

**DEPARTMENT OF MANAGED HEALTH CARE
HELP CENTER
DIVISION OF PLAN SURVEYS**

TECHNICAL ASSISTANCE GUIDE

GRIEVANCES AND APPEALS

ROUTINE DENTAL SURVEY

OF

PLAN NAME

(A Medi-Cal Dental Managed Care Plan)

DATE OF SURVEY:

PLAN COPY

Issuance of this January 15, 2016 Technical Assistance Guide renders all other versions obsolete.

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GRIEVANCES AND APPEALS REQUIREMENTS

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Requirement GA-001: Grievance System Description

STATUTORY/REGULATORY CITATION(S)

CA Health and Safety Code sections 1368(a)(1)

(a) Every plan shall do all of the following:

(1) Establish and maintain a grievance system approved by the department under which enrollees may submit their grievances to the plan. Each system shall provide reasonable procedures in accordance with department regulations that shall ensure adequate consideration of enrollee grievances and rectification when appropriate.

CA Health and Safety Code sections 1368(a)(4)(A) and (B)

(a) Every plan shall do all of the following:

(4) (A) Provide for a written acknowledgment within five calendar days of the receipt of a grievance, except as noted in subparagraph (B). The acknowledgment shall advise the complainant of the following:

(i) That the grievance has been received.

(ii) The date of receipt.

(iii) The name of the plan representative and the telephone number and address of the plan representative who may be contacted about the grievance.

(B) Grievances received by telephone, by facsimile, by e-mail, or online through the plan's Internet Web site pursuant to Section 1368.015, that are not coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment and that are resolved by the next business day following receipt are exempt from the requirements of subparagraph (A) and paragraph (5). The plan shall maintain a log of all these grievances. The log shall be periodically reviewed by the plan and shall include the following information for each complaint:

(i) The date of the call.

(ii) The name of the complainant.

(iii) The complainant's member identification number.

(iv) The nature of the grievance.

(v) The nature of the resolution.

(vi) The name of the plan representative who took the call and resolved the grievance.

28 CCR 1300.68(a)

(a) The grievance system shall be established in writing and provide for procedures that will receive, review and resolve grievances within 30 calendar days of receipt by the plan, or any provider or entity with delegated authority to administer and resolve the plan's grievance system. The following definitions shall apply with respect to the regulations relating to grievance systems:

(1) "Grievance" means a written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by an enrollee or the enrollee's representative. Where the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.

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(2) “Complaint” is the same as “grievance.”

(3) “Complainant” is the same as “grievant,” and means the person who filed the grievance including the enrollee, a representative designated by the enrollee, or other individual with authority to act on behalf of the enrollee.

(4) “Resolved” means that the grievance has reached a final conclusion with respect to the enrollee’s submitted grievance, and there are no pending enrollee appeals within the plan’s grievance system, including entities with delegated authority.

(A) If the plan has multiple internal levels of grievance resolution or appeal, all levels must be completed within 30 calendar days of the plan’s receipt of the grievance.

(B) Grievances that are not resolved within 30 calendar days, or grievances referred to the Department’s complaint or independent medical review system, shall be reported as “pending” grievances pursuant to subsection (f) below. Grievances referred to external review processes, such as reviews of Medicare Managed Care determinations pursuant to 42 C.F.R. Part 422, or the Medi-Cal Fair Hearing process, shall also be reported pursuant to subsection (f) until the review and any required action by the plan resulting from the review is completed.

28 CCR 1300.68(b)(1)

(b) The plan’s grievance system shall include the following:

(1) An officer of the plan shall be designated as having primary responsibility for the plan’s grievance system whether administered directly by the plan or delegated to another entity. The officer shall continuously review the operation of the grievance system to identify any emergent patterns of grievances. The system shall include the reporting procedures in order to improve plan policies and procedures.

28 CCR 1300.68(b)(3)

(b) The plan’s grievance system shall include the following:

(3) The grievance system shall address the linguistic and cultural needs of its enrollee population as well as the needs of enrollees with disabilities. The system shall ensure all enrollees have access to and can fully participate in the grievance system by providing assistance for those with limited English proficiency or with a visual or other communicative impairment. Such assistance shall include, but is not limited to, translations of grievance procedures, forms, and plan responses to grievances, as well as access to interpreters, telephone relay systems and other devices that aid disabled individuals to communicate. (Note: Plans shall develop and file with the Department a policy describing how they ensure that their grievance system complies with this subsection within 90 days of the effective date of this regulation.)

28 CCR 1300.68(b)(5)

(b) The plan’s grievance system shall include the following:

(5) A written record shall be made for each grievance received by the plan, including the date received, the plan representative recording the grievance, a summary or other documents describing the grievance, and its disposition. The written record of grievances shall be reviewed periodically by the governing body of the plan, the public policy body created pursuant to section 1300.69, and by an officer of the Plan or his designee. This review shall be thoroughly documented.

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28 CCR 1300.68(b)(8)

(b) The plan shall respond to grievances as follows:

(8) The plan shall assure that there is no discrimination against an enrollee or subscriber including cancellation of the contract) on the grounds that the complainant filed a grievance.

28 CCR 1300.68(d)(2)

(d) The plan shall respond to grievances as follows:

(2) The grievance system shall provide for a prompt review of grievances by the management or supervisory staff responsible for the services or operations which are the subject of the grievance.

28 CCR 1300.68(d)(6)

(d) The plan shall respond to grievances as follows:

(6) Copies of grievances and responses shall be maintained by the Plan for five years, and shall include a copy of all medical records, documents, evidence of coverage and other relevant information upon which the plan relied in reaching its decision.

28 CCR 1300.68(d)(8)

(d) The plan shall respond to grievances as follows:

(8) Grievances received over the telephone that are not coverage disputes, disputed health care services involving medical necessity or experimental or investigational treatment, and that are resolved by the close of the next business day, are exempt from the requirement to send a written acknowledgment and response. The plan shall maintain a log of all such grievances containing the date of the call, the name of the complainant, member identification number, nature of the grievance, nature of resolution, and the plan representative's name who took the call and resolved the grievance. The information contained in this log shall be periodically reviewed by the plan as set forth in Subsection (b).

28 CCR 1300.68(e)

(e) The plan's grievance system shall track and monitor grievances received by the plan, or any entity with delegated authority to receive or respond to grievances. The system shall:

(1) Monitor the number of grievances received and resolved; whether the grievance was resolved in favor of the enrollee or plan; and the number of grievances pending over 30 calendar days. The system shall track grievances under categories of Commercial, Medicare and Medi-Cal/other contracts. The system shall indicate whether an enrollee grievance is pending at: 1) the plan's internal grievance system; 2) the Department's consumer complaint process; 3) the Department's Independent Medical Review system; 4) an action filed or before a trial or appellate court; or 5) other dispute resolution process. Additionally, the system shall indicate whether an enrollee grievance has been submitted to: 1) the Medicare review and appeal system; 2) the Medi-Cal fair hearing process; or 3) arbitration.

(2) The system shall be able to indicate the total number of grievances received, pending and resolved in favor of the enrollee at all levels of grievance review and to describe the issue or issues raised in grievances as 1) coverage disputes, 2) disputes involving medical necessity, 3) complaints about the quality of care and 4) complaints about access to care (including complaints

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about the waiting time for appointments), and 5) complaints about the quality of service, and 6) other issues.

28 CCR 1300.68(f)(1)

(f) Quarterly Reports

(1) All plans shall submit a quarterly report to the Department describing grievances that were or are pending and unresolved for 30 days or more. The report shall be prepared for the quarters ending March 31st, June 30th, September 30th and December 31st of each calendar year. The report shall also contain the number of grievances referred to external review processes, such as reconsiderations of Medicare Managed Care determinations pursuant to 42 C.F.R. Part 422, the Medi-Cal fair hearing process, the Department's complaint or Independent Medical Review system, or other external dispute resolution systems, known to the plan as of the last day of each quarter.

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Dental Director and/or officer who has primary responsibility for the grievance system
- Manager of Member Services
- QM Director
- Director of Operations

DOCUMENT(S) TO BE REVIEWED

- Description of the grievance system
- Position description of the officer with primary responsibility for the grievance system
- Policy and procedure for generation and review of aggregated and tabulated grievances
- Grievance logs (including Exempt grievances)
- Grievance forms
- Policies and procedures to maintain a system of aging of grievances pending and unresolved for 30 calendar days or more
- Policy and procedure to report quarterly to the DMHC all grievances pending and unresolved for 30 calendar days or more
- Policies and procedures for the processing of grievances
- Committee Minutes (Governing Body, QA, Public Policy, Grievance Committee, etc.), including grievance reports reviewed
- Reports and analysis by Plan's grievance officer regarding emergent patterns of grievances for most recent 6-12 month period.
- Review licensing filing of the Plan's Grievance Program and confirm submission of appropriate policies and procedures

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GA-001 - Key Element 1:

1. The Plan has a grievance system, approved by the Department, for the receipt, review, and resolution of grievances.

CA Health and Safety Code section 1368(a)(1); 28 CCR 1300.68(a); 28 CCR 1300.68(b)(8); 28 CCR 1300.68(d)(6)

Assessment Questions	Yes	No	N/A
1.1 Does the Plan have a written description of its grievance system?			
1.2 Does the grievance system description include grievance <u>system structure</u> including personnel, lines of authority, forms, and grievance materials?			
1.3 Does the grievance system description include grievance <u>system scope</u> including a clear definition of the grievance system and use of terms (e.g., grievance, complaint, complainant, resolved, and pending), proper assistance provided to enrollees, length of time for filing grievances, consideration for the linguistic and cultural needs of the enrollee population, and the needs of enrollees with disabilities?			
1.4 Does the grievance system description include grievance <u>system processes</u> including filing a grievance, grievance filing and resolution timeframes, assistance provided to enrollees, logging and responding to a grievance, evaluating and resolving a grievance, and enrollee communications?			
1.5 Does the grievance system description include <u>oversight</u> of <u>delegated</u> entities, as applicable, and <u>procedures</u> for oversight?			
1.6 Does the grievance system description include grievance <u>system monitoring</u> procedures including a description of how the Plan's grievance officer continuously reviews the operation of the grievance system to identify any emergent patterns of grievances and how the Plan might use various grievance reports to improve service or care (i.e., improve Plan policies and procedures)?			
1.7 Does the Plan's grievance system provide for the <u>maintenance</u> of <u>copies of grievances</u> and responses for five years, which shall include a copy of all medical records, documents, evidence of coverage, and other relevant information upon which the Plan relied in reaching its decision?			
1.8 If the Plan has multiple levels of grievance/appeal, are all levels completed within 30 days?			
1.9 Does the Plan assure that there is no discrimination against an enrollee or subscriber (including cancellation of the contract) on the grounds that the complainant filed a grievance?			

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GA-001 - Key Element 2:

- 2. There is an officer of the Plan who has primary responsibility for the grievance process who identifies and reports emergent patterns of grievances to formulate policy changes and procedural improvements in the Plan’s administration.**

28 CCR 1300.68(b)(1) and (5); 28 CCR 1300.68(d)(2)

Assessment Questions	Yes	No	N/A
2.1 Is there a designated Plan officer who has primary responsibility for oversight and evaluation of the grievance process?			
2.2 Does this officer identify and report patterns of grievances to formulate policy changes and procedural improvements in Plan administration?			
2.3 Does this officer regularly monitor Plan compliance with grievance regulations, policies, and procedures?			
2.4 Does the Plan regularly conduct aggregate analysis of grievances and appeals to track and trend potential issues and barriers to care?			
2.5 Does the Plan’s <u>grievance officer</u> or his designee review the written record of grievances periodically and document such review?			
2.6 Does the Plan’s <u>governing body</u> review the written record of grievances periodically and document such review?			
2.7 Does the Plan’s grievance process require that management responsible for the operational area that is the subject of the grievance review such grievances?			

GA-001 - Key Element 3:

- 3. The Plan has established an effective mechanism for documenting and tracking grievances.**

CA Health and Safety Code section 1368(a)(4)(A) and (B); 28 CCR 1300.68(b)(5); 28 CCR 1300.68(d)(8); 28 CCR 1300.68(e)

Assessment Questions	Yes	No	N/A
3.1 Does the Plan keep a written record of each grievance received, including the date received, the Plan representative recording the grievance, a summary or other documents describing the grievance, and its disposition?			
3.2 Does the Plan’s grievance system have the capability of indicating the total number of grievances received, pending and resolved in <u>favor of the enrollee</u> ?			
3.3 Does the Plan’s grievance system have the capability of indicating the total number of grievances received, pending and resolved at <u>all levels</u> of grievance <u>review</u> ?			
3.4 Does the Plan’s grievance system have the capability of indicating the total number of grievances received, pending and resolved <u>describing</u>			

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Assessment Questions	Yes	No	N/A
<p><u>the issue</u> or issues raised in grievances as 1) coverage disputes, 2) disputes involving medical necessity, 3) complaints about the quality of care, 4) complaints about access to care (including complaints about the waiting time for appointments), 5) complaints about the quality of service, and 6) other issues? (GMC Requirement GA-008, KE2, AQ 2.6)</p>			
3.5 Does the Plan’s grievance system track the number and percentage of grievances pending over 30 calendar days?			
3.6 For grievances exempt from acknowledgement requirements (grievances received over the phone, resolved the next day, and not coverage or medical necessity), does the Plan maintain a log of such grievances?			
3.7 For grievances exempt from acknowledgement requirements (grievances received over the phone, resolved the next day, and not coverage or medical necessity), does the log include the date of the call, the name and id number of the complainant, the nature of the grievance, the resolution, and the representative who took the call and resolved the grievance?			

End of Requirement GA-001: Grievance System Description

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Requirement GA-002: Grievance Filing

STATUTORY/REGULATORY CITATION(S)

CA Health and Safety Code section 1368(a)(1)

(a) Every plan shall do all of the following:

(1) Establish and maintain a grievance system approved by the department under which enrollees may submit their grievances to the plan. Each system shall provide reasonable procedures in accordance with department regulations that shall ensure adequate consideration of enrollee grievances and rectification when appropriate.

CA Health and Safety Code section 1368.015

(a) Effective July 1, 2003, every plan with a Web site shall provide an online form through its Web site that subscribers or enrollees can use to file with the plan a grievance, as described in Section 1368, online.

(b) The Web site shall have an easily accessible online grievance submission procedure that shall be accessible through a hyperlink on the Web site's home page or member services portal clearly identified as "GRIEVANCE FORM." All information submitted through this process shall be processed through a secure server.

(c) The online grievance submission process shall be approved the Department of Managed Health Care and shall meet the following requirements:

(1) It shall utilize an online grievance form in HTML format that allows the user to enter required information directly into the form.

(2) It shall allow the subscriber or enrollee to preview the grievance that will be submitted, including the opportunity to edit the form prior to submittal.

(3) It shall include a current hyperlink to the California Department of Managed Health Care Web site, and shall include a statement in a legible font that is clearly distinguishable from other content on the page and is in a legible size and type, containing the following language: [*See* 1368.02(b) below for the specific language]. The plan shall update the URL, hyperlink, and telephone numbers in this statement as necessary.

CA Health and Safety Code section 1368.02(b)

(b) Every health care service plan shall publish the Department's toll-free telephone number, the Department's TDD line for the hearing and speech impaired, the plan's telephone number, and the Department's Internet address, on every plan contract, on every evidence of coverage, on copies of plan grievance procedures, on plan complaint forms, and on all written notices to enrollees required under the grievance process of the plan, including any written communications to an enrollee that offer the enrollee the opportunity to participate in the grievance process of the plan and on all written responses to grievances. The Department's telephone number, the Department's TDD line, the plan's telephone number, and the Department's Internet address shall be displayed by the plan in each of these documents in 12-point boldface type in the following regular type statement:

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“The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at (insert health plan’s telephone number) and use your health plan’s grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free **telephone number (1-888-HMO-2219)** and a **TDD line (1-877-688-9891)** for the hearing and speech impaired. The department’s Internet **Web site <http://www.hmohelp.ca.gov>** has complaint forms, IMR application forms and instructions online.”

28 CCR 1300.68(b)(3)

(b) The plan’s grievance system shall include the following:

(3) The grievance system shall address the linguistic and cultural needs of its enrollee population as well as the needs of enrollees with disabilities. The system shall ensure all enrollees have access to and can fully participate in the grievance system by providing assistance for those with limited English proficiency or with a visual or other communicative impairment. Such assistance shall include, but is not limited to, translations of grievance procedures, forms, and plan responses to grievances, as well as access to interpreters, telephone relay systems and other devices that aid disabled individuals to communicate.

28 CCR 1300.68(b)(4)

(b) The plan’s grievance system shall include the following:

(4) The plan shall maintain a toll-free number, or a local telephone number in each service area, for the filing of grievances.

28 CCR 1300.68(b)(6)

(b) The plan’s grievance system shall include the following:

(6) The plan grievance system shall ensure that assistance in filing grievances shall be provided at each location where grievances may be submitted. A “patient advocate” or ombudsperson may be used.

28 CCR 1300.68(b)(7)

(b) The plan’s grievance system shall include the following:

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(7) Grievance forms and a description of the grievance procedure shall be readily available at each facility of the plan, on the plan’s website, and from each contracting provider’s office or facility. Grievance forms shall be provided promptly upon request.

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Dental Director
- Officer with primary responsibility for the grievance system
- Information Technology Officer
- Manager of Member Services

DOCUMENT(S) TO BE REVIEWED

- Policies and procedures for the filing of grievances at each facility of the Plan, on the Plan’s Web site and from each contracting provider’s office or facility
- Policies and procedures that describe how the Plan addresses the linguistic and cultural needs of its enrollee population as well as the needs of enrollees with disabilities
- Grievance forms and description of the grievance procedure that are made available at Plan and provider sites
- Grievance forms and other materials for those with limited English proficiency or with a visual or other communicative impairment
- Plan Web site
- Web site system documentation, flow charts, and protocols
- Evidence of toll-free or local numbers for each service area
- Toll-free or local telephone number wait-time and abandonment rate reports

GA-002 - Key Element 1:

- 1. The Plan ensures that grievance forms, a description of the grievance procedure, and assistance in filing grievances are readily available at each contracting provider’s office, contracting facility, or Plan facility.
CA Health and Safety Code section 1368(a)(1); 28 CCR 1300.68(b)(6) and (7)**

Assessment Questions	Yes	No	N/A
1.1 Does the Plan provide assistance in filing grievances at each location where grievances may be submitted?			
1.2 Is assistance in filing grievances readily available at each facility of the Plan?			
1.3 Is assistance in filing grievances readily available at each contracting provider’s office or facility?			
1.4 Are grievance forms and description of the grievance procedure readily			

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Assessment Questions	Yes	No	N/A
available at each Plan facility?			
1.5 Are grievance forms and description of the grievance procedure readily available at each contracting provider’s office or facility?			
1.6 Are grievance forms and description of the grievance procedure readily available at the Plan’s Web site?			

GA-002 - Key Element 2:

- 2. The Plan maintains a toll-free or local telephone number in each service area, for the filing of grievances.**
28 CCR 1300.68(b)(4)

Assessment Questions	Yes	No	N/A
2.1 Does the Plan have at least one toll-free or local telephone number for the filing of grievances located within each service area?			
2.2 Is the telephone number reasonably accessible?			

GA-002 - Key Element 3:

- 3. The Plan’s grievance system effectively addresses the linguistic and cultural needs of its enrollee population as well as the needs of enrollees with disabilities.**
28 CCR 1300.68(b)(3)

Assessment Questions	Yes	No	N/A
3.1 Does the Plan provide assistance for those with limited English proficiency?			
3.2 Does the Plan provide assistance for those with a visual, hearing, or other communicative impairment?			
3.3 Does the Plan’s assistance include translations of grievance procedures, forms, and Plan responses to grievances, as well as access to interpreters, telephone relay systems and other devices that aid disabled individuals to communicate?			

GA-002 - Key Element 4:

- 4. The Plan has an online grievance submission procedure.**
CA Health and Safety Code section 1368.015; CA Health and Safety Code section 1368.02(b)

Assessment Questions	Yes	No	N/A
4.1 Does the Plan have an online grievance submission process?			
4.2 Is the process easily accessible through a hyperlink on the Web site’s home page or member services portal clearly identified as,			

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	“GRIEVANCE FORM”?			
4.3	Does the process utilize an online grievance form that allows the user to enter required information directly into the form?			
4.4	Does the process allow the grievant/complainant to preview and edit the grievance form prior to submission?			
4.5	Does the process include a hyperlink to the DMHC Web site?			
4.6	Does the process include a statement in a legible font and size clearly distinguishable from other content on the page containing the statement from 1368.02(b) in which URL, hyperlink, and telephone numbers are updated as necessary?			
4.7	Is all information submitted online done through a secure server?			

End of Requirement GA-002: Grievance Filing

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Requirement GA-003: Grievance Receipt, Review and Resolution

STATUTORY/REGULATORY CITATION(S)

CA Health and Safety Code section 1368(a)(1)

(a) Every plan shall do all of the following:

(1) Establish and maintain a grievance system approved by the department under which enrollees may submit their grievances to the plan. Each system shall provide reasonable procedures in accordance with department regulations that shall ensure adequate consideration of enrollee grievances and rectification when appropriate.

CA Health and Safety Code section 1368(a)(5)

(a) Every plan shall do all of the following:

(5) Provide subscribers and enrollees with written responses to grievances, with a clear and concise explanation of the reasons for the plan's response. For grievances involving the delay, denial, or modification of health care services, the plan response shall describe the criteria used and the clinical reasons for its decision, including all criteria and clinical reasons related to medical necessity. If a plan, or one of its contracting providers, issues a decision delaying, denying, or modifying health care services based in whole or in part on a finding that the proposed health care services are not a covered benefit under the contract that applies to the enrollee, the decision shall clearly specify the provisions in the contract that exclude that coverage.

CA Health and Safety Code section 1368.01(a)

(a) The grievance system shall require the plan to resolve grievances within 30 days.

CA Health and Safety Code section 1368.02(b)

(b) Every health care service plan shall publish the department's toll-free telephone number, the department's TDD line for the hearing and speech impaired, the plan's telephone number, and the department's Internet address, on every plan contract, on every evidence of coverage, on copies of plan grievance procedures, on plan complaint forms, and on all written notices to enrollees required under the grievance process of the plan, including any written communications to an enrollee that offer the enrollee the opportunity to participate in the grievance process of the plan and on all written responses to grievances. The department's telephone number, the department's TDD line, the plan's telephone number, and the department's Internet address shall be displayed by the plan in each of these documents in 12-point boldface type in the following regular type statement:

“The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at (insert health plan's telephone number) and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If

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you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free **telephone number (1-888-HMO-2219)** and a **TDD line (1-877-688-9891)** for the hearing and speech impaired. The department's **Internet Web site <http://www.hmohelp.ca.gov>** has complaint forms, IMR application forms and instructions online.”

CA Health and Safety Code section 1370.2

Upon an appeal to the plan of a contested claim, the plan shall refer the claim to the medical director or other appropriately licensed health care provider. This health care provider or the medical director shall review the appeal and, if he or she determines that he or she is competent to evaluate the specific clinical issues presented in the claim, shall make a determination on the appealed claim. If the health care provider or medical director determines that he or she is not competent to evaluate the specific clinical issues of the appealed claim, prior to making a determination, he or she shall consult with an appropriately licensed health care provider who is competent to evaluate the specific clinical issues presented in the claim. For the purposes of this section, “competent to evaluate the specific clinical issues” means that the reviewer has education, training, and relevant expertise that is pertinent for evaluating the specific clinical issues that serve as the basis of the contested claim. The requirements of this section shall apply to claims that are contested on the basis of a clinical issue, the necessity for treatment, or the type of treatment proposed or utilized. The plan shall determine whether or not to use an appropriate specialist provider in the review of contested claims.

CA Health and Safety Code section 1374.30(m)

(m) As part of its notification to the enrollee regarding a disposition of the enrollee’s grievance that denies, modifies, or delays health care services, the plan shall provide the enrollee with a one-page application form approved by the department, and an addressed envelope, which the enrollee may return to initiate an independent medical review. The plan shall include on the form any information required by the department to facilitate the completion of the independent medical review, such as the enrollee’s diagnosis or condition, the nature of the disputed health care service sought by the enrollee, a means to identify the enrollee’s case, and any other material information. The form shall also include the following:

(1) Notice that a decision not to participate in the independent medical review process may cause the enrollee to forfeit any statutory right to pursue legal action against the plan regarding the disputed health care service.

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(2) A statement indicating the enrollee's consent to obtain any necessary medical records from the plan, any of its contracting providers, and any out-of-plan provider the enrollee may have consulted on the matter, to be signed by the enrollee.

(3) Notice of the enrollee's right to provide information or documentation, either directly or through the enrollee's provider, regarding any of the following:

(A) A provider recommendation indicating that the disputed health care service is medically necessary for the enrollee's medical condition.

(B) Medical information or justification that a disputed health care service, on an urgent care or emergency basis, was medically necessary for the enrollee's medical condition.

(C) Reasonable information supporting the enrollee's position that the disputed health care service is or was medically necessary for the enrollee's medical condition, including all information provided to the enrollee by the plan or any of its contracting providers, still in the possession of the enrollee, concerning a plan or provider decision regarding disputed health care services, and a copy of any materials the enrollee submitted to the plan, still in the possession of the enrollee, in support of the grievance, as well as any additional material that the enrollee believes is relevant.

28 CCR 1300.68(a)(4)(A)

(a) The grievance system shall be established in writing and provide for procedures that will receive, review and resolve grievances within 30 calendar days of receipt by the plan, or any provider or entity with delegated authority to administer and resolve the plan's grievance system. The following definitions shall apply with respect to the regulations relating to grievance systems:

(4) "Resolved" means that the grievance has reached a final conclusion with respect to the enrollee's submitted grievance, and there are no pending enrollee appeals within the plan's grievance system, including entities with delegated authority.

(A) If the plan has multiple internal levels of grievance resolution or appeal, all levels must be completed within 30 calendar days of the plan's receipt of the grievance.

28 CCR 1300.68(b)(3)

(b) The plan's grievance system shall include the following:

(3) The grievance system shall address the linguistic and cultural needs of its enrollee population as well as the needs of enrollees with disabilities. The system shall ensure all enrollees have access to and can fully participate in the grievance system by providing assistance for those with limited English proficiency or with a visual or other communicative impairment. Such assistance shall include, but is not limited to, translations of grievance procedures, forms, and plan responses to grievances, as well as access to interpreters, telephone relay systems and other devices that aid disabled individuals to communicate.

28 CCR 1300.68(d)(1)

(d) The plan shall respond to grievances as follows:

(1) A grievance system shall provide for a written acknowledgment within five (5) calendar days of receipt, except as noted in subsection (d)(8). The acknowledgment will advise the complainant that the grievance has been received, the date of receipt, and provide the name of

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the plan representative, telephone number and address of the plan representative who may be contacted about the grievance.

28 CCR 1300.68(d)(3)

(d) The plan shall respond to grievances as follows:

(3) The plan's resolution, containing a written response to the grievance shall be sent to the complainant within thirty (30) calendar days of receipt, except as noted in subsection (d)(8). The written response shall contain a clear and concise explanation of the plan's decision. Nothing in this regulation requires a plan to disclose information to the grievant that is otherwise confidential or privileged by law.

28 CCR 1300.68(d)(4), (5) and (7)

(d) The plan shall respond to grievances as follows:

(4) For grievances involving delay, modification or denial of services based on a determination in whole or in part that the service is not medically necessary, the plan shall include in its written response, the reasons for its determination. The response shall clearly state the criteria, clinical guidelines or medical policies used in reaching the determination. The plan's response shall also advise the enrollee that the determination may be considered by the Department's independent medical review system. The response shall include an application for independent medical review and instructions, including the Department's toll-free telephone number for further information and an envelope addressed to the Department of Managed Health Care, HMO Help Center, 980 Ninth Street, 5th Floor, Sacramento, CA 95814.

(5) Plan responses to grievances involving a determination that the requested service is not a covered benefit shall specify the provision in the contract, evidence of coverage or member handbook that excludes the service. The response shall either identify the document and page where the provision is found, direct the grievant to the applicable section of the contract containing the provision, or provide a copy of the provision and explain in clear concise language how the exclusion applied to the specific health care service or benefit requested by the enrollee. In addition to the notice set forth at Section 1368.02(b) of the Act, the response shall also include a notice that if the enrollee believes the decision was denied on the grounds that it was not medically necessary, the Department should be contacted to determine whether the decision is eligible for an independent medical review.

(7) The Department's telephone number, the California Relay Service's telephone numbers, the plan's telephone number and the Department's Internet address shall be displayed in all of the plan's acknowledgments and responses to grievances in 12-point boldface type with the statement contained in subsection (b) of Section 1368.02 of the Act.

28 CCR 1300.68(d)(7)

(d) The plan shall respond to grievances as follows:

(7) The Department's telephone number, the California Relay Service's telephone numbers, the plan's telephone number and the Department's Internet address shall be displayed in all of the plan's acknowledgments and responses to grievances in 12-point boldface type with the statement contained in subsection (b) of Section 1368.02 of the Act.

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28 CCR 1300.68(d)(8)

(d) The plan shall respond to grievances as follows:

(8) Grievances received over the telephone that are not coverage disputes, disputed health care services involving medical necessity or experimental or investigational treatment, and that are resolved by the close of the next business day, are exempt from the requirement to send a written acknowledgment and response. The plan shall maintain a log of all such grievances containing the date of the call, the name of the complainant, member identification number, nature of the grievance, nature of resolution, and the plan representative's name who took the call and resolved the grievance. The information contained in this log shall be periodically reviewed by the plan as set forth in Subsection (b).

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Dental Director
- Officer with primary responsibility for the grievance system
- Information Technology Officer
- Manager of Member Services

DOCUMENT(S) TO BE REVIEWED

- Policies and procedures that describe the grievance system and processes
- Sample of grievance and appeal template letters
- Documentation of translated Plan responses to grievances in languages other than English
- Sample of grievance/appeal files to be reviewed on site

GA-003 - Key Element 1:

1. The Plan acknowledges grievances and appeals in writing within five (5) calendar days of receipt.

28 CCR 1300.68(d)(1)

Assessment Question	Yes	No	N/A
1.1 Does the Plan consistently acknowledge grievances and appeals in writing <u>within five (5) calendar days</u> of receipt (except as noted in 28 CCR 1300.68(d)(8))? (Standard Grievance/Appeals Worksheet #9)			

GA-003 - Key Element 2:

2. The Plan's written acknowledgment contains all required information.

CA Health and Safety Code section 1368.02(b); 28 CCR 1300.68(b)(3); 28 CCR 1300.68(d)(1) and (7)

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Assessment Questions	Yes	No	N/A
2.1 Does the Plan’s written acknowledgment advise the grievant of the date the Plan received the grievance? (Standard Grievance/Appeals Worksheet #11)			
2.2 Does the Plan’s written acknowledgment provide the name, address, and telephone number of the Plan representative who may be contacted about the grievance? (Standard Grievance/Appeals Worksheet #12)			
2.3 Does the Plan’s written acknowledgment display the Plan’s telephone number, the Department’s telephone number, TDD line, and Internet address in 12-point boldface type with the required statement contained in subsection (b) of Section 1368.02 of the Act? (Standard Grievance/Appeals Worksheet #10)			
2.4 Do acknowledgements address the language and disability needs of enrollees by providing assistance (including translation and interpretation services, access to telephone relay services, and other devices to aid disabled enrollees)? (Standard Grievance/Appeals Worksheet #13)			

GA-003 - Key Element 3:

- 3. The Plan resolves grievances (all levels) in a timely manner.**
28 CCR 1300.68(a)(4)(A); 28 CCR 1300.68(b)(3); 28 CCR 1300.68(d)(3)

Assessment Questions	Yes	No	N/A
3.1 Does the Plan consistently resolve non-urgent grievances (all levels) and send its written resolution to the grievant <u>within 30 calendar days</u> of Plan receipt of the grievance? (Standard Grievance/Appeals Worksheet #17)			
3.2 If the Plan cannot resolve the grievance within 30 calendar days, does the Plan report the grievance as pending or unresolved in its quarterly report to the Department?			

GA-003 - Key Element 4:

- 4. The Plan’s written response contains all required information.**
CA Health and Safety Code section 1368(a)(5); CA Health and Safety Code section 1370.2; CA Health and Safety Code section 1374.30(m); 28 CCR 1300.68(b)(3); 28 CCR 1300.68(d)(4), (5), and (7);

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Assessment Questions	Yes	No	N/A
<p>4.1 For grievances involving delay, modification or denial of services based on a determination in whole or in part that the service is <u>not medically necessary</u>, does each response contain a <u>clear and concise</u> explanation of the Plan’s decision? (Standard Grievance/Appeals Worksheet #22)</p>			
<p>4.2 For grievances involving delay, modification or denial of services based on a determination in whole or in part that the service is <u>not medically necessary</u>, does each response contain the <u>criteria</u>, clinical guidelines, or medical policies used in reaching the determination? (Standard Grievance/Appeals Worksheet #21)</p>			
<p>4.3 For grievances involving delay, modification or denial of services based on a determination in whole or in part that the service is <u>not medically necessary</u>, does each response contain <u>notification</u> that the determination may be considered by the Department’s independent medical review system? (Standard Grievance/Appeals Worksheet #24)</p>			
<p>4.4 For grievances involving delay, modification or denial of services based on a determination in whole or in part that the service is not medically necessary, does each response contain an <u>application</u> for independent medical review (<u>IMR</u>) and instructions? (Standard Grievance/Appeals Worksheet #24)</p>			
<p>4.5 For grievances involving delay, modification or denial of services based on a determination in whole or in part that the service is <u>not medically necessary</u>, does each response contain the <u>Department’s</u> toll-free telephone <u>number</u> for further information? (Standard Grievance/Appeals Worksheet #24)</p>			
<p>4.6 For grievances involving delay, modification or denial of services based on a determination in whole or in part that the service is <u>not medically necessary</u>, does each response contain an <u>envelope</u> addressed to the <u>Department of Managed Health Care</u>, Help Center, 980 Ninth Street, 5th Floor, Sacramento, CA 95814? (Standard Grievance/Appeals Worksheet #24)</p>			
<p>4.7 For grievances involving <u>medical necessity</u> or other clinical issues, does the Plan have reasonable procedures that ensure adequate consideration of the enrollee grievance? (Standard (Grievance/Appeals Worksheet #18)</p>			
<p>4.8 For grievances involving a determination that the requested service is <u>not a covered benefit</u>, does each response contain the <u>specific provision</u> in the contract, <u>EOC</u> or member handbook that excludes the services (either by identifying the document and page where the provision is found, by directing the grievant to the applicable section of the contract or by providing a copy of the provision)? (Standard Grievance/Appeals Worksheet #20)</p>			

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Assessment Questions	Yes	No	N/A
<p>4.9 For grievances involving a determination that the requested service is <u>not a covered benefit</u>, does each response contain <u>clear and concise</u> language that explains how the exclusion applied to the specific health care service or benefit requested by the enrollee? (Standard Grievance/Appeals Worksheet #22)</p>			
<p>4.10 For grievances involving a determination that the requested service is <u>not a covered benefit</u>, does each response contain <u>notice</u> that if the <u>enrollee believes</u> the decision was denied on the grounds that it was <u>not medically necessary</u>, the Department should be contacted to determine whether the decision is eligible for an <u>independent medical review</u>? (Standard Grievance/Appeals Worksheet #24)</p>			
<p>4.11 For grievances involving <u>contested claims</u>, does the Plan appropriately refer the claim for review to a <u>licensed</u> and competent health care provider to <u>evaluate</u> the clinical issues of the appealed claim, as applicable? (Standard Grievance/Appeals Worksheet #18)</p>			
<p>4.12 Does each written response display the Department’s telephone number, the CA Relay Service’s telephone numbers, the Plan’s telephone number, and the Department’s Internet address in 12-point boldface type with the statement contained in Section 1368.02(b) of the Act? (Standard Grievance/Appeals Worksheet #19)</p>			
<p>4.13 Do Plan responses address the language and disability needs of enrollees by providing assistance (including translation and interpretation services, access to telephone relay services, and other devices to aid disabled enrollees)? (Standard Grievance/Appeals Worksheet #23)</p>			

End of Requirement GA-003: Receipt, Review, and Resolution

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Requirement GA-004: Enrollee Education/Notification Requirements

STATUTORY/REGULATORY CITATION(S)

CA Health and Safety Code section 1368(a)(2)

(a) Every plan shall do all of the following:

(2) Inform its subscribers and enrollees upon enrollment in the plan and annually thereafter of the procedure for processing and resolving grievances. The information shall include the location and telephone number where grievances may be submitted

CA Health and Safety Code section 1368.02(b)

(b) Every health care service plan shall publish the Department's toll-free telephone number, the Department's TDD line for the hearing and speech impaired, the plan's telephone number, and the Department's Internet address, on every plan contract, on every evidence of coverage, on copies of plan grievance procedures, on plan complaint forms, and on all written notices to enrollees required under the grievance process of the plan, including any written communications to an enrollee that offer the enrollee the opportunity to participate in the grievance process of the plan and on all written responses to grievances. The Department's telephone number, the Department's TDD line, the plan's telephone number, and the Department's Internet address shall be displayed by the plan in each of these documents in 12-point boldface type in the following regular type statement:

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **(insert health plan's telephone number)** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's Internet Web site <http://www.hmohelp.ca.gov> has complaint forms, IMR application forms, and instructions online.

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CA Health and Safety Code section 1374.30(e)

(e) Every health care service plan contract that is issued, amended, renewed, or delivered in this state on or after January 1, 2000, shall, effective January 1, 2001, provide an enrollee with the opportunity to seek an independent medical review whenever health care services have been denied, modified, or delayed by the plan, or by one of its contracting providers, if the decision was based in whole or in part on a finding that the proposed health care services are not medically necessary. For purposes of this article, an enrollee may designate an agent to act on his or her behalf, as described in paragraph (2) of subdivision (b) of Section 1368. The provider may join with or otherwise assist the enrollee in seeking an independent medical review, and may advocate on behalf of the enrollee.

CA Health and Safety Code section 1374.30(i)

(i) No later than January 1, 2001, every health care service plan shall prominently display in every plan member handbook or relevant informational brochure, in every plan contract, on enrollee evidence of coverage forms, on copies of plan procedures for resolving grievances, on letters of denials issued by either the plan or its contracting organization, on the grievance forms required under Section 1368, and on all written responses to grievances, information concerning the right of an enrollee to request an independent medical review in cases where the enrollee believes that health care services have been improperly denied, modified, or delayed by the plan, or by one of its contracting providers.

28 CCR 1300.68(b)(2) and (9)

(b) The plan's grievance system shall include the following:

(2) Each plan's obligation for notifying subscribers and enrollees about the plan's grievance system shall include information on the plan's procedures for filing and resolving grievances, and the telephone number and address for presenting a grievance. The notice shall also include information regarding the Department's review process, the independent medical review system, and the Department's toll-free telephone number and Web site address

(9) The grievance system shall allow enrollees to file grievances for at least 180 calendar days following any incident or action that is the subject of the enrollee's dissatisfaction.

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Officer designated with having primary responsibility for the grievance system
- Staff involved in the grievance process
- Staff of Member Services
- Officer or staff responsible for member education

DOCUMENT(S) TO BE REVIEWED

- Enrollee/Member handbook
- Evidence of Coverage (EOC)

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- Copies of Plan grievance procedure
- Grievance forms (Including availability at each facility of the Plan, on the Plan’s Web site, and from each contracting provider’s office or facility)
- Denial letter templates (claims, prior authorization, etc.)
- Documents used by the Plan to communicate to enrollees the telephone numbers for filing grievances (i.e. informational brochures, enrollee handbook, etc.)
- Documents used by the Plan to notify subscribers and enrollees of the grievance system upon enrollment and annually thereafter

GA-004 - Key Element 1:

- 1. The Plan informs its enrollees upon enrollment and annually thereafter of the procedure for processing and resolving grievances.
CA Health and Safety Code section 1368(a)(2); 28 CCR 1300.68(b)(2) and (9)**

Assessment Questions	Yes	No	N/A
1.1 Does the Plan provide enrollees upon enrollment and on an annual basis with the Plan’s procedures for filing and resolving grievances?			
1.2 Does the Plan provide enrollees upon enrollment and on an annual basis with the locations and telephone numbers (i.e., a toll-free number or a local telephone number in each service area) for filing complaints and grievances?			
1.3 Does the Plan provide enrollees with information regarding the Department’s review process, the independent medical review system, and the Department’s toll-free telephone number and Web site address?			

GA-004 - Key Element 2:

- 2. The Plan displays the required notice set forth at Section 1368.02(b) in all relevant written materials.
CA Health and Safety Code section 1368.02(b)**

Assessment Questions	Yes	No	N/A
2.1 Does the Plan display the required notice set forth at Section 1368.02(b) in all relevant informational materials including <u>enrollee handbook</u> ?			
2.2 Does the Plan display the required notice set forth at Section 1368.02(b) in every Plan <u>contract</u> ?			
2.3 Does the Plan display the required notice set forth at Section 1368.02(b) in every <u>evidence of coverage</u> ?			
2.4 Does the Plan display the required notice set forth at Section 1368.02(b) in copies of Plan <u>grievance procedures</u> ?			

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Assessment Questions	Yes	No	N/A
2.5 Does the Plan display the required notice set forth at Section 1368.02(b) in Plan <u>complaint/grievance forms</u> ?			
2.6 Does the Plan display the required notice set forth at Section 1368.02(b) in <u>any written communications</u> to an enrollee that offer the enrollee the opportunity to participate in the grievance process of the Plan?			

GA-004 - Key Element 3:

- 3. The Plan includes the information concerning the right of an enrollee to request an independent medical review in cases where the enrollee believes that health care services have been improperly denied, modified, or delayed by the Plan, or by one of its contracting providers in all relevant informational materials and all written communications to enrollees.**
CA Health and Safety Code section 1374.30(i)

Assessment Questions	Yes	No	N/A
3.1 Does the Plan include the information concerning the <u>right</u> of an enrollee to <u>request</u> an <u>independent medical review</u> in cases where the enrollee believes that health care services have been improperly denied, modified, or delayed by the Plan, or by one of its contracting providers in all relevant informational materials including <u>enrollee handbook</u> ?			
3.2 Does the Plan include the information concerning the <u>right</u> of an enrollee to <u>request</u> an <u>independent medical review</u> in cases where the enrollee believes that health care services have been improperly denied, modified, or delayed by the Plan, or by one of its contracting providers in every <u>Plan contract</u> ?			
3.3 Does the Plan include the information concerning the <u>right</u> of an enrollee to <u>request</u> an <u>independent medical review</u> in cases where the enrollee believes that health care services have been improperly denied, modified, or delayed by the Plan, or by one of its contracting providers in every evidence of coverage (<u>EOC</u>)?			
3.4 Does the Plan include the information concerning the <u>right</u> of an enrollee to <u>request</u> an <u>independent medical review</u> in cases where the enrollee believes that health care services have been improperly denied, modified, or delayed by the Plan, or by one of its contracting providers in copies of Plan <u>grievance procedures</u> ?			
3.5 Does the Plan include the information concerning the <u>right</u> of an enrollee to <u>request</u> an <u>independent medical review</u> in cases where the enrollee believes that health care services have been improperly denied, modified, or delayed by the Plan, or by one of its contracting providers in Plan <u>complaint/grievance forms</u> ?			

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Assessment Questions	Yes	No	N/A
3.6 Does the Plan include the information concerning the <u>right</u> of an enrollee to <u>request</u> an <u>independent medical review</u> in cases where the enrollee believes that health care services have been improperly denied, modified, or delayed by the Plan, or by one of its contracting providers in any <u>written</u> communications to an enrollee that offer the enrollee the opportunity to <u>participate</u> in the <u>grievance process</u> of the Plan?			

End of Requirement GA-004: Enrollee Education / Notification Requirements

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Requirement GA-005: Expedited Review of Urgent Grievances

STATUTORY/REGULATORY CITATION(S)

CA Health and Safety Code section 1368(a)(5)

(a) Every plan shall do all of the following:

(5) Provide subscribers and enrollees with written responses to grievances, with a clear and concise explanation of the reasons for the plan's response. For grievances involving the delay, denial, or modification of health care services, the plan response shall describe the criteria used and the clinical reasons for its decision, including all criteria and clinical reasons related to medical necessity. If a plan, or one of its contracting providers, issues a decision delaying, denying, or modifying health care services based in whole or in part on a finding that the proposed health care services are not a covered benefit under the contract that applies to the enrollee, the decision shall clearly specify the provisions in the contract that exclude that coverage.

CA Health and Safety Code section 1368.01(b)

(b) The grievance system shall include a requirement for expedited plan review of grievances for cases involving an imminent and serious threat to the health of the patient, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function. When the plan has notice of a case requiring expedited review, the grievance system shall require the plan to immediately inform enrollees and subscribers in writing of their right to notify the Department of the grievance. The grievance system shall also require the plan to provide enrollees, subscribers, and the Department with a written statement on the disposition or pending status of the grievance no later than three days from receipt of the grievance.

CA Health and Safety Code section 1368.02(b)

(b) Every health care service plan shall publish the department's toll-free telephone number, the department's TDD line for the hearing and speech impaired, the plan's telephone number, and the department's Internet Web site address, on every plan contract, on every evidence of coverage, on copies of plan grievance procedures, on plan complaint forms, and on all written notices to enrollees required under the grievance process of the plan, including any written communications to an enrollee that offer the enrollee the opportunity to participate in the grievance process of the plan and on all written responses to grievances. The department's telephone number, the department's TDD line, the plan's telephone number, and the department's Internet Web site address shall be displayed by the plan in each of these documents in 12-point boldface type in the following regular type statement:

“The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at (insert health plan's telephone number) and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your

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health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department's Internet Web site <http://www.hmohelp.ca.gov> has complaint forms, IMR application forms and instructions online.”

28 CCR 1300.68.01(b)(1) through (4)

(b) Each plan's grievance system shall allow for the Department to contact the plan regarding urgent grievances 24 hours a day, 7 days a week. During normal work hours, the plan shall respond to the Department within 30 minutes after initial contact from the Department. During non-work hours, the plan shall respond to the Department within 1 hour after initial contact from the Department.

- (1) The system established by the plan shall provide for the availability of a plan representative with authority on the plan's behalf to resolve urgent grievances and authorize the provision of health care services covered under the enrollee's plan contract in a medically appropriate and timely manner. Such authority shall include making financial decisions for expenditure of funds on behalf of the plan without first having to obtain approval from supervisors or other superiors within the plan. Nothing in this subsection shall restrict the plan representative from consulting with other plan staff on urgent grievances.
- (2) Plans shall provide the Department with the following information concerning urgent grievances:
 - (A) A description of the system established by the plan to resolve urgent grievances. The description shall include the system's provisions for scheduling qualified plan representatives, including back-up plan representatives as necessary, to be available twenty-four (24) hours a day, seven days a week to respond to Department contacts regarding urgent grievances. Provisions for scheduling shall include the names and titles of those plan representatives who will be available under the system, their telephone numbers, and, as applicable, pager numbers, answer service numbers, voice-mail numbers, e-mail addresses, or other means for contact.
 - (B) A description of how the Department may access the grievance system established by the plan.
- (3) If the plan revises the system established pursuant to subsection (b), the plan shall notify the Department at least 30 days in advance of implementing the revisions.
- (4) No requirement that the enrollee participate in the plan's grievance process prior to applying to the Department for review of the urgent grievance.

28 CCR 1300.68.01(a) and (b)

(a) Every plan shall include in its grievance system, procedures for the expedited review of grievances involving an imminent and serious threat to the health of the enrollee, including, but

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not limited to, severe pain, potential loss of life, limb or major bodily function (“urgent grievances”). At a minimum, plan procedures for urgent grievances shall include:

(1) Immediate notification to the complainant of the right to contact the Department regarding the grievance. The plan shall expedite its review of the grievance when the complainant, an authorized representative, or treating physician provides notice to the plan. Notice need not be in writing, but may be accomplished by a documented telephone call.

(2) A written statement to the Department and the complainant on the disposition or pending status of the urgent grievance within three (3) calendar days of receipt of the grievance by the Plan.

(3) Consideration by the plan of the enrollee’s medical condition when determining the response time.

(4) No requirement that the enrollee participate in the plan’s grievance process prior to applying to the Department for review of the urgent grievance.

(b) Each plan’s grievance system shall allow for the Department to contact the plan regarding urgent grievances 24 hours a day, 7 days a week. During normal work hours, the plan shall respond to the Department within 30 minutes after initial contact from the Department. During non-work hours, the plan shall respond to the Department within 1 hour after initial contact from the Department.

(1) The system established by the plan shall provide for the availability of a plan representative with authority on the plan’s behalf to resolve urgent grievances and authorize the provision of health care services covered under the enrollee’s plan contract in a medically appropriate and timely manner. Such authority shall include making financial decisions for expenditure of funds on behalf of the plan without first having to obtain approval from supervisors or other superiors within the plan. Nothing in this subsection shall restrict the plan representative from consulting with other plan staff on urgent grievances.

(2) Plans shall provide the Department with the following information concerning urgent grievances:

(A) A description of the system established by the plan to resolve urgent grievances. The description shall include the system’s provisions for scheduling qualified plan representatives, including back-up plan representatives as necessary, to be available twenty-four (24) hours a day, seven days a week to respond to Department contacts regarding urgent grievances. Provisions for scheduling shall include the names and titles of those plan representatives who will be available under the system, their telephone numbers, and, as applicable, pager numbers, answer service numbers, voice-mail numbers, e-mail addresses, or other means for contact.

(B) A description of how the Department may access the grievance system established by the plan.

(3) If the plan revises the system established pursuant to subsection (b), the plan shall notify the Department at least 30 days in advance of implementing the revisions.

28 CCR 1300.68.01(b)

(b) Each plan’s grievance system shall allow for the Department to contact the plan regarding urgent grievances 24 hours a day, 7 days a week. During normal work hours, the plan shall respond to the Department within 30 minutes after initial contact from the Department. During

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non-work hours, the plan shall respond to the Department within 1 hour after initial contact from the Department.

(1) The system established by the plan shall provide for the availability of a plan representative with authority on the plan's behalf to resolve urgent grievances and authorize the provision of health care services covered under the enrollee's plan contract in a medically appropriate and timely manner. Such authority shall include making financial decisions for expenditure of funds on behalf of the plan without first having to obtain approval from supervisors or other superiors within the plan. Nothing in this subsection shall restrict the plan representative from consulting with other plan staff on urgent grievances.

(2) Plans shall provide the Department with the following information concerning urgent grievances:

(A) A description of the system established by the plan to resolve urgent grievances. The description shall include the system's provisions for scheduling qualified plan representatives, including back-up plan representatives as necessary, to be available twenty-four (24) hours a day, seven days a week to respond to Department contacts regarding urgent grievances. Provisions for scheduling shall include the names and titles of those plan representatives who will be available under the system, their telephone numbers, and, as applicable, pager numbers, answer service numbers, voice-mail numbers, e-mail addresses, or other means for contact.

(B) A description of how the Department may access the grievance system established by the plan.

(3) If the plan revises the system established pursuant to subsection (b), the plan shall notify the Department at least 30 days in advance of implementing the revisions.

28 CCR 1300.68(d)(3), (4) and (5)

(d) The plan shall respond to grievances as follows:

(3) The plan's resolution, containing a written response to the grievance shall be sent to the complainant within thirty (30) calendar days of receipt, except as noted in Subsection (d)(8). The written response shall contain a clear and concise explanation of the plan's decision. Nothing in this regulation requires a plan to disclose information to the grievant that is otherwise confidential or privileged by law.

(4) For grievances involving delay, modification or denial of services based on a determination in whole or in part that the service is not medically necessary, the plan shall include in its written response, the reasons for its determination. The response shall clearly state the criteria, clinical guidelines or medical policies used in reaching the determination. The plan's response shall also advise the enrollee that the determination may be considered by the Department's independent medical review system. The response shall include an application for independent medical review and instructions, including the Department's toll-free telephone number for further information and an envelope addressed to the Department of Managed Health Care, HMO Help Center, 980 Ninth Street, 5th Floor, Sacramento, CA 95814.

(5) Plan responses to grievances involving a determination that the requested service is not a covered benefit shall specify the provision in the contract, evidence of coverage or member handbook that excludes the service. The response shall either identify the document and page where the provision is found, direct the grievant to the applicable section of the contract containing the provision, or provide a copy of the provision and explain in clear concise

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language how the exclusion applied to the specific health care service or benefit requested by the enrollee. In addition to the notice set forth at Section 1368.02(b) of the Act, the response shall also include a notice that if the enrollee believes the decision was denied on the grounds that it was not medically necessary, the Department should be contacted to determine whether the decision is eligible for an independent medical review.

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Officer with primary responsibility for the grievance system
- Member Services Manager
- Plan’s designated representative(s) for DMHC contacts
- QM Director

DOCUMENT(S) TO BE REVIEWED

- Policies and procedures for expedited/urgent review
- Policies and Procedures providing for Plan contacts for the DMHC to utilize regarding expedited urgent grievances
- Schedule of Plan contacts for expedited/urgent grievances
- Copies of Plan’s notification letter(s) to the DMHC and complainant regarding expedited/urgent grievances
- Policies and procedures regarding reporting responsibilities (including timeframes) to the DMHC and complainant regarding expedited/urgent grievances
- Expedited/Urgent grievance logging system
- Sample of expedited/urgent files to be reviewed onsite

GA-005 - Key Element 1:

1. The Plan’s grievance system has policies and procedures for the expedited review of grievances for cases involving imminent and serious threat to the health of the patient (“urgent grievances”).

CA Health and Safety Code section 1368.01(b); 28 CCR 1300.68.01(a) and (b)

Assessment Questions	Yes	No	N/A
1.1 Do the Plan’s grievance procedures include an expedited review process? (GMC Requirement GA-007, KE5, AQ 5.1)			
1.2 Do the procedures include criteria that trigger expedited review (e.g., severe pain, potential loss of life, limb, or major bodily function)? (GMC Requirement GA-007, KE5, AQ 5.1)			
1.3 Do procedures provide for the immediate notification to the			

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Assessment Questions	Yes	No	N/A
complainant of the right to contact the Department regarding the urgent grievance? (GMC Requirement GA-007, KE5, AQ 5.2)			
1.4 Do the Plan’s procedures provide for the receipt of Department contacts regarding urgent grievances 24 hours a day, 7 days a week?			
1.5 Do the Plan’s procedures provide for the scheduling of qualified Plan representatives including back-up Plan representatives as necessary to be available 24 hours a day, 7 days a week?			
1.6 If the Plan revises the urgent grievance system established pursuant to 1300.68.01 (b), does the Plan notify the Department at least 30 days in advance of implementing the revisions?			

GA-005 - Key Element 2:

- 2. The Plan’s grievance system allows for the Department to contact the Plan regarding urgent grievances 24 hours a day, 7 days a week. During normal work hours, the Plan responds to the Department within 30 minutes after initial contact from the Department. During non-work hours, the Plan responds to the Department within one hour after initial contact from the Department.
28 CCR 1300.68.01(b)**

Assessment Questions	Yes	No	N/A
2.1 Does the Plan respond to the Department within 30 minutes after initial contact from the Department during normal working hours?			
2.2 Does the Plan respond to the Department within one hour after initial contact from the Department during non-work hours?			
2.3 Has the Plan identified a Plan representative with authority to resolve urgent grievances and authorize the provision of health care services on the Plan’s behalf?			
2.4 Does the Plan representative have authority to make financial decisions on behalf of the Plan?			
2.5 Does the Plan schedule qualified Plan representatives including back-up Plan representatives as necessary to be available 24 hours a day, 7 days a week?			

GA-005 - Key Element 3:

- 3. The Plan reviews, resolves, and responds to urgent grievances in a timely and appropriate manner.
CA Health and Safety Code section 1368.01(b); CA Health and Safety Code section 1368.02(b); 28 CCR 1300.68(d)(3), (4), and (5); 28 CCR 1300.68.01(a) and (b)**

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Assessment Questions	Yes	No	N/A
3.1 Upon receipt of an urgent grievance, does the Plan immediately inform the complainant of his/her right to contact the Department regarding the urgent grievance? (Notice need not be in writing, but may be accomplished by a documented telephone call.) (Standard Grievance/Appeals Worksheet #6)			
3.2 Does the Plan consider the enrollee’s medical condition when determining the response time? (Standard Grievance/Appeals Worksheet #7)			
3.3 Is the expedited appeal reviewed by appropriate personnel? (Standard Grievance/Appeals Worksheet #18)			
3.4 Does the Plan consistently provide a written statement to the complainant on the disposition or pending status of the urgent grievance <u>within three (3) calendar days</u> from receipt of the grievance? (GMC Requirement GA-007, KE 5, AQ 5.4) (Standard Grievance/Appeals Worksheet #9)			
3.5 Do acknowledgement and/or response letters include required Department contact information in appropriate format? (Standard Grievance/Appeals Worksheet #10 and #19)			
3.6 For grievances involving delay, modification or denial of services based on a determination in whole or in part that the service is <u>not medically necessary</u> , does the Plan’s response contain a <u>clear and concise</u> explanation of the Plan’s decision? (Standard Grievance/Appeals Worksheet #22)			
3.7 For grievances involving delay, modification or denial of services based on a determination in whole or in part that the service is <u>not medically necessary</u> , does the Plan’s response contain a clear statement of the <u>criteria, clinical guidelines, or medical policies</u> used in reaching the determination? (Standard Grievance/Appeals Worksheet #21)			
3.8 For grievances involving delay, modification or denial of services based on a determination in whole or in part that the service is <u>not medically necessary</u> , does the Plan’s response contain an <u>application</u> for <u>independent medical review</u> and instructions, including the Department’s toll-free telephone number for further information? (Standard Grievance/Appeals Worksheet #24)			
3.9 For grievances involving delay, modification or denial of services based on a determination in whole or in part that the service is <u>not medically necessary</u> , does the Plan’s response contain an <u>envelope</u> addressed to the <u>Department of Managed Health Care</u> , Help Center, 980 Ninth Street, 5 th Floor, Sacramento, CA 95814? (Standard Grievance/Appeals Worksheet #24)			

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Assessment Questions	Yes	No	N/A
<p>3.10 For grievances involving a determination that the requested service is <u>not a covered benefit</u>, does each response contain the specific <u>provision in the contract, EOC</u> or <u>member handbook</u> that excludes the services? (Standard Grievance/Appeals Worksheet #20)</p>			
<p>3.11 For grievances involving a determination that the requested service is <u>not a covered benefit</u>, does each response contain <u>clear and concise</u> language that explains how the <u>exclusion applied to the specific health care service or benefit</u> requested by the enrollee? (Standard Grievance/Appeals Worksheet #22)</p>			
<p>3.12 For grievances involving a determination that the requested service is <u>not a covered benefit</u>, does each response contain <u>notice</u> of opportunity to seek <u>independent medical review</u>? (Standard Grievance/Appeals Worksheet #24)</p>			
<p>3.13 Does the Plan resolve the urgent grievance and send notification to the enrollee in a timely manner considering the enrollee’s medical condition? (GMC Requirement GA-007, KE5, AQ 5.5) (Standard Grievance/Appeals Worksheet #17)</p>			

End of Requirement GA-005: Expedited Review of Urgent Grievances

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Requirement GA-006: Independent Medical Review (IMR)

STATUTORY/REGULATORY CITATION(S)

CA Health and Safety Code section 1367.01(h)(3)

(h) In determining whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, based in whole or in part on medical necessity, a health care service plan subject to this section shall meet the following requirements:

(3) Decisions to approve, modify, or deny requests by providers for authorization prior to, or concurrent with, the provision of health care services to enrollees shall be communicated to the requesting provider within 24 hours of the decision. Except for concurrent review decisions pertaining to care that is underway, which shall be communicated to the enrollee's treating provider within 24 hours, decisions resulting in denial, delay, or modification of all or part of the requested health care service shall be communicated to the enrollee in writing within two business days of the decision. In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.

CA Health and Safety Code sections 1374.30(a), (e), and (h)

(a) Commencing January 1, 2001, there is hereby established in the Department the Independent Medical Review System.

(e) Every plan contract that is issued, amended, renewed or delivered in this state (California) on or after January 1, 2000, shall, effective January 1, 2001, provide an enrollee with the opportunity to seek an independent medical review whenever health care services have been denied, modified, or delayed by the plan, or by one of its contracting providers, if the decision was based in whole or in part, on a finding that the proposed health care services are not medically necessary. An enrollee may designate an agent to act on his or her behalf. The provider may join with or otherwise assist the enrollee in seeking an independent medical review and may advocate on behalf of the enrollee.

(h) The independent medical review process authorized by this article is in addition to any other procedures or remedies that may be available.

CA Health and Safety Code section 1374.30(i)

(i) No later than January 1, 2001, every health care service plan shall prominently display in every plan member handbook or relevant informational brochure, in every plan contract, on enrollee evidence of coverage forms, on copies of plan procedures for resolving grievances, on letters of denials issued by either the plan or its contracting organization, on the grievance forms required under Section 1368, and on all written responses to grievances, information concerning the right of an enrollee to request an independent medical review in cases where the enrollee believes that health care services have been improperly denied, modified, or delayed by the plan, or by one of its contracting providers.

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CA Health and Safety Code section 1374.30(j)(3)

(j) The enrollee may apply to the department for an independent medical review when all of the following conditions are met:

(3) The enrollee has filed a grievance with the plan or its contracting provider pursuant to Section 1368, and the disputed decision is upheld or the grievance remains unresolved after 30 days. The enrollee shall not be required to participate in the plan's grievance process for more than 30 days. In the case of a grievance that requires expedited review pursuant to Section 1368.01, the enrollee shall not be required to participate in the plan's grievance process for more than three days.

CA Health and Safety Code section 1374.30(l)

(l) The enrollee shall pay no application or processing fees of any kind.

CA Health and Safety Code section 1374.34(a)

(a) Upon receiving the decision adopted by the director pursuant to Section 1374.33 that a disputed health care service is medically necessary, the plan shall promptly implement the decision. In the case of reimbursement for services already rendered, the plan shall reimburse the provider or enrollee, whichever applies, within five working days. In the case of services not yet rendered, the plan shall authorize the services within five working days of receipt of the written decision from the director, or sooner if appropriate for the nature of the enrollee's medical condition, and shall inform the enrollee and provider of the authorization in accordance with the requirements of paragraph (3) of subdivision (h) of Section 1367.01.

28 CCR 1300.68(d)(4)

(d) The plan shall respond to grievances as follows:

(4) For grievances involving delay, modification or denial of services based on a determination in whole or in part that the service is not medically necessary, the plan shall include in its written response, the reasons for its determination. The response shall clearly state the criteria, clinical guidelines or medical policies used in reaching the determination. The plan's response shall also advise the enrollee that the determination may be considered by the Department's independent medical review system. The response shall include an application for independent medical review and instructions, including the Department's toll-free telephone number for further information and an envelope addressed to the Department of Managed Health Care, HMO Help Center, 980 Ninth Street, 5th Floor, Sacramento, CA 95814.

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Utilization Management Director
- Dental Director
- Officer with primary responsibility for the grievance system

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DOCUMENT(S) TO BE REVIEWED

- Documents that demonstrate the Plan provides opportunity to seek an independent medical review whenever health care services have been denied, modified, or delayed by the plan, or by one of its contracting providers, if the decision was based in whole or in part, on a finding that the proposed health care services are not medically necessary, or on a determination that a therapy is experimental or investigational.
- Check Plan’s grievance policies for reference to the Plan’s obligation to provide enrollees the opportunity to seek IMR.

NOTE: The following documents require the Plan to prominently display information concerning the right of an enrollee to request an independent medical review in cases where the enrollee believes that health care services have been improperly denied, modified, or delayed by the plan, or by one of its contracting providers:

- 1) Member Handbook, Informational Brochures
- 2) Every Plan contract
- 3) Enrollee evidence of coverage forms
- 4) On copies of grievance procedures
- 5) Denial letters issued by either the plan, or by one of its contracting organization.
- 6) Grievance forms required under Section 1368
- 7) All written responses to grievances.

GA-006 - Key Element 1:

1. The Plan provides its enrollees opportunity to seek independent medical review (IMR) and prominently displays information concerning the right to and IMR in all required documents.

CA Health and Safety Code sections 1374.30(a), (e), (h), (i) and (l); 28 CCR 1300.68 (d)(4)

Assessment Questions	Yes	No	N/A
1.1 Does the Plan prominently display information concerning the right of an enrollee to request an independent medical review in the <u>member handbook/informational brochures</u> ?			
1.2 Does the Plan prominently display information concerning the right of an enrollee to request an independent medical review in every <u>Plan Contract</u> ?			
1.3 Does the Plan prominently display information concerning the right of an enrollee to request an independent medical review in all <u>enrollee evidence of coverage forms</u> ?			
1.4 Does the Plan prominently display information concerning the right of an enrollee to request an independent medical review on copies of <u>grievance procedures</u> ?			
1.5 Does the Plan prominently display information concerning the right of an enrollee to request an independent medical review in all			

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Assessment Questions	Yes	No	N/A
of the denial letters issued by either the Plan, or by one of its contracting organizations?			
1.6 Does the Plan prominently display information concerning the right of an enrollee to request an independent medical review in all of the grievance forms required under section 1368?			
1.7 Does the Plan prominently display information concerning the right of an enrollee to request an independent medical review in all written responses to grievances ?			
1.8 Are enrollees informed that the IMR is at no cost?			

GA-006 - Key Element 2

- 2. The Plan implements IMR decisions promptly.**
CA Health and Safety Code section 1374.34(a); CA Health and Safety Code section 1367.01(h)(3)

Assessment Questions	Yes	No	N/A
2.1 In cases of reimbursement of services already rendered in which a disputed health care is found to be medically necessary, did the Plan reimburse the provider or enrollee , whichever applies, within five working days ?			
2.2 In cases in which services have not been rendered, did the Plan authorize the services within five working days of receipt of the written decision from the Director, or sooner if appropriate for the nature of the enrollee's medical condition?			
2.3 In decisions to approve, modify, or deny requests by providers for authorization prior to, or concurrent with, the provision of health care services to enrollees, did the Plan communicate such decision to the requesting provider within 24 hours of the decision?			
2.4 For concurrent review decisions pertaining to care that is underway , did the Plan communicate such decision to the enrollee's treating provider within 24 hours ?			
2.5 Did the Plan communicate decisions resulting in denial, delay, or modification of all or part of the requested health care service to the enrollee in writing within two business days of the decision? (This does not include concurrent review decisions pertaining to care that are underway, which shall be communicated to the enrollee's treating provider within 24 hours as noted above.)			

End of Requirement GA-006: Independent Medical Review

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DHCS REQUIREMENTS FOR GMC PROGRAMS

Introduction:

Any negative finding in Requirements GA-001 through GA-006 could potentially be a GMC finding. The GMC surveyor is instructed to confer with the Surveyor responsible for Requirements GA-001 through GA-006, especially regarding any shaded element below, to ensure uniform findings. The shaded elements indicate elements that are also included in Requirements GA-001 through GA-006.

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Requirement GA-007: Grievance Policies and Procedures

CONTRACT CITATION(S)

Medi-Cal Dental GMC Program Exhibit A, Attachment 15, Provision

A. Member Grievance System

Contractor shall implement and maintain a Member Grievance system in accordance with 28 CCR 1300.68 (except Subdivision 1300.68(g).), and 1300.68.01, 22 CCR 53858, Exhibit A, Attachment 14, Member Services, Provision D, Written Member Information, Subprovision 4, Paragraph l). Contractor shall resolve each grievance and provide notice to the Member as quickly as the Member's dental condition requires, or no later than thirty (30) calendar days from the date Contractor receives the grievance. Contractor shall notify the Member of the grievance resolution in a written Member notice.

22 CCR 53858(a) through (d)

(a) Each plan in a designated region shall establish and maintain written procedures for the submittal, processing, and resolution of all member grievances and complaints. The grievance system shall include the handling of complaints and shall:

(1) Operate according to the written procedures, which shall be approved in writing by the department prior to use. Amendments shall be approved in writing by the department prior to implementation of the revised procedure.

(2) Be described in information sent to each member within 7 days of the date of enrollment in the plan and annually thereafter, pursuant to sections 53893 and 53894. The description shall include:

(A) An explanation of the plan's system for processing and resolving grievances, and how a member is to use it.

(B) A statement that grievance forms are available in the office of each primary care provider, or in each member services department of the plan, in the case of a plan in which all primary care providers are the exclusive providers of that plan and are contiguously located.

(C) A statement that grievances may be filed in writing or verbally directly with the plan in which the member is enrolled or at any office of the plan's providers.

(D) The local or toll-free telephone number a member may call to obtain information, request grievance forms, and register a verbal grievance.

(E) A written statement explaining the member's right to request a fair hearing, provided pursuant to sections 50951, 51014.1, 51014.2, and 53894.

(F) An explanation of the state's Medi-Cal Managed Care Ombudsman program and the program's voice and TDD telephone numbers.

(b) Each plan shall make local or toll-free telephone service available to members during normal business hours for requesting grievance forms, filing verbal grievances, and requesting information.

(c) Each plan shall provide upon request a grievance form, either directly or by mail if mailing is requested to any member requesting the form.

(d) Each plan shall provide assistance to any member requesting assistance in completing the grievance form.

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22 CCR 53858(e)(1)

(e) The member grievance procedures shall at a minimum provide for:

(1) The recording in a grievance log of each grievance received by the plan, either verbally or in writing. The grievance log shall include the following information:

(A) The date and time the grievance is filed with the plan or provider.

(B) The name of the member filing the grievance.

(C) The name of the plan provider or staff person receiving the grievance.

(D) A description of the complaint or problem.

(E) A description of the action taken by the plan or provider to investigate and resolve the grievance.

(F) The proposed resolution by the plan or provider.

(G) The name of the plan provider or staff person responsible for resolving the grievance.

(H) The date of notification of the member of the proposed resolution.

22 CCR 53858(e)(2) through (7)

(2) The immediate submittal of all medical quality of care grievances to the medical director for action.

(3) The submittal, at least quarterly, of all member grievances to the plan's quality assurance committee or review and appropriate action. For purposes of this subsection, member grievances shall include but not be limited to those related to access to care, quality of care, and denial of services.

(4) The review and analysis, on at least a quarterly basis, of all recorded grievances related to access to care, quality of care and denial of services, and take appropriate action to remedy any problems identified in such reviews.

(5) The mailing of a written notice of the proposed resolution to the member. Each notice shall include information about the member's right to request a fair hearing pursuant to sections 50951, 51014.1, 51014.2, and 53894.

(6) A system for addressing any cultural or linguistic requirements related to the processing of member grievances prescribed in the contract between the plan and the department.

(7) A procedure for the expedited review and disposition of grievances in the event of a serious or imminent health threat to a member, in accordance with Health and Safety Code section 1368 and 1368.02.

22 CCR 53858(f)

(f) Grievance forms shall be available in the offices of each of the plan's primary care providers, or in each member services department of the plan, in the case of a plan in which all primary care providers are the exclusive providers of that plan and are contiguously located.

22 CCR 53858(g) through (i)

(g) Each plan shall adhere to the following requirements and time frames in processing member grievances:

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- (1) Member grievances shall be resolved within thirty days of the member's submittal of a written grievance or if the grievance is made verbally, it shall be resolved within 30 days of the written record of the grievance.
- (2) In the event resolution is not reached within thirty days, the member shall be notified in writing by the plan of the status of the grievance and shall be provided with an estimated completion date of resolution.
- (3) Such notice shall include a statement notifying the member they may exercise their right to request a fair hearing in accordance with sections 50951, 51014.1, 51014.2, and 53894.
- (h) Each plan shall maintain in its files copies of all grievances, the responses to them, and logs recording them for a period of five years from the date the grievance was filed.
- (i) Any member whose grievance is resolved or unresolved shall have the right to request a fair hearing. Submission of a grievance shall not be construed as a waiver of the member's right to request a fair hearing in accordance with sections 50951, 51014.1, 51014.2, and 53894.

28 CCR 1300.68.01(a)

- (a) Every plan shall include in its grievance system, procedures for the expedited review of grievances involving an imminent and serious threat to the health of the enrollee, including, but not limited to, severe pain, potential loss of life, limb or major bodily function ("urgent grievances"). At a minimum, plan procedures for urgent grievances shall include:
- (1) Immediate notification to the complainant of the right to contact the Department regarding the grievance. The plan shall expedite its review of the grievance when the complainant, an authorized representative, or treating physician provides notice to the plan. Notice need not be in writing, but may be accomplished by a documented telephone call.
 - (2) A written statement to the Department and the complainant on the disposition or pending status of the urgent grievance within three (3) calendar days of receipt of the grievance by the Plan.
 - (3) Consideration by the plan of the enrollee's medical condition when determining the response time.
 - (4) No requirement that the enrollee participate in the plan's grievance process prior to applying to the Department for review of the urgent grievance.

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Dental Director
- Officer with primary responsibility for the grievance system
- Plan staff responsible for overseeing the grievance system
- Plan staff responsible for managing the DHCS agreement

DOCUMENT(S) TO BE REVIEWED

- Plan policies and procedures related to the grievance system and related processes.

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- Documents that evidence the Plan’s timely grievance reporting to DMHC, inclusive of the Medi-Cal Category of the report.
- Grievance Logs and required elements
- Quality Management Committee Minutes
- Quarterly Reports

GA-007 - Key Element 1:

1. The Plan has maintains written grievance procedures, including procedures for the submission, processing, and resolution of all member grievances and complaints. Medi-Cal Dental GMC Program Exhibit A, Attachment 15, Provision A 22 CCR 53858(a) through (d)

Assessment Questions	Yes	No	N/A
1.1 Does the Plan have and maintain written procedures for the submittal, processing, and resolution of all member grievances and complaints?			
1.2 Have the procedures been approved in writing by the DHCS? 22 CCR 53858(a)(1)			
1.3 Does the Plan submit amendments to the DHCS for approval prior to implementation of revised procedures? 22 CCR 53858(a)(1)			
1.4 Does the Plan send information to each member describing the procedures for submittal, processing, and resolution of member grievance and complaints in information sent to each member?			
A. Does the description include an explanation of the Plan’s system for processing and resolving grievances? And how a member is to use it?			
B. Does the description include a statement that grievance forms are available in the office of each primary care provider? Or, in the case of a Plan in which all primary care providers are the exclusive providers of that Plan and are contiguously located, in each Member Services Department of the Plan?			
C. Does the description include a statement that grievances may be filed in writing or verbally directly with the Plan or at any office of the Plan’s providers?			
D. Does the description include the local or toll-free telephone number a member may call to obtain information, request grievance forms, and register a verbal grievance?			
E. Does the description include a written statement explaining the member’s right to request a Fair Hearing?			
F. Does the description include an explanation of the State’s Medi-Cal Managed Care Ombudsman Program? And the Program’s voice and TDD telephone numbers?			
1.5 Does the Plan send this information to each member within 7 days			

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Assessment Questions	Yes	No	N/A
of the date of enrollment in the Plan? And annually thereafter?			
1.6 Does the Plan make local or toll-free telephone service available to members during normal business hours for requesting grievance forms, filing verbal grievances, and requesting information?			
1.7 Does the Plan provide, upon request, a grievance form? Either directly or by mail?			
1.8 Does the Plan provide assistance to any member requesting assistance in completing the grievance form?			

GA-007 - Key Element 2:

- 2. The Plan’s grievance procedures provide for the recording of each grievance received by the Plan in a grievance log, including the elements specified in Section 53858(e)(1). Medi-Cal Dental GMC Program Exhibit A, Attachment 15, Provision A Section 53858(e)(1)**

Assessment Questions	Yes	No	N/A
2.1 Does the Plan maintain procedures for the recording of each grievance received by the Plan, either verbally or in writing, in a grievance log?			
2.2 Do the procedures specify that the grievance log shall include the following information:			
A. The date and time the grievance is filed with the Plan or provider?			
B. The name of the Member filing the grievance?			
C. The name of the Plan provider or staff person receiving the grievance?			
D. A description of the complaint or problem?			
E. A description of the action taken by the Plan or provider to investigate and resolve the grievance?			
F. The proposed resolution by the Plan or provider?			
G. The name of the Plan provider or staff person responsible for resolving the grievance?			
H. The date of notification of the Member of the proposed resolution?			

GA-007 - Key Element 3:

- 3. The Plan’s grievance procedures ensure that the Plan complies with the DHCS Contract requirements. Medi-Cal Dental GMC Program Exhibit A, Attachment 15, Provision A 22 CCR 53858(e)(2) through (7) ; Section 53858(f)**

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Assessment Questions	Yes	No	N/A
3.1 Do the Plan’s grievance procedures provide for the immediate submittal of all medical quality of care grievances to the Medical Director for review and action? 22 CCR 53858(e)(2)			
3.2 Do the Plan’s grievance procedures provide for the submittal, at least quarterly, of all Member grievances to the Plan’s quality assurance committee for review and appropriate action? Including, but not limited to, those related to access to care, quality of care, and denial of services? 22 CCR Section 53858(e)(3)			
3.3 Do the Plan’s grievance procedures provide for the review and analysis, on at least a quarterly basis, of all recorded grievances related to access to care, quality of care, and denial of services? And take appropriate action to remedy problems identified through such review? 22 CCR Section 53858(e)(4)			
3.4 Do the Plan’s grievance procedures provide for the mailing of a written notice of the proposed resolution to the Member? Including information about the Member’s right to request a Fair Hearing? 22 CCR Section 53858(e)(5)			
3.5 Do the Plan’s grievance procedures include a system for addressing any cultural or linguistic requirements related to the processing of Member grievances in the contract between the Plan and the Department? 22 CCR Section 53858(e)(6)			
3.6 Do the Plan’s grievance procedures include the expedited review and disposition of grievances in the event of a serious or imminent health threat to a Member? 22 CCR Section 53858(e)(7)			
3.7 Do the Plan’s grievance procedures ensure that grievance forms are available in the offices of each of the Plan’s primary care providers? Or, in the case of a Plan in which all primary care providers are the exclusive providers of that Plan and are contiguously located, in each Member Services Department of the Plan? 22 CCR Section 53858(f)			

GA-007 - Key Element 4:

4. The Plan maintains procedures which ensure the Plan processes Member grievances in accordance with the requirements and timeframes stated in the DHCS Contract. Medi-Cal Dental GMC Program Exhibit A, Attachment 15, Provision A

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22 CCR Section 53858(g) through (i)

Assessment Questions	Yes	No	N/A
4.1 Do the Plan’s grievance procedures ensure that the Plan resolves Member grievances within 30 days of the Member’s submittal of a written grievance or, if the grievance was made verbally, within 30 days of the written record of the grievance? 22 CCR Section 53858(g)(1)			
4.2 Do the Plan’s grievance procedures ensure that the Plan notifies the Member, in writing, of the status of the grievance and an estimated completion date of resolution if a resolution is not reached within 30 days? 22 CCR Section 53858(g)(2)			
4.3 Do the Plan’s grievance procedures ensure that the notice includes a statement notifying the Member of their right to request a Fair Hearing? 22 CCR Section 53858(g)(3)			
4.4 Do the Plan’s grievance procedures ensure that the Plan maintains copies of all grievances, the responses to them, and logs recording them for a period of 5 years from the date the grievance was filed? 22 CCR Section 53858(h)			
4.5 Do the Plan’s grievance procedures ensure that any Member whose grievance is resolved or unresolved shall have the right to request a Fair Hearing? And that submission of a grievance does not constitute a waiver of the Member’s right to request a fair hearing? 22 CCR Section 53858(i)			

GA-007 - Key Element 5:

- 5. The Plan develops and implements procedures for the expedited review of grievances. Medi-Cal Dental GMC Program Exhibit A, Attachment 15, Provision A
28 CCR 1300.68.01(a)**

Assessment Questions	Yes	No	N/A
5.1 Does the Plan maintain procedures for the expedited review of urgent grievances? Urgent grievances are defined as including, but not limited to, severe pain, potential loss of life, limb, or major bodily function? (KKA Requirement GA-005, KE1, AQs 1.1 and 1.2)			
5.2 Do the Plan’s procedures include immediate notification to the complainant of the right to contact the Department regarding the grievance? (KKA Requirement GA-005, KE1, AQ 1.3)			

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Assessment Questions	Yes	No	N/A
5.3 Do the Plan’s procedures expedite a review of the grievance when notice is provided in writing or by a documented telephone call by a complainant, their representative, or a provider?			
5.4 Do the Plan’s procedures include a written statement to the Department and the complainant on the disposition or pending status of the urgent grievance within 3 calendar days of receipt of the grievance by the Plan? (KKA Requirement GA-005, KE3, AQ 3.4)			
5.5 Do the Plan’s procedures include consideration by the Plan of the enrollee’s medical condition when determining the response time? (KKA Requirement GA-005, KE3, AQ 3.13)			
5.6 Do the Plan’s procedures stipulate that the enrollee is not required to participate in the Plan’s grievance process prior to applying to the Department for review of the urgent grievance?			

End of Requirement GA-007: Grievance Policies and Procedures

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Requirement GA-008: Grievance Log and Quarterly Grievance Report

CONTRACT CITATION(S)

Medi-Cal Dental GMC Program Exhibit A, Attachment 15, Provision C

C. Grievance Log and Quarterly Grievance Report

1. Contractor shall maintain, and have available for DHCS review, grievance logs, including copies of grievance logs of any sub-contracting entity delegated the responsibility to maintain and resolve grievances. Grievance logs shall include all the required information set forth in 22 CCR 53858(e).
2. Contractor shall submit quarterly grievance reports in the required DMHC format no later than thirty (30) calendar days following the end of the reporting quarter, to include, but not be limited to, the required elements set forth in 28 CCR 1300.68(f). The grievance report should include an explanation for each grievance that was not resolved within thirty (30) calendar days of receipt of the grievance.
 - a. In addition to the types or nature of grievances listed in 28 CCR 1300.68(f)(2)(D), the report shall also include, but not be limited to, untimely assignments to a Primary Care Dentist, issues related to cultural sensitivity and linguistic access, and difficulty with accessing specialists.
 - b. In addition to the reporting requirements above, Contractor shall provide the following in the Medi-Cal Category of the report:
 - 1) The total number of grievances received.
 - 2) The average time it took to resolve grievances, which includes providing written notification to the Member.
 - 3) A listing of the zip codes, ethnicity, gender, and primary language of Members who filed grievances.
3. Contractor shall submit reports resulting from its quarterly review and analysis of all recorded grievances as required by 22 CCR 53858(e)(4) in the required DMHC format. Upon request Contractor shall submit the additional information on a grievance to DHCS within five (5) calendar days.

22 CCR 53858(e)

- (e) The member grievance procedures shall at a minimum provide for:
- (1) The recording in a grievance log of each grievance received by the plan, either verbally or in writing. The grievance log shall include the following information:
 - (A) The date and time the grievance is filed with the plan or provider.
 - (B) The name of the member filing the grievance.
 - (C) The name of the plan provider or staff person receiving the grievance.
 - (D) A description of the complaint or problem.
 - (E) A description of the action taken by the plan or provider to investigate and resolve the grievance.
 - (F) The proposed resolution by the plan or provider.
 - (G) The name of the plan provider or staff person responsible for resolving the grievance.
 - (H) The date of notification of the member of the proposed resolution.
 - (2) The immediate submittal of all medical quality of care grievances to the medical director for

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action.

(3) The submittal, at least quarterly, of all member grievances to the plan's quality assurance committee or review and appropriate action. For purposes of this subsection, member grievances shall include but not be limited to those related to access to care, quality of care, and denial of services.

(4) The review and analysis, on at least a quarterly basis, of all recorded grievances related to access to care, quality of care and denial of services, and take appropriate action to remedy any problems identified in such reviews.

(5) The mailing of a written notice of the proposed resolution to the member. Each notice shall include information about the member's right to request a fair hearing pursuant to sections 50951, 51014.1, 51014.2, and 53894.

(6) A system for addressing any cultural or linguistic requirements related to the processing of member grievances prescribed in the contract between the plan and the department.

(7) A procedure for the expedited review and disposition of grievances in the event of a serious or imminent health threat to a member, in accordance with Health and Safety Code section 1368 and 1368.02.

28 CCR 1300.68(f)

(f) Quarterly Reports

(1) All plans shall submit a quarterly report to the Department describing grievances that were or are pending and unresolved for 30 days or more. The report shall be prepared for the quarters ending March 31st, June 30th, September 30th and December 31st of each calendar year. The report shall also contain the number of grievances referred to external review processes, such as reconsiderations of Medicare Managed Care determinations pursuant to 42 C.F.R. Part 422, the Medi-Cal fair hearing process, the Department's complaint or Independent Medical Review system, or other external dispute resolution systems, known to the plan as of the last day of each quarter.

(2) The quarterly report shall include:

(A) The licensee's name, quarter and date of the report;

(B) The total number of grievances filed by enrollees that were or are pending and unresolved for more than 30 calendar days at any time during the quarter under the categories of Commercial, Medicare, and Medi-Cal/other products offered by the plan;

(C) A brief explanation of why the grievance was not resolved in 30 days, and indicate whether the grievance was or is pending at: (1) the plan's internal grievance system; (2) the Department's consumer complaint process; (3) the Department's Independent Medical Review system; (4) court; or (5) other dispute resolution processes. Alternatively, the plan shall indicate whether the grievance was or is submitted to: (1) the Medicare review and appeal system; (2) the Medi-Cal fair hearing process; or (3) arbitration.

(D) The nature of the unresolved grievances as (1) coverage disputes; (2) disputes involving medical necessity; (3) complaints about the quality of care; (4) complaints about access to care (including complaints about the waiting time for appointments); (5) complaints about the quality of service; and (6) other issues. All issues reasonably described in the grievance shall be separately categorized.

(E) The quarterly report shall not contain personal or confidential information with respect to any

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enrollee.

(3) The quarterly report shall be verified by an officer authorized to act on behalf of the plan. The report shall be submitted in writing or through electronic filing to the Department’s Sacramento Office to the attention of the Filing Clerk no later than 30 days after each quarter. The quarterly report shall not be filed as an amendment to the plan application.

(4) The quarterly report shall be filed in the format specified in subsection (i).

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Dental Director
- Officer with primary responsibility for the grievance system
- Plan staff responsible for overseeing the grievance system

DOCUMENT(S) TO BE REVIEWED

- Documents that evidence the Plan’s timely grievance reporting to DMHC, inclusive of the Medi-Cal Category of the report.
- Grievance Logs

GA-008 - Key Element 1:

1. **Grievance Logs:** The Plan maintains, and has available for DHCS review, grievance logs, including copies of grievance logs of any sub-contracting entity delegated the responsibility to maintain and resolve grievances, that include all required information set forth in 22 CCR 53858(e).
Medi-Cal Dental GMC Program Exhibit A, Attachment 15, Provision C(1) and 22 CCR 53858(e)

Assessment Questions	Yes	No	N/A
1.1 Does the Plan maintain grievance logs? Including copies of grievance logs of any sub-contracting entity delegated with the responsibility to maintain and resolve grievances?			
1.2 Are the Plan’s grievance logs available for DHCS review?			
1.3 Do the Plan’s grievance logs include the following information for each written or verbal grievance received:			
A. The date and time the grievance is filed with the Plan or provider?			
B. The name of the Member filing the grievance?			
C. The name of the Plan provider or staff person receiving the grievance?			
D. A description of the complaint or problem?			
E. A description of the action taken by the Plan or provider to investigate and resolve the grievance?			

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Assessment Questions	Yes	No	N/A
F. The proposed resolution by the Plan or provider?			
G. The name of the Plan provider or staff person responsible for resolving the grievance?			
H. The date of notification of the Member of the proposed resolution?			

GA-008 - Key Element 2:

- 2. Quarterly Grievance Reports: The Plan submits quarterly grievance reports containing the required information in the required DMHC format.**
Medi-Cal Dental GMC Program Exhibit A, Attachment 15, Provision C(2) and (3)
28 CCR 1300.68(f)

Assessment Questions	Yes	No	N/A
2.1 Does the Plan submit quarterly grievance reports in the required DMHC format no later than 30 days following the end of the reporting quarter?			
2.2 Does the Plan's quarterly report include the Plan name, quarter and date of the report?			
2.3 Does the Plan include the total number of grievances filed by enrollees that were or are pending and unresolved for more than 30 calendar days at any time during the quarter under the categories of Commercial, Medicare, and Medi-Cal/other products offered by the Plan in its quarterly grievance reports?			
2.4 Does the Plan include an explanation for each grievance that was not resolved within 30 calendar days of receipt of the grievance in its quarterly grievance reports?			
2.5 Does the Plan's explanation for each grievance indicate whether the grievance was or is pending at the Plan's internal grievance system, the department's consumer complaint process, the Department's Independent Medical review system, the court, or other dispute resolution process? Alternatively, does the Plan indicate whether the grievance was submitted to, the Medi-Cal review and appeal system, the Medi-Cal Fair Hearing Process or arbitration?			
2.6 Does the Plan's quarterly grievance report include the following types or nature of grievances: (KKA Requirement GA-001, KE3, AQ 3.4)			
A. Coverage disputes?			
B. Disputes involving medical necessity?			
C. Complaints about the quality of care?			
D. Complaints about access to care? Including complaints about the waiting time for appointments?			

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Assessment Questions	Yes	No	N/A
E. Complaints about the quality of service?			
F. Other issues?			
G. Untimely assignments to a Primary Care Dentist?			
H. Issues related to cultural sensitivity and linguistic access?			
I. Difficulty with accessing specialists?			
2.7 Does the Plan include the total number of grievances resolved in the Medi-Cal Category of the report?			
2.8 Does the Plan include the average time it took to resolve grievances, which includes providing written notification to the Member, in the Medi-Cal Category of the report?			
2.9 Does the Plan include a listing of zip codes, ethnicity, gender, and primary language of Members who filed grievances in the Medi-Cal Category of the report?			
2.10 Does the Plan submit additional information on grievances to DHCS within 5 calendar days upon request from DHCS?			
2.11 Does the Plan submit reports resulting from its quarterly review and analysis of all recorded grievances in the required DMHC format?			
2.12 Is the Plan's quarterly report verified by an officer authorized to act on behalf of the Plan?			

End of Requirement GA-008: Grievance Log and Quarterly Grievance Report

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Requirement GA-009: Grievance System Oversight

STATUTORY/REGULATORY CITATION(S)

Medi-Cal Dental GMC Program Exhibit A, Attachment 15, Provisions A and B A. Member Grievance System

Contractor shall implement and maintain a Member Grievance system in accordance with 28 CCR 1300.68 (except Subdivision 1300.68(g).), and 1300.68.01, 22 CCR 53858, Exhibit A, Attachment 14, Member Services, Provision D, Written Member Information, Subprovision 4, Paragraph l). Contractor shall resolve each grievance and provide notice to the Member as quickly as the Member's dental condition requires, or no later than thirty (30) calendar days from the date Contractor receives the grievance. Contractor shall notify the Member of the grievance resolution in a written Member notice.

B. Grievance System Oversight

Contractor shall implement and maintain procedures as pursuant to 28 CCR 1300.68, 1300.68.01 and 22 CFR 53858 to monitor Contractor's Member Grievance system and the expedited review of grievances, which shall include, but not limited to:

1. Procedure to ensure timely resolution and feedback to complainant. Provide verbal notice of the resolution of an expedited review.
2. Procedure for systematic aggregation and analysis of the grievance data and use for quality improvement.
3. Procedure to ensure that the grievance submitted is reported to an appropriate level, i.e., dental issues versus dental care delivery issues. To this end, Contractor shall ensure that any grievance involving the appeal of a denial based on lack of medical necessity, appeal of a denial of a request for expedited resolution of a grievance, or an appeal that involves clinical issues shall be resolved by a dental care professional with appropriate clinical expertise in treating the Member's condition or disease.
4. Procedure to ensure the participation of individuals with authority to require corrective action. Grievances related to medical/dental quality of care issues shall be referred to the Contractor's Dental Director.
5. Procedure to ensure that the person making the final decision for the proposed resolution of a grievance has not participated in any prior decisions related to the grievance.
6. Procedures to ensure that Members are given a reasonable opportunity to present, in writing or in person before the individual(s) resolving the grievance, evidence, facts and law in support of their grievance.

CA Health and Safety Code section 1368.02(b)

(b) Every health care service plan shall publish the Department's toll-free telephone number, the Department's TDD line for the hearing and speech impaired, the plan's telephone number, and the Department's Internet address, on every plan contract, on every evidence of coverage, on copies of plan grievance procedures, on plan complaint forms, and on all written notices to enrollees required under the grievance process of the plan, including any written communications to an enrollee that offer the enrollee the opportunity to participate in the grievance process of the plan and on all written responses to grievances. The Department's

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telephone number, the Department's TDD line, the plan's telephone number, and the Department's Internet address shall be displayed by the plan in each of these documents in 12-point boldface type in the following regular type statement:

“The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at (**insert health plan's telephone number**) and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (**1-888-HMO-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department's Internet Web site <http://www.hmohelp.ca.gov> has complaint forms, IMR application forms and instructions online.”

28 CCR 1300.68(a)

(a) The grievance system shall be established in writing and provide for procedures that will receive, review and resolve grievances within 30 calendar days of receipt by the plan, or any provider or entity with delegated authority to administer and resolve the plan's grievance system. The following definitions shall apply with respect to the regulations relating to grievance systems:

- (1) “Grievance” means a written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns. and shall include a complaint. dispute. request for reconsideration or appeal made by an enrollee or the enrollee's representative. Where the plan is unable to distinguish between a grievance and an inquiry. it shall be considered a grievance.
- (2) “Complaint” is the same as ‘grievance.’”
- (3) “Complainant” is the same as “grievant,” and means the person who filed the grievance including the enrollee. a representative designated by the enrollee. or other individual with authority to act on behalf of the enrollee.
- (4) “Resolved” means that the grievance has reached a final conclusion with respect to the enrollee's submitted grievance. and there are no pending enrollee appeals within the plan's grievance system. including entities with delegated authority.

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(A) If the plan has multiple internal levels of grievance resolution or appeal, all levels must be completed within 30 calendar days of the plan's receipt of the grievance.

(B) Grievances that are not resolved within 30 calendar days, or grievances referred to the Department's complaint or independent medical review system, shall be reported as "pending" grievances pursuant to subsection (f) below. Grievances referred to external review processes, such as reviews of Medicare Managed Care determinations pursuant to 42 C.F.R. Part 422, or the Medi-Cal Fair Hearing process, shall also be reported pursuant to subsection (f) until the review and any required action by the plan resulting from the review is completed.

28 CCR 1300.68(b)

(b) The plan's grievance system shall include the following:

(1) An officer of the plan shall be designated as having primary responsibility for the plan's grievance system whether administered directly by the plan or delegated to another entity. The officer shall continuously review the operation of the grievance system to identify any emergent patterns of grievances. The system shall include the reporting procedures in order to improve plan policies and procedures.

(2) Each plan's obligation for notifying subscribers and enrollees about the plan's grievance system shall include information on the plan's procedures for filing and resolving grievances, and the telephone number and address for presenting a grievance. The notice shall also include information regarding the Department's review process, the independent medical review system, and the Department's toll-free telephone number and website address.

(3) The grievance system shall address the linguistic and cultural needs of its enrollee population as well as the needs of enrollees with disabilities. The system shall ensure all enrollees have access to and can fully participate in the grievance system by providing assistance for those with limited English proficiency or with a visual or other communicative impairment. Such assistance shall include, but is not limited to, translations of grievance procedures, forms, and plan responses to grievances.

as well as access to interpreters, telephone relay systems and other devices that aid disabled individuals to communicate. Plans shall develop and file with the Department a policy describing how they ensure that their grievance system complies with this subsection within 90 days of the effective date of this regulation.

(4) The plan shall maintain a toll-free number, or a local telephone number in each service area, for the filing of grievances.

(5) A written record shall be made for each grievance received by the plan, including the date received, the plan representative recording the grievance, a summary or other document describing the grievance, and its disposition. The written record of grievances shall be reviewed periodically by the governing body of the plan, the public policy body created pursuant to section 1.300.69, and by an officer of the plan or his designee. This review shall be thoroughly documented.

(6) The plan grievance system shall ensure that assistance in filing grievances shall be provided at each location where grievances may be submitted. A "patient advocate" or ombudsperson may be used.

(7) Grievance forms and a description of the grievance procedure shall be readily available at each facility of the plan, on the plan's website, and from each contracting provider's office or

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facility. Grievance forms shall be provided promptly upon request.

(8) The plan shall assure that there is no discrimination against an enrollee or subscriber (including cancellation of the contract) on the grounds that the complainant filed a grievance.

(9) The grievance system shall allow enrollees to file grievances for at least 180 calendar days following any incident or action that is the subject of the enrollee's dissatisfaction.

28 CCR 1300.68(d)

(d) The plan shall respond to grievances as follows:

(1) A grievance system shall provide for a written acknowledgment within five (5) calendar days of receipt, except as noted in subsection (d)(8). The acknowledgment will advise the complainant that the grievance has been received, the date of receipt, and provide the name of the plan representative, telephone number and address of the plan representative who may be contacted about the grievance.

(2) The grievance system shall provide for a prompt review of grievances by the management or supervisory staff responsible for the services or operations which are the subject of the grievance.

(3) The plan's resolution, containing a written response to the grievance shall be sent to the complainant within thirty (30) calendar days of receipt, except as noted in subsection (d)(8). The written response shall contain a clear and concise explanation of the plan's decision. Nothing in this regulation requires a plan to disclose information to the grievant that is otherwise confidential or privileged by law.

(4) For grievances involving delay, modification or denial of services based on a determination in whole or in part that the service is not medically necessary, the plan shall include in its written response, the reasons for its determination. The response shall clearly state the criteria, clinical guidelines or medical policies used in reaching the determination. The plan's response shall also advise the enrollee that the determination may be considered by the Department's independent medical review system.

The response shall include an application for independent medical review and instructions, including the Department's toll-free telephone number for further information and an envelope addressed to the Department of Managed Health Care, HMO Help Center, 980 Ninth Street, 5th Floor, Sacramento, CA 95814.

(5) Plan responses to grievances involving a determination that the requested service is not a covered benefit shall specify the provision in the contract, evidence of coverage or member handbook that excludes the service. The response shall either identify the document and page where the provision is found, direct the grievant to the applicable section of the contract containing the provision, or provide a copy of the provision and explain in clear concise language how the exclusion applied to the specific health care service or benefit requested by the enrollee. In addition to the notice set forth at Section 1368.02(b) of the Act, the response shall also include a notice that if the enrollee believes the decision was denied on the grounds that it was not medically necessary, the Department should be contacted to determine whether the decision is eligible for an independent medical review.

(6) Copies of grievances and responses shall be maintained by the Plan for five years, and shall include a copy of all medical records, documents, evidence of coverage and other relevant information upon which the plan relied in reaching its decision.

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(7) The Department's telephone number, the California Relay Service's telephone numbers, the plan's telephone number and the Department's Internet address shall be displayed in all of the plan's acknowledgments and responses to grievances in 12-point boldface type with the statement contained in subsection (b) of Section 1368.02 of the Act.

(8) Grievances received over the telephone that are not coverage disputes, disputed health care services involving medical necessity or experimental or investigational treatment, and that are resolved by the close of the next business day, are exempt from the requirement to send a written acknowledgment and response. The plan shall maintain a log of all such grievances containing the date of the call, the name of the complainant, member identification number, nature of the grievance, nature of resolution, and the plan representative's name who took the call and resolved the grievance. The information contained in this log shall be periodically reviewed by the plan as set forth in subsection (b).

28 CCR 1300.68(e)

(e) The plan's grievance system shall track and monitor grievances received by the plan, or any entity with delegated authority to receive or respond to grievances. The system shall:

(1) Monitor the number of grievances received and resolved; whether the grievance was resolved in favor of the enrollee or plan; and the number of grievances pending over 30 calendar days. The system shall track grievances under categories of Commercial, Medicare and Medi-Cal/other Contracts. The system shall indicate whether an enrollee grievance is pending at: (1) the plan's internal grievance system; (2) the Department's consumer complaint process; (3) the Department's Independent Medical Review system; (4) an action filed or before a trial or appellate court; or (5) other dispute resolution process. Additionally, the system shall indicate whether an enrollee grievance has been submitted to: (1) the Medicare review and appeal system; (2) the Medi-Cal fair hearing process; or (3) arbitration.

(2) The system shall be able to indicate the total number of grievances received, pending and resolved in favor of the enrollee at all levels of grievance review and to describe the issue or issues raised in grievances as (1) coverage disputes, (2) disputes involving medical necessity, (3) complaints about the quality of care and (4) complaints about access to care (including complaints about the waiting time for appointments), and (5) complaints about the quality of service, and (6) other issues.

28 CCR 1300.68(f)

(f) quarterly reports

(1) All plans shall submit a quarterly report to the Department describing grievances that were or are pending and unresolved for 30 days or more. The report shall be prepared for the quarters ending March 31st, June 30th, September 30th and December 31st of each calendar year. The report shall also contain the number of grievances referred to external review processes, such as reconsiderations of Medicare Managed Care determinations pursuant to 42 C.F.R. Part 422, the Medi-Cal fair hearing

process, the Department's complaint or Independent Medical Review system, or other external dispute resolution systems, known to the plan as of the last day of each quarter.

(2) The quarterly report shall include:

(A) The licensee's name, quarter and date of the report:

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- (B) The total number of grievances filed by enrollees that were or are pending and unresolved for more than 30 calendar days at any time during the quarter under the categories of Commercial, Medicare, and Medi-Cal/other products offered by the plan;
- (C) A brief explanation of why the grievance was not resolved in 30 days, and indicate whether the grievance was or is pending at: (1) the plan's internal grievance system; (2) the Department's consumer complaint process; (3) the Department's Independent Medical Review system; (4) court; or (5) other dispute resolution processes. Alternatively, the plan shall indicate whether the grievance was or is submitted to: (1) the Medicare review and appeal system; (2) the Medi-Cal fair hearing process; or (3) arbitration.
- (D) The nature of the unresolved grievances as (1) coverage disputes; (2) disputes involving medical necessity; (3) complaints about the quality of care; (4) complaints about access to care (including complaints about the waiting time for appointments); (5) complaints about the quality of service; and (6) other issues. All issues reasonably described in the grievance shall be separately categorized.
- (E) The quarterly report shall not contain personal or confidential information with respect to any enrollee.
- (3) The quarterly report shall be verified by an officer authorized to act on behalf of the plan. The report shall be submitted in writing or through electronic filing to the Department's Sacramento Office to the attention of the Filing Clerk no later than 30 days after each quarter. The quarterly report shall not be filed as an amendment to the plan application.
- (4) The quarterly report shall be filed in the format specified in subsection (i).

28 CCR 1300.68.01(a)

- (a) Every plan shall include in its grievance system, procedures for the expedited review of grievances involving an imminent and serious threat to the health of the enrollee, including, but not limited to, severe pain, potential loss of life, limb or major bodily function ("urgent grievances"). At a minimum, plan procedures for urgent grievances shall include:
- (1) Immediate notification to the complainant of the right to contact the Department regarding the grievance. The plan shall expedite its review of the grievance when the complainant, an authorized representative, or treating physician provides notice to the plan. Notice need not be in writing, but may be accomplished by a documented telephone call.
- (2) A written statement to the Department and the complainant on the disposition or pending status of the urgent grievance within three (3) calendar days of receipt of the grievance by the Plan.
- 3) Consideration by the plan of the enrollee's medical condition when determining the response time.
- (4) No requirement that the enrollee participate in the plan's grievance process prior to applying to the Department for review of the urgent grievance.

28 CCR 1300.68.01(b)

- (b) Each plan's grievance system shall allow for the Department to contact the plan regarding urgent grievances 24 hours a day, 7 days a week. During normal work hours, the plan shall respond to the Department within 30 minutes after initial contact from the Department. During

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non-work hours, the plan shall respond to the Department within 1 hour after initial contact from the Department.

(1) The system established by the plan shall provide for the availability of a plan representative with authority on the plan's behalf to resolve urgent grievances and authorize the provision of health care services covered under the enrollee's plan contract in a medically appropriate and timely manner. Such authority shall include making financial decisions for expenditure of funds on behalf of the plan without first having to obtain approval from supervisors or other superiors within the plan. Nothing in this subsection shall restrict the plan representative from consulting with other plan staff on urgent grievances.

(2) Plans shall provide the Department with the following information concerning urgent grievances:

(A) A description of the system established by the plan to resolve urgent grievances. The description shall include the system's provisions for scheduling qualified plan representatives, including back-up plan representatives as necessary, to be available twenty-four (24) hours a day, seven days a week to respond to Department contacts regarding urgent grievances. Provisions for scheduling shall include the names and titles of those plan representatives who will be available under the system, their telephone numbers, and, as applicable, pager numbers, answer service numbers, voice-mail numbers, e-mail addresses, or other means for contact.

(B) A description of how the Department may access the grievance system established by the plan.

(3) If the plan revises the system established pursuant to subsection (b) the plan shall notify the Department at least thirty (30) days in advance of implementing the revisions.

28 CCR 1300.68.01(c)

(c) The plan shall notify the Department before changing or modifying any benefit or services that relates to the urgent grievance submitted to the Department pursuant to subsection (b)(1)(A) of section 1368 of the Act if the enrollee or the enrollee's representative objects to the change or modification.

22 CCR 53858(e)(4)

(e) The member grievance procedures shall at a minimum provide for:

(4) The review and analysis, on at least a quarterly basis, of all recorded grievances related to access to care, quality of care and denial of services, and take appropriate action to remedy any problems identified in such reviews.

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Dental Director
- Officer with primary responsibility for the grievance system
- Plan staff responsible for overseeing the grievance system

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DOCUMENT(S) TO BE REVIEWED

- Documents that evidence the Plan’s timely processing and issuance of applicable notices, including those related to expedited grievances.
- Grievance policies and procedures related to evaluation and monitoring of the grievance system.
- Documents that demonstrate that grievances are reviewed and resolutions determined by the appropriate level, including the Dental Director.
- Documents that demonstrate that individuals involved in the final resolution decision were not involved in prior determinations, and that Members are provided opportunity to present in writing or verbally to the individuals resolving the grievance.

GA-009 - Key Element 1:

- 1. The Plan has a written grievance system that provides for procedures to receive, review and resolve grievances within 30 calendar days of receipt.
Medi-Cal Dental GMC Program Exhibit A, Attachment 15, Provisions A and B;
28 CCR 1300.68(a)**

Assessment Questions	Yes	No	N/A
1.1 Does the Plan have a grievance system established in writing?			
1.2 Does the Plan have processes in place to ensure that its procedures for receiving, reviewing and resolving grievances within 30 days of receipt are being followed?			
1.3 Does the Plan have multiple internal levels of grievance resolution or appeal?			
1.4 If the Plan has multiple levels of appeal, does the Plan have a process in place to ensure that all levels are completed within 30 calendar days of the Plan’s receipt of the grievance?			
1.5 Does the Plan have a process in place for ensuring that grievances that are not resolved within 30 calendar days are tracked and reported?			
1.6 Does the Plan a system for monitoring and reporting grievances referred to the Department’s complaint or independent medical review system as “pending” grievances.			
1.7 Does the Plan’s grievance system provide for monitoring and reporting of grievances referred to external review processes, such as reviews of Medicare Managed Care determinations or the Medi-Cal Fair Hearing process?			
1.8 Does the Plan’s grievance system provide a written notice of resolution to the member?			

DENTAL TAG

GA-009 - Key Element 2:

- 2. The Plan implements and maintains procedures to monitor the Member grievance system and the expedited review of grievances
Medi-Cal Dental GMC Program Exhibit A, Attachment 15, Provisions A and B;
28 CCR 1300.68.01(a)**

Assessment Questions	Yes	No	N/A
2.1 Does the Plan maintain a procedure to ensure timely resolution and feedback to the complainant?			
2.2 Does the Plan provide verbal notice of the resolution of an expedited review?			
2.3 Does the Plan maintain a procedure for systematic aggregation and analysis of the grievance data? And use for quality improvement?			
2.4 Does the Plan maintain a procedure to ensure that submitted grievances are reported to an appropriate level (i.e., dental issues versus dental care delivery issues)?			
2.5 Does the Plan ensure that any grievance involving the appeal of a denial based on lack of medical necessity, appeal of a denial of a request for expedited resolution of a grievance, or an appeal that involves clinical issues is resolved by a dental care professional with appropriate clinical expertise in treating the Member's condition or disease?			
2.6 Does the Plan maintain a procedure to ensure the participation of individuals with authority to require corrective action?			
2.7 Does the Plan refer grievances related to medical/dental quality of care issues to the Dental Director?			
2.8 Does the Plan maintain a procedure to ensure that the person making the final decision for the proposed resolution of a grievance has not participated in any prior decisions related to the grievance?			
2.9 Does the Plan maintain a procedure to ensure that Members are given a reasonable opportunity to present, in writing or in person, evidence, facts and law in support of their grievance?			

GA-009 - Key Element 3:

- 3. The Plan's grievance system tracks and monitors grievances received by the Plan, or any entity with delegated authority to receive or respond to grievances.
Medi-Cal Dental GMC Program Exhibit A, Attachment 15, Provisions A and B;
28 CCR 1300.68(e), 28 CCR 1300.68.01(a)**

DENTAL TAG

Assessment Questions	Yes	No	N/A
3.1 Does the Plan’s grievance monitoring system monitor the number of grievances received and resolved; whether the grievance was resolved in favor of the enrollee or Plan; and the number of grievances pending over 30 calendar days?			
3.2 Does the system track grievances under categories of Commercial, Medicare and Medi-Cal/ other Contracts?			
3.3 Does the system indicate whether an enrollee grievance is pending at: (1) the Plan’s internal grievance system; (2) the Department’s consumer complaint process; (3) the Department’s Independent Medical Review system; (4) an action filed or before a trial or appellate court; or (5) other dispute resolution process?			
3.4 Does the system indicate whether an enrollee grievance has been submitted to: (1) the Medicare review and appeal system; (2) the Medi-Cal Fair Hearing process; or (3) arbitration?			
3.5 Does the system indicate the total number of grievances received, pending, and resolved in favor of the enrollee at all levels of grievance review and to describe the issue or issues raised in grievances as (1) coverage disputes, (2) disputes involving medical necessity, 3) complaints about the quality of care and (4) complaints about access to care (including complaints about the waiting time for appointments), and (5) complaints about the quality of service, and (6) other issues?			

GA-009 - Key Element 4:

4. The Plan’s Grievance System includes all requirements outlined in 28 CCR 1300.68(b). Medi-Cal Dental GMC Program Exhibit A, Attachment 14, Provision D (4)(1); Medi-Cal Dental GMC Program Exhibit A, Attachment 15, Provisions A and B; 28 CCR 1300.68(b)

Assessment Questions	Yes	No	N/A
4.1 Does the Plan have a designated officer of the Plan who has primary responsibility for the Plan’s grievance system? 28 CCR 1300.68(b)(1)			
4.2 Does the designated officer continuously review the operation of the grievance system to identify any emergent patterns of grievances? 28 CCR 1300.68(b)(1)			
4.3 Does the system include the reporting procedures in order to improve Plan policies and procedures? 28 CCR 1300.68(b)(1)			

DENTAL TAG

Assessment Questions	Yes	No	N/A
4.4 Does the Plan notify its subscribers and enrollees about the Plan’s grievance system, and include information on the Plan’s procedures for filing and resolving grievances, and the telephone number and address for presenting a grievance? 28 CCR 1300.68(b)(2)			
4.5 Does the notification include information regarding the Department’s review process, the independent medical review system, and the Department’s toll-free telephone number and Web site address? 28 CCR 1300.68(b)(2)			
4.6 Does the Plan’s grievance system address the linguistic and cultural needs of its enrollee population as well as the needs of enrollees with disabilities? 28 CCR 1300.68(b)(3)			
4.7 Does the Plan ensure all enrollees have access to and can fully participate in the grievance system by providing assistance for those with limited English proficiency or with a visual or other communicative impairment? 28 CCR 1300.68(b)(3)			
4.8 Does the Plan provide translations of its grievance procedures, forms, and Plan responses to grievances? 28 CCR 1300.68(b)(3)			
4.9 Does the Plan provide access to interpreters, telephone relay systems and other devices that aid disabled individuals to communicate? 28 CCR 1300.68(b)(3)			
4.10 Does the Plan maintain a toll-free number, or a local telephone number in each service area, for the filing of grievances? 28 CCR 1300.68(b)(4)			
4.11 Does the Plan maintain a record for each grievance received by the plan, including the date received, the Plan representative recording the grievance, a summary or other document describing the grievance, and its disposition? 28 CCR 1300.68(b)(5)			
4.12 Does the Plan ensure and thoroughly document that the written record of grievances is reviewed periodically by the governing body, the public policy body, and by an officer of the Plan or his designee? 28 CCR 1300.68(b)(5)			
4.13 Does the Plan have processes in place to ensure that assistance in filing grievances is provided at each location where grievances may be submitted? 28 CCR 1300.68(b)(6)			

DENTAL TAG

Assessment Questions	Yes	No	N/A
4.14 Are grievance forms and a description of the grievance procedure readily available at each facility of the Plan, on the Plan's Web site? And from each contracting provider's office or facility? 28 CCR 1300.68(b)(7)			
4.15 Does the Plan have procedures in place to assure that there is no discrimination against an enrollee or subscriber (including cancellation of the contract) on the grounds that the complainant filed a grievance? 28 CCR 1300.68(b)(8)			
4.16 Does the Plan's grievance system allow enrollees to file grievances for at least 180 calendar days following any incident or action that is the subject of the enrollee's dissatisfaction? 28 CCR 1300.68(b)(9)			

GA-009 - Key Element 5:

- 5. The Plan has processes in place to respond to grievances in accordance with 28 CCR 1300.68(d).
Medi-Cal Dental GMC Program Exhibit A, Attachment 15, Provisions A and B;
28 CCR 1300.68(d)**

Assessment Questions	Yes	No	N/A
5.1 Does the Plan provide a written acknowledgment to the Member within five (5) calendar days of receipt, except in the case of exempt grievances? 28 CCR 1300.68(d)(1)			
5.2 Does the acknowledgment advise the complainant that the grievance has been received, the date of receipt, and provide the name of the Plan representative, telephone number and address of the Plan representative who may be contacted about the grievance? 28 CCR 1300.68(d)(1)			
5.3 Does the Plan have processes in place to ensure prompt review of grievances by the management or supervisory staff responsible for the services or operations which are the subject of the grievance? 28 CCR 1300.68(d)(2)			
5.4 Does the Plan ensure that a resolution letter is sent to the complainant within thirty (30) calendar days of receipt, except in exempt grievances? 28 CCR 1300.68(d)(3)			
5.5 Does the Plan ensure that written responses contain a clear and concise explanation of the Plan's decision? 28 CCR 1300.68(d)(3)			

DENTAL TAG

Assessment Questions	Yes	No	N/A
<p>5.6 In the event that a grievance involves a delay, modification or denial of services based on a determination in whole or in part that the service is not medically necessary, does the Plan include in its written response the reasons for its determination? 28 CCR 1300.68(d)(4)</p>			
<p>5.7 If the determination is made in whole or in part that the service is not medically necessary, does the Plan ensure responses clearly state the criteria, clinical guidelines or medical policies used in reaching the determination? 28 CCR 1300.68(d)(4)</p>			
<p>5.8 Does the Plan ensure that responses advise the enrollee that the determination may be considered by the Department’s independent medical review system? 28 CCR 1300.68(d)(4)</p>			
<p>5.9 Does the Plan ensure that the response includes an application for independent medical review and instructions, including the Department’s toll-free telephone number for further information and an envelope addressed to the Department of Managed Health Care, HMO Help Center, 980 Ninth Street, 5th Floor. Sacramento, CA 95814? 28 CCR 1300.68(d)(4)</p>			
<p>5.10 Does the Plan ensure that its responses to grievances involving a determination that the requested service is not a covered benefit specify the provision in the contract, evidence of coverage or member handbook that excludes the service, and either identify the document and page where the provision is found, direct the grievant to the applicable section of the contract containing the provision, or provide a copy of the provision and explain in clear concise language how the exclusion applied to the specific health care service or benefit requested by the enrollee? 28 CCR 1300.68(d)(5)</p>			
<p>5.11 Does the Plan ensure that Members receive the notice set forth at Section 1368.02(b) and instructs the Member that if the enrollee believes the decision was denied on the grounds that it was not medically necessary, the Department should be contacted to determine whether the decision is eligible for an independent medical review? 28 CCR 1300.68(d)(5)</p>			
<p>5.12 Does the Plan ensure that copies of grievances and responses are maintained by the Plan for at least five years, including copies of all medical records, documents, evidence of coverage, and other relevant information upon which the Plan relied in reaching its decision? 28 CCR 1300.68(d)(6)</p>			

DENTAL TAG

Assessment Questions	Yes	No	N/A
<p>5.13 Does the Plan ensure that the Department’s telephone number, the California Relay Service’s telephone numbers, the Plan’s telephone number and the Department’s Internet address are displayed in all of the Plan’s acknowledgments and responses to grievances in 12-point boldface type with the statement contained in subsection (b) of Section 1368.02 of the Act (statement provided below)?</p> <p>“The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at (insert health plan’s telephone number) and use your health plan’s grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department’s Internet Web site http://www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online.” 28 CCR 1300.68(d)(7)</p>			
<p>5.14 Does the Plan have a process in place for receiving grievances over the telephone that are not coverage disputes, disputed health care services involving medical necessity or experimental or investigational treatment, and that are resolved by the close Of the next business day? 28 CCR 1300.68(d)(8)</p>			
<p>5.15 Does the Plan maintain a log of all such grievances containing the date of the call, the name of the complainant, member identification number, nature of the grievance, nature of resolution, and the Plan representative’s name who took the call and resolved the grievance? 28 CCR 1300.68(d)(8)</p>			
<p>5.16 Does the Plan have a process for periodically reviewing the grievance log? 28 CCR 1300.68(d)(8)</p>			

DENTAL TAG

GA-009 - Key Element 6:

- 6. The Plan performs expedited review of grievances involving an imminent and serious threat to the health of the enrollee, including severe pain, potential loss of life, limb or major bodily function (“urgent grievances”).
Medi-Cal Dental GMC Program Exhibit A, Attachment 15, Provisions A and B;
28 CCR 1300.68.01(a)**

Assessment Questions	Yes	No	N/A
6.1 Does the Plan have procedures in place for the immediate notification to the complainant of the right to contact the Department regarding the grievance?			
6.2 Does the Plan have procedures in place to expedite its review of the grievance when the complainant, an authorized representative, or treating Physician provides notice to the Plan?			
6.3 Do the Plan’s procedures allow for the notice to be accomplished by a documented telephone call?			
6.4 Does the Plan have procedures in place to ensure submission of a written statement to the Department and the complainant on the disposition or pending status of the urgent grievance within three (3) calendar days of receipt of the grievance by the Plan?			
6.5 Does the Plan take into consideration the enrollee’s medical condition when determining the response time?			
6.6 Do the Plan policies and documents make it clear to the enrollee that the enrollee is not required to participate in the Plan’s grievance process prior to applying to the Department for review of the urgent grievance?			

GA-009 - Key Element 7:

- 7. The Plan provides access to staff and information regarding urgent grievances to the Department as outlined in the DHCS contract .
Medi-Cal Dental GMC Program Exhibit A, Attachment 15, Provisions A and B;
28 CCR 1300.68.01(b)**

Assessment Questions	Yes	No	N/A
7.1 Does the Plan’s grievance system allow for the Department to contact the Plan regarding urgent grievances 24 hours a day, 7 days a week?			
7.2 Does the Plan, during normal work hours, provide for a response to the Department within 30 minutes after initial contact from the Department?			

DENTAL TAG

Assessment Questions	Yes	No	N/A
7.3 During non-work hours, does the Plan have provisions in place for responding to the Department within 1 hour after initial contact from the Department?			
7.4 Does the Plan provide for the availability of a Plan representative with authority on the Plan’s behalf to resolve urgent grievances and authorize the provision of health care services covered under the enrollee’s Plan Contract in a medically appropriate and timely manner?			
7.5 Does the authority of the Plan representative include making financial decisions for expenditure of funds on behalf of the Plan without first having to obtain approval from supervisors or other superiors within the Plan?			
7.6 Does the Plan have a description of the system established by the Plan to resolve urgent grievances, including the system’s provisions for scheduling qualified Plan representatives, including back-up Plan representatives as necessary, to be available twenty-four (24) hours a day, seven (7) days a week to respond to Department contacts regarding urgent grievances?			
7.7 Do the Plan’s provisions for scheduling include the names and titles of those Plan representatives who will be available under the system, their telephone numbers, and, as applicable, pager numbers, answering service numbers, voice-mail numbers, e-mail addresses, or other means for contact?			
7.8 Does the Plan have a description of the how the Department may access the grievance system established by the Plan?			

End of Requirement GA-009: Grievance System Oversight

DENTAL TAG

Requirement GA-010: Parties to State Hearing

CONTRACT CITATION(S)

Medi-Cal Dental GMC Program Exhibit A, Attachment 15, Provision D

D. Parties to State Hearing

The parties to the State hearing shall include the Plan as well as the Member and his or her representative or the representative of a deceased enrollee's estate.

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Dental Director
- Officer with primary responsibility for the grievance system
- Plan staff responsible for overseeing the grievance system

DOCUMENT(S) TO BE REVIEWED

- Policies and procedures related to the Fair Hearing process
- Information provided to members regarding the Fair Hearing process.

GA-010 - Key Element 1:

1. The Plan participates in State hearings.

Medi-Cal Dental GMC Program Exhibit A, Attachment 15, Provision D

Assessment Questions	Yes	No	N/A
1.1 Does the Plan ensure that parties to the State Hearing include the Plan as well as the Member and his or her representative? Or the representative of a deceased enrollee's estate?			

End of Requirement GA-010: Parties to State Hearing