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
Director of Operations Behavioral Health Services	Signature on File	3/27/18

SUBJECT:	Beneficiary Appeal of Actions Process

PURPOSE:

To outline the process for responding to and resolving appeals of actions submitted by Medi-Cal beneficiaries receiving or requesting services through Orange County's Behavioral Health Services (BHS) County-operated and County-contracted clinics and Inpatient Treatment Programs in the Medi-Cal Mental Health Plan (MHP) or the Drug Medi-Cal Organized Delivery System (DMC-ODS).

POLICY:

It is the policy of BHS that at every step of these procedures, staff shall maintain the confidentiality of beneficiaries, 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 receiving or requesting services within BHS MHP and DMC-ODS.

REFERENCES:

BHS P&P 09.02.01 Beneficiary Problem Resolution and Grievance Process

BHS P&P 02.06.02 - Informing Materials for Behavioral Health Services Consumers and Intake/Advisement Checklist

FORMS:

Grievance or Appeals Form F346-706 DTP318

State Fair Hearing Request Form F346-742 DTP1115

Authorization to Use or Disclose Protected Health Information

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

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

Your Rights Under Medi-Cal (NOABD-Your Rights)

Your Rights Under Medi-Cal (NAR-Your Rights)

Non-Discrimination Notice

Language Assistance Notice

Acknowledgement of Receipt

Notice of Adverse Benefit Determination - About Your Treatment Request (NOABD-Denial)

Notice of Adverse Benefit Determination - About Your Treatment Request (NOABD-Payment Denial)

Notice of Adverse Benefit Determination - About Your Treatment Request (NOABD-Delivery System)

Notice of Adverse Benefit Determination - About Your Treatment Request (NOABD-Modification)

Notice of Adverse Benefit Determination - About Your Treatment Request (NOABD-Termination)

Notice of Adverse Benefit Determination - About Your Treatment Request (NOABD-Timely Access)

Notice of Adverse Benefit Determination - About Your Financial Liability (NOABD-Financial Liability)

DEFINITIONS:

Adverse benefit determination:

(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 the State.

(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 a beneficiary'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).

Authority and Quality Improvement Services (AQIS) – Is an administrative unit providing oversight and coordination of quality improvement and compliance activities across the Divisions of BHS.

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

Days - Defined as calendar days unless otherwise specified.

Enrollee – A beneficiary receiving services under the MHP or DMC-ODS.

Notice of Adverse Benefit Determination (NOABD) - Form used to notify the requesting provider, and give the enrollee written notice 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. There are multiple versions of this form, to be used depending on the situation.

Patients' Rights Advocacy Services (PRAS) - A department within BHS with multiple responsibilities, including providing assistance, advice and advocacy services to beneficiaries and their family members who have filed a grievance or requested a State Fair 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. Appeals information shall be made available to beneficiaries, in all clinics and inpatient treatment programs, and placed in a conspicuous location.

II. The beneficiary 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, for assistance and representation.

III. Staff at all levels shall assist the 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.

IV. Following receipt of a NOABD from the MHP or DMC-ODS, a beneficiary has **60 calendar days** from the date on the NOABD in which to file a request for an appeal to the health plan.

V. An appeal may be filed in writing or orally. If filed orally, the MHP or DMC-ODS may request a written follow-up from the beneficiary, however the appeal shall proceed regardless of whether or not the written follow-up is received.

VI. Staff shall inform beneficiaries of their rights and assist them in problem resolution through the appeals process.

VII. The beneficiary 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 shall provide written confirmation of the authorization of a Representative by completion of an Authorization to Use and Disclose Protected Health Information (PHI). The beneficiary will complete all necessary sections and document the representative's name, address and phone number and indicate under Part 4 Other: "Acting as the representative for the appeal or expedited appeal process."

VIII. No beneficiary 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 may request assistance with an appeal from PRAS at any point in the process. The PRAS Advocate, upon the beneficiary'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 adverse benefit determination, 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. Consumer Grievance and Appeals Process poster.

XI. Appeals Process – Authority and Quality Improvement Services (AQIS) responsibilities:

A. If an appeal is received by phone, the AQIS Appeal Representative shall complete an appeal form.

B. AQIS Appeals Representative shall complete an Appeal Acknowledgement letter to the beneficiary, and give it to the AQIS Office Support who will scan it into the beneficiary's appeal file and mail it out within 5 days of the receipt of the appeal.

C. AQIS Appeals Representative shall log receipt of the appeal on the day the appeal is received. All sections of the appeals log shall be completed on the day the appeal is received, with the exception of the resolution section.

D. Appeals will be investigated by a designated Investigating Representative.

E. The AQIS designated Investigating 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** days, unless the beneficiary requests additional time or agrees to a continuance.

1. Exceptions to the 30 day timeframe.

a) If the beneficiary requests an extension, this timeframe may be extended by up to 14 days.

b) If the MHP or DMC-ODS determines that there is a need for additional information and the delay is in the beneficiary's interest, the timeframe may be extended by up to 14 days.

i) If the MHP or DMC-ODS extends the timeframe, not requested by the beneficiary, the AQIS Investigating Representative will:

1. Make reasonable efforts to give the beneficiary prompt oral notice of the extension and the reasons for the extension, and document the attempt and the outcome in the beneficiary's appeals file.

2. Follow up in writing within two days of the decision to extend the timeframe. The written notification will include the information that the beneficiary may file a grievance regarding the extension.

F. The AQIS Investigating Representative will have the appropriate 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.

G. The AQIS Investigating 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.

H. The AQIS Investigating 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.

I. 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.

J. If the appeal has not been resolved within the required timeframe, then the AQIS Investigating Representative shall prepare a NOABD to the consumer and shall give the NOABD, the NOABD - Your Rights form, the Non-Discrimination Notice and the Language Assistance Notice to the AQIS Office Support staff who will scan the documents into the beneficiary's appeal file and mail to the beneficiary on the date the timeframe expires.

1. The NOABD shall advise the consumer of the right to request a State Fair Hearing.

K. Upon resolution of the appeal, the AQIS Investigating Representative shall enter the disposition into the Appeals Log and prepare the Appropriate Notice of Appeal Resolution (NAR) and other required documents as follows.

1. If the original action by the MHP or DMC-ODS is upheld, the AQIS Investigating Representative shall:

a) Prepare the NAR-Upheld.

b) Give the NAR-Upheld, the NAR Your Rights form, the Non-Discrimination Notice and the Language Assistance Notice to the AQIS Office Support staff who will scan them into the beneficiary's appeal file and mail them using Delivery Confirmation.

2. If the original action by the MHP or DMC-ODS is overturned, the AQIS Investigating Representative shall:

a) Prepare the NAR-Overturned.

b) Give the NAR-Overturned, the Non-Discrimination Notice and the Language Assistance Notice to the AQIS Office Support staff who will scan them into the beneficiary's appeal file and mail them using Delivery Confirmation.

3. 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 fair hearing is 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.

L. The AQIS Investigating Representative shall send a copy of the NAR letter to the clinic Service Chief/Program Director or the Inpatient Program Director (i.e., to the provider), Program Manager, AQIS Appeal Representative, AQIS Support Staff and Patients' Rights**.**

1. When the Delivery Confirmation is received, the AQIS Office Support staff will scan it into the beneficiary's appeal file.

2. If there is no address for the beneficiary, e-filed letter will remain stored in the designated appeals folder.

XII. Expedited Appeals Process

A. An expedited review process for appeals shall take place when it is determined by the AQIS Appeals 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, or if the beneficiary and/or the provider requests.

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 consumer's appeal.

D. The request for expedited resolution may be denied by the MHP or DMC-ODS. If the AQIS Appeals Representative denies a request for an expedited resolution of appeal, the Appeals Representative shall:

1. Transfer the appeal to the timeframe for standard notification.

2. Make reasonable efforts to provide the beneficiary with prompt oral notification of the decision to transfer the appeal to the timeframe for standard resolution, and document the efforts and the outcome in the beneficiary's appeal file.

3. Provide written notice of the decision to transfer the appeal to the timeframe for standard resolution within two days of making the decision.

4. Notify the beneficiary of the right to file a grievance if the beneficiary disagrees with the extension.

E. The AQIS Investigating Representative will have the appropriate 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 AQIS Investigating 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.

G. The AQIS Investigating 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.

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. 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 requests additional time or agrees to a continuance.

1. Exceptions to the 72 hour timeframe.

a) If the beneficiary requests an extension, this timeframe may be extended by up to 14 days.

b) If the MHP or DMC-ODS determines that there is a need for additional information and the delay is in the beneficiary's interest, the timeframe may be extended by up to 14 days.

i) If the MHP or DMC-ODS extends the timeframe, not requested by the beneficiary, the AQIS Investigating Representative will:

1. Make reasonable efforts to give the beneficiary prompt oral notice of the extension and the reasons for the extension, and document the attempt and the outcome in the beneficiary's appeals file.

2. Follow up in writing within two days of the decision to extend the timeframe. The written notification will include the information that the beneficiary may file a grievance regarding the extension.

J. If the appeal has not been resolved within the specified timeframe, then the AQIS Investigating Representative shall provide a NOABD in Grievance/Appeal Processing to the beneficiary advising the beneficiary of the right to request a Fair Hearing. This NOABD shall be provided (mailed) on the date that the timeframe expires. A copy shall be sent to AQIS Appeals Representative.

XIII. Decision Notification

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

1. The AQIS Investigating Representative shall prepare a NAR Upheld form and;

2. Give the NAR Upheld Form, the NAR-Your Rights form, the Non-Discrimination Notice and the Language Assistance Notice to the AQIS

Office Support staff who will 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 AQIS Investigating Representative shall prepare a NAR Overturned and;

2. Give the NAR Overturned, the Non-Discrimination Notice and the Language Assistance Notice to the AQIS Office Support staff who will 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 AQIS Investigating Representative shall also make and document reasonable efforts to provide oral notice to the beneficiary and/or his/her representative.

XIV. State Fair Hearing

A. Beneficiary may file a State Fair Hearing after receiving notice that the adverse benefit determination was upheld.