56262 Provider Grievance and Complaints

(a)

A provider of medical services may submit a grievance or complaint concerning the authorization or denial of a service or the processing, payment or nonpayment of a claim by a PCCM plan as follows: (1) The provider shall initiate a first level appeal, by submitting a grievance or complaint in writing, within 30 calendar days of the action precipitating the grievance or complaint, to the PCCM plan identifying the claim involved and specifically describing the disputed action or inaction regarding the claim. (2) The PCCM plan shall acknowledge the written grievance or complaint within 15 calendar days of its receipt. (3) The PCCM plan may refer a grievance or complaint to professional peer review. (A) When the grievance or complaint is not referred to professional peer review, the PCCM plan shall review the merits of the grievance or complaint and send a written report of its conclusion and reasons to the provider within 30 calendar days of the acknowledgement of the receipt of the grievance or complaint. (B) When the grievance or complaint is referred to professional peer review:1. All parties concerned shall be notified that a referral has been made to professional peer review and that a final determination may require up to 60 calendar days from the acknowledgement of the receipt of the grievance or complaint. 2. The professional peer review shall make its evaluation and submit its findings and recommendations to the PCCM plan and the provider within 30 calendar days after the receipt of the referral from the PCCM

plan. 3. The PCCM plan, after taking into consideration the findings and recommendations of the professional peer review, shall send a written report of its conclusions and reasons to the provider within 30 calendar days of receipt of the recommendation. 4. The PCCM plan shall retain all documentation related to the peer review in accordance with section 56310.

(1)

The provider shall initiate a first level appeal, by submitting a grievance or complaint in writing, within 30 calendar days of the action precipitating the grievance or complaint, to the PCCM plan identifying the claim involved and specifically describing the disputed action or inaction regarding the claim.

(2)

The PCCM plan shall acknowledge the written grievance or complaint within 15 calendar days of its receipt.

(3)

The PCCM plan may refer a grievance or complaint to professional peer review. (A) When the grievance or complaint is not referred to professional peer review, the PCCM plan shall review the merits of the grievance or complaint and send a written report of its conclusion and reasons to the provider within 30 calendar days of the acknowledgement of the receipt of the grievance or complaint. (B) When the grievance or complaint is referred to professional peer review:1. All parties concerned shall be notified that a referral has been made to professional peer review and that a final determination may require up to 60 calendar days from the acknowledgement of the receipt of the grievance or complaint. 2. The professional peer review shall make its evaluation and submit its findings and recommendations to the PCCM plan and the provider within 30 calendar days after the receipt of the referral from the PCCM plan. 3. The PCCM plan, after taking into consideration the findings and recommendations of

the professional peer review, shall send a written report of its conclusions and reasons to the provider within 30 calendar days of receipt of the recommendation. 4. The PCCM plan shall retain all documentation related to the peer review in accordance with section 56310.

(A)

When the grievance or complaint is not referred to professional peer review, the PCCM plan shall review the merits of the grievance or complaint and send a written report of its conclusion and reasons to the provider within 30 calendar days of the acknowledgement of the receipt of the grievance or complaint.

(B)

When the grievance or complaint is referred to professional peer review:1. All parties concerned shall be notified that a referral has been made to professional peer review and that a final determination may require up to 60 calendar days from the acknowledgement of the receipt of the grievance or complaint. 2. The professional peer review shall make its evaluation and submit its findings and recommendations to the PCCM plan and the provider within 30 calendar days after the receipt of the referral from the PCCM plan. 3. The PCCM plan, after taking into consideration the findings and recommendations of the professional peer review, shall send a written report of its conclusions and reasons to the provider within 30 calendar days of receipt of the recommendation. 4. The PCCM plan shall retain all documentation related to the peer review in accordance with section 56310.

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All parties concerned shall be notified that a referral has been made to professional peer review and that a final determination may require up to 60 calendar days from the acknowledgement of the receipt of the grievance or complaint.

2.

The professional peer review shall make its evaluation and submit its findings and recommendations

to the PCCM plan and the provider within 30 calendar days after the receipt of the referral from the PCCM plan.

3.

The PCCM plan, after taking into consideration the findings and recommendations of the professional peer review, shall send a written report of its conclusions and reasons to the provider within 30 calendar days of receipt of the recommendation.

4.

The PCCM plan shall retain all documentation related to the peer review in accordance with section 56310.

(b)

A provider may, after complying with subdivision (a) above, refer the grievance or complaint to the Department for a second level of appeal: (1) Within 30 calendar days of receipt of the PCCM plan's written report of its conclusion, or (2) When the PCCM plan has failed to act within the deadlines set forth in subdivision (a).

(1)

Within 30 calendar days of receipt of the PCCM plan's written report of its conclusion, or

(2)

When the PCCM plan has failed to act within the deadlines set forth in subdivision (a).

(c)

In a second level appeal for a grievance or complaint to the Department, the provider shall submit the following to the Department:(1) A letter requesting the Department to review the first level of appeal. (2) A copy of the letter sent to the PCCM plan requesting the first level of appeal. (3) A copy of the original documents submitted to the PCCM plan. (4) A copy of the first level appeal denial response letter if the second level of appeal is based on denial. (5) A copy of any other

correspondence between the PCCM plan and the provider that documents timely submission and the validity of the appeal.

(1)

A letter requesting the Department to review the first level of appeal.

(2)

A copy of the letter sent to the PCCM plan requesting the first level of appeal.

(3)

A copy of the original documents submitted to the PCCM plan.

(4)

A copy of the first level appeal denial response letter if the second level of appeal is based on denial.

(5)

A copy of any other correspondence between the PCCM plan and the provider that documents timely submission and the validity of the appeal.

(d)

The Department shall acknowledge the second level appeal request by a provider within 15 calendar days of its receipt, and shall send written notice to the PCCM plan of the appeal.

(e)

The Department shall review the written documents submitted in the provider's appeal, may ask for additional information, and may hold an informal meeting with the involved parties. The Department shall send a written report of its conclusions and reasons to the provider and the PCCM plan within 60 calendar days of receipt of the appeal from the provider.