Frequently Asked Questions

FAQs for Provider Complaints Related to Medi-Cal Services

1. Does CalOptima have a provider complaint process?

Yes. There are several options in the complaint process:

A. **Level 1 Complaints** involve disputes related to decisions or actions taken by a CalOptima health network, or disputes related to utilization management (UM) decisions or claims payment decisions by CalOptima. Depending upon the situation, Level 1 complaints are filed with either the health network or CalOptima.

B. **Level 2 Complaints** are disputes of health network Level 1 Provider Dispute Resolution (PDR) decisions, or disputes of Level 1 decisions issued by CalOptima's Utilization Management or Claims departments. Level 2 complaints typically include review of:

a. Health network Level 1 decisions
b. CalOptima UM appeal decisions
c. Pharmacy decisions
d. Long-Term Care UM appeal decisions
e. CalOptima PDR claims decisions

C. **For grievances related to any aspect of the CalOptima program,** providers may file their complaints directly with CalOptima Grievance and Appeals Resolution Services (GARS) for issues that fall outside of the Level 1 and Level 2 complaint process.

2. Are there any time frames for filing a provider complaint?

Yes. There are specific time frames for filing a provider complaint. These time frames vary by type of complaint, so it is important that the provider understand the time frame associated with the specific type of dispute. Failure to file within those timelines may result in the denial of the appeal or grievance.

Level 1

- **PDR claims issue** — 365 calendar days from date of the Remittance Advice (RA)
- **UM retro-authorizations decisions** — 90 calendar days from the date of the Notice of Action (NOA) letter

Level 2

- **Medical necessity disputes** or **UM retro-authorizations appeals** — 60 calendar days from the date CalOptima or the health network issued the Level 1 decision letter
- **PDR claims issues** — 180 calendar days from date of the Level 1 PDR decision letter issued by CalOptima or a health network

Grievances

- Complaints related to any aspect of the CalOptima program or policies — 180 calendar days from date of initial incident or occurrence of the issue

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3. Are there any other requirements for filing a provider complaint?

It is critical to include complete documentation. Claims disputes submitted with incomplete information will be returned to the provider clearly identifying the missing information necessary for the review and resolution of the dispute. The provider has 30 working days after the receipt of a returned provider dispute/complaint to resubmit the dispute with the additional information. If the information is not submitted, or not submitted timely, the dispute is closed without further action.

4. How do I file a health network complaint?

Level 1
If you have a dispute with a CalOptima contracted health network related to decisions or actions taken, you must file your written complaint with the appropriate health network prior to submitting a complaint to CalOptima.

Level 2
If you are dissatisfied with the Level 1 dispute decision issued by the health network, you may file your dispute with CalOptima GARS for a second level review. You may use the Level 2 Provider Complaint Resolution Request form located on CalOptima's website (www.caloptima.org/Home/Providers/CommonForms.aspx) and submit the completed form to:

CalOptima
Attention: Grievance and Appeals Resolution Services
505 City Parkway West
Orange, CA 92868

5. How do I file a complaint with CalOptima Direct?

Level 1
UM Disputes:
If you have a dispute with CalOptima related to a UM decision issued for a CalOptima Direct or CalOptima Care Network (CCN) member, you may file your written complaint directly with CalOptima's UM department. You may submit your complaint to:

CalOptima
Attention: Utilization Management
P.O. Box 11033
Orange, CA 92868

Claims Disputes:
If you have a dispute related to a claim processed by CalOptima's Claims department, you may file your written complaint directly with CalOptima's Claims
department by submitting your Level 1PDR form located on the CalOptima website (www.caloptima.org/Home/Providers/CommonForms.aspx) to:

CalOptima

Attention: Claims Resolution Unit
P.O. Box 11037
Orange, CA 92856

Level 2
If you are dissatisfied with the Level 1 appeal decision issued by the CalOptima Direct/CCN UM department or the Provider Dispute Resolution (PDR) decision issued by the CalOptima Claims department, you may file your dispute with CalOptima GARS for a second level review. You may use the Level 2 Provider Complaint Resolution Request form located on CalOptima's website (www.caloptima.org/Home/Providers/CommonForms.aspx) or a written request and submit to:

CalOptima
Attention: Grievance and Appeals Resolution Services
505 City Parkway West
Orange, CA 92868

6. What documentation is required when filing a provider complaint?

For a Level 1 complaint, you may file using a PDR request form or a letter. It is necessary to include the following information to support your position:

1. Provider name and Provider Identification Number
2. Contact information
3. Copy of clean claim or authorization request, when applicable
4. Patient's name, when applicable
5. Date of service, when applicable
6. The original claim identification number, when applicable
7. Copy of Remittance Advice (RA), or denial notices, when applicable
8. A clear explanation of the issue the provider believes to be incorrect, including supporting medical records, contract or other documentation that support the appeal or grievance

To submit a Level 2 dispute regarding CalOptima or a health network's response to a PDR Level 1 submission, you may complete a Level 2 Provider Complaint Resolution Request form located on CalOptima's website (www.caloptima.org/Home/Providers/CommonForms.aspx) or a written request and submit to:

CalOptima
Attention: Grievance and Appeals Resolution Services
505 City Parkway West
Orange, CA 92868

7. When will I receive a decision on my complaint?
All complaints in paper form are acknowledged within 15 working days or within two working days

if submitted electronically.

The resolution to your complaint will be sent to you in writing within 45 working days from the receipt of the complaint or amended complaint.

8. What other options do providers have?

Providers have a right to a hearing. A provider who disputes recoupment of funds based upon audit findings of overpayment; the imposition of sanctions or penalties; or suspension or termination of the provider's participation in CalOptima, a health network or third-party administrator (TPA); may request a hearing before the Provider Grievance Review Panel if:

a) The provider has received a Complaint Resolution Letter from CalOptima, or

b) The provider has received a Complaint Resolution Letter from a health network or TPA and pursues a hearing in lieu of filing a written complaint to CalOptima.

A provider may submit to CalOptima GARS a written request for a hearing within 15 calendar days from the date of the complaint resolution letter from CalOptima, a health network or a TPA.