

	Appeals Process		GA-002
	Department	Health Services	
	Functional Area	Grievances & Appeals	
	Impacted Delegate	☒ Subcontractor ☐ NA	

DATES			
Policy Effective Date	6/12/2023	Reviewed/Revised Date	10/01/2024
Next Annual Review Due	10/02/2025	Regulatory Approval	12/15/2023

APPROVALS			
Internal		Regulator	
Name	Gordon Arakawa, MD	☐ DHCS	☐ NA
Title	Chief Medical Officer	☒ DMHC	

ATTACHMENTS
NA

AUTHORITIES/REFERENCES
• Internal ◦ CHPIV, Delegation Oversight Policy and Procedure, CMP-002 • Federal ◦ 42 CFR Sections 438.3, 438.400, 438.402, 438.406, 438.408, 438.410, 438.416, 438.420, 438.424, 18446 • State ◦ California Health and Safety Code Sections ("H&S Code") 1367.01, 1367.042, 1368, 1368.015, 1368.016, 1368.02, 1368.2, 1370.2, 1374.31, 1374.34 ◦ California Welfare and Institutions Code Sections ("W&I Code") 10950 ◦ Title 22 California Code of Regulations Rules ("CCR") 51014.1, 51014.2, 53858 ◦ Title 28 CCR Rules 1300.68, 1300.68.01, 1300.74.30 ◦ 2024 DHCS Contract Exhibit A, Attachment III, 4.6 Member Grievance and Appeal System ◦ DHCS All Plan Letters ("APL") 22-002, 21-011, 21-004, 20-020 • Accreditation ◦ NCQA: Utilization Management (UM) 8, Element A, UM 9, Elements A-D, Member Experience (ME) 7, Element B, ME 7, Elements C-F

HISTORY	
Revision Date	Description of Revision
6/12/2023	Policy creation
7/10/2023	Revised requirement around IMRs

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10/01/2024	Annual Review- added requirement HSC 1368.01(b) to immediately notify members of their right to notify DMHC of the appeal

I. **OVERVIEW**

- A. This policy addresses Community Health Plan of Imperial Valley's ("CHPIV" or the "Plan") APPEALS requirements, policies, and procedures. The purpose of this policy is to establish an APPEAL Process pursuant to applicable statutory, regulatory, and contractual requirements.

II. **POLICY**

- A. Standard APPEALS
1. Pursuant to 42 CFR sections 438.228 and 438.400 - 424, CHPIV has an APPEAL process as required below to attempt to resolve MEMBER APPEALS before the MEMBER requests a STATE FAIR HEARING or an IMR. CHPIV may have only one level of APPEAL for MEMBERS. Upon a MEMBER's request, CHPIV must assist any MEMBER in preparing their APPEAL which includes assisting the MEMBER with navigating CHPIV's website, providing all documents that were relied on for its decision and providing the APPEAL form to the MEMBER.
 2. Following the receipt of a NOA, a MEMBER has 60 calendar days from the date on the NOA to file a request for an APPEAL either orally or in writing. The MEMBER, or a Provider or AUTHORIZED REPRESENTATIVE acting on behalf of the MEMBER and with the MEMBER's written consent, may request an APPEAL. Unless the MEMBER is requesting an expedited APPEAL, the date of the MEMBER's oral or written request for an APPEAL establishes the filing date for the APPEAL. The contractor must resolve the APPEAL within 30 calendar days of the MEMBER's oral or written request for an APPEAL.
 3. If CHPIV fails to send a written NOA within 30 calendar days or fails to comply with notice and language translation requirements in 42 CFR sections 438.10, 438.404, 438.408, W&I Code section 14029.91, 22 CCR section 53876 and Exhibit A, Attachment III, Section 5.1.3 (MEMBER Information), the MEMBER is deemed to have exhausted the internal APPEAL process and may request a STATE FAIR HEARING pursuant to 42 CFR section 438.402(c)(1)(i)(A). Deemed Exhaustion means the MEMBER has effectively exhausted Contractor's internal APPEAL because Contractor failed to timely resolve the APPEAL.
 4. CHPIV ensures the NOA informing the MEMBER of its NAR at a minimum, must indicate whether the decision on the APPEAL is upheld and the date of the decision on the APPEAL. For decisions not wholly in the MEMBER's favor, the NAR at a minimum, must include:
 - a. MEMBER's right to request a STATE FAIR HEARING.
 - b. How to request a STATE FAIR HEARING.
 - c. That the MEMBER has a right to continuation of benefits during the STATE FAIR HEARING, and that Contractor is obligated to continue benefits as long as the requirements of 42 CFR section 438.420 are met.



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- d. The right to request an IMR or a review of the decision by DMHC, if the MEMBER has not presented the disputed health care services for resolution by the Medi-Cal fair hearing process.
 - e. The IMR is not required for final STATE FAIR HEARING decision; and
 - f. The DHCS-approved "Your Rights" Attachment.
 5. The timeframe to resolve an APPEAL may be extended by up to 14 calendar days if the MEMBER requests an extension or Contractor shows that there is a need for additional information. The contractor must maintain documentation to demonstrate to DHCS why the delay is in the MEMBER's interest. If the timeframe extension has not been requested by the MEMBER, CHPIV ensures the following:
 - a. Make reasonable efforts to give the MEMBER prompt oral notice of the delay.
 - b. Give the MEMBER a written notice of the reason to extend the timeframe within two calendar days, including information on the right to file an additional GRIEVANCE for the delay; and
 - c. Resolve the APPEAL as expeditiously as the MEMBER's health condition requires and no later than the date the extension expires.
 6. If the decision is reversed during the APPEAL, it must authorize or provide the disputed services promptly, and as expeditiously as the MEMBER's health condition requires, but no later than 72 hours from the date it reverses the action if the disputed services were not provided during the APPEAL.
 7. CHPIV must pay for disputed services if the MEMBER received the disputed services while the APPEAL was pending.
 8. The MEMBER must be given the opportunity before and during their APPEAL process to examine their case file. CHPIV ensures provision of, sufficiently in advance of the resolution timeframe and free of charge, the MEMBER's case file, including medical records, clinical criteria, guidelines and all documents and records relied on during the APPEAL process for its decision. CHPIV must assist any MEMBER who requires assistance preparing their APPEAL.
- B. Expedited APPEALS
1. CHPIV ensures implementation and maintenance of a process resolve expedited APPEALS as described below. CHPIV ensures the expedited APPEAL process is followed when it determines or the requesting Provider indicates that taking the time for a standard resolution could seriously jeopardize the MEMBER's life, physical or mental health, or ability to attain, maintain, or regain maximum function.
 2. A MEMBER, or a Provider or an AUTHORIZED REPRESENTATIVE, and with the MEMBER's written consent, may file an expedited APPEAL either orally or in writing. No additional follow-up from the MEMBER is required. CHPIV ensures that punitive action is not taken against a Provider who requests an expedited resolution or supports a MEMBER's APPEAL.
 3. CHPIV must inform the MEMBER of the limited time available for the MEMBER to present evidence and allegations of fact or law, in person, by phone or in writing, sufficiently in advance of the resolution timeframe.

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4. CHPIV ensures that the Member, or a provider or AUTHORIZED REPRESENTATIVES are immediately notified of their right to notify DMHC of the APPEAL.
5. CHPIV must provide a MEMBER notice, as quickly as the MEMBER's health condition requires, but no later than 72 hours from the day Contractor receives the request for an expedited APPEAL.
6. CHPIV may extend the timeframe to resolve an expedited APPEAL by up to 14 calendar days if the MEMBER requests an extension or if there is a need for additional information and how the delay is in the MEMBER's interest. If the extension was not requested by the MEMBER, CHPIV ensures reasonable efforts are made to give the MEMBER prompt oral notice of the delay, and within two calendar days provide the MEMBER with written notice that includes the reason the extension is needed. The notice must include information on the right to file a GRIEVANCE if the MEMBER disagrees that the extension is appropriate. CHPIV ensures that the APPEAL is resolved as expeditiously as the MEMBER's health condition requires and no later than the date the extension expires. CHPIV ensures documentation is maintained to demonstrate to the Department why the extension is necessary.
7. CHPIV ensures reasonable efforts are made to provide oral notice of an expedited APPEAL decision.
8. If a request for an expedited resolution of an APPEAL is denied, the request for an APPEAL must be processed in accordance with the standard APPEAL process timeframes for resolutions and extensions as required in Exhibit A, Attachment III, Subsection 4.6.4 (APPEAL Process).
9. A MEMBER, or a Provider or AUTHORIZED REPRESENTATIVE acting on behalf of the MEMBER, and with the MEMBER's written consent, has the right to file an APPEAL in the timeframes set forth in this Policy.
10. CHPIV ensures the APPEAL Process addresses the receipt, handling, and disposition of a MEMBER's APPEAL, in accordance with applicable statutory, regulatory, and contractual requirements.
11. CHPIV ensures assistance is provided to MEMBERS requiring assistance with filing an APPEAL, including, but not limited to, a MEMBER with limited English proficiency (LEP), disabilities, or cultural needs.
12. CHPIV ensures prompt review and investigation of an APPEAL.
13. CHPIV ensures referral of all APPEALS related to medical quality of care issues to the Quality Improvement (QI) Department for review by the Chief Medical Officer (CMO) or their Designee and any action deemed necessary under the quality review process.
14. CHPIV ensures MEMBERS are informed during the APPEAL Process of his or her right to request a State Hearing after the internal APPEAL Process has been exhausted or should have been exhausted, and of his or her right to Aid Paid Pending (i.e., continuation of benefits).
15. Continuation of Benefits Pending an APPEAL (i.e., Aid Paid Pending)
 - a. CHPIV ensures MEMBERS are advised and assisted with the provision of Aid Paid Pending, regardless of whether the MEMBER makes a separate request during the APPEAL process, if all of the following conditions are met:

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- i. The MEMBER filed their APPEAL within the required timeframes for Aid Paid Pending (within ten (10) calendar days of when the Notice of ADVERSE BENEFIT DETERMINATION (ABD)/Notice of Action (NOA) was sent or before the intended effective date of the proposed action, whichever is later).
 - ii. The APPEAL involves the termination, suspension, or reduction of previously authorized Covered Services.
 - iii. The Covered Services were ordered by an authorized Provider; and
 - iv. The period covered by the original authorization has not expired.
 - b. A MEMBER shall continue to receive Aid Paid Pending while an APPEAL is pending until one (1) of the following occurs:
 - i. MEMBER withdraws the APPEAL.
 - ii. GRIEVANCE and APPEALS Resolution Services (GARS) issues an APPEAL decision adverse to the MEMBER; or
 - iii. The time period or service limits of a previously authorized service has been met.
16. CHPIV ensures payment for disputed Covered Services if the MEMBER received the disputed Covered Services while the APPEAL was pending.
17. CHPIV ensures that neither CHPIV, nor any of its Health Networks, Practitioners, or other Providers shall discriminate against a MEMBER, or a Provider or MEMBER's AUTHORIZED REPRESENTATIVE on the grounds that he or she filed an APPEAL.
18. A NABD/ NOA sent notifying a Provider or a MEMBER of a decision to delay, deny, modify, or recommend an alternative option to a requested service, shall inform a MEMBER of their right to file an APPEAL within sixty (60) calendar days of the date of the NABD/NOA.
19. CHPIV ensures communication of any changes to its GRIEVANCES and APPEALS Policies and Procedures to its Providers, Subcontractors and Downstream Subcontractors.
20. A Provider may request an APPEAL on his or her own behalf within sixty (60) calendar days after receipt of the denial for authorization or payment for services already received by the MEMBER.
21. A Provider, with the CHPIV MEMBER's written consent, may request an APPEAL on behalf of the MEMBER, for services rendered to that CHPIV MEMBER, by submitting a written request to CHPIV within sixty (60) calendar days from the date of the NABD/NOA, in accordance with the provisions of this Policy.
22. CHPIV ensures a MEMBER, or a Provider or AUTHORIZED REPRESENTATIVE acting on behalf of the MEMBER and with the MEMBER's written consent, are given a reasonable opportunity to present, in writing or in person, before the individual(s) resolving the APPEAL, evidence, testimony, facts, and law in support of the APPEAL.
23. CHPIV ensures MEMBERS, or a Provider or AUTHORIZED REPRESENTATIVE, acting on behalf of the MEMBER and with the MEMBER's written consent, are informed of the limited time available to present evidence sufficiently in advance of the resolution timeframes, including for expedited APPEALS.
24. CHPIV ensures the provision of culturally and linguistically appropriate notices of the APPEALS process to MEMBERS, including but not be limited to, Acknowledgement Letters and Notices of APPEAL Resolution.
 - a. CHPIV ensures assistance is provided to MEMBERS or a MEMBER's AUTHORIZED REPRESENTATIVE, with disabilities, limited English proficiency, vision disorders, or other communicative impairments, when completing APPEAL forms and other



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procedural steps, including but not limited to, providing all documents relied on for the decision to the MEMBER, in addition to the following services:

- i. Alternative formats (as set forth in All Plan Letter (APL) 21-004: Standards for Determining Threshold Languages, Nondiscrimination Requirements, And Language Assistance Services)
 - ii. Providing Auxiliary Aids and services upon request, such as interpreter services and a toll-free number with TTY/TDD and interpreter capability; and
 - iii. Assistance in the APPEAL Process, or to provide translation of APPEAL correspondence.
25. A MEMBER may be represented by anyone they choose during the APPEAL Process, including a legal representative.
26. The MEMBER has the right to request an APPEAL in the event a ABD/NOA is not issued within the required time frame, which shall be considered a denial and therefore constitutes an ADVERSE BENEFIT DETERMINATION.
27. CHPIV ensures the provision, upon request by the MEMBER, or a Provider or AUTHORIZED REPRESENTATIVE acting on behalf of the MEMBER and with the MEMBER's written consent, before and during the APPEALS Process, the opportunity to examine and/or obtain a copy of the MEMBER's case file, including Medical Records, and any other relevant documents and records considered during the APPEALS Process. CHPIV ensures the provision of records at no cost.
28. CHPIV ensures that the person reviewing the APPEAL was not involved in the initial determination and he or she is not the subordinate of any person involved in the initial determination.
29. CHPIV ensures that for APPEALS, the person making the final decision for the proposed resolution of an APPEAL has not participated in any prior decisions related to the APPEAL and is of the same or similar specialty, has clinical expertise in treating the MEMBER's condition or disease, and is able to treat complications that may result from the service or procedure, if deciding on any of the following:
 - a. An APPEAL of a denial based on lack of Medical Necessity or experimental/clinical investigation; and
 - b. Any APPEAL involving clinical issues.
30. Upon notice of the decision to deny an authorization request, a MEMBER, or a Provider or AUTHORIZED REPRESENTATIVE acting on behalf of the MEMBER, and with the MEMBER's written consent, may request an expedited APPEAL, when it is determined or the requesting Provider indicates that taking the time for a standard resolution could seriously jeopardize the MEMBER's life, physical or mental health, or ability to attain, maintain, or regain maximum function.
31. All medical APPEALS are referred to the Chief Medical Officer (CMO) or to his or her Designee who has the authority to require CORRECTIVE ACTION and did not make the initial utilization management decision.
32. CHPIV ensures the provision of GRIEVANCE and APPEAL system requirements to subcontractors at the time they enter into a subcontract, on an annual basis, and when the relevant GRIEVANCE and APPEALS policies and procedures are updated.
33. CHPIV ensures language assistance is provided to MEMBERS, by plan staff or language line interpreter services, for Threshold Languages to register and resolve APPEALS.

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34. In addition to any rights set forth in this Policy, a MEMBER or a MEMBER's AUTHORIZED REPRESENTATIVE shall also have the right to:
 - a. Request a standard or expedited State Hearing with the Department of Social Services (DSS).
 - b. CHPIV ensures MEMBERS are informed of such State Hearing rights annually, and in every Notice of APPEAL Resolution (NAR) letter.
35. If adequate notice is not provided to a MEMBER with a visual impairment or other disabilities requiring the provision of written materials in alternative formats, within applicable federal or state timeframes, then the MEMBER is deemed to have exhausted the internal APPEAL process and may immediately request a State Hearing.
36. CHPIV ensures APPEALS processes for pharmacy services rendered or requested before implementation of Medi-Cal Rx.
37. CHPIV ensures the maintenance of records of GRIEVANCES and APPEALS and must have policies and procedures in place governing the review of the information as part of its ongoing Quality Improvement System. CHPIV ensures the identification of systemic patterns of wrongful denials and impose CORRECTIVE ACTION as necessary. The records must be accurately maintained in a manner accessible to the State and available to CMS upon request. Records must include all required information set forth in 42 CFR section 438.416. Contractors must ensure that all documents and records, whether in a written or electronic format generated or obtained are retained for at least 10 years pursuant to 42 CFR section 438.3(u).

III. **PROCEDURE**

- A. CHPIV delegates the APPEAL process to its Subcontractor, Health Net.
- B. Delegation Oversight
 1. CHPIV shall provide oversight and continually assess the delegated functions, responsibilities, processes, and performance of Health Net. CHPIV ensures Health Net's compliance with regulatory and contractual requirements through the following activities which are detailed in *CHPIV Policy CMP-002: Delegation Oversight Policy and Procedure*:
 - a. Ongoing monitoring
 - b. Performance reviews
 - c. Data analysis
 - d. Utilization of benchmarks, if available
 - e. Annual desktop and on-site audits

IV. **DEFINITIONS**

Whenever a word or term appears capitalized in this policy and procedure, the reader should refer to the "Definitions" below.

TERM	DEFINITION
Adverse Benefit Determination ("ABD")	Means any of the following actions taken by Contractor: • The denial or limited authorization of a requested service, including determinations based on the type or level of a Covered Service, Medical Necessity,

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TERM	DEFINITION
	appropriateness, setting, or effectiveness of a Covered Service. • The reduction, suspension, or termination of a previously authorized Covered Service. • The denial, in whole or in part, of payment for a Covered Service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of Clean Claim is not an Adverse Benefit Determination. • The failure to provide Covered Services in a timely manner. • The failure to act within the required timeframes for standard resolution of Grievances and Appeals. • The denial of the Member's request to obtain services out of Network when a Member is in an area with only one Medi-Cal managed care health plan; or • The denial of a Member's request to dispute financial liability.
Member	A beneficiary enrolled in a CHPIV program.
Appeal	Means a review by a Contractor of an ABD, which includes one of the following actions: • A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service. • A reduction, suspension, or termination of a previously authorized service. • The denial, in whole or in part, of payment for a Covered Service, except payment denials based solely because the claim does not meet the definition of a Clean Claim. • Failure to provide services in a timely manner; or • Failure to act within the timeframes provided in 42 CFR section 438.408(b).
Authorized Representative	Means any individual appointed in writing by a competent Member or Potential Member, to act in place or on behalf of the Member or Potential Member for purposes of assisting or representing the Member or Potential Member with Grievances and Appeals, State Fair Hearings, Independent Medical Reviews, and in any other capacity, as specified by the Member or Potential Member.
Corrective Action	Means specific identifiable activities or undertakings of Contractor which address Contract deficiencies or noncompliance.

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TERM	DEFINITION
Grievance	Means an oral or written expression of dissatisfaction about any matter other than an ABD, and may include, but is not limited to: the quality of care or services provided, interpersonal relationships with a Provider or Contractor's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by Contractor to make an authorization decision.
State Fair Hearing (SFH)	Means a hearing with a State Administrative Law Judge to resolve a member's dispute about an action taken by Contractor, its Network Providers, Subcontractors, or Downstream Subcontractors.