Health Care Agency **Behavioral Health Services** **Policies and Procedures**	Section Name: Sub Section: Section Number: Policy Status:	Medi-Cal Managed Care Beneficiary Rights 09.02.02 ☐New ☒Revised

	SIGNATURE	DATE APPROVED
Deputy Director Behavioral Health Services	Signature on File	2/14/2024

SUBJECT: Beneficiary/Client Appeal of Actions Process

PURPOSE:

To outline the process for responding to and resolving appeals of actions submitted by all Medi-Cal beneficiary/client (and parents/guardians/conservators as appropriate) receiving services through Orange County's Behavioral Health Services (BHS) County and County Contracted clinics and Inpatient Treatment Programs.

POLICY:

It is the policy of BHS that at every step of these procedures, staff shall maintain the confidentiality of beneficiaries/clients, consistent with other policies related to State and Federal confidentiality and privacy regulations.

Orange County BHS shall strive for the timely resolution of appeals of actions in a manner that is consistent with regulations and quality services. A uniform documentation process shall be followed to track the number and types of appeals and the resolution outcomes, including timeliness of all appeals.

SCOPE:

These procedures apply to all Medi-Cal beneficiaries and parents/guardians/conservators receiving services within BHS County and County Contracted clinics and Inpatient Treatment Programs, including but not limited to Medi-Cal Mental Health Plan (MHP) and Drug Medi-Cal Organized Delivery System (DMC-ODS), except students only receiving educationally related mental health services.

REFERENCES:

BHS P&P 02.02.02 – Beneficiary Problem Resolution and Grievance Process and Log Procedures in Outpatient County and Contracted Clinics and Inpatient Treatment Programs

BHS P&P 02.06.02 – Informing Materials for Mental Health and Recovery Services Beneficiaries/Clients and Intake/Advisement Checklist

Medi-Cal Mental Health Plan Contract with the Department of Health Care Services

Drug Medi-Cal Organized Delivery System (DMC-ODS) Intergovernmental Agreement (IA) for the provision of substance use disorder (SUD) services, multi-year and subsequent revisions

FORMS:

Grievance or Appeals Form F346-706 DTP318

State Hearing Request Form F346-742 DTP1115

Authorization to Use or Disclose Protected Health Information

Adverse Benefit Determination Upheld – Notice of Appeal Resolution (NAR)

Adverse Benefit Determination Overturned – Notice of Appeal Resolution (NAR)

Acknowledgement of Appeal Letter

Delivery System Notice- NOABD

Denial Notice – NOABD

Termination Notice – NOABD

Modification Notice – NOABD

Timely Access – NOABD

Delay in Processing Authorization of services – NOABD

Failure to Timely Resolve Grievances and Appeals – NOABD

Financial Liability Notice – NOABD

Payment Denial Notice – NOABD

NOABD ATTACHMENTS:
- NAR Your Rights
- Language Assistance Taglines
- Beneficiary Non-discrimination Notice

DEFINITIONS:

Adverse benefit determination is defined to mean any of the following actions taken by a Plan:

(1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.

(2) The reduction, suspension, or termination of a previously authorized service.

(3) The denial, in whole or in part, of payment for a service.

(4) The failure to provide services in a timely manner, as defined by Federal guidelines and State law.

(5) The failure of an MCO, PIHP, or PAHP to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.

(6) For a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network.

(7) The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

Appeals – Appeals are explicitly defined as a request for a review of an "adverse benefit determination" (see above for definition).

Quality Management Services (QMS) – Is an administrative service area within BHS, providing oversight and coordination of quality improvement and compliance activities across all Divisions of BHS.

Beneficiary – A person with Medi-Cal coverage. For the purpose of this policy and procedure, "beneficiary" includes a parent, guardian, conservator, or other authorized representative, unless otherwise specified.

Client – A person with no Medi-Cal coverage. For the purpose of this policy and procedure, "client" includes a parent, guardian, conservator, or other authorized representative, unless otherwise specified.

Days – Defined as calendar days unless otherwise specified.

Notice of Adverse Benefit Determination (NOABD) - Written notification to the requesting provider and the enrollee of any decision by the Plan to deny or delay a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.

Patients' Rights Advocacy Services (PRAS) – A program within BHS with multiple responsibilities, including providing assistance, advice and advocacy services to beneficiary/client (MHP only) and their family members who have filed a grievance or requested a State Hearing.

Participating Inpatient Health Plan (PIHP) – The State Department of Health Care Services (DHCS) has notified counties that the county MHP and DMC-ODS are considered PIHPs for purposes of CFR, Title 42, Chapter IV, § 438.

Provider Representative – The individual assigned at each clinic and treatment site to educate and assist beneficiaries and family members with the appeals process. The Provider Representative is the person designated to provide information to the beneficiary about the status of an appeal upon request.

Working Day – A working day is defined as Monday through Friday, 8:00am-5:00pm, excluding County holidays.

PROCEDURES:

I. Staff at all levels shall assist beneficiaries in completing the forms and other procedural steps related to an appeal or expedited appeal. This includes, but is not limited to, providing interpreter services and toll-free numbers with TTY/TDD and interpreter capability.

II. Following receipt of a NOABD from a health plan, an enrollee has **60 calendar days** from the date on the adverse benefit determination notice in which to file a request for an appeal to the health plan.

III. An appeal may be filed in writing or orally. If filed orally, the Orange MHP or DMC-ODS shall require a written follow-up from the beneficiary; however, the appeal shall proceed regardless of whether or not the written follow-up is received. There is only one level of appeal for beneficiaries.

IV. All BHS County and County Contracted clinics and inpatient treatment programs shall have a mechanism for beneficiaries and/or the parent/guardian/conservator to appeal NOABD. Staff shall inform beneficiaries and/or their parent/guardian/conservator of their rights and assist them in problem resolution through the appeals process.

V. Appeals information shall be made available to the beneficiary, in all clinics and inpatient treatment programs, and placed in a conspicuous location.

VI. The beneficiary and/or parent/guardian/conservator shall be informed of their right to access Patients' Rights Advocacy Services (PRAS) at any time before, during, or after the appeals process for information and/or for assistance and representation.

VII. The beneficiary and/or parent/guardian/conservator may choose an authorized representative to act on his/her behalf. This person can be a family member, significant other, or other person of his/her choice. The beneficiary and/or parent/guardian/ conservator shall provide written confirmation of the authorization of a representative by completion of an Authorization to Use and Disclose Protected Health Information to that representative which documents that it is for the purpose of acting as the representative for the appeal or expedited appeal process. If the beneficiary is deceased, their representative, or the legal representative of the beneficiary's estate, is to be included as parties to the appeal.

VIII. No beneficiary or parent/guardian/conservator shall be subject to discrimination or any other penalty for filing an appeal. The beneficiary's legal representative may use the appeals process on the beneficiary's behalf.

IX. A beneficiary or parent/guardian/conservator may request assistance with an appeal from PRAS at any point in the process. The Patients' Rights Advocate, upon the beneficiary's or parent/guardian/conservator's request, shall provide information and assistance

regarding the beneficiary's legal rights and may represent the beneficiary through the process.

X. Appeals Process – Outpatient Clinic and Inpatient Program Responsibilities:

A. If a beneficiary informs outpatient clinic staff or inpatient program staff of the desire to appeal an action, the staff shall inform the beneficiary of the process for filing an appeal, including the location of appeal materials that are available in each service site. The materials shall be placed where the beneficiary may obtain them without the beneficiary needing to ask anyone for them. The staff shall also provide the beneficiary with the phone number, 866-308-3074 or 866-308-3073-TDD for filing an appeal without the need to complete an appeal form.

B. The outpatient clinic Service Chief, Program Director or the Inpatient Program Director shall ensure that the following materials are located in a conspicuous location in the clinic or hospital. Materials shall be in English and in all of the threshold languages. The location of the materials shall be such that the beneficiary does not have to make a verbal or written request to anyone for the materials.

1. Grievance or Appeals form (which includes the phone number for filing an appeal verbally).

2. Pre-addressed envelopes for submitting the form.

3. Beneficiary Grievance and Appeals Process poster.

XI. Appeals Process – Quality Management Services (QMS) responsibilities:

A. Appeals may reach QMS in either of three primary ways:

1. A beneficiary may mail in a Grievance or Appeal Form, or

2. A beneficiary may phone in an appeal, but a written follow-up is required. If written follow up is received, the date of receipt of the oral request is the start of the timeline for resolution.

3. A clinic may send in a Grievance or Appeal Form.

B. QMS Grievance/Appeal Representative shall complete and send an Appeal Acknowledgement letter, the NAR Your Rights, Language Assistance Taglines and Beneficiary Non-discrimination Notice to the beneficiary within 5 business days of the receipt of the appeal. The acknowledgement letter includes the date of receipt, name of representative to contact, telephone number of contact representative and address of either the MHP or DMC-ODS plans.

C. QMS Grievance/Appeal Representative shall log receipt of the appeal on the day the appeal within 1 business day, with the exception of the resolution section which would be completed at the end.

D. The QMS Grievance/Appeal Representative shall research the appeal and prepare the decision and/or action of the appeal. Within the parameters of confidentiality, all relevant information, resources and involvement of others shall be utilized to resolve the appeal within **30** calendar days, unless the beneficiary or parent/guardian/conservator requests additional time or agrees to a continuance. If the beneficiary requests an extension or if the QMS Grievance/Appeal Representative determines that there is a need for additional information and that the delay is in the beneficiary's interest, this timeframe may be extended by up to 14 business days. If extended, the QMS Grievance/Appeal Representative shall make reasonable efforts to give the beneficiary prompt oral notice of the extension and the reasons for the extension, and will follow up in writing within two days of the decision to extend the timeframe.

E. The QMS Grievance/Appeal Representative shall have the appropriate and clinical expertise to treat the beneficiary's condition and in addition shall not have been involved in any previous level of review or decision-making and shall not be the subordinate of any individual who was involved in a previous level of review or decision making.

F. The QMS Grievance/Appeal Representative shall ensure the beneficiary has a reasonable opportunity to present evidence, testimony and allegations of fact or law, in person as well as in writing.

G. The QMS Grievance/Appeal Representative shall ensure the beneficiary and his or her representative have opportunity before and during the appeals process, to examine the beneficiary case file, including medical records and any other documents and records considered during the appeals process including any new or additional evidence considered, relied upon, or generated in connection with the appeal. The case file shall be provided free of charge and sufficiently in advance of the resolution timeframe.

H. Decision makers on appeals of adverse benefit determinations shall take into account all comments, documents, records, and other information submitted by the beneficiary or beneficiary's representative, without regard to whether such information was submitted or considered in the initial adverse benefit determination.

I. The QMS Grievance/Appeal Representative shall send a resolution letter to the beneficiary within 30 calendar days of receiving the appeal information (or within 44 calendar days if an extension has been invoked as described above). The resolution letter shall contain:

1. The results of the appeal resolution process.

2. The date that the appeal decision was made.

3. The written notice of the appeal resolution informs the beneficiary's right to request and receive benefits while the State Hearing is pending, and how the beneficiary makes this request.

4. If the appeal has not been resolved wholly in favor of the beneficiary, the notice shall also contain information regarding the beneficiary's right to a State Hearing and the procedures for filing for a State Hearing.

5. If the appeal has not been resolved wholly in favor of the beneficiary, the notice shall also contain information on the right to continue to receive benefits while the appeal and/or state hearing are pending, and inform the beneficiary that he or she may be liable for the cost of any continued benefits if the denial is upheld by the state.

J. If the appeal has not been resolved within the required timeframe, then the QMS Grievance/Appeal Representative shall prepare a Failure to Resolve grievance and Appeals NOABD for the beneficiary and shall include the Failure to Resolve Grievance and Appeals NOABD, the NAR Your Rights, Language Assistance Taglines and Beneficiary Non-discrimination Notice and mail it to the beneficiary on the date the timeframe expires.

K. Upon resolution of the appeal (upheld/overturned), the QMS Investigating Representative shall enter the disposition into the Appeals Log and prepare the appropriate Notice of Appeal Resolution (NAR) and other required documents. The QMS Grievance/Appeal Representative shall send a copy of the NAR letter to the beneficiary.

L. The NAR resolution letter shall be mailed via Delivery Confirmation to the beneficiary and other designated parties, including any provider named on the appeal, by the QMS Grievance/Appeal Representative. If there is no address for the beneficiary, the e-filed letter shall remain stored in the designated appeals folder.

1. The logging of the disposition shall include the date the decision is sent to the beneficiary or if there has not been a final resolution the reasons for the lack of resolution.

XII. Expedited Appeals Process:

A. An expedited review process for appeals shall take place when it is determined by the QMS Grievance/Appeal Representative, or when the beneficiary or the beneficiary's provider certifies, that taking the time for a standard resolution could seriously jeopardize the beneficiary's life, physical or mental health or ability to attain, maintain or regain maximum function.

B. If the request for expedited review is filed orally, no written follow up shall be required.

C. No punitive/discriminatory action shall be taken against a beneficiary or a provider who requests an expedited resolution or supports a beneficiary's appeal.

D. The QMS Grievance/Appeal Representative shall have the appropriate and clinical expertise to treat the beneficiary's condition and in addition shall not have been involved in any previous level of review or decision-making and shall not be the subordinate of any individual who was involved in a previous level of review or decision making.

E. The QMS Grievance/Appeal Representative shall ensure the beneficiary has a reasonable opportunity to present evidence, testimony and allegations of fact or law, in person as well as in writing.

1. The beneficiary will be informed of the limited time available to present this information within the timeframes for the expedited appeal.

F. The QMS Grievance/Appeal Representative shall ensure the beneficiary and his or her representative have opportunity before and during the appeals process, to examine the beneficiary's case file, including medical records and any other documents and records considered during the appeals process including any new or additional evidence considered, relied upon, or generated in connection with the appeal. The case file will be provided free of charge and sufficiently in advance of the resolution timeframe.

G. Decision makers on appeals of adverse benefit determinations shall take into account all comments, documents, records, and other information submitted by the beneficiary or beneficiary's representative, without regard to whether such information was submitted or considered in the initial adverse benefit determination.

H. Within the parameters of confidentiality, all relevant information, resources and involvement of others shall be utilized to resolve the appeal as expeditiously as the beneficiary's health condition requires and no later than 72 hours (including weekends and holidays), unless the beneficiary or parent/guardian/conservator requests additional time or agrees to a continuance. If the beneficiary requests an extension or if the QMS Grievance/Appeal Representative determines that there is a need for additional information and that the delay is in the beneficiary's interest, this timeframe may be extended by up to 14 days. If the QMS Grievance/Appeal Representative extends the timeframe without such an extension being requested by the beneficiary, then the QMS Grievance/Appeal Representative shall provide the beneficiary with a written notice of the reason for the delay.

I. If the appeal has not been resolved within the specified timeframe, then the QMS Grievance/Appeal Representative shall provide a NOABD-Delay in Grievance/Appeal Processing to the beneficiary advising the beneficiary of the

right to request a Fair Hearing. This NOABD-Delay shall be provided (mailed) on the date that the timeframe expires.

J. In addition to providing the beneficiary with written notice of the appeals decision, the QMS Grievance/Appeal Representative shall also make and document reasonable efforts to provide oral notice to the beneficiary and/or his/her representative.

K. If a request for an expedited appeal is denied, the appeal shall be transferred to the timeframe for non-expedited appeal resolution. In this circumstance, the QMS Grievance/Appeal Representative shall make reasonable efforts to give the beneficiary and his/her representative prompt oral notice of transfer of the appeal to the timeframe for standard resolution, and shall document the efforts and the outcome in the beneficiary's appeal file, and shall follow up within two calendar days with a written notice. Notify the beneficiary of the right to file a grievance if the beneficiary disagrees with the extension.

XIII. Decision Notification

A. If the original adverse benefit determination is wholly or partially upheld:

1. The QMS Investigating Representative shall prepare an Adverse Benefit Determination Upheld NAR form and;

2. The Adverse Benefit Determination Upheld NAR Form, the NAR-Your Rights form, the Beneficiary Non-Discrimination Notice and the Language Assistance Taglines will be provided to QMS Office Support staff who shall scan the documents into the beneficiary's appeal file and mail them to the beneficiary using Delivery Confirmation.

B. If the adverse benefit decision is overturned:

1. The QMS Investigating Representative shall prepare an Adverse Benefit Determination Overturned NAR and;

2. The Adverse Benefit Determination Overturned NAR, the Beneficiary Non-Discrimination Notice and the Language Assistance Taglines will be provided to QMS Office Support staff who shall scan the documents into the beneficiary's appeal file and mail them to the beneficiary using Delivery Confirmation.

C. In addition to providing the beneficiary with written NAR, the QMS Investigating Representative shall also make and document reasonable efforts to provide oral notice to the beneficiary and/or his/her representative.

XIV. State Hearing

A. Beneficiary may file a State Hearing after receiving the NAR stating that the adverse benefit determination was upheld. The form for filing a State Hearing is included with the resolution letter for both the Appeal and the Expedited Appeal.