MEDI-CAL PROVIDER FEE-FOR-SERVICE (FFS) AND MANAGED CARE PLAN (MCP) COMPLAINT PATHWAYS

This resource provides a clear overview of Medi-Cal's FFS and MCP complaint and dispute pathways for providers. It outlines how to submit inquiries, challenge claim denials or enrollment decisions, file discrimination grievances, and navigate managed care plan dispute processes to ensure timely, fair resolution. This document does not supersede any applicable All Plan Letters (APLs), Provider Manual sections, the MCP Contract, and/or other DHCS publications.

FFS Provider Complaint, Grievances & Appeals Processes

This Department of Health Care Services (DHCS) resource is intended to explain the process for Medi-Cal FFS providers relative to submitting inquiries (related to claims, checkwrite, or authorization), complaints, and/or appeals regarding claim denials, disputes or provider enrollment decisions. It can also be used to file discrimination grievances relative to any aspect of the Medi-Cal program.

FFS Checkwrite, Claims, and Authorization Inquiries

Option 1: Log into DHCS' secure, online Medi-Cal Provider Portal to check the status of claims submission. For questions or assistance, you can reach out to the Provider Portal Support Line, also known as the Telephone Service Center (TSC), which is available from 8:00 a.m. to 5:00 p.m. PT, Monday through Friday, except holidays.

> **Note:** For new providers or providers who have never accessed the secure, online Medi-Cal Provider Portal, you will need to first register for a new account with your unique username (email) and password. These will become your log in credentials. For helpful information, please visit DHCS' New Providers webpage.

Option 2: Call DHCS' Provider Telecommunications Network (PTN), which is an automated voice-response system that providers may use as a primary source of checkwrite, claim, and authorization information or services rendered through Medi-Cal and other supported programs. The PTN can be reached by calling one of the following telephone numbers:

- (800) 786-4346
- (916) 636-1950

Note: Access the PTN, providers will need a touch-tone telephone, a Provider Identification Number (PIN), and will need to follow all prompts and steps as outlined in the Provider Telecommunications Network (PTN) (prov tele) section of the Medi-Cal Provider Manual. Additional information can be found in the Form: Main Menu Prompt Options (prov rel frm3) section of the Medi-Cal Provider Manual.

If you forgot your PIN, you may contact DHCS' TSC at 1-800-541-5555 for assistance. Additional information can be found in the this section of the Medi-Cal Provider Manual Form: TSC Main Menu Prompt Options (prov rel frm1 ref).

FFS Claim Denial Complaints and Appeals

- **Step 1**: Call the Telephone Service Center (TSC) at: (800) 541-5555.
- **Step 2:** Submit Claims Inquiry Form (CIF) to:

  California MMIS Fiscal Intermediary
  P.O. Box 15300
  Sacramento, CA 95851-1300
  Attention: Correspondence Specialist Unit
- **Step 3:** Receive status inquiries on submitted CIF by calling: (800) 541-5555.

  Additional information on claims denial or dispute process is located in the Medi-Cal Provider Manual: CIF Submission and Timeliness Instructions (cif sub)
- **Step 4:** Submit Appeals using Appeal Form (90-1). An appeal is the final step in the administrative process and a method for Medi-Cal providers with a dispute to resolve problems related to their claims. The appeals request must be mailed to:

  California MMIS Fiscal Intermediary
  P.O. Box 15300
  Sacramento, CA 95851-1300
  Attn: Appeals Unit

  Additional information on the claim's appeals process is located in the Medi-Cal Provider Manual: Appeal Process Overview (appeal)
- **Step 5:** If a provider is unsatisfied with the resolutions provided from steps one through four above, the provider may contact DHCS directly. Contact Benefits Division at email: medi-cal.benefits@dhcs.ca.gov

Appeals of FFS Provider Enrollment Application Denials

Pursuant to Welfare and Institutions Code section 14043.65, you have the right to appeal the DHCS' action for your enrollment application to the Director of DHCS or the Director's designee. The appeal procedure shall not include a formal administrative hearing under the Administrative Procedure Act. The appeal is a review of the Department's action in denying your application at the time the denial was made. The appeal review is to adjudicate the appropriateness of the denial, and to determine if DHCS' denial should be upheld, continued, or reversed, in whole or in part; it is not to remedy application errors or omissions. An applicant or provider that appeals a decision shall submit the written appeal along with all pertinent documents and all other relevant evidence within 60 days of the date of notification of the Department's action. The Director or the Director's designee shall review all of the relevant materials submitted and shall issue a decision within 90 days of the receipt to the appeal. The decision will be final, and any further appeal shall be required to be filed in accordance with Section 1085 of the Code of Civil Procedure.

If you believe your enrollment application was incorrectly denied, please submit your original written appeal request including any supporting evidence to:

Department of Health Care Services
Office of Administrative Hearings and Appeals
3831 North Freeway Boulevard, Suite 200
Sacramento, CA 95834-1933

In addition, a complete set of documents or relevant evidence must also be sent to:

Department of Health Care Services
Provider Enrollment Division
Policy & Administration Branch
MS 4704
P.O. Box 997412
Sacramento, CA 95899-7412

Should you have any questions or require further information, you may submit your inquiry easily and securely through the Medi-Cal provider enrollment messaging portal via Messages button or visit the DHCS' website for further program information.

If you have any additional enrollment questions, please contact the Provider Enrollment Message Center at (800) 541-5555, or submit your question using the PED online automated inquiry form.

MCP Provider Dispute Resolution Process

All Medi-Cal Managed Care Plans (MCPs) are contractually required to have a fast, fair and cost-effective provider dispute resolution mechanism in place for network providers and out-of-network providers to submit disputes in accordance with the MCPs' contract with DHCS; Health and Safety Code (H&S) section 1367(h); and 28 CCR section 1300.71.38. The mechanism must be documented, reported, and available for access and review.

All network providers and out-of-network providers can submit disputes related to the processing of a payment or non-payment of a claim by the MCP, authorization or denial of a service, and the timeliness of the reimbursement and any interest.

Network providers may, in addition, submit disputes on other issues. Providers disputing a claims payment, or other issues, should submit their dispute through the provider dispute resolution process with the MCP.

When to Submit a Provider Dispute

CLAIMS AND INTEREST

The dispute resolution process can be used for claims disputes for both network providers and out-of-network providers. Providers should submit a provider dispute resolution to the MCP if they submitted a clean claim that was not paid within 30 days of the claim submission. All MCPs are required by law to pay clean claims within 30 days of receipt. If a MCP does not, then the MCP is required to pay interest on this claim in accordance with the MCP's contract with DHCS and H&S section 1371.

> **Note:** A clean claim has all the required information needed for the MCP to process a provider's payment. If the claims were rejected due to insufficient information or other issues, those issues must be resolved, and a clean claim must be submitted prior to the submission of a provider dispute.

Network providers and out-of-network providers may also submit a dispute regarding the authorization or denial of a service.

OTHER ISSUES

Additionally, network providers can submit a dispute if they have concerns about:

- The processing of retroactive rate or payment adjustments pursuant to the terms of a State Directed Payment or other payment policy that is contractually required;
- Contract disputes; or

- Other issues not related to a claim (which must include a clear explanation of the issue and the provider's position thereon, per 28 CCR 1300.71.38).

TIMING OF PROVIDER DISPUTE SUBMISSION AND RESOLUTION

Providers have 365 calendar days to submit a dispute to an MCP, or more if the MCP permits. For disputes related to claims, the 365-calendar day timeframe starts from the date of the last action taken on the claim by the MCP or, in the case of inaction, from the expiration of the most recent time for contesting or denying claims.

Provider dispute resolution submissions related to claims must be processed in a timely manner by the MCP. The MCP must resolve each provider dispute and issue a written determination stating the pertinent facts and explaining the reasons for its determination within 45 Working Days after the date of receipt of the provider dispute or the amended provider dispute.

Who Can Submit Provider Dispute Resolutions

Both network providers and out-of-network providers should submit disputes directly to MCPs to obtain resolution.

How to Submit a Provider Dispute Resolution

Network Providers will have the provider dispute resolution mechanism and process detailed in their network provider agreements, in the MCP's provider manual, and/or on the MCP's website. Many MCPs also accept claims disputes through their provider portals. Providers who are unable to locate the information on their own can contact the MCP for assistance. More contact information for MCPs can be found at: Medi-Cal Managed Care Health Plan Directory | DHCS

- **Step 1:** Initiate Provider Resolution Process with the Applicable MCP.

  Note: MCPs are obligated under 28 CCR section 1300.71.38 to resolve provider disputes within 45 Working Days of receiving the provider dispute or the amended provider dispute.

- **Step 2:** If providers receive an unsatisfactory provider dispute resolution response from a Knox-Keene MCP, they may file a complaint directly with the Department of Managed Health Care (DMHC) through the Provider Complaint Against a Plan web page.

- **Step 3:** If the provider is in a Knox-Keene MCP, file a complaint directly with DMHC at: How to File a Complaint
  - For questions email: providercomplaintunit@dmhc.ca.gov

- Complaint line toll-free at 1-877-525-1295.
- Other Resource: Frequently Asked Questions and View All Health Plans.

Note: Knox-Keene MCPs are commercial managed care plans licensed by DMHC under the Knox-Keene Health Care Service Plan Act of 1975 and do not include certain Medi-Cal County Organized Health Systems (COHS) MCPS.

Lists of MCP plans by county and model can be found using the following links: Medicare Medi-Cal Advantage Plans and Medi-Cal Managed Care Plans.

Before the DMHC conducts a review, the provider is required to submit the dispute to the payor's Provider Dispute Resolution (PDR) mechanism for a minimum of 45 working days or until receipt of the payor's written determination, whichever period is shorter.

» **Step 4:** If a provider is unsatisfied with the resolution provided from the steps above, they may contact DHCS at: medi-cal.benefits@dhcs.ca.gov.

Note: Helpful information when contacting DHCS includes, provider information, the MCP involved, details on the dispute, and steps already taken to resolve.

MCP Network Adequacy and Contracting Concerns

MCPs must ensure they have a network that is adequate to meet member needs. However, MCPs generally have the discretion to contract or not contract with any Medi-Cal eligible or enrolled provider.

If an MCP is screening and enrolling a provider, it must provide the provider with a written determination on MCP letterhead within 120 calendar days of its receipt of a provider application. At any point during the contracting process, if an MCP has decided it is not going to proceed with contracting with a provider, the MCP must inform the provider immediately (APL 22-013, pg. 12). MCPs are not required to have an appeals process for screening and enrollment decisions. If providers have concerns about not being contracted and that there is discrimination involved, the provider should file a complaint with the DHCS Office of Civil Rights (OCR) as noted above.

For members who have a pre-existing relationship with an out-of-network provider, such as a doula, midwife, etc., and then move from fee for service into managed care or from one managed care plan to another, continuity of care protections may apply. This means that if the doula is in good standing with Medi-Cal, willing to accept the MCP's rates, and willing to work with the MCP, the MCP may be required to allow the member to continue to work with the doula for up 12 month's. Continuity of Care | DHCS

How Can Providers Address Member Concerns?

» Step 1: Members can file a grievance/complaint with the MCP

If a member has a problem with an MCP, provider, or with the healthcare treatment received from a provider, a member may file a grievance/complaint with the MCP. A complaint is the same as a grievance. To file a complaint, you must:

1. Contact your MCP to file a complaint

   Note: If you do not know your MCP contact information, visit the DHCS Medi-Cal Managed Care Health Plan Directory
2. The MCP must generally notify the member within 5 calendar days of receipt to confirm the complaint has been received.
3. The MCP has 30 calendar days from receipt to respond to a member's complaint if it is a standard complaint. The MCP has 72 hours from receipt to respond to a member's complaint if it is an expedited complaint.

For members with a Knox--Keene MCP: If the complaint is still not resolved within the required timeframe or the member is unhappy with the result after completing the MCP's grievance process, the member can contact the California Department of Managed Health Care (DMHC) to file a complaint as outlined in #2 below.

For members with a non-Knox-Keene MCP: If the complaint is still not resolved within the required timeframe or the member is unhappy with the result after completing the MCP's grievance process, the member can file a State Hearing request as outlined in #3 below.

» Step 2: Members in Knox-Keene MCPs can file a complaint with DMHC

If a member's issue has not been resolved within the required timeframe or a member is not satisfied with the MCP's decision after completing the MCP's grievance process, a member in a Knox-Keene MCP may file a complaint with DMHC.

To file a complaint, the member can call DMHC for free at 1-888-466-2219 (TTY 1-877-688-9891 or 711) or go to How to File a Complaint.

» Step 3: Members can file a State Hearing request with the California Department of Social Services (CDSS)

If a member's issue has not been resolved within the required timeframe or a member is not satisfied with the MCP's decision after completing the MCP's grievance process, a member may request a State Hearing with CDSS.

Additional information on how to file a state hearing can be found at Hearing Requests.

» Step 4: Members can contact the Medi-Cal Ombudsman

Members may contact the DHCS Medi-Cal Managed Care Ombudsman to address problems with joining, changing, or leaving a health plan. They may also help with getting a member's Medi-Cal transferred to a new county. Members can call the Ombudsman Monday through Friday, 8 a.m. to 5 p.m. at 1-888-452-8609.

Additional information can be found at the Medi-Cal Managed Care and Mental Health Office of the Ombudsman | DHCS.

» Step 5: Providers or other Advocates can become the Authorized Representative for Members and take on actions in 1-4 above on behalf of the member

Providers and/or advocates can use the standard authorized representative form MC 382 or a plan authorized representative form to become the member's authorized representative (AR). Being a member's AR means that they can act on behalf of the member. This means the AR can file a grievance with the MCP, DMHC, or the Ombudsman and/or request a State Hearing on behalf of the member.

Discrimination Grievances for both FFS and MCP

DHCS administers Medi-Cal and does not unlawfully discriminate on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or any other basis protected by federal or State civil rights laws.

DHCS' Office of Civil Rights has adopted a grievance procedure providing for the resolution of complaints alleging unlawful discrimination in the Medi-Cal program. Any member or provider who believes that they or another member or provider has been subjected to unlawful discrimination in the Medi-Cal program may file a grievance under this procedure.

- **Step 1**: Providers must complete and submit the Discrimination Complaint Form (Title VI and ADA) (DHCS 1044) to DHCS within 365 days from the date the alleged discrimination took place by either of the following methods:
    - By mail: Office of Civil Rights, Department of Health Care Services
      P.O. Box 997413, MS 0009
      Sacramento, CA 95899-7413
    - By email: CivilRights@dhcs.ca.gov.

  Note: Discrimination grievances may also be filed by calling DHCS' Office of Civil Rights at 916-440-7370 or by written correspondence. DHCS provides free aids and services to people with disabilities. If you need these services, call the Office of Civil Rights, at (916) 440-7370, 711 (California State Relay) or by email.
- **Step 2:** Within ten (10) days of receipt of a discrimination grievance, the DHCS Office of Civil Rights will send you written notification that your grievance has been received. DHCS' Office of Civil Rights will also let you know if more information is needed.
- **Step 3:** Within thirty (30) days of receipt of a discrimination grievance, DHCS' Office of Civil Rights will begin an investigation if the grievance is within its jurisdiction.

  Note: As part of its investigation, DHCS' Office of Civil Rights may share information about your discrimination grievance with other parties, including the person or entity that is the source of your grievance or Medi-Cal managed care plan. To the extent possible, and in accordance with applicable law, DHCS' Office of Civil Rights will take appropriate steps to preserve confidentiality of files and records relating to discrimination grievances and will share them only with those who have a need to know.
- **Step 4:** Within ninety (90) days of receipt of a discrimination grievance, DHCS' Office of Civil Rights will issue a written determination explaining its findings, or, if the investigation is ongoing, will provide an update on the status of the investigation and the expected date of completion. Upon completion of its investigation, the DHCS Office of Civil Rights will issue a final, written determination. The written determination will be based on a preponderance of the evidence and will include a notice of your right to pursue further administrative or legal remedies. In the event DHCS' Office of Civil Rights

determines the grievance is not within its jurisdiction, it will notify you of that determination in writing within 90 days of receipt of the discrimination grievance.

- **Step 5 (if applicable):** Providers may appeal the written determination of a discrimination grievance within fifteen (15) days of receipt. The written determination will be deemed received five (5) days after mailing, if mailed, or immediately upon electronic transmission, if faxed or emailed. Appeals may be submitted to DHCS by either of the following methods:
  - By mail: Office of Civil Rights, Department of Health Care Services

    P.O. Box 997413, MS 0009
    Sacramento, CA 95899-7413
  - By email: CivilRights@dhcs.ca.gov.

  Note: Appeals must identify the written determination being appealed or include a copy of the DHCS Office of Civil Rights written determination and an explanation of the reason for appealing the determination.
- **Step 6 (if applicable):** DHCS' Director, or designee, will issue a written determination of an appeal no later than sixty (60) days after DHCS' Office of Civil Rights receives the appeal.

For more information, please see DHCS' Discrimination Grievance Policies and Procedures webpage.