PARTNERSHIP HEALTHPLAN OF CALIFORNIA
POLICY/PROCEDURE

Policy Number: MP PR-GR 210				**Lead Department:** Provider Relations	
Policy Title: Provider Grievance					
Original Date: April 25, 1994				**Revision Date:** 8/23/1996, 10/10/1997, 3/29/2000, 7/24/2000, 9/13/2000, 7/17/2002, 11/17/2003, 2/11/2004, 2/9/2005, 3/8/2006, 7/11/2007, 3/12/2008, 4/8/2009, 7/8/2009, 8/11/2010, 8/10/2011, 8/8/2012, 8/14/2013, 8/13/2014	
Applies to:	☒ **MediCal**	☒ **Healthy Kids**	☒ **Partnership*Advantage***		
Reviewing Entities:	☐ **CREDENTIALING**	☒ **IQI**	☐ **P & T**	☐ **QUAC**	
Approving Entities:	☐ **BOARD**	☐ **CEO**	☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
Approval Signature: *Richard Bell, MD*				**Approval Date: August 13, 2014**	

RELATED POLICIES: None

DEFINITIONS: N/A

I. ATTACHMENTS: None

II. PURPOSE:

To describe the process for resolving provider grievances related to determinations of medical decisions made by Partnership HealthPlan of California or contractual disputes between the Health Plan and providers. A provider may request a grievance after all applicable PHC Appeal processes have been exhausted.

III. POLICY:

1. The Partnership HealthPlan of California, (PHC) Chief Executive Officer has primary responsibility for maintenance, review, formulation of policy changes and procedural improvements of the grievance review system. The Chief Executive Officer is assisted by the PHC Chief Medical Officer, Health Services Director and Provider Relations Director.

2. Providers must be given an opportunity to have their grievance heard and evaluated. Two mechanisms, an informal and a formal grievance procedure, have been established for that purpose.

    a. Informal grievances may be registered by the provider, by telephone, letter or visit to the PHC office. The provider should contact the Provider Relations Department to register a grievance. The grievance is immediately recorded. If a satisfactory solution has not been reached through discussion with the parties within ten (10) working days after an informal grievance is registered, the grievance automatically becomes a formal grievance.

    b. Formal grievance is filed in writing at the PHC offices or by mail within 45 working days of the final appeal determination. There is a fifteen (15) working day resolution period during which time the PHC staff proposes a resolution to the provider. If the proposed resolution is not satisfactory, the provider may request in writing Provider Grievance Review Committee hearing. Decisions of the Provider Grievance Review Committee are binding unless reversed by the Partnership HealthPlan of California Board of Commissions. The Provider Grievance Committee will meet within forty-five (45) working days of receipt of the written provider request of a Provider Grievance Review Committee meeting.

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The Provider Grievance Review Committee has been established to provide a formal grievance mechanism. The Provider Grievance Review Committee consists of five members:

a. The PHC Chief Medical Officer or an alternative physician selected by the Chief Medical Officer.
b. The PHC Chief Executive Officer or an alternative non-physician selected by the Chief Executive Officer.
c. Three members selected by the Physician Advisory Committee on an ad hoc basis. They are one physician member, one non-physician provider ie: a mid-level practitioner or ancillary provider, and a third member who represents the provider type or specialty type of the party raising the issue(s).
d. The Provider Grievance Review Committee members selected should have the ability to be fair and impartial. Physician members may not be members of the active medical staff on a hospital if the hospital is the grieving party and non-physician providers may not be representative of a hospital if the grieving party is a physician on the active medical staff of that hospital.
e. Any person involved in the initial evaluation of the issue may not serve as a member of the Committee but may provide information on the issue as appropriate.
f. The Physician Advisory Committee appoints the Chairperson of the Provider Grievance Review Committee. The chairperson is responsible for conducting the meeting.
g. PHC staff is responsible for selecting a recording secretary, setting the date, time, and location for the meeting. PHC will forward all correspondence and documents submitted by the provider and PHC which are relevant to the grievance to the Committee Members five (5) working days prior to the Grievance Committee hearing.
h. The Committee meets as needed. The Committee's meeting is documented in minutes and the provider and PHC are advised in writing of the Committee's decision within ten (10) working days of the meeting.

4. Providers appealing utilization management decisions on behalf of members must follow the procedure outlined in health services policies and procedures “Appeals/Expedited Appeals of UM Decisions” prior to filing a request for a Provider Grievance Review hearing.

5. If during the review process, the Provider Grievance Review Committee determines that a provider may be deficient in rendering or managing care, or problem areas are discovered, this information is referred to the Performance Improvement Clinical Specialist as a Potential Quality Issue (PQI).

6. The plan or the plan’s capitated provider shall not discriminate or retaliate against a provider (including but not limited to the cancellation of the provider’s contract) because the provider filed a contracted provider dispute or a non-contracted provider dispute.

IV. REFERENCES

- NCQA, PHC Board of Commissions

V. DISTRIBUTION

- PHC Provider Manual