Standard and Expedited Resolutions of Appeals Procedure

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Veronica Kelley, DSW, LCSW, Director

Purpose

To provide guidance to the Department of Behavioral Health (DBH), contract agencies, and Fee for Service (FFS) providers in assisting Medi-Cal clients with the Appeals and Expedited Appeals procedures that are afforded to them following receipt of a Notice of Adverse Benefit Determination (NOABD).

Medi-Cal Clients Appeal Rights

Medi-Cal clients may file an appeal directly with DBH or with their treatment provider who may be a contract agency or FFS provider. As indicated in the Grievance and Appeal Policy (QM6029), only Medi-Cal clients have the right to file an appeal after receiving a NOABD.

A client who wants to continue receiving treatment services after a NOABD has been issued, will need to request an appeal **within ten (10) calendar days** from the date of the NOABD or before the date DBH indicates the treatment services will stop. DBH, contract agencies or FFS providers will advise and assist clients in requesting a continuation of benefits during an appeal of an adverse benefit determination.

Clients can request assistance from DBH, contract agencies and FFS providers in completing the Action Appeal Form. DBH, contract agencies and FFS providers will assist clients with completing this form as well as taking other procedural steps to file an appeal such as providing the client with necessary forms or notifying them of the form(s) location on the DBH website.

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Standard Appeals Process

The following table provides steps on handling a requested appeal from a Medi Cal Client:

Step	Responsible Party	Action
1	Medi Cal Client	Files a verbal or written request for appeal directly with DBH or the treatment provider that issued the NOABD. **If ...** / **Then ...** The client files a written request for appeal → Proceed to step 4 The client files a verbal request for appeal → Proceed to steps 2 and 3
2	DBH, Contract Agency, FFS Provider	Requests the client complete and sign an **Action Appeal Form and written confirmation of the client's desire to continue with the standard (non-expedited) appeals process. The date of the verbal appeal** establishes the filing date for the appeal. ***Note:*** It is recommended that the **Action Appeal Form be completed on behalf of a client at the time** a verbal request is made. If the client agrees with the completed Action Appeal Form, they can sign and provide written confirmation of their desire to continue the standard appeals process directly on the form.
3	DBH, Contract Agency, FFS Provider	Make a copy or scan of the completed form and provide the original and a blank copy to the client.

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Standard and Expedited Resolutions of Appeals Procedure,
Continued

Standard Appeals Process, continued

Step	Responsible Party	Action
4	DBH, Contract Agency, FFS Provider	Forward Appeal to the DBH Access Unit the same business day via the DBH-NOABD@dbh.sbcounty.gov mailbox with the subject line: Appeal Filed. Treatment providers are required to notify the DBH Access Unit even if the client has not yet completed and/or provided the written appeal to the treatment provider. ***Important Note:*** DBH privacy safeguards prohibit sending any Protected Health Information outside of the county network without first encrypting the email. If an agency or provider does not have the ability to encrypt emails, the agency/person must contact the DBH Access Unit at 1-888-743-1478 for assistance.
5	DBH Access Unit	Will record the appeal request in the Appeal Log within one (1) working day from receipt of the grievance, and assign to a DBH Appeals Coordinator.
6	DBH Appeals Coordinator	The DBH Appeals Coordinator completes the following actions: • Reviews the completed Action Appeal Form or other documentation if the appeal request was verbal; • Contacts the client, provider or authorized representative if clarification is needed, and • Sends a Receipt of Appeal Letter to the client with the Beneficiary Nondiscrimination Notice and Language Assistance Taglines to the client, provider or authorized representative within five (5) calendar days of receipt of the appeal.

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Standard Appeals Process, continued

Step	Responsible Party	Action
7	DBH Appeals Coordinator	Notifies the appropriate DBH Program Manager, contract agency manager, or FFS provider through email [encrypted email for contract agencies or FFS providers] or by phone regarding the appeal if more information is needed to review and/or resolve the appeal.
8	DBH Appeals Coordinator	Resolves the appeal **within 30 calendar days** of receipt by issuing the client, provider or authorized representative the appropriate Notice of Appeal Resolution (NAR): either the Adverse Benefit Determination Upheld or Adverse Benefit Determination Overturned. ***Note:*** DBH will notify the impacted treatment provider if the adverse benefit determination is overturned by sending a copy of the applicable NAR.

DBH Quality Management Action Committee (QMAC) reviews appeals summaries during QMAC meetings.

Extension of Timeframes

DBH can **extend the resolution timeframes for appeals up to 14 calendar days** if the Medi-Cal client requests the extension. DBH can also extend the timeframe if it demonstrates (to the satisfaction of the California Department of Health Care Services (DHCS) upon request) that there is a need for additional information and how the delay is in the client's best interest.

DBH will provide the client with written notice of the reason for the delay if neither of those conditions are met.

DBH will make reasonable efforts to provide the Medi-Cal client with prompt verbal notice of the extension. DBH will also provide the client with a written notice of the extension **within two (2) calendar days** of deciding to extend the timeframe and notify them of their right to file a grievance if they disagree with the decision. DBH will resolve the appeal as expeditiously as the client's health condition requires and will not extend the resolution beyond the **14 calendar day** extension. If DBH does not adhere to the notice and timing requirements, the client will have exhausted DBH's appeal process and may initiate a State hearing.

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Expedited Appeals Requirements

Should DBH determine or if the treatment provider indicates (based on the client's request) that taking **30 calendar days** to resolve a standard appeal resolution could jeopardize the client's mental health or substance use disorder condition, DBH will resolve the matter as an expedited resolution of an appeal.

DBH will resolve the expedited appeals process and provide notice to the Medi-Cal client, authorized representative or provider **no longer than 72 hours** after DBH receives the expedited appeal request or determines an expedited process is necessary. In addition to other logging requirements for appeals, DBH will log the time and date of appeal receipt when an expedited resolution is requested as the specific time of receipt drives the timeframe for resolution.

If DBH receives a request for an expedited appeal via the **Action Appeal Form, and determines the request does not qualify for an expedited** resolution of an appeal, it must complete the appeal in the standard timeframe for resolution, which is **within 30 calendar days**. Additionally, DBH must complete all of the following actions:

- Make reasonable efforts to provide the client with prompt verbal notice of the decision to transfer the appeal to the timeframe for standard resolution;
- Provide written notice of the decision to transfer the appeal to the timeframe for standard resolution **within two (2) calendar days** of making the decision and notify the client of the right to file a grievance if the client disagrees with the standard timeframe, and
- Resolve the appeal as expeditiously as the client's health condition required and within the timeframe for standard resolution of an appeal (**within 30 calendar days** of receipt of the appeal).

Expedited Appeals Procedure

The process and steps for expedited appeals is the same as indicated in the *Standard Appeals Procedure* section of this procedure, with the following exceptions:

- All appeals received must be forwarded to the DBH Access Unit **within one hour** of receipt via the DBH-NOABD@dbh.sbcounty.gov mailbox with the subject line: Expedited Appeal Filed;
- An acknowledgement letter is not required, yet it is recommended that the DBH Appeals Coordinator contact the client to verbally acknowledge the expedited request if time permits;

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Expedited Appeals Procedure, continued

- The DBH Appeals Coordinator resolves the appeal **within 72 hours** of receipt by issuing the client, provider or authorized representative the appropriate Notice of Appeal Resolution (NAR): either the Adverse Benefit Determination Upheld or Adverse Benefit Determination Overturned; and
- The DBH Appeals Coordinator is required to make reasonable efforts to provide prompt verbal notice to the client of the resolution (since written notice maybe be received by the client after the 72 hour timeframe).
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Notice of Appeal Resolution (NAR) Requirements

For appeals resolved wholly in favor of the Medi-Cal client, written notice to the client shall include the results of the resolution and the date it was completed. DBH is also required to provide a written response that contains a clear and concise explanation of the reason, including why the decision was overturned. DBH is required to utilize and send the following:

1. The Adverse Benefit Determination Overturned NAR, and
2. The NAR Your Rights attachment.

DBH must authorize or provide the disputed services promptly and as expeditiously as the client's condition requires if DBH reverses the decision to deny, limit, or delay services that were not furnished while the appeal was pending. DBH must authorize or provide services **no later than 72 hours** from the date and time it reverses the determination.

For appeals not resolved wholly in favor of the Medi-Cal client, DBH is required to utilize and send the following:

1. The Adverse Benefit Determination Upheld NAR, and
2. The NAR Your Rights attachment.

The written NAR must include all the following:

- The results of the resolution and the date it was completed;
- The reasons for the Plan's determination, including the criteria, clinical guidelines or policies used in reaching the determination;
- For appeals not resolved wholly in the favor of the Medi-Cal client, the right to request a State hearing and how to request it;

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Standard and Expedited Resolutions of Appeals Procedure, Continued

Notice of Appeal Resolution (NAR) Requirements, continued

- For appeals not resolved wholly in favor of the Medi-Cal client, the right to request and receive benefits while the hearing is pending and how to make the request, and
- Notification that the Medi-Cal client may be held liable for the cost of those benefits if the hearing decision upholds DBH's adverse benefit determination

Appropriate Investigating Staff Selection

DBH is responsible to ensure that staff who make decisions on appeals are individuals who:

- Were neither involved in any previous level of review or decision-making, nor a subordinate of any such individual, and
- Have the appropriate clinical expertise in treating the client or potential client's condition or disease in the following cases:
  - If the decision involves an appeal based on a denial of medical necessity, or
  - If the appeal involves clinical issues.

DMC-ODS State Reporting Requirements

Utilizing the DHCS Grievance and Appeals Log, the following elements will be provided to DHCS on a quarterly basis, within 15 days of the end of each quarter. The log contains tabs for each month and each tab is broken down into weeks. The Grievance and Appeal Log will be submitted via email to ODSSubmissions@dhcs.ca.gov.

The following information must be reported for each week of the fiscal year:

- Number of beneficiary appeals received, and
- Number of appeal resolutions.

Related Policy or Procedure

DBH Standard Practice Manual

- Grievance and Appeal Policy (QM6029)
- Grievance Procedure (QM6029-1)
- State Hearing Procedure (QM6029-2)
- Notice of Adverse Benefit Determination (NOABD) Procedure (QM6029-4)

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Reference(s)

- California Code of Regulations, Title 9, Sections 1810.230.5 and 1850.207
- Code of Federal Regulations, Title 42, Section 438.400 et al.
- California Department of Health Care Services, All Plan Letter 17-006 (APL 17-006)