SECTION 8: PROBLEM RESOLUTION AND APPEAL PROCESS

8.0 Provider Problem Resolution and Appeal Process

The Fresno County Mental Health Plan (FCMHP) uses a simple, informal procedure in identifying and resolving provider concerns and problems regarding payment, other complaints and concerns.

8.0.1 Informal Provider Problem Resolution Process

- The provider may first speak to a Provider Relations Specialist (PRS) regarding his or her complaint or concern.
- The PRS will attempt to settle the complaint or concern with the provider. If the attempt is unsuccessful and the provider chooses to forego the informal complaint process, the provider will be advised to file a written complaint to the FCMHP addressed to:

  Fresno County Mental Health Plan
  Attn.: Appeals
  P.O Box 45003
  Fresno, CA 93718-9886

8.0.2 Formal Provider Appeal Process

The provider has the right to access the provider appeal process at any time before, during, or after the provider problem resolution process has begun, when the complaint concerns the processing or payment of a provider's claim to the FCMHP.

8.0.2.1 Payment Issues

- The provider may appeal a dispute with the FCMHP regarding the processing or payment of a provider's claim to the FCMHP. The written appeal must be submitted to the FCMHP within 90 calendar days of the date of the receipt of the non-approval of payment.
- The FCMHP shall have 60 calendar days from its receipt of the appeal to inform the provider in

writing of the decision, including a statement of the reasons for the decision that addresses each issue raised by the provider, and any action required by the provider to implement the decision.

- If the Managed Care staff member reverses the appealed decision, the provider will be asked to submit a revised request for payment within 30 calendar days of receipt of the decision.

8.0.2.2 Other Complaints

If there are other issues or complaints, which are not related to payment authorization issues, providers are encouraged to send a letter of complaint to the FCMHP. The provider will receive a written response from the FCMHP within 60 calendar days of receipt of the complaint. The decision rendered by the FCMHP is final.

8.1 Beneficiary Grievance and Appeal Process

The FCMHP provides beneficiaries with a grievance and appeal process and an expedited appeal process to resolve grievances and appeals at the earliest and the lowest possible level.

Grievance and appeal forms and self-addressed, no postage necessary envelopes are available for beneficiaries to pick up at all provider sites without having to make a verbal or written request. Notices explaining the grievance and appeal process are also posted in prominent locations at all provider sites.

Should you receive a grievance, appeal, or expedited appeal at your office or site, please report the grievance, appeal, or expedited appeal to the Managed Care Division within one working day of the date of receipt. See the beginning of this manual for contact information. Per Title 9, Division 1, Chapter 11, Section 1850.205 (d) (1), the FCMHP is required to log all grievances, appeals, and expedited appeals within one working day of the date of receipt, so timely submission of all grievances, appeals, and expedited appeals received by contracted providers is critical.

Grievance: An expression of dissatisfaction about any matter other than a matter covered by an Appeal.

Appeal: A request for review of an action or for review of a provider's determination to deny, in whole or in part, a beneficiary's request for a covered specialty mental health service or for review of a determination by the FCMHP or its providers that the medical necessity criteria have not been met and the beneficiary is not entitled to any specialty mental health services from the FCMHP. A beneficiary may request an appeal within 60 days of the action taken by the FCMHP. The FCMHP has one level of appeal for beneficiaries.

Action: An action occurs when the FCMHP does at least one of the following:

1) Denies, in whole or in part, payment for a service based on a determination that the service was not medically necessary or otherwise not a service covered by the FCMHP.

2) Fails to provide services in a timely manner, as determined by the FCMHP or;

3) Fails to act within the timeframes for disposition of standard grievances, the resolution of standard appeals, or the resolution of expedited appeals.

For both the grievance and the appeal process, the FCMHP shall:

a. Allow a beneficiary to authorize another person to act on his/her behalf. Providers may represent a beneficiary during the Grievance, Appeal, or State Fair Hearing process with the written consent of the beneficiary.

b. Give beneficiaries any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. Interpreter services and auxiliary aids are available for beneficiaries upon request. Beneficiaries may dial 711 to reach the California Relay Service (which supports TTY/TTD.)

c. Allow a beneficiary's legal representative to use the grievance or the appeal process.

d. Identify a staff person or other individual as having responsibility for assisting a beneficiary with the problem resolution processes at the beneficiary's request.

e. Not subject a beneficiary to discrimination or any other penalty for filing a grievance or appeal.

e. Have procedures for the processes that maintain the confidentiality of beneficiaries.

f. Maintain a grievance and appeal log and record grievances and appeals in a log within one working day of the date of receipt of the grievance or appeal. The log entry shall include but not be limited to the name of the beneficiary, the date of receipt of the grievance or appeal, the nature of the problem.

g. Record the final dispositions of grievances and appeals, including the date the decision is sent to the beneficiary, or documenting the reason(s) that there has not been final disposition of the grievance.

h. Provide a staff person or other individual with responsibility to provide information on request by the beneficiary or an appropriate representative regarding the status of the beneficiary's grievance or appeal.

i. Acknowledge the receipt of each grievance or appeal to the beneficiary in writing.

j. Have procedures by which issues identified as a result of the grievance or appeal processes are transmitted to the FCMHP's Managed Care Division and, if applicable, implementation of needed system changes.

k. Notify those providers cited by the beneficiary or otherwise involved in the grievance or appeal of the final disposition of the beneficiary's grievance or appeal.

l. Ensure that grievance and appeal process files are logged, and that the files and logs will be open for review by the state Department of Health Care Services, or any other appropriate oversight agency.

m. Ensure that no provision of the FCMHP's beneficiary problem resolution processes shall be construed to replace or conflict with the duties of county patients' rights advocates as described in Welfare and Institution Code, Section 5520.

The grievance process shall, at a minimum:

a. Provide for resolution of a beneficiary's grievance as quickly and simply as possible.

b. Involve simple, and easily understood procedures that allow beneficiaries to present their grievance orally or in writing.

c. Ensure that the individual(s) making the decision on the grievance were not involved in any previous level of review or decision-making or are not a subordinate of any such individual(s); and, if the grievance is regarding the denial of an expedited resolution of an appeal, or is about clinical issues, ensure that the decision-maker has the appropriate clinical expertise, as determined by the FCMHP and scope of practice considers, in treating the beneficiary's condition.

d. Identify the roles and responsibilities of the FCMHP, the provider, and the beneficiary.

e. Provide for a decision on the grievance and notify the affected parties within 90 calendar days of receipt of the grievance. This timeframe may be extended by up to 14 calendar days if the beneficiary requests an extension, or if the FCMHP determines that there is a need for additional information and that the delay is in the beneficiary's interest.

f. If the FCMHP fails to notify the affected parties of the grievance decision within the timeframes, provide a notice of action to the beneficiary advising the beneficiary of the right to request a State Fair Hearing.

g. Notify the beneficiary or the beneficiary's representative in writing of the grievance decision or document the notification or efforts to notify the beneficiary, if he or she could not be contacted.

The appeal process shall, at a minimum:

a. Allow a beneficiary to file an appeal orally, or in writing. Standard oral appeals shall be followed-up with written, signed appeals. The FCMHP shall treat the oral appeal as an appeal to establish the earliest possible filing date.

b. Ensure that the individual(s) making the decision on the appeal was not involved in any previous level of review or decision-

making, nor a subordinate of any such individual(s); and, if the appeal is regarding a denial based on lack of medical necessity, or is about clinical issues, ensure that the decision-maker has the appropriate clinical experience as determined by the FCMHP and scope of practice considerations, in treating the beneficiary's condition.

c. Inform the beneficiary of his or her right to request a State Fair Hearing once the Appeal process has concluded.

d. Allow the beneficiary to have a reasonable opportunity to present evidence and allegations of factor or law, in person or in writing.

e. Allow the beneficiary and/or his or her representative to examine the beneficiary's case file, including medical records, and any other documents or records considered during the appeal process before and during the appeal process.

f. Allow the beneficiary and/or his or her representative, or the legal representative of a deceased beneficiary's estate, to be included as parties to the appeal.

g. Provide for a decision on the appeal and notify the affected parties within 30 calendar days of receipt of the appeal. This timeframe may be extended by up to 14 calendar days if the beneficiary requests an extension, or the FCMHP determines that there is a need for additional information and that the delay is in the beneficiary's interest.

h. Notify the beneficiary and/or his/her representative of the resolution of the appeal in writing. The notice shall contain:

(1) The results of the appeal resolution process and;

(2) The date that the appeal decision was made;

(3) If the appeal is not resolved wholly in favor of the beneficiary, the notice shall contain information regarding the beneficiary's right to a State Fair Hearing and procedure for filing for a State Fair Hearing.

(4) If the FCMHP reverses a decision to deny, limit, or delay services that were not furnished while the Appeal was pending, the FCMHP will authorize, provide, and pay for the disputed services promptly and as expeditiously as the beneficiary's

health condition requires, but no later than 72 hours from the time the decision is reached.

Expedited Appeal Process: The FCMHP shall develop and maintain a system for an Expedited Review Process for Appeals in accordance with Title 42, CFR, Section 438.408 (b)(3). An expedited review process for appeals shall take place when the FCMHP determines or the beneficiary and/or the provider certifies 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. For expedited appeals, the FCMHP shall:

a. Allow the beneficiary to file the request orally without written follow-up.

b. Ensure that the punitive action is not taken against a beneficiary or a provider who requests an expedited resolution or supports a beneficiary's appeal.

c. Resolve an appeal and notify the affected parties in writing, no later than 72 hours after the FCMHP receives the appeal. This timeframe may be extended by up to 14 calendar days if the beneficiary requests an extension, or the FCMHP determines that there is need for additional information and that the delay is in the beneficiary's interest. If the FCMHP extends the timeframes, for any extension not requested by the enrollee, the FCMHP shall give the beneficiary written notice of the reason for the delay.

d. Provide the beneficiary with written notice of the expedited appeal disposition and make reasonable efforts to provide oral notice to the beneficiary and/or his/her representative.

f. If the FCMHP denies a request for expedited resolution or an appeal, the FCMHP shall:

(1) Transfer the appeal to the timeframe for standard appeal resolution; and

(2) 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 two calendar days with a written notice.

8.1.1 State Fair Hearing Process

The FCMHP provides its beneficiaries with information on how to file for a State Fair Hearing when the beneficiary's appeal is not resolved entirely in favor of the beneficiary. The beneficiary must first exhaust the FCMHP problem resolution process before filing for a State Fair Hearing.

The Client Informing Materials provide information about the State Fair Hearing process. These materials are given to each client upon first accessing services and upon request. The reverse side of the Notice of Action form also contains information on how to file for a State Fair Hearing. Beneficiaries must request a State Fair Hearing no later than one hundred twenty (120) calendar dates from the date of the FCMHP's notice of resolution. Providers may represent a beneficiary during the State Fair Hearing process with the written consent of the beneficiary.

Beneficiaries have the right to request an external medical review, at no cost to the beneficiary. This medical review must not extend the State Fair Hearing timeframe nor disrupt possible Aid Paid Pending. The review must not be required by the FCMHP, and may not be required before or used as a deterrent to proceeding to a State Fair Hearing.

If the result of the State Fair Hearing **reverses** the FCMHP's decision to deny, limit, or delay services that were not furnished while the State Fair Hearing was pending, the FCMHP will authorize or provide the disputed services as expeditiously as the beneficiary's health condition requires, but no later than 72 hours from the date the FCMHP receives notice of the State Fair Hearing decision.

8.1.1.1 Aid Paid Pending

A beneficiary who is currently receiving services must request a State Fair Hearing with ten (10) calendar days of receipt of the NOA to be eligible for Aid Paid Pending. The FCMHP will provide Aid Paid Pending to a beneficiary who wants continued services and has filed a timely request (10 days from the date a NOA was mailed or personally given to the beneficiary, or before the effective date of the change, whichever is later) for an appeal or State Fair Hearing. When

these criteria are met, benefits will continue while an appeal or State Fair Hearing is pending.

If the result of the State Fair Hearing **reverses** the FCMHP's decision to deny or limit services that **were** furnished while the State Fair Hearing or Appeal was pending, the FCMHP will pay for the costs of the services provided paid pending the State Fair Hearing or Appeal.

If the result of the State Fair Hearing **upholds** the FCMHP's decision to deny or limit services that **were** furnished while the State Fair Hearing or Appeal was pending, the beneficiary may be required to pay the costs of the services provided paid pending the State Fair Hearing or Appeal.

8.1.2 Notice of Action

A Notice of Action (NOA) is provided to a Medi-Cal beneficiary when the FCMHP or its providers determine during the initial intake assessment that the beneficiary does not meet medical necessity and is not entitled to any specialty mental health services; the FCMHP fails to act within the timeframes for disposition of standard grievances, the resolution of standard appeals, or the resolution of expedited appeals; or the FCMHP fails to provide a service within the standard timeline established by the FCMHP.

Each NOA shall inform beneficiaries of their 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. This may include assessments, progress notes, and other medical records ordinarily maintained by contract providers.

Organizational providers' responsibility regarding NOAs:

- Issue an NOA-A to beneficiary when it is determined during the initial intake assessment that the beneficiary does not meet medical necessity and is not entitled to any specialty mental health services.

- Issue an NOA-E to beneficiary when provider is unable to schedule an appointment within 30 days of beneficiary's request for an assessment.

- Fax, mail, or e-mail copies of the assessment and completed NOA forms to Managed Care.