



Section 3

Member Complaints

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Introduction

This Section describes the procedures that Members and their authorized representatives may use to submit complaints to HPSM. The information is included in this Manual since Providers may file Complaints on behalf of Members, or offer assistance to Members in filing Complaints. The Section begins with definitions and then details the Grievance and Appeals processes. Providers need to be aware that Members have different Appeal rights depending upon the line of business in which the Member is enrolled. These differences are described in the sections that follow. Also, please keep in mind that HPSM Members may be dually eligible for both Medicare and Medi-Cal, but not be enrolled in HPSM's Medicare line of business, CareAdvantage. If dually eligible members are covered under Medicare fee-for-service, the CareAdvantage procedures described in this Section will not apply. HPSM does not discriminate against or disenroll members for filing Complaints. HPSM has interpreter services available to assist members with language barriers.

Member Complaints

Members have the right to submit Complaints to HPSM. A Complaint is any oral or written expression of dissatisfaction with any HPSM service – clinical or non-clinical – a Member receives or regarding reimbursement for a bill that a Member has paid. A Complaint can be a Grievance or an Appeal or both.

A **Grievance** is a Complaint expressing dissatisfaction with any aspect of HPSM's or a Provider's operations, activities, or behaviors – including quality of care concerns – regardless of whether any remedial action is requested or can be taken. A Grievance may be filed by a Member with HPSM either directly, or by referral from the Legal Aid Society of San Mateo County or another advocacy group, and may be filed either verbally by telephone or in person, in writing via mail, or electronically via HPSM's website. Grievances may also be communicated directly to Providers and be resolved by a Medical Group or facility.

An **Organization Determination** is any decision made by or on behalf of HPSM regarding the payment or provision of a service a Member believes he or she is entitled to receive. An Organization Determination is made in response to a Treatment Authorization Request or a request for Prior Authorization submitted by a Provider and may include approval, denial, deferral, or modification of the request.

An **Appeal** is a Complaint that deals with the review of an adverse Organization Determination of a health care service a Member believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care service, or on any amounts the Member must pay for a service.

Member Grievances

Members may submit a Grievance to HPSM if they are dissatisfied with any aspect of HPSM's or a Provider's operations, activities, or behaviors. Please note that the Grievance procedures for Members receiving Medicare benefits under HPSM CareAdvantage differ slightly from procedures for Members receiving benefits under HPSM's other lines of business. These differences are clearly indicated throughout this section.

Filing a Grievance

Member Grievances can be submitted through the following routes:

- Verbally, by visiting HPSM in person or calling (650) 616-2850
- In writing via mail or facsimile at:

Heath Plan of San Mateo
Attn: Grievance and Appeals
701 Gateway Boulevard, Suite 400
South San Francisco, CA 94080

(650) 829-2002 Fax

For HPSM CareAdvantage: Grievances must be filed within **60** calendar days of the incident or action with which the member is dissatisfied.

For All Other Lines of Business: Grievances must be filed within **180** calendar days of the incident or action with which the member is dissatisfied.

Member Grievances may be received by HPSM's Member Services Department, the CareAdvantage Unit, or by one of HPSM's Grievance and Appeals Coordinators. Except in the case of an Expedited Grievance (see below), if a Complaint is received by Member Services or CareAdvantage that staff will make every effort to resolve the Complaint within 24 hours. If the complaint cannot be resolved in 24 hours, the complaint will be forwarded to a Grievance and Appeals Coordinator for further processing.

Processing and Resolving Standard Grievances

Once a Grievance is filed, a Grievance and Appeals Coordinator will send an acknowledgment letter to the Member within 5 calendar days. He or she will investigate the Grievance, which may include notifying the Member's Provider of the Grievance, if applicable.

Making a Determination

The Grievance and Appeals Coordinator will issue a resolution letter within 30 days of receipt of the Grievance. Appropriate administrative review and follow-up will continue until all actions stated in the resolution have been completed.

Submitting Grievances to the Department of Managed Health Care

This applies to Members in Healthy Families, Healthy Kids, HealthWorx, and Medi-Cal. Members enrolled in CareAdvantage do not have this option.

Members may submit Grievances to the Department of Managed Health Care (DMHC) under the following conditions:

- They disagree with the decision made by HPSM
- HPSM has not resolved their Grievances within the 30-day time frame

To submit a Grievance to the DMHC, a member must complete a Consumer Complaint Form, which can be accessed at www.dmhc.ca.gov/gethelp and submit it via fax or mail to:

Department of Managed Health Care
California HMO Help Center
980 Ninth Street, Suite 500
Sacramento, CA 95814-2725
(916) 229-0465 Fax

HPSM will abide by the decision made by the DMHC and will work to complete the actions recommended by the DMHC as quickly as possible.

Mediation

Prior to filing a Grievance with the Department of Managed Health Care, a Member may request voluntary mediation with HPSM. A Member does not have to participate in voluntary mediation for longer than thirty (30) days before being able to submit a Grievance to the Department of Managed Health Care. Expenses for mediation are paid for equally by HPSM and the Member.

Expedited Grievances (for CareAdvantage Members ONLY)

HPSM CareAdvantage members have the option of requesting an Expedited Grievance under certain circumstances. These circumstances are:

- HPSM refused to expedite an Organization Determination.
- HPSM extended the time frame to process an Organization Determination.
- HPSM refused to expedite an Appeal (also called a reconsideration).
- HPSM extended the time frame to process an Appeal (or reconsideration).

In these cases, CareAdvantage members may ask to speak to the Grievance and Appeals Coordinator immediately. The Grievance and Appeals Coordinator who will consult with appropriate HPSM staff and respond to the Grievance within 24 hours of HPSM's receipt of the original Grievance.

Appeals of Organization Determinations

Any member who is dissatisfied with an Organization Determination made by HPSM regarding the status of a service or benefit may request an Appeal of this determination. This is true for Organization Determinations regarding both pre-service and retrospective authorizations and usually is the result of a denial.

As an HPSM contracted Provider, you may file an Appeal on behalf of HPSM members, but you cannot charge members for performing this service. An authorized representative of the member may also request an Appeal.

Appeals procedures for members receiving Medicare benefits provided under HPSM's CareAdvantage program differ from the Appeals procedures for members receiving benefits through HPSM's other lines of business. Discussion of the procedures is clearly separated to avoid confusion. HPSM also distinguishes between standard Appeals and Appeals that require expedited review in cases where standard time frames would jeopardize a member's life, health, or ability to regain maximum function. Please be sure to refer to the appropriate Appeals procedures if you would like to submit an Appeal. They are discussed as indicated below:

Medi-Cal, Healthy Kids (HK), Healthy Families (HF), and HealthWorx (HW)

- Standard Appeals under Medi-Cal, Healthy Kids, Healthy Families, and HealthWorx.
- Expedited Appeals under Medi-Cal, Healthy Kids, Healthy Families, and HealthWorx
- Independent Medical Review for Medi-Cal, Healthy Kids, Healthy Families, and HealthWorx

Medi-Cal Only

- State Hearing
- Expedited State Hearing

HPSM CareAdvantage

- Standard Appeals under HPSM CareAdvantage
- Fast-Track Appeals to a Quality Improvement Organization under HPSM CareAdvantage
- Expedited Appeals under HPSM CareAdvantage
- External Appeals under HPSM CareAdvantage

CareAdvantage Appeals can be for medical services and supplies or for drugs covered under the Medicare Part D prescription drug benefit. The timeframes and processes for Part D Appeals differ from Appeals for medical services and supplies. These differences are noted in the following sections.

Note: Members or their authorized representatives may cancel their request for an Appeal at any time by forwarding the request in writing to HPSM's Grievance and

Appeals Coordinator. Verbal requests can be accepted for all product lines except HPSM CareAdvantage.

Standard Appeals (for Medi-Cal, Healthy Kids, Healthy Families, and HealthWorx)

The first step in the Appeals process is called a reconsideration. You may request a reconsideration of an HPSM adverse Organization Determination for a member participating under the programs listed above if you or your member disagrees with HPSM's decision. You may also be called upon to assist a member or authorized representative if he/she requests an Appeal, or to forward relevant medical records to help us make a determination on an Appeal.

How to File an Appeal

Appeals can be submitted through the following routes:

- Verbally, by visiting HPSM in person or calling (650) 616-2850
- In writing via mail or facsimile at:

Health Plan of San Mateo
Attn: Grievance and Appeals
701 Gateway Boulevard, Suite 400
South San Francisco, CA 94080

(650) 829-2002 Fax

- Electronically via HPSM's website: www.hpsm.org.

Appeals may be received by HPSM's Member Services Department or by a Grievance and Appeals Coordinator.

An Appeal must be filed within **90** calendar days from receipt of HPSM's notice of an adverse Organization Determination. HPSM may allow an exception to this 90-day requirement for good cause.

Processing the Appeal

Once the Appeal is filed, a Grievance and Appeals Coordinator will send an acknowledgment letter within 5 calendar days and work with appropriate HPSM staff to begin investigation of the case. Additional information may be required from Providers involved in the member's treatment.

After all relevant documentation is collected, the case is forwarded to either HPSM's Medical Director or Associate Medical Director. The physician who made the initial determination will not be involved in the appeal process.

Making a Determination

Using all available information, HPSM will make a reconsideration determination and notify the Provider and/or the member within 30 calendar days. This timeframe applies to both pre-service and retrospective authorizations. For determinations that reverse the initial adverse determinations, HPSM will provide both oral and written notification, and will follow-up to ensure that the service has been rendered or the payment has been made.

For determinations that uphold initial adverse determinations, HPSM provides written notification that includes the reason for denial and information about additional levels of Appeal that may be available.

Expedited Appeals (for Medi-Cal, Healthy Families, Healthy Kids, and HealthWorx)

You may request an expedited reconsideration of an HPSM adverse Organization Determination for a member participating in the programs listed above if you or your member believes that applying the standard 30-day timeframe for processing a reconsideration would jeopardize the member's life, health, or ability to regain maximum function. HPSM will also expedite a reconsideration for decisions regarding termination or changes in level of care for inpatient stays, skilled nursing facilities, home health agencies, and comprehensive outpatient rehabilitation facilities.

In addition to HPSM's expedited Appeals process, Medi-Cal, Healthy Kids, Healthy Families, and HealthWorx members can also contact the California Department of Managed Health Care (DMHC) and request an urgent review. Members do not need to go through HPSM's expedited reconsideration process before contacting the DMHC.

How to File an Expedited Appeal

Expedited Appeals can be submitted to HPSM through the following routes:

- Verbally, by visiting HPSM in person or calling: (650) 616-0050
- In writing via mail or facsimile to:

Health Plan of San Mateo
Attn: Grievance and Appeals
701 Gateway Boulevard, Suite 400
South San Francisco, CA 94080

(650) 829-2002 Fax

Requests for expedited Appeals will automatically be forwarded to an HPSM Grievance and Appeals Coordinator.

For telephone and facsimile requests for expedited reconsideration that are submitted during non-business hours, HPSM's answering service will receive the request and immediately page HPSM's Medical Director to provide expedited review.

An Expedited Appeal must be filed within **90** calendar days from receipt of HPSM's notice of an adverse Organization Determination. HPSM may allow an exception to this 90-day requirement for good cause.

Requests for urgent review by the Department of Managed Health Care can be submitted by calling (888) HMO-2219.

Processing the Appeal

Upon receiving the request for an expedited reconsideration, a Grievance and Appeals Coordinator will confer with licensed clinical staff to determine if the request meets the criteria for an expedited review. This decision will be made within the first 24 hours from the receipt of the request.

If the reconsideration does not qualify for an expedited review, a Grievance and Appeals Coordinator will immediately notify the member and Provider of this decision and any Grievance and Appeal rights, including the right to contact the DMHC. The case will then be forwarded through the standard reconsideration process.

If the reconsideration qualifies for expedited review, a Grievance and Appeals Coordinator will immediately notify the member and Provider of the decision and of the member's right to contact the DMHC. He/she will work with appropriate HPSM staff to collect all relevant information about the member's condition and forward the case file to an independent local physician for review within the first 48 hours after receiving the request if necessary.

Making a Determination

Using all available information, HPSM will make a reconsideration determination and will notify you and/or the member as expeditiously as the member's health requires, but no later than 72 hours of HPSM's receipt of the request.

For determinations that reverse the initial adverse determinations, HPSM will provide both oral and written notification, and will follow-up to ensure that the service has been rendered.

For determinations that uphold initial adverse determinations, HPSM provides written notification that includes the reason for denial and information about additional levels of Appeal that may be available.

Independent Medical Review (IMR) (for Medi-Cal, Healthy Families, Healthy Kids, and HealthWorx)

If you or your member disagrees with a decision HPSM has made on a reconsideration based on medical necessity, or if HPSM does not make a decision within the standard

30-day time frame, the member can request an Independent Medical Review (IMR) by the Department of Managed Health Care (DMHC). ***An IMR may also be requested if HPSM denies a treatment because it is experimental or investigational; in this case, the member does not need to complete HPSM's reconsideration process before requesting an IMR.*** Information on requesting an IMR can be obtained by calling (888) HMO-2219, or by visiting the DMHC website at www.hmohelp.ca.gov

Note: A Medi-Cal member who has already participated in a State Hearing (see below) is not eligible to receive an IMR from the DMHC.

The IMR will review the case to determine whether or not the care requested is medically necessary. A decision on an IMR must be returned within 30 days of the DMHC's receipt of the IMR application for standard Appeals, or within 3 business days for expedited Appeals.

If the IMR determines that the service is medically necessary, HPSM will approve the requested service or make a payment within 5 business days.

State Hearing (for Medi-Cal ONLY)

Medi-Cal members or their authorized representatives have the option of filing a State Hearing with the Department of Social Services if they disagree with HPSM's decision regarding approval of a requested service. A State Hearing is an Appeal with an Administrative Law Judge from the Department of Social Services. Expedited State Hearings may also be requested.

Requests for State Hearings can be submitted by telephone at (800) 952-5253 or in writing to:

State Department of Social Services
State Hearing Division
Post Office Box 944243
Mail Station 19-37
Sacramento, CA 94244-2430
Fax: (916) 229-4110

Requests for Expedited State Hearings should be submitted to:

Expedited Hearing Unit
State Hearings Division
744 P Street, MS 19-65
Sacramento, CA 95814
Fax: (916) 229-4267

A Medi-Cal member may request a State Hearing at any time, without completing HPSM's reconsideration process. Requests for State Hearings must be submitted within **90** days of an action with which the member is dissatisfied. For standard State

Hearings, a decision must be made within 90 days of the request. For expedited State Hearings, a decision must be made within 72 hours.

Standard Appeals for CareAdvantage Members ONLY

Please refer to the section on Part D Appeals for additional information.

As with HPSM's other product lines, the first step in the Appeals process for HPSM CareAdvantage is a reconsideration. You may request a reconsideration of an HPSM adverse Organization Determination for a CareAdvantage member if you or your member disagrees with this decision. You may, as a physician providing treatment to a member, upon providing notice to the member, request a standard reconsideration on the member's behalf. If you appeal the decision on behalf of a member, **the member will not have to submit documentation designating you as the member's authorized representative.** You may also be called upon to assist a member or authorized representative if he/she requests an Appeal, or to forward relevant medical records information to help us make a determination on an Appeal.

How to File an Appeal

Appeals can be submitted through the following routes:

- Verbally, by visiting HPSM in person or calling (650) 616-2850
- In writing via mail or facsimile at:

Health Plan of San Mateo
Attn: Grievance and Appeals
701 Gateway Boulevard, Suite 400
South San Francisco, CA 94080

(650) 829-2002 Fax

Note: Appeals under HPSM CareAdvantage cannot be submitted via HPSM's website.

An Appeal must be filed within **60** calendar days from receipt of HPSM's notice of an adverse Organization Determination. HPSM may allow an exception to this 60 day requirement for good cause.

Appeals may be received by HPSM's CareAdvantage Unit or by a Grievance and Appeals Coordinator.

Processing the Appeal

Once the Appeal is filed, a Grievance and Appeals Coordinator will send an acknowledgment letter within 5 calendar days and work with appropriate HPSM staff to begin investigation of the case. Additional information may be required from Providers involved in the member's treatment.

After all relevant documentation is collected, the case is forwarded to either HPSM's Medical Director or Associate Medical Director.

Making a Determination

Using all available information, HPSM will make a reconsideration determination, and will notify you and/or the member within 30 calendar days or within 60 calendar days for reconsiderations on retrospective authorizations. For all reconsiderations HPSM may extend these timeframes for up to 14 calendar days if requested, or if such extension is in the best interest of the member. A member may request an expedited Grievance if he/she disagrees with HPSM's decision to extend the timeframe.

For determinations that reverse the initial adverse determinations, HPSM will provide both oral and written notification, and will follow-up to ensure that the service has been rendered or the payment has been made.

For determinations that uphold initial adverse determinations, HPSM provides written notification that includes the reason for denial. The case will automatically be forwarded to the Independent Review Entity (IRE). The IRE is contracted by the Medicare program to conduct additional levels of review for Medicare Appeals. See External Appeals for HPSM CareAdvantage for more information.

Fast-Track Appeals to a Quality Improvement Organization (for CareAdvantage Members ONLY)

If a member disagrees with HPSM's decision to terminate or change the level of care for services received in an inpatient stay, skilled nursing facility (SNF), home health agency (HHA), or a comprehensive outpatient rehabilitation facility (CORF), he/she may Appeal the decision to the Quality Improvement Organization (QIO) with which the Medicare program has contracted. In California, the QIO is Health Services Advisory Group (HSAG).

Members are notified of their right to submit this Appeal to the QIO when they receive their Notice of Discharge and Medicare Appeal Rights for inpatient stays, their Notice of Medicare Non-Coverage for SNF, CORF, or HHA terminations, or other notice of non-coverage.

Members must request an Appeal by noon of the first business day following receipt of the notice in order to avoid financial liability during the contested time. The QIO will make a determination within 24 hours. If the member misses the deadline for a QIO fast-track Appeal, he/she may still request an expedited reconsideration from HPSM as described below.

Expedited Appeals (for CareAdvantage Members ONLY)

You may request an expedited reconsideration of an HPSM adverse Organization Determination for a CareAdvantage member if you or your member believes that applying the standard timeframe for processing a reconsideration would jeopardize a member's life, health, or ability to regain maximum function. HPSM will also expedite a reconsideration for decisions regarding termination or changes in level of care for inpatient stays, skilled nursing facilities, home health agencies, and comprehensive outpatient rehabilitation facilities if a member does not request an Appeal to a QIO within the required timeframes.

How to File an Expedited Appeal

Expedited Appeals can be submitted to HPSM through the following routes:

- Verbally, by visiting HPSM in person or calling: (650) 616-2850
- In writing via mail or facsimile to:

Health Plan of San Mateo
Attn: Grievance and Appeals
701 Gateway Boulevard, Suite 400
South San Francisco, CA 94080

(650) 829-2002 Fax

An Appeal must be filed within **60** calendar days from receipt of HPSM's notice of an adverse Organization Determination. HPSM may allow an exception to this 60-day requirement for good cause.

Appeals submitted by an authorized representative must be accompanied by documentation indicating the member's authorization.

Requests for expedited Appeals will automatically be forwarded to HPSM's Grievance and Appeals Coordinator.

For telephone and facsimile requests for expedited reconsideration that are submitted during non-business hours, HPSM's answering service will receive the request and immediately page HPSM's Medical Director to provide expedited review.

Processing the Appeal

Upon receiving the request for expedited reconsideration, the Grievance and Appeals Coordinator will confer with licensed clinical staff to determine if the request meets the criteria for expedited review. This decision will be made within the first 24 hours from the receipt of the request.

Note: All requests for expedited review that have the support of a physician will automatically be approved.

If the reconsideration does not qualify for expedited review, a Grievance and Appeals Coordinator will immediately notify the member and Provider of this decision and any Grievance and Appeal rights. The case will then be forwarded through the standard reconsideration process. A member may request an expedited Grievance if he/she disagrees with HPSM's decision to process the request according to the standard timeframe.

If the reconsideration qualifies for expedited review, a Grievance and Appeals Coordinator will immediately notify the member and Provider of the decision and work with appropriate HPSM staff to request all relevant information about the member's condition within the first 24 hours.

Making a Determination

Using all available information, HPSM will make a reconsideration determination, and HPSM will notify you and/or the member as expeditiously as the member's health requires, but no later than 72 hours after HPSM's receipt of the request. HPSM may extend this timeframe for up to 14 calendar days if requested, or if such extension is in the best interest of the member. A member may request an expedited Grievance if he/she disagrees with HPSM's decision to extend the timeframe.

For determinations that reverse the initial adverse determinations, HPSM will provide both oral and written notification, and will follow-up to ensure that the service has been rendered.

For determinations that uphold initial adverse determinations, HPSM will provide both oral and written notification that includes the reason for denial. The case will automatically be forwarded to the IRE. See External Appeals for HPSM CareAdvantage for more information.

Appeals regarding Part D (Prescription Drug) Benefits (for CareAdvantage Members ONLY)

Although the appeal process is similar, the timelines for Part D prescription drug benefit appeals differ as do the rules regarding who can file an appeal. For a Part D Standard Appeal (known as a redetermination), only the member or a member's authorized representative can appeal an HPSM decision. A physician can be a member's authorized representative. However, you and the member will have to complete and submit the member authorization form or information requested. Using all available information, HPSM will make a determination, and will notify the member or authorized representative within 7 calendar days. A member, physician, or authorized representative can request an Expedited Appeal. In that case HPSM will notify you and/or the member within 72 hours of our determination. If HPSM's upholds its decision, a member or authorized representative must request external review by the IRE. A physician, unless also an authorized representative, cannot request this external review.

External Appeals (for CareAdvantage ONLY)

HPSM CareAdvantage members have access to successive levels of Appeal to contest adverse Organization Determinations, reconsideration determinations, and redeterminations (for Part D). These include:

- Review by an Independent Review Entity (IRE)
- Administrative Law Judge (ALJ) hearing
- Medicare Appeals Council (MAC) hearing
- Judicial review

Independent Review Entity

As noted above, all adverse reconsideration determinations except those regarding Part D benefits are automatically forwarded to and reviewed by the Medicare-contracted Independent Review Entity (IRE) for external review. For a Part D reconsideration to be reviewed by the IRE, the member must submit a written request to the IRE within 60 days of the date of the reconsideration decision. In this case, the IRE is required to solicit the prescribing physician's views on the case.

The IRE will make a determination on the case within the same time frames as HPSM:

- 7 days for a Part D Appeal;
- 30 days for a standard pre-service authorization Appeal;
- 60 days for a standard retrospective authorization Appeal; and
- 72 hours for an expedited Part D or pre-service authorization Appeal.

If the IRE overturns HPSM's decision, HPSM will authorize and/or provide service or payment within the following timeframes:

- 72 hours for a standard Part D appeal
- 14 calendar days for a standard pre-service authorization
- 30 calendar days for a standard retrospective authorization
- 72 hours for an expedited pre-service authorization
- 24 hours for an expedited Part D appeal

Administrative Law Judge Hearing

In cases where the service being contested has met minimal dollar amount standards (set annually) the member, Provider, or authorized representative can request a hearing before an Administrative Law Judge (ALJ). This request must be made within 60 calendar days of receiving notice by the IRE and should be submitted to the Social Security Administration or the IRE. Upon request, HPSM can also forward members' requests for an ALJ hearing to the IRE.

If the ALJ overturns HPSM's decision, the following timeframes will apply:

- 72 hours to authorize and/or provide service for pre-service Part D appeals
- 72 hours to authorize payment for Part D appeals and 30 days to issue payment
- 60 calendar days to authorize and/or provide service or payment for non-Part D appeals

HPSM may request a review by the Medicare Appeals Council (MAC; see below), in which case HPSM may wait for the MAC's decision before authorizing service or payment.

Medicare Appeals Council

Any party to an Appeal, including a member, Provider, authorized representative, or HPSM, can request a hearing before the Medicare Appeals Council (MAC). This request must be made within 60 calendar days of receiving notice by the ALJ and should be submitted in writing to the MAC. Upon request, HPSM can also forward members' requests for a MAC review.

If the MAC overturns HPSM's decision, the same timeframes for acting upon the decision as are required for ALJ decisions will apply.

Judicial Review

Any party to an Appeal, including a member, Provider, authorized representative, or HPSM, can request judicial review of a MAC decision if: (1) the MAC denied the request for a review, and (2) the amount of the service in question meets the minimal dollar amount set annually. To request judicial review, the party must file a civil action in a U.S. District Court.

If judicial review overturns HPSM's decision, the same timeframes for acting upon the decision as are required for ALJ and MAC decisions will apply.