Grievances and Appeals

L.A. Care Health Plan

Please read carefully.

Complaints: What should I do if I am unhappy?

If you are not happy, are having problems, or have questions about the service or care given to you, you have the option of letting your PCP know. Your PCP may be able to help you or answer your questions. However, you may file a grievance with L.A. Care at any time and do not have to contact your PCP before filing a grievance with L.A. Care.

What is a grievance?

A grievance is a complaint. This complaint is written down and tracked. You might be unhappy with the health care services you get or how long it took to get a service, and have the right to complain.

Some examples are complaints about:

- The service or care your PCP or other providers give you:
- The service or care your PCP's medical group gives you
- The service or care your pharmacy gives you
- The service or care your hospital gives you
- The service or care L.A. Care gives you

You have the right to file an urgent grievance with DMHC without filing a grievance with L.A. Care. For information on how to file a grievance with DMHC, go to "Review by the Department of Managed Health Care (DMHC)" section.

How to File a Grievance

You have many ways to file a grievance. You can do any of the following:

Write, visit or call L.A. Care. You may also file a grievance online in English or in Spanish through L.A. Care's Website at www.lacarecovered.org. Please contact L.A. Care as listed below if you need a grievance form in a language other than Spanish or English, or in another format (large print or audio).

L.A. Care Health Plan
Member Services Department
1055 W. 7th Street, 10th Floor
Los Angeles, CA 90017
1-855-270-2327TTY Service: 1-855-576-1620
www.lacarecovered.org

Fill out a grievance form at your doctor's office

L.A. Care can help you fill out the grievance form over the phone or in person. If you need interpreter services, we will work with you to make sure we can communicate with you in a language you understand.

For Members with hearing or speech loss, you may call L.A. Care's TTY telephone number for Member Services at 1-866-522-2731. You may call the TTY/TDD Statewide access number at 1-888-877-5379 (Sprint) or 1-800-735-2922 voice (MCI). Members and providers can also dial 711 on their phones to call the California Relay Service directly.

Within five calendar days of receiving your grievance, you will get a letter from L.A. Care saying we have your grievance and are working on it. Then, within 30 calendar days of receiving your grievance, L.A. Care will send you a letter explaining how the grievance was resolved.

Filing a grievance does not affect your medical benefits. If you file a grievance you may be able to continue a medical service while the grievance is being resolved. To find out more about continuing a medical service, call L.A. Care.

Review by the Department of Managed Health Care

The California Department of Managed Health Care (DMHC) is responsible for regulating health care service plans. If you have a grievance against L.A. Care Health Plan, you should first telephone L.A. Care Health Plan at 1-855-270-2327 (TTY for the hearing impaired at 1-855-576-1620) and use L.A. Care Health Plan's grievance process before contacting the DMHC. Using this grievance procedure does not prohibit any 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 L.A. Care Health Plan, or a grievance that has remained unresolved for more than 30 days, you may call the DMHC 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 view 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 and urgent medical services. The Department of Managed Health Care has a toll-free telephone, 1-888-HMO-2219, to receive complaints regarding health plans. The hearing and speech impaired may use the department's TTY line (1-877-688-9891) to contact DMHC. DMHC's Internet website (http://www.hmohelp.ca.gov) has complaint forms, IMR application forms and instructions online.

L.A. Care Health Plan's grievance process and DMHC's complaint review process are in addition to any other dispute resolution procedures that may be available to you, and your failure to use these processes does not preclude your use of any other remedy provided by law.

Appeals Process

How to file an Appeal for health care services denied or delayed as not medically necessary
If you believe a health care service has been wrongly denied, changed, or delayed by L.A. Care because it was found not medically necessary, you may file an appeal. This is known as a disputed health care service.

Within five calendar days of receiving your appeal, you will get a letter from L.A. Care saying we have received your appeal and that we are working on it. The letter will also let you know the name of the person

working on your appeal. Then, within 30 calendar days you will receive a letter explaining how the appeal was resolved.

Filing an appeal does not affect your medical benefits. If you file an appeal you may be able to continue a medical service while the appeal is being resolved. To find out more about continuing a medical service, call L.A. Care.

How to File an Appeal for Urgent Cases

Examples of urgent cases include:

- Severe pain
- Potential loss of life, limb or major bodily function
- Immediate and serious deterioration of your health

In urgent cases, you can request an "expedited review" of your grievance. You will receive a call and/or a letter about your grievance within 24 hours. A decision will be made by L.A. Care within three calendar days (or 72 hours) from the day your grievance was received.

Making an Appeal

If we make a decision and you are not satisfied with this decision, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a decision we have made.

How to make an Appeal

Step 1: Contact our Plan and make your appeal. If your health requires a quick response, you must ask for an "expedited appeal".

When we are using standard deadlines, we must give you our answer within 30 days after we receive your appeal. We will give you our answer sooner if your health requires us to do so.

- To start an appeal, you, your representative, or in some cases your doctor must contact our Plan.
- If you are asking for a standard appeal, make your standard appeal in writing by submitting a signed request.
- If you are asking for an "expedited appeal", make your appeal in writing or call us at Member Services: 1-855-270-2327 (TTY/TDD 1-855-576-1620). L.A. Care Covered™ representatives are available 24 hours a day, 7 days a week, including holidays.
- You must make your appeal request within 60 calendar days from the date on the written notice we sent to you our answer to your grievance.
- You can ask for a copy of information regarding your medical decision and add more information to support your appeal.
- If you are appealing a decision our Plan made about coverage for care you have not yet received, you and/or your doctor will need to decide if you need an "expedited appeal". If your doctor tells us that your health requires an "expedited appeal", we will give you a fast appeal.

Step 2: Our Plan considers your appeal and we give you our answer.

When we are using the expedited deadlines, we must give you our answer within 72 hours after we receive your appeal. We will give you our answer sooner if your health requires us to do so.

- When our Plan is reviewing your appeal we take another careful look at all of the information about your request for coverage of medical care. We check to see if we were following rules when we said no to your request.
- If our answer is yes to part or all of what you requested, we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- If our answer is no to part or all of what you requested, we will send you a written denial notice informing you that we have automatically sent your appeal to the Independent Review Organization

If you don't agree with the decision made on your appeal

If you don't agree with the decision made on your appeal, you may request a State Fair Hearing and file a grievance with the DMHC. You can also file a grievance with the DMHC if you do not hear from L.A. Care Health Plan within thirty (30) calendar days. You may also request an Independent Medical Review (IMR) with the DMHC.

When to File an Independent Medical Review (IMR)

You may file an IMR if you meet the following requirements:

- Your doctor says you need a health care service because it is medically necessary and it is denied; or
- You received urgent or emergency services determined to be necessary and they were denied; or
- You have seen a network doctor for the diagnosis or treatment of the medical condition, even if the health care services were not recommended.
- The disputed health care service is denied, changed or delayed by L.A. Care based in whole or in part on a decision that the health care service is not medically necessary, and/or
- You have filed a grievance with L.A. Care and the health care service is still denied, changed, delayed or the grievance remains unresolved after 30 days.

You must first go through the L.A. Care grievance process, before applying for an IMR. In special cases, the DMHC may not require you to follow the L.A. Care grievance process before filing an IMR.
The dispute will be submitted to a DMHC medical specialist if it is eligible for an IMR. The specialist will make an independent decision on whether or not the care is medically necessary. You will receive a copy of the IMR decision from DMHC. If it is decided that the service is medically necessary, L.A. Care will provide the health care service.

You may request an Independent Medical Review (IMR) from DMHC. You have up to six months from the date of denial to file an IMR. You will receive information on how to file an IMR with your denial letter. You may reach DMHC toll-free at 1-888-HMO-2219 or 1-888-466-2219.

There are no fees for an IMR. You have the right to provide information to support your request for an IMR. After the IMR application is submitted, a decision not to take part in the IMR process may cause you to lose certain legal rights to pursue legal action against the plan.

Non-urgent cases

For non-urgent cases, the IMR decision must be made within 30 days. The 30-day period starts when your application and all documents are received by DMHC.

Urgent cases

If your grievance is urgent and requires fast review, you may bring it to DMHC's attention right away. You will not be required to participate in the health plan grievance process.

For urgent cases the IMR decision must be made within three calendar days from the time your information is received.

Examples of urgent cases include:

- Severe pain
- Potential loss of life, limb or major bodily function
- Immediate and serious deterioration of your health

Independent Medical Review for Denials of Experimental/ Investigational Therapies
You may also be entitled to an Independent Medical Review, through the Department of Managed Health Care, when we deny coverage for treatment we have determined to be experimental or investigational.

- We will notify you in writing of the opportunity to request an Independent Medical Review of a decision denying an experimental/ investigational therapy within five (5) business days of the decision to deny coverage.
- You are not required to participate in L.A. Care Health Plan's grievance process prior to seeking an Independent Medical Review of our decision to deny coverage of an experimental/ investigational therapy.
- If a physician indicates that the proposed therapy would be significantly less effective if not promptly initiated, the Independent Medical Review decision shall be rendered within seven (7) days of the completed request for an expedited review.