Policy:	HH.1109
Title:	**Complaints Decision Matrix**
Department:	Grievance and Appeals Resolution Services
Section:	Not Applicable
CEO Approval:	*/s/ Michael Hunn 12/26/2023*
Effective Date:	01/01/2001
Revised Date:	12/01/2023
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines the process and structure for identifying and referring all Member and Provider Complaints that requires administrative approval for resolution by CalOptima Health.

II. POLICY

A. All Member and Provider Complaints, that are the adjudication responsibility of CalOptima Health's Grievance and Appeals Resolution Services (GARS), shall be escalated for resolution approval to the appropriate authority, as defined by this Policy and CalOptima Health's Complaint Decision Matrix.

B. All quality of care issues identified through the Complaint Process shall be referred to CalOptima Health's Quality Improvement (QI) Department for review, in accordance with CalOptima Health Policy GG.1611: Potential Quality Issue Review Process.

C. All Complaints involving denials for Medical Necessity shall be referred to CalOptima Health's Chief Medical Officer (CMO) or their Designee for review. CalOptima Health shall utilize board-certified physicians from appropriate specialty areas, as determined by the CMO or their Designee to assist in making determinations of Medical Necessity.

D. Providers must first complete the CalOptima Health Utilization Management (UM) appeal process, pharmacy UM appeal process, long-term care level of care process, or the CalOptima Health Provider Dispute Resolution process prior to filing a Complaint with CalOptima Health, in accordance with CalOptima Health Policies HH.1101: CalOptima Health Provider Complaint, and MA.9006: Contracted Provider Complaint Process.

E. Complaints that are the adjudication and resolution responsibility of a Health Network shall be processed by the Health Network, in accordance with CalOptima Health Policies HH.1103: Health Network Member Grievance and Appeal Process, HH.1101: CalOptima Health Provider Complaint, and MA.9006: Contracted Provider Complaint Process and are not subject to referral for resolution approval, as defined by CalOptima Health's Complaint Decision Matrix.

F. Complaints involving alleged acts of discrimination shall be processed as required by federal and State nondiscrimination law and in accordance with CalOptima Health Policy HH.1104: Complaints of Discrimination.

III. PROCEDURE

A. The CalOptima Health GARS staff shall review, process, investigate, and make decision recommendations regarding the resolution of Member and Provider Complaints.

B. All Complaints related to access to services, quality of care, or quality of service that impacts the Member's ability to obtain care and resulted in a complication shall be referred to CalOptima Health's QI Department for review, trending, and any action deemed necessary based on the review.

C. CalOptima Health shall approve Complaint decisions, in accordance with the Complaint Decision Matrix.

D. The CalOptima Health GARS Director, or their Designee, shall determine when a Complaint decision requires escalation for administrative approval.

E. The CalOptima Health GARS staff shall prepare the Complaint case for review by the appropriate level of decision-maker, including the referral of all clinical cases for review by the CMO, or their Designee.

F. The CalOptima Health GARS staff shall record the Complaint decision in the electronic Complaint file and complete the Complaint Process, in accordance with CalOptima Health Policies HH.1102: Member Grievance, CMC.9002: Member Grievance Process, MA.9002: Enrollee Grievance Process, HH.1101: CalOptima Health Provider Complaint, and MA.9006: Contracted Provider Complaint Process.

IV. ATTACHMENT(S)

A. Complaint Decision Matrix

V. REFERENCE(S)

A. CalOptima Health Contract for Health Care Services
B. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Health Contract with Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Health Three-Way Contract with the Centers for Medicare and Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
E. CalOptima Health Policy CMC.9002: Member Grievance Process
F. CalOptima Health Policy HH.1101: CalOptima Health Provider Complaint
G. CalOptima Health Policy HH.1102: Member Grievance
H. CalOptima Health Policy HH.1103: Health Network Member Grievance and Appeal Process
I. CalOptima Health Policy HH.1104: Complaints of Discrimination
J. CalOptima Health Policy GG.1611: Potential Quality Issue Review Process
K. CalOptima Health Policy MA.9002: Enrollee Grievance Process
L. CalOptima Health Policy MA.9006: Contracted Provider Complaint Process
M. CalOptima Health Utilization Management Program
N. Centers for Medicare and Medicaid Services (CMS) Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance
O. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-011: Grievance and Appeals Requirements, Notice and "Your Rights" Templates

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
10/21/2009	Department of Health Care Services (DHCS)	Approved as Submitted
06/10/2015	Department of Health Care Services (DHCS)	Approved as Submitted
06/21/2017	Department of Health Care Services (DHCS)	Approved as Submitted
04/06/2022	Department of Health Care Services (DHCS)	Approved as Submitted - AIR

VII. BOARD ACTION(S)

Date	Meeting
05/05/2022	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2001	HH.1109	Complaints Decision Matrix	Medi-Cal
Revised	11/01/2004	HH.1109	Complaints Decision Matrix	Medi-Cal
Revised	01/01/2009	HH.1109	Complaints Decision Matrix	Medi-Cal
Revised	01/01/2013	HH.1109	Complaints Decision Matrix	Medi-Cal
Revised	03/01/2014	HH.1109	Complaints Decision Matrix	Medi-Cal
Revised	05/01/2015	HH.1109	Complaints Decision Matrix	Medi-Cal
Revised	06/01/2016	HH.1109	Complaints Decision Matrix	Medi-Cal OneCare OneCare Connect
Revised	07/01/2017	HH.1109	Complaints Decision Matrix	Medi-Cal OneCare OneCare Connect
Revised	10/01/2019	HH.1109	Complaints Decision Matrix	Medi-Cal OneCare OneCare Connect
Revised	05/05/2022	HH.1109	Complaints Decision Matrix	Medi-Cal OneCare OneCare Connect
Revised	12/01/2023	HH.1109	Complaints Decision Matrix	Medi-Cal OneCare OneCare Connect

IX. GLOSSARY

Term	Definitions
Complaint	Medi-Cal: A complaint is the same as a Grievance. If CalOptima Health is unable to distinguish between a Grievance and an Inquiry, it must be considered a Grievance. OneCare: Any expression of dissatisfaction to CalOptima Health, a Provider, or the Quality Improvement Organization (QIO) by a Member made orally or in writing. A Complaint may also involve CalOptima Health's refusal to provide services to which a Member believes he or she is entitled. A Complaint may be a Grievance or an Appeal, or a single Complaint could include both. OneCare Connect: A Complaint may be a Grievance or an Appeal, or a single Complaint could include both.
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.
Medically Necessary or Medical Necessity	Medi-Cal: Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of medical necessity set forth in Section 1396d(r)(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under 21 years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima Health shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child. OneCare: 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. OneCare Connect: 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.
Member	A beneficiary enrolled in a CalOptima Health program.

Term	Definitions
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Licensed Midwife (LM) Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services..
Provider	Medi-Cal: A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, or other person or institution that furnishes Covered Services. OneCare: 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. OneCare Connect: 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.