



SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

GRIEVANCE AND APPEAL RESOLUTION SYSTEM MANUAL
 ATTACHEMENT A TO BHRS POLICY 19-01

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I. PURPOSE

The Grievance and Appeal Resolution System Manual is an attachment to San Mateo County Behavioral Health and Recovery Services (BHRS) Policy 19-01. BHRS has a grievance and appeal system in place for all beneficiaries and has only one level of appeal (CFR 438.402). This manual explains how to resolve issues related to Specialty Mental Health Services (SMHS) and Substance Use Disorder Services (SUDS) using the Grievance and Appeal System, as required by 42 CFR Part 438, Subpart F and BHRS’s contract with the Department of Health Care Services (DHCS). The information in this manual applies to beneficiaries being served in all BHRS programs, including all contracted agency and private providers.

All BHRS providers, including all contracted agencies and private providers, are required to understand and follow the grievance and appeal process requirements outlined in Policy 19-01 and in this manual, including providing beneficiaries assistance with the process when requested.

BHRS provides information about the grievance and appeal system to all providers and contractors at the time they enter into a contract with BHRS, including copies of the Grievance and Appeals Resolution Poster and the Grievance and Appeals Resolution Brochure in BHRS’s threshold languages. Copies of the poster and brochure are posted and available to beneficiaries at service locations (CFR 438.414).

II. DEFINITIONS

Adverse Benefit Determination (ABD): Any decision made by BHRS or its contractors that denies, reduces, or terminates mental health services to a beneficiary in-whole or in-part, including denial of payment and failure to meet timeliness standards, as outlined by the state.

Authorized Representative: With written consent of the beneficiary or guardian, providers and/or other authorized representatives may file a grievance, request an appeal, or request a State Fair Hearing on behalf of the beneficiary. Providers and authorized representatives cannot request continuation of benefits during appeals/State Fair Hearings.

Appeal: A review of an Adverse Benefit Determination (ABD) upon oral and written request (oral requests must be followed by a written request). Appeals must be filed within 60 days of the original decision.

Beneficiary: A Medi-Cal recipient who is currently receiving services from BHRS or a BHRS contracted provider. Throughout this manual, policy and attachments, the terms beneficiary, client and consumer are used interchangeably.

Expedited Appeal: An appeal used when BHRS determines (for request from a beneficiary) or the provider indicates (in making the request on the beneficiary's behalf or supporting the beneficiary's request) 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.

Grievance: An expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may include, but are not limited to, the quality of care of services provided, aspects of interpersonal relationships such as rudeness by a provider or employee, and failure to respect the beneficiary's rights regardless of whether remedial action is requested. Grievances includes a beneficiary's right to dispute an extension of time proposed by BHRS to make an authorization decision.

BHRS considers a complaint to be the same as a formal grievance. A beneficiary need not use the term grievance for a complaint to be captured as an expression of dissatisfaction and, therefore, a grievance. Even if the beneficiary expressly declines to file a formal grievance, their complaint will be categorized as a grievance unless, it instead meets the definition of an Adverse Benefit Determination or appeal. As with all grievances, these grievances will be analyzed to monitor trends.

Grievance and Appeal System: The processes BHRS uses to resolve grievances, appeals of ABDs, and State Fair Hearings. It also includes the mandated collection and tracking of information about the grievances, appeals and State Fair Hearings.

Limited English Proficient (LEP): Potential and current beneficiaries who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English. These individuals may be eligible to receive language assistance for a particular type of service, benefit, or encounter. BHRS will provide assistance by providing translation and interpretation services.

Office of Consumer and Family Affairs (OCFA): The BHRS team that assists beneficiaries with resolving grievances and appeals in a timely manner. The toll-free number is 1-800-388-5189.

Readily accessible: Electronic information and services which comply with modern accessibility standards in the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines (WCAG) 2.0 AA and successor versions.

III. SAN MATEO COUNTY BHRS GRIEVANCE AND APPEALS TEAM

The Grievance and Appeals Team (GAT) is responsible for managing the Grievance and Appeals System and assist beneficiaries in resolving grievances and appealing ABD decisions. The GAT meets regularly to review all active grievances and appeals.

Membership

The GAT includes the following members:

- Office of Consumer and Family Affairs Director
- Family Education and Support Coordinator
- Consumer/Family Liaisons from the OCFA
- OCFA Grievance Program Coordinator
- Licensed clinical staff from the Quality Management (QM) team

Reporting

Annually, a member of the GAT provides a written report to the Quality Improvement Committee (QIC) describing the number and nature of grievances, appeals and expedited appeals received by the GAT. The issues that are identified are considered in the QIC and the QM Manager tracks the results and implementation of any subsequent system changes. In addition, by October 1st of each year, a report is provided to DHCS summarizing the grievances, appeals and expedited appeals filed from July 1st of the previous year through June 30th of the current year.

GAT Grievance and Appeal Responsibilities

- Upon receipt of a grievance or appeal, the GAT will first determine whether the request is a grievance, or an appeal of an ABD.
- For both a grievance and an appeal of an ABD, the GAT will send an Acknowledgment Letter to the beneficiary postmarked **within 5 calendar days**

of the receipt of the grievance, or appeal of an ABD.

- For both grievances and appeals, an investigation will be completed. After the investigation is complete, either a written Notice of Grievance Resolution letter or a written Notice of Appeal Resolution letter will be sent to the beneficiary within the specified timelines. The resolution letters inform the beneficiary and any authorized representative of the outcome. Any provider identified or involved in the grievance, appeal or expedited appeal, will also receive in writing, a copy of the final disposition of the grievance, appeal or expedited appeal, such as the Notice of Grievance Resolution or Notice of Appeal Resolution.
- If BHRS fails to provide the beneficiary with a Notice of Grievance Resolution letter or a Notice of Appeal Resolution letter within the specified timeline, BHRS will issue a NOABD Grievance and Appeal Timely Resolution Notice.
- Following the initial receipt of a NOABD, a beneficiary has **60 calendar days** from the date on the NOABD to file a request for an appeal to BHRS, according to the instructions included with the notice. The beneficiary may request an appeal either orally or in writing. An oral appeal must be followed by a written, signed appeal unless it is an expedited resolution request. In this case, a beneficiary may file their request for an expedited appeal orally, without the requirement that the request be followed by a written appeal.
- If the grievance is related to medication support/prescriber (MD or Nurse Practitioner), the Office of Consumer and Family Affairs (OCFA) will notify the BHRS Medical Director. The BHRS Medical Director will assign a physician or other medical staff to review the grievance and work with the GAT on the resolution. In an appeal of an unfavorable medication decision, the Medical Director or his designee will review the appeal. If the Medical Director is involved in the grievance itself, or part of the grievance resolution, and a beneficiary objects to the resolution finding, they can file a new grievance. At that point, another appropriate licensed staff person who is not a subordinate of the Medical Director will review and make the next resolution decision.

Assistance with the Grievance and Appeal Process

With written authorization from the beneficiary or legal guardian, another person such as a friend, family member, provider or legal/authorized representative, may be designated to act on their behalf during the grievance and appeal process or in requesting a State Fair Hearing. The GAT will verify that the beneficiary has authorized another to act as their representative and obtain written authorization before releasing Protected Health Information (PHI). Should the other person be designated to act on their behalf, the grievance process will officially start when OCFA has received the written authorization.

At the beneficiary's request, BHRS may also identify staff or another individual, such as a

legal guardian, to be responsible for assisting a beneficiary with the grievance and appeal process, including assisting in writing the grievance, appeal or expedited appeal. If the staff identified by BHRS is the person providing specialty mental health services to the beneficiary requesting assistance, BHRS will identify another individual to assist that beneficiary.

BHRS (all staff within the network of care) will give beneficiaries any reasonable assistance in completing forms and taking other procedural steps related to a grievance. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability (42 CFR 438.406).

IV. HANDLING OF GRIEVANCES AND APPEALS (CFR 438.406)

BHRS ensures that the individuals who make decisions on grievances and appeals are individuals who:

- Were not involved in any previous level of review or decision-making, or a subordinate of any individual who was involved in a previous level of review or decision-making;
- Have the appropriate clinical expertise, as determined by BHRS, in treating the beneficiary's condition or disease if deciding any of the following:
 - An appeal of an ABD that is based on lack of medical necessity;
 - A grievance regarding denial of an expedited resolution of an appeal; or
 - Any grievance or appeal involving clinical issues;
- Take into account all comments, documents, records, and other information submitted by the beneficiary or their representative without regard to whether such information was submitted or considered in the initial ABD.

BHRS OCFA Record Keeping Requirements (CFR 438. 420)

BHRS OCFA maintains a grievance and appeal log and records grievances, appeals and expedited appeals in the log within **one working day** of the day of receipt of the grievance, appeal or expedited appeal. This includes grievances, appeals and expedited appeals that are received orally and/or in writing, including those resolved by the close of the next business day. BHRS OCFA also records in the log the final disposition of grievances, appeals and expedited appeals, including the date the decision is sent to the beneficiary. If there has not been a final disposition of the grievance, appeal or expedited appeal, the reasons are included in the log. Information in the log and records, including tracking sheets and

any letters or notices sent in relation to the complaint are accessible to BHRS Quality Management. A beneficiary or their representative may contact OCFA to request information regarding the status of their grievance, appeal, or expedited appeal.

The OCFA reviews the information in the records as part of its ongoing monitoring procedures, as well as for updates and revisions to the State quality strategy. The GAT team will audit these records regularly to ensure compliance. BHRS maintains the confidentiality of each beneficiary's information during the resolution process.

Each record shall include, but not be limited to:

- A general description of the reason for the appeal or grievance;
- The date received;
- The date of each review or, if applicable, review meeting;
- Resolution information at each level of the appeal or grievance, if applicable;
- Date of resolution at each level, if applicable; and
- Name of the covered person for whom the appeal or grievance was filed.

All records will be accurately maintained in manner accessible to the State and available upon request to CMS.

V. DISCRIMINATION GRIEVANCES

BHRS has a designated Discrimination Grievance Coordinator who ensures compliance with federal and state nondiscrimination requirements and investigates discrimination grievances related to any action that would be prohibited by, or out of compliance with federal or state nondiscrimination law. BHRS has procedures in place to ensure the prompt and equitable resolution of discrimination-related complaints.

BHRS does not require a beneficiary to file a discrimination grievance with BHRS before filing the complaint directly with the DHCS Office of Civil Rights and the U.S. Health and Human Services Office for Civil Rights.

For more information and to access the forms to file a discrimination grievance with either the DHCS Office of Civil Rights or the U.S. Health and Human Service Office for Civil Rights, please see the links below:

- *DHCS Office of Civil Rights:*
<https://www.dhcs.ca.gov/discrimination-grievance-procedures>
- *U.S. Health and Human Services Office for Civil Rights:*
<https://www.hhs.gov/civil-rights/index.html>

Within 10 calendar days of mailing a discrimination resolution letter to a beneficiary, BHRS must submit the following information regarding the complaint to the DHCS Office of Civil Rights:

- a. The original complaint.

- b. The provider's or other accused party's response to the complaint.
- c. Contact information for the personnel primarily responsible for investigating and responding to the complaint on behalf of BHRS.
- d. Contact information for the beneficiary filing the complaint, and for the provider or other accused party that is the subject of the complaint.
- e. All correspondence with the beneficiary regarding the complaint, including, but not limited to, the discrimination grievance acknowledgement letter and resolution letter sent to the beneficiary.
- f. The results of BHRS' investigation, copies of any corrective action taken, and any other information that is relevant to the allegation(s) of discrimination.

VI. GRIEVANCE PROCEDURES AND TIMELINES

How to file a Grievance

Any beneficiary of BHRS and/or a provider, or authorized representative may file a grievance orally or in writing, at any time, by completing the Grievance form, speaking directly to staff, or by contacting the OCFA at 1-800-388-5189. Alcohol and Other Drug (AOD) clients may also file a grievance directly with the State.

Any beneficiary receiving services anywhere in the BHRS network of care can file a grievance with their clinic supervisor/manager/staff or with OCFA. If a beneficiary asks to file a grievance at a BHRS clinic, clinic staff will assist them by locating the grievance form, and, if requested, help to fill out the form and/or call the OCFA with the beneficiary. Grievances not resolved in 24 hours by the provider to the beneficiary's satisfaction, must be immediately sent to the OCFA.

Any beneficiary receiving Substance Use Disorder Services (SUDS) may file a complaint by calling the DHCS Office of the Ombudsman at 1-800-896-4042 or by calling the Department of Health Care Services SUD Compliance Division at 1-877-685-8333 or online at the DHCS website

Beneficiaries receiving services from the Private Provider Network (PPN), such as a BHRS contracted therapist in the community, may also file a grievance at any time by contacting the BHRS ACCESS Call Center at 1-800-686-0101 or by contacting the Health Plan of San Mateo at 1-888-576-7227.

BHRS does not discourage the filing of grievances and a beneficiary may file a grievance either orally or in writing at any time. There is no limit to the number of times a beneficiary can file a grievance. Additionally, a grievance that has already received a resolution may be re-filed as a grievance. BHRS will not subject the beneficiary to any discrimination or any penalty for filing a grievance, appeal, or expedited appeal. Clients may seek assistance at any time during the grievance process from the OCFA.

Grievance Resolution and Notification Timeline (CFR 438.408)

BHRS must resolve each grievance and provide notice, as expeditiously as the client's health condition requires, within the State-established timelines that may not exceed the timelines specified in this manual.

BHRS will provide written notification to the beneficiary or the appropriate representative of the resolution of a grievance and documentation of the notification or efforts to the beneficiary, if the beneficiary could not be contacted. The beneficiary will be notified of the grievance resolution in a format and language that meets the applicable notification standards. (42 CFR 438.408 (d)(1); 42 CFR 438.10).

For standard resolution of a grievance and notice to the affected parties, the timeline is established by the State and may not exceed **90 calendar days** from the day BHRS receives the grievance.

Grievance Process Notification Letters and Templates

Notice of Grievance Acknowledgement: Sent by OCFA within **5 calendar days** of receipt of a grievance by the beneficiary or their representative.

Notice of Grievance Resolution (Attachment N): Sent by OCFA after it has concluded its investigation of any grievance. This is sent to the beneficiary and/or parent/legal guardian. This letter is sent **within 2 business days** of the resolution decision. A copy of this letter will also be sent to the provider(s) named in the grievance.

The content of the Notice of Grievance Resolution must explain the following:

- The original complaint;
- The decision/determination BHRS has made or intends to make;
- The reasons for the decision/determination; and
- Any recommendation or follow-up information for the client.

Extension of Grievance Resolution Timelines

BHRS may extend the timelines of a grievance resolution by **up to 14 calendar days** if:

- The beneficiary requests the extension; or
- BHRS shows (to the satisfaction of the State agency, upon its request) that there is need for additional information and how the delay is in the beneficiary's interest.

Following an extension made by BHRS, and not the beneficiary, BHRS must complete all the following:

- Make reasonable efforts to give the beneficiary prompt oral notice of the delay;
- **Within 2 calendar days**, give the beneficiary written notice of the reason for the decision to extend the timeline and inform the beneficiary of the right to file a grievance if they disagree with that decision; and
- Resolve the appeal as expeditiously as the beneficiary's health condition requires and no later than the date the extension expires.

The written notice of the extension is not a Notice of an ABD.

Grievance Process Exemptions

Grievances that are received over the telephone or in-person by BHRS, or a network provider of BHRS, that are resolved to the beneficiary's satisfaction by the **close of the next business day** following receipt, are exempt from the requirement to send a written Acknowledgment Letter and the Notice of Grievance Resolution letter. Grievances received via mail are not exempt from the requirement to send a written Acknowledgment Letter **within 5 calendar days** of the receipt of the grievance or from the requirement to send a written Notice of Grievance Resolution letter.

Grievances that are resolved within 24 hours are otherwise exempt from notification, but still need to be logged by the Grievance and Appeals Team and included in reports submitted to DHCS.

VII. NOTICE OF ADVERSE BENEFITS DETERMINATIONS AND APPEALS

A Notice of Adverse Benefits Determination (NOABD) is sent to a beneficiary after a decision by BHRS and/or its contracted providers is made that limits or changes the beneficiary's services.

BHRS must provide beneficiaries a NOABD under the following circumstances:

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 BHRS to act within the specified timelines regarding the standard resolution of grievances and appeals.
6. For a resident of a rural area with only one provider, the denial of an enrollee's request to exercise his or her right, to obtain services outside the network.
7. The denial of a beneficiary's request to dispute financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other beneficiary financial liabilities.

Notice of Adverse Benefits Determination Timeline

The BHRS Management Information System (MIS) department, Quality Management, all same day assistance programs, the BHRS Call Center Assessment and Authorization Team, and AOD (SUDS) providers are required to follow all the mandated elements below.

BHRS must mail a NOABD within the following timelines:

<p>For termination, suspension, or reduction of previously authorized Medi-Cal-covered services:</p>	<p>A minimum of 10 days before the date of the action.</p>
<p>For denial of payment:</p>	<p>At the time of any action affecting the claim.</p>
<p>For standard service authorization decisions that deny or limit services:</p>	<p>Timelines may not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if:</p> <ul style="list-style-type: none"> • The beneficiary, or the provider, requests extension; or • BHRS justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest. <p>If BHRS meets the criteria set forth for extending the timeline for standard service authorization decisions, it must:</p> <ul style="list-style-type: none"> • Give the beneficiary written notice of the reason for the decision to extend the timeline and inform the beneficiary of the right to file a grievance if they disagree with that decision; and • Issue and carry out its determination as expeditiously as the beneficiary's health condition requires and no later than the date the extension expires. • If an authorization decision is not made within the specified timeline, this constitutes an ABD as of the date the timeline expires.
<p>For expedited service authorization decisions (in cases where a provider determines that following the standard timeline could seriously jeopardize the beneficiary's life, health or ability to attain,</p>	<p>No later than 72 hours after the receipt of the request for service.</p>

maintain, or regain maximum functioning):	
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Content of the Notice of Adverse Benefit Determination (CFR 438.404)

The letter/notice to a beneficiary of an Adverse Benefit Determination (ABD) must include:

1. The ABD BHRS has made or intends to make;
2. The reasons for the ABD;
3. The right of the beneficiary to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the ABD. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits;
4. The beneficiary's right to file, and the procedure for exercising, an appeal or an expedited appeal with BHRS, including information about exhausting BHRS' one level of appeal and right to request a State Fair Hearing after receiving notice that that adverse benefit determination is upheld;
5. The circumstances under which an appeal process can be expedited and how to request it; and
6. The beneficiary's right to have benefits continue pending resolution of the appeal and how to request that benefits be continued, and the circumstances, under which a beneficiary may be required to pay the costs of these services.

Notice of Adverse Benefits Determination Templates & Information

- NOABD Denial Notice (Attachment C): Use this template when BHRS denies a request for service. Denials include determinations based on the type and level of service, requirements for medical necessity, and appropriateness, setting or effectiveness of a covered benefit. For Drug Medi-Cal-Organized Delivery System (DMC-ODS) also use this template for denied residential service requests.
- NOABD Modification Notice (Attachment D): Use this template when BHRS modifies or limit's the providers request for a service, including reductions in frequency and/or duration of service, and approval of alternative treatments and services.
- NOABD Termination Notice (Attachment E): Use this template when BHRS terminates, reduces, or suspends a previously authorized service.
- NOABD Delivery System Notice (Attachment F): Use this template when BHRS has determined that the beneficiary does not meet the criteria to be eligible for Specialty Mental Health (SMHS) or Substance Use Disorder services (SUDS). The beneficiary will be provided contact information for the Managed Care Plan (MCP), or other appropriate system, for mental health, substance use disorder, or other

services.

- NOABD Authorization Delay (Attachment G): Use this template when there is a delay in processing a provider's request of specialty mental health services or substance use disorder residential services. Also includes:
 - When BHRS extends the timeline to make an authorization decision;
 - The provider or client requests a delay in authorization;
 - There is a need for additional information from the provider or client; or
 - The extension of benefits is in the client's interest.
- NOABD Timely Access Notice (Attachment H): Use this template when there is a delay in providing the beneficiary with timely services as outlined by the timely access standards applicable to the service.
- NOABD Financial Liability Notice (Attachment I): Use the template when BHRS requests to dispute financial liability, including cost sharing and other beneficiary's other financial liabilities.
- NOABD Payment Denial Notice (Attachment J): Use this template when BHRS denies, in whole or in part, for any reason, a provider's request for payment for a service that has already been delivered to the beneficiary.
- NOABD Grievance and Appeal Timely Resolution Notice (Attachment K): Use this form when BHRS does not meet required timelines for the standard resolution of grievances and appeals.
- NOABD "Your Rights" (Attachment O): Informs beneficiaries of critical appeal and State hearing rights and accompanies all the NOABD's. The "NOABD Your Rights" attachment provides beneficiaries with the following required information pertaining to all NOABD:
 - The beneficiary's or parent's/guardian's or provider's right to request an internal appeal with BHRS **within 60 calendar days** from the date on the NOABD;
 - The beneficiary's right to request a State Fair Hearing (hereafter "hearing") only after filing an appeal with BHRS and receiving a notice that the Adverse Benefit Determination has been upheld;
 - The beneficiary's right to request a hearing if BHRS fails to send a resolution notice in response to the appeal within the required timeline;
 - Procedures for exercising the beneficiary's rights to request an appeal;
 - Circumstances under which an expedited review is available and how to request it; and
 - The beneficiary's right to have benefits continue pending resolution of the appeal and how to request continuation of benefits in accordance with

Title 42, CFR, Section 438.420.

- Notice of Appeals Resolution (NAR) “Your Rights” (Attachment P): This is included with any notice of appeals resolution correspondence.
- Language Assistance Taglines (Attachment Q): Included in all grievances, notices of ABD, and appeals correspondence forms.
- Beneficiary Non-Discrimination Notice (Attachment R): This is included with any grievance, notice of an ABD, and appeals correspondence forms.

Second Opinions

At the request of the beneficiary when BHRS or its network provider has determined that the beneficiary is not entitled to SMHS due to not meeting the medical necessity criteria, BHRS provides for a second opinion by a licensed mental health professional (other than a psychiatric technician or a licensed vocational nurse). BHRS provides a second opinion from a network provider or arranges for the beneficiary to obtain a second opinion outside the network at no cost to the beneficiary. Any beneficiary may contact the ACCESS Call Center at (800) 686-0101 or TDD: (800) 943-2833 to request a second opinion outside the network at no cost to the beneficiary. The ACCESS Call Center maintains records of these requests and outcomes.

VIII. APPEALING A NOTICE OF ADVERSE BENEFITS DETERMINATION

How to file an Appeal and Assistance with the Appeal Process

Any beneficiary of BHRS and/or a provider or authorized representative acting on the beneficiary’s behalf, may file an oral or written appeal of an ABD **within 60 calendar days** from the date on the ABD notice by completing the Grievance and Appeal form, speaking directly to staff, or by contacting the OCFA at 1-800-388-5189. Oral inquiries seeking to appeal an ABD are treated as appeals and confirmed in writing unless the beneficiary or the provider requests an expedited resolution. The date BHRS receives the oral appeal is considered the filing date, in order to establish the earliest possible filing date for the appeal. An oral appeal must be followed by a written and signed appeal, unless the beneficiary or the provider requests an expedited resolution.

Any beneficiary or parent/guardian of a child receiving services anywhere in the BHRS network of care can file an appeal of an ABD with their clinic supervisor/manager/staff or with OCFA. If a beneficiary asks to file an appeal at their BHRS clinic, staff will assist them by locating the appropriate form, and if requested, help to fill out the form and/or call the OCFA with the beneficiary.

Beneficiaries receiving services in the contracted provider network, (such as a BHRS contracted therapist in the community), may file an appeal of an ABD by contacting the BHRS ACCESS Call Center at 1- 800-686-0101 or by contacting the Health Plan of San Mateo at 1-888-576-7227.

BHRS (all staff and providers within the network of care) will give beneficiary's any reasonable assistance that the beneficiary or parent/guardian requests to complete forms and/or help with other procedural steps related to an appeal. This includes, but is not limited to, auxiliary aids and interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability (42 CFR 438.406).

Beneficiaries may seek assistance from the OCFA at any time during the appeal process.

Appeal Resolution and Notification Timelines (CFR 438.408)

For standard resolution of appeals, BHRS will send the beneficiary or parent/guardian a written Acknowledgement Letter within **5 calendar days** of receiving the appeal.

This letter will include the following information:

- Date of receipt;
- Name of BHRS representative to contact;
- Telephone number of contact; and
- Address of contact.

BHRS must resolve each appeal, and provide notice, as expeditiously as the beneficiary's health condition requires, within the State-established timelines that may not exceed the timelines specified in this manual.

The Notice of Appeal Resolution letter for a standard resolution appeal must be sent in writing to the affected parties (beneficiary, parent and provider) within **30 calendar days** of the date BHRS receives the appeal. The letter used is either the Notice of Appeal Resolution- Overturned template or the Notice of Appeal Resolution-Upheld template.

Notice of Appeal Resolution Templates & Information

- Notice of Appeal Resolution - Overturned (Attachment L): This template letter is used when BHRS staff have resolved the NOABD Appeal and have **overturned** the original decision. The content of this notice must include:
 - The results of the resolution and the date it was completed.
 - The reasons for BHRS's determination, including the criteria, clinical guidelines, or policies used in reaching the determination.
 - For appeals not resolved wholly in the favor of the beneficiary, the right to request a State Fair Hearing and how to request it. The beneficiary's or representative's hearing request must be sent **within 120 days** of the date the Notice of Appeals Resolution letter was post- marked or delivered to the client.
 - For appeals not resolved wholly in the favor of the beneficiary, the

beneficiary's right to request and receive continuation of benefits (services) while the State Fair Hearing is pending and how to make the request. In this case, the beneficiary's or their representative's request must be sent **within 10 days** from the date the Notice of Appeals Resolution letter was post-marked or delivered to the client.

- Notification that the beneficiary may be held liable for the cost of those benefits if the State Fair Hearing decision upholds BHRS's adverse benefit determination.
- Notice of Appeal Resolution - Upheld (Attachment M): This template letter is used when BHRS staff have resolved the NOABD Appeal and have **upheld** the original decision. The content of this notice must include:
 - The results of the resolution and the date it was completed.
 - The reasons for BHRS's determination, including the criteria, clinical guidelines, or policies used in reaching the determination.
 - For appeals not resolved wholly in the favor of the beneficiary, the right to request a hearing and how to request it. The beneficiary's or representative's hearing request must be sent **within 120 days** of the date the Notice of Appeal Resolution letter was post-marked or delivered to the beneficiary;
 - For appeals not resolved wholly in the favor of the beneficiary, the beneficiary's right to request and receive continuation of benefits (services) while the State Fair Hearing is pending and how to make the request. In this case, the beneficiary's or representative's request must be sent **within 10 days** from the date the Notice of Appeal Resolution letter was post-marked or delivered to the beneficiary.
 - Notification that the beneficiary may be held liable for the cost of those benefits if the hearing decision upholds BHRS's adverse benefit determination.

The Right to Present Information and Request Materials

Beneficiaries and their representatives are provided a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments in support of their appeal or expedited appeal requests. BHRS must inform the beneficiary of the limited time available for this and communicate this sufficiently in advance of the resolution timeline for appeals and expedited appeals, as specified in this manual.

Upon request, beneficiaries and their representatives are provided copies of the beneficiary's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by BHRS (or at the

discretion of BHRS) in connection with the appeal of the ABD provided that there is no disclosure of the PHI of any individual other than the beneficiary. This information must be provided to the beneficiary or their representative free of charge and sufficiently in advance of the resolution timeline for standard and expedited appeals resolutions, as specified in this manual. This must be provided to all parties involved in the appeal, including the beneficiary and his or her representative; or the legal representative of a deceased beneficiary's estate.

Expedited Appeal Resolution

BHRS maintains an expedited review process for appeals when BHRS determines that the standard 30-day resolution timeline could seriously jeopardize the beneficiary's life, physical or mental health, or ability to attain, maintain, or regain maximum function. BHRS may accept the request for an expedited appeal resolution when they agree with the beneficiary's request or a provider's advocacy on behalf of the beneficiary that the standard 30-day timeline is too long based on the beneficiary's situation. BHRS ensures that no punitive actions are taken against a provider who requests an expedited resolution or supports a beneficiary's expedited appeal. A beneficiary may file a request for an expedited appeal orally, without the requirement to submit a subsequent written, signed appeal.

Expedited Appeal Decision and Resolution Timeline

A decision on a request for an expedited appeal resolution will be made **within 72 hours** of the initial request for the expedited appeal resolution. BHRS must log the exact time and date that the expedited appeal resolution request is received, as this begins the 72-hour timeline for the decision to be accepted or denied.

Acceptance of the Expedited Appeal Resolution

If the expedited appeal resolution request is accepted, BHRS will resolve and notify the affected parties in writing, as expeditiously as the beneficiary's health condition requires and **no later than 72 hours** after BHRS receives the request for the expedited appeal resolution. BHRS must make reasonable efforts to provide oral notice to the beneficiary and/or their representative and additionally, send the Notice of Appeal Resolution letter, to the beneficiary or representative **within 72 hours** of BHRS's receipt of the request for the expedited appeal resolution. This time may be extended in some situations.

Denial of an Expedited Appeal Resolution

If BHRS denies the request for the expedited resolution of an appeal:

- BHRS will transfer the expedited appeal request to the timeline for standard resolutions (as referenced in CFR 438.408) and resolve the appeal as expeditiously as possible, **within 30 days** of the date the appeal was received.
- BHRS will make reasonable efforts to provide the beneficiary with prompt

verbal notice of the denial of the request for an expedited appeal and the decision to transition the appeal to the standard resolution timeline.

- BHRS will also provide written notice of the decision to transfer the appeal for standard resolution **within 2 calendar** days of the decision.

Extension of an Appeal Resolution

BHRS may extend the timeframe for resolving appeals **up to 14 calendar days** if either of the following conditions apply:

- The beneficiary requests the extension; or
- BHRS demonstrates, to the satisfaction of DHCS upon request, that there is a need for additional information and how the delay is in the beneficiary's interest.

In addition, BHRS complies with the following Federal regulation mandates:

- If BHRS extends the timeframe of the appeal resolution, for any extension that is not requested by the beneficiary, BHRS will make reasonable efforts to give the beneficiary prompt oral notice of the delay.
- BHRS shall provide written notice of the extension **within 2 calendar days** of making the decision to extend the timeframe and notify the beneficiary of the right to file a grievance if the beneficiary disagrees with the extension.
- BHRS shall resolve the appeal as expeditiously as the beneficiary's health condition requires and in no event extend resolution beyond **14-calendar days**.
- If BHRS fails to adhere to the notice and timing requirements, the beneficiary is deemed to have exhausted the BHRS appeal process and, if desired, may initiate a State Fair Hearing.
- The written notice of the extension is not a NOABD.

Continuation of Benefits (CFR 438.420)

BHRS will continue the beneficiary's benefits if all of the following occur:

- The beneficiary files a request for an appeal **within 60 calendar days**, or the intended effective date, of the notice of the notice of ABD (CFR438.402.);
- The appeal involves the termination, suspension or reduction of a previously authorized service;
- The services were ordered by an authorized provider
- The period covered by the original authorization has not expired; and
- The beneficiary files for the continuation of benefits within the required timelines.

If, at the beneficiary's request, BHRS continues or reinstates the beneficiary's benefits while the

appeal or State Hearing is pending, the benefits must be continued until one of the following occurs:

- The beneficiary withdraws the appeal or the request for a State Hearing;
- The beneficiary fails to request a State Hearing and continuation of benefits within 10 calendar days after the MHP sends the notice of adverse resolution (i.e. Notice of Appeal Resolution) to the beneficiary's appeal; or
- A State Hearing office issues a hearing decision adverse to the beneficiary.

IX. STATE FAIR HEARING PROCESS (CFR 438.424, Subpart E, part 431)

The State Fair Hearing Process ("hearing") is an independent review by the California DHCS which the client may request after receiving notice that their appeal of an ABD has been denied. Hearings must be requested **within 120 days** of receiving notice of the denied appeal; however, to continue receiving services, the hearing request must be submitted **within 10 days** of the appeal denial.

General Requirements for a State Fair Hearing

If a beneficiary is dissatisfied with the outcome of the grievance and appeal process, they may request a hearing after receiving notice that the Adverse Benefit Determination has been upheld.

The beneficiary must request a State Fair Hearing **within 120 calendar days** of the date of the notice of the decision.

The client must be told about their rights to seek a hearing in their preferred language and to have benefits continue if they request a State Fair Hearing **within 10 days** of the notice that the Adverse Benefit Determination is being upheld.

Deemed Exhaustion of Appeals Processes

If BHRS fails to adhere to the notice and timing requirements as detailed in this policy, the beneficiary is deemed to have exhausted the appeals process. The beneficiary may initiate a State Fair Hearing.

Effectuation of Reversed Appeal Resolutions (CFR 438.424)

If BHRS or the Hearing Officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, BHRS must authorize or provide the disputed services promptly and as expeditiously as the beneficiary's health condition requires but **no later than 72 hours** from the date it receives notice reversing the determination.

Services Furnished While the Appeal is Pending

If BHRS or the Hearing Officer reverses a decision to deny authorization of services, and the beneficiary received the disputed services while the appeal was pending, BHRS or the State must pay for those services, in accordance with State policy and regulations.

X. RESOURCES

- Office of Consumer and Family Affairs: (OCFA) 1-800-388-5189
<http://www.smchealth.org/support-clients-family>
- California Department of Health Care Services (DHCS) Office of the Ombudsman:
888-452-8609
<http://www.dhcs.ca.gov/services/ccs/Documents/CCSGrievancesAFHP.pdf>