# 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.: Provider 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 Problem Resolution System

The FCMHP maintains a Problem Resolution System that includes three processes:

1. Grievance Process
2. Appeal & expedited Appeal Process
3. State Fair Hearing Process.

Grievance: An expression of dissatisfaction about any matter other than an adverse benefit determination.

Appeal: An expression of dissatisfaction about an adverse benefit determination.

Adverse Benefit Determination:

- The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefits.
- The reduction, suspension, or termination of a previously authorized service.
- The denial, in whole or in part, of payment for a service.
- The failure to provide services in a timely manner.
- The failure to act within the required timeframes for standard resolution of grievances and appeals.
- The denial of a person's served request to dispute financial liability.

Providers must make brochures related to the Beneficiary Problem Resolution

System, in all threshold languages, readily available at each service site without a beneficiary having to make a verbal or written request. Providers may contact Managed Care when additional self-address envelopes are needed.

Providers must post the Problem Resolution System poster, in all threshold languages, at each service site.

Provider must allow a beneficiary to authorize another person to act on their behalf. Providers may represent a beneficiary during the Grievance, Appeal, or State Fair Hearing process with the written consent of the beneficiary.

Provider must 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.)

Providers must not subject a beneficiary to discrimination or any other penalty for filing a grievance or appeal.

Providers must have procedures for the processes that maintain the confidentiality of beneficiaries.

Providers must email encrypted grievances, appeals, and expedited appeals to Managed Care at mcare@fresnocountyca.gov within one business day of the date of receipt.

Providers must log all complaints and the disposition of all complaints the disposition of all complaints from a beneficiary, then submit a monthly summary of the complaint log. Individual and group will submit their logs to DBH Managed Care Division. Contracted organizations must submit their log to the Contract Analyst.

Providers must work Managed Care to resolve each request as expeditiously as a beneficiary's health condition requires, not to exceed 90 calendar days for a grievance or 30 calendar days for an appeal.

### 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's Appeal 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 Adverse Benefit Determination notice 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 days 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 an NOABD 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 NOABD 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 Adverse Benefit Decision

A Notice of Adverse Benefit Decision (NOABD) is written notification to beneficiary when the FCMHP makes any adverse benefit determinations. A NOABD provides information to the beneficiary about their appeal rights and other rights under the Medi-Cal program.

- Providers will use NOABD templates or the equivalent of these templates generated from DBH's Electronic Health Record System to issue the following NOABDs:

- NOABD Delivery System – Providers will issue this NOABD template, following an assessment, when the person served does not meet medical necessary criteria for specialty mental health services and they refer the beneficiary to the Managed Care Plan or other appropriate system for mental health and/or other services. The NOABD Delivery System must be issued to the beneficiary within two business days of the decision.

- NOABD Timely Access – Provider will issue this NOABD template when a person service has requested specialty mental health services and the first available/offered appointment is outside of timely access standards. The NOABD Timely Access must be issued within two business days of the decision.

- NOABD Termination – Provider will issue this NOABD template when terminating, reducing, or suspended a previously authorized service. The NOABD Termination must be issued to the beneficiary within 10 days prior to the date of the action.

When issuing a NOABD, providers must enclose the 1) NOABD Your Rights, 2) Language Assistance Taglines, and 3) Beneficiary Discrimination Notice.

Providers must issue a NOABD and the required enclosures in

the beneficiary's preferred Fresno County threshold language.

In addition to issuing a NOABD to a beneficiary, providers must retain a copy of the NOABD and place it in the beneficiary's file and send a copy to Managed Care.