Policy:	MA.9009
Title:	**Non-Contracted Provider Complaint Process**
Department:	Grievance and Appeals Resolution Services
Section:	Not Applicable
CEO Approval:	*/s/ Michael Hunn 12/07/2023*
Effective Date:	01/01/2010
Revised Date:	12/07/2023
Applicable to:	☐ Medi-Cal ☒ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines the process by which CalOptima Health ensures that Non-Contracted Providers (NCPs) have a clear and reliable Complaint process that meets the requirements of the Centers for Medicare & Medicaid Services (CMS).

II. POLICY

A. CalOptima Health and Health Networks shall establish and maintain a process that addresses the receipt, handling, and disposition of Complaints for NCPs in accordance with applicable statutes, regulations, and contractual requirements.

B. CalOptima Health shall provide all parties to a Complaint with a reasonable opportunity to present evidence related to the issue in dispute in writing. CalOptima Health shall take all relevant evidence into account when making its decision.

C. The CalOptima Health Grievance and Appeal Resolution Services (GARS) Department and Health Networks shall process Provider Dispute Resolutions (PDR)s involving Disputes regarding payment being less than what is paid by Medicare fee-for-service, within forty-five (45) business days after receipt.

D. CalOptima Health shall process all NCP claims payment Appeals, within thirty (30) calendar days of receipt of the Waiver of Liability (WOL) form for all dates of service after January 1, 2023 (sixty (60) calendar days for dates of service prior to January 1, 2023). NCP claims payment Appeals can constitute any adverse Organization Determination. An adverse Organization Determination includes but is not limited to the following situations:

1. Reopening: when reopening leads to an adverse Organization Determination;

2. Diagnosis code/DRG payment denials: An NCP submits a claim to CalOptima Health. CalOptima Health initially approves the claim, which is considered a favorable

Organization Determination (pursuant to Title 42 Code of Federal Regulations (CFR), section 422.566(b)). CalOptima Health later reopens and revises the favorable Organization Determination and denies the DRG code on the basis that a different DRG code should have been submitted and recoups funds;

3. Downcoding: CalOptima Health approves coverage for inpatient services from a NCP, which is considered a favorable Organization Determination (pursuant to Title 42, CFR section 422.566(b)). CalOptima Health later reopens and revises the favorable Organization Determination (e.g., retrospective review) and determines the Member should have received outpatient services;

4. Bundling issues and disputed rate of payment: Pre-and post-pay bundling and global payment determinations. For example, denial of procedure codes – as mutually exclusive to another, or due to inclusion in a previously paid global surgical package; and

5. Level of care or rate of payment denials: Payment of a reduced fee schedule amount for a course treatment. For example, an NCP bills a procedure code for a visit, but CalOptima Health reimburses based on a lower level of care.

E. NCPs may file an Appeal with CalOptima Health's GARS Department within sixty (60) calendar days from the receipt of the Remittance Advice (RA), notwithstanding the PDR process as described in Section II.C. of this Policy.

F. NCP's may file a payment dispute with CalOptima Health's GARS Department within one hundred twenty (120) calendar days from the receipt of the RA for any payment dispute as referenced in Section II.C. of this Policy.

G. CalOptima Health shall notify an NCP of the Appeal process:

1. In all RAs;

2. On the CalOptima Health Website at www.caloptima.org; and

3. Upon request by the NCP.

III. PROCEDURE

A. Submission of a Complaint:

1. An NCP shall submit the initial Complaint, in writing, within the required timeframe using the Provider Complaint Resolution Request form located on the CalOptima Health website, or a letter and shall include, at a minimum:

a. The Member's name;

b. Medicare Beneficiary Identifier (MBI) (formally known as Medicare Health Insurance Claim (HIC) number) or Client Index Number (CIN);

c. The specific service(s) and/or items(s) for which the Complaint is being filed;

d. The specific date(s) of the service;

e. Copy of the original claim or remittance notification showing the denial;

f. The name and signature of the party or the representative of the party filing the request;

g. A Waiver of Liability Form; and

h. Any additional information that supports the request, including, but not limited to, Medical Records.

2. CalOptima Health shall notify the NCP if any required information, as stated in Section III.A.1 of this Policy, is missing. CalOptima Health shall allow the NCP thirty (30) days to resubmit the request with the missing information. If not received, the request is invalidated.

B. For a PDR handled by a Health Network or CalOptima Health GARS Department:

1. For disputes for a payment less than that paid by Medicare fee-for-service, the NCP shall file the dispute with the payer as identified on the RA, either the Health Network or CalOptima Health's GARS Department.

a. Contact information for Health Networks is available on the CalOptima Health website at www.caloptima.org, or by contacting CalOptima Health's Health Network Relations Department at 714-246-8600.

b. Claims processed by the CalOptima Health Claims Administration Department, mail to:

Attn: Grievance and Appeal Resolution Services (GARS) Department
CalOptima Health
505 City Parkway West
Orange CA 92868

C. CalOptima Health's GARS Department and the Health Network shall issue a Resolution Letter to the NCP within the timeframe shown below, following the receipt of the request.

1. Thirty (30) calendar days for services rendered on or after January 1, 2023.

2. Sixty (60) calendar days for services rendered on or before December 31, 2022.

D. For an Appeal handled by CalOptima Health

1. File the request, in writing, within sixty (60) calendar days from the notice of denial with CalOptima Health GARS, based on the payer on the RA.

2. The NCP may request an extension to this timeframe for good cause by submitting a written request for such an extension that includes the reason the NCP cannot meet the timeframe, in accordance with Title 20 CFR, Section 404.911.

3. Upon verification that the request meets criteria for processing as an NCP Appeal, CalOptima Health's GARS Department shall send the NCP an acknowledgement letter and a WOL form, if not already included with the NCP Appeal request, after receipt of the NCP Appeal request.

4. If the NCP fails to submit a signed WOL form after three (3) attempts (written and verbal requests) by CalOptima Health GARS, the GARS Department shall notify the NCP that the request shall be dismissed due to lack of the WOL, no sooner than sixty (60) calendar days from the receipt of the request. The Notice of Dismissal of Appeal Request shall inform the NCP of the process and the right to request a review of the dismissal by the Independent Review Entity (IRE).

5. CalOptima Health GARS Department shall commence review of the NCP Appeal upon receipt of the signed WOL form or letter of good cause, as applicable, and the review shall be completed within sixty (60) calendar days of that the receipt date.

6. Upon completion of review of the NCP Appeal, GARS shall send a Resolution Letter to the NCP informing the NCP of the review decision within sixty (60) calendar days of receipt of the signed WOL form.

7. Failure of the CalOptima Health GARS Department to provide the NCP with a decision within the sixty (60) calendar day period constitutes an adverse decision and CalOptima Health GARS shall forward the NCP Appeal to the IRE for review.

8. An Appeal decision which upholds in whole, or in part, the initial denial shall be forwarded to the IRE for review.

E. Complaint Review

1. CalOptima Health shall designate an individual other than the person involved in making the initial adverse Organization Determination to review a request for NCP Complaint.

    a. If the original denial is based 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 NCP Complaint. 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 NCP Complaint involves Emergency Services, CalOptima Health shall apply the Prudent Layperson Standard when reviewing the Appeal.

2. GARS staff shall present the NCP Complaint request to the appropriate reviewer for a decision.

3. CalOptima Health GARS shall document the decision made by the reviewer, the rationale for the decision, and include the name of the staff member who reviewed the case in a Resolution Letter.

4. If, upon the NCP Complaint review, CalOptima Health completely reverses its adverse Organization Determination, GARS staff shall:

    a. Notify the NCP of the decision, in writing;

    b. Notify and request claim payment from CalOptima Health or the Health Network Claims Department;

c. Verify that CalOptima Health or the Health Network made payment through the claims system and/or that a retro-authorization was issued;

d. Ensure that CalOptima Health or the Health Network adjusts claims for payment within sixty (60) calendar days after the date of receipt of the request for NCP Complaint;

e. Ensure that the NCP's case file includes documentation of payment and retro-authorization, if required; and

f. Note the NCP Complaint as "closed" in the Complaint database.

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

a. Notify the NCP who requested the NCP Complaint no later than sixty (60) calendar days after receipt of the signed WOL, including notice that CalOptima Health forwarded the Appeal to the IRE.

b. Forward a copy of the case file, and the Reconsideration Background Data Form and Case Narrative Form to the IRE, no later than sixty (60) calendar days of receipt of the signed WOL.

F. IRE Determination

1. The IRE shall decide on an Appeal in accordance with its CMS contracted timeframe.

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

3. If the IRE upholds CalOptima Health's adverse Organization Determination, it shall notify CalOptima Health and the NCP of such decision, in writing. Upon receipt of such notice, GARS staff shall place the notice in the NCP's Appeal file.

4. If the IRE reverses or partially reverses CalOptima Health's adverse Organization Determination, CalOptima Health GARS shall:

a. Coordinate with the CalOptima Health Claims Administration Department to arrange for the payment or adjustment of the Appealed claim no later than thirty (30) calendar days after notice from the IRE;

b. Coordinate with the Health Network's Claims Administration Department to arrange for the payment or adjustment of the Appealed claim no later than twenty (20) calendar days after notice from the IRE;

c. Notify the NCP of the IRE's decision and compliance with IRE decision;

d. Send a notification of compliance letter to the IRE; and

e. Document all activities in the Appeal tracking system.

5. The Health Network shall notify CalOptima Health of the final decision by the IRE, with proof of effectuation within twenty (20) calendar days of notification.

G. Administrative Law Judge (ALJ) Hearing

1. An NCP 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 threshold amount specified in the Medicare Managed Care Manual, as determined by Medicare regulations and the ALJ.

2. An NCP 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 NCP may request an extension to this timeframe for good cause by submitting a written request for such extension that includes the reason the NCP cannot meet the timeframe in accordance with Title 20 CFR, section 40 4.911.

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

4. If the Health Network receives a request for an ALJ hearing from an NCP, the Health Network shall forward the NCP request for ALJ hearing to the IRE with a Carbon Copy to CalOptima Health. The IRE shall compile and forward the NCP's file to the ALJ.

5. CalOptima Health or the Health Network shall not have the right to request an ALJ hearing but may remain a party to the hearing.

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

   a. Pay the disputed claim within sixty (60) calendar days after the date it receives notice from the ALJ reversing the adverse Organization Determination unless it requests Medicare Appeals Council (MAC) review of the ALJ decision in accordance with Section III.H. of this Policy; or

   b. Request a MAC Hearing of the ALJ decision; and

   c. Wait for the MAC's decision before it authorizes, or provides, the disputed service; and

   d. 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 Health, may request a MAC Hearing of the ALJ decision, or dismissal.

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

   a. In writing, directly to the MAC; and

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

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

4. If the Health Network receives an NCP's request for a MAC Hearing the Health Network shall forward a copy of the NCP request for MAC Hearing, the NCP's complete case file, and a cover letter to CalOptima Health within five (5) days of receipt.

5. If CalOptima Health requests a MAC Hearing, it shall:

   a. Submit a CalOptima Health Request for MAC Hearing and a complete case file to the MAC;

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

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

6. 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 a review.

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

   a. Pay the disputed claim within 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.

I. Judicial Review

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

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

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

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

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

   b. It is the final decision of CMS; and

c. The amount in controversy meets the 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 judicial review, a party shall file a civil action in a district court of the United States in accordance with Section 205(g) of the Social Security Act.

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

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

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

   b. Inform the IRE when it effectuates the decision.

J. Documentation of Data

1. CalOptima Health's GARS Department shall document all actions taken related to a NCP Appeal request in its tracking system and/or hard copy including, but not limited to:

   a. Provider's name;

   b. Date received;

   c. Name of staff that received the Complaint at CalOptima Health;

   d. Designated contact person;

   e. Description of the Complaint;

   f. Date; and

   g. Disposition.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCES

A. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Health Three-Way Contract with the Department of Health Care Services (DHCS) and the Centers for Medicaid and Medicare Services (CMS) for Cal MediConnect
C. CalOptima Health Policy MA.9006: Contracted Provider Complaint Process
D. CalOptima Health Policy MA.9015: Standard Integrated Appeals

E. Centers for Medicare & Medicaid Services Letter, Provider Payment Dispute Resolution for Non-Contracted Providers, January 4, 2010
F. "Part C Dismissals Procedure," Health Plan Management System (HPMS) Memorandum, Issued September 10, 2013
G. "Model Dismissal Notice," Health Plan Management System (HPMS) Memorandum, Issued October 30, 2013
H. MA Payment Guide for Out of Network Payments, Revised April 15, 2015
I. MAXIMUS Medicare Health Plan Reconsideration Process Manual, Revised January 2020
J. Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance, Revised January 2020
K. "Non-Contract Provider Access to Medicare Administrative Appeals Process," Health Plan Management System (HPMS) Memorandum, Issued September 23, 2020
L. Social Security Act, §§1852(k) and 1894(b)(3)
M. Title 20, Code of Federal Regulations (C.F.R.), § 404.911.
N. Title 20, California Code of Regulations (C.C.R.), §§ 1300.71 and 1300.71.38.
O. Title 42, Code of Federal Regulations (C.F.R.), §§417.588, 422.214, 422.520, 422.560, 422.566(b) et. seq.

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/05/2022	Regular Meeting of the CalOptima Board of Directors
12/07/2023	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2010	MA.9009	Non-Contracted Provider Payment Disputes	OneCare
Revised	03/01/2012	MA.9009	Non-Contracted Provider Payment Disputes	OneCare
Revised	01/01/2014	MA.9009	Non-Contracted Provider Payment Disputes	OneCare
Revised	03/01/2014	MA.9009	Non-Contracted Provider Payment Disputes	OneCare
Revised	01/01/2015	MA.9009	Non-Contracted Provider Payment Disputes	OneCare OneCare Connect
Revised	01/01/2017	MA.9009	Non-Contracted Provider Payment Disputes	OneCare OneCare Connect
Revised	04/01/2022	MA.9009	Non-Contracted Provider Payment Appeals	OneCare OneCare Connect
Revised	12/07/2023	MA.9009	Non-Contracted Provider Complaint Process	OneCare OneCare Connect

IX. GLOSSARY

Term	Definition
Appeal(s)	OneCare: Any of the procedures that deal with the review of an adverse Organization Determination made by CalOptima Health on health care services or benefits under Part C or D the Member 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 Member), or on any amounts the Member must pay for a service or drug as defined in 42 CFR §422.566(b) and §423.566(b). These procedures include reconsideration or redetermination, a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (MAC), and judicial review. OneCare Connect: In general, a Member's actions, both internal and external to CalOptima Health requesting review of CalOptima Health's denial, reduction or termination of benefits or services, from CalOptima Health. Appeals relating to Medi-Cal covered benefits and services shall proceed pursuant to the laws and regulations governing Medi-Cal Appeals and 42 CFR sections 422.629 through 422.634, 438.210, 438.400, and 438.402. 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 Health of an Adverse Benefit Determination.
Complaint	The general term used to identify all provider-filed requests for review and expressions of dissatisfaction with any aspect of CalOptima Health or its Health Networks. This includes Appeals, disputes and Grievances.
Contracted Provider	A Provider who is obligated by a written contract to provide Covered Services to Members on behalf of CalOptima Health, or its contracted Health Networks.
Covered Services	Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under CalOptima's contract with the Centers of Medicare & Medicaid Services (CMS).
Dispute	A dispute of payment regarding an amount that is less than the expected contracted amount or the amount that would be paid by Medicare.
Emergency Services	Those covered inpatient and outpatient services required that are: 1. Furnished by a physician qualified to furnish Emergency Services; and 2. Needed to evaluate or stabilize an Emergency Medical Condition.
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 Health to provide Covered Services to Members assigned to that Health Network.
Independent Review Entity (IRE)	An independent entity contracted by the Centers for Medicare & Medicaid Services (CMS) to review denial of Coverage Determinations.

Term	Definition
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.
Medically Necessary/Medical Necessity	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.
Non-Contracted Provider (NCP)	A Provider that is not obligated by written contract to provide Covered Services to a Member on behalf of CalOptima Health or a Health Network.
Organization Determination	Any determination made by CalOptima Health with respect to any of the following: 1. Payment for temporarily Out-of-Area renal dialysis services, Emergency Services, post-stabilization care, or urgently needed services; 2. Payment for any other health services furnished by a Provider that the Member believes: a. Are covered under Medicare; or b. If not covered under Medicare, should have been furnished, arranged for, or reimbursed by CalOptima Health. 3. Refusal to authorize, provide or pay for services, in whole or in part, including the type or level of services, that the Member believes should be furnished or arranged for by CalOptima Health; 4. Reduction or premature discontinuation, of a previously authorized 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 the Member with timely notice of an adverse determination, such that a delay would adversely affect the health of the Member.
Prudent Layperson Standard	A person who possesses an average knowledge of health and medicine, and the standard establishes the criteria that insurance coverage is based not on ultimate diagnosis, but on whether a prudent person could reasonably expect serious impairment to his or her health in an emergency situation.
Remittance Advice (RA)	A summary report, by claim, that supports the detail payment, denial, or adjustment made by check.

Term	Definition
Reopening	A remedial action taken to change a binding determination or decision even though the determination or decision may have been correct at the time it was made based on the evidence of record.
Resolution Letter	Written notification of the CalOptima Health's resolution of the complaint.
Waiver of Liability	The Waiver of Liability statement ensures the Non-Contracted Provider shall hold the Member harmless regardless of the outcome of the Appeal.