SAN BERNARDINO COUNTY
Behavioral Health
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Grievance and Appeal Policy

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Policy

In accordance with State and Federal regulations, the Department of Behavioral Health (DBH) provides verbal and written information to clients or potential clients describing their right to file a grievance and/or appeal regarding services, and to file for a State fair hearing. This policy and related procedures apply to mental health and substance use disorder services (SUD), including Specialty Mental Health Services (SMHS) and Drug Medi-Cal Organized Delivery System (DMC-ODS) services.

Purpose

The purpose of this policy is to outline grievance and appeal requirements to ensure DBH, contract agencies, and Fee for Service (FFS) providers make entitled clients or potential clients aware of their grievance, appeal, and State hearing rights.

Definition(s)

Appeal is a client objection to a DBH adverse benefit determination requiring further consideration and review by DBH via appeal review process.

Grievance is an expression of dissatisfaction about any matter other than an adverse benefit determination. A complaint is considered a grievance unless if meets the definition of adverse benefit determination (see definition next page). Grievances may include, but are not limited to, the following dissatisfactions:

- Quality of care or services rendered;
- Rudeness of a provider or employee;
- Failure to respect the client or potential client's rights;
- Dispute an extension of time proposed by DBH to make an authorization decision, etc.

Grievance and Appeal Process is the process implemented to handle grievances and appeals of an adverse benefit determination, including the systems used to collect and track information about each grievance/appeal.

Medi-Cal client is an individual who has been determined eligible for Medi-Cal benefits. Not all DBH clients meet Medi-Cal eligibility requirements.

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Definition(s), continued

Notice of Adverse Benefit Determination (NOABD) replaced the former terminology of "Notice of Action" (NOA). An NOABD is any of the following actions taken by DBH, contract agency or FFS provider:

- Denial or limited authorization of requested service(s), including determinations based on the type or level of service(s), medical necessity, appropriateness, setting or effectiveness of a covered benefit;
- Reduction, suspension or termination of a previously authorized service(s);
- Denial, in whole or in part, of payment for a service;
- Failure to provide services in a timely manner;
- Failure to act within the required timeframe for standard resolutions of grievance and/or appeal; or
- Denial of a client or potential clients' request to dispute financial liability.

Notice of Appeal Resolution is a formal letter informing a client or potential client that an Adverse Benefit Determination has been overturned or upheld.

Notice of Grievance Resolution is a formal letter notifying a client or potential client of the results of the grievance resolution, which is DBH's decision regarding the grievance filed.

Resolved means DBH has reached a decision with respect to the client or potential client's grievance and notified the client or potential client of the disposition.

State Hearing means a clear expression by the client or potential client, or his/her authorized representative, that the client or potential client wants the opportunity to present his/her case to the State reviewing authority.

Grievance Requirements

Federal regulation and State guidelines outline grievance requirements as follows:

- A client or potential client has the right to file a grievance, formally or informally, if they are dissatisfied about any matter, other than an adverse benefit determination (as defined in the Definitions section of this policy);
- Even if a client or potential client declines to file a written grievance, DBH, contract agencies and/or FFS providers shall report their dissatisfaction or complaint as a grievance for the purposes of monitoring trends. A client or potential client does not need to use the term "grievance" to be treated as such;

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Grievance Requirements, continued

- DBH, contract agencies and FFS providers shall not discourage the filing of a grievance;
- If a client or potential client files a grievance and the program that receives the grievance addresses the grievance to the satisfaction of the client or potential client, the grievance shall still be reported to the DBH Access Unit (see Grievance Procedure);
- A client or potential client may file a grievance at any time;
- A client or potential client, provider and/or authorized representative may file a grievance either verbally or in writing;
- Any client or potential client who files a grievance shall receive written acknowledgement of receipt of the grievance and the acknowledgement shall include the following, at minimum: date of receipt, first and last name, telephone number and address of the DBH grievance representative who he/she may contract about the grievance, and
- All clients and potential clients of DBH, contract agencies or FFS providers are afforded the grievance process; however, Federal regulations apply to Medi-Cal clients regarding the ability to request a State Hearing or file an appeal.

Grievance Process Exemption

Regulations state that grievances received over the telephone or in-person by DBH, contract agency, and/or FFS provider that are resolved to the client or potential client's satisfaction by the close of the next business day following receipt of the grievance are exempt from the requirement to send a written acknowledgement and disposition letter, referred to as a Notice of Grievance Resolution (NGR).

To meet this grievance process exemption, DBH, contract agency, and/or FFS providers or staff must complete the following actions:

- Report the verbal or written grievance from the client or potential client, and immediately, but no later than end of the same work day the grievance was filed, send the completed grievance via email to DBH-Grievances@dbh.sbcounty.gov.
- By close of the next business day after the grievance is filed, send advisement of the resolution and the client or potential client's satisfaction with the resolution via email to DBH-Grievances@dbh.sbcounty.gov. List the subject line as follows: Grievance Resolved Next Biz Day and the name of the DBH program.

Note: Grievances received via mail are **NOT** exempt from the requirement to send an acknowledgment and disposition letter in writing.

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NOABD Requirements

Federal regulation and State guidelines outline specific requirements for NOABDs, listed as follows:

- Written requirements for the NOABD, include the following:
  - Explanation of the adverse benefit determination DBH, contract agency or FFS provider has made or intends to make;
  - Clear and concise explanation of the reason(s) for the decision;
  - For determination based on medical necessity criteria, the NOABD must include clinical reasons for the decision by explicitly stating why client/potential client's condition does not meet SMHS and/or DMC-ODS medical necessity criteria;
  - A description of the criteria used, including medical necessity criteria, and any processes, strategies or evidentiary standards used in making such determinations, and
  - Client or potential client's right to be provided upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the client or potential client's adverse benefit determination.

Note: Refer to the Notice of Adverse Benefit Determination Procedure for detailed information.

Authorized Representative

A client or potential client does not have to file a grievance, request for appeal or State hearing directly, as regulation permits a provider or authorized client representative with written consent from client/potential client to file any of the aforementioned actions. Providers and authorized representatives cannot request a continuation of benefits as specified in Federal regulations.

Attachments

Based on State requirements, there are two (2) types of "Your Rights" attachments that inform clients and potential clients of critical appeal and State hearing rights:

The NOABD Your Rights Attachment is included when a NOABD is issued and provides clients, potential clients, and/or treatment providers with the following information:

- Clients' or treatment providers' right to request an appeal **within 60 calendar days** from the date of the NOABD;
- Clients' right to request a State hearing ***only*** after filing an appeal and receiving notice that the adverse benefit determination has been upheld;
- Clients' right to request a State hearing ***if*** DBH fails to send a resolution notice in response to the appeal within the required timeframe;
- Procedures for exercising the clients' right to request an appeal;
- Circumstances under which an expedited review is available and how to request it; and

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Attachments, continued

- Clients' right to have benefits continue pending resolution of the appeal *and* how to request continuation of benefits in accordance with Federal law.

The Notice of Appeal Resolution (NAR) Attachment shall be included when an NAR Overturned, or Upheld, is issued.

Appeal Requirements

Federal regulation and State guidelines outline the following appeal requirements:

- Must be filed **within sixty (60) calendar days** from the date on the NOABD.
- Clients' must exhaust the DBH appeals process prior to requesting a State hearing.
- Appeals can be verbal or in writing and can be requested by the client or potential client, treatment provider and/or authorized representative.
  - Appeals filed by the provider on behalf of the client require written consent from the client/potential client/legal representative.

Note: Refer to the Standard and Expedited Resolutions of Appeals Procedure for detailed information.

Expedited Resolution of Appeals Requirements

DBH is required to establish and maintain an expedited review process for appeals when it determines or the provider indicates that taking time for a standard resolution could seriously jeopardize the client's mental health or SUD condition and/or the Medi-Cal client's ability to attain, maintain, or regain maximum function.

For expedited resolution of an appeal and notice to affected party, DBH must resolve the appeal and provide notice as expeditiously as the client's health condition requires, **no longer than seventy-two (72) hours** after the Plan receives the expedited appeal request.

Note: Refer to the **Standard and Expedited Resolutions of Appeals Procedure for more detailed information.**

Notice of Appeal Resolution (NAR) Requirements

The Notice of Appeal Resolution (NAR) is a formal letter informing a client that a NOABD has been overturned or upheld.

Note: Refer to the **Standard and Expedited Resolutions of Appeals Procedure for more detailed information.**

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State Hearing Requirements

A Medi-Cal client has the right to request a State hearing **only** after receiving notice that DBH is upholding an adverse benefit determination.

If ...	Then ...
DBH fails to adhere to the notice and timing requirements in federal regulations and State requirements.	The Medi-Cal client is deemed to have exhausted the appeals process. The Medi-Cal client may then initiate a State hearing.

Per Federal regulations, Medi-Cal clients have **120 calendar days** from the date of the NAR to request a State hearing.

For standard State Hearings, DBH must notify Medi-Cal clients that the State must reach its decision on the hearing **within 90 calendar days** of the date of the request for hearing.

For Expedited Hearings, DBH must notify Medi-Cal clients that the State must reach its decision on the State Hearing **within three (3) working days** of the request for the hearing.

Note: Refer to the State Hearing Procedure for more detailed information.

DBH Oversight Requirements

DBH is required to implement and maintain a Grievance and Appeal System to ensure receipt, review and resolution of grievances and appeals. The Grievance and Appeal System shall operate in accordance with applicable federal regulations and state requirements as follows:

- Have written policies and procedures regarding its Grievance and Appeal System;
- Notify clients and potential clients about its Grievance and Appeal System. This shall include information on its procedures for filing and resolving grievance and appeals, a toll-free and/or local telephone number(s), and the address for mailing grievances and appeals;
- Inform clients of how to obtain grievance and appeals forms:
  - Grievance and appeals forms shall be provided promptly upon request.
  - Clients, potential clients and authorized representatives shall be able to access grievance, appeal and expedited appeals forms and self-addressed stamped envelopes at all provider sites without needing to make a written or verbal request.
  - Descriptions for filing grievances and appeal procedures will be readily available and posted at the location where grievances and/or appeals are submitted at every DBH, contract agency and FFS provider's office or facility.

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DBH Oversight Requirements, continued

- Appropriate and adequate consideration of grievances and appeals will be conducted as well as rectification when appropriate. All issues presented by the client will be addressed and resolved.
- Individuals with authority to require corrective action will conduct decision-making.
- Linguistic and cultural needs of the client population, as well as the needs of clients with disabilities will be addressed. DBH shall ensure all clients have access to fully participate in the Grievance and Appeal System by assisting those with limited English proficiency or with a communicative impairment. Assistance will include, but is not limited to, translation of forms, grievance and appeal procedures, DBH responses, access to interpreters, telephone relay systems and other devices that aid individuals with disabilities to communicate.
- Clients or potential clients will not be discriminated against because of their filing of a grievance or appeal.
- The individual making the final decision for the proposed resolution of a grievance or appeal will not have participated in any prior decisions related to this grievance or appeal. The decision-maker shall be a health care professional with clinical expertise in treating a client's condition or disease if any of the following apply:
    - An appeal of an Adverse Benefit Determination 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.
- The designated decision maker on clinical appeals will take into account all information submitted by the client, potential client or their authorized representative regardless of whether such information was submitted or considered in the initial Adverse Benefit Determination.
- The client, potential client or their authorized representative will be provided the opportunity to review the client's case file that may include medical records, supplementary documents and any additional evidence considered or generated by DBH in connection with any standard or expedited appeal of an Adverse Benefit Determination. The information will be provided free of charge and sufficiently in advance of the resolution timeframe.

DBH Access Unit shall maintain a log of each grievance and appeal with the following information:

- Date and time of receipt of the grievance or appeal;
- Name of the individual filing the grievance or appeal;
- Name of the representative recording the grievance or appeal;
- Description of the complaint or problem;

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DBH Oversight Requirements, continued

- Description of the action taken by DBH or provider to investigate and resolve the grievance or appeal;
- Proposed resolution by DBH or provider; Name of the DBH provider or staff responsible for resolving the grievance or appeal; and
- Date of notification to the client of the resolution.

Grievances related to discrimination under ACA 1557 criteria will be forwarded to the DBH Office of Cultural Competency and Ethnic Services (OCCES).

Grievances related to inpatient mental health services, including Lanterman-Petris Short Act (LPS) will be forwarded to the DBH Patients' Rights Office.

DBH Access Unit shall submit the Annual Medi-Cal Beneficiary Grievance and Appeal Report (ABGAR) to DHCS on an annual basis.

DBH Access Unit shall submit a written record of grievances and appeals to the DBH Quality Management Action Committee (QMAC) at least quarterly for systemic aggregation and analysis for quality improvement. Grievances and appeals reviewed shall include, but not be limited to, those related to access to care, quality of care and denial of services. Appropriate action shall be taken to remedy any problems identified.

DBH Access Unit shall submit the DMC-ODS Waiver Grievance and Appeal Quarterly Report to the Department of Health Care Services (DHCS) on a quarterly basis. The results of investigations will be forwarded to DHCS by secure, encrypted email to SUDCountyReports@dhcs.ca.gov within two (2) business days of completion.

Related Policy or Procedure

DBH Standard Practice Manual

- Grievance Procedure (QM6029-1)
- State Hearing Procedure (QM6029-2)
- Standard and Expedited Resolutions of Appeals Procedure (QM6029-3)
- Notice of Adverse Benefit Determination Procedure (QM6029-4)

Reference(s)

- California Code of Regulations, Title 9, Sections 1810.360, 1810.405, 1810.410, 1850.206, 1850.207, and 1850.208 et al.
- Code of Federal Regulations, Title 42, Sections 431.211, 438.10 and 438.400 et al.
- Revenue Agreement with the State of California for the Substance Use Disorder Drug Medi-Cal Organized Delivery System
- California Department of Health Care Services, All Plan Letter 17-006 (APL 17-006)