letter and a complete case file 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 initial adverse Organization Determination in whole, or in part, CalOptima Health shall:

   a. Effectuation: Authorize or provide the service under dispute 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 initial adverse Organization Determination; and

   b. Inform the IRE when it effectuates the decision.

J. Judicial Review

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

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

b. The amount in controversy meets the CMS designated amount for judicial reviews.

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

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

   b. It is the final decision of CMS; and

   c. The amount in controversy meets the 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 expedited Appeal prior to requesting a judicial review.

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

   a. Effectuation: Authorize or provide the service under dispute as directed by the Court, or 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 if the Court does not specify a time for performance; and

   b. Inform the IRE 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.9003: Standard Pre-Service Integrated Appeal
H. Health Plan Management System (HPMS) Notice September 10, 2013, Change in Part C Reconsideration Dismissal Procedures
I. MAXIMUS Appendix: Reconsideration Case Forms and Instructions
J. MAXIMUS Federal Medicare Health Plan Reconsideration Process Manual
K. Medicare Managed Care Manual, Chapter 13
L. OneCare Evidence of Coverage/Member Handbook
M. Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance, Effective November 18, 2024
N. Social Security Act, §205(g)
O. Title 42, Code of Federal Regulations (CFR), §§422.2267(31), 422.560, 422.632, 422.633, 438.420(d), CFR 422.582(f)(e), CFR 422.592(d) and 423.600(g)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

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

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/01/2005	MA.9004	Expedited Service Appeal	OneCare
Revised	10/01/2012	MA.9004	Expedited Service Appeal	OneCare
Revised	01/01/2014	MA.9004	Expedited Service Appeal	OneCare
Revised	12/01/2016	MA.9004	Expedited Appeal	OneCare
Revised	01/01/2018	MA.9004	Expedited Appeal	OneCare
Revised	04/01/2022	MA.9004	Expedited Pre-Service Appeal	OneCare
Revised	12/01/2022	MA.9004	Expedited Pre-Service Integrated Appeal	OneCare
Revised	02/01/2025	MA.9004	Expedited Pre-Service Integrated Appeal	OneCare

IX. GLOSSARY

Term	Definition
Acknowledgement Letter	A written statement acknowledging receipt of a Grievance.
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, this is a Enrollee, a 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.
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.
Dismissal	A decision not to review a request for a grievance, initial determination, or appeal because it is considered invalid or does not otherwise meet Medicare Advantage or Part D requirements.
Effectuation	Authorization or provision of a benefit that a plan has approved, payment of a claim or compliance with a complete or partial reversal of a plan's original adverse determination.
Enrollee	For purposes of this policy, the term "Enrollee" will be applied both synonymously and/or in lieu of the term "Member" to reflect regulatory and/or contractual language of the Centers for Medicare and Medicaid Services (CMS). An eligible individual who has elected a Medicare Advantage, Prescription Drug, or cost plan or health care prepayment plan (HCPP).
Expedited Grievance	A Grievance involving: 1. CalOptima Health's decision to invoke an extension relating to an Organization Determination or a Reconsideration; or 2. CalOptima Health's refusal to grant an Enrollee's request for an Expedited Organization Determination or Reconsideration.
Expedited Service 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.
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

Term	Definition
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.
Organization Determination	Any determination made by CalOptima Health, or its delegated entity with respect to 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 Enrollee 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. Refusal to authorize, provide or pay for services, in whole or in part, including the type or level of services, which the Enrollee believes should be furnished or arranged by CalOptima Health; 4. Reduction or premature discontinuation, of a previously authorized ongoing course of treatment; or 5. Failure to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide timely notice of an adverse determination, such that a delay would adversely affect the health of the Enrollee.
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 Enrollee obtaining medical care or services. Pre-authorization and precertification are pre-service decisions.

Term	Definition
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.
Reconsideration	For purposes of this policy, under Part C, the first level in the appeals process which involves a review of an adverse organization determination by an MA plan, the evidence and findings upon which it was based, and any other evidence submitted by a party to the organization determination, the MA plan or CMS. Under Part D, the second level in the appeals process which involves a review of an adverse coverage determination by an independent review entity (IRE), the evidence and findings upon which it was based, and any other evidence the enrollee submits, or the IRE obtains. As used in this guidance, the term may refer to the first level in the Part C appeals process in which the MA plan reviews an adverse Part C organization determination or the second level of appeal in both the Part C and Part D appeals process in which an independent review entity reviews an adverse plan decision.
Redetermination	For purposes of this policy, first level in the Part D appeal process in which the plan sponsor reviews an adverse Part D coverage determination, including the findings upon which the decision was based, and any other evidence submitted or obtained.
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 Language	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.