SAN MATEO COUNTY HEALTH SYSTEM
BEHAVIORAL HEALTH & RECOVERY SERVICES

GRIEVANCE & APPEAL RESOLUTION SYSTEM

Attachment A to BHRS Policy 03-03

This manual is an attachment to BHRS Policy 03-03 and applies to clients being served in all BHRS programs including all contracted agency and private providers. The manual explains how to resolve issues related to mental health and alcohol and other drug (AOD) services using the Grievance and Appeal System as required by 42 CFR Part 438, Subpart F and BHRS's contract with DHCS. BHRS has a grievance and appeal system in place for all clients and has only one level of appeal. (CFR 438.402)

Clients may seek assistance at any time during the grievance and appeal process from the Office of Consumer and Family Affairs (OCFA).

When the term "client" is used throughout this manual it includes any providers and/or other authorized representative whom the client requests help from, with the exception that providers cannot request continuation of benefits during appeals/State Fair Hearings (see relevant sections.)

DEFINITIONS

A. **Appeal:** means a review of an adverse benefit determination upon request. Appeals must be filed within 60 days of the original decision.

B. **Grievance:** Any expression of unhappiness regarding but not limited to - the quality of care or services provided, aspects of interpersonal relationships such as rudeness by a provider or employee, or failure to respect the client's rights regardless of whether remedial action is requested. Grievance includes a client's right to dispute an extension of time proposed by BHRS to make an authorization decision. A grievance must be filed within 60 days of the event or it will not be reviewed.

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

D. **Adverse benefit determination:** Means any of the following:
   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 timeframes 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 an client's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other client financial liabilities.

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

F. **GAT:** The Grievance and Appeal Team manages the resolution of grievances and appeals. GAT includes the following members: The Director of the Office of Consumer Affairs, the Director of Family Services and Support, family liaisons/peer workers from the OCFA and licensed members from the Quality Management (QM) team.

G. **Reports to Quality Improvement Committee:** 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 QIC tracks the results and implementation of any subsequent system changes.

GRIEVANCE AND APPEAL PROCEDURES

Overview

A. **The Grievance and Appeal Team (GAT)** assists clients in resolving grievances and appealing actions. The GAT meets regularly to review all active grievances and appeals.
   1. Upon receipt of a grievance or appeal, GAT sends an acknowledgment letter and after the investigation is complete they send a resolution letter. The resolution letter informs the client and any authorized representative of the outcome. The provider whom the complaint was about also receives a copy of the resolution letter.
   2. If the outcome results in an Adverse Benefit Determination, the client may file an appeal in order to request a review of the grievance decision.
   3. If the grievance is medication related, the Med Chief responsible for the clinic or site where the grievance originated reviews it. If the Med Chief is clinically involved in the issue, the review will be completed by the Deputy Medical Director. In case of an appeal of an adverse decision by one of the above, the BHRS Medical Director makes the final decision only after the earlier reviews.
      i. External medical review (CFR 438.402): The State may offer and arrange for an external medical review if the following conditions are met.
         - The review must be at the client's option and must not be required before or used as a deterrent to proceeding to the State Fair Hearing
         - The review must be independent of both the State and BHRS.
         - The review must be offered without any cost to the client.
         - The review must not extend any of the timeframes specified and must not disrupt the continuation of benefits.
   4. Clients may authorize another person (friend or family member) or legal representative to act on their behalf during the grievance process.

i. Clients may designate a provider as their representative during the grievance process.
ii. GAT will verify that the client has authorized another to act as their representative, and must obtain written authorization before releasing protected health information to a client's representative.

5. With the written consent of the client, a provider or an authorized representative may request an appeal or file a grievance, or request a State Fair Hearing, on behalf of a client.

B. **Timely and adequate notice of adverse benefit determination (CFR 438.404)**

1. Timing:

   i. A grievance may be filed at any time.

   ii. Appeal: following receipt of a notification of adverse benefit determination, a client has 60 calendar days from the date on the adverse benefit notice to file a request for an appeal to BHRS.

   iii. A grievance that has already received a resolution may not be re-filed as a grievance. If it is substantially the same issue it is an appeal and it must be submitted within 60 calendar days.

2. Procedures

   i. The client may file a grievance orally or in writing with either the State or with BHRS.

   ii. The client 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.

C. **Notice of an adverse benefit determination** (NOABD) must be in writing consistent with the following requirements:

1. **Content of notice**: The notice must explain the following:
   i. The adverse benefit determination BHRS has made or intends to make.
   ii. The reasons for the adverse benefit determination, including the right of the client to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits.
   iii. The client's right to request an appeal of BHRS's adverse benefit determination, including information on exhausting BHRS's one level of appeal and the right to request a State Fair Hearing.
   iv. The circumstances under which an appeal process can be expedited and how to request it.
   v. The client's right to continuing benefits pending resolution of the appeal, how to request that benefits be continued, and the circumstances, consistent with state policy, under which the client may be required to pay the costs of these services.
2. **Timing of notices.** BHRS must mail the notice within the following timeframes:
   i. For termination, suspension, or reduction of previously authorized Medicaid-covered services: 10 days before the date of the action.
   ii. For denial of payment: at the time of any action affecting the claim.

iii. For standard service authorization decisions that deny or limit services: Timeframes 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 –
    - The client, 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.

3. If BHRS meets the criteria set forth for extending the timeframe for standard service authorization decisions, it must –
    i. Give the client written notice of the reason for the decision to extend the timeframe and inform the client of the right to file a grievance if they disagree with that decision; and
    ii. Issue and carry out its determination as expeditiously as the client's health condition requires and no later than the date the extension expires.
4. For service authorization decisions not reached within the timeframes specified in (which constitutes a denial and is thus an adverse benefit determination), on the date that the timeframes expire.
5. For expedited service authorization decisions (in cases where a provider determines that following the standard timeframe could seriously jeopardize the client's life, health or ability to attain, maintain or regain maximum function) no later than 72 hours after receipt of the request for service.

D. **Handling of Grievances and Appeals (CFR 438.406)**

1. In handling grievances and appeals, BHRS gives clients any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. 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. Assistance is available at the Office of Consumer and Family Affairs (OCFA) at 1-800-388-5189.

2. ***Special requirements.*** BHRS's process for handling client grievances and appeals of adverse benefit determinations must:
    i. Acknowledge receipt of each grievance and appeal in writing.
3. Ensure that the individuals who make decisions on grievances and appeals are individuals-
    i. Who were not involved in any previous level of review or decision-making, or a subordinate of any such individual.
    ii. Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by BHRS, in treating the client's condition or disease.
    iii. Who take into account all comments, documents, records, and other information submitted by the client or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.
4. An appeal will be decided within 30 calendar days.
5. Oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the client or the provider requests expedited resolution.
6. Clients are provided a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. BHRS must inform the client of the

limited time available for this sufficiently in advance of the resolution timeframe for appeals as specified in this manual the case of expedited resolution.

7. Clients and their representatives are provided copies of the client'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 direction of BHRS) in connection with the appeal of the adverse benefit determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals as specified in this manual:
8. Included, as parties to the appeal –
   i. The client and his or her representative; or
   ii. The legal representative of a deceased client's estate.

E. **Resolution and notification (CFR 438.408)**

1. BHRS must resolve each grievance and appeal, and provide notice, as expeditiously as the client's health condition requires, within State-established timeframes that may not exceed the timeframes specified in this section.
2. *Standard resolution of grievances.* For standard resolution of a grievance and notice to the affected parties, the timeframe is established by the State but may not exceed 90 calendar days from the day BHRS receives the grievance.
3. *Standard resolution of appeals.* For standard resolution of an appeal and notice to the affected parties, no longer than 30 calendar days from the day BHRS receives the appeal. This timeframe may be extended under paragraph C below.
4. *Expedited resolution of appeals and grievances.* For expedited resolution of an appeal and grievances and notice to affected parties, no longer than 72 hours after BHRS receives the appeal. This timeframe may be extended under paragraph C below.

F. **Extension of timeframes**

1. BHRS may extend the timeframes of this section by up to 14 calendar days if
   i. The client requests the extension; or
   ii. 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 client's interest.
2. Following an extension BHRS must complete all of the following:
   i. Make reasonable efforts to give the client prompt oral notice of the delay.
   ii. Within 2 calendar days give the client written notice of the reason for the decision to extend the timeframe and inform the client of the right to file a grievance if they disagree with that decision.
   iii. Resolve the appeal as expeditiously as the client's health condition requires and no later than the date the extension expires.
3. Deemed exhaustion of appeals processes. If BHRS fails to adhere to the notice and timing requirements of an appeal, the client is deemed to have exhausted BHRS's, appeals process. The client then has 120 days to initiate a State Fair Hearing.

G. **Format of notices**

1. Grievances: BHRS must notify clients of the resolution of a grievance and ensure that such methods meet, at a minimum, the standards described below:
   i. *Limited English proficient (LEP)* means potential clients and clients who do not speak English as their primary language and who have a limited ability to read, write, speak, or

understand English may be LEP and may be eligible to receive language assistance for a particular type of service, benefit, or encounter.

ii. BHRS will provide information about the grievance and appeal system to all providers and subcontractors at the time they enter into a contract, including copies of the attached posters and brochures in threshold languages.

iii. *Prevalent* means a non-English language determined to be spoken by a significant number or percentage of potential clients and clients that are limited English proficient

iv. *Readily accessible* means 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.

2. Appeals
   i. For all appeals, BHRS must provide written notice of resolution in a format and language that, at a minimum, meet the standards as described above.
   ii. For notice of an expedited resolution, BHRS must also make reasonable efforts to provide oral notice.

H. **Content of notice of appeal resolution**

1. The written notice must include the following:
   i. The determination BHRS has made or intends to make.
   ii. Reasons for the adverse benefit determination, including the right to be provided upon request and free of charge, reasonable access to and copies of all documents, records and other relevant information to the clients NOABD. This includes medical necessity, and processes, strategies or evidentiary standards used in coverage limits.
   iii. A client's right to request an appeal, including information on exhausting the one level appeal process and the right to a State Fair Hearing. (CFR 438.402(c))
   iv. The circumstances for an expedited appeal and how to request it.
   v. The client's right to have benefits continue pending the resolution of an appeal, how to request that continuation, and the circumstances under which a client may be required to pay the costs of these services.

I. **Expedited Resolution of appeals (CFR 438.410)**

1. *General rule.* BHRS maintains an expedited review process for appeals when BHRS determines (on request from the client) or the provider indicates (in making the request on the client's behalf or supporting the client's request) that taking 30 days for a standard resolution could seriously jeopardize the client's life, physical or mental health, or ability to attain, maintain, or regain maximum function. If an expedited appeal is accepted, it will be decided within 72 hours after BHRS receives the appeal.
2. *Punitive action.* BHRS ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a client's appeal.
3. *Action following denial of a request for expedited resolution.* If BHRS denies a request for expedited resolution of an appeal, it will transfer the appeal to the timeframe for standard resolution (as referenced in CFR 438.408).

J. **Information about the grievance and appeal system for providers and contractors (CFR 438.414)**

1. BHRS must provide information specified in § 438.10(g)(2)(xi) about the grievance and appeal system to all providers and subcontractors at the time they enter into a contract.

K. **Recordkeeping requirements (CFR 438.420)**

1. BHRS is required to maintain records of grievances and appeals and must review the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the State quality strategy. The record must be accurately maintained in a manner accessible to the state and available upon request to CMS.
    i. A general description of the reason for the appeal or grievance.
    ii. The date received.
    iii. The date of each review or, if applicable, review meeting.
    iv. Resolution at each level of the appeal or grievance, if applicable.
    v. Date of resolution at each level, if applicable.
    vi. Name of the client for whom the appeal or grievance was filed
    vii. The request must be accurately maintained in manner accessible to the state and available upon request to CMS.

L. **Continuation of benefits (CFR 438.420)**

1. BHRS will continue the client's benefits if all of the following occur:
    i. The client files a request for an appeal in a timely manner in accordance with CFR 438.402
    ii. The appeal involves the termination, suspension or reduction of a previously authorized service(s).
    iii. The period covered by the original authorization has not expired.
    iv. The client timely files for continuation of benefits.

M. **Client Responsibility**

1. Clients may be responsible for the cost of services furnished while an appeal or state hearing is pending: If the final resolution of an appeal or State Fair Hearing is adverse to a client and upholds the adverse benefit determination, BHRS *may* recover the cost of services for the time the decision was pending.

N. **Effectuation of reversed appeal resolutions (CFR 438.424)**

1. If BHRS or the State Fair 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 client's health condition requires but no later than 72 hours from the date it receives notice reversing the determination.
2. *Services furnished while the appeal is pending.* If BHRS or the State Fair Hearing officer reverses a decision to deny authorization of services, and the client 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.

O. **State Fair Hearing (CFR 438.408, Subpart E, part 431)**

1. An independent review by the California Department of Health Care Services (DHCS) that the client may request after receiving notice that their appeal of an adverse benefit determination has been denied. Hearings must be requested no later than 60 days after receiving notice of the denied appeal; however, to continue receiving services, the SFH request must be submitted within 10 days of the appeal denial.

2. General Requirements:
    i. If a client is dissatisfied with the outcome of the grievance and appeal process, they may request a State Fair Hearing after receiving notice that the adverse benefit determination has been upheld. A SFH is an independent review by the California DHCS.
3. Client must request a hearing no later than 60 calendar days from 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 SFH within 10 days of the notice that the adverse benefit determination is being upheld.
    i. ***Deemed exhaustion of appeals processes.*** If BHRS fails to adhere to the notice and timing requirements as detailed in this policy, the client is deemed to have exhausted the appeals process. The client may initiate a State Fair Hearing.

WHERE TO FILE GRIEVANCES AND APPEALS

A. Any client of BHRS may file a grievance or appeal by contacting the OCFA at the number below.

B. Any client receiving services in the BHRS network of care can file a grievance with their clinic supervisor or manager, or with OCFA.

C. Clients receiving services in the contracted provider network, (such as a therapist in the community), may also file a grievance 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.

D. In addition to contacting OCFA, any client receiving alcohol and drug treatment services (AOD) may file a complaint by calling the DHCS Office of the Ombudsman 1-800-896-4042 or by filing a complaint by calling the Department of Health Care Services SUD Compliance Division at 1-877-685-8333.

RESOURCES

A. Office of Consumer and Family Affairs: (OCFA) 800-388-5189

   http://www.smchealth.org/support-clients-family

B. California Department of Health Care Services (DHCS)

   Office of the Ombudsman: 888-452-8609

   http://www.dhcs.ca.gov/services/ccs/Documents/CCSGrievancesAFHP.pdf