Health Care Agency **Behavioral Health Services** **Policies and Procedures**	Section Name: Sub Section: Section Number: Policy Status:	Client's Rights Problem Resolution 02.02.03 ☐New ☒Revised

	SIGNATURE	DATE APPROVED
Director of Operations Behavioral Health Services	_Signature on File__	__9/8/17__

SUBJECT: Beneficiary Appeal of Actions Process

PURPOSE:

To outline the process for responding to and resolving appeals of actions submitted by all Medi-Cal consumers (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 consumers, 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 consumers 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), 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 Behavioral Health Services Consumers and Intake/Advisement Checklist

FORMS:

Grievance or Appeals Form F346-706 DTP318

State Fair Hearing Request Form F346-742 DTP1115

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 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).

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.

Days - Defined as calendar days unless otherwise specified.

Notice of Adverse Benefit Determination (NOA) - Written notification to the requesting provider and 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.

Patients' Rights Advocacy Services (PRAS) - A department within BHS with multiple responsibilities, including providing assistance, advice and advocacy services to consumers 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 consumers and family members with the appeals process. The Provider Representative is the person designated to provide information to the consumer 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 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.

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

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

V. The consumer 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, for assistance and representation.

VI. The consumer 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 consumer 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.

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

VIII. A consumer or parent/guardian/conservator may request assistance with an appeal from PRAS at any point in the process. The Patients' Rights Advocate, upon the consumer's or parent/guardian/conservator's request, shall provide information and assistance regarding the consumer's legal rights and may represent the consumer through the process.

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

A. If a consumer informs outpatient clinic staff or inpatient program staff of the desire to appeal an action, the staff shall inform the consumer 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 consumer may obtain them without the consumer needing to ask anyone for them. The staff shall also provide the consumer 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 consumer 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.

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

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

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

2. A consumer 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. AQIS Appeals Representative shall complete and send an Appeal Acknowledgement letter to the consumer on the day the appeal is received.

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. Designated AQIS Office Support shall scan the form and/or letter into the appropriate folder.

E. Designated AQIS Office Support staff will email the link where the form or letter is located to the designated reviewer (AQIS AOABH/CYPBH/SUD Representative).

F. The AQIS AOABH/CYPBH/SUD 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 consumer or parent/guardian/conservator requests additional time or agrees to a continuance. If the consumer requests an extension or if the AQIS designated staff or Inpatient Services Divisional Monitor determines that there is a need for additional information and that the delay is in the consumer's interest, this timeframe may be extended by up to 14 days. If extended, the AQIS Representative will 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.

G. The AQIS Representative will have the appropriate and clinical expertise to treat the consumer'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.

H. The AQIS AOABH/CYPBH/SUD Representative shall ensure the consumer has a reasonable opportunity to present evidence, testimony and allegations of fact or law, in person as well as in writing.

I. The AQIS AOABH/CYPBH/SUD Representative shall ensure the consumer and his or her representative have opportunity before and during the appeals process, to examine the consumer'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.

J. 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.

K. The AQIS AOABH/CYPBH/SUD Representative shall send a resolution letter to the consumer within 30 days of receiving the appeal information from AQIS

Appeals Representative (or within 44 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. If the appeal has not been resolved wholly in favor of the consumer, the notice shall also contain information regarding the consumer's right to a State Fair Hearing and the procedures for filing for a State Fair Hearing.

4. If the appeal has not been resolved wholly in favor of the consumer, 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.

5. AQIS Appeals Representative shall track the appeal and if no letter regarding the resolution of the appeal is received from the AQIS AOABH/CYPBH/SUD Representative within 30 days of receipt of the appeal, AQIS Appeals Representative shall call the AQIS AOABH/CYPBH/SUD Representative and obtain information on the resolution status or follow up to completion if the appeal had not been resolved.

L. If the appeal has not been resolved within the specified timeframe then the AQIS AOABH/CYPBH/SUD Representative shall provide a Notice of Adverse Benefit Determination-Delay (NOA-D) in Grievance/Appeal Processing to the consumer advising the consumer of the right to request a State Fair Hearing. This NOA-D shall be provided (mailed) on the date that the timeframe expires. A copy shall be sent to AQIS Appeals Representative.

M. The AQIS AOABH/CYPBH/SUD Representative shall send a copy of the resolution 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**.**

N. A signed resolution letter will be hand carried by AQIS AOABH/CYPBH/SUD Representative Office Support to the designated AQIS Office Support.

O. Upon receipt of resolution letter from the AQIS AOABH/CYPBH/SUD Representative Office Support, the designated AQIS Office Support will scan and e-file letter into the appeals folder.

P. Original resolution letter will be mailed via Delivery Confirmation to the consumer and other designated parties, including any provider named in the appeal, by the designated AQIS Office Support. The designated AQIS Office Support staff will then:

1. Scan and e-file a copy of the Delivery Confirmation into the designated appeals folder.

2. Upon verification of delivery, e-file a copy of the Delivery Confirmation status into the designated grievance folder.

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

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

XI. Expedited Appeals Process:

A. An expedited review process for appeals shall take place when it is determined by the AQIS AOABH/CYPBH/SUD Representative, or when the beneficiary or the beneficiary's provider certifies, that taking the time for a standard resolution could seriously jeopardize the consumer's life, physical or mental health or ability to attain, maintain or regain maximum function, or if the consumer 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 consumer or a provider who requests an expedited resolution or supports a consumer's appeal.

D. The AQIS Representative will have the appropriate and clinical expertise to treat the consumer'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 AQIS AOABH/CYPBH/SUD Representative shall ensure the consumer 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 AQIS AOABH/CYPBH/SUD Representative shall ensure the consumer and his or her representative have opportunity before and during the appeals process, to examine the consumer'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 consumer or parent/guardian/conservator requests additional time or agrees to a continuance. If the consumer requests an extension or if the AQIS AOABH/CYPBH/SUD Representative determines that there is a need for additional information and that the delay is in the consumer's interest, this timeframe may be extended by up to 14 days. If the AQIS AOABH/CYPBH/SUD Representative extends the timeframe without such an extension being requested by the consumer, then the AQIS AOABH/CYPBH/SUD Representative shall provide the consumer with a written notice of the reason for the delay.

I. If the appeal has not been resolved within the specified timeframe, then the AQIS AOABH/CYPBH/SUD Representative shall provide a NOA-Delay in Grievance/Appeal Processing to the consumer advising the consumer of the right to request a Fair Hearing. This NOA-Delay shall be provided (mailed) on the date that the timeframe expires. A copy shall be sent to AQIS Appeals Representative.

J. In addition to providing the consumer with written notice of the appeals decision, the AQIS AOABH/CYPBH/SUD Representative shall also make and document reasonable efforts to provide oral notice to the consumer 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 AQIS AOABH/CYPBH/SUD Representative shall make reasonable efforts to give the consumer and his/her representative prompt oral notice of the denial of the expedited appeal process, and shall follow up within two calendar days with a written notice.

XII. State Fair Hearing

A. Beneficiary may file a State Fair Hearing after receiving notice that the adverse benefit determination was held. The form for doing so is included with the resolution letter for both the Appeal and the Expedited Appeal.