

**PARTNERSHIP HEALTHPLAN OF CALIFORNIA
POLICY/ PROCEDURE**

Policy/Procedure Number: MPPRGR210		Lead Department: Provider Relations	
Policy/Procedure Title: Provider Grievance		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy	
Original Date: 04/25/1994		Next Review Date: 08/10/2022 Last Review Date: 08/11/2021	
Applies to:	<input checked="" type="checkbox"/> Medi-Cal	<input type="checkbox"/> Employees	
Reviewing Entities:	<input checked="" type="checkbox"/> IQI	<input type="checkbox"/> P & T	<input checked="" type="checkbox"/> QUAC
	<input type="checkbox"/> OPERATIONS	<input type="checkbox"/> EXECUTIVE	<input type="checkbox"/> COMPLIANCE <input type="checkbox"/> DEPARTMENT
Approving Entities:	<input type="checkbox"/> BOARD	<input type="checkbox"/> COMPLIANCE	<input type="checkbox"/> FINANCE <input checked="" type="checkbox"/> PAC
	<input type="checkbox"/> CEO <input type="checkbox"/> COO	<input type="checkbox"/> CREDENTIALING	<input type="checkbox"/> DEPT. DIRECTOR/OFFICER
Approval Signature: Jeffrey Gaborko, MD		Approval Date: 08/11/2021	

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 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 PHC Appeal processes have been exhausted.

VI. POLICY / PROCEDURE:

- A. The Partnership HealthPlan of California, (PHC) 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 Chief Executive Officer is assisted by the PHC Chief Medical Officer, Senior Director, Health Services and Senior Director, 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.

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1. Informal grievances may be registered by the provider, by telephone, letter or visit to the PHC 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 PHC 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 PHC staff proposes a resolution to the provider. If the proposed resolution is not satisfactory, the provider may request in writing Provider Grievance Review Committee hearing.

Decisions of the Provider Grievance Review Committee are binding unless reversed by the Partnership HealthPlan of California Board of Commissions. The Provider Grievance Committee will meet within forty-five (45) working days of receipt of the written provider request of a Provider Grievance Review Committee meeting.

- C. The Provider Grievance Review Committee has been established to provide a formal grievance mechanism.
 1. The Provider Grievance Review Committee (PGRC) consists of the members of the Peer Review Committee (PRC) who are not PHC 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 and the provider and PHC 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 policies and procedures MCUP3037, Appeals of Utilization Management/Pharmacy Decisions prior to filing a request for a Provider Grievance Review 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 Provider Grievance Review Committee 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. [DHCS All Plan Letter, APL 17-006 Grievance and Appeal Requirements](#)
- B. NCQA UM 7 Element C, Non-Behavioral Healthcare Notice of Appeal Rights/Process and Element I, Pharmacy Notice of Appeal Rights/Process

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VIII. DISTRIBUTION:

- A. PHC Provider Manual
- B. PHC Department Directors

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Senior Director, 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

PREVIOUSLY APPLIED TO:

N/A