SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH AND RECOVERY SERVICES

GRIEVANCE & APPEAL RESOLUTION SYSTEM MANUAL
Attachment A to BHRS Policy 19-01

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I. PURPOSE:

This manual is an attachment to BHRS Policy 19-01 and applies to clients being served in all Behavioral Health and Recovery System (BHRS) programs including all contracted agency and private providers. 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 Department of Health Care Services (DHCS). BHRS has a grievance and appeal system in place for all clients and has only one level of appeal. (CFR 438.402)

All BHRS contractors/agencies are required to understand and follow the grievance and appeal process requirements and provide clients assistance with the process when requested. BHRS provides 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. Copies of the San Mateo County BHRS grievance and appeal brochures and posters are posted and available to clients at the site of service. (CFR 438.414)

II. DEFINITIONS:

Appeal: means a review of an "Adverse Benefit Determination" (see definition below) upon request. Appeals must be filed within 60 days of the original decision.

Consumer/Client/Beneficiary: The terms "Client", "Consumer" and "Beneficiary" are interchangeable throughout this manual.

Authorized Representative: With written consent of the client 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.

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

Grievance: Grievance means an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances 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 client's rights regardless of whether remedial action is requested. Grievances also include a client's right to dispute an extension of a deadline proposed by BHRS to make an authorization decision.

A complaint is the same as a formal grievance. A complaint shall be considered a grievance unless it meets the definition of an Adverse Benefit Determination appeal.

BHRS does not discourage the filing of grievances. 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 client expressly declines to file a formal grievance, their complaint will be categorized as a grievance. As for other 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 Hearings.

Limited English Proficient (LEP) Potential and current clients 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): A BHRS team that assists clients with resolving grievances and appeals in a timely manner. The toll-free number is 1-800-388-5189.

Grievance and Appeals Team (GAT): The Grievance and Appeals Team manages the resolution of grievances and appeals. GAT includes the following members:

1. Office of Consumer and Family Affairs Director
2. Family Education and Support Coordinator
3. Consumer/Family Liaisons from the OCFA
4. OCFA Grievance Program Coordinator
5. Licensed members from the Quality Management (QM) team.

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.

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.

III. The San Mateo County BHRS Grievance and Appeals Team (GAT)

The Grievance and Appeals Team (GAT) is responsible for managing the Grievance and Appeals System and will assist clients in resolving grievances and appealing Adverse Benefits Determination actions. The GAT meets regularly to review all active grievances and appeals.

Grievance and Appeal Protocol

1. Upon receipt of a grievance or appeal, the GAT will first determine whether the request is a grievance or an appeal of an Adverse Benefits Determination (ABD).
2. The GAT will send an acknowledgment letter of receipt of the Grievance or Appeal of an ABD postmarked **within 5 calendar days** of the receipt of the Grievance or Appeal of an ABD.
3. After the investigation is complete a Notice of Grievance Resolution (NGR) letter or Notice of Appeal Resolution (NAR) letter will be sent. The resolution letter informs the client and any authorized representative of the outcome. For grievances, the provider whom the complaint was about also receives a copy of the resolution letter.
4. If BHRS fails to provide the beneficiary with a Notice of Grievance Resolution (NGR) letter within the allowed timeline, BHRS will issue an ABD Grievance and Appeal Timely Resolution Notice.
5. Following receipt of an ABD notification, a client has 60 calendar days from the date on the adverse benefit notice to file a request for an appeal to BHRS according to the instruction included with the notice. 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.
6. If the grievance is medication support/prescriber (MD or Nurse Practitioner) related, 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 client 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 the re-filed grievance and make the next resolution decision.

7. Clients and/or the parent or legal guardian may authorize another person (friend or family member) or legal representative to act on their behalf during the grievance and appeal process.

    - Clients may designate a provider or other person as their representative during the grievance and appeal process.
    - 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.
    - Once the GAT has received the written authorization, the grievance process will officially start.

8. 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.

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 such individual.
- 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.

    1. An appeal of an Adverse Benefit Determination that is based on lack of medical necessity;
    2. A grievance regarding denial of an expedited resolution of an appeal; or
    3. Any grievance or appeal involving clinical issues.

- 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.

Resolution and Notification (CFR 438.408)

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

Extension of Resolution Timelines

BHRS may extend the timelines of this section by up to 14 calendar days if:

- The client 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 client's interest.

Following an extension BHRS must complete all the following:

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

BHRS OCFA Record keeping requirements (CFR 438.420)

BHRS OCFA is required to maintain records of grievances and appeals received in writing and/or orally including those resolved by the close of the next business day. OCFA must review the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the State quality strategy. All information reviewed tracking sheets, logs, any information provided to or by the client or provider, any letters or notices sent in relation to the complaint will be maintained in a folder accessible to BHRS Quality Management. The GAT team will audit these folders regularly to ensure compliance. Grievances and appeals will be recorded in the log within one working day of receipt.

- 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 at each level of the appeal or grievance, if applicable.
- Date of resolution at each level, if applicable.
- Name of the client for whom the appeal or grievance was filed
- The request must be accurately maintained in manner accessible to the state and available upon request to CMS.

V. GRIEVANCE PROCEDURES

A. Timelines for Filing a Grievance: A grievance may be filed at any time. A grievance that has already received a resolution may be re-filed as a grievance. The client may file a grievance orally or in writing with BHRS. Any client of BHRS and/or a provider or authorized representative may file a grievance by completing the Grievance form, speaking directly to staff, or by contacting the OCFA at 1-800-388-5189. Clients may seek assistance at any time during the grievance process from the OCFA. Alcohol and Other Drug (AOD) clients may also file a grievance directly with the state.

1. Any client receiving services anywhere in the BHRS network of care can file a grievance with their clinic supervisor/manager/staff or with OCFA. If a client asks to file a grievance at their 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 client. Grievances not resolved in 24 hours by the provider to the client's satisfaction, must be immediately sent to OCFA.
    i. In handling grievances, BHRS (all staff within the network of care) will give clients 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).

2. 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.
3. In addition to contacting OCFA, any client 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 1-877-685-8333or online at the DHCS website

Grievance Process Exemptions: Grievances 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 and disposition letter. Grievances received via mail are not exempt from the requirement to send an acknowledgment and resolution/determination letter in writing.

Grievances that are resolved within 24 hours or are otherwise exempt from notification still need to be logged by the Grievance and Appeals Team and included in reports submitted to Department of Health Care Services (DHCS)

Standard resolution of grievances: 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.

Content of Notice of Grievance Resolution/Determination

The Content of notice/letter must explain the following:

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

Letters and Templates for Grievance Process

- **Notice of Grievance Acknowledgement**: This is sent by OCFA within 5 business days upon receipt of a grievance by the client or their representative.
- **Notice of Grievance Resolution:** This form is sent by OCFA after it has concluded its investigation of any grievance and is sent to the client and/or parent or the legal guardian. This form is sent within 2 business days of the resolution decision. A copy of this letter will be sent to the provider(s) named in the grievance.

VI. NOTICE OF ADVERSE BENEFITS DETERMINATIONS (NOABD) and APPEALS

A Notice of Adverse Benefits Determination (NOABD) is a decision by BHRS and its contracted providers that limits or changes services to a client for any of the following reasons:

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 client's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other client financial liabilities.

Timing of Notice of Adverse Benefit Determination

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

BHRS must mail the notice/letter within the following timelines:

- For termination, suspension, or reduction of previously authorized Medi-Cal-covered services: 10 days before the date of the action.
- For denial of payment: at the time of any action affecting the claim.
- For standard service authorization decisions that deny or limit services: 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:
  - 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.
- If BHRS meets the criteria set forth for extending the timeline for standard service authorization decisions, it must:
  - Give the client written notice of the reason for the decision to extend the timeline and inform the client of the right to file a grievance if they disagree with that decision; and
  - Issue and carry out its determination as expeditiously as the client'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 Adverse Benefit Determination as of the date the timeline expires.
- For expedited service authorization decisions (in cases where a provider determines that following the standard timeline 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.

Content of Notice of Adverse Benefit Determination (CFR 438.404)

The letter/notice to client of an Adverse Benefit Determination (ABD) must include the following requirements:

- The ABD BHRS has made or intends to make.
- The reasons for the ABD, 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 ABD. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits.
- The client's right to request an appeal of BHRS's ABD including information on exhausting BHRS's one level of appeal and the right to request a State Fair Hearing.
- The circumstances under which an appeal process can be expedited and how to request it.
- 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.

Notice of Adverse Benefits Determination template/forms information

- **Notice of Denial** – Use this template when BHRS denies a request for service. Denials include determinations based on the type of 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.
- **Payment Denial** – 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.
- **Delivery System** – 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 referred to the Managed Care Plan (MCP), or other appropriate system, for mental health, substance use disorder, or other services
- **Modification of Requested Services** – 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.
- **Termination of Previously Authorized Service** - Use this template when BHRS terminates, reduces, or suspends a previously authorized service.
- **Delay in Processing Authorization of Services** - 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.

        - The extension of benefits is in the client's interest.
- **Failure to Provide Timely Access to Services** - Use this template when there is a delay in providing the client with timely services as outlined by the timely access standards applicable to the service.
- **Dispute of Financial Liability** - Use the template when BHRS requests to dispute financial liability, including cost sharing and other client's other financial liabilities.
- **Failure of Timely Resolution of Grievances and Appeals** - Use this form when BHRS does not meet required timelines for the standard resolution of grievances and appeals.
- **NOABD "Your Rights" Attachment -** Informs beneficiaries of critical appeal and State hearing rights and accompanies all of the NOABD's. The "NOABD Your Rights" attachment provides beneficiaries with the following required information pertaining to 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 "Your Rights"** attachment - This is included with any notice of appeals resolution correspondence.
- **Beneficiary Non-Discrimination Notice** - This is included with any grievance, notice of an ABD, and appeals correspondence forms.
- **Language Assistance Taglines** - Included in all grievances, notices of ABD, and appeals correspondence forms.

VII. APPEALING A NOTICE OF ADVERSE BENEFITS DETERMINATION (NOABD)

Timelines for Filing an Appeal: Any client of BHRS and/or a provider or authorized representative may file an Appeal of an ABD within 60 days of the ABD decision by completing the Grievance and Appeal form, speaking directly to staff, or by contacting the OCFA at 1-800-388-5189. Clients may seek assistance from the OCFA at any time during the appeal process. Appeals may be filed orally (this starts the appeal timeline) but needs to be followed by a written request.

Steps for Filing an Appeal:

1. Any client or parent/guardian for 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 client 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 client.
2. In handling appeals, BHRS (all staff and providers within the network of care) will give clients any reasonable assistance that the client 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).
3. Clients receiving services in the contracted provider network, (such as a 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.

The Right to Present Information and Request Materials:

Clients 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 requests. In the case of an expedited appeal, BHRS must inform the client of the limited time available for this and communicate this sufficiently in advance of the resolution timeline for appeals as specified in this manual.

Upon request, 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 discretion of BHRS) relating to the appeal of the ABD. This information must be provided free of charge and sufficiently in advance of the resolution timeline for appeals as specified in this manual. This must be provided to all parties involved in the appeal including the client and his or her representative; or the legal representative of a deceased client's estate.

Standard resolution of appeals

Within 5 calendar days of receiving an appeal, BHRS will send the client or parent/guardian written acknowledgement of receipt of the appeal. This letter will include the following information:

1. Name of Beneficiary
2. Date of receipt
3. BHRS Representative handling the appeal
4. Contact phone number and address for the above

The Notice of the Appeal Resolution (NAR) letter for a standard resolution appeal must be sent in writing to the affected parties (client, parent and provider) within 30 calendar days of the

date BHRS receives the appeal. The letter used is either the NAR Overturned template or the NAR Upheld template. (Please see below for more information.)

Resolution of Expedited Appeals

BHRS maintains an expedited review process for appeals when BHRS determines that the standard 30-day resolution timeline could seriously jeopardize the client's life, physical or mental health, or ability to attain, maintain, or regain maximum function. The expedited timeline is put into effect when BHRS agrees with the client's request or a provider's advocacy on behalf of their client that the standard 30-day timeline is too long based on the client's situation (as described within the previous sentence.)

For expedited resolution of an appeal, BHRS must send the NAR letter to the client or representative within 72 hours of BHRS's receipt of the appeal. This time may be extended in some situations.

In addition to other appeal logging requirements, BHRS must log the time along with the date that the appeal was received. The exact time that the appeal was received begins the 72-hour timeline.

1. **If an expedited appeal is accepted**, it will be resolved within 72 hours of when BHRS received the appeal. BHRS ensures that no punitive actions are taken against a provider who requests an expedited resolution or supports a client's appeal.

2. **If BHRS denies a request for the expedited resolution of an appeal:**
    a. BHRS will transfer the appeal 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.
    b. BHRS will make reasonable efforts to provide the client with prompt verbal notice of the decision to transition the appeal to the standard resolution timeline.
    c. 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 Appeal Resolution

BHRS may extend the resolution timeline for appeals by up to 14 calendar days if either of the following conditions apply:

1. The beneficiary requests the extension.
2. 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 best interest.

For any extension not requested by the beneficiary, BHRS is required to provide the beneficiary with written notice of the reason for the delay. New federal regulations mandate the following additional requirements that BHRS must comply with:

1. BHRS shall make reasonable efforts to provide the beneficiary with prompt verbal notice of the extension.

2. BHRS shall provide written notice of the extension within two calendar days of making the decision to extend the time and notify the beneficiary of the right to file a grievance if the beneficiary disagrees with the extension.
3. BHRS shall resolve the appeal as expeditiously as the beneficiary's health condition requires and in no event extend resolution beyond 14-calendar days.
4. 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.

- **Notice of Appeal Resolution - Overturned** - 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 client's or representative's hearing request must be sent within 120 days of the date the NAR letter was post-marked or delivered to the client;
    - For appeals not resolved wholly in the favor of the beneficiary, the client's right to request and receive continuation of benefits (services) while the Hearing is pending and how to make the request. In this case, the client's or representative's request must be sent within 10 days from the date the NAR 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** - 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 client's or representative's hearing request must be sent within 120 days of the date the NAR letter was post-marked or delivered to the client;
    - For appeals not resolved wholly in the favor of the beneficiary, the client's right to request and receive continuation of benefits (services) while the State hearing is pending and how to make the request. In this case, the client's or representative's

request must be sent within 10 days from the date the NAR 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 Hearing decision upholds BHRS's adverse benefit determination.

Continuation of benefits (Title 42, CFR 438.420)

BHRS will continue the client's benefits if all of the following occur:
- The client files a request for an appeal within 10 calendar days, or the intended effective date, of the notice of the notice of ABD (CFR 438.402.)
- The appeal involves the termination, suspension or reduction of a previously authorized service.
- The period covered by the original authorization has not expired.
- The client files for the continuation of benefits within the required timelines.

VIII. STATE FAIR HEARING PROCESS (CFR 438.408, Subpart E, part 431)

The State Fair Hearing Process ("hearing") is an independent review by the California Department of Health Care Services (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 client 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.
- Client 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 SFH 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 client is deemed to have exhausted the appeals process. The client may initiate a 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 client'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 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.
- 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.

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