# Monterey County Behavioral Health
# Policies and Procedures

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| **Policy Number** | 128 |
| **Policy Title** | Beneficiary Problem Resolution Process (Grievance, Standard Appeals, Expedited Appeals) |
| **References** | Code of Federal Regulations (CFR), Title 9, Sections 1850.205 and 1850.210; Title 42, Sections 431 and 438<br>Intergovernmental Agreement (IGA), Exhibit A, Attachment I, Article III.OO:<br>Mental Health Substance Use Disorder Services (MHSUDS) Information Notice 18-010E |
| **Effective** | January 1, 2004<br>Revised: December 14, 2004<br>Revised: March 30, 2006<br>Revised: December 1, 2008<br>Revised: January 22, 2014<br>Revised: October 16, 2014<br>Revised: June 9, 2016<br>Revised: June 22, 2017<br>Revised: December 31, 2018<br>Revised: January 10, 2019<br>Revised: March 11, 2019<br>Revised: November 11, 2021<br>Revised: April 14, 2023 |

## Policy

Monterey County Behavioral Health (MCBH) will identify Medi-Cal beneficiary's concerns, resolve those concerns, and facilitate resolution of those concerns in accordance with all appropriate laws and regulations. The beneficiary problem resolution system contains grievances, standard appeals and expedited appeals for Medi-Cal beneficiaries for Specialty Mental Health Services (SMHS) and Drug-Medi-Cal Organized Delivery System (DMC-ODS).

MCBHassures that staff who are making decisions on appeals and grievances have appropriate clinical expertise in treating the beneficiary's condition and expertise in medical necessity and problem resolution issues.

MCBH assures that staff who make decisions on grievances and appeals or are involved in the treatment of the beneficiary are not in any way involved in previous

level of reviews or decision making or treatment of the beneficiary.

MCBH provides information and training regarding grievances, appeals and State Fair Hearings to contract providers at the time they enter the contract.

Beneficiary Rights

A Medi-Cal beneficiary is entitled to:

- Respectful treatment and due consideration of dignity and privacy.
- Services to be provided in a safe environment.
- Informed consent to treatment and prescribed medication(s).
- Confidential care and record keeping.
- Request for a second opinion or change of clinician.
- Participate in planning for their treatment and the right to refuse treatment.
- Right to request and receive a copy of their medical records including access of protected health records and amending or correcting protected health information.
- Authorize a friend or other person to act on their behalf during the grievance or State Fair Hearing process.
- Be free of discrimination or any other penalty for initiating a grievance or State Fair Hearing.
- Receive a Beneficiary Handbook that identifies the grievance process.
- Notices that are posted at all MCBH provider sites explaining the Problem Resolution (Grievance) procedures.
- Grievance forms and self-addressed envelopes available for all MCBH provider sites without the beneficiary having to make a verbal or written request to anyone for the forms.
- Prompt resolution of beneficiary grievance/appeals.
- Simple, informal, and easily understood procedures that do not require beneficiaries to present their grievance in writing.
- Use of State Fair Hearing after an appeal is denied.
- The names and contents of grievances and appeals are kept confidential.
- Receive information on:
- Available treatment options and alternatives.
- Informational materials (English and/or Spanish) to include informing beneficiaries concerning non-compliance with advance directives may be filed with the state Survey and Certification Agency.
- Receive enrollment notices, informal and instructional materials, provider lists, clinic addresses, telephone numbers, clinic hours, and language availability.
- Right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Be free of discrimination because of their race, gender, SOGIE, religion, or

age or any other penalty for filing a grievance or appeal.

In addition, beneficiaries will continue receiving services even after filing a grievance or complaint and while awaiting the outcome of an appeal when the following conditions are met:

- The beneficiary files the request of an appeal timely in accordance with 42 C.F.R.
- §438.402(c)(1 )(ii) and (c)(2)(ii);
- The appeal involves the termination, suspension, or reduction of previously authorized services;
- The services were ordered by an authorized provider;
- The period covered by the original authorization has not expired; and
- The beneficiary files timely for continuation of benefits.

Services will be continued until one of the below occurs:

- The beneficiary withdraws the appeal of request for State Hearing;
- The beneficiary fails to request a State Hearing and continuation of benefits within 10 calendar days after MCBH sends the notice of adverse resolution (e.g., NOABD) to the beneficiary's appeal;
- A State Hearing office issues a hearing decision adverse to the beneficiary.

**Procedure**

1. Grievance Procedure

    A. Beneficiary presents their oral or written expression of dissatisfaction to any MCBH staff or contract provider except fee-for-service providers.
    B. MCBH staff or contracted staff notifies Quality Improvement (QI) of the grievance either by email 415QI@co.monterey.ca.us, fax (831) 755-4350,or telephone (831) 755-4545, within 1 working day.
    C. QI will log the grievance within 1 calendar day of receipt of the grievance. The log consists of the following:
        i. Name of grievant/authorized representative;
        ii. Date grievance is received;
        iii. Date acknowledgement is mailed;
        iv. Nature of grievance;
        v. Final disposition of grievance, or reason why final disposition is/was not made 90 days from receipt of grievance;
        vi. Date final disposition is made.
        vii. Date final disposition is mailed to grievant/authorized representative;
        viii. Date copy of final disposition mailed to provider, if provider is involved in the grievance;
        ix. Log the date the grievance is forwarded to the MCBH designated

Deputy Director or designee.

D. QI will acknowledge in writing receipt of all grievances within 24 hours of receipt.
E. Grievances received over the telephone or in person by MCBH or a contractor, 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 acknowledgement and disposition letter. Exempt Grievances must still be logged.
F. MCBH shall 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 a beneficiary expressly declines to file a formal grievance, their complaint shall still be categorized as a grievance.
G. QI determines if grievance filed is clinical (i.e., issues with medication dosage, side effects, etc.) or administrative (i.e., prescriptions notes available on time, customer service is lacking, indifferent case management style, inability to understand physician due to ESL, etc.) in nature.
H. QI will review grievances that are clinical in nature and make decisions regarding the disposition of the grievance.
I. QI will forward administrative grievances to the Patient's Rights Advocate (PRA) who will review and determine the disposition.
J. The PRA and MCBH Medical Director or QI has 90 days from the receipt of the grievance to reach a final disposition/resolution (Title 28, CCR, Section 1300.68(a)).)) That could be extended for up to 14 calendar days if requested by the beneficiary, and when the delay is for additional information, and in the beneficiary's best interest (Title 42, CFR, Sections 438.408(b) and (c)).
K. In the event that resolution of a standard grievance is not reached within 90 calendar days as required, MCBH shall provide the beneficiary with the applicable NOABD, and include the status of the grievance and the estimated date of resolution, which shall not exceed 14 calendar days.
L. If MCBH extends the timeframe, not at the request of the beneficiary, it must complete all of the following:
    i. Give the beneficiary prompt oral notice of the delay;
    ii. Within 2 calendar days of making the decision, give the beneficiary written notice of the reason for the decision to extend the timeframe and inform the beneficiary of the right to file a grievance if they disagree with that decision; and
    iii. Resolve the grievance no later than the date the extension expires.
M. The PRA and/or MCBH Medical Director/Designee and/or Quality Services Manager/Designee must inform the beneficiary of the final

decision in writing using the Notice of Grievance Resolution (NGR) format (includei a beneficiary non-discrimination notice) and must include the following:

i. The results/disposition of the grievance;
ii. The date the resolution/disposition was made.

N. The decision maker must not be involved in any previous level of review or decision-making.

2. Adverse Benefit Determinations

A. Beneficiaries must receive a written Notice of Adverse Benefit Determination (NOABD) when MCBH takes any of the following actions:
   i. Denies or limits authorization of requested services, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
   ii. Reduces, suspends or terminates a previously authorized service;
   iii. Denies, in whole or in part, payment for the service;
   iv. Fails to provide services in a timely manner, as determined by the MCBH;
   v. Fails to act within the time frames for disposition of standard Grievances, the resolution of standard appeals, or the resolution of appeals, or;
   vi. The denial of a beneficiary's request to dispute financial liability.

B. MCBH must give beneficiaries timely and adequate notice of an Adverse Benefit Determination in writing, consistent with the requirements in 42 CFR §438.10. The NOABD must explain all of the following:
   i. The adverse benefit determination that MCBH has made or intends to make;
   ii. A clear and concise explanation of the reason(s) for the decision. For determinations based on medical necessity criteria, the notice must include the clinical reasons for the decision. MCBH shall explicitly state why the beneficiary's condition does not meet SMHS and/or DMC-ODS medical necessity criteria;
   iii. A description of the criteria used. This includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in making such determinations;
   iv. The beneficiary'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 beneficiary's adverse benefit determination.

C. Decisions shall be communicated to the beneficiary in writing. In addition, decisions shall be communicated to the provider initially by telephone or facsimile, and then in writing, except for decisions rendered retrospectively. For written notification to the provider, MCBH must also

include the name and direct telephone number or extension of the decision-maker.

3. Timing of the Notice

   A. MCBH must mail the notice to the beneficiary within the following timeframes (Title 42, CFR, Section 438.404(c)):
      i. For termination, suspension, or reduction of a previously authorized SMHS and/or DMC-ODS service, at least 10 days before the date of action (Title 42, CFR, Section 431.211)), except as permitted under 42 CFR §§ 431.213 and 431.214;
      ii. For denial of payment, at the time of any action denying the provider's claim, or;
      iii. For decisions resulting in denial, delay, or modification of all or part of the requested SMHS and/or DMC-ODS services, within two business days of the decision.
   B. MCBH must also communicate the decision to the affected provider within 24 hours of making the decision.

4. NOABD "Your Rights" Attachment

   A. The "Your Rights" attachment is a form that informs beneficiaries of critical appeal and State hearing rights. There are two types of "Your Rights" attachments. One accompanies the NOABD and the other accompanies the Notice of Appeals Resolution (NAR). These attachments must be sent to beneficiaries with each NOABD or NAR.
   B. The "NOABD Your Rights" attachment provides beneficiaries with the following required information pertaining to NOABD:
      i. The beneficiary's or provider's right to request an internal appeal with MCBH within 60 calendar days from the date on the NOABD (Title 42, CFR, Section 438.404 (b)(3));
      ii. The beneficiary's right to request a State hearing only after filing an appeal with MCBH and receiving a notice that the Adverse Benefit Determination has been upheld (Title 42, CFR, Section 438.404(b)(3));
      iii. The beneficiary's right to request a State hearing if MCBH fails to send a resolution notice in response to the appeal within the required timeframe (Title 42, CFR, Section 438.408(c)(3));
      iv. Procedures for exercising the beneficiary's rights to request an appeal (Title 42, CFR, Section 438.404(b)(4));
      v. Circumstances under which an expedited review is available and how to request it (Title 42, CFR, Section 438.404(b)(S))·and
      vi. The beneficiary's right to have benefits continue pending resolution of the appeal

vii. and how to request continuation of benefits in accordance with Title 42, CFR, Section 438.420 (Title 42, CFR, Section 438.404(b)(6)).

5. Standard Appeals Procedure

A. A beneficiary or authorized representative may present an oral or written request to review an Adverse Benefit Determination (ABO) to the MCBH Deputy Director or Designee (QI).QI Oral appeals MUST be followed up with a written, signed appeal (Title 42, CFR, Sections 438.402(c)(3)(ii) and 438.406(b)(3)). The date of the oral appeal establishes the filing date for the appeal. Appeals filed by the provider on behalf of the beneficiary require written consent from the beneficiary (Title 42, CFR, Section 438.402(c)(l)(ii)). The nature of the problem MUST be a request to review an ABD.
B. Beneficiary MUST file an appeal within 60 days of the date of the ABD (Title 42, CFR, Section 438.402(c)(2)(ii)).
C. QI will log the appeal within one (1) working day of the receipt of the appeal. The log must include but is not limited to:
    i. The date and time of receipt of the grievance or appeal;
    ii. The name of the beneficiary filing the grievance or appeal;
    iii. The name of the representative recording the grievance or appeal;
    iv. A description of the complaint or problem;
    v. A description of the action taken by MCBH or provider to investigate and resolve the grievance or appeal;
    vi. The proposed resolution by MCBH or provider;
    vii. The name of MCBH provider or staff responsible for resolving the grievance or appeal; and
    viii. The date of notification to the beneficiary of the resolution.
D. QI will acknowledge in writing receipt of all appeals within 24 hours of receipt.
E. QI must notify the beneficiary or authorized representative of the appeal disposition/resolution in writing within 30 calendar days of receipt of the appeal (Title 42, CFR, Section 438.408(b)(2)).
F. The decision maker must not be involved in any previous level of review of decision-making.
G. QI has 30 calendar days from the receipt of the appeal to make a final decision. The time frame may be extended by up to 14 days in certain circumstances.
    i. The beneficiary requests an extension (Title 42, CFR, Section 438.408(c)(l)(i)).
    ii. MCBH demonstrates additional information is necessary and how the delay may benefit the beneficiary's best interest (Title 2, CFR,

Section 438.408(c)(l)(ii)).

H. For any extension not requested by the beneficiary, MCBH will provide the beneficiary with written notice of the reason for the delay. New federal regulations delineate the following additional requirements that MCBH must comply with the following:
    i. MCBH shall make reasonable efforts to provide the beneficiary with prompt oral notice of the extension (Title 42, CFR, Section 438.408(c)(2)(i));))
    ii. MCBH shall provide written notice of the extension within two calendar days of making the decision to extend the timeframe and notify the beneficiary of the right to file a grievance if the beneficiary disagrees with the extension (Title 42, CFR, Section 438.408(c)(2)(ii));))
    iii. MCBH shall resolve the appeal as expeditiously as the beneficiary's health condition requires and in no event extend resolution beyond the 14-calendar day extension (Title 42, CFR, Section 438.408(c)2)(iii)); and
    iv. In the event that MCBH fails to adhere to the notice and timing requirements, the beneficiary is deemed to have exhausted MCBH's appeal process and may initiate a State hearing (Title 42, CFR, Section 438.408(c)(3)).))
I. MCBH maintains a single level of appeal for beneficiaries.

6. Expedited Appeals

A. The Expedited Appeals process is used when the standard resolution process could jeopardize the beneficiary's mental health, or substance used disorder condition and/or ability to attain, maintain, or regain maximum function. Oral expedited appeals DO NOT have to be followed in writing. The request must be presented to the MCBH Deputy Director or designee (QI).
B. The nature of the problem must be a request to review an action as defined in this policy.
C. The beneficiary must file an Expedited Appeal within 60 days of the date of the ABD.
D. QI will log the appeal within one working day of the receipt of the Appeal. The log must contain the same requirement as of the Standard Appeal.
E. QI must determine if MCBH agrees that the Appeal meets the requirements for an Expedited Appeal. QI will notify the beneficiary or authorized representative of the Appeal decision within 72 hours from receipt of the request for expedited appeal. The time frame may be extended by up to 14 days in certain circumstances. The notice must contain the same requirements as of the Standard Appeal. In addition to the written notice, QI must make reasonable efforts to provide the

beneficiary with an oral notice.

F. If QI decide that the Expedited Appeal do NOT qualify for an Expedited Appeal, MCBH will notify the beneficiary within two (2) calendar days.
G. The decision maker must not be involved in any previous level of review of decision-making.
H. In addition to the written NAR, QI must notify the beneficiary and all affected parties orally and in writing.
I. MCBH does not take punitive action against a provider who requests an expedited resolution or supports a beneficiary's' expedited appeal, (42 C.F.R§ 438.410((b)). MCBH receives all requests for expedited appeals according to DHCS requirements regardless of the source of request.

7. Notice of Appeal Resolution (NAR)

A. A NAR is a formal letter informing a beneficiary that an Adverse Benefit Determination has been overturned or upheld.

8. Adverse Benefit Determination Upheld

A. For appeals not resolved wholly in favor of the beneficiary, MCBH shall send: 1) Notice of Appeal Resolution and 2) "Your Rights" attachments. These documents are viewed as a "packet" and must be sent in conjunction to comply with all requirements of the NAR.
    i. Notice of Appeal Resolution (NAR).MCBH shall send written NARs to beneficiaries. The written NAR shall include the following:
        a. The results of the resolution and the date it was completed (Title 42, CFR, Section 438.408(e)(l));
        b. The reasons for the MCBH's determination, including the criteria, clinical guidelines, or policies used in reaching the determination (Title 42, CFR, Section 438.404(b)(2));
        c. For appeals not resolved wholly in the favor of the beneficiary, the right to request a State hearing and how to request it;
        d. For appeals not resolved wholly in the favor of the beneficiary, the right to request and receive benefits while the hearing is pending and how to make the request; and,
        e. Notification that the beneficiary may be held liable for the cost of those benefits if the hearing decision upholds MCBH's adverse benefit determination.
    ii. NAR "Your Rights" Attachment. The NAR "Your Rights" attachment provides beneficiaries with the following required information pertaining to NAR:
        a. The beneficiary's right to request a State hearing no later than 120 calendar days from the date of MCBH's written

appeal resolution and instructions on how to request a State hearing (Title 42, CFR, Section 438.408(e)(2)(i); Title 22, CCR, Section 53858(e)(S)); and,

b. The beneficiary's right to request and receive continuation of benefits while the State hearing is pending and instructions on how to request continuation of benefits, including the timeframe in which the request shall be made (i.e., within ten days from the date the letter was post-marked or delivered to the beneficiary) in accordance with Title 42, CFR, Section 438.420 25 (Title 42, CFR, Section 438.408(e)(2)(ii)).

9. Adverse Benefit Determination Overturned

A. For appeals resolved wholly in favor of the beneficiary, written notice to the beneficiary shall include the results of the resolution and the date it was completed. MCBH shall also ensure that the written response contains and concise explanation of the reason, including why the decision was overturned.

B. MCBH must authorize or provide the disputed services promptly and as expeditiously as the beneficiary's condition requires if MCBH reverses the decision to deny, limit, or delay services that were not furnished while the appeal was pending. MCBH shall authorize or provide services no later than 72 hours from the date and time it reverses the determination (Title 42, CFR, Section 438.424(a)).))

10. State Fair Hearing

A. A State Fair Hearing is an independent review conducted by the California Department of Social Services to ensure beneficiaries receive the SMHS they are entitled under the Medi-Cal program. A beneficiary may file a request for a State Fair Hearing when they exhaust MCBH's Problem Resolution Process. A beneficiary may also file a State Fair Hearing whether or not a Notice of Adverse Benefits Determination has been issued.

i. The beneficiary may ask for a State Fair Hearing by writing to:
California Department of Social Services State Hearings Division
P.O. Box 944243, Mail Station 9-17-37
Sacramento, CA 94244-2430

ii. By fax at: 916-651-5210 or 916-651-2789

iii. Online at: https://acms.dss.ca.gov/acms/login.request.do

iv. The beneficiary may also ask for a State Fair Hearing by calling 800-743-8525 or 855-795-0634. Or call the Public Inquiry and Response line at 800-952-5253 or TDD at 800-952-8349

v. The beneficiary may ask for a State Hearing within 120-days of the date the Notice of Adverse Benefits Determination was mailed or personally handed to the beneficiary.
vi. The beneficiary may ask for a State Hearing within 120-days of the postmark date of the MCBH's Appeal decision.
vii. The beneficiary may ask for a State Hearing at any time if the beneficiary did NOT receive a Notice of Adverse Benefits Determination or file an Appeal with MCBH (the State shall make a decision within 90-calendar days for standard hearing requests).
viii. The beneficiary may continue services during the State Fair Hearing process by requesting a State Fair Hearing within 10-days from the date the Notice of Adverse Benefits Determination was mailed or personally given to the beneficiary.
ix. The beneficiary may request an Expedited State Fair Hearing if the normal 120-day timeframe will cause serious problems with the beneficiary's mental health, or SUD condition, including problems with their ability to gain, maintain, or regain important life functions. The Department of Social Services, State Hearing Division, will review the request and decide if it qualifies.
x. If the Expedited State Fair Hearing is approved, a hearing will be held, and a hearing decision will be issued within 3-working days of the date of the State Hearing Division received the beneficiary's request.

11. Beneficiary Files

A. Beneficiary files and information related to the appeals and grievances will be kept electronically using Monterey County's secure server.
B. The beneficiary may authorize or identify a person to act on their behalf or assist in the grievance/appeal process. The patients' rights advocate may represent the beneficiary if they have no person to authorize.
C. The beneficiary may select their provider of choice to represent them in the appeal process.
D. MCBH staff who investigate the grievance/appeal assures the beneficiary that they are not subject to penalty or discrimination for filing the grievance or appeal.
E. Upon request, a beneficiary may identify a staff person or individual to provide information regarding the status of their grievance or appeal.
F. The beneficiary is allowed to designate another person to file a grievance or appeal orally. The beneficiary or designee is allowed to treat the date of the oral appeal as the earliest filing date.
G. The beneficiary or designee is allowed by MCBH staff to present evidence and allegations of fact or law in person or in writing.

H. The beneficiary or designee is allowed before or during the appeal process, to examine their files and medical records, and any other documents considered during the appeal process.

12. Quality Improvement

A. MCBH staff is responsible for notifying the QI Committee (QIC) of clinical or administrative issues identified as a result of grievances and appeals.
B. MCBH QIC transmits its recommendations or policy changes to the MCB Administration, or another appropriate office within the MDBH.
C. MCBH QIC, if applicable, follows up recommended system changes, and documents on its QI work plan.
D. MCBH Training Committee will provide training and education to MCBH staff regarding policies and advance directives.
E. MCBH will update all written materials as per DMH Letter and Information Notices on a regular basis to reflect changes in state and federal laws.
F. MCBH implements all written policies and procedures related to beneficiary rights.

13. Complaints Regarding a DMC Certified Facility

A. In accordance with the Intergovernmental Agreement, Exhibit A, Attachment I, Article III.OO:
    i. MCBH shall report DMC-ODS complaints (to include grievances and appeals) to DHCS using the Secure Managed File Transfer system specified by DHCS (i.e., MOVEit) within two business days of completion.
    ii. Complaints for Residential Adult Alcoholism or Drug Abuse Recovery or Treatment Facilities may made to the Department of Healthcare Services Licensing and Certification Division (LCD) using the online Complaint Form located on the DHCS website and may be submitted online or via telephone, mail, or fax.
    iii. C. Suspected Medi-Cal fraud, waste, or abuse shall be reported to DHCS Medi-Cal Fraud: (800) 822-6222 or Fraud@dhcs.ca.gov.

**Definitions**

I. Grievance: An expression of dissatisfaction with MCBH about any matter other than those defined as "Adverse Benefit Determination" (Title 42, CFR, Section 438.400(b).
II. Appeal: A request for review of an "Adverse Benefit Determination."
III. Adverse Benefit Determination: Occurs when MCBH does at least one of the following:
    A. Denies or limits authorization of requested services, including

determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit;

B. Reduces, suspends, or terminates a previously authorized service;
C. Denies, in whole or in part, payment for the service;
D. Fails to provide services in a timely manner, as determined by MCBH;
E. Fails to act within the time frames for disposition of standard grievances, the resolution of standard appeals, or the resolution of expedited appeals; or
F. The denial of a beneficiary's request to dispute financial liability.

IV. State Fair Hearing: An independent review conducted by the California Department of Social Services to ensure beneficiaries receive the SMHS they are entitled under the Medi-Cal program.

V. Authorized Representative: A person designated by the beneficiary to represent them in the grievance, appeal, or State Fair Hearing process.