SANTA CRUZ COUNTY
Behavioral Health Services

POLICIES AND PROCEDURE MANUAL

Subject: Beneficiary Grievance and Appeal Process	**Policy Number: 3224**
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Prior Version: 3/9/2018	**Responsible for Updating:** Quality Improvement Staff
Approval: _____ Behavioral Health Director	11-16-18 Date

POLICY:
Santa Cruz County Behavioral Health Services shall provide all Medi-Cal beneficiaries with information regarding grievance and appeal procedures. Beneficiaries shall have access to these grievance and appeal procedures in accordance with state and federal mandates, as described in this policy. Information regarding the process for filing grievances and appeals is also available in the MHP Guide to Specialty Mental Health Services and the DMC-ODS Beneficiary Booklet.

PURPOSES:
To provide beneficiaries with clear, viable procedures for the resolution of grievances and appeals.

DEFINITIONS:
1. **Adverse Benefit Determination**
   An Adverse Benefit Determination occurs when the MHP or the County Drug Medi-Cal- Organized Delivery System (DMC-ODS) does at least one of the following:
   a. Finds that a beneficiary does not meet medical necessity for specialty mental health or DMC-ODS services.
   b. Denies or modifies a request for services from a provider, terminates or reduces previously authorized services (not agreed to by beneficiary) or there is a delay by the Plan in processing an authorization of services (the Plan did not respond in specified timeframe).
   c. Denies a partial or entire payment of a service that has already been delivered to a beneficiary, including inpatient psychiatric day(s), or denies payment of a service that has been requested but not yet delivered.
   d. Does not respond to a beneficiary's grievance or appeal within the designated timeframes without written notice requesting an extension.

e. Does not provide covered services within 10 working days from the date services were requested (delay in timely access to services).
f. Denies a beneficiary's request to dispute financial liability.
g. Does not respond to a request for authorization of services within required timeframes.

2. **Grievance**
An expression of dissatisfaction to MHP or the County DMC-ODS about any matter other than an Adverse Benefit Determination.

3. **Appeal**
An oral or written request to MHP or the County DMC-ODS for review of an Adverse Benefit Determination (as defined above).

PROCEDURES:

1. **Beneficiary Notification**
   a. Beneficiaries will be notified of grievance and appeal procedures through a brochure (available in both Spanish and English) that explains their rights and the grievance and appeal process, along with a self-addressed mailing envelope.

   b. These brochures will be provided to beneficiaries at the following times and/or locations:
      i) Upon entry into the MHP system or the County DMC-ODS
      ii) By clinic providers upon admission to their program or service
      iii) Be posted in plain view at each provider location
      iv) Upon receiving a Notice of Adverse Benefit Determination (NOABD)
      v) By calling the 24-hour Toll Free Access line for information about the grievance and appeal procedures

2. **Confidentiality**
All information pertaining to grievances and appeals will be treated as confidential information.

3. **Other Related Beneficiary Rights**
Other related beneficiary rights that will be honored, include:
   a. A beneficiary may authorize another person, including a Provider, to act on his/her behalf regarding a grievance or appeal procedure:
      i) The authorized person will need a release of information signed by the beneficiary in order to receive confidential clinical information.
      ii) Minors may be represented by their parents or guardians, except when prohibited by law or when they consent to substance use disorder treatment.
   b. Beneficiaries will not be subjected to discrimination or any other penalty or punitive action for filing a grievance, appeal or expedited appeal.

c. Beneficiaries may present their grievance or appeal orally or in writing, though oral appeals must be followed up in writing.
d. Beneficiaries may request records or other documents generated by either Plan in connection with the appeal.
e. Beneficiaries must exhaust the MHP Appeal process or the County DMC-ODS Appeal process prior to applying for a State Fair Hearing.

4. Grievance and Appeal Logs

a. QI staff will maintain a Grievance Log and an Appeal Log for the MHP and the County DMC-ODS.
b. Log entries must be completed within one (1) working day of receipt of either the grievance or appeal. Beneficiaries will receive written acknowledgment that their grievance or appeal has been received within five (5) calendar days of receipt of the grievance or appeal.
c. The log entry will contain the name of the beneficiary, date of receipt and nature of the problem.
d. The log entry will contain the date of each review or, if applicable, meeting.
e. A log entry will also be made that notes resolution of the grievance or appeal, date it was reached at each level if applicable and date notification was sent to the beneficiary.
f. The logs are available for review by oversight agencies.

5. Grievance Process

a. Beneficiary Filing:
A beneficiary may file any expression of dissatisfaction (grievance) orally, using the 1-800 multi-lingual line, in writing or by mail, using the form on the **Behavioral Health Grievance Resolution Request brochure** and provided envelope.

b. MHP and County DMC-ODS Response:
   i) Upon receipt of any grievance, service providers must report the grievance within one (1) working day to the Quality Improvement Manager (or designated staff) where it will entered immediately into the Grievance Log.
   ii) The Quality Improvement Manager will assign the grievance to a Quality Improvement (QI) staff member to assist in the resolution of the grievance.
   iii) The designated QI staff member will be a licensed clinician who did not provide direct services when the matter is of a clinical nature.
   iv) The QI member will not have been involved in any previous level of review or decision-making.

c. QI Staff Responsibilities:
The assigned QI staff will be responsible for:
   i) Assisting the beneficiary in completing the grievance form, if necessary.

ii) Responding to the beneficiary in writing to confirm receipt of the grievance.
iii) Assisting the beneficiary in resolving the grievance.

d. Resolution:
i) The beneficiary will be notified in writing by the MHP or the County DMC-ODS regarding the final resolution of the grievance within thirty (30) days from the date the grievance is filed.
ii) The timeframe may be extended by up to fourteen (14) days in certain circumstances (i.e., beneficiary requests more time to gather information).
iii) The final resolution of each grievance, including the date of the decision, will be documented in the Grievance Log.

6. Standard Appeal Process

a. Beneficiary Filing:
i) A beneficiary may file an appeal, either orally or in writing, using the MHP/County DMC-ODS Appeal Resolution Process brochure, within 60 calendar days of an action taken by either.
ii) If the appeal is oral, the beneficiary must follow up with a signed, written appeal within 60 days of Notice of Adverse Benefit Determination. If a signed written appeal is never received, the appeal expires.
iii) The date of the oral appeal starts the response time clock.
iv) A beneficiary may request to continue receiving currently authorized services while the hearing is pending.

b. MHP/County DMC-ODS Response:
i) Upon receipt of any appeal, staff must report the appeal within one (1) working day to the Quality Improvement Manager (or designated staff) where it will be entered immediately into the Appeal Log.
ii) The Quality Improvement Manager will assign the appeal to a Quality Improvement (QI) staff member to assist in the review and resolution of the appeal.
iii) The designated QI staff member will be a licensed clinician who did not provide direct services and will not have been involved in any previous level of review or decision-making.

c. Beneficiary Participation in Appeal:
Beneficiaries may:
i) Present evidence in person or in writing; and
ii) Examine his/her medical record and any other records pertaining to the appeal before and during the appeal process.
iii) Be provided with their medical records, other documents & records, and any new or additional evidence considered, relied upon, or generated by the MHP in connection with the appeal. This information

must be provided free of charge and sufficiently in advance of the resolution timeframes for appeals.

d. Notification of Appeal Resolution:
   i) The beneficiary will be notified in writing by the MHP or the County DMC-ODS (including the decision date) regarding the final resolution of the appeal within thirty (30) calendar days from the date the appeal is filed.
   ii) The timeframe may be extended by up to fourteen (14) days in certain circumstances (i.e., beneficiary requests more time to gather information or MHP or the County DMC-ODS determines there is need for additional information and the delay is in the beneficiary's interest).
   iii) The final resolution of each appeal, including the date of the decision, will be documented in the Appeal Log.

7. Expedited Appeal Process

a. Criteria:
Beneficiaries have the right to an Expedited Appeal if using the Standard Appeal resolution process could jeopardize their life, health or ability to attain, maintain or regain maximum function.

b. Notification:
Beneficiaries will be notified of their right to an Expedited Appeal and the necessary criteria in the grievance and appeal brochure.

c. Differences from Standard Appeal:
All procedures related to Standard Appeal apply for an Expedited Appeal, except for the following differences:
   i) The MHP or the County DMC-ODS will determine whether or not the beneficiary meets the criteria for an Expedited Appeal before proceeding on an expedited timeframe.
   ii) The MHP or the County DMC-ODS will reach a decision regarding the Expedited Appeal and notify (orally and in writing) the beneficiary of the resolution within 72 hours of receipt of the Expedited Appeal.
   iii) The beneficiary may make the request orally, without written follow-up. No punitive action will be taken against a beneficiary or provider because they request an expedited appeal or support a beneficiary's request for an expedited appeal.

d. Denial of Expedited Appeal Process:
If the MHP or the County DMC-ODS determines that the criteria for an Expedited Appeal are not met and deny an Expedited Appeal process:

   i) The MHP or the County DMC-ODS will notify the beneficiary and/or his/her representative orally and will notify him/her in writing within 72 hours from the date of the denial; and

ii) The Standard Appeal process will apply.

8. Appeal Denied/State Fair Hearing

a. If the MHP fails to adhere to the notice and timing requirements of the appeal process, or if an appeal is denied, the beneficiary has the right to file for a State Fair Hearing (SFH) and be informed about filing instructions.

b. The written notice informing a beneficiary that their appeal has been denied will include information regarding their right to:

i) File for a State Fair Hearing and instructions on how to file a SFH or call the toll free number on the form. A beneficiary must request a SFH no later than 120 calendar days from the date of the appeal resolution.

ii) Request services while the hearing is pending and how to make that request.

9. Report to Quality Improvement Steering Committee:

Quarterly reports on Grievances, Appeals and State Fair Hearings will be made to the Quality Improvement Steering Committee for appropriate action.

PRIOR VERSIONS: 3/9/2018, 2/8/2018, 10/27/2017, 7/1/2017, 9/26/2016, March 30, 2015 and October 1, 2009

REFERENCES: 42 CFR Section 438.402; 438.404; 438.408.

FORMS: Behavioral Health Grievance Resolution Request Form & MHP/County DMC-ODS Appeal Resolution Request Form