



ADMINISTRATIVE/FISCAL/CLINICAL/PHF POLICY AND PROCEDURES

COUNTY OF SANTA BARBARA
ALCOHOL, DRUG AND MENTAL HEALTH SERVICES

Section - QUALITY ASSURANCE

Effective: 5/31/2004

**Policy - #20 BENEFICIARY PROBLEM RESOLUTION
PROCESS**

Revised:

Director's Approval See signature page

Date _____

Assistant Director's Approval _____

Date _____

Form Ref. -

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POLICY:

1. Problem resolution will consist of a *Grievance Process*, *Appeal Process*, and *Expedited Appeal Process*.

Legal Citations:

CCR, Title 9, Chapter 11, Section 1850.205

CFR, Title 42, Section 438.402

2. Definitions:

Grievance is either an oral or written expression of dissatisfaction about any matter other than a matter covered by an appeal.

Appeal is a request for review of an action.

- a. An action occurs when the:

- i. MHP denies or modifies MHP payment authorization of a requested service,
- ii. Reduces, suspends, or terminates a previously authorized service
- iii. Denies, in whole or in part, payment for a service prior to the delivery of the service or denies, in whole or in part, payment for a service post-service delivery but pre-payment based on a determination that the service was not medically necessary or otherwise not a service covered by this contract
- iv. Fails to provide services in a timely manner, as determined by the MHP
- v. Fails to act within the timeframes for disposition of standard grievances, the resolution of standard appeals, or the resolution of expedited appeals.

Expedited appeal will take place at the request of the MHP or the beneficiary and/or the provider in situations in which taking the time for a standard resolution could seriously

jeopardize the beneficiary's life, health or ability to attain, maintain, or regain maximum function.

3. Beneficiaries must file grievances and appeals directly with the MHP and are not permitted to file directly with the state.
4. The Manager of Quality Improvement, Grievance Coordinator, Program Managers, Patient Right's Advocate, or designee as appropriate are available to assist the client/beneficiary throughout the grievance or appeal process, as well as provide information on the status of the grievance or appeal process. Upon request, beneficiaries will be directed to the appropriate staff person who can assist the beneficiary with the grievance and appeal process and in providing information regarding status of grievance or appeal.
5. Beneficiaries and persons seeking services will be informed of the procedure for resolution of grievances and appeals at the point of intake/first contact. This includes information about the availability of individuals to assist in making, completing and resolving complaints or to assist in pursuing a grievance, appeal, or state fair hearing.
6. A beneficiary may authorize another person to act on his/her behalf. A support person chosen by the client such as family, friend, or other advocate, including legal representative or provider, may also accompany the client to any meetings and hearings regarding a grievance or appeal at the beneficiary's request. The authorized individual will be permitted to use the grievance and appeal process on behalf of the beneficiary.
7. Beneficiaries will not be subject to any discrimination, penalty, sanction or restriction for filing a grievance, appeal, or State Fair Hearing. Records will be kept separate from the medical record/chart, as a means of maximizing beneficiaries' confidentiality on these matters.
8. Beneficiary grievances and appeals are confidential and retained only by quality assurance. Complaints and grievances will not become part of the medical record and information pertaining to a grievance, appeal or State Fair Hearing will be available only to those identified by the beneficiary to act on his/her behalf and all other mandated individuals involved in the resolution process. Records of grievances, appeals, state fair hearings will be stored and maintained according to HIPAA standards.
9. Requests for change in therapist or service provider, including the right culture-specific providers, are routinely accommodated and not considered a grievance unless the beneficiary/client is denied and files a grievance. (A copy of the Request for Change of Therapist/Provider shall be forwarded to the Quality Improvement Coordinator/Grievance Coordinator, with notations which describe outcome of the requests).
10. The grievances and appeals log, as well as other grievance and appeal information, will be made available to the State Department of Health Services and any other oversight agency when appropriate and necessary.
11. The MHP will notify contract providers at the time they enter into a contract of the following beneficiaries rights regarding grievance and appeals:
 - a. Beneficiary's right to a State Fair Hearing, how to obtain a hearing, and representation rules at a hearing;
 - b. Beneficiary's right to file grievances and appeals and the requirements and timeframes for filing;
 - c. The availability of assistance in filing;
 - d. The toll free number for filing grievances and appeals;

- e. Beneficiary's right to request continuation of benefits during an appeal or State Fair Hearing filing; and
 - f. The MHP's problem resolution process pursuant to Title 9, CCR, Section 1850.
12. The MHP will ensure that the Beneficiary Problem Resolution Processes will not conflict or replace the duties of county Patient's Rights Advocate as described in Welfare & Institutions Code, Section 5520.
13. The individual making the decision on the grievance, appeal, or expedited appeal will have no prior involvement in any previous level of review of decision making. The MHP will ensure that the staff who have the appropriate clinical expertise (as determined by the MHP and the scope of practice) in treating the beneficiaries condition or disease make decisions in the following situations:
- a. Appeals based on lack of medical necessity,
 - b. Grievances regarding denials of expressed resolution of an appeal,
 - c. Grievance/Appeal that involve clinical issues.
- If the grievance is regarding the denial of an expedited resolution of an appeal or is about clinical issues, the MHP will ensure that the decision maker has the appropriate clinical expertise, as determined by the scope of practice considerations in treating the beneficiary's condition.
14. The MHP Quality Assurance department generates a report of the number, type, and nature of all grievances and appeals which is presented to the Quality Improvement Committee for quarterly review. The QIC makes recommendations to the MHP executive team which includes the Mental Health Director for the purpose of improving service delivery and implementing system changes.
15. The MHP allows for providers other than the MHP to establish grievance and appeal processes for beneficiaries receiving services from them. When such processes exist the MHP does not require beneficiaries to use or exhaust the provider's processes prior to using the MHP's beneficiary problem resolution process, unless:
- a. The MHP delegated the responsibility for the beneficiary problem resolution process to the provider in writing, specifically outlining the provider's responsibility under the delegation;
 - b. The provider's beneficiary problem resolution process fully complies with Title 42, CFR, Chapter IV, Subchapter C, Part 438, Subpart F and this Section; and
 - c. No beneficiary is prevented from accessing the grievance and appeal process solely on the grounds that the grievance or appeal was incorrectly filed with either the MHP or the provider.

PROCEDURE:

A. Beneficiary Notice of Available Processes and Procedure

- a. Written and oral information explaining the grievance, appeal and expedited appeal procedure and the availability of State Fair Hearings are made available to beneficiaries upon admission to the Mental Health Plan/ADMHS and periodically thereafter.

- b. Beneficiary brochures and other notices outlining these procedures will also be displayed and readily available in service areas, including waiting rooms, staff areas, and contract provider sites. Information outlining procedures will be available in English and Spanish.
- c. The MHP will make interpreters available and maintain toll-free numbers with adequate TDD/TTY and interpreter services available to beneficiaries at a minimum during business hours. Staff will assist beneficiaries with other language or communication needs at no cost to the beneficiary.
- d. When a Beneficiary has a concern about their services they will be informed about the processes in place to resolve concerns.
- e. Forms and self-addressed envelopes will be available at provider sites and county clinics and in areas that do not require beneficiaries to make an oral or written request for them.

B. Grievance Procedure

- a. A beneficiary may initiate a grievance verbally or in writing. When a beneficiary has a grievance or appeal they will be directed to the designated representative in the Quality Assurance office. This individual will gather information and log the date of receipt.
- b. All grievances will be recorded in a grievance and appeals log within 1 working day of the date of receipt of the grievance. The log entry will include the name of the beneficiary, the date of receipt and the nature of the problem.
- c. In order to maintain the confidentiality of beneficiaries, grievance records will be maintained in the quality assurance office in a file that is separate from the beneficiary's medical record. These files will be maintained in accordance with HIPPA standards.
- d. A written acknowledgement of the grievance is sent to the beneficiary.
- e. The MHP will make every effort to resolve the beneficiary's grievance as quickly and as simply as possible.
- f. The MHP has processes in place for beneficiaries to present information regarding their grievance and desired resolution, orally or in writing.
- g. Grievances will be resolved within 60 calendar days of receipt of the grievance or within a 14 calendar day extension. An extension of up to 14 calendar days is permitted if the beneficiary requests an extension or if the MHP determines that there is a need for additional information and that the delay is in the beneficiary's interest. If the MHP initiates the extension, the MHP must provide reason for the extension in writing to the beneficiary.
- h. Final disposition of a grievance including the date the decision is sent to the beneficiary and will be recorded in the grievances and appeals log. If a final disposition has not been reached within the 60 calendar days of receipt, the reason for extension will be documented in the grievances and appeals log.
- i. Notification to the provider cited by the beneficiary or otherwise involved in the grievance of the final disposition of the grievance will be provided in writing.
- j. If the MHP fails to notify the affected parties of the grievance decision within the timeframes identified for grievances, the MHP will provide a notice of action to the beneficiary advising the beneficiary of the right to request a fair hearing. The MHP shall provide the notice of action on the date that the timeframe expires.

- k. Notification to the beneficiary and/or the beneficiary's representative of the grievance decision will be provided in writing. If the beneficiary could not be contacted, the MHP will document efforts to notify the beneficiary of the grievance decision and information on where they can pick up written acknowledgement.
- l. The individual making the decision on the grievance, appeal, or expedited appeal will have no prior involvement in any previous level of review of decision making. If the grievance is regarding the denial of an expedited resolution of an appeal or is about clinical issues, the MHP will ensure that the decision maker has the appropriate clinical expertise, as determined by the scope of practice considerations in treating the beneficiary's condition.

C. Appeal Procedure

- a. An appeal may be filed by the beneficiary orally or in writing. When a beneficiary has a grievance or appeal they will be directed to the designated representative in the Quality Assurance office. This individual will gather information and log the date of receipt.
- b. A written acknowledgement of the appeal is sent to the beneficiary.
- c. The MHP will inform the beneficiary of his/her right to request a fair hearing at any time before, during, or after the appeal process has begun. Beneficiaries are informed of this right by enclosing the beneficiary brochure with the written acknowledgement of appeal.
- d. Standard oral appeals will be followed up with written, signed appeals. The oral appeal will be recorded within 1 working day to establish the earliest possible filing date.
- e. All appeals will be recorded in a grievance and appeals log within 1 working day of the date of receipt of the appeal. The log entry will include the name of the beneficiary, the date of receipt and the nature of the problem.
- f. In order to maintain the confidentiality of beneficiaries, appeal records will be maintained in the quality assurance office in a file that is separate from the beneficiary's medical record. These files will be maintained in accordance with HIPPA standards.
- g. Individuals making the decision on the appeal will not be involved in any previous level of review or decision-making process. If the appeal is regarding a denial based on lack of medical necessity, or is about clinical issues, the decision-maker will have the appropriate clinical expertise, determined by the MHP and the scope of practice considerations, in treating the beneficiary's condition.
- h. To ensure that beneficiaries have reasonable opportunity to present evidence of fact or law they will be notified of timeframes on receipt of grievance. Beneficiaries are given the opportunity to present evidence and allegations of fact or law regarding their appeal and desired resolution, orally, in person, or in writing.
- i. In accordance with HIPPA standards, the MHP will allow the beneficiary or his/her representative, before and during the appeal process, to examine the beneficiary's case file, including medical records, and any other documents or records considered during the appeal process. Upon request, the beneficiary will be directed to the Patients' Right Advocate for assistance in obtaining these records.
- j. The MHP will allow the beneficiary and/or his/her representative, or the legal representative of a deceased beneficiary's estate to be included as parties to the appeal.

- k. The beneficiary and all affected parties will be notified of resolution/disposition within 45 calendar days of receipt of the appeal. An extension of up to 14 calendar days will be allowed if requested by the beneficiary or the MHP determines that there is a need for additional information and that the delay is in the beneficiary's interest. If the MHP initiates the extension the MHP must provide reason for the extension in writing to the beneficiary.
- l. Final disposition of an appeal including the date the decision is sent to the beneficiary will be recorded in the grievances and appeals log. If a final disposition has not been reached within the 45 calendar days of receipt, the reason for extension will be documented in the grievances and appeals log.
- m. The MHP will notify the beneficiary and/or his/her representative of the resolution of the appeal in writing. This notice will contain, at minimum, the following information: the result of the appeal resolution process; the date that the appeal decision was made; and if the appeal is not resolved wholly in favor of the beneficiary, the notice will contain information regarding the beneficiary's right to a state fair hearing and the procedure for filing a state fair hearing.
- n. If the MHP fails to notify the affected parties of the appeal decision within the timeframes identified for appeals, the MHP will provide a notice of action to the beneficiary advising the beneficiary of the right to request a fair hearing. The MHP shall provide the notice of action on the date that the timeframe expires.
- o. Notification to the provider cited by the beneficiary or otherwise involved in the appeal of the final disposition of the appeal will be provided in writing. If the beneficiary could not be contacted, the MHP will document efforts to notify the beneficiary of the grievance decision and information on where they can pick up written acknowledgement.
- p. The MHP will provide or arrange payment for disputed services in a timely manner if the action taken by the MHP is reversed as a result of the appeal resolution process.

D. Expedited Appeal Procedure

- a. An expedited review process for appeals will be provided when the MHP determines, or the beneficiary and/or the provider requests, that taking the time for a standard resolution could seriously jeopardize the beneficiary's life, health or ability to attain, maintain, or regain maximum function.
- b. The beneficiary may request an expedited appeal orally or in writing. A written follow-up is not required.
- c. The MHP will inform the beneficiary of his/her right to request a fair hearing at any time before, during, or after the appeal process has begun. Beneficiaries are informed of this right by enclosing beneficiary brochure with written acknowledgement of appeal.
- d. All expedited appeals will be recorded in a grievance and appeals log within 1 working day of the date of receipt of the expedited appeal. The log entry will include the name of the beneficiary, the date of receipt and the nature of the problem.
- e. Individuals making the decision on the appeal will not be involved in any previous level of review or decision-making process. If the appeal is regarding a denial based on lack of medical necessity, or is about clinical issues, the decision-maker will have the appropriate clinical expertise, determined by the MHP and scope of practice considerations, in treating the beneficiary's condition.

- f. The MHP has processes in place for beneficiaries to present evidence and allegations of fact or law regarding their appeal and desired resolution, orally or in writing. To ensure that beneficiaries have reasonable opportunity to present evidence they will be notified of timeframes on receipt of grievance. This will allow them the opportunity to present evidence and allegations of fact or law regarding their appeal and desired resolution, orally, in person, or in writing. The beneficiary will be notified of the limited time available for this in the case of expedited appeal case resolution.
- g. In accordance with HIPPA standards, the MHP will allow the beneficiary or his/her representative, before and during the appeal process, to examine the beneficiary's case file, including medical records, and any other documents or records considered during the appeal process.
- h. The MHP will allow the beneficiary and/or his/her representative, or the legal representative of a deceased beneficiary's estate to be included as parties to the appeal.
- i. The MHP will provide or arrange payment for disputed services in a timely manner, if the action taken by the MHP is reversed as a result of the appeal resolution process.
- j. The MHP will ensure that punitive action is not taken against a beneficiary or a provider who requests an expedited resolution or supports a beneficiary's appeal.
- k. The expedited appeal will be resolved and the affected parties will be notified no later than 3 working days after the MHP receives the appeal. This timeframe may be extended by up to 14 calendar days if the beneficiary requests an extension, or the MHP determines that there is a need for additional information and that the delay is in the beneficiary's best interest. If the MHP extends the timeframes, the MHP shall, for any extension not requested by the enrollee, give the beneficiary written notice of the reason of the delay.
- l. The MHP will notify those providers cited by the beneficiary or otherwise involved in the expedited appeal of the final disposition of the beneficiary's appeal. If the beneficiary could not be contacted, the MHP will document efforts to notify the beneficiary of the grievance decision and information on where they can pick up written acknowledgement.
- m. The MHP will notify the beneficiary and/or his/her representative of the resolution of the appeal in writing. This notice will contain, at minimum, the following information: the result of the appeal resolution process; the date that the appeal decision was made; and if the appeal is not resolved wholly in favor of the beneficiary, the notice will contain information regarding the beneficiary's right to a state fair hearing and the procedure for filing a state fair hearing.
- n. If the MHP fails to notify the affected parties of the appeal decision within the time frames written above a Notice of Action will be sent to the beneficiary advising the beneficiary of the right to a state fair hearing. The MHP shall provide the NOA on the date the timeframe expires.
- o. The beneficiary will be provided with written notice of the expedited appeal disposition. Reasonable efforts will be made to provide oral notice to the beneficiary and/or his/her representative.
- p. If the contractor denies a request for expedited resolution of an appeal, the contractor shall:
 - i. Transfer the appeal to the timeframe for standard appeal resolution: and

- ii. Make reasonable efforts to give the beneficiary and his/her representative prompt oral notice of the denial of the expedited appeal, process, and follow up within 2 calendar days with a written notice.

E. State Fair Hearing (Medi-Cal Beneficiary Only) and Notice of Action

- a. If the grievance or appeal involves the denial, reduction, or termination of services, the beneficiary or their representative has the right to request a State Fair Hearing within 90 days receipt of the notice of action (NOA).
- b. Beneficiaries or their representatives may request the State Fair Hearing Form from the Access Team or Quality Care Management. Quality Care Management or Patient's Rights Advocate will be available to provide assistance, if requested.
- c. When aid paid pending criteria per CCR, Title 22, Section 51014.2, the MHP will ensure continued benefits while state fair hearing within 10 days of the date the NOA was mailed or received by beneficiary before effective date of change if effective date is longer than 10 days.

Assistance:

Rob Walton, R.N., M.P.A.

Reference:

Beneficiary Concerns

Replaces:

This new policy & procedure replaces Mental Health Plan Access Team Policy & Procedures Provider Problem Resolution Process.