SANTA CRUZ COUNTY
Behavioral Health Services

POLICIES AND PROCEDURE MANUAL

Subject: MHP and DMC-ODS Beneficiary Grievance and Appeal Process	**Policy Number: 3224**
Date Effective: 10/1/2023	**Pages: 8**
Prior Version: 5/18/2021	**Responsible for Updating:** Quality Improvement Staff
Approval: DocuSigned by: Jiffany Cantrell-Warren 89088AE6B9B64AF... Behavioral Health Director	10/5/2023 Date

BACKGROUND:
Santa Cruz County Behavioral Health Services [Mental Health Plan (MHP) and Drug Medi-Cal Organized Delivery System (DMC-ODS)] is committed to respecting and protecting a person's right to express service dissatisfaction, and to reviewing each notification as a means to support quality behavioral health care. We adhere to federal and state requirements for processing beneficiary grievances and appeals.

SCOPE:
Providers who render MHP and/or DMC-ODS Network services shall adhere to this policy to ensure beneficiaries are informed of their grievance and appeal rights and have access to methods for filing a grievance and appeal with County Quality Improvement.

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

POLICY:
Santa Cruz County Behavioral Health Services shall provide all Medi-Cal beneficiaries with information, in both English and Spanish, 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 available as brochure forms, and also in the Mental Health Plan (MHP) Beneficiary Handbook for Specialty Mental Health Services and the Drug Medi-Cal Organized Delivery System (DMC-ODS) Beneficiary Handbook.

DEFINITIONS:

1. **Adverse Benefit Determination**
   An Adverse Benefit Determination occurs when the MHP or the DMC-ODS Plan 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, 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. When there is a delay in providing covered services to the beneficiary, from the date the service was requested, as required by the timely access standards applicable to the delayed service. (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.
   h. Terminates a service, including loss of contact with the beneficiary.
   (See Policy & Procedure 3223 Notice of Adverse Benefit Determination)

2. **Grievance**
   An expression of dissatisfaction at any time to MHP or the DMC-ODS Plan about any matter other than an Adverse Benefit Determination. If client states in a written grievance that they experienced sexual misconduct from a licensed, registered or certified BH or contracted provider, QI staff must report this allegation to the staff member's licensing board within 15 calendar days. If client states, either orally or in writing, that the grievance was discrimination related, this grievance information will be submitted to the DHCS Office of Civil Rights within 10 calendar days of mailing the grievance resolution letter to the client.

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. The brochures include the following information, which must also be posted in clinic waiting areas: If you are receiving psychotherapy services by a Board of Behavioral Sciences (BBS) licensed or registered provider, you can send a complaint regarding

provided services by an AMFT / LMFT, ASW / LCSW, APCC / LPCC or licensed educational psychologist to the BBS online: www.bbs.ca.gov, or phone: (916) 574-7830.

- If you have a grievance regarding substance use disorder services, you may also contact the State Department of Social Services: (800) 952-5253.

c. 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 or legal representative, 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 DMC-ODS Plan.

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. If the grievance is noted by the client to be discrimination related, this will be noted in the log.

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. A grievance may be made at any time by a beneficiary.

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 be entered immediately into the Grievance Log.
ii) The Quality Improvement Director 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.
iv) If client states in a written grievance that they experienced sexual misconduct from a licensed, registered or certified BH staff member, QI staff must report this allegation to the staff member's licensing board within 15 calendar days.

d. Resolution:
i) The beneficiary will be notified in writing by the MHP or the DMC-ODS Plan regarding the final resolution of the grievance within thirty (30) days from the date the grievance is filed utilizing the Notice of Grievance Resolution (NGR). The Language Taglines enclosure will be sent with the NGR.
ii) The timeframe may be extended by up to fourteen (14) days in certain circumstances (i.e., beneficiary requests more time to gather information). Resolution of a grievance is not to exceed 90 calendar days.
iii) The final resolution of each grievance, including the date of the decision, will be documented in the Grievance Log.
iv) If the grievance is discrimination related, QI staff who processed the grievance will scan all grievance related documents and letters into one pdf and email this pdf to the QI management team or designee within 2 business days of closing the grievance; the discrimination related grievance will be submitted to the DHCS Office of Civil Rights within 10 calendar days of mailing the

grievance resolution letter to the client via secure email: DHCS.DiscriminationGrievances@dhcs.ca.gov

6. Standard Appeal Process

a. Beneficiary Filing:

i) A beneficiary may file an appeal, either orally or in writing, using the MHP/DMC-ODS Appeal Resolution Request 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 appeal is processed.

v) If the beneficiary withdraws the appeal, and currently authorized services had continued during the appeal, services may be terminated.

b. MHP/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 QI Manager or designated staff will respond to the beneficiary in writing to confirm receipt and review of the appeal.

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 and testimony 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/DMC-ODS Plan in connection with the appeal. This information must be provided free of charge and sufficiently in advance of the resolution timeframes for appeals.

iv) Be allowed to have a legal representative and / or legal representative of a deceased member's estate included as parties to the appeal.

d. Notification of Appeal Resolution:

i) The beneficiary will be notified in writing by the MHP or the DMC-ODS Plan (including the decision date) regarding the final resolution of the appeal within thirty (30) calendar days from the date the oral appeal is filed using the Notice

of Appeal Resolution (NAR) Upheld or Overturned. The NAR Your Rights enclosure will be sent with the NAR.

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 DMC-ODS Plan 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.

iv) If the MHP reverses a decision to deny, limit or delay services that were not furnished while the appeal was pending, the service will be authorized, and an available appointment for the appropriate service will be promptly offered and provided as expeditiously as the beneficiary's health condition requires, but no later than 72 hours from the date of the decision reversal.

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 appeal resolution 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 DMC-ODS Plan 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 DMC-ODS Plan 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) If granted an expedited appeal, the beneficiary will be informed that there is limited time available to present evidence and testimony, in person and in writing, because an expedited appeal must have resolution within 72 hours of receipt of the appeal.

iv) 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. Beneficiary Participation in Expedited Appeal:
Beneficiaries may:

i) Present evidence and testimony in person or in writing. The beneficiary will be informed that there is a limited time available to present evidence and

testimony, because an expedited appeal must have resolution within 72 hours of receipt of the appeal; 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/DMC-ODS Plan in connection with the appeal. This information must be provided free of charge and sufficiently in advance of the resolution timeframes for appeals.

iv) Be allowed to have a legal representative and / or legal representative of a deceased member's estate included as parties to the appeal.

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

i) The MHP or the DMC-ODS Plan 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/DMC-ODS Plan 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 continued services while the hearing is pending and how to make that request; if the beneficiary withdraws the request for a State Fair Hearing, and currently authorized services had continued pending the hearing, services may be terminated.

c. The parties to State hearing include the Plan, as well as the beneficiary and their authorized representative or the representative of a deceased beneficiary's estate.

d. If the State Fair Hearing decision is adverse to the beneficiary, and currently authorized services had continued, services will be terminated.

e. If the State Fair Hearing officer reverses the decision to deny, limit or delay services that were not furnished while the appeal or hearing was pending, the MHP will authorize the service and an available appointment for the appropriate service will be promptly offered and provided as expeditiously as the beneficiary's health

condition requires but no later than 72 hours from the date it receives notice reversing the determination.

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: 5/18/21, 4/26/21, 12/13/18, 11/15/2018, 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/ DMC-ODS Plan Appeal Resolution Request Form, Notice of Grievance Resolution (NGR) letter, Notice of Appeal Resolution Letter (NAR Upheld and Overturned), Language Taglines enclosure, NAR Your Rights enclosure.