Policy:	MA.9006
Title:	**Contracted Provider Complaint Process**
Department:	Grievance and Appeals Resolution Services
Section:	Not Applicable
CEO Approval:	*/s/ Michael Hunn 12/07/2023*
Effective Date:	08/01/2005
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, a Health Network, and a Third Party Administrator (TPA) shall address and resolve Contracted Provider Complaints, which includes, but is not limited to, Provider Dispute Resolution (PDR), Appeals and Grievances.

II. POLICY

A. CalOptima Health, Health Networks, and TPAs shall maintain a fast, fair, and cost-effective system to process and resolve Contracted Provider Complaints, in accordance with applicable statutory, regulatory, and contractual requirements.

B. Non-Contracted Provider Complaints shall be processed under CalOptima Health Policy MA.9009: Non-Contracted Provider Complaint Process.

C. Contracted Providers shall utilize the Health Network and TPA Grievance systems prior to filing a complaint directly with CalOptima Health, in accordance with this policy.

D. CalOptima Health, Health Networks, and TPAs shall promptly review and investigate Complaints and resolve them, in accordance with the timeframes set forth herein.

E. CalOptima Health, Health Networks, and TPAs shall not discriminate or retaliate against any Contracted Provider including, but not limited to, terminating the Contracted Provider's contract on grounds that such Contracted Provider filed a complaint.

F. CalOptima Health, Health Networks, and TPAs shall designate a Principal Officer to be primarily responsible for the maintenance, oversight, and analysis of trends and preparation of reports related to Complaints as required by this policy and applicable regulations.

G. CalOptima Health, Health Networks, and TPAs shall train assigned staff to process Complaints expeditiously in accordance with this policy.

H. CalOptima Health, Health Networks, and TPAs shall not impose a deadline for receipt of a Complaint for an individual claim, billing dispute, or other dispute that is less than three hundred sixty-five (365) calendar days after the date of an action or, in the case of inaction, that is less than three hundred sixty-five (365) calendar days after the time for contesting or denying claims has expired. If the dispute relates to a demonstrable and unfair payment pattern by CalOptima Health, or CalOptima Health Contracted Provider, neither CalOptima Health nor the Contracted Provider shall impose a deadline for the receipt of a dispute that is less than three hundred sixty-five (365) calendar days from CalOptima Health or the Contracted Provider's most recent action, or in the case of inaction, that is less than three hundred sixty-five (365) calendar days after the most recent time for contesting or denying claims has expired.

I. CalOptima Health, Health Networks, and TPAs shall not charge a Contracted Provider for the cost of processing a Complaint. Notwithstanding the foregoing, CalOptima Health, Health Networks, and TPAs shall have no obligation to reimburse a Contracted Provider for any costs incurred in connection with utilizing the Complaint process.

J. CalOptima Health shall have the right to extend, or stay, or require a Health Network or TPA to delay, or stay, the implementation of a decision in order to allow the affected Contracted Provider an opportunity to file a complaint under this policy.

K. A Contracted Provider who seeks to contest any decision made by CalOptima Health pursuant to this policy is required to comply with CalOptima Health Policy AA.1217: Legal Claims and Judicial Review, if applicable.

III. PROCEDURE

A. Submission of a Complaint

1. A Complaint shall contain the following:

a. Provider Dispute Resolution (PDR) form, Appeal, Grievance or dispute letter and supporting documentation

b. Contracted Provider name and Provider Identification Number (PIN);

c. Contact information;

d. Claim number assigned the original claim, if applicable;

e. Clear description of the disputed item;

f. Date of service;

g. Clear explanation of the basis upon which the Contracted Provider believes the action is incorrect;

h. If the Complaint involves a bundled group of substantially similar multiple claims, identification of the original claim number; and

i. If the Complaint involves a dispute involving a Member, or group of Members; the name(s), identification number(s), claim numbers (if applicable) of the Member(s), a clear explanation of the disputed item(s) including the date(s) of service, and the Contracted Provider's position on the issue(s).

2. A Contracted Provider may submit an amended Complaint within thirty (30) business days after the date of receipt of a returned Complaint that is missing required information.

3. A Contracted Provider that (i) has furnished Covered Services to a Member for which a Health Network is financially responsible, or (ii) is dissatisfied with any aspect of CalOptima Health's program shall file a Complaint with that Health Network prior to filing a Complaint with CalOptima Health within three hundred sixty-five (365) calendar days after the Health Network's action, or in the case of inaction, within three hundred sixty-five (365) calendar days after the time for contesting or denying claims has expired.

4. A Contracted Provider that (i) has furnished Covered Services to a Member or (ii) is dissatisfied with any aspect of a TPA's program, shall file a Complaint with that TPA prior to filing a Complaint with CalOptima Health within three hundred sixty-five (365) calendar days after the TPA's action, or in the case of inaction, three hundred sixty-five (365) calendar days after the time for contesting, or denying, claims has expired.

5. A Contracted Provider may file a Complaint with CalOptima Health as follows:

    a. The Contracted Provider has provided Covered Services to a Member for which CalOptima Health is financially responsible, or is dissatisfied with any aspect of CalOptima Health;

    b. The Contracted Provider has provided Covered Services to a Member for which a Health Network, or TPA, is financially responsible, is dissatisfied with a Complaint Resolution Letter received from the Health Network, or TPA, as set forth in this policy, and files within the following timeframes:

        i. Sixty (60) calendar days after the date of the Health Network's, or TPA's, Complaint Resolution Letter for Complaints related to Medical Necessity; or

        ii. One hundred eighty (180) calendar days after the date of the Health Network's, or TPA's, Complaint Resolution Letter for all other types of Complaints.

B. CalOptima Health, Health Network, or TPA Complaint Receipt and Resolution

1. Record of Complaint

    a. CalOptima Health, or a Health Network, shall enter into its complaint tracking system each Complaint (whether or not complete) received and create an electronic, or hard copy, Grievance file.

        i. The Complaint tracking system shall include the original claim number assigned to each claim being disputed.

    b. A TPA will track and maintain records of each Complaint (whether or not complete) it receives.

2. Acknowledgement of a Complaint

    a. CalOptima Health, a Health Network, or TPA shall acknowledge the receipt of a Complaint in paper form (whether or not complete) within fifteen (15) business days after the date of receipt by the office, or department, designated to receive Complaints.

b. CalOptima Health, a Health Network, or TPA shall acknowledge the receipt of a Complaint in electronic form (whether or not complete) within two (2) business days after the date of receipt by the office or department designated to receive Complaints.

3. Incomplete Complaints

a. CalOptima Health, a Health Network, or TPA may return to a Contracted Provider any Complaint lacking reasonably relevant information, or information necessary to determine payer liability, that is in the possession of the Contracted Provider and not readily accessible to CalOptima Health, Health Network, or TPA.

b. The returned Complaint shall clearly identify, in writing, the missing reasonably relevant information, or information necessary to determine payer liability. In no event shall CalOptima Health, Health Network, or TPA request the Contracted Provider to resubmit claim information that the Contracted Provider previously and appropriately submitted to CalOptima Health, Health Network, or TPA as part of the claims adjudication process, except in those cases in which the claim documentation was returned to the Contracted Provider.

4. Investigation and Resolution of Complaints

a. Investigation

i. CalOptima Health, Health Network, or TPA shall promptly investigate a Complaint by consulting, as appropriate, with the appropriate department(s) at CalOptima Health, Health Network, or TPA responsible for the services, or operations that are the subject of the Complaint (e.g., Utilization Management, Claims).

ii. The applicable CalOptima Health, Health Network, or TPA department(s) shall investigate the factual matters that are the subject of the Complaint and shall report factual findings and a proposed resolution to the CalOptima Health, or Health Network, Grievance staff within ten (10) business days after the date of the initial receipt of the Complaint.

iii. The applicable CalOptima Health, Health Network, or TPA department shall use the Complaint Referral and Investigation Request form, or a similar form, to report findings and proposed resolutions to the CalOptima Health, or Health Network, Grievance staff as set forth in this Policy.

iv. CalOptima Health may request that the Contracted Provider submit any written materials relevant to the Contracted Provider's Complaint.

v. If the Contracted Provider is appealing a Health Network, or TPA, Complaint Resolution Letter, CalOptima Health shall review the Health Network's, or TPA's, Complaint file.

b. Resolution

i. CalOptima Health, the Health Network, or TPA shall resolve and issue a Complaint Resolution Letter for each Complaint it receives within forty-five (45) business days after the date of receipt of the Complaint or amended Complaint, in accordance with applicable laws, including those regulatory provisions identified in Title 28, California Code of Regulations, Section 1300.71.38(f).

ii. The Complaint Resolution Letter shall describe the pertinent facts of the Complaint, the reasons for the Health Networks' determination, and applicable Contracted Provider Appeal rights including the following:

a) For claims Complaints related to Medical Necessity, the right to Appeal the determination to CalOptima Health Grievance and Appeals Resolution Services (GARS) staff within sixty (60) calendar days after the date of the Health Network's, or TPA's, Complaint Resolution Letter; or

b) For other Complaints, the right to Appeal the determination to CalOptima Health GARS staff within one hundred eighty (180) calendar days after the date of the Health Network, or TPA's, Complaint Resolution Letter.

c. Implementation of Complaint Resolution

i. CalOptima Health and its Health Networks, or TPA, shall take immediate action to implement the determinations set forth in a Complaint Resolution Letter.

ii. If the Complaint, or amended Complaint, is determined in whole, or in part, in favor of the Contracted Provider, the Health Network shall pay:

a) Any outstanding monies that it determines to be due; and

b) All interest and penalties required within five (5) business days after the date of the Complaint Resolution Letter.

iii. Accrual of interest and penalties for the payment of any resolved Complaints shall commence on the day following the expiration of the time for reimbursement.

d. Resolution of complaints submitted by Contracted Provider to CalOptima Health in accordance with this policy.

i. CalOptima Health GARS staff shall review the factual findings, proposed resolution, and any other relevant information and shall issue a decision with respect to the Complaint, or amended Complaint.

ii. Within forty-five (45) business days after receipt of the Complaint, or amended Complaint, CalOptima Health GARS staff shall send a Complaint Resolution Letter to the Contracted Provider and copy the Health Network, or TPA, as appropriate.

e. Implementation of Resolution by CalOptima Health

i. CalOptima Health may take immediate action or, as appropriate, require that a Health Network, or TPA, take immediate action to implement the decision set forth in CalOptima Health's Complaint Resolution Letter.

ii. If the Complaint is a payment related issue and CalOptima Health determines that a Health Network is financially responsible, the Health Network shall make payment in the amount specified by CalOptima Health to the Contracted Provider within five (5) business days after the date of CalOptima Health' Complaint Resolution Letter. The Health Network shall send proof of payment by facsimile, or email, to the CalOptima Health GARS Manager, or his or her designee.

iii. If the Health Network does not pay the claim as required by this policy, CalOptima Health shall pay the claim on behalf of the Health Network and shall deduct from the Health Network's capitation payment the amount paid on behalf of the Health Network plus the greater of a two hundred fifty dollars ($250.00) administrative fee, or ten percent (10%) of the amount paid.

iv. If the Complaint is a payment-related issue and CalOptima Health determines that a TPA is financially responsible, the TPA shall make payment in the amount specified by CalOptima Health to the Contracted Provider within five (5) business days after the date of CalOptima Health's Complaint Resolution Latter. The TPA shall send proof of payment by facsimile, or email, to the CalOptima Health GARS Manager, or his or her designee.

C. CalOptima Health Responsible Staff

1. CalOptima Health GARS Director shall have primary responsibility for the maintenance of the Provider Complaint process.

2. A CalOptima Health Executive Officer shall have primary responsibility for the oversight and review of operations and for identifying any emergent patterns of Complaints to improve administrative capacity, Provider relations, claims payment procedures, and Member care.

D. CalOptima Health Monitoring

1. CalOptima Health shall assess on no less than an annual basis the Contracted Providers, subcontractors, and downstream subcontractors that regularly utilize the Provider Complaint process to identify trends and systemic issues.

2. If CalOptima Health determines that a Contracted Provider or Health Network has failed to comply with any requirements of this policy, CalOptima Health may take appropriate action, including, but not limited to, imposing corrective action plans, or sanctions, against the Health Network under CalOptima Health Policies HH.2005: Corrective Action Plan and HH.2002: Sanctions.

3. CalOptima Health shall monitor a TPA.

E. Notices, Records, and Reports

1. Notice to Contracted Providers of the Complaint Process

a. A Health Network shall include a reference to this policy in each Contracted Provider contract.

2. Records

a. CalOptima Health, Health Networks, and TPAs shall maintain written records of each Complaint including at least the following information:

i. Date of receipt;

ii. Names of staff who is designated as the contact person;

iii. Description of the Complaint; and

iv. Disposition.

b. A Health Network and TPA shall retain written records of each Complaint, including copies of all Complaints and responses thereto, including all notes, documents, and other information upon which CalOptima Health, the Health Network, or TPA relied upon to reach its decision for a period of five (5) years following the termination of their contracts with CalOptima Health. A Health Network and TPA shall make records for the last two (2) years available on-site.

c. A Health Network and TPA shall make available warehoused, or stored, records within five (5) business days after a request for such records by CalOptima Health, or the department.

3. Reporting Contracted Provider Complaint Activity

a. A Health Network shall submit to CalOptima Health on a quarterly basis, within thirty (30) calendar days after the end of each quarter, aggregate Complaint data in the format required by CalOptima Health.

b. Each claim within a Complaint that has bundled substantially similar claims disputes must be listed separately as individual Complaints (including original claim numbers) on the report.

c. A Principal Officer shall sign the report certifying that the report is true and correct to the best of his or her knowledge and belief.

F. Other Contracted Provider Rights

1. In addition to any rights set forth in this policy and allowed by law, a Contracted Provider also has the following rights:

2. Claim Resubmission.

a. Prior to filing a Complaint related to payment of a claim, a Contracted Provider may resubmit the claim to the Health Network, or TPA, as appropriate, in accordance with the applicable Health Network, or TPA, claim resubmission policy.

3. Contracted Provider's Right to Hearing

a. Request for Hearing

i. A Contracted Provider that disputes recoupment of funds based upon audit findings of overpayments; the imposition of sanctions or penalties; or suspension or termination of the Contracted Provider's participation in CalOptima Health, or a Health Network, may request a hearing before the Provider Grievance Review Panel if:

a) The Contracted Provider has received a Complaint Resolution Letter from CalOptima Health; or

b) The Contracted Provider has received a Complaint Resolution Letter from a Health Network, or TPA, and pursues a hearing in lieu of filing a written Complaint to CalOptima Health under Section III.A. of this policy.

ii. No other hearings are provided under this policy.

iii. A Contracted Provider may submit to CalOptima Health GARS staff a written request for hearing within fifteen (15) calendar days after CalOptima Health, a Health Network's, or TPA's issuance of a Complaint Resolution Letter. The written request shall set forth with specificity the reasons for the hearing, including if the Contracted Provider challenges:

a) The factual basis of the decision, and if so, which facts in particular;

b) The legal basis for the decision; or

c) The rationale for the decision, sanctions, or penalties imposed.

b. Acknowledgment of Request for Hearing

i. Upon receipt of a request for hearing, CalOptima Health shall set a hearing date to be held within thirty (30) calendar days after receipt of the request.

ii. CalOptima Health shall send to the Contracted Provider a Hearing Acknowledgment Letter within five (5) calendar days after the Contracted Provider's request for a hearing, setting forth the date, time, and location of the hearing.

c. Hearing

i. The purpose of the hearing is to afford the Contracted Provider an opportunity to contest the factual, or legal, basis of the decision, or the rationale for the decision.

ii. The hearing is intended to be informal in nature. Formal rules of evidence and discovery do not apply. There shall be no cross-examination of witnesses. The Contracted Provider, CalOptima Health, Health Network, and TPA, as appropriate, shall have the opportunity to present oral testimony and documentary evidence.

iii. The Provider Grievance Review Panel shall select a hearing officer to preside at the hearing. The hearing officer may, from time to time, establish hearing guidelines governing the hearing procedure. The hearing officer may ask questions to any party at the hearing, and shall ensure proper decorum at the hearing.

iv. The hearing officer may cause a recording of the hearing to be made either by tape recording, or providing a court reporter service.

v. After the conclusion of the hearing, the Provider Grievance Review Panel may adopt, reject, or modify, in whole or in part, the actions addressed at the hearing. The hearing officer shall send the Provider Grievance Review Panel's written decision to the Contracted Provider, Health Network, and TPA, as appropriate, within forty-five (45) calendar days after the close of the hearing. The decision shall be effective on the date issued by the hearing officer.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. California Health and Safety Code, §1367(h)
B. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Health Policy AA.1217: Legal Claims and Judicial Review
D. CalOptima Health Policy HH.2002: Sanctions
E. CalOptima Health Policy HH.2005: Corrective Action Plan
F. CalOptima Health Policy MA.9009: Non-Contracted Provider Complaint Process
G. Title 28, California Code of Regulations (C.C.R.), §§1300.71.38 and 1300.85.1.
H. CalOptima Health Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

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

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	08/01/2005	MA.9006	Provider Complaint Process	OneCare
Revised	05/01/2010	MA.9006	Provider Complaint Process	OneCare
Revised	10/01/2012	MA.9006	Provider Complaint Process	OneCare
Revised	02/01/2015	MA.9006	Provider Complaint Process	OneCare OneCare Connect PACE
Revised	12/01/2016	MA.9006	Provider Complaint Process	OneCare OneCare Connect PACE
Revised	12/01/2022	MA.9006	Provider Complaint Process	OneCare OneCare Connect
Revised	12/07/2023	MA.9006	Provider Complaint Process	OneCare OneCare Connect

IX. GLOSSARY

Term	Definition
Appeal	OneCare: Any of the procedures that deal with the review of an adverse initial 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 Health'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.
Executive Officer	For the purposes of this policy, refers to the Chief Operating Officer or their designee.
Grievance	Any complaint or dispute, other than one that constitutes an organization determination under 42 C.F.R. § 422.566 or other than an Adverse Benefit Determination under 42 C.F.R. § 438.400, expressing dissatisfaction with any aspect of the CalOptima Health's or Provider's operations, activities, or behavior, regardless of whether remedial action is requested pursuant to 42 C.F.R. § 422.561. (Possible subjects for Grievances include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the Member's rights). Also called a "Complaint."
Health Network	A Physician Hospital Consortium (PHC), Physician Medical Group (PMG) under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with

	CalOptima Health to provide Covered Services to Members assigned to that Health Network.
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.
Resolution Letter	Written notification of the CalOptima Health's resolution of the complaint.
Third Party Administrator (TPA)	An individual or entity that has a written agreement with CalOptima Health to perform certain functions and tasks relating to, and necessary for, the delivery of Covered Services.