KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Appeals Regarding Authorization				POLICY #: 3.23-P	
DEPARTMENT: Utilization Management					
Effective Date: 11/1998	Review/Revised Date: 3/14/2023	DMHC	X	PAC	
		DHCS	X	QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

_____ Date _____
Emily Duran
Chief Executive Officer

_____ Date _____
Chief Medical Officer

_____ Date _____
Chief Operating Officer

_____ Date _____
Chief Health Services Officer

_____ Date _____
Director of Compliance and Regulatory Affairs

_____ Date _____
Director of Member Services

_____ Date _____
Director of Utilization Management

POLICY[1]:
Kern Health Systems (KHS) shall establish and maintain a fast, fair, and cost-effective appeal resolution mechanism to process and resolve Provider Appeals regarding prior authorizations. Contracting providers shall have the opportunity to appeal authorizations that have been denied or modified.

Only those appeals regarding authorization are subject to this policy and procedure.

Appeals submitted on behalf of an enrollee or a group of enrollees will be processed according to *KHS Policy and Procedure #5.01-P – Grievance Process*.[2] Disputes regarding claims payment will be processed according to *KHS Policy and Procedure #6.04-P – Practitioner/Provider Disputes Regarding Claims Payment*. Disputes regarding all other issues will be processed according to *KHS Policy and Procedure #4.03 – Practitioner/Provider Disputes Regarding Issues Other than Authorization and Claims Payment*.

Appeals will be processed in accordance with statutory, regulatory, and contractual requirements including those outlined in the following sources:

- California Health and Safety Code § 1367(h); 1367.01; 1370.2; and 1374.30
- CCR Title 28 § 1300.68 and 1300.71.38
- DHS Contract Exhibit A – Attachment 7 (2)

PURPOSE:
To establish procedures for providers to appeal authorizations which have been denied or modified before the service has been rendered.

DEFINITIONS:

Appeal[3]	A review by KHS of an Adverse Benefit Determination. These types of appeals involve the delay, modification, or denial of services based on medical necessity, or a determination that the requested service was not a covered benefit. These requests shall be treated as Appeals under federal regulations. An "appeal" is federally defined as a review by Kern Health Systems (KHS) of an adverse determination. As the All-Plan Letter 21-011 certain types of grievances fall under the federal definition of appeal because they involve the delay, modification, or denial of services based on medical necessity or a determination that the requested service is not a covered benefit. All such requests are treated under the federal regulations.

PROCEDURE[4]:

1.0 SUBMISSION OF APPEAL[5]

Appeals may be mailed or physically delivered to the following address:

KHS Utilization Management Department
2900 Buck Owens Boulevard
Bakersfield, California 93308

1.1 Timeframes for Requesting (Filing) an Appeal

Timeframes for filing Appeals are delineated in the DHCS Contract, as well as in federal regulations. Members (beneficiaries) must file an appeal within 60 calendar

days from the date of the NOA. Members must exhaust the KHS appeal process prior to requesting a state hearing, except in instances of deemed exhaustion.

1.2. Method of Requesting (Filing) an Appeal

In accordance with existing federal and state regulations, Appeals may be filed either orally or in writing by a beneficiary, a provider acting on behalf of the beneficiary, or an authorized representative. Appeals filed by the provider on behalf of the beneficiary require written consent from the beneficiary (Attachment A). If the written consent is not received with the appeal request, the appeal will be returned and not processed. Substantially similar multiple appeals may be filed in batches as a single appeal, provided that such appeals are submitted in the following format[6]:

A. Batched by similar issue
B. One *Provider Authorization Appeal Resolution Request* form provided for each batch.

1.3 Format

Appeals must be submitted using a *Provider Authorization Appeal Resolution Request* form. (See Attachment A). Simple resubmission of the authorization request is not sufficient to qualify as an appeal.

1.4 Content

Appeals must contain the following information[7]:

A. Provider name
B. Provider identification number
C. Provider contact information
D. Clear explanation of the issue and the provider's position thereon
E. The original authorization number that the provider is appealing
F. Member consent to the appeal.

Appeals that do not contain all the necessary information are returned to the provider.

1.5 Supporting Documentation

Additional medical information pertinent to the appeal should be included at this time.

2.0 STANDARD APPEALS[8]

2.1 Acknowledgement

In accordance with existing state laws and regulations, KHS will provide the member with written acknowledgment that is dated and postmarked within five calendar days of receipt of the Appeal. The acknowledgment letter must advise the beneficiary that the Appeal has been received, the date of receipt, and provide the name, telephone number, and address of the representative who may be contacted about the Appeal.

2.2 Resolution

Federal regulations timeframe for resolving Appeals is 30 calendar days. KHS may extend the timeframe for Appeals resolution by 14 calendar days in accordance with federal regulations delineated under Section IV(E) below.

2.3 Deemed Exhaustion

In the event that Kern Health Systems fail to adhere to the state and federal notice timeframe requirements for either a Notice of Action (NOA) or a Notice of Appeal Resolution (NAR), including KHS failure to provide a filly translated notice, the member is deemed to have exhausted the KHS internal appeal process and may initiate a state hearing.

3.0 EXPEDITED APPEALS

State laws and regulations, which do not distinguish Grievances from Appeals, require expedited resolution of Grievances within three calendar days, which is inclusive of Appeals. Federal regulations timeframe for resolving Appeals is no longer than 72 hours. KHS will comply with the 72-hour timeframe in accordance with new federal regulations. The 72-hour timeframe would require KHS to additionally record the time of Appeal receipt, and not just the date, as the specific time of receipt would drive the timeframe for resolution. KHS may extend the timeframe for expedited Appeals resolution by 14 calendar days in accordance with federal regulations delineated under Section IV(E) below.

Additionally, KHS is required to make reasonable efforts to provide the member (beneficiary) with oral notice of the expedited appeal resolution.

KHS will comply with all other existing state regulations pertaining to expedited Appeal handling in accordance with Title 28, CCR, and Section 1300.68.01.

3.1 EXTENSIONS OF TIMEFRAMES

KHS may extend the resolution timeframes for either standard or expedited Appeals by up to 14 calendar days if either of the following two conditions apply:

a. The beneficiary requests the extension.
b. KHS demonstrates, to the satisfaction of DHCS upon request, that there is a need for additional information and how the delay is in the beneficiary's best interest.

For any extension not requested by the beneficiary, KHS is required to provide the beneficiary with written notice of the reason for the delay. New federal regulations delineate the following additional requirements that KHS must comply with:

a. KHS will make reasonable efforts to provide the beneficiary with oral notice of the extension.
b. KHS will provide written notice of the extension within two calendar days and notify the beneficiary of the right to file a Grievance if the beneficiary disagrees with the extension.
c. KHS will resolve the Appeal as expeditiously as the beneficiary's health condition requires and in no event extend resolution beyond the initial 14-calendar day extension.
d. In the event that KHS fails to adhere to the notice and timing requirements, the beneficiary is deemed to have exhausted KHS's internal Appeal process and may initiate a State Hearing.

4.0 PROCESSING [9]

Upon receipt of an appeal the Chief Medical Officer or designee reviews the facts surrounding the appeal and issues a written decision granting or denying the appeal within 30 working days of the date the appeal was submitted. The written decision states the pertinent facts and explains the reasons for the determination. [10] Notification is sent by KHS Utilization Management Department personnel at the direction of the Chief Medical Officer or designee.

If the appeal is granted in whole or in part, then authorization is issued within 72 hours of the date of the decision. If the appeal is urgent or emergent as there is an imminent and serious threat to the health of the member, including, but not limited to, severe pain, potential loss of life, limb or major bodily function, the Chief Medical Officer or designee will review the matter promptly and communicate the decision verbally within seventy-two (72) hours of initial notification of the appeal. The decision of the Chief Medical Officer or designee is forwarded to the Utilization Management Department.

4.1 Competency of Review

In compliance with Health and Safety Code Section 1370.2, KHS adheres to competency of review guidelines. If the Chief Medical Officer or designee determines that he/she is competent to evaluate the specific clinical issues presented in the appeal, a decision is made regarding the appeal without further consultation. If the Chief Medical Officer or designee determines that he/she is not competent to evaluate the specific clinical issues of the appeal, prior to making a determination, he/she consults or refers the appeal to a contracted vendor outside of KHS who is appropriately licensed health care provider who is competent to evaluate the specific clinical issues presented. For the purposes of this definition, "competent to evaluate the specific clinical issues" means that the reviewer has education, training, and relevant expertise that is pertinent for evaluating the specific clinical issues that serve as the basis of the contested services. This applies to authorizations that are contested on the basis of a clinical issue, the necessity for treatment, or the type of treatment proposed or utilized.

4.2 Upheld Decisions

Federal definitions separately define Notice of Adverse Benefit Determination (NOA) and NAR, which in turn trigger a separate set of Appeal rights, necessitating the need for unique notices for denials and Appeals. DHCS has therefore created distinct notice templates to inform beneficiaries of their Appeal rights depending on whether a NOA or NAR is issued.

For Appeals not resolved wholly in favor of the beneficiary, KHS will utilize the DHCS template packet for upheld decisions, which is comprised of two components:

1) the NAR and
2) “Your Rights” attachments. These revised documents are viewed as a “packet” and must be sent in conjunction to comply with all requirements of the NAR.

1. Notice of Appeal Resolution (NAR) (Attachment B, C)
   KHS will comply with federal and state regulations in sending written response to Appeals as follows:
   a. The results of the resolution and the date it was completed.
   b. If KHS's denial determination is based in whole or in part on medical necessity, KHS will include in its written response the reasons for its determination and clearly state the criteria, clinical guidelines, or medical policies used in reaching the determination.
   c. If KHS's determination specifies the requested service is not a covered benefit, KHS will include in its written response the provision in the DHCS Contract, Evidence of Coverage, or Member Handbook that excludes the service. The response will either identify the document and page where the provision is found, direct the beneficiary to the applicable section of the contract containing the provision, or provide a copy of the provision and explain in clear and concise language how the exclusion applied to the specific health care service or benefit requested.

2. "Your Rights" (Attachment D)
   In accordance with federal and state regulations, the written NAR shall, at a minimum, include all of the following required requirements:
   a. The beneficiary's right to request a State Hearing no later than 120
      calendar days from the date of KHS's written Appeal resolution and instructions on how to request a State Hearing.
   b. The beneficiary's right to request and receive continuation of benefits while the State Hearing is pending and instructions on how to request continuation of benefits, including the timeframe in which the request shall be made in accordance with Title 42, CFR, and Section 438.420.
   c. For Knox-Keene licensed health plans, such as KHS, the beneficiary's right to request an Independent Medical Review (IMR) from the DMHC if KHS's decision is based in whole or in part on a determination that the service is not medically necessary, is experimental/investigational, or is an emergency service. KHS will include the IMR application, instructions, DMHC's toll-free telephone number, and an envelope addressed to DMHC.

4.3. Overturned Decisions

For Appeals resolved in favor of the beneficiary, written notice to the beneficiary shall include the results of the resolution and the date it was completed. KHS will also ensure that the written response contains a clear and concise explanation of the reason, including the reason for why the decision was overturned. KHS will utilize the

DHCS template packet for Appeals, which contains the NAR for overturned decisions.

KHS will authorize or provide the appealed services promptly and as expeditiously as the beneficiary's condition requires if KHS reverses the decision to deny, limit, or delay services that were not furnished while the Appeal was pending. KHS will authorize or provide services no later than 72 hours from the date it reverses the determination.

Providers can make inquiries regarding appeals by calling 1-800-391-2000.

5.0. NONDISCRIMINATION NOTICE AND LANGUAGE ASSISTANCE TAGLINES

Section 1557 of the Affordable Care Act (ACA) prohibits discrimination on the basis of race, color, national origin, sex, age, or disability. On May 18, 2016, the United States Department of Health and Human Services (HHS), Office for Civil Rights (OCR) issued the Nondiscrimination in Health Program and Activities Final Rule to implement Section 1557. Federal regulations require KHS to post nondiscrimination notice requirements and language assistance taglines in significant communications to beneficiaries. DHCS has thus created a sample "Nondiscrimination Notice" and "Language Assistance" taglines. KHS may utilize the templates provided by DHCS, make modifications to the templates, or create new templates. If modifications or new templates are created, DHCS review and approval must be obtained prior to use. These templates must be sent in conjunction with each of the following significant notices sent to beneficiaries: NOA, Grievance acknowledgment letter, Appeal acknowledgment letter, Grievance resolution letter, and NAR.
(Attachment E, F)

6.0 GRIEVANCE AND APPEAL SYSTEM OVERSIGHT

KHS will establish, implement, and maintain a Grievance and Appeal System to ensure the receipt, review, and resolution of Grievances and Appeals. The Grievance and Appeal System shall operate in accordance with all applicable federal regulations, state laws, and state regulations.

A. KHS will operate in accordance with its written procedures. These procedures shall be submitted to DHCS prior to use.

B. KHS will designate an officer that has primary responsibility for overseeing the Grievance and Appeal System. The officer shall continuously review the operation of the Grievance and Appeal System to identify any emergent patterns of Grievances and Appeals. The Grievance and Appeal System shall include the reporting procedures in order to improve KHS policies and procedures.

C. KHS will notify beneficiaries about its Grievance and Appeal System and shall include information on KHS's procedures for filing and resolving Grievances and Appeals, a toll-free telephone number or a local telephone number in each service area, and the address for mailing Grievances and Appeals. The notice shall also include information regarding the DMHC's review process, the IMR system, and DMHC's toll-free telephone number and website address, as appropriate.

D. KHS will notify beneficiaries of the process for obtaining Grievance and Appeals forms. A description of the procedure for filing Grievances and Appeals shall be readily available at each facility of the KHS, on the KHS's website, and at each contracting provider's office or facility. KHS will ensure that assistance in filing

Grievances and Appeals will be provided at each location where Grievances and Appeals are submitted. Grievance and Appeal forms shall be provided promptly upon request.

E. KHS will ensure adequate consideration of Grievances and Appeals and rectification when appropriate. If multiple issues are presented by the beneficiary, KHS will ensure that each issue is addressed and resolved.

F. KHS will maintain a written record for each Grievance and Appeal received by KHS. The record of each Grievance and Appeal shall be maintained in a log and include the following information:

1. The date and time of receipt of the Grievance or Appeal
2. The name of the beneficiary filing the Grievance or Appeal
3. The representative recording the Grievance or Appeal
4. A description of the complaint or problem
5. A description of the action taken by KHS or provider to investigate and resolve the Grievance or Appeal
6. The proposed resolution by the KHS or provider
7. The name of the KHS provider or staff responsible for resolving the Grievance or Appeal
8. The date of notification to the beneficiary of resolution.

G. The written record of Grievances and Appeals shall be submitted at least quarterly to the KHS's quality assurance committee for systematic aggregation and analysis for quality improvement. Grievances and Appeals reviewed shall include, but not be limited to, those related to access to care, quality of care, and denial of services. Appropriate action shall be taken to remedy any problems identified.

H. The written record of Grievances and Appeals shall be reviewed periodically by the governing body of the MCP, the public policy body, and by an officer of KHS or designee. The review shall be thoroughly documented.

I. KHS will ensure the participation of individuals with authority to require corrective action. All Grievances and Appeals related to medical quality of care issues shall be immediately submitted to KHS's Quality Improvement department and medical director for action.

J. KHS will address the linguistic and cultural needs of its beneficiary population as well as the needs of beneficiaries with disabilities. KHS will ensure all beneficiaries have access to and can fully participate in the Grievance and Appeal System by assisting those with limited English proficiency or with a visual or other communicative impairment. Such assistance shall include, but is not limited to, translations of Grievance and Appeal procedures, forms, and KHS's responses to Grievances and Appeals, as well as access to interpreters, telephone relay systems and other devices that aid disabled individuals to communicate.

K. KHS will assure that there is no discrimination against a beneficiary on the grounds that the beneficiary filed a Grievance or Appeal.

L. KHS will establish and maintain a system of aging of Grievances and Appeals that are pending and unresolved for 30 days or more and shall include a brief explanation of the reasons each Grievance and Appeal is pending and unresolved.

M. KHS will ensure that the person making the final decision for the proposed resolution of a Grievance or Appeal has not participated in any prior decisions related to the Grievance or Appeal. Additionally, the decision-maker shall be a health care

professional with clinical expertise in treating a beneficiary's condition or disease if any of the following apply:

1. An Appeal of an Adverse Benefit Determination that is based on lack of medical necessity.
2. A Grievance regarding denial of an expedited resolution of an Appeal. The determination as to whether an appeal should be expedited is not considered a contributing factor to the resolution of the appeal and therefore can be determined by any medical director or physician advisor, even if previously involved in the case.
3. Any Grievance or Appeal involving clinical issues.

N. KHS will ensure that individuals making decisions on clinical Appeals take into account all comments, documents, records, and other information submitted by the beneficiary or beneficiary's designated representative, regardless of whether such information was submitted or considered in the initial Adverse Benefit Determination.

O. KHS will provide the beneficiary or beneficiary's designated representative the opportunity to review the beneficiary's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by KHS in connection with any standard or expedited Appeal of an Adverse Benefit Determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe.

P. KHS will provide the beneficiary a reasonable opportunity, in person and in writing, to present evidence and testimony. KHS will inform the beneficiary of the limited time available for this sufficiently in advance of the resolution timeframe for Appeals as specified and in the case of expedited resolution.

7.0 DELEGATION

KHS is responsible for ensuring that our delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Dual Plan Letters. These requirements must be communicated by KHS to all delegated entities and subcontractors.

ATTACHMENTS:

- Attachment A – *Provider Authorization Appeal Resolution Request* form
- Attachment B – *Notice of Appeal Resolution Overturn* Letter
- Attachment C – *Notice of Appeal Resolution Upheld* Letter
- Attachment D – *Your Rights Under Medi-Cal Managed Care*
- Attachment E – *Notice of Non-Discrimination*
- Attachment F – *Language Assistance Tagline*
- Attachment G – *Independent Medical Review*

REFERENCE:

Revision 2023-03: Revision to include revised IMR form per DMHC APL 23-006. **Revision 2022-04:** Revision related to the publication of DHCS APL 21-011, Grievance and Appeal Templates, DHCS APL 21-004 Nondiscrimination and Tagline Templates, and DMHC IMR Form Rev:02/22. Policy received DHCS approval on 7/19/2022 and DMHC approval on 12/5/2022.[1] **Revision 2021-09: Revision 2020-12:** Revised by Director of Utilization Management to update address, attachments, added language on expedited appeal. **Revision 2018-03:** Added language on expedited appeal determination. Removed section 1.3

Deadlines as requested by Administrative Director of Health Services. Not a material change to policy. **Revision 2017-08: Revised per APL17-006. Revision 2009-11: Revision 2006-02:** Revised per DHS Workplan Comment 7.a (1/4/06). **Revision 2003-12:** Updated KHS address and phone numbers on 9/16/2005. Revised to comply with new AB1455 DMHC Regs (effective 01/01/04). **Formerly: #3.49.** Number changed during 2006-02 revision.

[2] CCR Title 28 §1300.71.38(c)(4)

[3] CCR Title 28§1300.71.38(a)(1)

[4] Required Disclosure: All dispute requirements (30.49)

[5] Required Disclosure: Identity of the office responsible for receiving and resolving disputes. Directions (including the mailing address) for the electronic submission (if available), physical delivery, and mailing of provider disputes. (30.49)

[6] Required Disclosure: Directions for filing batched multiple disputes (30.49)

[7] CCR Title 28§1300.71.38(a)(1)

[8] CCR Title 28 §1300.71.38(e). Required disclosure: timeframe for acknowledgement (30.49).

[9] Leaving all review deadlines as is. Not changing to 45 working days allowed by dispute regulations Title 28 §1300.71.38. More strict authorization review deadlines found in HSC §1367.01.

[10] CCR Title 28 §1300.71.38(f)

Kern Family Health Care
The Friendly Face
Of Kern Health Systems

3.23-P Attachment A

PROVIDER AUTHORIZATION APPEAL RESOLUTION REQUEST

INSTRUCTIONS

- Please complete the below form. Fields with an asterisk (*) are required.
- Be specific when completing the DESCRIPTION OF APPEAL and EXPECTED OUTCOME.
- Provide additional information to support the description of the appeal.
- Mail the completed form to: Utilization Management Department –Kern Family Health Care
  P.O. Box 21960
  Bakersfield, CA 93311-1960

***PROVIDER NAME:**	***PROVIDER TAX ID # / Medicare ID #:**
PROVIDER ADDRESS:	

PROVIDER TYPE ☐ MD ☐ Mental Health ☐ Hospital ☐ ASC ☐ SNF ☐ DME ☐ Rehab
☐ Home Health ☐ Ambulance ☐ Other _____
(please specify type of "other")

*** AUTHORIZATION INFORMATION** ☐ Single ☐ Multiple "**LIKE**" Authorizations (complete attached spreadsheet)
Number of authorizations:___

*** Patient Name:**		**Date of Birth:**
*** Health Plan ID Number:**	**Patient Account Number:**	***Original Authorization Number:** (If multiple claims, use attached spreadsheet)

APPEALTYPE: First Level _____

*** DESCRIPTION OF APPEAL (**must include a clear explanation of the basis upon which you believe KHS' action is incorrect**):**

EXPECTED OUTCOME:

***Contact Name (please print)**	**Title**	**( ) *Phone Number**
Signature	**Date**	**( ) *Fax Number**

Kern Family Health Care received this appeal on _____. If you have a question regarding this dispute, please call the Utilization Management Department at 1 800 391-2000.

_____(signature)
Acknowledgement of Receipt

3.23-P Attachment B

"Overturn"

Kern Family Health Care™

NOTICE OF APPEAL RESOLUTION

[Date]

[Member's Name]
[Address]
[City, State Zip]

[Treating Provider's Name]
[Address]
[City, State Zip]

Identification Number

RE: *[Service requested]*

You or *[Name of requesting provider or authorized representative]* appealed the *[denial, delay, modification, or termination]* of *[Service requested].* Kern Family Health Care has decided to overturn the original decision. This request is now approved. This is because *[Insert: 1. A clear and concise explanation of the reasons for the decision; 2. A description of the criteria or guidelines used, including a reference to the specific regulations or plan authorization procedures that support the action; and 3. The clinical reasons for the decision regarding medical necessity]*.

Kern Family Health Care will authorize or provide the requested service within 72 hours. Kern Family Health Care has also notified the doctor that requested the service of its decision.

The State Medi-Cal Managed Care "Ombudsman Office" can help you with any questions. You can call them at 1-888-452-8609. You can also get help from your doctor, **(661) 632-1590** inside Bakersfield, or **(800) 391-2000** outside of Bakersfield.

This letter does not change your other Medi-Cal care.

[Medical Director's Name]

3.23-P Attachment C

"Uphold"

Kern Family Health Care™

NOTICE OF APPEAL RESOLUTION

[Date]

[Member's Name]
[Address]
[City, State Zip]

[Treating Provider's Name]
[Address]
[City, State Zip]

Identification Number

RE: *[Service requested]*

You or *[Name of requesting provider or authorized representative]* appealed the *[denial, delay, modification, or termination]* of *[Service requested].* Kern Family Health Care has decided to uphold the decision. This request is still denied. This is because *[Insert: 1. A clear and concise explanation of the reasons for the decision; 2. A description of the criteria or guidelines used, including a reference to the specific regulations or plan authorization procedures that support the action; and 3. The clinical reasons for the decision regarding medical necessity]*.

You can get free copies of all information used to make this decision. To get this this, please call Kern Family Health Care at **(661) 632-1590**, inside Bakersfield, or **(800) 391-2000** outside of Bakersfield.

You may appeal this decision. The enclosed "Your Rights" information letter tells you how. It also tells you how you can get free help. This can be free legal help. You can send in any information that could help your case. The "Your Rights" letter tells you the last day you can ask for an appeal.

The State Medi-Cal Managed Care "Ombudsman Office" can help you with any questions. You may call them at 1-888-452-8609. You can also get help from your doctor, or call us at **(661) 632-1590** inside Bakersfield, or **(800) 391-2000** outside of Bakersfield.

This letter does not change your other Medi-Cal care.

[Medical Director's Name]

Enclosed: "Your Rights under Medi-Cal Managed Care"

(Enclose notice with each letter)

If you still do not agree with this decision, you can:

- Ask for an Independent Medical Review and an outside reviewer that is not related to your health plan will review your case.
- Ask for a State Hearing and a judge will review your case.

You can ask for both an Independent Medical Review and State Hearing at the same time. You can also ask for one before the other to see if it will resolve your problem first. For example, if you ask for an Independent Medical Review first, but do not agree with the decision, you can still ask for a State Hearing later. However, if you ask for a State Hearing first, and the State Hearing has already taken place, then you cannot ask for an Independent Medical Review. In this case, the State Hearing has the final say.

You will not have to pay for an Independent Medical Review or State Hearing.

INDEPENDENT MEDICAL REVIEW

If you want an Independent Medical Review, you must ask for one within 180 days from the date of this Notice of Appeal Resolution letter. The paragraph below provides you with information on how to request an Independent Medical Review.[1] Note that the term "grievance" is talking about both "complaints" and "appeals."

"The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-661-632-1590** inside Bakersfield, or **1-800-391-2000** outside of Bakersfield and use your health plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for an IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms, and instructions online."

[1] Health and Safety Code (HSC) section 1368.02(b). HSC is searchable at: http://leginfo.legislature.ca.gov/faces/home.xhtml.

STATE HEARING

If you want a State Hearing, you must ask for one within 120 days from the date of this Notice of Appeal Resolution letter. However, if your health plan continued to provide you with the disputed service(s) (Aid Paid Pending) during the health plan's appeal process and you want the service(s) to continue until there is a decision on your State Hearing, you must request a State Hearing within 10 days of this Notice of Appeal Resolution letter. Even though your health plan must give you Aid Paid Pending when you ask for a State Hearing in this way, you should let your health plan know you want to get Aid Paid Pending until your State Hearing is decided. You should contact Kern Family Health Care between 8:00 a.m. to 5:00 p.m. by calling **(661) 632-1590** inside Bakersfield, or **1-800-391-2000** outside Bakersfield. If you cannot hear or speak well, please call **711**.

You can ask for a State Hearing in the following ways:

- Online at www.cdss.ca.gov

- By phone: Call 1-800-743-8525. This number can be very busy. You may get a message to call back later. If you cannot speak or hear well, please call TTY/TDD 1-800-952-8349.

- In writing: Fill out a State Hearing form or write a letter. Send it by mail or fax to:

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

  Fax: (916) 309-3487 or toll-free at 1-833-281-0903

  A State Hearing Form is included with this letter. Be sure to include your name, address, telephone number, Social Security Number and/or CIN number, and the reason you want a State Hearing. If someone is helping you ask for a State Hearing, add their name, address, and telephone number to the form or letter. If you need an interpreter, tell the State Hearings Division what language you speak. You will not have to pay for an interpreter. The State Hearings Division will get you one. If you have a disability, the State Hearings Division can get you special accommodations free of charge to help you participate in the hearing. Please include information about your disability and the accommodation you need.

After you ask for a State Hearing, it could take up to 90 days to decide your case and send you an answer. If you think waiting that long will hurt your health, you might be able to get an answer within 3 days. Ask your doctor or health plan to write a letter for you. The letter must explain in detail how waiting for up to 90 days for your case to be decided will seriously harm your life, your health, or your ability to attain, maintain, or

regain maximum function. Then, make sure you ask for an Expedited Hearing and provide the letter with your request for a hearing.

You may speak at the State Hearing yourself. Or, someone like a relative, friend, advocate, doctor, or attorney can speak for you. If you want another person to speak for you, then you must tell the State Hearings Division that the person is allowed to speak for you. This person is called an Authorized Representative.

LEGAL HELP

You may be able to get free legal help. Call the Greater Bakersfield Legal Assistance at (661) 325-5943. You may also call the local Legal Aid Society in your county at 1-888-804-3536.

Attachment E

Kern Family Health Care™

NONDISCRIMINATION NOTICE

Discrimination is against the law. Kern Family Health Care follows State and Federal civil rights laws. Kern Family Health Care does not unlawfully discriminate, exclude people, or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.

Kern Family Health Care provides:

- Free aids and services to people with disabilities to help them communicate better, such as:
  - ✓ Qualified sign language interpreters
  - ✓ Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Free language services to people whose primary language is not English, such as:
  - ✓ Qualified interpreters
  - ✓ Information written in other languages

If you need these services, contact Kern Family Health Care at 1-800-391-200 between 8:00am – 5:00pm, Monday through Friday. If you cannot hear or speak well, please call the California Relay Service at 711. Upon request, this document can be made available to you in braille, large print, audiocassette, or electronic form. To obtain a copy in one of these alternative formats, please call or write to:

Kern Family Health Care
2900 Buck Owens Boulevard
Bakersfield, CA 93308
1-800-391-2000
711 (**California Relay Service**)

HOW TO FILE A GRIEVANCE

If you believe that Kern Family Health Care has failed to provide these services or unlawfully discriminated in another way on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, you can file a grievance with Kern Family Health Care's Discrimination Grievance Coordinator. You can file a grievance by phone, in writing, in person, or electronically:

- By phone: Contact Kern Family Health Care's Discrimination Grievance Coordinator between 8:00am – 5:00pm, Monday through Friday by calling 1-800-391-2000. Or, if you cannot hear or speak well, please call the California Relay Service at 711.

- In writing: Fill out a complaint form or write a letter and send it to:

  Discrimination Grievance Coordinator
  Kern Family Health Care
  2900 Buck Owens Boulevard
  Bakersfield, CA 93308
- In person: Visit your doctor's office or Kern Family Health Care and say you want to file a grievance.

- Electronically: Visit Kern Family Health Care's website at www.kernfamilyhealthcare.com.

OFFICE OF CIVIL RIGHTS – CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

You can also file a civil rights complaint with the California Department of Health Care Services, Office of Civil Rights by phone, in writing, or electronically:

- By phone: Call **916-440-7370**. If you cannot speak or hear well, please call **711 (California Relay Service)**.

- In writing: Fill out a complaint form or send a letter to:

  Deputy Director, Office of Civil Rights
  Department of Health Care Services
  Office of Civil Rights
  P.O. Box 997413, MS 0009
  Sacramento, CA 95899-7413

  Complaint forms are available at http://www.dhcs.ca.gov/Pages/Language_Access.aspx.

- Electronically: Send an email to CivilRights@dhcs.ca.gov.

OFFICE OF CIVIL RIGHTS – U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

If you believe you have been discriminated against on the basis of race, color, national origin, age, disability or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by phone, in writing, or electronically:

- By phone: Call **1-800-368-1019**. If you cannot speak or hear well, please call **TTY/TDD 1-800-537-7697**.

- In writing: Fill out a complaint form or send a letter to:

  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201

  Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

- Electronically: Visit the Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

Kern Family Health Care™

TAGLINES

English Tagline

ATTENTION: If you need help in your language call 1-800-391-2000 (TTY: 711). Aids and services for people with disabilities, like documents in braille and large print, are also available. Call 1-800-391-2000 (TTY: 711). These services are free of charge.

الشعار بالعربية (Arabic)

يُرجى الانتباه: إذا احتجت إلى المساعدة بلغتك، فاتصل بـ 1-800-391-2000 (TTY: 711). تتوفر أيضًا المساعدات والخدمات للأشخاص ذوي الإعاقة، مثل المستندات المكتوبة بطريقة بريل والخط الكبير. اتصل بـ 1-800-391-2000 (TTY: 711). هذه الخدمات مجانية.

Հայերեն պիտակ (Armenian)

ՈՒՇԱԴՐՈՒԹՅՈՒՆ: Եթե Ձեզ օգնություն է հարկավոր Ձեր լեզվով, զանգահարեք 1-800-391-2000 (TTY: 711): Կան նաև օժանդակ միջոցներ ու ծառայություններ հաշմանդամություն ունեցող անձանց համար, օրինակ՝ Բրայլի գրատիպով ու խոշորատառ տպագրված նյութեր: Զանգահարեք 1-800-391-2000 (TTY: 711): Այդ ծառայություններն անվճար են:

ឃ្លាសម្គាល់ជាភាសាខ្មែរ (Cambodian)

ចំណាំ៖ បើអ្នក ត្រូវ ការជំនួយ ជាភាសា របស់អ្នក សូម ទូរស័ព្ទទៅលេខ 1-800-391-2000 (TTY: 711)។ ជំនួយ និង សេវាកម្ម សម្រាប់ ជនពិការ ដូចជាឯកសារសរសេរជាអក្សរផុស សម្រាប់ជនពិការភ្នែក ឬឯកសារសរសេរជាអក្សរពុម្ពធំ ក៏អាចរកបានផងដែរ។ ទូរស័ព្ទមកលេខ 1-800-391-2000 (TTY: 711)។ សេវាកម្មទាំងនេះមិនគិតថ្លៃឡើយ។

简体中文标语 (Chinese)

请注意：如果您需要以您的母语提供帮助，请致电 1-800-391-2000 (TTY: 711)。另外还提供针对残疾人士的帮助和服务，例如文盲和需要较大字体阅读，也是方便取用的。请致电 1-800-391-2000 (TTY: 711)。这些服务都是免费的。

مطلب به زبان فارسی (Farsi)

توجه: اگر می‌خواهید به زبان خود کمک دریافت کنید، با 1-800-391-2000 (TTY: 711) تماس بگیرید. کمک‌ها و خدمات مخصوص افراد دارای معلولیت، مانند نسخه‌های خط بریل و چاپ با حروف بزرگ، نیز موجود است. با 1-800-391-2000 (TTY: 711) تماس بگیرید. این خدمات رایگان ارائه می‌شوند.

हिंदी टैगलाइन (Hindi)
ध्यान दें: अगर आपको अपनी भाषा में सहायता की आवश्यकता है तो 1-800-391-2000 (TTY: 711) पर कॉल करें। अशक्तता वाले लोगों के लिए सहायता और सेवाएं, जैसे ब्रेल और बड़े प्रिंट में भी दस्तावेज़ उपलब्ध हैं। 1-800-391-2000 (TTY: 711) पर कॉल करें। ये सेवाएं नि: शुल्क हैं।

Nqe Lus Hmoob Cob (Hmong)
CEEB TOOM: Yog koj xav tau kev pab txhais koj hom lus hu rau 1-800-391-2000 (TTY: 711). Muaj cov kev pab txhawb thiab kev pab cuam rau cov neeg xiam oob qhab, xws li puav leej muaj ua cov ntawv su thiab luam tawm ua tus ntawv loj. Hu rau 1-800-391-2000 (TTY: 711). Cov kev pab cuam no yog pab dawb xwb.

日本語表記 (Japanese)
注意日本語での対応が必要な場合は 1-800-391-2000 (TTY: 711)へお電話ください。点字の資料や文字の拡大表示など、障がいをお持ちの方のためのサービスも用意しています。 1-800-391-2000 (TTY: 711)へお電話ください。これらのサービスは無料で提供しています。

한국어 태그라인 (Korean)
유의사항: 귀하의 언어로 도움을 받고 싶으시면 1-800-391-2000 (TTY: 711) 번으로 문의하십시오. 점자나 큰 활자로 된 문서와 같이 장애가 있는 분들을 위한 도움과 서비스도 이용 가능합니다. 1-800-391-2000 (TTY: 711) 번으로 문의하십시오. 이러한 서비스는 무료로 제공됩니다.

ແທກໄລພາສາລາວ (Laotian)
ປະກາດ: ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໃຫ້ໂທຫາເບີ 1-800-391-2000 (TTY: 711). ຍັງມີຄວາມຊ່ວຍເຫຼືອແລະການບໍລິການສໍາລັບຄົນພິການ
ເຊັ່ນເອກະສານທີ່ເປັນອັກສອນນູນແລະມີໂຕພິມໃຫຍ່ ໃຫ້ໂທຫາເບີ
1-800-391-2000 (TTY: 711). ການບໍລິການເຫຼົ່ານີ້ບໍ່ຕ້ອງເສຍຄ່າໃຊ້ຈ່າຍໃດໆ.

Mien Tagline (Mien)
LONGC HNYOUV JANGX LONGX OC: Beiv taux meih qiemx longc mienh tengx faan benx meih nyei waac nor douc waac daaih lorx taux 1-800-391-2000 (TTY: 711). Liouh lorx jauv-louc tengx aengx caux nzie gong bun taux ninh mbuo wuaaic fangx mienh, beiv taux longc benx nzangc-pokc bun hluo mbiutc aengx caux aamz mborqv benx domh sou se mbenc nzoih bun longc. Douc waac daaih lorx 1-800-391-2000 (TTY: 711). Naaiv deix nzie weih gong-bou jauv-louc se benx wang-henh tengx mv zuqc cuotv nyaanh oc.

ਪੰਜਾਬੀ ਟੈਗਲਾਈਨ (Punjabi)
ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਕਾਲ ਕਰੋ 1-800-391-2000 (TTY: 711). ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ, ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਅਤੇ ਮੋਟੀ ਛਪਾਈ ਵਿੱਚ ਦਸਤਾਵੇਜ਼, ਵੀ ਉਪਲਬਧ ਹਨ| ਕਾਲ ਕਰੋ 1-800-391-2000 (TTY: 711). ਇਹ ਸੇਵਾਵਾਂ ਮੁਫਤ ਹਨ|

Русский слоган (Russian)
ВНИМАНИЕ! Если вам нужна помощь на вашем родном языке, звоните по номеру 1-800-391-2000 (линия TTY: 711). Также предоставляются средства и услуги для людей с ограниченными возможностями, например документы крупным шрифтом или шрифтом Брайля. Звоните по номеру 1-800-391-2000 (линия TTY: 711). Такие услуги предоставляются бесплатно.

Mensaje en español (Spanish)
ATENCIÓN: si necesita ayuda en su idioma, llame al 1-800-391-2000 (TTY: 711). También ofrecemos asistencia y servicios para personas con discapacidades, como documentos en braille y con letras grandes. Llame al 1-800-391-2000 (TTY: 711). Estos servicios son gratuitos.

Tagalog Tagline (Tagalog)
ATENSIYON: Kung kailangan mo ng tulong sa iyong wika, tumawag sa 1-800-391-2000 (TTY: 711). Mayroon ding mga tulong at serbisyo para sa mga taong may kapansanan,tulad ng mga dokumento sa braille at malaking print. Tumawag sa 1-800-391-2000 (TTY: 711). Libre ang mga serbisyong ito.

แท็กไลน์ภาษาไทย (Thai)
โปรดทราบ: หากคุณต้องการความช่วยเหลือเป็นภาษาของคุณ กรุณาโทรศัพท์ไปที่หมายเลข 1-800-391-2000 (TTY: 711) นอกจากนี้ ยังพร้อมให้ความช่วยเหลือและบริการต่าง ๆ สำหรับบุคคลที่มีความพิการ เช่น เอกสารต่าง ๆ ที่เป็นอักษรเบรลล์และเอกสารที่พิมพ์ด้วยตัวอักษรขนาดใหญ่ กรุณาโทรศัพท์ไปที่หมายเลข 1-800-391-2000 (TTY: 711) ไม่มีค่าใช้จ่ายสำหรับบริการเหล่านี้

Примітка українською (Ukrainian)
УВАГА! Якщо вам потрібна допомога вашою рідною мовою, телефонуйте на номер 1-800-391-2000 (TTY: 711). Люди з обмеженими можливостями також можуть скористатися допоміжними засобами та послугами, наприклад, отримати документи, надруковані шрифтом Брайля та великим шрифтом. Телефонуйте на номер 1-800-391-2000 (TTY: 711). Ці послуги безкоштовні.

Khẩu hiệu tiếng Việt (Vietnamese)
CHÚ Ý: Nếu quý vị cần trợ giúp bằng ngôn ngữ của mình, vui lòng gọi số 1-800-391-2000 (TTY: 711). Chúng tôi cũng hỗ trợ và cung cấp các dịch vụ dành cho người khuyết tật, như tài liệu bằng chữ nổi Braille và chữ khổ lớn (chữ hoa). Vui lòng gọi số 1-800-391-2000 (TTY: 711). Các dịch vụ này đều miễn phí.

Attachment G

State of California - Health and Human Services Agency
Department of Managed Health Care
IMR APPLICATION/COMPLAINT FORM - ENGLISH
DMHC 20-224 New: 11/15 Rev: 01/23

INDEPENDENT MEDICAL REVIEW (IMR) APPLICATION/COMPLAINT FORM

IMPORTANT INFORMATION

You can submit your IMR Application/Complaint Form online at: www.HealthHelp.ca.gov

- **FREE:** The IMR/Complaint process is free.
- **FAST:** IMRs are usually decided within 45 days, or within 7 days if the health issue is urgent.
- **SUCCESSFUL:** Approximately **68** percent of patients receive the requested service through IMR.
- **FINAL:** Health plans must follow the IMR decision and promptly provide the service.

PATIENT INFORMATION

First Name _____ Middle Initial __ Last Name _____

Patient's Date of Birth (mm/dd/yyyy) _____

Gender: ☐ Male ☐ Female ☐ Something Else _____

Name of Parent or Guardian if Filing for Minor Child _____

Street Address _____

City _____ State _____ Zip _____

Phone # _____ Email Address _____

Would you like communication/correspondence sent to this email? ☐ Yes ☐ No

Health Plan Name _____ Patient's Membership # _____

Medical Group Name (if enrolled in a medical group) _____

Employer _____

Do you want someone to help you with your complaint? ☐ Yes ☐ No

If yes, please complete the attached 'Authorized Assistant Form.'

Do you have Medi-Cal? ☐ Yes ☐ No

If yes, have you filed a Request for a State Fair Hearing? ☐ Yes ☐ No

Do you have Medicare or Medicare Advantage? ☐ Yes ☐ No

Have you filed a complaint or grievance with your health plan? ☐ Yes ☐ No

Do you want payment for a health care service that you already received? ☐ Yes ☐ No

If yes, list the date(s) of service, and the provider's name:

_____

YOUR HEALTH PROBLEM

(Use a separate sheet and attach other documents, if needed.)

Do you want your health plan to pay for future services? ☐ Yes ☐ No

What is your medical condition or doctor's diagnosis (Please be specific) _____

What medical treatment(s)/service(s) and/or medication(s) are you asking for? (Please be specific)

_____

Did your health plan deny, delay or modify your treatment? ☐ Yes ☐ No

If yes, please check the reason given: (Check one)

☐ Not Medically Necessary ☐ Experimental or Investigational ☐ Not an Emergency/Urgent
☐ Not an Emergency/Urgent ☐ Other (Please explain below)

_____

List the name and phone number of your primary care doctor and other providers who have seen, treated, or advised you for this condition.

_____

Have you seen any out-of-network providers for your condition? ☐ Yes ☐ No

If yes, please include the medical records with this form.

Briefly describe the problem you are having with your plan. For example, explain if the problem is a denied treatment, an unpaid bill, trouble getting an appointment or medication, or if your coverage has been cancelled by the health plan.

MEDICAL RELEASE

I request the Department of Managed Health Care (Department) to make a decision about my problem with my health plan. I request the Department to review my Independent Medical Review (IMR) Application/Complaint Form to determine if my complaint qualifies for an IMR or the Department's Complaint process. I allow my providers, past and present, and my plan to release my medical records and information to review this issue. These records may include medical, mental health, substance abuse, HIV, diagnostic imaging reports, and other records related to my case. These records may also include non-medical records and any other information related to my case. I allow the Department to review these records and information and send them to my plan. My permission will end one year from the date below, except as allowed by law. For example, the law allows the Department to continue to use my information internally. I can end my permission sooner if I wish. All the information that I have provided on this sheet is true.

Patient or Parent Name (Print) _____

Patient or Parent Signature _____ Date _____

Please see the instruction sheet for mailing or faxing information.

STATISTICAL INFORMATION ONLY

You are asked to voluntarily provide the following information. Giving this information will help the Department identify any patterns of problems. Health and Safety Code section 1374.30 authorizes the Department to obtain this information for research and statistical purposes. Giving this information is optional and will not affect the IMR or complaint decision in any way.

Primary Language Spoken: _____

Would you like us to communicate/correspond with you in your primary language? ☐ Yes

Race/Ethnicity: _____

State of California - Health and Human Services Agency
Department of Managed Health Care
AUTHORIZED ASSISTANT FORM - English
DMHC 20-160 New: 04/06 Rev: 01/20

AUTHORIZED ASSISTANT FORM

- If you want to give another person permission to assist you with your Independent Medical Review (IMR) or complaint, complete Parts A and B below.
- If you are a parent or legal guardian filing this IMR or complaint for a child under the age of 18, you do not need to complete this form.
- If you are filing this IMR or complaint for a patient who cannot complete this form because the patient is either incompetent or incapacitated, and you have legal authority to act for this patient, please complete Part B only. Also attach a copy of the power of attorney for health care decisions or other documents that say you can make decisions for the patient.

PART A: COMPLETED BY PATIENT

I allow the person named below in Part B to assist me in my IMR or complaint filed with the Department of Managed Health Care (Department). I allow the Department and IMR staff to share information about my medical condition(s) and care with the person named below. This information may include mental health treatment, HIV treatment or testing, alcohol or drug treatment, or other health care information.

I understand that only information related to my IMR or complaint will be shared.

My approval of this assistance is voluntary and I have the right to end it. If I want to end it, I must do so in writing.

Patient Name (Print)_____

Patient Signature_____ Date_____

PART B: COMPLETED BY PERSON ASSISTING PATIENT

Name of Person Assisting (Print)_____

Address_____

City_____ State_____ Zip_____

Relationship to Patient_____

Primary Phone #_____ Secondary Phone #_____

Email Address_____

☐ My power of attorney for health care decisions or other legal document is attached.

IMR Application/Complaint Form Instruction Sheet

If you have questions, call the Help Center at 1-888-466-2219 or TDD at 1-877-688-9891. This call is free.

Before You File:

In most cases, you must complete your plan's complaint or grievance process before you file a complaint or IMR request to the Department. Your plan must give you a decision within 30 days or within 3 days if your problem is an immediate and serious threat to your health.

If your plan denied your treatment because it was experimental/investigational, you do not have to take part in your plan's complaint or grievance process before you file an IMR application.

You must apply for an IMR within six months after your health plan sends you a written response to your appeal. The Department may accept your application after six months if it is determined that circumstances prevented timely submission. Please be aware that if you decide not to file a complaint with the DEPARTMENT for an issue that would qualify for an IMR, you may be giving up your rights to pursue legal action against your plan regarding the service or treatment you are requesting.

How to File:

1. File online at www.HealthHelp.ca.gov. [This is the fastest way.]
   OR
   Fill out and sign the IMR Application/Complaint Form.
2. If you want someone to help you with your IMR or complaint, complete the 'Authorized Assistant Form.'
3. If you have medical records from ***out of network*** *providers*, please include them with your IMR Application/Complaint Form. Your plan will provide medical records from network providers.
4. You may include other documents that support your request. However, there is no need to provide any documents or correspondence between you and your plan relating to this complaint. The Department will obtain this information directly from your plan as part of the investigation.
5. If you are not submitting online, please mail or fax your form and any supporting documents to:

   Department of Managed Health Care Help Center
   980 9th Street, Suite 500
   Sacramento, CA 95814-2725
   FAX: 916-255-5241

What Happens Next?

The Help Center will send you a letter within seven days telling you if you qualify for an IMR. If it is determined that your complaint qualifies for an IMR, your case is assigned to a state contractor who will perform the review. The state contractor is also known as the Independent Medical Review Organization (IMRO). All of the information in the Help Center's possession related to your complaint, including your medical records, will be sent to the IMRO. The IMRO will make a decision usually within 30 days or within seven days if your case is urgent. You will be notified in writing of the decision.

If it is determined that your complaint should be reviewed through the Consumer Complaint process, a decision about your issue will be made within 30 days. You will be notified in writing of the decision.

IMR Application/Complaint Form Instruction Sheet

The Information Practices Act of 1977 (California Civil Code Section 1798.17) requires the following notice.

- California's Knox-Keene Act gives the Department the authority to regulate health plans and investigate the complaints of health plan members.
- The Department's Help Center uses your personal information to investigate your problem with your plan and to provide an IMR if you qualify for one.
- You provide the Department this information voluntarily. You do not have to provide this information. However, if you do not, the Department may not be able to investigate your complaint or provide an IMR.
- The Department may share your personal information, as needed, with the plan and providers who conduct the IMR.
- The Department may also share your information with other government agencies as required or allowed by law.
- You have a right to see your personal information. To do this, contact the Department Records Request Coordinator, Department of Managed Health Care, Office of Legal Services, 980 9th Street Suite 500, Sacramento CA 95814-2725, or call 916-322-6727.

Attachment G

State of California - Health and Human Services Agency
Department of Managed Health Care
IMR APPLICATION/COMPLAINT FORM - SPANISH
DMHC 20-224 New: 11/15 Rev: 01/23

Formulario de queja/solicitud de revisión médica independiente (IMR)

INFORMACIÓN IMPORTANTE

Puede presentar su formulario de queja/solicitud de IMR en línea en:

www.HealthHelp.ca.gov

- **GRATIS:** El proceso de solicitud de IMR y de presentación de quejas de parte de los consumidores es gratis.
- **RÁPIDO:** Las IMR generalmente se deciden dentro de 45 días o dentro de 7 días si el asunto de salud es urgente.
- **EXITOSO:** Aproximadamente el **68 por ciento** de los pacientes reciben el servicio solicitado a través de una IMR.
- **DEFINITIVO:** Los planes de salud deben acatar la decisión de la IMR y proveer el servicio con prontitud.

INFORMACIÓN DEL PACIENTE

Nombre_____ Inicial del segundo nombre____ Apellido_____

Fecha de nacimiento del paciente (mm/dd/aaaa)_____

Género: ☐ Masculino ☐ Femenino ☐ Algo Más_____

Nombre del padre o tutor si el solicitante es menor de edad_____

Dirección_____

Ciudad_____ Estado_____ Código postal_____

Teléfono _____ Correo electrónico_____

¿Desea que le envíen mensajes/correspondencia a este correo electrónico? ☐ Sí ☐ No

Nombre del plan de salud_____ Núm. de membresía del paciente_____

Nombre del grupo médico (si está en uno)_____

Empleador_____

¿Desea que alguien lo ayude con su queja? ☐ Sí ☐ No

De ser así, llene el 'Formulario de asistente autorizado' adjunto.

¿Desea recibir un pago por un servicio de atención médica que ya recibió? ☐ Sí ☐ No

De ser así, anote la(s) fecha(s) de servicio y el nombre del proveedor:

_____

SU PROBLEMA DE SALUD **(**Use una hoja aparte y adjunte otros documentos de ser necesario)

¿Desea que su plan de salud pague servicios futuros? ☐ Sí ☐ No
¿Cuál es su condición médica o el diagnóstico del doctor? (sea específico)_____
¿Qué tratamiento(s)/servicio(s) o medicamento(s) está pidiendo? (sea específico)

_____

¿Su plan de salud le negó, retrasó o modificó su tratamiento?
Si fue así, marque la razón que le dieron: (marque una opción):

☐ No es medicamente necesario
☐ No es una emergencia/no es urgente
☐ Es experimental o de investigación
☐ No es un beneficio cubierto
☐ Otro (explicar a continuación)

_____

Anote el nombre y el teléfono de su doctor de atención primaria y de otros proveedores que lo hayan visto, tratado o informado de su condición.

_____

¿Ha visto a proveedores que no están dentro de su red en relación con esta condición? ☐ Sí ☐ No
De ser así, incluya los registros médicos con este formulario.

Describa brevemente el problema que tiene con su plan de salud. Por ejemplo, explique si es el problema es acerca de un tratamiento denegado, una factura no pagada, problemas para obtener una cita o medicamento, o si el plan de salud canceló su cobertura.

Divulgación de información médica

Solicito al Departamento de Atención Administrada de la Salud (Departamento) que tome una decisión acerca del problema que tengo con mi plan de salud. Solicito al Departamento que revise mi formulario de queja/solicitud de revisión médica independiente para que determine si mi queja reúne los requisitos para una IMR o para el proceso de queja del consumidor del Departamento. Autorizo a mis proveedores, pasados y presentes, y a mi plan a divulgar mi información y registros médicos para que revisen este asunto. Estos registros podrían incluir informes médicos, de salud mental, abuso de sustancias, VIH, diagnóstico por imágenes y otros registros relacionados con mi caso. Estos registros podrían también incluir registros no médicos y cualquier información relacionada con mi caso. Autorizo al Departamento a que revise estos registros e información y a que los envíe a mi plan. Mi autorización caducará en un año a partir de la fecha que se indica a continuación, a excepción de lo que permita la ley. Por ejemplo, la ley permite al Departamento continuar usando mi información internamente. Puedo revocar mi autorización más pronto si así lo deseo. Toda la información que proporcioné en esta hoja es verdadera.

Nombre del paciente o padre (en letra de molde) _____

Firma del paciente o padre_____ **Fecha**_____

Consulte la hoja de instrucciones para obtener la información para el envío por correo o fax.

PARA INFORMACIÓN ESTADÍSTICA

Se le pide que proporcione la siguiente información de manera voluntaria. Proporcionar esta información ayudará al Departamento a identificar cualquier patrón de los problemas. El artículo 1374.30 del Código de Salud y Seguridad (Health and Safety Code) autoriza al Departamento a que obtenga esta información para fines de investigación y estadística. Proporcionar esta información es opcional y no afectará de ninguna manera la decisión sobre la IMR o la queja.

Idioma principal que habla:_____

¿Desea que nos comuniquemos con usted/le enviemos mensajes en su idioma principal? Sí ☐

Raza/origen étnico:_____

State of California
Health and Human Services Agency
Department of Managed Health Care
AUTHORIZED ASSISTANT FORM – SPANISH
DMHC 20-160 New: 04/06 Rev: 01/20

FORMULARIO DE ASISTENTE AUTORIZADO

- Si desea dar permiso a otra persona para que lo asista con su queja o revisión médica independiente (Independent Medical Review, IMR), llene las partes A y B a continuación
- Si es un padre o tutor legal que presenta este formulario de queja/IMR en nombre de un menor de 18 años, no necesita llenar este formulario.
- Si presenta esta queja o solicitud de IMR en nombre de un paciente que no puede llenar este formulario debido a que es incompetente o tiene una discapacidad, y si usted tiene autoridad legal para actuar en nombre de este paciente, llene la parte B solamente. Además, adjunte una copia de la carta poder para tomar decisiones de atención de salud u otros documentos que digan que usted puede tomar decisiones en nombre del paciente.

PARTE A: COMPLETADA POR EL PACIENTE

Autorizo a la persona mencionada en la parte B a continuación para que me asista con la queja o solicitud de IMR que presenté ante el Departamento de Atención Administrada de la Salud (Departamento). Autorizo al personal del Departamento y la IMR a que compartan la información sobre mi(s) condición(es) y atención médicas con la persona mencionada a continuación. Esta información podría incluir tratamientos de salud mental, tratamientos y pruebas de VIH, tratamientos de alcoholismo o drogadicción u otra información de atención de salud.

Entiendo que sólo se compartirá la información relacionada con mi queja o IMR.

Mi autorización para esta asistencia es voluntaria y tengo derecho a anularla. Si deseo anularla, tengo que hacerlo por escrito.

Nombre del paciente (en letra de molde) _____

Firma del paciente_____ Fecha_____

PARTE B: COMPLETADA POR LA PERSONA QUE ASISTE AL PACIENTE

Nombre de la persona que asiste al paciente (en letra de molde)_____

Dirección_____

Ciudad_____Estado_____Código postal_____

Relación con el paciente_____

Teléfono principal _____

Teléfono secundario _____

Correo electrónico _____

☐ Mi carta poder para tomar decisiones de atención de salud u otro documento legal está incluida.

FORMULARIO DE QUEJA/SOLICITUD DE REVISIÓN MÉDICA INDEPENDIENTE

Si tiene preguntas, llame al Departamento al 1-888-466-2219 o TDD al 1-877-688-9891. La llamada es gratuita.

Antes de presentar el formulario:

En la mayoría de los casos, debe agotar el proceso de quejas o reclamaciones de su plan de salud antes de presentar una queja o solicitud de IMR ante el Departamento. Su plan de salud debe proporcionarle una decisión en un plazo de 30 días o de 3 días en caso de que su problema represente una amenaza seria e inmediata para su salud.

Si su plan de salud le negó el tratamiento debido a que era experimental/de investigación, usted no debe participar en el proceso de quejas o reclamaciones de su plan de salud antes de presentar una solicitud de IMR.

Debe solicitar una IMR dentro de un plazo de seis meses a partir de que su plan de salud le envíe una respuesta por escrito referente a su apelación. Usted todavía puede presentar su solicitud después de seis meses si hubo circunstancias especiales que evitaron que la presentara de forma oportuna. Tenga en cuenta que, si decide no presentar una queja ante el Departamento por un asunto que reúne los requisitos para una IMR, podría renunciar a su derecho a emprender acciones legales contra su plan en relación con el servicio o tratamiento que está solicitando.

Cómo presentar el formulario:

1) Preséntelo en línea en www.HealthHelp.ca.gov. **Esta es la manera más rápida.**
   o
   Llene y firme el formulario de queja/solicitud de IMR. Use el sobre que viene con el formulario.

2) Si desea que alguien lo ayude con su queja o IMR, llene el 'Formulario de asistente autorizado'. Tanto usted como su asistente autorizado deben firmar el formulario.
3) Si tiene registros médicos de proveedores ***fuera de la red***, inclúyalos con su formulario de queja/solicitud de IMR. Su plan proveerá los registros médicos de los proveedores dentro de la red.
4) Puede incluir otros documentos que apoyen su solicitud. Sin embargo, no es necesario proveer ningún documento o carta entre usted y su plan en relación con su queja. El Departamento obtendrá esta información directamente de su plan como parte de la investigación.
5) Si no hace su presentación en línea, envíe su formulario y todos los documentos de apoyo por correo postal o fax a:
   Department of Managed Health Care Help Center
   980 9th Street Suite 500
   Sacramento CA 95814-2725
   FAX: 916-255-5241

¿Qué sucederá a continuación?

El Departamento determinará si su caso reúne los requisitos para una IMR o una queja. Un caso reúne los requisitos para una IMR si los servicios de atención médica se retrasaron, modificaron o denegaron con base en una necesidad médica o por ser experimentales/de investigación.

Los casos que no reúnen los requisitos para una IMR se procesan a través del proceso de queja del consumidor. Estos casos implican asuntos como la negación de un servicio de atención médica por no ser un beneficio cubierto, las disputas por el pago de una reclamación, la cancelación de la cobertura, la calidad de la atención y el deducible/los gastos de bolsillo. El Departamento le enviará una carta dentro de un plazo de siete días informándole si reúne los requisitos para una IMR. Si el Departamento decide que su queja reúne los requisitos para una IMR, su caso se asignará a un contratista estatal que llevará a cabo la revisión. Al contratista estatal también se le conoce como una organización de revisión médica independiente. Toda la información que el Centro de Ayuda ha relacionado con su queja, incluyendo sus registros médicos, se enviará a la organización de revisión. La organización de revisión tomará una decisión, generalmente dentro de un plazo de 45 días o dentro de siete días si su caso es urgente. El Departamento le enviará una carta con la decisión.

Si el Departamento decide que su queja debe revisarse mediante el proceso de Queja del Consumidor, se tomará una decisión acerca de su asunto dentro de un plazo de 30 días. El Departamento le enviará una carta con la decisión.

La Ley de Prácticas Informativas (Information Practices Act) de 1977 (artículo 1798.17 del Código Civil de California) requiere que se haga la siguiente notificación.

- La Ley Knox-Keene de California otorga al Departamento la autoridad para que regule los planes de salud e investigue las quejas de los miembros de los planes de salud.
- El Centro de Ayuda del Departamento usa su información personal para investigar el problema que tiene con su plan de salud y para concederle una IMR si reúne los requisitos para una.
- Usted proporciona esta información al Departamento de manera voluntaria. Usted no tiene que proporcionar esta información. Sin embargo, si no lo hace, el Departamento podría ser incapaz de investigar su queja o concederle una IMR.
- El Departamento podría compartir su información personal, según sea necesario, con el plan, los proveedores y la organización de revisión que lleva a cabo la IMR.
- El Departamento podría también compartir su información con otras agencias gubernamentales como lo exija o permita la ley.
- Usted tiene derecho a ver su información personal. Para hacerlo, comuníquese con el Coordinador de Solicitudes de Registros del Departamento, Department of Managed Health Care, Office of Legal Services, 980 9th Street Suite 500, Sacramento CA 95814-2725, o llame a 916-322-6727.