PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MPPRGR210</td><td colspan="3">Lead Department: Provider Relations</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Provider Grievance</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 04/25/1994</td><td colspan="4">Next Review Date: 08/13/2025
Last Review Date: 08/14/2024</td></tr>
<tr><td>Applies to:</td><td colspan="2">☒ Medi-Cal</td><td colspan="3">☐ Employees</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Steven Gwiazdowski, MD</td><td colspan="3">Approval Date: 08/14/2024</td></tr>
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I. RELATED POLICIES:

A. MCUP3037 – Appeals of Utilization Management/Pharmacy Decisions
B. MPQP1053 – Peer Review Committee
C. MPQP1016 – Potential Quality Issue Investigation and Resolution
D. CGA024 – Medi-Cal Member Grievance System

II. IMPACTED DEPTS:

A. Provider Relations
B. Health Services

III. DEFINITIONS:

Provider Grievance: For the purposes of this policy, a Provider Grievance is defined as an expression of dissatisfaction from a provider that, after exhausting all Plan appeal processes, requests to have their complaint, appeal or dispute submitted to the Provider Grievance Review Committee for final review of the medical or pharmacy decision or how the Plan implemented a regulatory requirement.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To describe the process for resolving provider grievances related to determinations of medical or pharmacy decisions made by Partnership HealthPlan of California, the Plan's implementation of DHCS Regulatory or other State and Federal requirements, or contractual disputes between the Health Plan and providers. The provider grievance process is not applicable to provider appeals filed on behalf of members and as such, is separate and distinct from the member grievance and appeal process. A provider may request a grievance after all applicable Partnership Appeal processes have been exhausted.

VI. POLICY / PROCEDURE:

A. The Partnership HealthPlan of California, (Partnership) Chief Executive Officer is ultimately responsible for the provider grievance process and has primary responsibility for maintenance, review, formulation of policy changes and procedural improvements of the grievance review system. The CEO is assisted by the Partnership Chief Medical Officer, Chief health Services Officer and Senior Director of Provider Relations. The provider grievance process is managed and monitored by the Provider Relations department.
B. Providers must be given an opportunity to have their grievance heard and evaluated. Two mechanisms, an informal and a formal grievance procedure, have been established for that purpose.

1. Informal grievances may be registered by the provider, by telephone, letter or visit to the Partnership office. The provider should contact the Provider Relations department to register a grievance. The grievance is immediately recorded. If a satisfactory solution has not been reached through discussion with the parties within ten (10) working days after an informal grievance is registered, the grievance automatically becomes a formal grievance.
2. Formal grievance is filed in writing at the Partnership offices or by mail within 45 working days of the determination or action that is the subject of the grievance. There is a fifteen (15) working-day resolution period during which time the Partnership staff proposes a resolution to the provider. If the proposed resolution is not satisfactory, the provider may request in writing a Provider Grievance Review Committee (PGRC) hearing.
3. The PGRC will meet within forty-five (45) working days of receipt of the written provider request for a meeting. PGRC decisions are binding unless reversed by Partnership's Board of Commissioners.

C. The Provider Grievance Review Committee (PGRC) has been established to provide a formal grievance mechanism.

1. The PGRC consists of the members of the Peer Review Committee (PRC) who are not Partnership medical directors, excluding any members of the PRC who have a potential conflict of interest. Potential conflict of interest for provider grievances includes being a member of the active medical staff on a hospital if the hospital is the grieving party and otherwise working for a hospital or institution if the grieving party is a physician on the active medical staff of that hospital or institution. PGRC will meet on the same date as the Peer Review Committee.
2. The Committee's meeting is documented in minutes. The provider and Partnership are advised in writing of the Committee's decision within ten (10) working days of the meeting.

D. Providers appealing utilization management or pharmacy decisions on behalf of members must follow the procedure outlined in Health Services policy MCUP3037, Appeals of Utilization Management/Pharmacy Decisions prior to filing a request for a PGRC hearing.

E. Providers retrospectively appealing a decision to deny or limit payment for a service based on application of UM criteria, for which the member is not financially responsible, should first submit an appeal (which is not on behalf of a member, but on behalf of the billing provider), with additional documentation responding to the reason for the initial denial or limitation. A provider grievance may not be filed until an initial appeal has been completed, which the provider disagrees with.

F. If during the review process, the PGRC determines that a provider may be deficient in rendering or managing care, or problem areas are discovered, this information is referred to the Performance Improvement Clinical Specialist as a Potential Quality Issue (PQI); see MPQP1016 - Potential Quality Issue Investigation and Resolution.

G. The plan or the plan's capitated provider shall not discriminate or retaliate against a provider (including but not limited to the cancellation of the provider's contract) because the provider filed a contracted provider grievance or a non-contracted provider grievance.

VII. REFERENCES:

A. California Department of Health Care Services (DHCS) All Plan Letter (APL) 21-011 Grievance and Appeal Requirements, Notice and "Your Rights" Templates (Aug. 31, 2021 supersedes APL 17-006)

B. National Committee for Quality Assurance (NCQA) Guidelines (effective July 1, 2024) UM 7 Element C, Written Notification of Non-Behavioral Healthcare Appeal Rights/Process and Element I, Written Notification of Pharmacy Appeal Rights/Process

VIII. DISTRIBUTION:

A. Partnership Provider Manual

B. Partnership Department Directors

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE:
Senior Director of Provider Relations

X. REVISION DATES:
08/23/1996, 10/10/1997, 03/29/2000, 07/24/2000, 09/13/2000, 07/17/2002, 11/17/2003, 2/11/2004, 02/09/2005, 03/08/2006, 07/11/2007, 03/12/2008, 04/08/2009, 07/08/2009, 08/11/2010, 08/10/2011, 08/08/2012, 08/14/2013, 08/13/2014, 08/12/2015, 08/10/2016, 08/09/2017, 08/08/2018, 01/09/2019, 01/08/2020, 08/12/2020, 08/11/2021, 08/10/2022, 08/09/2023, 08/14/2024

PREVIOUSLY APPLIED TO:
N/A