Appeals & Grievances Process

PROCEDURES FOR COMPLAINTS, GRIEVANCES, REQUESTS FOR RECONSIDERATION, APPEALS AND INDEPENDENT MEDICAL REVIEW

These procedures are established to safeguard the Member's right to have Medically Necessary treatment, as covered by this Agreement, for himself/herself and covered Dependents, that is accessible, safe, effective, affordable and delivered in the least restrictive environment consistent with applicable professional standards for achieving these objectives.

As a condition of enrollment and a contractual term of the Agreement and the Evidence of Coverage, Members are required to submit all Grievances through MHN's internal grievance procedures. MHN's internal grievance procedures, as specified below, are required to be completed before the Member may file for arbitration to receive a final and binding resolution of the Grievance.

A. Complaint Procedures:

1. Grievances may be filed with any staff member in writing, online or by telephone.
2. MHN staff members who are alerted to member complaints document these by filling out an MHN Complaint Report Form.
3. Complaints involving quality of care are investigated/resolved by Grievance and Appeals staff in the MHN corporate office.
4. When a complaint form is completed by any staff member, the original is forwarded to the Grievance and Appeals Department Unit in the Quality Management department for tracking. All complaints are tracked by the Grievance and Appeals Unit.
5. All complaints are acknowledged by the Grievance and Appeals Unit in writing within five (5) calendar days of MHN's receiving the complaint.
6. MHN has a standard of thirty (30) calendar days for resolution of complaints.
7. When the complaint is resolved, a Resolution Report is completed. Records are retained and tracked in the Grievance and Appeals Unit.
8. Members shall receive a letter regarding the resolution of their complaint (and outlining the resolution of the complaint whenever appropriate).
9. For administrative complaints where detailed resolution information can be given, if the Member is dissatisfied with the outcome of the complaint, he/she can appeal by writing to the MHN Manager of Grievances and Appeals, MHN, P.O. Box 10697, San Rafael, CA 94912.
10. Grievances shall be reported on a quarterly basis as a part of the Quality Management quarterly report.

B. Requests for Appeals of Denials of Authorizations can be made by Members, Member's Representatives Practitioners, or Facilities

MANDATORY MHN APPEAL

Expedited Appeal

If the Member has an Urgent Care Claim,[1] the Member, Practitioner or Facility can request an expedited appeal of a denial of Authorization of payment by calling MHN at (888) 426-0028. An appeal determination via telephone will be made as soon as possible, taking into account the medical exigencies, but no later than seventy-two (72) hours after receipt of the request for review.

This review will be conducted by a MHN Peer Reviewer different from the one who issued the initial denial.

Written Appeal

If the Member does not have an Urgent Care Claim, the Member, Practitioner or Facility may submit a Written Appeal. Appeal determinations are made within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days after receipt of the request for review for Pre-Service Claims[2] and 30 days after such receipt for Post-Service Claims.[3] A Peer Reviewer, different from the one who made the initial denial decision, reviews the request. The appeal request may be made telephonically by calling MHN at (888) 426-0028 or sending a written request to:

Appeals Unit
PO Box 10697
San Rafael, CA 94912

FOR CALIFORNIA MEMBERS ONLY:

All Information below this line is for California Members Only

Please note, after participating in MHN's Grievance and/or Appeals Process for a period of thirty (30) days, (or three days if the Department of Managed Health Care (the "Department") determines an earlier review is necessary in cases of emergency grievances), the Member has the right to file a request for assistance with the Department. When MHN has notice of a case involving imminent and serious threat to the health of the patient, including, but not limited to, severe pain, potential loss of life, limb or major bodily function, MHN provides the following: (a) immediate notification to the Member of their right to notify the Department of the Grievance, and (b) no later than three days from receipt of the notice of such Grievance request, a written statement to the Member and the Department on the disposition or the pending status of the Grievance. The Department of Managed Health Care has a toll-free telephone number 1-888-HMO-2219 (888-466-2219) to receive complaints. The hearing and speech impaired may use the California Relay Service's toll-free telephone numbers (1-800-735-2929 (TTY) or 1-888-877-5378 (TTY)) to contact the Department. The Department's Internet website (http://www.hmohelp.ca.gov) also has complaint forms and instructions online.

LEVEL II INDEPENDENT MEDICAL REVIEW (Voluntary for Members)

Upon receipt of the mandatory MHN appeal Level I decision, the Member has the right under California law to apply with the Department for Independent Medical Review ("IMR") when the member's health care service is denied, delayed or modified due to MHN's determination that such services are not Medically Necessary. See IMR requirements on the following pages for further details on procedures and processes.

C. ARBITRATION

Sometimes disputes or disagreements may arise between you (including your enrolled Dependents, heirs or personal representatives) and MHN regarding the construction, interpretation, performance or breach of matters relating to or arising out of your membership in this Plan. Typically such disputes are handled and resolved through the MHN Grievance and Appeal(s) Process described above. However, in the event that a dispute is not resolved in that process, MHN uses binding arbitration as the final method for resolving all such disputes, whether stated in tort, contract or otherwise, and whether or not other parties such as employer groups, health care practitioners, or their agents or employees, are also involved. In addition, disputes with MHN involving alleged professional liability or medical malpractice (that is, whether any medical services rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) also must be submitted to binding arbitration.

As a condition to becoming a MHN Member, you agree to submit all disputes you may have with MHN, except those described below, to final and binding arbitration. Likewise, MHN agrees to arbitrate all such disputes. This mutual agreement to arbitrate disputes means that both you and MHN are bound to use binding arbitration as the final means of resolving disputes that may arise between the parties, and thereby the parties agree to forego any right they may have to a jury trial on such disputes. However, no remedies that otherwise would be available to either party in a court of law will be forfeited by virtue of this agreement to use and be bound by MHN's binding arbitration process. This agreement to arbitrate shall be enforced even if a party to the arbitration is also involved in another action or proceeding with a third party arising out of the same matter.

MHN's binding arbitration process is conducted by selection of mutually acceptable arbitrator(s) by the parties. The Federal Arbitration Act, 9 U.S.C. Â§ 1, et seq., will govern arbitrations under this process. In the event that total amount of damages claimed is $200,000 or less, the parties shall, within 60 days of the demand for arbitration to MHN, appoint a mutually acceptable single neutral arbitrator who shall hear and decide the case and have no jurisdiction to award more than $200,000. In the event that total amount of damages is over $200,000, the parties shall, within 60 days of the demand for arbitration to MHN, appoint a panel of three neutral arbitrators (unless less than three is mutually agreed upon), who shall hear and decide the case.

Arbitration can be initiated by submitting a demand for arbitration to MHN at the address provided below. The demand must have a clear statement of the facts, the relief sought and a dollar amount.

Litigation Administrator
21650 Oxnard Street, #1520
Woodland Hills, CA 91367

Upon receipt of a demand for arbitration by MHN, the parties will have 60 days to attempt to reach an agreement to select mutually acceptable arbitrator(s) as outlined above. If the parties fail to reach an agreement during this time frame, then either party may apply to a Court of Competent Jurisdiction for appointment of the arbitrator(s) who would hear and decide the matter.

The arbitrator is required to follow applicable state or federal law. The arbitrator may interpret the provisions of this Plan, but will not have any power to change, modify or refuse to enforce any of its terms, nor will the arbitrator have the authority to make any award that would not be available in a court of law. At the conclusion of the arbitration, the arbitrator will issue a written opinion and award setting forth findings of fact and conclusions of law, and that award will be binding on all parties. The parties will share equally the arbitrator's fee involved in the arbitration. Each party also will be responsible for their own attorneys' fees.

In cases of extreme hardship to a Member, MHN may assume all or a portion of a Member's share of the fees and expenses of the arbitration. Upon written notice by the Member requesting a hardship application, MHN will forward the request to an independent professional dispute resolution organization for a determination. Such a request for hardship should be submitted to the Litigation Administrator at the address provided above.

Effective July 1, 2002, Members who are enrolled in an employer's plan that is subject to ERISA, 29 U.S.C. Â§ 1001 et seq., a federal law regulating benefit plans, are not required to submit disputes about certain "adverse benefit determinations" made by MHN to mandatory binding arbitration. Under ERISA, an "adverse benefit determination" means a decision by MHN to deny, reduce, terminate or not pay for all or a part of a benefit. However, you and MHN may voluntarily agree to arbitrate disputes about these "adverse benefit determinations" at the time the dispute arises.

INDEPENDENT MEDICAL REVIEW REQUIREMENTS

Experimental or Investigational Therapy

If MHN's decision involves a delay, denial or modification of health care services related to a **denial of coverage for an Experimental or investigational therapy**, MHN's written determination will inform the enrollee of his/her right to file an application with the Department of Managed Health Care for an independent medical review. The Member must meet the following criteria:

(1) The Member must have a Life-threatening or Seriously Debilitating condition as defined below.

(2) The Member's Practitioner must certify that the Member has a disease or condition, as defined in (1) above, for which (a) standard therapies have not been effective in improving the condition of the Member, (b) standard therapies would not be medically appropriate for the Member, or (c) there is no more beneficial standard therapy covered by MHN than the therapy proposed.

(3) Either (a) The Member's contracted Practitioner has recommended a drug, device, procedure or other therapy that the Practitioner certifies in writing is likely to be more beneficial than any available standard therapies, or (b) the Member or the Member's Practitioner who is *not* under contract with MHN, but is appropriately licensed and qualified to treat the Member's condition, has requested a therapy that, based upon two (2) documents from the Medical and Scientific Evidence, is likely to be more beneficial than standard therapies. The physician certification shall include a statement of the evidence relied upon by the physician in certifying his or her recommendation.

(4) The specific drug, device, procedure or other therapy recommended would be a Covered Service except for MHN's determination that the therapy is Experimental or investigational.

For purposes of independent review, "*life-threatening*" means either or both (i) diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted, and/or (ii) diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival. "*Seriously debilitating*," means diseases or conditions that cause major irreversible morbidity.

Medical Necessity

A Member may request an independent medical review ("IMR") of Disputed Health Care Services from the Department of Managed Health Care ("Department") if the Member believes that health care services eligible for coverage and payment under the MHN Plan have been improperly denied, modified, or delayed by MHN or one of its Participating Providers. Disputed Health Care Service is any health care service eligible for coverage and payment under MHN's plan that has been denied, modified, or delayed by MHN or one of its contracting Practitioners, in whole or in part because the service is not Medically Necessary.

The IMR process is in addition to any other procedures or remedies that may be available to the Member. The Member will pay no application or processing fees of any kind for IMR. The Member has the right to provide information in support of the request for IMR. MHN must provide the Member with an IMR application form and an addressed envelope, which the Member may return to initiate an IMR. In addition, MHN will provide its grievance response letter that states its position on the Disputed Health Care Service. A decision not to participate in the IMR process may cause the Member to forfeit any statutory right to pursue legal action against MHN regarding the Disputed Health Care Service. A Member may request IMR any time within six months, or later, if the Department agrees to extend the application deadline, of receiving MHN's grievance response letter.

A Member's application for IMR will be reviewed by the Department to confirm that it meets all the eligibility requirements of the law for IMR set out below:

(1) (A) The Member's Practitioner has recommended a health care service as medically necessary, or (B) The Member has received urgent care or emergency services that a Practitioner determined to have been medically necessary or (C) in the absence of the Practitioner recommendation described in (1)(A) above, the Member has been seen by a MHN Practitioner for the diagnosis or treatment of the medical condition for which the Member seeks IMR;

(2) The Disputed Health Care Service has been denied, modified, or delayed by MHN or one of its contracting Practitioners, based in whole or in part on a decision that the health care service is not Medically Necessary; and

(3) The Member has filed a grievance with MHN or its contracting Practitioner and the disputed decision is upheld or the grievance remains unresolved after 30 days.

If the Member's grievance requires expedited review, the Member may bring it immediately to the Department's attention. The Department may waive the requirement that the Member follow MHN's grievance process in extraordinary and compelling cases.

If the Member's case is eligible for IMR, the dispute will be submitted to a medical specialist who will make an independent determination of whether or not the care is Medically Necessary. Within three business days of MHN's receipt of notice from the Department that the Member has applied for IMR, MHN or its contracting Practitioners shall provide to the IMR organization a copy of all of the following documents:

(1)(A) A copy of all of the Member's medical records in the possession of the plan or its contracting Practitioners relevant to each of the following:

i. The Member's medical condition
ii. The healthcare services being provided by the plan and its contracting Practitioners for the condition
iii. The Disputed Health Care Services requested by the Member for the condition

(B) Any newly developed or discovered relevant medical records in the possession of the plan or its contracting Practitioners after the initial documents are provided to the independent medical review organization shall be forwarded immediately to the independent medical review organization. The plan shall concurrently provide a copy of medical records required by this subparagraph to the Member or the Member's Practitioner, if authorized by the Member, unless the offer of medical records is declined or otherwise prohibited by law. The confidentiality of all medical record information shall be maintained pursuant to applicable state and federal laws.

(2) A copy of all information provided to the Member by the plan and any of its contracting Practitioners concerning plan and Practitioner decisions regarding the Member's condition and care, and a copy of any materials the Member or the Member's Practitioner submitted to the plan and to the plan's contracting Practitioners in support of the Member's request for Disputed Health Care Services. This documentation shall include the written response to the Member's grievance, required by paragraph (4) of subdivision (a) of Section 1368. The confidentiality of any Member medical information shall be maintained pursuant to applicable state and federal laws.

(3) A copy of any other relevant documents or information used by the plan or its contracting Practitioners in determining whether Disputed Health Care Services should have been provided, and any statements by the plan and its contracting Practitioners explaining the reasons for the decision to deny, modify, or delay Disputed Health Care Services on the basis of Medical Necessity. The plan shall concurrently provide a copy of documents required by this paragraph,

except for any information found by the Director to be legally privileged information, to the Member and the Member's Practitioner. The Department and the independent review organization shall maintain the confidentiality of any information found by the Director to be the proprietary information of the plan. Once the IMR organization has reviewed the Member's case, the Member will receive a copy of the assessment made in their case from the IMR. If the IMR determines the service is Medically Necessary, MHN will provide the Disputed Health Care Service. If the Member's case is not eligible for IMR, the Department will advise the Member of their alternatives.

For non-urgent cases, the IMR organization designated by the Department must provide its determination within 30 days of receipt of the Member's application for review and the supporting documents. For urgent cases involving imminent and serious threat to the Member's health, including, but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of the Member's health, the IMR organization must provide its determination within three business days.

For more information regarding the IMR process the Member may call MHN at the number listed under the Grievance section above or the Department at 1-800-HMO-2219 (888-466-2219).

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[1]A claim involving urgent care is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations (a) could jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or (b) in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Any claim that a physician with knowledge of the claimant's medical condition determines is a "claim involving urgent care" under this definition must be treated as an urgent care claim by the plan. Absent a determination by the claimant's physician, the determination of whether a claim involves urgent care is to be made by an individual acting on behalf of the plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

[2] A pre service claim is any claim for a benefit under a group health plan with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

[3] "Post-service claims" are health care claims that are not urgent care or pre-service claims.