HealthPlan OF SAN MATEO
Healthy is for everyone

Provider Manual | Section 3

Member Complaints

Introduction

This section describes the procedures that members and their authorized representatives may use to submit complaints to Health Plan of San Mateo (HPSM). The Centers for Medicare and Medicaid Services (CMS) and the State of California have regulations that give health care consumers the right to file a complaint whether the consumer is covered by Medicare, Medi-Cal or a private insurance plan.

HPSM must follow these federal and state regulations in processing HPSM member complaints. HPSM handles complaints for members in all lines of business: CareAdvantage Cal MediConnect (CMC), Medi-Cal, HealthWorx and San Mateo County ACE.

Information about the complaints process is included in the Provider Manual because providers may file complaints on behalf of members, or offer assistance to members in filing a complaint. HPSM may also ask providers for assistance in resolving member complaints through requests for additional medical information or the provider's perspective on a complaint.

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. HPSM members may be dually eligible for both Medicare and Medi-Cal, but not be enrolled in CareAdvantage Cal MediConnect, HPSM's Medicare line of business. If dually eligible members are covered under Original Medicare, the CareAdvantage procedures described in this section will not apply.

Overview of Member Complaints

Members have the right to submit complaints to HPSM. A complaint is any **verbal or written expression of dissatisfaction** with any HPSM covered service a member receives. A complaint may also be about reimbursement for a bill that a member has paid. A complaint can be a grievance or an appeal.

Grievance: 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. Examples of grievances include member concerns about:

- Quality of the care that was provided
- Customer service that was perceived as rude or unhelpful
- Difficulty accessing care and/or the timeliness of care
- Billing related issues such as receipt of a balance bill or collections notice
- Other issues, such as HIPAA violations or potential instances of fraud

Appeal: a complaint about HPSM's denial of coverage or reimbursement. In an appeal, a member or provider requests HPSM to reconsider its decision regarding services that were denied, limited, or taken away, such as:

- A denied request for services (i.e. prior authorization)
- A denied request for payment to a provider (i.e. claim)
- A denied request for reimbursement to a member

Timeframes in the Complaint Process

The following are the timeframes that must be followed when processing a grievance and/or an appeal. Timeframes for filing a grievance or appeal vary by line of business and are regulated by CMS and the State.

CareAdvantage Timeframes for Filing

Part C Appeal:	60 calendar days from denial notification
Part D Appeal:	60 calendar days from denial notification
Grievance:	No time limit

CareAdvantage Timeframe for processing

Part C – Standard Grievance or Appeal:	30 calendar days
Part C – Expedited Appeal:	72 hours
Part C – Expedited Grievance:	24 hours
Part D – Standard Appeal:	7 calendar days
Part D – Standard Grievance:	30 calendar days
Part D – Expedited Appeal:	72 hours
Part D – Expedited Grievance:	24 hours

HPSM Medi-Cal Timeframe for filing

Appeal:	60 calendar days from denial notification
Grievance:	No time limit

HPSM Medi-Cal Timeframe for processing

Standard Grievance or Appeal:	30 calendar days
Expedited Grievance or Appeal:	72 hours

HealthWorx HMO and ACE Timeframe for filing

Appeal:	180 calendar days from denial notification
Grievance:	180 calendar days from occurrence

HealthWorx HMO and ACE Timeframe for processing

Standard Grievance or Appeal:	30 calendar days
Expedited Grievance or Appeal:	72 hours

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

Members can submit grievances through the following routes:

- **In-person by visiting HPSM**
- **Call Member Services or the CareAdvantage Unit**
  Medi-Cal, HealthWorx and ACE Members: call Member Services at **650-616-2133**
  CareAdvantage Members: call the CareAdvantage Unit: **650-616-2174**
- **Fax: 650-829-2002**
- **Mail:** Health Plan of San Mateo
  801 Gateway Blvd., Suite 100
  South San Francisco, CA 94080

Timing

Medi-Cal and CareAdvantage Cal MediConnect members may file a grievance at any time regarding services they received while covered under Medi-Cal or CareAdvantage Cal MediConnect.

All other members must file a grievance within 180 calendar days from the date of occurrence. HPSM may allow an exception to this timeframe requirement for good cause.

How to Submit a Grievance

If filing a grievance in writing, members may submit a grievance online at HPSM's website, www.hpsm.org. Members may also fill out a Grievance Form, found on HPSM's website, or write a letter or other statement stating the reason for their dissatisfaction.

Member grievances may be received by HPSM's Member Services Unit, the CareAdvantage Unit, Care Coordination Unit, or Grievance and Appeals Unit. If a grievance is received by Member Services or CareAdvantage Unit, staff will make every effort to resolve the grievance within 24 hours. If the grievance cannot be resolved in 24 hours, the complaint will be forwarded to Grievance and Appeals for further processing.

Cancelling/Withdrawing a Grievance

Members or their authorized representatives may cancel their grievance at any time by contacting HPSM's Grievance and Appeals Unit.

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. The Grievance and Appeals Coordinator will investigate the grievance, which may include notifying the member's provider, if applicable.

Provider Response and Timing

A critical part of resolving a member complaint involves getting a provider's perspective about the situation under review. **Requests for a provider's perspective are not an accusation of wrong-doing**. HPSM understands that many complaints arise because of a difference in perception or misunderstanding about a situation. We want to get your honest opinion about what transpired.

In order to meet the strict timeframes for processing a complaint, providers must submit their response within 5 calendar days from the date the Grievance and Appeals Coordinator sends the request to the provider.

Making a Decision on a Grievance

For standard complaints, the Grievance and Appeals Coordinator will issue a resolution letter within 30 calendar days of receipt of the grievance. The resolution letter will be the result of the research and review conducted by the Grievance and Appeals Coordinator. The resolution letter will be mailed to the member or the member's representative. If the grievance involves a provider, a copy of the resolution letter will also be sent to the provider.

If a grievance is related to quality of care concerns, HPSM will request medical records and a written response from all relevant providers. These medical records and responses will be reviewed by HPSM's Clinical Review Nurse and by an HPSM Medical Director. Providers will be informed in writing of any concerns or deficiencies found by HPSM's Quality Improvement Department. For questions regarding the quality of care review process, please contact the Quality Department at **650-616-2170.**

Non-Retaliation Policy for Filing a Grievance

Members have the right to file a complaint about HPSM or the care that they receive from a provider without the complaint adversely affecting how the member is treated by HPSM and/or the member's providers. **Retaliation against Members for filing a complaint is strictly prohibited.**

HPSM does not discriminate against or disenroll members for filing complaints.

Examples of prohibited retaliation by providers include:

- Terminating or threatening to terminate a member from your practice after the member has filed a complaint
- Refusing to provide treatment or needed prescription refills to a member because of a complaint filed
- Treating the member in a disrespectful, hostile, or otherwise negative manner in response to the member filing a complaint

Grievances to the Department of Managed Health Care

Members in Medi-Cal and HealthWorx 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 grievance within the 30 calendar day timeframe

Submitting Grievances to DMHC

Members can call DMHC at **1-888-466-2219** or complete an Independent Medical Review/Complaint Form online, which can be accessed at http://www.dmhc.ca.gov/FileaComplaint.aspx.

HPSM will abide by the decision made by DMHC and will work to complete the actions recommended by 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

Medi-Cal, HealthWorx and ACE Participants

If processing a grievance under the standard 30 calendar day timeframe would have an adverse impact on a member's life, health, or ability to regain maximum function, a member or provider can request that a grievance be processed under an expedited, *72-hour timeframe*. If a member requests expedited grievance processing, HPSM clinical staff will determine whether the request meets the criteria for expedited processing. If the request does not meet the criteria for expedited processing, an HPSM Grievance and Appeals Coordinator will notify the member of this decision verbally, by phone, and in writing. If this request is made by a member's physician or other provider, HPSM will process the grievance under the expedited timeframe.

CareAdvantage Cal MediConnect Members

CareAdvantage members have the option of requesting an expedited grievance under limited circumstances. Unlike the other lines of business, the decision to expedite processing of a CareAdvantage grievance is not based on clinical criteria. The circumstances in which an expedited grievance may be filed by or for a CareAdvantage member are:

- HPSM refused to expedite an authorization request
- HPSM extended the timeframe to process an authorization request
- HPSM refused to expedite an appeal
- HPSM extended the timeframe to process an appeal

In these cases, CareAdvantage members may request an expedited grievance. The Grievance and Appeals Coordinator will consult with the appropriate HPSM staff and respond to the grievance within 24 hours of HPSM's receipt of the expedited grievance.

Appeals of Denied Services/ Authorization Requests

Any member who is dissatisfied that HPSM has denied services may request an appeal of this decision. As an HPSM contracted provider, you may file an appeal on behalf of a HPSM member, but you cannot charge the member for filing an appeal on their behalf. An authorized representative of the member may also file an appeal.

Provider Payment Appeals

For providers disputing payment, please refer to the Provider Dispute Resolution Process described in Section 5 of this manual.

Pharmacy Appeals

For appeals of drugs covered under the pharmacy benefit, please refer to the section on pharmacy appeals.

Authorization Appeals

You may ask HPSM to reconsider a denial of an authorization request for services if you or your patient disagrees with HPSM's decision to deny the request. 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 decision on an appeal.

For CareAdvantage Members: If you are a physician and you appeal the decision on behalf of a member, the member will not need to submit documentation designating you as the member's authorized representative. However, if you are a provider other than a physician (e.g. DME provider, SNF, physical therapist, etc.), the member will need to provide documentation designating you as the member's authorized representative.

Filing an Appeal

Appeals can be filed through the following routes:

- **Call the Grievance and Appeals Unit** at **650-616-2850**
- **Fax: 650-829-2002**
- **Mail:** Health Plan of San Mateo
  Attn: Grievance and Appeals
  801 Gateway Blvd., Suite 100
  South San Francisco, CA 94080

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

Timing

For Medi-Cal and CareAdvantage Cal MediConnect members, an appeal must be filed within 60 calendar days from the date of HPSM's Notice of Denial. All other members must file an appeal within 180 calendar days of this date. HPSM may allow an exception to this timeframe requirement for good cause.

Cancelling/Withdrawing an Appeal

Members or their authorized representatives may cancel their request for an appeal at any time by contacting HPSM's Grievance and Appeals Unit.

Processing a Standard Appeal

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

After all relevant documentation is collected the case is forwarded to an HPSM Medical Director for review. The Medical Director that made the initial decision to deny the authorization request will not be involved in the appeal process.

Using all available information, the HPSM Medical Director will make a decision on the appeal request. HPSM will notify the provider and the member within 30 calendar days of the initial request. HPSM will call both the member and the provider to inform them of the appeal decision. The member and provider will also receive a letter confirming the decision.

For all appeals HPSM may extend the timeframe for up to 14 calendar days if requested, or if such extension is in the best interest of the member.

Requesting an Expedited Appeal

You may request an expedited appeal of an HPSM authorization denial if you or the member believes that applying the standard 30 calendar day timeframe for processing an appeal will jeopardize the member's life, health, or ability to regain maximum function. HPSM will also expedite an appeal for decisions regarding termination or changes in level of care for inpatient stays, skilled nursing facilities, home health agencies, and comprehensive outpatient rehabilitation facilities.

CareAdvantage requests for expedited appeals that are submitted by telephone during non-business hours are received by HPSM's answering service. The answering service will immediately page an HPSM Medical Director to provide expedited review.

Requests submitted by fax during non-business hours will be processed the following business day. **If you are submitting an expedited appeal on a weekend or holiday, please do not submit the request by fax.** All requests for expedited review that have the support of a physician will automatically be approved.

In addition to HPSM's expedited appeals process, Medi-Cal, 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 appeals process before contacting the DMHC. Requests for urgent review by the Department of Managed Health Care can be submitted by calling **1-888-466-2219**.

Processing an Expedited Appeal

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

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

If the appeal qualifies for expedited review, a Grievance and Appeals Coordinator will immediately notify you and the member of the decision and of the member's right to contact the DMHC. He/she will work with the appropriate HPSM staff to collect all relevant information about the member's condition and forward the case file to a HPSM Medical Director for review within 48 hours of receiving the request.

Using all available information, HPSM will make a decision and will notify you and the member as expeditiously as the member's health requires, but no later than 72 hours of HPSM's receipt of the request. HPSM will notify you and the member of the decision by phone and in writing. If the original denial is upheld, HPSM's written notification will include the reason for denial and information about additional levels of appeal that may be available.

Denials of CareAdvantage Part C Benefits

If a denial is upheld on appeal, HPSM will auto-forward the appeal to the Independent Review Entity (IRE) for a secondary, independent review. The IRE will render a decision within 30 days of receiving the appeal from HPSM. HPSM will comply with the decision by the IRE and notify the member and provider if the IRE instructs HPSM to overturn the denial, in full or in part.

For all appeals HPSM may extend the timeframe for up to *14 calendar days* if requested, or if such extension is in the best interest of the member.

Independent Medical Review (IMR) for Medi-Cal & HealthWorx

If you or your patient disagrees with a decision HPSM has made on an appeal based on medical necessity, or if HPSM does not make a decision within the standard 30 calendar day timeframe, 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 appeals process before requesting an IMR.

Information on requesting an IMR can be obtained by calling **1-888-466-2219**, or by visiting the DMHC website at https://www.dmhc.ca.gov/FileaComplaint/FrequentlyAskedQuestions.aspx

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. DMHC will render a decision on an IMR within 30 days of 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 Members 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 denial 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:

California Department of Social Services
State Hearing Division
Post Office Box 944243, Mail Station 9-17-37 Sacramento, CA 94244-2430
Fax: (916) 651-5210 or (916) 651-2789
Online: http://www.dss.cahwnet.gov/shd/PG1110.htm

A Medi-Cal member must first exhaust HPSM's appeals process prior to proceeding with a State Hearing. Requests for State Hearings must be submitted within *120 calendar days* of an action with which the member is dissatisfied. For standard State Hearings, the State will make a decision within 90 days of the request. For expedited State Hearings, the State will make a decision *within 72 hours*.

Fast-Track Appeals to a Quality Improvement Organization for CareAdvantage CMC 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) which the Medicare program has contracted. In California, the QIO is Livanta.

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 decision within 24 hours. If the member misses the deadline for a QIO fast-track appeal, he/she may still request an expedited appeal from HPSM.

Pharmacy Appeals for Drug/ Medication Denials

Appeals for medications or drugs are processed by HPSM's Pharmacy Unit. Although the appeal process is similar, the timelines for prescription drug appeals differ.

Using all available information, HPSM will make a decision, and will notify the member and provider within 7 calendar days for standard pharmacy appeals. A member, physician, or authorized representative can request an expedited appeal. In that case, HPSM will notify you and the member within 72 hours of our decision.

Filing a Pharmacy Appeal

Providers can file pharmacy appeals through the following routes:

- **Call the Pharmacy Unit** at **650-616-2088**
- **Fax: 650-829-2002**
- **Mail:** Health Plan of San Mateo
  Attn: Pharmacy Unit
  801 Gateway Blvd., Suite 100
  South San Francisco, CA 94080

Members can file appeals through the following routes:

- **In-person by visiting HPSM**
- **Call Member Services or the CareAdvantage Unit**
  Medi-Cal, HealthWorx and ACE Members: call Member Services at **650-616-2133**
  CareAdvantage Members: call the CareAdvantage Unit: **650-616-2174**
- **Fax: 650-829-2002**
- **Mail:** Health Plan of San Mateo
  801 Gateway Blvd., Suite 100
  South San Francisco, CA 94080

Independent Reviews for CareAdvantage Part D Benefits

For CareAdvantage members only, if HPSM upholds its original denial, a member, authorized representative, or physician may request external review by the IRE. Unlike appeals for Part C benefits, appeals for Part D covered drugs will *not* be automatically forwarded to the IRE for review. To file a second-level appeal with the IRE, the provider or member should fill out the form attached to the written notification from HPSM.

External Appeals for CareAdvantage Members ONLY

HPSM CareAdvantage members have access to successive levels of appeal to contest adverse denials and appeals. These include:

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

Independent Review Entity (IRE)

As noted above, all adverse appeals 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 appeal denial to be reviewed by the IRE, the member must submit a written request to the IRE within *60 days* of the date of the appeal denial decision. In this case, the IRE is required to solicit the prescribing physician's views on the case.

The IRE will make a decision on the case within the same timeframes as HPSM:

- 7 days for a Part D appeal;
- 30 days for a standard Part C pre-service authorization appeal;
- 60 days for a Part C payment appeal; and
- 72 hours for an expedited Part D or Part C 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
- 24 hours for an expedited Part D appeal
- 14 calendar days for a standard Part C pre-service authorization
- 72 hours for an expedited Part C pre-service authorization
- 30 calendar days for a standard Part C payment appeal

Administrative Law Judge Hearing

In cases where the denied 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 unfavorable 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 Part C appeals

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

Medicare Appeals Council (MAC)

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.