CENTER FOR ELDERS' independence
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From CHAPTER 13 Member Handbook

MEMBER GRIEVANCE & APPEAL PROCESS

All of us at CEI share the responsibility for ensuring your satisfaction with the care you receive. We encourage you and your family, caregiver(s) or designated legal representative(s) to express any concerns or dissatisfaction with CEI services, including any violation of your rights as a member. If you wish to file either a grievance or an appeal, please follow the procedures described below.

CEI will not discriminate against a participant solely on the grounds that a grievance or appeal has been filed. We will continue to provide you with all services at the frequency designated in your current plan of care, as well as maintain confidentiality, throughout the grievance or appeal process. In this chapter, we explain how to file a grievance or an appeal, the timeframe for resolution, and the forms used to document. We will review this process with you at enrollment, each year thereafter, and whenever a grievance has been filed or CEI denies a request you have made for service or payment.

If you do not speak English, a bilingual staff member or volunteer will be made available to help you in filing a grievance or appeal.

I. Grievance Procedure

Definition: A grievance is an oral or written expression of dissatisfaction with service delivery or the quality of care furnished by CEI and/or contracted specialists.

Steps for using the grievance process:

A. You or your representative, such as a family member, friend or caregiver, may express your dissatisfaction with services or quality of care by speaking or writing to any CEI staff member.

   If you wish to file a written grievance, please send it to:

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Center for Elders' Independence
510 - 17th Street
Oakland, CA 94612

Or, you may call or fax:
Telephone: (510) 433-1150 (M-F, 8 a.m.-5 p.m.)
Facsimile: (510) 452-8836
TDD (for the hearing impaired): (510) 433-1165 (M-F, 8 a.m.-5 p.m.)

1. The staff member taking your grievance will summarize the grievance on CEI's Grievance Form.

2. The Center Director will send you or your representative written acknowledgement of receipt of your grievance within five (5) working days of the initial staff member receiving your grievance.

3. An investigation of your grievance will be performed by one of the following staff members identified below, with involvement from appropriate staff as necessary:

    a) Center Director if the grievance is related to a non-medical issue at the site where you receive services;
    b) Chief Medical Officer if the grievance is related to your medical care;
    c) Vice President of Operations if the grievance is related to general program services;
    d) Vice President of Operations if the grievance involves a violation of your participant's rights.

4. Within 30 calendar days of receipt of the grievance, you or your representative will be notified in writing about the findings of the investigation and action, if any, that will be taken. The letter will include the grievance review options available if you and/or your representative are still dissatisfied.

5. If your grievance is pending and cannot be resolved within 30 calendar days from the date it was filed, the Vice President of Operations shall be involved in the process and the Center Director will notify you of the following in writing:
    - The status of the grievance

- Estimated resolution date
- Your right to request a Fair Hearing (see Grievance Review Options below)

A copy of this letter will also be sent to the CA Department of Health Care Services, Long Term Care Division.

Note: If the grievance involves serious or imminent threat to your health or safety, you may request that an expedited (fast) process be used. The Compliance Manager, VP of Operations, and Chief Medical Officer will immediately turn over an expedited grievance to the appropriate staff person who will respond with a decision within 72 hours of receiving your written or verbal grievance and request to expedite the process.

In this case, you will be immediately informed of: (a) the receipt of your request for expedited review and (b) your right to notify the State Department of Health Care Services and the State Department of Social Services of the grievance (see "Grievance Review Options" below for more information.)

B. Grievance Review Options:

If after completing the CEI grievance process or participating in the process for at least thirty (30) calendar days, you are still dissatisfied, you or your representative have the option to pursue the steps described below. (Note: If the grievance involves an imminent and serious threat to your health or safety, you do not need to complete the entire grievance process nor wait 30 calendar days.) Your grievance review options are:

If you are covered by Medi-Cal only or Medi-Cal and Medicare, you are entitled to pursue your grievance with the California Department of Health Care Services by contacting:

Ombudsman Unit
Medi-Cal Managed Care Division
California Department of Health Care Services

P.O. Box 997413, Mail Station 4412

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Sacramento, CA 95899-7413
1 (888) 452-8609

At any time during the grievance process, you may request a Fair Hearing from the California Department of Social Services by contacting:

California Department of Social Services
State Hearings Division
P.O. Box 944243, Mail Station 9-17-37
Sacramento, CA 94244-2430

Telephone: 1 (800) 952-5253
Facsimile: 1 (916) 651-5210 or
1 (916) 651-2789
(Attention: State Hearing Support)
TDD (for the hearing impaired): 1 (800) 952-8349

II. Appeal Process

Definition: An appeal is action taken by a participant (or representative) with respect to CEI's decision not to cover, or not to pay for, a service. There are two types of appeals:

Standard Appeal: If you or your representative requests a standard appeal, your appeal must be filed within 180 calendar days of when your request for service or payment of service was denied. (The 180-day limit may be extended by CEI for good cause.) We will respond to your appeal as quickly as your health requires, but no later than 30 calendar days after receipt of your appeal.

Expedited or "Fast" Appeal: If you, your representative, or your treating physician believes that your life or health could be seriously harmed without the requested services, you may request an expedited (fast) appeal. An expedited appeal is resolved as expeditiously as your health condition requires but no later than 72 hours after receipt of the appeal. This may be extended for up to 14 calendar days if you or your representative request an extension and/or if CEI is able to justify to the California Department of Health Care Services that additional time is needed to gather information and the delay is in your best interest.

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As a member of CEI, you have the right to appeal any treatment decision made by CEI or our contracted specialists, including decisions not to authorize or pay for services and equipment. You will receive written information about appeals when you enroll, annually thereafter, and whenever CEI denies a request for service or payment.

CEI will not discontinue providing a service for which an appeal has been filed until the appeal process has concluded if the following conditions are met:

1. CEI is proposing to discontinue or reduce services *currently* being provided to you.
2. You request continuation of the service with the understanding that if CEI's initial decision to discontinue or reduce a service is upheld, you will be financially responsible for the cost of disputed service provided during the appeals process.

Steps to initiating an appeal:

A. You can request a standard appeal by speaking or writing to a CEI Social Worker, Center Director, Home Care Nurse, Nurse Practitioner or Physician, or other CEI staff member.

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Oakland, CA 94612

Or, you may call or fax:
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Facsimile: (510) 452-8836 Fax
TDD (for the hearing impaired): (510) 433-1165 (M-F, 8 a.m.-5 p.m.)

1. The staff member will summarize the appeal on a CEI Appeal Form.
2. The Center Director will send you written acknowledgement of receipt of your appeal within five (5) working days of the initial staff member receiving your appeal.

B. The Center Director will immediately forward the appeal form and all relevant information to an appropriately credentialed and impartial third party who was not involved in the original decision-making process.

1. The assigned third party will investigate the unresolved appeal with involvement from appropriate individuals as necessary.
2. The assigned third party will make a decision regarding the necessity of the service(s) or payment at issue.

C. If it is a "Standard Appeal" as defined above, you or your representative will be notified of our decision regarding your appeal no later than 30 calendar days from the initial receipt of the appeal.

D. If it is an "Expedited (Fast) Appeal" as defined above, you or your representative will be notified of our decision regarding your appeal within 72 hours from the initial receipt of the appeal, unless the timeframe is extended for reasons described above.

CEI's Decision on Your Appeal

If CEI decides fully in your favor on a standard appeal of a request for service, we must either provide the service or arrange for you to get the service as quickly as your health condition requires, but no later than 30 calendar days from the date we received your request for an appeal.

If CEI decides fully in your favor on a request for payment, CEI must make the requested payment within 60 calendar days after receiving your request for an appeal.

If CEI does not decide fully in your favor on a **standard appeal**, either in whole or in part, or if CEI fails to provide you with a decision within the proper timeframe, you have the right to pursue an external appeal through either the Medicare or Medi-Cal program (see Additional Appeal Rights below). CEI will inform you or your representative in writing of your appeal rights under either Medicare or Medi-Cal and also notify the federal Centers for Medicare and Medicaid Services and the California Department of Health Care Services. CEI will assist you to determine which appeal route to pursue if both are applicable and will forward your appeal to the appropriate external entity.

If CEI decides fully in your favor on an **expedited** appeal, we must either provide the service or arrange for you to get the service as quickly as your health condition requires, but no later than 72 hours after receiving your request for an appeal.

If CEI does not decide fully in your favor on an expedited appeal, either in whole or in part, or if CEI fails to provide you with a decision within the appropriate 72 hour timeframe, you have the right to pursue an external appeal process under either Medicare or Medi-Cal (see Additional Appeal Rights below). CEI will inform you or your representative in writing of your appeal rights under either Medicare or Medi-Cal and also notify the federal Centers for Medicare and Medicaid Services and the California Department of Health Care Services. CEI will assist you to determine which appeal route to pursue if both are applicable and will forward your appeal to the appropriate external entity.

Additional Appeal Rights under Medicare and Medi-Cal

If you are denied your request for a service or payment of service, you have additional appeal rights. This is referred to as the right to an "external appeal." Your request to file an external appeal can be made either verbally or in writing. The external appeal involves a new and impartial review of your case through either the Medicare or Medi-Cal program. If you are enrolled in both Medicare and Medi-Cal, you can choose to use either the Medicare or Medi-Cal external appeal process. Both are described below. CEI will help you choose which external appeal process you should follow if both are applicable and will forward your appeal to the appropriate external entity.

Medi-Cal External Appeals Process:

Medi-Cal conducts its next level of appeal through the State's Fair Hearing process.

If you are enrolled in both Medi-Cal and Medicare, or Medi-Cal only, and choose to appeal CEI's decision using the Medi-Cal appeals process, CEI

will send the appeal to the California Department of Social Services, or you may request a fair hearing from:

California Department of Social Services
State Hearings Division
P.O. Box 944243, Mail Station 9-17-37
Sacramento, CA 94244-2430

Telephone: 1 (800) 952-5253
Facsimile: 1 (916) 651-5210 or
1 (916) 651-2789
(Attention: State Hearing Support)
TDD (for the hearing impaired): 1 (800) 952-8349

Medicare External Appeals Process:

Medicare contracts with an "independent review organization" to provide external review of appeals.

If you are enrolled in both Medicare and Medi-Cal, or Medicare only, you may appeal using Medicare's appeal process. After completing the CEI appeal process, we will send your case file to Medicare's independent review organization for you. Medicare currently contracts with the Center for Health Dispute Resolution (CHDR) to impartially review appeals involving PACE programs like CEI. CHDR will contact us with the results of their review. CHDR will either maintain CEI's original decision or change CEI's decision and rule in your favor. (If CHDR's decision is not in your favor, there are further levels of appeal, which we will assist you in pursuing if you choose to do so.)

There is a standard and an expedited Medicare external appeal process:

- You can request a <u>standard</u> external appeal if we deny your request for non-urgent services or for nonpayment of a claim. For a standard appeal, you will get a decision no later than thirty (30) calendar days after you request the appeal. If CHDR's decision is in your favor and you have requested a service that you have not received, we must give you the service you asked for as quickly as your health condition

requires. If you have requested payment for a service that you have already received, we must pay for the service.

- You can request an expedited appeal if you believe your health would be jeopardized by not receiving a specific service. In an expedited appeal, we will send your case file to CHDR as quickly as your health requires. CHDR must give us a decision within 72 hours after they receive the appeal from us. If CHDR asks for more time to review the appeal, they must give us their decision within fourteen (14) calendar days. If CHDR's decision is in your favor, we must give permission for you to get the service or give you the service as quickly as your health condition requires.