Section 17
Resolution of Disputes and Grievances

Alliance members and both contracted and non-contracted providers may access the Alliance Grievance Process at any time. To download the necessary forms, go to the Form Library.

Provider Inquiries and Disputes

The Alliance has a two-level process to resolve Provider disputes. Provider Inquiries investigate and resolve contested claims and/or payment issues. A Dispute may be submitted to contest the processing, payment or non-payment of a previously submitted Provider Inquiry. Providers must complete the Provider Inquiry process prior to submitting a Dispute.

The Alliance scans and reviews all inquiries, disputes and written statements of contested claims or provider dissatisfaction to determine if the request meets criteria for processing as a Provider Inquiry (level 1) or a Dispute (level 2). The Alliance will process written statements and requests according to the criteria stated in the definitions for these processes. Example: If the provider states on their PIF that they are disputing a claim denial, but the contested claim has not yet been reviewed through the level 1 Provider Inquiry process, the Alliance will first process the contested claim as a Provider Inquiry, allowing the provider to further submit a level 2 Dispute if still dissatisfied with the Inquiry decision.

Inquiries and disputes must be filed with the Alliance within 365 days of the action or decision being disputed or, in a case where the dispute addresses the Alliance's inaction, within 365 days of the expiration of the Alliance's time to act. Contracted providers must exhaust this dispute resolution process before pursuing other available legal remedies.

Prior to filing an inquiry or dispute, providers should contact the Alliance Claims department to identify whether or not their claim denial issue can be addressed immediately over the phone. Please contact a Claims Customer Service Representative at (831) 430-5503, Monday-Friday, 9AM-4PM.

For more information, please see Policy 600-1017 Provider Inquiry and Dispute Resolution.

Inquiry and Dispute Resolution Process

Provider Inquiries and Disputes must be submitted in writing. You may mail, fax or deliver your hard copy dispute to:

Central California Alliance for Health
ATTN: Provider Inquiries and Disputes
1600 Green Hills Road, Suite 101
Scotts Valley, CA 95066

Fax: (831) 430-5569

You may also submit a Provider Inquiry or Dispute electronically using the form located on the Alliance website. Inquiries and disputes may be emailed to CQID@ccah-alliance.org.

Inquiries and disputes must include the following information:

- Provider name.
- Provider NPI, Tax ID, or Alliance ID number.
- Provider contact information.
- A clear explanation of the issue in question.
- Your position on the matter.
- If the inquiry or dispute involves a claim or request for reimbursement of overpayment, you also must include:
- The contested claim number, and all other claim control numbers if there have been multiple resubmissions of the claim.
- A clear identification and description of the contested item.
- The date of service.
- A clear explanation of why you believe the payment or other action is incorrect.
- If the inquiry or dispute involves a member, you must include the member's full name and Alliance ID number.

You also may include additional supporting clinical information, if applicable. Please note that, if the inquiry or dispute does not include the above information and we cannot readily obtain it, we will return the request to you for more information. Providers have thirty (30) working days to submit an amended dispute to the Alliance.

If you have multiple inquiries or disputes addressing a single issue you may file a single request using the system described above. Please include a list of each individual issue, along with the original CCN(s) and all other information required for filing multiple disputes.

The Alliance will acknowledge inquiries and disputes within ten (10) business days of receipt for hard copy cases, or within two (2) business days of receipt for requests received electronically.

The Alliance will send a written resolution to inquiries and disputes within thirty (30) business days of the date we receive the request for contracted providers and forty-five (45) business days for non-contracted providers.

For assistance in filing a dispute, or to receive the status update of a dispute, please contact a Dispute Coordinator at (831) 430-4105,

FAQs about Provider Disputes

What next steps should I take if a pre-service or prior authorization denies for lack of information?

Resubmit the authorization request to Health Services with the requested information directly to their Fax number at (831) 430-5850.

What if I disagree with the claims denial for all cases except an unclean claim?

The provider should submit a provider inquiry request to contest the denial within three hundred sixty five (365) days from the original Remittance Advice (RA) date. Ensure to include all required information listed above such as the original Claims Control Number (CCN), provider information, and a short explanation explaining the provider's position.

What if I noticed a mistake and adjusted the claim? May I still file a dispute?

Please submit a clean claim within the allowable timeframe as a corrected claim or resubmission directly to the Claims department for a complete review. New information should be reviewed by Claims prior to initiating a dispute.

May I balance bill a member when a claim is disputed?

Central California Alliance for Health prohibits Providers from balance billing a member for contested claim denials. The Provider is expected to adjust the balance owed. For more detailed information regarding balance billing, please see section 10 Claims in this manual.

Member Grievances and Appeals

The Alliance Grievance Process addresses member grievances, also referred to as complaints, and appeals. An Alliance member may file a complaint about their experiences with the Plan or with a contracted provider. If a member is filing an appeal about a denial, modification or deferral of services by the Alliance, it must be filed within 60 days of the Notice of Action. While most providers have their own internal mechanisms for resolving patient complaints, we provide complaint forms in English, Spanish and Hmong.

Provider Responsibilities

When a member brings a complaint to your attention, you must investigate and try to resolve the complaint in a fair and equitable manner. In addition, providers must cooperate with the Alliance in identifying, processing and resolving all member complaints and appeals. Cooperation includes: speaking or meeting with representatives of the plan if asked to do so, providing us with information pertinent to the complaint or appeal, including supplying medical records, and taking all reasonable actions suggested by our staff to resolve member's complaint. Member complaints are also considered by the Peer Review and Credentialing Committee (PRCC) in re-credentialing of providers.

If a member asks to file a complaint, you may click the link(s) below to access the appropriate forms and instructions. *Please note that the Member Complaint and Appeal Form must be signed by the member or the Member's Authorized Representative in Step 3.

English Member Grievance Packet
Spanish Member Grievance Packet
Hmong Member Grievance Packet

Members have the right to express their dissatisfaction with any aspect of the plan or its providers. Providers can refer members to the following resources to file a complaint or appeal. A complaint or appeal may be filed by a member or a member's authorized representative:

- In person, by making an appointment to meet with a Member Services Representative at one of our offices:

  Santa Cruz County:
  1600 Green Hills Road, Suite 101
  Scotts Valley, CA 95066-4981

  Monterey County:
  950 East Blanco Road, Suite 101
  Salinas, CA 93901-3400

  Merced County:
  530 West 16th Street, Suite B
  Merced, CA 95340-4710

- By calling a Member Services Representative at:

  Santa Cruz County: (831) 430-5500

  Monterey County: (831) 755-6000

  Merced County: (209) 381-5300

  The TTY line for the hearing and/or speech impaired: (877) 548-0857.

- By fax to (831) 430-5579.
- By calling the Grievance Coordinator at (800) 700-3874, ext.5816.
- By filling out a complaint form or putting the complaint in writing and sending it to the Grievance Coordinator at:

  Central California Alliance for Health
  ATTN: Grievance Coordinator
  1600 Green Hills Road, Suite 101
  Scotts Valley, CA 95066-4981

- Electronically, by visiting the File a Complaint page on the Alliance website.

When we receive a complaint or appeal, we will send the member a written acknowledgement letter within five (5) calendar days. The letter will reiterate the issue(s) of concern as we understand it. We will also identify the Grievance Coordinator as the contact person for the complaint, notify the member of their rights in the Grievance Process, and tell the member they will receive a proposed resolution letter within thirty (30) calendar days from the date the complaint or appeal was received.

In some cases, members do not need to use the Alliance Grievance System to resolve their complaint or appeal. Refer to the member Grievance packets linked above, or the Alliance website for information about other options Medi-Cal and IHSS members have to resolve their grievances.

Member Rights in the Alliance Grievance Process

A member may authorize a friend or family member to act on their behalf in the grievance process.
If the member does not speak English fluently, they have the right to interpreter services.

A member has the right to obtain representation by an advocate or legal counsel to assist them in resolving the grievance.

The State Office of the Ombudsman will help Medi-Cal members who are having problems with the Alliance. Members may call (888)-452-8609.

Medi-Cal members have the right to file a request for a State Fair Hearing (SFH) with the Department of Social Services if they have gone through the Alliance appeal process and received a notice of appeal resolution letter, or if the Alliance failed to adhere to appeal timeframes. Members must request a SFH within one hundred and twenty (120) days of receiving their appeal resolution letter.

Members have the right to request continuation of benefits during an appeal or SFH. Alliance Care IHSS members have the right to request a review by the California Department of Managed Health Care if they are unhappy with the Alliance's resolution of their complaints or if a complaint remains unresolved after 30 days.

Alliance Care IHSS members have the right to request an Independent Medical Review (IMR) if their complaint involves a denial or partial denial of a health care service that was determined not to be medically necessary.

FAQs for Members on Grievances and Appeals

What is the Alliance Member Grievance System?

This is the system for resolving member complaints and appeals about the services a member receives as an Alliance member. Filing a complaint or appeal will not affect a member's health care coverage through the Alliance. Filing a complaint or appeal is the member's choice and their cooperation in the process is voluntary.

Why would a member file a grievance or complaint?

A member could file a complaint if they:

- Encounter delays receiving health care services that the member thinks they need; such as medications, medical equipment, or doctors appointments.
- Are not happy with the services they received from a health care provider.
- Are unhappy with any aspect of their health care.
- Feel a health care provider or the Alliance has not respected their privacy.

Why would a member file an appeal?

Another reason why a member might file a grievance is if they receive Notice of Action. A Notice of Action is a formal letter telling the member that a medical service has been denied, deferred, or modified. This type of complaint is also called an appeal. If a member receives a Notice of Action from the Alliance, the member has sixty (60) days from the date on the Notice of Action to file an appeal with the Alliance.

How do a member file a grievance/complaint or appeal?

A member can file a complaint or appeal in one of the following ways:

Call Member Services Representative at:

Scotts Valley:	(831) 430-5505
Salinas:	(831) 755-6000
Merced:	(209) 381-5300
Toll Free:	(800) 700-3874
TTY:	(877) 548-0857

Call an Alliance Grievance Coordinator at (800) 700-3874 ext.5816.

Document the complaint and mail it to:
Grievance Coordinator
Central California Alliance for Health
1600 Green Hills Road, Suite 101, Scotts Valley, CA 95066

Fill out a How To File a Complaint form on the Alliance website.

Call and make an appointment to come to any of our offices in person, Monday - Friday, 8:00 a.m. -11:00 a.m. or 2:00 p.m. -4:00 p.m. We have offices in Scotts Valley, Salinas and Merced:

Scotts Valley:
1600 Green Hills Road, Suite 101
Scotts Valley, CA 95066-4981
(831) 430-5500

Salinas:
950 East Blanco Road, Suite 101
Salinas, CA 93901-3400
(831) 755-6000

Merced:
530 West 16th Street, Suite B
Merced, CA 95340-4710
(209) 381-5300

What if the member prefer to speak a language other than English?

The Alliance has staff who speak Spanish and Hmong. We will also arrange an interpreter for the member through a telephone language line if the member does not speak English, Spanish, or Hmong.

Are there other ways to resolve a member's problem if they are a Medi-Cal member?

If the member has filed an appeal with the Alliance and received an appeal resolution letter, or if the Alliance did not resolve or respond to the member's appeal according to the timelines outlined above, the member can ask for a State Hearing. The member must request the hearing within 120 days from the date of receiving the Alliance's appeal resolution letter.

The member may call the California Department of Social Services (DSS) at **1-800-952-5253** (**TDD: 1-800-952-8349**) to request a hearing or can fax their request to DSS at **1-916-651-5210**.

The member can also ask for a hearing at any of these local offices:

Santa Cruz County:
Human Resources Agency
1000 Emeline Street

Santa Cruz, CA 95060
(831) 454-4117

Monterey County:
Department of Social Services
1000 South Main Street, Suite 208
Salinas, CA 93901
(831) 755-4477

Merced County:
Merced County Human Services Agency
Attn: Hearing Coordinator
2115 West Wardrobe Avenue
Merced, CA 95341
(209) 385-3000

Alliance members also have the right to file a complaint with the Department of Health and Human Services at any time if they feel that their privacy has not been respected. Members can file their complaint by contacting:

Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201

What if the member needs help to file their complaint or appeal?

The member can authorize another person such as a family member or a friend to help them. The member can call the State Office of the Ombudsman at **1-888-452-8609** if the member has Medi-Cal. The member can call the California Office of the Patient Advocate at **1-866-HMO-8900** if the member has Alliance Care IHSS.

What happens after a member files a complaint or appeal?

The Grievance Coordinator will send the member a letter within five (5) days after receipt of a complaint or appeal. This letter tells the member that we received the grievance. It explains the members rights in the grievance process.

How is the complaint or appeal resolved?

Depending on the type of complaint or appeal made, our staff may be able to resolve the grievance very quickly. If this is not possible, we work with our own Alliance departments or providers to get it resolved.

If we need more information we will ask for it. For example, if the Chief Medical Officer wants more information, we may ask for medical records from the doctors involved. The Grievance Coordinator will send the resolution in a Proposed Resolution Letter.

How long does the member have to wait until they get the Proposed Resolution Letter?

The Grievance Coordinator will send the proposed resolution letter within thirty (30) days from the day the complaint was received.

What if the complaint or appeal involves a serious threat to the members health?

If the members health problem is urgent, meaning it is a serious threat to their health, the member may ask for an Expedited Review. If the member requests an Expedited Review, the Grievance Coordinator will inform the member within twenty-four (24) hours that the complaint has been received. A resolution will be completed within seventy-two (72) hours. An Expedited Review involves an imminent or serious threat to the members health, including but not limited to severe pain, potential loss of life, limb, or major bodily function.

If the member is an In-Home Supportive Service (IHSS) member, the following applies:

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 **1-800-700-3874** or **TDD 1-877-548-0857** 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 **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's internet website **http://www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.