Central Valley PACE Network Provider Manual

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About This Document

Author Director of PACE

Authority to Approve GVHC Board of Directors

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Resources

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Revised Date The table below outlines the changes to this document

Date	Changes
08/13/2020	New policy

Approvals The GVHC Board of Directors are responsible for establishing and/or approving policies that govern the health center operations. The respective committees (Quality Improvement, Finance, Personnel, and Compliance) are responsible for reviewing and making recommendations for approval to the Board of Directors. GVHC Leadership is responsible for implementing, training and ensuring adherence to these policies through operating procedures. The administrative policy approvers are the CEO, Department Chiefs, and Department leadership of GVHC. All approvals at GVHC for policies and procedures will be recorded electronically.

Scope Applies to the Central Valley PACE program and workforce.

Central Valley PACE
Provider Manual

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APPENDICES

1. WELCOME

Welcome to Central Valley PACE! As a contracted provider of services you have a special place at Central Valley PACE. Through efficient and effective use of services that focus on enhancing the participants' functional capacity, we can achieve our program goal of managing the frail elderly in their community as long as it is socially, medically, and economically feasible.

Tony Weber

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CEO, Central Valley PACE

2. OVERVIEW OF CENTRAL VALLEY PACE

Central Valley PACE provides community-based services to the frail elderly who reside in Stanislaus County and San Joaquin County.

To be eligible to enroll as a Central Valley PACE participant, an individual must:

A. be 55 years or older;

B. live in the Central Valley PACE service area;

C. be eligible for Nursing Home Placement based on the California criteria for need of nursing home level of care;

D. be able to be safely cared for in the community

Upon enrolling in Central Valley PACE, participants agree to receive all health care services - primary, acute and long-term care - through the capitated, community-based program. This feature, known as "lock in", assures a coordinated, comprehensive approach to all medical care. In exchange, Central Valley PACE assumes full financial responsibility for all medical needs of its participants.

The participant's care is planned and directed by the interdisciplinary team that consists of the Center Director, physicians, registered nurses, physical therapists, occupational therapists, recreational therapists, registered dietitians, social workers, home care coordinators, and transportation coordinators. Care is focused on preventive services and functional maintenance as well as ongoing medical care. Periodic assessment by the full interdisciplinary team keeps the care plan and service delivery on track.

Central Valley PACE offers a full range of services which include, but are not limited to, adult day health (including transportation), home care, in-patient services, nursing home care, primary medical care, drugs, laboratory tests, x-rays and durable medical equipment.

3. REFERRAL/BILLING PROCEDURES

The following procedures must be followed for all routine services provided to Central Valley PACE participants. All non-emergency services must be authorized by Central Valley PACE before services are rendered. Providers who render emergency services must notify Central Valley PACE within 24 hours or on the next business day after that service has been rendered.

A. Central Valley PACE will contact the provider by telephone requesting the specific service. A Contract Provider Referral Form (see Appendix E) will be completed at that time and forwarded to the provider.

B. The provider will receive a provider referral form at the time of the participant visit.

C. ALL CLAIMS MUST BE SUBMITTED TO:

PEAK TPA
PO Box 21631
Eagan, MN 55121

OR

Electronic claims are to be submitted to:
PEAK TPA Payer ID 27034

D. Invoices for services rendered to Central Valley PACE:

Invoices for services rendered to PACE participants must be submitted to Central Valley PACE within 90 calendar days. Institutional providers should use Form UB92 (HCFA 1450) to submit their charges; physicians use Form HFCA 1500; and all other providers submit standard invoices. To ensure timely payment (30 days), providers should inform their billing department that they must bill Central Valley PACE directly and **not** Medicare or Medi-Cal.

E. Any questions regarding reimbursement should be directed to Central Valley PACE Accounting Office at 209-384-6516 and/or the PACE director at 209-726-7223.

4. POLICY AND PROCEDURE GUIDELINES FOR MANAGEMENT OF CENTRAL VALLEY PACE PARTICIPANTS REQUIRING IN-PATIENT SURGICAL CONSULTATION

Because of the uniqueness of Central Valley PACE, it has been helpful to us and our consultants to formalize some guidelines for surgical consultation. These are outlined below, and may also be useful for other procedural consultations.

4.1 Purpose

It is the purpose of this document to delineate some basic procedures that will help ensure participant centered care for our participants and will effectively utilize the resources of Central Valley PACE and the expertise of our surgical consultants. Further recognizing that medicine is as much art as science and best answers are not always evident, guidelines are provided for resolving any disagreements that may arise.

4.2 Policy

It is the policy of Central Valley PACE to establish and to maintain effective working relationships with our consultants, thereby promoting appropriate quality care for our participants. A few simple principles supply the foundation for consultative management of Central Valley PACE participants and will be utilized to guide the management of care. These principles are as follows:

A. primary concern for participant welfare;

B. mutual respect;

C. open communication; and

D. open-mindedness.

4.3 Procedures

A. Admission and consultation:

When Central Valley PACE participants are hospitalized, they will be admitted through hospitalist services, and appropriate consultation will be obtained based on the participant's condition in coordination with the Central Valley PACE provider. Referrals will be made per hospital policy.

B. Communicating with the family:

With the resources available to Central Valley PACE for out-of-hospital management, we are generally able to discharge participants with enhanced outpatient support or to transitional care earlier than is typical, and we are able to do so without compromising their care. As a result, it is important to discuss care in terms of types of services rather than length of stay. We ask our consultants to inform participants and their families that they will be working with Central Valley PACE provider(s) to determine when discharge is appropriate rather than providing information on typical lengths of stay for the participant's condition or procedure.

C. Surgery:

When surgical intervention is recommended, the consulting physician, hospitalist, and Central Valley PACE provider will discuss the risks and benefits and will agree on the proposed treatment plan. The surgeon will have primary responsibility for presenting the proposed intervention to the participant and family, obtaining informed consent, and answering their questions.

The hospitalist, in conjunction with the Central Valley PACE provider, will coordinate all preoperative care and evaluation, obtaining any additional consultation required.

During surgery and the immediate post-operative period (first 24 hours), the surgeon will be the attending physician with primary responsibility for management of the participant. This period may be lengthened or shortened based on circumstances and by mutual consent between the surgeon and the Central Valley PACE provider.

Following the immediate post-operative period, the hospitalist and the Central Valley PACE provider will again assume primary responsibility for participant management with the advice and consultation of the surgeon related to management of the surgical condition. If there is concern that the surgical condition remains unstable, either provider may request additional consultation to clarify the appropriateness of this transfer of responsibility.

The surgeon and Central Valley PACE provider will work together to delineate the care needs during the post-operative period. When Central Valley PACE resources can effectively meet those needs in a non-hospital setting, discharge will be arranged. When the surgeon and Central Valley PACE provider cannot agree on the appropriateness of discharge, the participant will be maintained at the higher level of care for an additional 24

hours during which time further evaluation, consultation, and/or mediation may be pursued to clarify the care needs and the suitability of the proposed environment.

D. Post hospitalization follow-up:

Communication is the key. Since Central Valley PACE participants attend the Day Health Center, with physician, nursing, and rehabilitation evaluation and treatment available five days a week, standard post-hospital follow-up is often not required. We request our consultants to work with Central Valley PACE providers to maximize the effectiveness of our Day Health Center monitoring, including educating our providers about special concerns or frequently encountered problems. At the same time, Central Valley PACE providers will work to ensure that the consultant is aware of and has the opportunity to see and to evaluate those problems directly related to the care they have provided.

5. QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT POLICY AND PROCEDURE FOR CONTRACT PROVIDERS

The following describes the relationship between Central Valley PACE contract providers and the specific requirements for the contract with you.

5.1 Overview

Central Valley PACE maintains overall responsibility for the quality of care delivered to its participants including services provided by contract providers and is committed to the goal of providing the highest quality of care. This goal, which is shared with its contract providers, only can be attained through effective working relationships with contract providers and a comprehensive Quality Assessment and Performance Improvement (QAPI) Program. The following is a brief description of Central Valley PACE quality assessment and performance improvement program related to contract providers and the specific quality assessment and performance improvement requirements that contract providers agree to fulfill.

5.2 Definitions

A. Central Valley PACE:

This Program of All-inclusive Care for the Elderly (PACE) program, Central Valley PACE, covers the full spectrum of health, rehabilitative, and social services required by frail elderly persons: primary medical care, medical specialty care, adult day health care, home health services, in-home support services, acute hospital care, physical and occupational rehabilitation and psychiatric facilities, and custodial nursing home care.

B. Central Valley PACE Medical Director:

The Central Valley PACE Medical Director is responsible for the QAPI Program and reports to the Board. The Central Valley PACE Medical Director confers and collaborates with Central Valley PACE Program Director on all matters related to the operations of Central Valley PACE. The Central Valley PACE Medical Director reports to the Program Director of Central Valley PACE for administrative purposes. Central Valley PACE Medical

Director oversees the implementation, evaluation, supervision, maintenance and reporting of program compliance and achievements related to the Central Valley PACE quality of health care and maintains responsibility for Central Valley PACE QAPI staff (e.g. the Quality Assurance Coordinator).

C. Central Valley PACE Program Director:

Central Valley PACE Program Director is responsible for Central Valley PACE operations, including managing contracts with service providers, ensuring administrative compliance with licenses, and acting as a liaison with regulatory agencies. The Central Valley PACE Program Director is a member of both the Quality Assessment and Performance Improvement Committee and Central Valley PACE Management Team and participates in the on-going review and revision of the QAPI Program.

D. Central Valley PACE Quality Coordinator:

The Central Valley PACE Quality Assurance Coordinator reports to Central Valley PACE Medical Director. The Quality Assurance Coordinator is responsible for implementation, monitoring, supervision and evaluation of the QAPI Program.

E. Medical Advisory Committee:

The Medical Advisory Committee is comprised of members of the medical or dental profession and non-physicians with expertise in the care of the frail elderly. Central Valley PACE Medical Director serves as an ex officio member of the committee. The Medical Advisory Committee meets quarterly and convenes additional meetings as necessary at the call of its chairperson. Its QAPI responsibilities include:

(i) Assessing the continuity and effectiveness of the QAPI Program, providing guidance on recommendations for improvement as needed and reporting findings and recommendations to Central Valley PACE Board of Directors.

(ii) Advising Central Valley PACE, Board of Directors regarding comprehensive care for the frail elderly including medical policies and procedures.

(iii) Acting as the liaison with the local medical community.

(iv) Advising on and promoting the maintenance of standards of quality in comprehensive, integrated care including medical care.

(v) Periodically reviewing Central Valley PACE contract providers.

F. Central Valley PACE Management Team:

Central Valley PACE Management Team serves as the Quality Assessment and Performance Improvement Committee and reports issues related to quality assessment and performance improvement to the Medical Advisory Committee.

G. Types of Contract Providers:

Central Valley PACE Medical Director is responsible for monitoring and maintaining the quality of care provided by contract providers. Central Valley PACE provides for the separation of medical services from fiscal and administrative management to assure that medical decisions are not unduly influenced by fiscal and administrative management. Central Valley PACE maintains the following types of contractual arrangements:

(i) Contracts with Individual Providers, including physicians as well as health professionals who are not delegated responsibility for quality assurance activities.

(ii) Contracts with Provider Organizations, including organized medical groups, hospitals, skilled nursing facilities, and ancillary service providers with established quality assurance programs.

Central Valley PACE retains overall responsibility for the provision of quality care to its participants and as such establishes specific requirements for each type of arrangement, which are delineated in the specific contract. In cases where providers have active quality assurance programs, Central Valley PACE assesses the provider's ability to effectively perform quality assurance activities and, as appropriate, delegates specific requirements for quality assurance to the provider.

5.3 General Procedures for All Contract Providers

For all types of contract providers, the following procedures apply regarding periodic communication, implementation of corrective action plans, and dispute resolution.

A. Central Valley PACE Communication with Contract Providers:

(i) Central Valley PACE is responsible for timely communications with all contract providers with regards to quality assurance and performance improvement activities.

(ii) Significant changes or updates to the Central Valley PACE QAPI Program will be sent to each provider.

(iii) The Central Valley PACE Program Director and other delegated staff that are members of the Interdisciplinary team may serve as liaisons with contract providers.

(iv) The Central Valley PACE Program Director may communicate on a periodic basis with contract providers, by phone and in writing, to notify contract providers of policy changes, follow-up on complaints and reported incidents, and ensure compliance with contract requirements.

(v) On an annual basis, the Central Valley PACE Medical Director reviews the QAPI plan. Any significant changes will be reviewed and approved by the Medical Advisory Committee and Central Valley PACE Board of Directors. A description of those changes will be sent to each contract provider.

(vi) Feedback from contract providers should be directed to the Central Valley PACE Medical Director or the Central Valley PACE Program Director who informs the Central Valley PACE Management Team.

B. Contract Provider Quality Assurance Responsibilities**:**

Central Valley PACE enters into contracts with providers for specific services outlined in their contract. These contracts delineate specific requirements for providers to adhere to the Central Valley PACE QAPI Program, grievance and appeals procedures and credentialing procedures as well as record keeping and other requirements related to assuring quality care. The quality of care delivered by these providers is evaluated as part of Central Valley PACE QAPI program.

(i) Any incident or unusual occurrence occurring at or in the contract provider's facility pertaining to Central Valley PACE participants shall be communicated to the Center Director by phone or in writing within 24 hours. The Center Director discusses the incident with the Central Valley PACE Medical Director to determine follow-up.

(ii) Each provider agrees to comply with the Central Valley PACE grievance and appeals procedures and abide by Central Valley PACE adjudication process. (See Appendix B and C)

(iii) On an ongoing basis, Central Valley PACE primary care physician (s) reviews timeliness and appropriateness of consultation reports and report concerns to the Central Valley PACE Medical Director for follow-up.

(iv) Central Valley PACE conducts on-site inspections, unannounced or scheduled, by the Central Valley PACE Medical Director, the Central Valley PACE Program Director or assigned Central Valley PACE staff to ascertain compliance with Central Valley PACE QAPI policies.

C. Implementation of Corrective Actions:

Central Valley PACE Management Team is responsible for documenting that quality of participant care is reviewed, problems are identified and appropriate corrective actions are instituted. Problems or deficiencies in care may be uncovered during the course of routine or unscheduled audits or reviews, interdisciplinary care planning, or may be raised through the grievance and appeals process. Each problem or deficiency will be addressed; for serious problems, a corrective action plan will be instituted that is specific to the problem identified. The procedure is as follows:

(i) The need for a corrective action plan (CAP) will be determined by the Central Valley PACE Medical Director or Program Director.

(ii) The CAP must identify the parties, providers, facilities, programs, or operations that have fallen below the QAPI standards.

(iii) The deficiency must be defined.

(iv) The Central Valley PACE Medical Director or Central Valley PACE Program Director contacts or meets with the parties involved to discuss the CAP.

(v) The Central Valley PACE Medical Director or the Central Valley PACE Program Director reports the deficiency and the CAP to the Medical Advisory Committee.

(vi) The Medical Advisory Committee reviews and approves the plan, indicating a time frame for compliance.

(vii) Follow-up audits may be conducted by the QAPI staff or assigned staff to verify implementation of the CAP.

(viii) A summary of the findings is submitted to the Medical Advisory Committee on a quarterly basis.

(ix) All CAPs are logged by the Quality Coordinator.

D. Provider Dispute Resolution:

Central Valley PACE maintains procedures for resolving disputes between Central Valley PACE and contract providers regarding administrative, operational, and contractual or payment issues. Central Valley PACE Program Director is responsible for processing disputes from contract providers. Providers wishing to challenge or appeal a claim or other administrative decision should follow the policy and procedures outlined in Appendix F – Provider Dispute Resolution Mechanism.

E. Skilled Nursing Facilities (SNF):

Central Valley PACE delegates some responsibilities for quality care review to the SNF. The facilities must agree to comply with the Central Valley PACE QAPI program including the grievance and appeals procedures. Central Valley PACE retains responsibility for investigating grievances regarding services rendered.

Central Valley PACE primary care providers are attending providers for all participants residing in contract SNF's. Each participant in a SNF is visited by Central Valley PACE primary care physician or nurse practitioner and other designated Central Valley PACE Staff as deemed appropriate by the Interdisciplinary Team. Central Valley PACE physicians and staff report quality of care problems observed in the facility or identified in reviewing participants records to Central Valley PACE Medical Director or Central Valley PACE Program Director for follow-up as part of the grievance process.

Each contract SNF is responsible for reporting to Central Valley PACE Medical Director within 24 hours the following systemic problems that may impact on the quality of care provided to Central Valley PACE participants. Such problems include:

(i) Outbreak of infectious disease reportable to the county health department;

(ii) strike involving health care personnel;

(iii) licensing or certification contingency; and

(iv) changes in key staff positions, including Administrator and Director of Nursing.

PROVIDER MANUAL APPENDIX A
Participant's Bill of Rights
Central Valley PACE

As a participant of Central Valley PACE, you have the following rights:

At Central Valley PACE we are dedicated to providing you with quality health care services so you may remain as independent as possible. Our staff is committed to treating each and every participant with dignity and respect, and ensuring that all participants are involved in planning for their care and treatment.

As a Central Valley PACE participant, you have the following rights:

YOU HAVE THE RIGHT TO BE TREATED WITH RESPECT.

You have the right to be treated with dignity and respect at all times, have all of your care kept private, and receive compassionate, considerate care. You have the right to:

- Receive your health care in an accessible manner and in a safe, clean environment.
- Be free from harm. Harm includes physical or mental abuse, neglect, excessive medications, physical punishment or being placed by yourself against your will, as well as any physical or chemical restraint used on you for discipline or convenience of staff that you do not need to treat your medical symptoms or prevent injury.
- Be free from hazardous procedures.
- Receive treatment and rehabilitation services designed to promote your functional ability to the optimal level and to encourage your independence.
- Receive care from professionally trained staff that has the education and experience to carry out the services for which they are responsible.
- Be ensured of auditory and visual privacy during all health care examinations and treatment visits.
- Be encouraged and assisted to use your rights in Central Valley PACE.
- Receive assistance, if you need it, to use the Medicare and Medi-Cal complaint and appeal processes, and your civil and other legal rights.

- Be encouraged and helped in talking to Central Valley PACE staff about changes in policy and services you think should be made.
- Use a telephone while at the Central Valley PACE Center, make and receive confidential calls and/or have such calls made, if necessary.
- Not have to do work or services for Central Valley PACE.

YOU HAVE A RIGHT TO PROTECTION AGAINST DISCRIMINATION.

Discrimination is against the law. Every company or agency that works with Medicare and Medi-Cal must obey the law. They cannot discriminate against you because of your:

- Race
- Ethnic origin
- National origin
- Religion
- Age
- Sex
- Sexual orientation
- Mental or physical ability
- Source of payment for your health care (for example, Medicare or Medi-Cal)

As a participant of Central Valley PACE, you have the right to receive competent, considerate, respectful care from staff and contractors without regard to race, national/ethnic origin, religion, age, sex, sexual orientation, mental or physical ability, or source of payment for your health care.

If you think you have been discriminated against for any of these reasons, contact a staff member at Central Valley PACE to help you resolve your concerns.

If you have any questions, you can call the Office for Civil Rights toll-free at:

1- 800-368-1019.

YOU HAVE A RIGHT TO INFORMATION AND ASSISTANCE.

You have the right to receive accurate, easy to understand information and to have someone help you make informed health care decisions. You have the right to:

- Have someone help you if you have a language or communication barrier in order that you can understand all information provided you.

- Have someone interpret all information given to you into your preferred language in a culturally competent manner, if your first language is not English and you cannot speak English well enough to understand the information being given to you.
- Have the Enrollment Agreement discussed fully and explained to you in a manner you understand.
- Receive marketing materials and Central Valley PACE Rights in English and any other frequently used language in your community. You can also receive these materials in Braille, if necessary.
- Get a written copy of your rights from Central Valley PACE. Central Valley PACE will post these rights in a public place in the Central Valley PACE Center where it is easy to read them.
- Be fully informed, in writing, of the services offered by Central Valley PACE. This includes telling you which services are provided by contractors instead of the Central Valley PACE staff. You will be given this information before you join Central Valley PACE, at the time you join and when there is a change in services.
- Review, with assistance if needed, the results of the most recent review of Central Valley PACE. Federal and State agencies review all PACE programs. You also have a right to review how Central Valley PACE plans to correct any problems that are found at inspection.

YOU HAVE A RIGHT TO A CHOICE OF PROVIDERS.

- You have the right to choose a health care provider within the Central Valley PACE network and to receive quality health care.
- Women have the right to get services from a qualified women's health care specialist for routine or preventive women's health care services.

YOU HAVE A RIGHT TO ACCESS EMERGENCY SERVICES.

You have the right to receive emergency services when and where you need them without Central Valley PACE' approval. A medical emergency is when you think your health is in serious danger – when every second counts. You may have a bad injury, sudden illness or an illness quickly getting much worse. You can get emergency care anywhere in the United States.

YOU HAVE A RIGHT TO PARTICIPATE IN TREATMENT DECISIONS.

You have the right to fully participate in all decisions related to your health care. If you cannot fully participate in your treatment decisions or you want to have someone you trust help you, you have the right to choose that person to act on your behalf. You have the right to:

- Have all treatment options explained to you in a language you understand, be fully informed of your health status and how well you are doing, and make health care decisions.
- Be informed of all treatment prescribed by the interdisciplinary team prior to being treated, when and how services will be provided, and the names and functions of people providing your care.
- Refuse treatment or medications. If you choose not to receive treatment, you must be told how this will affect your health.
- Be assured that decisions regarding your care will be made in an ethical manner.
- Be assured that you and your family will be educated about an illness affecting you so that you can help yourself, and your family can understand your illness and help you.
- Receive information on advance directives and have Central Valley PACE help you create an advance directive. An advance directive is a written document that says how you want medical decisions to be made in case you cannot speak for yourself.
- Participate in making and carrying out your plan of care, which will be designed to promote your functional ability to the highest level and encourage your independence. You can ask for your plan of care to be reviewed at any time. You also can request a reassessment by the interdisciplinary team at any time.
- Be given advance notice, in writing, of any plan to move you to another treatment setting, and the reason you are being moved.

YOU HAVE A RIGHT TO HAVE YOUR HEALTH INFORMATION KEPT PRIVATE.

You have the right to:

- Talk with health care providers in private and have your personal health care information kept private as protected under state and federal laws.

- Review and receive copies of your medical records and request amendments to those records.

- Be assured that all information contained in your health record will be held in confidence, including information contained in any automated data bank. Central Valley PACE will require your written consent for the release of information to persons not otherwise authorized under law to receive it. You may provide written consent, which limits the degree of information and the persons to whom information may be given.

- There is a new participant privacy rule that gives you more access to your own medical records and more control over how your personal health information is used. If you have any questions about this privacy rule you may call the Office for Civil Rights toll-free at:

1-800-368-1019
TTY users should call
1-800-537-7697

YOU HAVE A RIGHT TO FILE A COMPLAINT.

You have a right to complain about the services you receive, or that you need and do not receive, about the quality of care, or any other concerns or problems you have with Central Valley PACE. You have the right to a fair and timely process for resolving concerns with Central Valley PACE. You have the right to:

- A full explanation of the complaint and appeals process.

- Be encouraged and helped to freely explain your complaints to Central Valley PACE staff and outside representatives of your choice. You must not be harmed in any way for telling someone your concerns. This includes being punished, threatened or discriminated against.

- Appeal any treatment decision by Central Valley PACE, staff or contractors.

YOU HAVE A RIGHT TO LEAVE THE PROGRAM.

If for any reason you do not feel that Central Valley PACE is what you want, you have the right to leave the program at any time.

If you feel any of your rights have been violated, please report them immediately to your social worker or call our office during regular business hours at: 855-461-7223 or for TTY 844-461-7223

If you want to talk with someone outside of Central Valley PACE about your concerns, you may call:

1-800-MEDICARE (1-800-633-4227), or
1-888-452-8609
(**California Department of Healthcare Services Office of the Ombudsman**)

PROVIDER MANUAL APPENDIX B
Grievance Policy & Procedure for Central Valley PACE Participants

1. PURPOSE

To provide for resolution of medical and non-medical Grievances within thirty (30) calendar days while maintaining confidentiality, in accordance with regulatory and contractual requirements for Participants in the Golden Valley Health Centers, d/b/a Central Valley Program of All-Inclusive Care for the Elderly (PACE).

2. POLICY

2.1 Central Valley PACE is committed to assuring that Participants are satisfied with the service delivery or quality of care they receive. Central Valley PACE established a Grievance process to address Participants' concerns or dissatisfaction about services provided, provision of care, or any aspect of Central Valley PACE.

2.2 Central Valley PACE shall handle all Grievances in a respectful manner and shall maintain the confidentiality of a Participant's Grievance at all times throughout and after the Grievance process is completed. Central Valley PACE shall only release information pertaining to Grievances to authorized individuals.

2.3 Contract providers are accountable for all Grievance procedures established by Central Valley PACE. Central Valley PACE shall monitor contract providers for compliance with this requirement on an annual basis or on an as-needed basis.

2.4 General Information:

A. The PACE Program Director has primary responsibility for maintenance of the procedures, review of operations, and utilization of any emergent patterns of Grievances to formulate policy changes and procedural improvements in the administration of the plan.

B. Central Valley PACE shall continue to furnish the Participant with all services at the frequency provided in the current Plan of Care during the Grievance process.

C. Central Valley PACE shall not discriminate against a Participant solely on the grounds that a Grievance has been filed.

D. In order to ensure Participants have access to and can fully participate in the Grievance process, Central Valley PACE shall ensure the following:

(i) If the person filing the Grievance does not speak English, a bilingual PACE Staff Member is available to facilitate the process. If a PACE staff member is not available, translation services/interpreter shall be available, such as through a Golden Valley Health Center staff member or interpreter service.

(ii) All written materials describing the Grievance process are available in the following languages: English and Spanish.

(iii) Central Valley PACE shall maintain a toll-free number: 855-461-7223 for the filing of Grievances and for hearing impaired Participants TDD/TTY: 844-461-7223

E. Central Valley PACE shall provide written information about the Grievance process to a Participant and/or his/her Representative upon enrollment, annually, and upon request. Information includes, but is not limited to:

(i) Procedures for filing Grievances;

(ii) Telephone numbers for the filing of Grievances received in-person or by telephone:

PACE Center Director: 855-461-7223

PACE Quality Assurance Coordinator: 855-461-7223

(iii) Location where a Participant may file a written Grievance:

Central Valley PACE Center at which the Participant is enrolled; or Central Valley PACE Quality Assurance Coordinator
2401 East Orangeburg Ave.
Suite 330
Modesto, CA
95355

F. Any method of transmission of Grievance information from one Central Valley PACE staff member to another shall be done with strictest confidence, in adherence with Health Insurance Portability and Accountability Act (HIPAA) regulations.

3. DEFINITIONS

3.1 Grievance: A complaint, either written or oral, expressing dissatisfaction with the services provided or the quality of Participant care. A Grievance may include, but is not limited to:

A. The quality of services a Participant receives in the home, at the PACE Center or in an inpatient stay (hospital, rehabilitative facility, skilled nursing facility, intermediate care facility or residential care facility);

B. Waiting times on the telephone, in the waiting room or exam room;

C. Behavior of any of the care providers or PACE staff members;

D. Adequacy of center facilities;

E. Quality of the food provided;

F. Transportation services; and

G. A violation of a Participant's rights.

3.2 Representative: A person who is acting on behalf of or assisting a Participant, and may include, but is not limited to, a family member, a friend, a Central Valley PACE staff member, or a person legally identified in a Power of Attorney for Health Care/Advanced Directive, Conservator, Guardian, etc.

4. PROCEDURE

4.1 Filing of Grievances

A. A Participant and/or his/her Representative, may voice a Grievance to a PACE Staff Member in person, by telephone, or in writing to a PACE location.

B. Any Golden Valley Health Center staff member can assist the Participant and/or his/her Representative in filing a Grievance in the event assistance is required.

C. The Grievance Report Form is available from the PACE Quality Assurance Coordinator. The PACE Social Worker shall provide the Participant and/or his/her Representative with a report form, if requested, (either in-person, by telephone or in writing).

D. In addition to the Grievance Report, the PACE Social Worker shall provide the Participant and/or his/her Representative with Information for Participants about the Grievance Process.

4.2 Documentation of Grievances

A. Central Valley PACE shall document all Grievances expressed, either orally and/or in writing, on the day that it is received, or as soon as possible after the event or events that precipitated the Grievance, in the PACE Participant Grievance Log.

B. Grievances submitted in writing are documented on the Grievance Report form by the Participant and/or his/her Representative. The Central Valley PACE Staff Member shall assist with the completion of the Grievance Report form, if necessary. The Central Valley PACE staff member shall document Grievances received either in-person or by telephone on the Grievance Report form. Participants are not required to sign the Grievance Report.

C. The PACE Quality Assurance Coordinator shall ensure complete details of the Grievance are documented so that the Grievance can be resolved within thirty (30) calendar days. In the event of insufficient information, the PACE Social Worker shall take reasonable efforts to obtain the missing information in order to resolve the Grievance within the specified timeframes.

D. Central Valley PACE shall hold all information related to a Participant's Grievance in strict confidence and shall not disclose information to Central Valley PACE staff members or contract providers, except where appropriate to process the Grievance. No reference that a Participant has elected to file a Grievance with Central Valley PACE shall appear in the medical record.

E. It is the responsibility of the PACE Staff Member receiving the Grievance to ensure confidentiality is maintained, documentation is complete and accurate, and the Grievance process is implemented and completed in accordance with this policy.

4.3 Acknowledgement, Notification and Initial Investigation of Grievance

A. Central Valley PACE Staff Members shall notify the PACE Quality Assurance Coordinator within one (1) working day of receipt of the Grievance.

B. The PACE Quality Assurance Coordinator shall:

(i) Be responsible for coordinating the investigation, designating the appropriate PACE staff member(s) to take corrective actions, and reporting the Grievance to the Interdisciplinary Team (IDT).

(ii) Acknowledge receipt of the Participant's Grievance in writing, within five (5) calendar days of receipt of the Grievance and document this step in the Grievance Log. When necessary, the PACE Quality Assurance Coordinator shall also acknowledge receipt of the Grievance by telephone.

(iii) Notify the Central Valley PACE management or supervisory staff responsible for the services or operations that are the subject of the Grievance.

(iv) Immediately submit to the Central Valley PACE Medical Director Grievances related to medical quality of care for appropriate action.

C. When Grievances related to services provided by a Central Valley PACE contract provider arise, the PACE Quality Assurance Coordinator shall notify the contract provider's Quality Assurance staff.

D. When a Grievance involves a violation of a Participant's rights, the PACE Quality Assurance Coordinator shall notify the PACE Center Director immediately to begin the investigation of the Grievance.

4.4 Resolution of Grievances

A. Central Valley PACE shall resolve Grievances within thirty (30) calendar days from the day the Grievance is received. The PACE Quality Assurance Coordinator shall make reasonable efforts to contact the Participant and/or his/her Representative by telephone or in-person to advise him/her of the outcome of the Grievance investigation, and determine his/her satisfaction or dissatisfaction with the outcome of the investigation.

B. The PACE Quality Assurance Coordinator shall send written notification of the resolution of the Grievance to the Participant and/or his/her Representative within 30 calendar days of the grievance being filed.

C. In the event resolution is not reached within thirty (30) calendar days, the PACE Quality Assurance Coordinator shall notify the Participant and/or his/her Representative in

writing of the status and estimated completion date of the Grievance resolution.

D. The Central Valley PACE staff member shall document all steps of the Grievance resolution in the PACE Participant Grievance Log. This will include how the PACE Participant and/or his/her representative was notified, and whether or not he/she was satisfied or dissatisfied with the outcome.

4.5 Expedited Review of Grievances

A. In the event the Grievance involves a serious or imminent health threat to a Participant, including, but not limited to, severe pain, potential loss of life, limb or major bodily function, or when a Participant's rights have allegedly been violated, the PACE Quality Assurance Coordinator shall expedite the review process to reach a decision within seventy-two (72) hours of receiving the Participant's Grievance.

B. The Participant and/or his/her Representative shall inform the PACE Quality Assurance Coordinator of his or her request either verbally or in writing. While the Participant may file a verbal Grievance, the PACE Quality Assurance Coordinator may assist the Participant and/or his/her Representative, as necessary, to document the Grievance, in writing, prior to resolution.

C. If the Participant files an expedited Grievance during weekend hours (4:30 p.m. Friday to 8:00 a.m. Monday), PACE Program Staff shall immediately contact an authorized supervisor of the program (Medical Director or Center Director or designee) to investigate the Grievance with the Participant and/or his/her Representative. This individual shall notify the PACE Quality Assurance Coordinator at the start of normal business hours of the status of the Grievance.

D. As soon as possible, but no later than one (1) business day after the Participant files an expedited Grievance, the PACE Quality Assurance Coordinator shall inform the Participant and/or his/her Representative by telephone or in-person of the receipt of the Grievance for expedited review, and describe the steps that Central Valley PACE shall take to resolve the Grievance.

E. The PACE Quality Assurance Coordinator shall inform the Participant and/or his/her Representative both verbally and in writing of their right to notify the Department of Health Care Services (DHCS) and California Department of Social Services (DSS) of the Grievance.

F. The PACE Quality Assurance Coordinator shall expedite the internal review process to reach a decision within seventy-two (72) hours of receiving the Grievance.

G. The PACE Quality Assurance Coordinator shall notify the Participant and/or his/her Representative in writing of the resolution of the expedited Grievance. The PACE Quality Assurance Coordinator shall also notify the Participant verbally and in writing if resolution is not possible within seventy-two (72) hours. The written notification of delay shall include the reason for the delay and the timeframe for resolution of the Grievance.

4.6 Grievance Review Options

A. After a Participant completes the Grievance process or participates in the Grievance process for at least thirty (30) calendar days and the Participant is dissatisfied with the resolution of the Grievance, the Participant may pursue other options as described in this Policy. If the situation represents a serious health threat, the Participant and/or his/her Representative need not complete the entire Grievance process nor wait thirty (30) calendar days the pursue to options described below.

B. If the Participant is eligible for Medi-Cal only or for Medi-Cal and Medicare, he or she is entitled to pursue the Grievance with the California Department of Health Care Services (DHCS) by contacting or writing to:

Ombudsman Unit
Medi-Cal Managed Care Division Department of Health Care Services
P.O. Box 997413 Mail Station 4412
Sacramento, CA 95899-7413
Telephone: 1-888-452-8609
TTY: 1-800-735-2922

C. At any time during the Grievance process, whether the Grievance is resolved or unresolved the Participant and/or his/her Representative may request a State Hearing from the California Department of Social Services by contacting or writing to:

California Department of Social Services State Hearings Division
P.O. Box 944243, Mail Station 19-17-37 Sacramento, CA 94244-2430 Telephone: 1-800-952-5253
Facsimile: 1-916-651-5210 or 1-916-651-2789
TDD: 1-800-952-8349

D. If a Participant and/or his/her Representative decide to pursue a State Hearing, he or she must request the State Hearing within ninety (90) days from the date of the resolution letter. A Participant and/or his/her Representative may speak at the State Hearing, or have someone else speak on the Participant's behalf, including a relative, friend or an attorney.

E. For legal assistance, the Participant and/or his/her Representative may be able to receive free legal assistance. To facilitate this, the PACE Quality Assurance Coordinator or designee shall provide a listing of Legal Services Offices to the Participant or his/her Representative.

F. Central Valley PACE is required to provide written position statements whenever notified by DHCS that a Participant requested a State Hearing. Central Valley PACE shall designate appropriate staff (Medical Director, Center Director, or designee) to provide testimony at State Hearings whenever notified by DHCS of the scheduled time and place for a State Hearing.

4.7 Documentation, Tracking, Analysis and Reporting

A. Central Valley PACE shall mark all Grievances and related information "confidential."

B. The PACE Quality Assurance Management Team shall document all Grievance

information and details of verbal communication in the PACE Participant Grievance Log, and store the PACE Participant Grievance Log in locked cabinets in the Quality Assurance Coordinator office(s).

C. The PACE Quality Assurance Coordinator is responsible for maintaining, aggregating, and analyzing information related to Grievances. On a quarterly basis, the PACE Quality Assurance Coordinator shall forward this information to the Golden Valley Health Center Incident Reporting Committee

D. The PACE Quality Assurance Coordinator shall submit a written summary of Grievances including number, type, location, and disposition to the PACE Quality Management Team, Quality Assurance Committee, Incident Reporting Committee, and the Board of Directors on a quarterly basis.

E. Central Valley PACE shall submit a summary of all Grievances in the quarterly report to the Long Term Care Division of DHCS and Centers for Medicare & Medicaid Services (CMS). The Grievance summary is due forty-five (45) calendar days from the date of the end of the reporting quarter.

F. The PACE Quality Assurance Coordinator shall maintain, aggregate, and analyze Grievance data and identify any trends or patterns for use by the Central Valley PACE internal quality improvement program.

G. Central Valley PACE shall hold records of all Grievances confidential, and make the records available as needed to State and Federal agencies upon request.

H. Central Valley PACE shall maintain in its files copies of all Grievances, the responses to Grievances, and recorded logs of the Grievances for a period of ten (10) years from the date the Grievance was filed.

I. To ensure timeliness and accuracy in the Grievance process, Central Valley PACE shall perform regular audits of the Grievance log and files to ensure they correspond with other data reporting systems (e.g., Health Plan Management System (HPMS) reports).

4.8 Annual Review

A. The PACE Program Director shall ensure that the Grievance process is reviewed with Participants and/or their Representatives, contract providers and all employees of Central Valley PACE on an annual basis as follows:

B. PACE Social Workers shall review the Grievance process with Participants at their annual re-certification, or more often as necessary, and will offer to provide another copy of the Information for Participants about the Grievance Process to the Participant;

C. The PACE Program Director, or designee, shall review the Grievance process with contract providers annually, either through writing or presentation;

D. The PACE Program Director, or designee, along with the Quality Management Team shall review the Grievance process annually with non-clinical PACE staff; and

E. The PACE Center Director, along with the Quality Assurance Coordinator, shall review the Grievance process annually with all clinical PACE Staff Members and IDT Members.

PROVIDER MANUAL APPENDIX C
Appeals Policy & Procedure for Central Valley PACE Participants

1. PURPOSE

Central Valley PACE is committed to ensuring that a participant, a participant's representative or a treating provider has the right to appeal Central Valley PACE's decision to deny, defer or modify a particular care-related service or its decision not to pay for a service received by a participant.

Central Valley PACE will handle all appeals in a respectful manner and will maintain the confidentiality of a participant's appeal at all times throughout and after the appeals process is completed. Information pertaining to appeals will not be disclosed to program staff or contract providers, except where appropriate to resolve the appeal.

Contract providers are accountable for all appeal procedures established by Central Valley PACE. Central Valley PACE will monitor contracted providers for compliance with this requirement on an annual basis or on an as needed basis.

2. DEFINITIONS

An appeal is defined as a participant's action taken with respect to the PACE organization's noncoverage of, or nonpayment for, a service including denials, reductions or termination of services.

An appeal may be filed verbally, either in person or by telephone or in writing. The appeals process may take one of two following forms:

A. A *standard* appeal means a standard review process for response to, and resolution of, appeals as expeditiously as the participant's health requires, but no later than 30 days after the PACE organization receives an appeal.

B. An *expedited* appeal occurs when a participant believes that his or her life, health, or ability to regain maximum function would be seriously jeopardized, absent provision of the service in dispute. The PACE organization will respond to the appeal as expeditiously as the participant's health condition requires, but no later than 72 hours after it receives the appeal.

The 72-hour timeframe may be extended by up to 14 calendar days for either of the following reasons:

C. The participant requests the extension.

D. The PACE organization justifies to the State Administering Agency the need for additional information and how the delay is in the interest of the participant.

Coverage Decision means the approval or denial of health services by Central Valley PACE based on a finding that the provision of a particular service is included or excluded as a covered benefit under the terms and conditions of the contract with the enrolled participant.

Disputed health care service means any health care service eligible for payment under the enrolled participant's contract with Central Valley PACE that has been denied, modified or delayed by a decision of Central Valley PACE in whole or in part due to the finding that the service is not medically necessary. A decision regarding a "disputed health care service" relates to the practice of medicine and is not a "coverage decision".

Medically necessary or Medical necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury.

Representative means a person who is acting on behalf of or assisting a participant, and may include, but is not limited to, a family member, a friend, a PACE employee, or a person legally identified as Power of Attorney for Health Care/Advanced Directive, Conservator, Guardian, etc.

3. POLICY

A. The Program Director has primary responsibility for maintenance of the procedures, review of operations, and utilization of any patterns of appeals to formulate policy changes and procedural improvements in the administration of the plan.

B. Central Valley PACE will continue to furnish the participant with all services at the frequency provided in the current plan of care during the appeals process.

C. Central Valley PACE will not discriminate against a participant solely on the grounds that an appeal has been filed.

D. Central Valley PACE will ensure that a participant is able to access and participate in the appeals process by addressing the linguistic and cultural needs of its participants, as well as the needs of participants with disabilities. Central Valley PACE will ensure the following:

(i) If the person filing the appeal does not speak English, a bilingual staff member will be available to facilitate the process. If a staff person is not available, translation services/interpreter will be made available.

(ii) All written materials describing the appeal process are available in the following languages: English and Spanish and can be translated on request.

(iii) Central Valley PACE shall maintain a toll-free number: 855-461-7223 for the filing of Appeals and for hearing impaired Participants TDD/TTY: 844-461-7223.

E. Central Valley PACE will provide written information about the appeal process to a participant and/or his/her representative upon enrollment, at least annually thereafter, and whenever the interdisciplinary team denies, defers, or modifies a request for services or refuses to pay for a service. Information includes, but is not limited to:

(i) Procedures for filing an appeal, including participant's external appeal rights under Medicare and Medicaid (in California, Medi-Cal).

(ii) Telephone numbers for the filing of appeals received in person or by telephone: Center Director: 855-461-7223

(iii) Location where written appeals may be filed:

Central Valley PACE
2401 East Orangeburg Ave.
Suite 330
Modesto, CA
95355

F. Any method of transmission of appeals information from one Central Valley PACE staff to another shall be done with strictest confidence, in adherence with HIPAA regulations.

G. Central Valley PACE will assist the participant in choosing which external appeals process to pursue if both are applicable, and forward the appeal to the appropriate external entity.

4. PROCEDURE

A. Receiving Requests to Provide a Service or Pay for a Service

(i) A participant or his/her representative may request to initiate, eliminate, or continue a particular service or pay for a service. A participant or his/her representative may submit the request to Central Valley PACE either verbally, by telephone or in person, or in writing.

(ii) In the event a participant or his/her representative requests provision of or payment for a particular service, the interdisciplinary team (IDT) will determine whether the requested service is medically necessary, based on the assessed needs of the participant.

(iii) Central Valley PACE will notify the participant or his/her representative of its decision to approve, deny, defer or modify the request as expeditiously as the participant's condition requires, but no later than 72 hours of receiving the participant's request.

(a) If the decision is to ***approve*** the requested service, without deferring or modifying provision of the service, or payment for a service, the participant or his/her representative will be notified verbally and/or in writing. The service will be furnished to the participant as determined by the interdisciplinary team's revised plan of care. Payment for a service will be made within 60 calendar days of receiving the request.

(b) If the decision is to deny, defer or modify a request for service or deny payment of a service, the participant or his/her representative will be notified verbally and in writing. If the participant or his/her representative appeals the denial for reconsideration, Central Valley PACE will initiate the Appeal Process as outlined in this policy and procedure.

B. Notification of a Decision to Deny, Defer or Modify a Request for Service or Deny Payment of a Service

(i) At the time of the decision, Central Valley PACE informs the participant, and as appropriate, the treating provider of the reason for denial, deferral or modification of a service or denial of payment for a service.

(ii) Notification of the denial, deferral or modification of service or denial of payment is made both verbally; either in person or by telephone, *and* in writing, using the *"Notice of Action for Service Request"* (NOA) Form (see Attachment 1).

(iii) The Center Director will document in the medical record that a denial, deferral or modification of service or denial or payment has been made, using "Denial of Service" in the title of the progress note.

(iv) Central Valley PACE will notify the participant in writing of their right to appeal the denial for reconsideration by Central Valley PACE and of their external appeal rights, using the *"Information for Participants about the Appeals Process"* notice (see Attachment 2).

(v) If the interdisciplinary team fails to provide the participant with timely notice of the resolution of the request or does not furnish the services required by the revised plan of care, this failure constitutes an adverse decision, and the participant's request must be automatically processed by Central Valley PACE as an appeal.

C. Filing an Appeal

(i) The appeal process is available to any participant, his/her representative or treating provider who disputes denial of payment for a service or the denial, deferral or modification of a service by the primary care physician (PCP) or any member of the interdisciplinary team (IDT) who is qualified to make referrals.

(ii) An appeal for denial, deferral or modification of a service or payment for a service may be filed verbally or in writing.

(a) A participant and/or his/her representative may verbally request an appeal by speaking to the Director, Center Director, Social Worker or other IDT member.

(b) At the time of denial or at any time upon request, Central Valley PACE provides a participant and/or his/her representative with an "Appeal for Reconsideration of Denial" form (see Attachment 3). The participant and/or his/her representative completes the form, which constitutes a written request to appeal Central Valley PACE decision.

(c) The Center Director will assist the PACE participant and/or his/her representative in filing an appeal in the event assistance is required.

(iii) An appeal may be filed as a "standard appeal" or an "expedited appeal", depending on the urgency of the case:

(a) A standard appeal may be filed verbally or in writing with any Central Valley PACE staff within 180 calendar days of a denial of service or payment. The 180-day limit may be extended for good cause by Central Valley PACE.

(b) An expedited appeal may be filed verbally or in writing to Central Valley PACE if the participant or a treating physician believes that the participant's life, health or ability to regain maximum function would be seriously jeopardized without provision of the service in dispute.

(c) In the case of an expedited appeal, the Center Director will immediately contact the Medical Director.

(iv) The Center Director notifies either the Program Director or the Medical Director of the appeal.

(a) Appeals related to disputed health care services should be directed to the Medical Director.

(b) Appeals related to coverage decisions or payment issues should be directed to the Program Director

(v) Central Valley PACE will continue to furnish the disputed service if the following conditions are met:

(a) Central Valley PACE is proposing to terminate or reduce services currently being furnished to the PACE participant.

(b) The participant requests continuation of the service with the understanding that he/she may be liable for the cost of the contested service if the determination is not made in his/her favor. (See "Appeal for Reconsideration of Denial" for participant's decision.)

(vi) If the above conditions are met, Central Valley PACE will not discontinue the disputed service for which an appeal has been filed until the appeals process has concluded.

D. Acknowledgement of Receipt of Appeal

(i) The Center Director will acknowledge a standard appeal in writing within five (5) working days of the initial receipt of appeal by Central Valley PACE.

(ii) For an expedited appeal, the Center Director informs the participant or representative within one (1) business day by telephone or in person that the request for an expedited appeal has been received and explains his/her additional appeal rights, as applicable.

E. Documentation of Receipt of Appeal

(i) All appeals expressed either verbally and/or in writing, will be documented on the day that it is received or as soon as possible after the event or events that precipitated the appeal, in an Appeal Log.

(ii) Appeals are documented on the *"Appeal for Reconsideration of Denial"* form by the participant, his/her representative or by a treating provider, on behalf of the participant. Complete information must be provided so that the appeal can be resolved in a timely manner.

(iii) In the event of insufficient information, the Center Director will take all reasonable steps to contact the participant, and/or his/her representative or other appropriate parties to the appeal to obtain missing information in order to resolve the case within the designated timeframes for an expedited and standard appeal.

F. Reconsideration of Decision for Service Request or Payment of a Service

(i) An appeal will be reviewed and decided by an appropriately credentialed and impartial third party who was not involved in the original action and who does not have a stake in the outcome of the appeal. At Central Valley PACE, [insert information regarding who this is and how the person(s) is/are selected].

(ii) All individuals involved with the appeal will be given reasonable opportunity to present evidence or submit relevant facts for review to Central Valley PACE, either verbally or in writing.

(iii) For a "standard appeal", the designate or Center Director will inform the participant in writing of the decision to reverse or uphold the decision within 30 calendar days of receipt of an appeal, or more quickly if the participant's health condition requires.

(iv) For an "expedited appeal" supported by a physician, the Central Valley PACE will make a decision regarding the appeal as promptly as the participant's health condition requires, but no later than 72 hours after receipt of the request for appeal.

(a) If a participant's request for expedited appeal is not supported by a physician, the Central Valley PACE Center Director decides if the participant's health situation requires making a decision within 72 hours.

(b) If the participant's health does not warrant an expedited appeal process, Center Director notifies the participant within 72 hours that the appeal will be treated as a standard appeal.

(c) The Center Director will provide the participant and/or his/her representative and the Department of Health Care Services with a written statement of the final disposition or pending status of an expedited appeal within 72 hours of receipt of an appeal.

(d) In the event the 72-hour timeframe must be extended, Central Valley PACE will provide justification to the DHCS for need of the extension. The Central Valley PACE will notify participant both verbally and in writing of the pending status and reason for the delay in resolving the appeal. The participant will be notified of the

anticipated date by which the appeal decision will be determined.

G. Determination of an Appeal

(i) When the decision of an appeal is *in favor of a participant*, that is, the Director's decision to deny, defer, or modify a service or payment of a service is reversed, the following applies:

(a) Center Director provides a written response to the participant and/or representative, sent by mail, within 30 calendar days of receiving a standard appeal or sooner if the participant's health condition requires (see Attachment 5, *"Notice of Appeal Resolution"*).
(b) Central Valley PACE will provide authorization to get the disputed service or provide the service as quickly as the participant's health condition requires, but no later than 30 calendar days from the receipt of the request for a standard appeal.
(c) For an expedited appeal, Central Valley PACE will provide the participant permission to obtain the disputed service or provide the service as quickly as the participant's health condition requires, but no later than 72 hours from the receipt of a request for an expedited appeal.
(d) If the decision to deny payment for a service is reversed by Central Valley PACE, then payment will be made within 60 calendar days of receiving the participant's or representative's request for a standard or expedited appeal.

(ii) When the decision of an appeal is *not in favor of the participant*, that is, the Program Director decision to deny, defer or modify provision or payment of a service is upheld, or if the participant is not notified of the decision within the specified time frame for a standard or expedited appeal, the Center Director will do the following:

(a) Notify in writing, at the time the decision is made, and within 30 days from the date of the request for a standard appeal and within 72 hours for an expedited appeal (see Attachment 6, *"Notice of Appeal Decision"*):

1. The participant and/or his/her representative

2. Centers for Medicare and Medicaid Services

3. Long-Term Care Division, Department of Health Care Services.

(b) Notify the participant and/or his/her representative in writing of his/her appeal rights through the Medicare or Medi-Cal program, or both, depending on the participant's eligibility.

(c) Offer to assist the participant or participant's representative in choosing which external appeal route to pursue (if desired) and to assist in preparation of appeal.

(d) Forward the appeal to appropriate external entity.

H. External Review Options for Appeal Medi-Cal External Appeal Process

(i) This option for external appeal is available to participants enrolled in Medi-Cal, that is, “Medi-Cal only” or “both Medi-Cal and Medicare”:

If the participant and/or representative chooses to appeal using the Medi-Cal external appeal process, the Center Director will assist the participant and forward the appeal to:

California Department of Social Services State Hearings Division
P.O. Box 944243,
Mail Station 19-37 Sacramento,
CA 94244-2430
Telephone: 1-800-952-5253

Facsimile: (916) 229-4410
TDD: 1-800-952-8349

(ii) Central Valley PACE will not discontinue services for which an external appeal has been filed until the external appeal process has concluded. However, if Central Valley PACE’s initial decision to deny, discontinue or reduce a service is upheld, the participant may be financially responsible for the cost of the disputed service provided during the external appeal process.

(iii) If a participant and/or his/her representative wants a State hearing, he or she must ask for it within 90 days from the date of the NOA (Attachment 1). A participant and/or his/her representative may speak at the State hearing or have someone else speak on the participant’s behalf, including a relative, friend or an attorney.

(a) For legal assistance, the participant and/or his/her representative may be able to get free legal help. To facilitate this, the Center Director will provide a listing of *“Legal Services Listing”* to the participant and/or his/her representative (Attachment 8).

(b) Central Valley PACE is required to provide written position statements whenever notified by DHCS that a participant has requested a State hearing. Central Valley PACE will designate the Program Director to make testimony at State hearings whenever notified by DHCS of the scheduled time and place for a State hearing.

(c) If the Administrative Law Judge (ALJ) decision is in favor of the participant’s appeal, Central Valley PACE will follow the judge’s instruction as to the timeline for provision of services to the participant or payment for services for a standard or expedited appeal.

(d) If the ALJ’s decision, adopted by the Director as final, is not in favor of the participant’s appeal, the participant may request a re- hearing with the Director within 30 days after receiving the final decision.

(e) Within one year after receiving notice of the Director’s final decision, the participant may file a petition with the superior court, under the provisions of Section 1094.5 of the Code of Civil Procedure.

(iv) The following option for external appeal is available to participants enrolled in Medicare, that is, "Medicare only" or "both Medicare and Medi-Cal":

(a) A Medicare enrollee may choose to appeal Central Valley PACE's decision using Medicare's external appeals process. Central Valley PACE will send the appeal to the Medicare's Independent Review Organization (IRO), the Center for Health Dispute Resolution (CHDR):

Center for Health Dispute Resolution
Medicare Managed Care and PACE Reconsideration Project
1 Fishers Road, 2nd Floor Pittsford, NY 14534
Telephone: 1-(585) 586-1770

(b) CHDR maintains a standard and expedited appeal process. Standard appeals will be resolved within 30 calendar days after filing of the appeal; expedited appeals will be resolved with 72 hours (with a possible 14 day extension).

(c) CHDR will contact Central Valley PACE with the results of the review. CHDR will either maintain Central Valley PACE's original decision or change Central Valley PACE's decision and rule in the participant's favor.

(d) If CHDR's decision is not in the participant's favor, there are further levels of external appeal, and if requested by the participant and/or representative, the Center Director will assist a participant in further pursuing the appeal.

I. Documentation, Tracking, Analysis and Reporting

(i) All appeals related information shall be marked "confidential".

(ii) All Appeal-related information and correspondence, including the appeals log will be stored in locked cabinets in the Center Director's Office.

(iii) The *Appeals Log* (Attachment 7) will contain, at a minimum, the following information:

(a) Name and telephone number of the staff person recording the appeal

(b) Date the appeal was filed

(c) Participant's and/or her/her representative's name and/or person filing the appeal

(d) Description of the appeal

(e) Action taken

(f) Description and date of the final resolution.

(iv) QA Coordinator is responsible for maintaining, aggregating, and analyzing information related to appeals to identify trends or patterns. On a quarterly basis, this information will be forwarded to the Quality Assurance Committee.

(v) Central Valley PACE will submit a summary of all grievances in the quarterly report to the DHCS, Long Term Care Division and Centers for Medicare and Medicaid Services. The DHCS grievance summary is due 45 days from the date of the end of the reporting quarter.

(vi) A written summary of appeals including number, type, location, and disposition are reported to the Quality Assurance Committee and the Board of Directors on a quarterly basis.

(vii) Records of all appeals will be held confidentially and made available as needed to State and Federal agencies upon request.

(viii) Central Valley PACE shall maintain in its files copies of all appeals, the responses and recording of log for ten (10) years from the date the appeal was filed.

J.Annual Review

The appeals process will be reviewed with participants and/or their representative, contract providers and all employees of Central Valley PACE on an annual basis. The Program Director or designee maintains responsibility for coordinating the annual review.

PROVIDER MANUAL APPENDIX D
Address and Telephone Number of Central Valley PACE Day Health Center and Administration:

2401 East Orangeburg Ave.
Suite 330
Modesto, CA
95355
1-209-726-7381

PROVIDER MANUAL APPENDIX E
Sample Contract Provider Referral Form

Authorization:_____ **Date**: _____

SPECIAL INSTRUCTIONS TO PROVIDER

1. A copy of this form must accompany the patient to the medical appointment and must be returned with the services rendered section filled out and signed by the physician.
2. Providers should submit invoices within fifteen (15) days from the service date.
3. Physicians should use the CMS-1500 (formerly the HCFA-1500) form when billing

This form must be returned to:
Central Valley PACE
2401 East Orangeburg Ave.
Suite 330
Modesto, CA
95355

In order to expedite payment, send paper claim form to:
PEAK TPA
PO Box 21631
Eagan, MN 55121

OR

Electronic claims are to be submitted to:
PEAK TPA Payer ID 27034

PARTICIPANT

DOB: Member ID:
Name:
Address: Authorization: Status: Approved/Denied
Effective From: to:

REQUESTS – The following services are requested by (Primary Care Practitioner)

Appointment Date: Appointment Time:
Description:

REFERRAL PROVIDERS REPORT

Providers Name:
Findings and/or Services Provided (Attach separate report if necessary):
Recommendations:

Signature:
Date:

PROVIDER MANUAL APPENDIX F
Provider Dispute Resolution Mechanism Policy and Procedure

I. PURPOSE:

A. To establish Central Valley PACE ("CVP" or "the Plan") policies and procedures for the provision of a fast, fair and cost-effective dispute resolution mechanism to process and resolve contracted and non-contracted provider disputes. This policy and procedure is utilized as applicable for all Plan business.

II. POLICY

A. It is CVP's policy to provide a fast, fair and cost-effective dispute resolution mechanism to process and resolve contracted and non-contracted provider disputes.

B. The CVP Provider Dispute Resolution Mechanism shall be the same for contracted and non- contracted providers as well as for claims and other types of billing and contract disputes (collectively "Provider Disputes").

C. The CVP Provider Dispute Resolution Mechanism will be used to resolve disputes from all provider types (practitioners, facilities, and provider organizations).

D. CVP will include information regarding its Provider Dispute Resolution Mechanism in following areas:

1. In the CVP Provider Manual;

2. In all relevant CVP Provider contracts; and

3. Whenever CVP contests, adjusts or denies a claim, a Plan Action Notice will be sent to the provider of the availability of the provider dispute resolution mechanism and the procedures for obtaining forms and instructions, including the mailing address, for filing a provider dispute. The following language will be include in the notice:

> "Central Valley PACE ("CVP") Provider Dispute Resolution. If you wish to challenge, appeal or request a reconsideration of this claim you must submit a written notice to CVP that includes the following information: Provider's name, provider's identification number, provider's contact information, and a clear identification of the disputed items, the Date of Service and a clear explanation of the basis upon which the provider believes CVP's decision to be incorrect.
>
> All provider disputes must be sent to the attention of the *CVP* Provider Dispute Resolution Unit at the following:
> Via Mail: 2401 East Orangeburg Ave. Suite 330
> Modesto, CA 95355

Provider disputes must be received by *CVP* within 90 calendar days, of the date of this remittance statement, unless an alternate contractual arrangement exists.

Further information regarding *CVP's* Provider Dispute process may be requested in writing to the address above.

For questions related to this process please call: (209) 726-7381 or toll free: 1 (855) 461-7223."

E. At no time does CVP discriminate or retaliate against a provider (including but not limited to the cancellation of the provider's contract) because the provider filed a contracted provider dispute or a non-contracted provider dispute. There is no charge to providers for the dispute process and the Plan has no obligation to reimburse a provider for any costs incurred in connection with utilizing the provider dispute resolution mechanism.

F. All aspects of the provider dispute resolution system will be under the daily direction, supervision and control of the CVP Executive Director.

G. Copies of provider disputes and determinations, including all notes, documents and other information upon which the plan relied to reach its decision, and all reports and related information must be kept for a period of not less than ten years.

H. Each provider dispute must contain, at a minimum, the following information:

1. All provider disputes must include:
   - Provider's name;
   - Provider's tax identification number;
   - Provider's contact information; and
   - The information in items 2 through 5 below, as applicable to the type of dispute.

2. Disputes concerning a claim or a CVP request for reimbursement of an overpayment of a claim must include:
   - A clear identification of the disputed item, including the original claim number,
   - The date of service, and
   - A clear explanation of the basis upon which the provider believes the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other CVP action is incorrect;

3. Contracted provider disputes that are not about a claim (e.g. contract issues) must include:
   - A clear explanation of the issue and

- The provider's position on such issue.

4. Disputes involving a member or group of members must include:
   - The name and identification number(s) of each member,
   - A clear explanation of the disputed item, including the date of service, and
   - Provider's position on the dispute.

5. Providers may file substantially similar multiple claims, billing or contractual disputes, in batches as a single dispute, provided that such disputes include the information described above. CVP recommends that disputes filed in batches be submitted in the following format:
   - Sort disputes by similar issue;
   - Provide cover sheet (see sample attachment to policy) for each batch of like issues (individually number and list the information required in the section above for each disputed item within the batch, as applicable);
   - Number each cover sheet;
   - Provide a cover letter for the entire submission describing each provider dispute with references to the numbered coversheets.

6. Provider disputes that do not include all required information as listed above may be returned to the submitter for completion if the information is in the possession of the provider and is not readily accessible to CVP.

I. Any provider dispute submitted on behalf of a member or a group of members treated by the provider (e.g. a clinical appeal of a UM certification decision, a clinical dispute during the concurrent care review process, provider is attempting to get an expedited review on behalf of member meeting urgent grievance definition, etc.) will be handled in the CVP consumer grievance process and not in the Plan's provider's dispute resolution mechanism. CVP may verify the member's authorization to proceed with the grievance prior to submitting the complaint to the Plan's consumer grievance process. When a provider submits a dispute on behalf of a member or a group of members, the provider shall be deemed to be joining with or assisting the member within the meaning of section 1368 of the Health and Safety Code.

J. Provider Disputes may be submitted in accordance with the following timeframes:

1. Unless alternate arrangements are contractually agreed upon, provider disputes for an individual claim, billing dispute, or other contractual dispute, or disputes related to demonstrable and unfair Plan payment patterns must be received by CVP within 90 calendar days, from the date of the Plan action (or the most recent Plan action if there are multiple actions) that led to the dispute. (Example: A disputed claim decision must be submitted within 90 calendar days from the date of the Plan action notice.)

2. Provider disputes for an individual claim, billing dispute, or other contractual dispute, or disputes related to demonstrable and unfair Plan payment patterns involving inaction on the part of CVP must be received by CVP within 90 calendar days after the Plan's most recent time for contesting or denying claims has expired. (E.g. The Plan has 30 working days from receipt of a claim to contest, deny, or reimburse a claim. If the Plan has not notified the provider of one of these actions within 30 working days of receipt of the most recent claim involved in the dispute issue, then the provider may file a dispute within 90 calendar days after the expiration of that 30 working day period.)

3. Provider disputes regarding a Plan notice of overpayment must be submitted by the provider within 30 working days of receipt of the notice of overpayment of a claim.

4. Providers may submit an amended provider dispute within thirty (30) working days of their receipt of a provider dispute that has been returned to the submitter for completion of information in the provider's possession and not readily accessible to CVP. The amended provider dispute must include the missing information identified in CVP's written notice accompanying the returned provider dispute.

5. A chart listing all Plan and provider timeline requirements found in this policy is included in the attachments.

III. DEFINITIONS:

A. "**Contracted Provider Dispute**" means a contracted provider's written notice to CVP challenging, appealing or requesting reconsideration of a claim (or a bundled group of substantially similar multiple claims that are individually numbered) that has been denied, adjusted or contested or seeking resolution of a billing determination or other contract dispute (or bundled group of substantially similar multiple billing or other contractual disputes that are individually numbered) or disputing a request for reimbursement of an overpayment of a claim.

B. "**Non-Contracted Provider Dispute**" means a non-contracted provider's written notice to CVP challenging, appealing or requesting reconsideration of a claim (or a bundled group of substantially similar claims that are individually numbered) that has been denied, adjusted or contested or disputing a request for reimbursement of an overpayment of a claim.

C. "**Non-Contracted Provider"** means a provider (practitioner, facility, or provider organization) licensed to provide health care services and who has not entered into an provider agreement with Central Valley PACE.

D. "**Date of Receipt**" means the working day when the provider dispute or amended

provider dispute, by physical or electronic means, is first delivered to the Plan's designated dispute resolution office or post office box.

E. "**Date of Determination**" means the date of postmark or electronic mark on the written provider dispute determination or amended provider dispute determination that is delivered, by physical or electronic means, to the claimant's office or other address of record. (For quality review purposes: To the extent that a postmark or electronic mark is unavailable to confirm the Date of Determination, the date the check is printed for any monies determined to be due and owing the provider and date the check is presented for payment may be used as determination dates.)

IV. PROCEDURES

A. Submission of Provider Disputes

1. Provider submits written dispute (letter or CVP dispute resolution form) to the Plan via email or physical delivery (Sample form is attached to this policy.)

2. Telephonic Provider Disputes
   a. Providers attempting to submit a dispute telephonically should be offered a CVP Provider Dispute Resolution Policy and Procedure and should be directed to the PACE Director to request additional information.
   b. Providers wishing to receive detailed information about the process (e.g. when to use the process, how to file a dispute, is the situation they are questioning a dispute or not, etc.) telephonically should be transferred to the PACE Director.
   c. Providers calling with information or questions related to the receipt of the Plan's Provider Dispute acknowledgement letter, request for additional information due to an incomplete provider dispute submission, or in follow-up to a Plan dispute resolution letter may be transferred to the PACE Director.

B. Receipt of Provider Disputes

1. All written Provider Disputes received by Plan staff will be forwarded immediately to the PACE Director.

2. Upon receipt of a Provider Dispute, the PACE Director will evaluate whether the dispute should be resolved in CVP's provider dispute mechanism or in the CVP consumer grievance process. Refer to section II-I above for additional details describing the basis for determining which process a dispute will be handled under.

   a. If the PACE Director determines that the written dispute should be handled

through the CVP grievance process, CVP may verify the member's authorization (permission) to proceed with the grievance prior to submitting the complaint to the CVP consumer grievance process.

3. The PACE Director will enter each provider dispute submission (whether or not complete) received by CVP into the dispute resolution tracking system. CVP will process and track the provider dispute in a manner that allows CVP and the Provider to link the provider dispute with the number assigned to the original claim, whenever applicable. (A sample provider dispute tracking form is included in the policy attachments.)
    a. All individual disputes involving a prior claim or related claim issue (e.g. overpayment notice, request for additional information, etc.) will be entered and tracked using the original claim number.
    b. Provider disputes involving a bundled group of substantially similar multiple claims will be entered individually and tracked using the original claim number and a code identifying the individual item as part of the larger batch submission.
    c. Non claim related Provider Disputes (individual and batched multiples) will be entered and tracked using the provider's tax ID number and a batch code if multiple items are entered individually in the tracking system.
    d. Provider Disputes that are going to be handled through the Plan's grievance process will be entered and tracked following the guidelines of the CVP Participant grievance policy.

4. The PACE Director opens a dispute record, which is maintained in electronic and/or paper-based format. The record includes at a minimum the following items as applicable to the type of dispute:
    a. The original claim/bill number;
    b. The enrollee's name;
    c. The Date(s) of Service;
    d. The provider's name;
    e. The provider's Tax Identification Number;
    f. Whether the provider is contracted or non-contracted;
    g. Type of provider – facility and practitioner by license level;
    h. The dispute type (category);
    i. Reason code for dispute;
    j. The Date of Receipt;
    k. The date of acknowledgement;
    l. Acknowledgement turnaround days;
    m. Date additional information requested if applicable and different from acknowledgement date;
    n. Date additional information received (if applicable);
    o. The Date of Determination (e.g. final response letter date);
    p. Final Response turnaround days;

q. Resolution code;
r. Identification if resolution is in favor of Provider or Plan;
s. Copies of all documentation that is in hard copy form;
t. Additionally, all appropriate staff involved in any aspect of the review will document the following in each case record, as applicable:
   i. Dates of dispute reviews;
   ii. Summary of nature of dispute and documentation of actions taken;
   iii. Names of other Plan managers or staff taking a documented action;
   iv. Identification of any external contacts and time, details of contact;
   v. Complete description of resolution decision;
   vi. Contractual or benefit provision supporting the decision;
   vii. Rationale to support the decision.

C. Acknowledgement.

1. CVP will acknowledge the receipt of each complete or incomplete Provider Dispute.
   a. In the case of an electronic (email) provider dispute, the PACE Director sends an acknowledgement notice titled "*Dispute Acknowledgement Letter*" within two (2) working days of the date of receipt of the electronic provider dispute.
   b. In the case of a paper provider disputes submitted by fax, mail or physical delivery, the PACE Director will send an acknowledgement titled "*Dispute Acknowledgement Letter*" within fifteen (15) working days or sooner of the date of receipt of the paper provider dispute.

2. Upon determination of an incomplete provider dispute the PACE Director will acknowledge and return the provider dispute in accordance with the provisions of section D below.

D. Incomplete Provider Disputes

1. Provider disputes that do not include all required information as set forth in section II-H above will be returned to the submitter for completion if:
   a. The information is in the possession of the provider; and
   b. The information is not readily accessible to CVP.

2. The PACE Director will:
   a. Send a notice titled "*Dispute Acknowledgement Letter with Request for Additional Information*" and clearly identify in writing the missing information necessary to resolve the dispute.
   b. Except in a situation where the claim documentation has been returned to the provider, the PACE Director will not request the provider to resubmit claim information or supporting documentation that the provider previously submitted to CVP as part of the claims adjudication process.

c. The PACE Director will keep a copy of the returned Provider Dispute in the case file for monitoring and tracking purposes.

3. The PACE Director will monitor the incomplete provider dispute until one of the following occurs:
   a. The provider submits an amended provider dispute which includes the missing information within 30 working days of the provider's receipt of a returned provider dispute. The PACE Director then proceeds to resolve the matter in accordance with the guidelines of this policy.
   b. If the provider does not return an amended provider dispute including the missing information within 30 working days of receipt of the Plan letter, the PACE Director will close the dispute and send the provider a written notice of closure titled *"Dispute Closure"*. To allow sufficient mailing time for the provider to receive the Plan's notice of closure, the PACE Director will not send this closure letter until at least 35 working days from the date of the Plan's "*Dispute Acknowledgement Letter with Request for Additional Information*".

E. Processing and Review of Provider Disputes

1. The PACE Director thoroughly researches the substance of the matter, coordinates with other departments as appropriate, and ensures the dispute is reviewed by management or supervisory personnel responsible for the service or operation which are the subject of the dispute. Within five (5) working days of receipt of the dispute or amended dispute, the PACE Director will forward the matter for review to the appropriate internal Plan manager as follows:
   - Refer disputes involving claim payment or billing issues, reconsiderations, adjustments, reimbursement rate issues, computation of reasonable and customary values for non-contracted providers, or appeal of administrative denials to the Claims Manager.
   - Refer disputes involving Plan Notice of Overpayment of Claim to the Finance Manager. (Note: Finance staff will suspend all actions related to recovery of the overpayment until the Provider Dispute process is completed.)
   - Refer disputes involving clinical issues or requiring medical necessity reviews to the Medical Director.
     - Claims that were initially denied or contested by the Plan and have been submitted as a provider dispute may require medical necessity review as part of the dispute resolution process. These are post service issues (service has already been rendered and claim submitted and denied/contested previously) and subject to a retrospective review. If these claim disputes require medical necessity review it will be performed using the existing IDT authorization and review processes but will be handled under the provider dispute policy guidelines. Note that this situation is different and separate from a clinical appeal

involving a UM / IDT pre-service review, concurrent review, or post service review (service has been rendered and a retrospective authorization has been requested but no claim/bill has yet been submitted for consideration) decision where the service has not yet been completed. Clinical appeals are handled through the Plan's grievance process. (Refer to section II-I for a description of disputes that must be handled in the Plan's grievance process.)

- Refer disputes involving potential Quality of Care or Provider Quality of Service issues initially to the Medical Director to determine if there are quality concerns which should be referred for further review and investigation by the Quality Improvement Committee (QIC).
- Refer disputes involving provider contract issues to the PACE Director or designee.
- Refer disputes involving other issues to the applicable department manager.

2. The reviewing manager ensures all information available related to the dispute is reviewed including any new or additional information provided.
   a. The reviewing manager provides the PACE Director with a status of the review every fourteen (15) calendar days until the manager makes a determination.
   b. The reviewing manager(s) takes all necessary internal action, as applicable, to complete resolution of the matter (i.e. processes claim if administrative denial is reversed or adjustment in amount is made, update records with authorization, adjusts finance records if overpayment request is overturned, etc.). The reviewing manager also ensures that appropriate action is completed for each claim or issue when a "bundled group of like disputes" was submitted by the provider.
   c. The reviewing manager returns the case to the PACE Director no later than thirty (30) calendar days after the case was referred for the manager's review. The case is returned with written documentation from the reviewing manager describing the decision, a clear and concise reason for the decision, a description of any applicable criteria, protocols, subscriber group agreement or provider contract provisions used in making the decision for each individual dispute or each item in a "bundled group of like disputes".
3. The PACE Director reviews the manager's response for completeness of documentation and issues the appropriate notice as described below.
   a. When applicable, the PACE Director will also review the response to ensure that each item in a "bundled group of like disputes" has been addressed in the reviewing manager's decision.

F. Time Period for Resolution and Written Determination. CVP will resolve each provider dispute or amended provider dispute, consistent with applicable state and federal law, and issue a written determination stating the pertinent facts and

explaining the reasons for its determination. The determination will be sent within **45 working days** after the date of receipt of the provider dispute or the amended provider dispute.

1. The PACE Director will monitor the review progress and status of the provider dispute case to ensure that timely resolution occurs and the written determination is sent within 45 working days of receipt of the dispute or amended dispute.
2. Within ten (10) calendar days of receiving the reviewing manager's response, the PACE Director will send the provider a written resolution letter to the provider dispute. A written resolution will be provided for each disputed item or claim in a "bundled groups of like disputes".
3. All written resolution determinations will be titled *"Dispute Resolution Determination"*
4. The written determination must state the pertinent facts and explain the reasons for CVP's determination. The written determination must address all issues involved in each dispute.
5. All decision notifications are documented in the applicable record to include the date and time of the notice, how it was delivered, and to whom the notice was given. Signed copies of written notices are also filed in the Provider Dispute record.

G. Past Due Payments. If the provider dispute or amended provider dispute involves a claim and is determined in whole or in part in favor of the provider, CVP will pay any outstanding monies determined to be due within five (5) working days of the issuance of the written determination. The PACE accountant will provide a check and any monies due the provider with the Manager's response to the PACE Director. Whenever possible, the check will be included with CVP's resolution determination notice.

H. Additional Appeal Rights

1. If a contracted provider is not satisfied with CVP's response after utilizing all Plan review processes, the contracted provider may submit a request to CVP for additional dispute resolution in accordance with the prevailing Provider Agreement.
2. There are no additional appeal or arbitration rights available to non-contracted providers.

I. Reporting

1. CVP has designated its PACE Director to be primarily responsible for the maintenance of its provider dispute resolution mechanism.
   a. The PACE Director coordinates with the Plan's Quality Manager to continuously review the operation of the Provider Dispute Resolution system to identify any emerging patterns of provider disputes in order to

improve administrative capacity, plan-provider relations, claim payment procedures and patient care.

b. The PACE Director shall be ultimately responsible for preparing all reports and disclosures required by law.

2. The UM Manager is responsible to ensure the timely resolution of provider disputes by regular review of the tracking database.

3. The PACE Director will provide quarterly reports of provider dispute activity to the Plan's Quality Committee, Compliance Committee, and Board of Directors. At a minimum, the quarterly reports will include:
   a. Number of provider disputes received;
   b. Number and types of providers using the dispute resolution mechanism;
   c. Aggregated number of type and reason for provider disputes;
   d. Compliance with 45 working day resolution timeframes;
   e. Number resolved in favor of Plan and number in favor of provider;
   f. Other elements as deemed necessary.

4. Under the direction and review of the PACE Director, the Quality Manager and/or Compliance Manager will prepare and submit the required annual report to DHCS. The report includes the following:
   - Report timelines based on date of receipt of provider dispute or amended provider dispute for the 12 month period ending 12/31 of the prior year;
   - Summary of disposition of all provider disputes;
   - Information on the number and types of providers submitting disputes;
   - Description of dispute types, terms and resolution;
   - Bundled disputes reported as separate disputes;
   - Information may be aggregated;
   - Detailed, informative statement disclosing emerging or established patterns of provider disputes, including how that information has been used in improvement efforts and in the development of corrective action plans. (May ask DMHC to have this "informative statement" treated as confidential.)

V. Attachments:

- Provider Dispute Process Time Frames
- CVP Provider Dispute Type and Reason Codes
- Provider Dispute Resolution Codes
- Provider Dispute Resolution Request Form
- Provider Dispute Resolution Request Form (For use with multiple "like" disputes)
  CVP Provider Dispute Resolution Request Tracking Form

PROVIDER DISPUTE PROCESS TIMEFRAMES

DESCRIPTION		TURNAROUND TIME FRAME
DEADLINE FOR PLAN RECEIPT OF PROVIDER DISPUTES	Dispute related to an individual claim, billing dispute or contractual dispute; OR Dispute related to a demonstrable and unfair payment pattern by the Plan	**90 Calendar days** after the most recent action, or in the case of inaction, 90 Calendar days after time for contesting or denying claims has expired.
	Dispute regarding a Plan notice of overpayment	Within **30 working days** of receipt of the Plan notice of overpayment of a claim
	Amended Provider Dispute	Within **30 working days** of the date of provider's receipt of a returned dispute with written Plan notice
TIME PERIOD FOR ACKNOWLEDGEMENT	Electronic provider Dispute (email submission)	Provided within **2 working days** of the date of receipt of the electronic provider dispute
	Paper provider Dispute (mail, fax, physical delivery)	Provided within **15 working days** of the date of receipt of the paper provider dispute
TIME PERIOD FOR PLAN RESEARCH	Utilization Manager refers to appropriate manager for review	Within **5 calendar days** of receipt of dispute or amended dispute by Plan
	Reviewing Manager research, resolution, and response	Within **15 calendar days** of receipt from Utilization Manager
	Utilization Manager issues written response	Within **10 calendar days** of response from Reviewing Manager
TIME PERIOD FOR RESOLUTION AND WRITTEN DETERMINATION	Resolution and issuance of written determination for each provider dispute or amended provider dispute.	Plan's goal is to resolve and issue written determination within **30 calendar** days of receipt of dispute and in all cases resolution and a written determination must be completed **no later than** within **45 working days** after the date of receipt of the provider dispute or the amended provider dispute.
PAST DUE PAYMENTS	Resolution of a dispute involving a claim which is determined in whole or in part in favor of the provider, shall include the payment of any outstanding monies determined to be due.	Plan goal is to issue payment **with the resolution letter** and in all cases payment will be made no later than within **5 working days** of the issuance of the written determination.

CVP PROVIDER DISPUTE TYPE AND REASON CODES

Claims-Insufficient Payment Issues
Paid Out of Network (OON) instead of in Network
Paid at Incorrect Per Diem
Paid Incorrect licensure level
Wrong copayment deducted
Paid Incorrect Benefit
Incorrect Amount-Outpatient
Incorrect Coordination of Benefits (COB) Applied
Claim not paid at agreed or regulated rate
Claims-Slow Payment Issues
Claim Rcv'd/Not Inventoried
Claim Rcv'd/Inventoried/Not Processed
Claim Rcv'd/Adjudicated/Sent to 3rd Party/Not Rcv'd/We Will Resend
Claim Rcv'd/Adjudicated/Sent to 3rd Party/They Rcv'd/They Denied After We Said Pay
Certification Issue/Build/Update
Provider/Vendor Build
Other Provider Issues
Eligibility Confirmation Required
Benefits Clarification Required
Claims not received
Claim not released for payment
Claims-Other Issues
Paid to Provider Instead of Subscriber
Paid Network Instead of Out of Network (OON)
Wrong Date of Service (DOS) Paid
Duplicate Payment Rcv'd
Paid to Wrong Patient
Paid to Wrong Provider
Paid to Wrong Facility
Claim Receipt Verification/Not Rcv'd/Caller needs to resend
Claim processed incorrectly
Unspecified
Claims-Refusal to Pay Treatment
Medical Charges Excluded
Amount Applied to Deductible
CVP Allowable Rate Exceeded
Portion of Treatment Non-Certified
Services Not Covered by CVP
Pre-Certification Required
Provider Does Not Meet Eligibility Standards
Need Diagnosis Related to Treatment

Claims-Refusal to Pay Treatment (cont'd)
Itemized Bill Required
Missing Provider Data
Benefits Exhausted
Returned Claim to Member/Provider
Timely Filing Limit
Check Not Received
Incorrect CPT/revenue code
Processed under incorrect vendor # (or "processing error")
Multiple services on same date
Member not eligible
Excessive or non-relevant additional information requested
Unspecified
Provider Issues
Provider Billing Error
Unfair Billing Pattern
Benefits/Coverage
Paid to Subscriber Instead of Provider
Member Demo/Elig. Update
Benefits Clarification Required
Benefit Exception Request
Policy/Procedure Question
Transition Benefit Issue
Employee Records Inaccurate
Provider Contractual Issues
Provider Network Status
Provider Contract Concern
Amendment of Provider Contract Concern
Disputing Policy/Procedure Requirement
Allegation of demonstrable and unjust payment pattern
Provider Financial Issues
Notice of Overpayment/Negative Balance Statement
Payment sent to incorrect address
Calculation of reasonable & customary value
Calculation of contractual rates
Per Diem Rate/Contract Question
Interest/penalty issue
Claim Payment not Timely (exceeds 30 working day rule.

PROVIDER DISPUTE RESOLUTION CODES

Closed due to non-receipt of additional information requested
Decision/policy/practice upheld – favors Plan
Decision/policy/practice overturned –favors provider
Decision/policy/practice modified

Claims – Payment issued
Claims – denial or original payment upheld
Claims – partial payment or adjustment issued

PROVIDER DISPUTE RESOLUTION REQUEST

NOTE: SUBMISSION OF THIS FORM CONSTITUTES AGREEMENT NOT TO BILL THE PATIENT

INSTRUCTIONS

- Please complete the below form. Fields with an asterisk (*) are required.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute. Do not include a copy of a claims that was previously processed
- For routine claim follow-up, please call the client specific telephone number on the member's identification card or 1(866) 501-0777 instead of using the Provider Dispute Resolution Form.
- Mail the completed form to: **Central Valley PACE**
  2401 East Orangeburg Ave.
  Suite 330
  Modesto, CA 95355

* Provider Name:	*Provider Tax ID #
*Provider Address:	

PROVIDER TYPE: ☐ MD ☐ PhD ☐ LCSW ☐ MFT ☐ Facility ☐ Other_____
(Please specify type of "other")

DISPUTE INFORMATION: ☐ Single ☐ Multiple "LIKE" Claims/Disputes (complete attached spreadsheet)
Number of claims/disputes:_____

* Patient Name:	Date of Birth:	
Member ID Number:	Employer Name:	Original Claim ID Number: (If multiple claims, use attached spreadsheet)
Service "From/To" Date: (* Required for Claim, Billing and Reimbursement of Overpayment Disputes)_____	Original Claim Amount Billed:	Original Claim Amount Paid:

DISPUTE TYPE
☐ Claim
☐ Appeal of Medical Necessity / Utilization Management Decision
☐ Request for Reimbursement of Overpayment
☐ Seeking Resolution of a Billing Determination
☐ Contract Dispute
☐ Other:

* DESCRIPTION OF DISPUTE:

EXPECTED OUTCOME:

Contact Name (please print) _____ Title _____ Phone Number _____

Signature _____ Date _____ Fax Number _____

[ ] Check Here if Additional Information is Attached

CVP Use Only Tracking Number_____
Provider ID#_____

GOLDEN VALLEY HEALTH CENTERS
737 West Childs Avenue
Merced, CA 95341
www.gvhc.org

PROVIDER DISPUTE RESOLUTION MULTIPLE REQUESTS

(For use with multiple "like" disputes – attach this form to the main Provider Dispute Resolution Request form)

#	*Patient Name (Last / First)	Date of Birth	*Health Plan ID Number	Original Claim ID Number	*Service From/To Date	Original Claim Amount Billed	Original Claim Amount Paid	Expected Outcome
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								

CVP PROVIDER DISPUTE RESOLUTION REQUEST

Tracking Form

INSTRUCTIONS

- This form may be used to track the status, time-frames and disposition of the Provider Dispute Resolution.
- The following information should be tracked internally for ensuring compliance with regulations.

TRACKING NUMBER:	**PROVIDER TAX ID#:**
IF BATCH OF "LIKE" DISPUTES SUBMITTED INDICATE TOTAL # IN BATCH:	
a. PROVIDER NAME (Include license level):	**b. CONTRACTED PROVIDER:_____YES_____NO**
c. DATE DISPUTE RECEIVED (Date Stamped):	**d. DATE OF ORIGINAL PAYMENT OR ACTION:**
e. WAS DISPUTE RECEIVED WITHIN TIMEFRAME? (c – d) _____YES _____NO (If NO, may be returned to provider without action)	
f. DISPUTE TYPE (Enter type category and reason code):	
g. DATE DISPUTE ACKNOWLEDGED:	**h. TURNAROUND TIME (g – c):**

TYPE OF LETTER SENT:

IF NO ADDITIONAL INFORMATION REQUESTED:

j. DATE OF ACTION:	**k. ACTION TURNAROUND TIME (j – c):**	**l. TYPE OF ACTION (Resolution Code):**

IF ADDITIONAL INFORMATION REQUESTED:

m. DATE ADDITIONAL INFO REQUESTED:	**n. TURNAROUND TIME (m – c):**	
o. DATE ADDITIONAL INFO RECEIVED:	**p. RECEIPT TURNAROUND TIME (o – m):**	
q. DATE OF ACTION:	**r. ACTION TURNAROUND TIME (q – o):**	**s. TYPE OF ACTION (Resolution code):**

COMPLETE DESCRIPTION OF DETERMINATION RATIONALE:

ACTION (If decided in whole or part on behalf of provider, make payment within 5 days of issuing determination.):