Current Medi-Cal Fee-For-Service, Medi-Cal Managed Care, In-Home Supportive Services and Medicare Advantage Grievance and Appeals Process

DHCS Working Document
Updated April 26, 2012

The following charts outline the current Medi-Cal and Medicare grievance and appeals process for the purpose of understanding how the current process works.

Chart 1: Current Medi-Cal Managed Care Grievance and Appeals Process

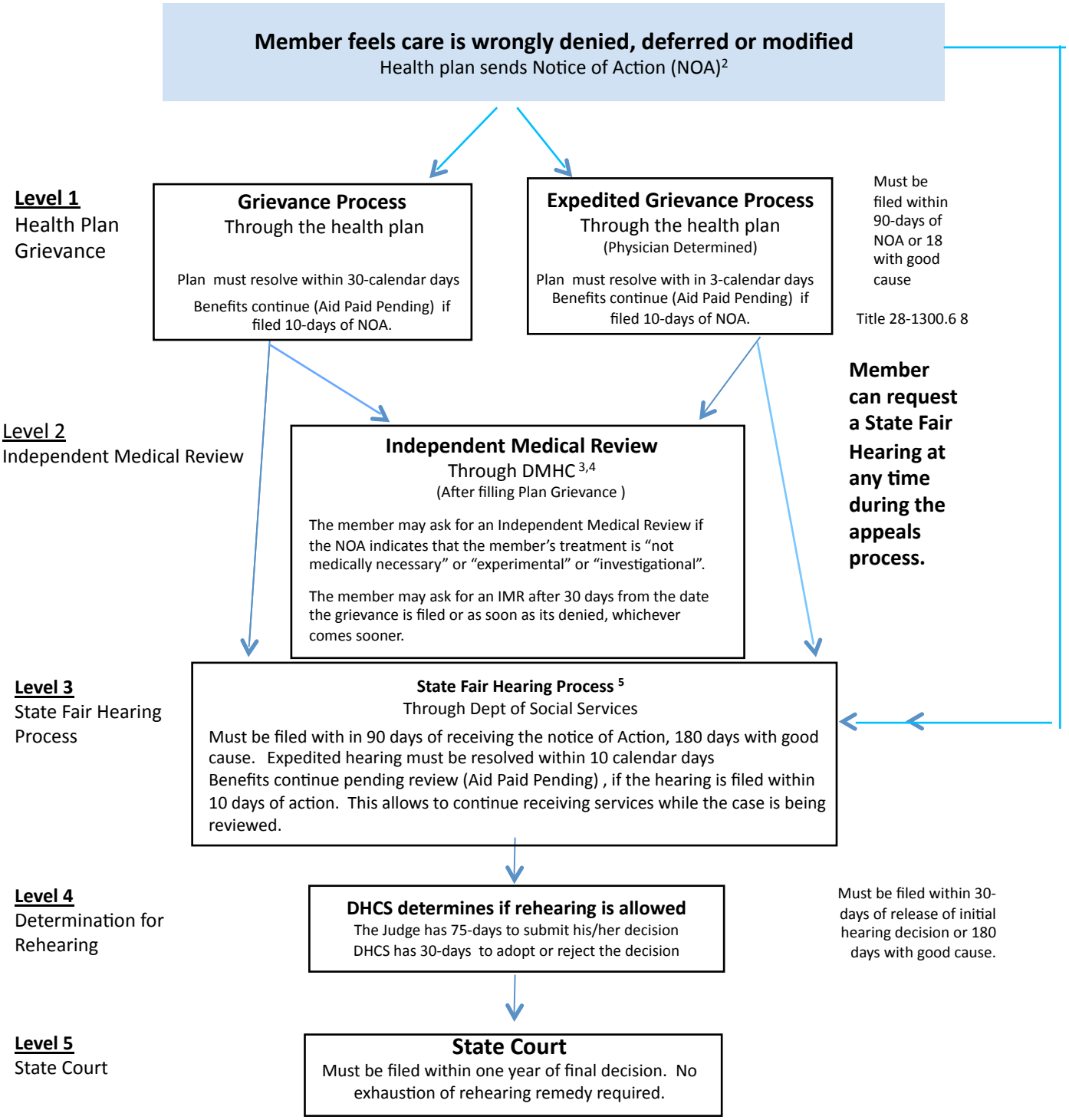
Chart 2: Current Medi-Cal Fee-For-Services Appeals Process

Chart 3: IHSS Fair Hearing Process

Chart 4: Medicare Advantage (Part C) Appeals Process

Chart 5: Medicare Part D Appeals Process

Current Medi-Cal Managed Care Grievance and Appeals Process [1]



Notes:

1. Health plan is required to notify beneficiary of protection rights within 7-days of enrollment.
2. Notice of Action (NOA) is a formal letter from the health plan informing a Member that a medical service has been denied, deferred or modified. Benefits continue pending appeal
3. IMR only applies to Knox-Keene licensed plans which is done through the Department of Managed Health Care. Most health plans are Knox-Keene licensed.
4. Independent Medical Review may not be requested if a state fair hearing has already been requested for that NOA. (this is per new contract language)
5. For more information on state fair hearing process see: http://www.dhcs.ca.gov/services/medi-cal/Pages/Medi-CalFairHearing.aspx

Statute Citations: 28 CCR 1300.68 (except Subdivision 1300.68(g).), 1300.68.01, 22 CCR 53858, 51014. W&I: 10950-10967 and 42 CFR 438.420(a)-(c)

Current Fee-For-Services Appeals Process

Consumer feels eligibility is wrongly denied, or disputes services allowed
Department of Health Care Sends Notice of Action (NOA)[1]

Level 1
State Fair Hearing Process

State Fair Hearing Process – Dept of Social Services [2]

If a person has received, or are currently receiving benefits/services from Medi-Cal AND they have a complaint about how your benefits/services are/were handled, or the services have been denied or modified they may file for a state fair hear.

Must be filed with in 90 days of receiving the notice of Action, 180 days with good cause.
Expedited hearing must be resolved within 10 calendar days.
Benefits continue pending review (Aid Paid Pending) , if the hearing is filed within 10 days of action
This allows to continue receiving services while the case is being reviewed.

Hearings can be requested verbally or in writing. To request a hearing verbally, call **800-952-5253** or TDD: **800-952-8349**. To request a hearing in writing, complete the form on the back of the NOA and fax it to **916-229-4110,** or send it by registered mail to either the address on the NOA or to:
California Department of Social Services - State Hearing Division
PO Box 944243, Mail Station 19-37
Sacramento, CA 94244-2430

Level 2
Determination for Rehearing

DHCS determines if rehearing is allowed
The Judge has 75-days to submit his/her decision
DHCS has 30-days to adopt or reject the decision

Level 3
State Court

State Court
Must be filed within one year of final decision. No exhaustion of rehearing remedy required.

Notes:

1. Notice of Action (NOA) is a formal letter from the Department of Health Care Services outlining
2. For more information on state fair hearing process see: http://www.dhcs.ca.gov/services/medi-cal/Pages/Medi-CalFairHearing.aspx

Current In-Home Supportive Services Appeals Process

Consumer feels eligibility is wrongly denied, or disputes services allowed and/or number of hours

Local County Social Service Agency Sends Notice of Action (NOA)[1]

Level 1
State Fair Hearing Process

State Fair Hearing Process – Dept of Social Services and Country

Must be filed with in 90 days of receiving the notice of Action, 180 days with good cause. [2]
Expedited hearing must be resolved within 10 calendar days.
Benefits continue pending review (Aid Paid Pending) , if the hearing is filed within 10 days of action [3]
This allows to continue receiving services while the case is being reviewed.

Hearings can be requested verbally or in writing. To request a hearing verbally, call **800-952-5253** or TDD: **800-952-8349**. To request a hearing in writing, complete the form on the back of the NOA and fax it to **916-229-4110,** or send it by registered mail to either the address on the NOA or to:
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Level 2
Determination for Rehearing

Rehearing Review Depart of Social Services
Optional remedy
Must be filed within 30 days of receipt of final decison

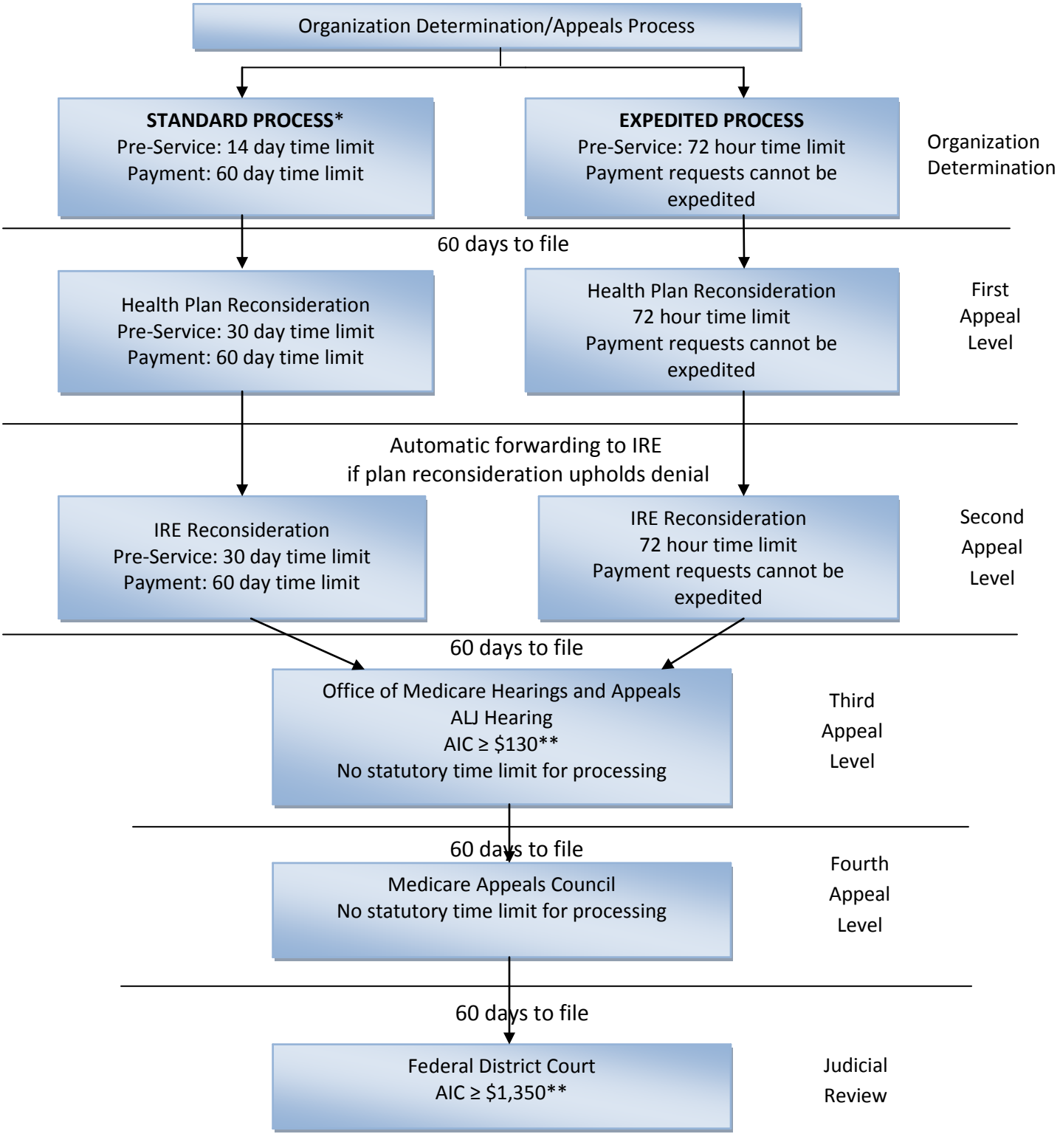
Level 3
State Court

State Court
Must be filed within one year of final decision. No exhaustion of rehearing remedy required.

Notes:

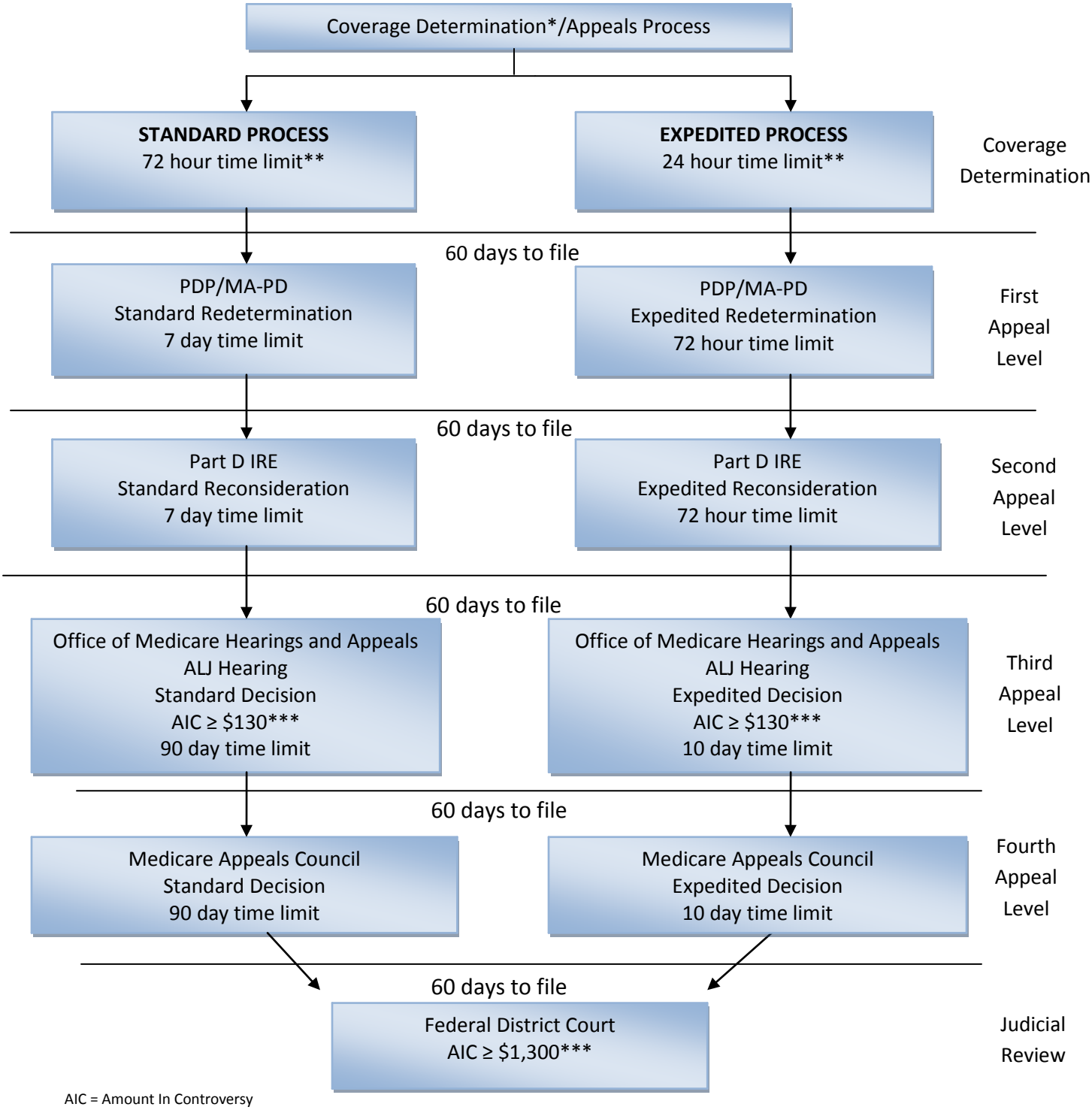
1. Notice of Action (NOA) is a formal letter from the Local County Social Service Agency informing Beneficiary that they are not approved for eligibility for IHSS or the types of services and/or number of hours they are eligible to receive has changed.
2. IHSS Manual of Policies and Procedures (MPP) 22-009.1, "The request for a state hearing shall be filled within 90 days after the date of the action or inaction with which the claimant is dissatisfied."
3. IHSS Manual of Policies and Procedures (MPP) 22-072.5 "When the claimant files a request for a state hearing prior to the effective date of the Notice of Action…aid shall be continued in the amount the claimant would have been paid if the proposed action were not to be taken, provided the claimant does not voluntarily and knowingly waive aid."

Medicare Managed Care (Part C - Medicare Advantage)



AIC = Amount In Controversy / ALJ = Administrative Law Judge / IRE = Independent Review Entity
*Plans must process 95% of all clean claims from out of network providers within 30 days. All other claims must be processed within 60 days.
**The AIC requirement for an ALJ hearing and Federal District Court is adjusted annually in accordance with the medical care component of the consumer price index. The chart reflects the amounts for calendar year (CY) 2012.

Medicare Prescription Drug (Part D)



AIC = Amount In Controversy
ALJ = Administrative Law Judge
IRE = Independent Review Entity
MA-PD = Medicare Advantage plan that offers Part D benefits
PDP = Prescription Drug Plan
*A request for a coverage determination includes a request for a tiering exception or a formulary exception. A request for a coverage determination may be filed by the enrollee, by the enrollee's appointed representative or by the enrollee's physician or other prescriber.
**The adjudication timeframes generally begin when the request is received by the plan sponsor. However, if the request involves an exception request, the adjudication timeframe begins when the plan sponsor receives the physician's supporting statement.
***The AIC requirement for an ALJ hearing and Federal District Court is adjusted annually in accordance with the medical care component of the consumer price index. The chart reflects the amounts for calendar year (CY) 2011.