SFHP POLICY AND PROCEDURE

Member Appeals

Policy and Procedure Number:	QI-17
Department Owner:	Health Outcomes Improvement
Lines of Business Affected:	Medi-Cal, Healthy Workers HMO, Healthy Kids HMO

POLICY STATEMENT

San Francisco Health Plan (SFHP) processes member requests for review of a delay, modification, or denial of services based on medical necessity, or a determination that the requested service was not a covered benefit, as Appeals. SFHP also processes requests made by Medi-Cal members for review of any Adverse Benefit Determinations as Appeals. The Access and Care Experience and Customer Service Departments process Appeals in a manner that is timely, fair and thorough. SFHP's Appeal process complies with applicable federal and state laws and regulations as well as applicable requirements in SFHP's Medi-Cal contract with the Department of Health Care Services (DHCS).

PROCEDURE

I. SCOPE

This policy and procedure describes the process by which Medi-Cal members may Appeal an Adverse Benefit Determination and the process by which Healthy Workers HMO and Healthy Kids HMO members may Appeal a decision by SFHP to deny, delay or modify a health care service based on medical necessity, or a determination that the requested service was not a covered benefit, using the same Appeal process.

SFHP's utilization management (UM) process, including the process for initially denying, delaying, or modifying health care services are described in CO-01, CO-22, and PHARM-02. Grievance and Appeals Member rights, intake, case creation, Exempt Grievances and Decline-to-File Grievances are discussed in CS-13. SFHP's procedures for reviewing Clinical and Non-Clinical Grievances are described in QI-06 and CS-14, respectively.

Appeals discussed in this policy and procedure are not Administrative Appeals. Administrative Appeals are Clinical or Non-Clinical Grievances. Refer to CS-14 for Non-Clinical Grievance procedures and QI-06 for Clinical Grievance procedures.

II. Standards for Processing Appeals

Unless otherwise specified, the following requirements apply to all standard, Expedited, Clinical, Non-Clinical, Pre-Service, or Post-Service Appeal types discussed herein:

a. Filing Timeframes

1. If a Medi-Cal member disagrees with an Adverse Benefit Determination, the member has sixty (60) calendar days from the date of the Notice of Action (NOA) to file an Appeal.
2. Healthy Workers HMO and Healthy Kids HMO members may request an Appeal within one-hundred and eighty (180) calendar days from the date of the decision to deny, modify or delay a health care service.

b. Intake and SFHP's Care Management System Entry

1. SFHP Customer Service performs intake of complaints, including Appeals, and entry of complaints in SFHP's Care Management System, pursuant to CS-13.
2. Per CS-13, Members requesting Expedited Review of complaints are informed of their right to contact the Department of Managed Health Care (DMHC) about their complaint.

c. Triage

1. SFHP Customer Service Representatives direct all Appeals to the HOI Quality Review (QR) RN. Within one (1) business day of receipt of the Appeal, the HOI QR RN determines whether the complaint:
    i. Is an Appeal or Grievance,
    ii. Involves clinical or non-clinical issues (complaints involving both clinical and non-clinical issues will be classified as clinical),
    iii. Meets Expedited Review criteria (i.e., involves a serious and imminent threat to the health of the member including, but not limited to, severe pain, potential loss of life, limb or major bodily function),
    iv. Involves services already rendered,
    v. Presents any Potential Quality Issues (PQIs),
    vi. Is related to any Carved Out Services, and
    vii. Is related to Other Health Coverage (e.g., Medicare benefits for Dual-Eligible Members).
2. The HOI QR RN considers the member's medical condition when determining SFHP's response time.
3. The HOI QR RN, Customer Service Grievance Coordinator/Specialist, and/ or HOI/Access and Care Experience (ACE) Grievance Coordinator/Specialist may contact the member or provider to obtain additional information needed to process the Appeal.
4. HOI QR RN conducts an initial case category determination for all Appeals.
5. Non-Clinical Post-Service Appeals are routed to the Customer Service (CS) Grievance Coordinator/Specialist.

a. Steps for documenting, investigating and resolving Non-Clinical Post-Service Appeals are described in section i. Non-Clinical Post-Service Appeals

6. Appeals related to medical quality of care issues or PQIs are described in QI-18.

d. Member Consent

1. Appeals may be filed by a SFHP member, a provider acting on behalf of the member, or an authorized representative, either verbally or in writing.
2. The date the Appeal is received (either verbally or in writing) establishes the filing date for the Appeal.
3. Appeals filed by the provider on behalf of a member require written consent from the member.
4. Except for Expedited Appeals, when an Appeal is submitted verbally or without a member's written consent, the HOI Grievance Coordinator/Specialist sends the SFHP's Member Grievance/Appeal Form to obtain the member's written, signed Appeal.
5. SFHP does not dismiss or delay the Appeal if a written consent form is not received from the member

e. Documentation

1. SFHP maintains a written record for each appeal received, including:
   a. Date and time of receipt
   b. Name of member, provider or authorized representative filing the Appeal
   c. SFHP representative recording the Appeal
   d. Description of the complaint or problem
   e. A description of the action taken by SFHP or the provider to investigate and resolve the Appeal
   f. The proposed resolution by SFHP or the provider
   g. Name of the SFHP staff responsible for resolving the Appeal
   h. Date of notification to the member of the resolution.
2. The Grievance Coordinator/Specialist ensures the case file for the Appeal documents the substance of the Appeal and any actions taken. This includes, but is not limited to:
   a. Member's, provider's, or authorized representative's reason for Appealing the previous decision.
   b. Additional clinical or other information provided with the Appeal request, any clinical care involved, previous denial or appeal history,
   c. Any follow-up activities associated with the denial and conducted before the current Appeal.

f. Acknowledgement

1. Except for Expedited Appeals, the HOI Grievance Coordinator/Specialist prepares and sends a written Acknowledgement Letter within five (5) calendar days of Appeal receipt. Acknowledgement Letters advise the member that the

Appeal has been received, the date of the receipt, and the name, telephone number and address of the HOI Grievance Coordinator/Specialist.

2. The Acknowledgement Letter informs the member that they may submit additional information or documentation supporting their Appeal.
3. Acknowledgement Letter notices are based on templates reviewed and approved by DHCS and DMHC.
4. The member may be contacted by the HOI Grievance Coordinator/Specialist, or designee, to present more information regarding the Appeal.
5. All Acknowledgement Letters include:
    a. The paragraph required by Health & Safety Code Section 1368.02, which provides information about how to contact the DMHC for further external review of the Grievance by the DMHC.
    b. For Medi-Cal members, the State Ombudsman's office contact information.
    c. Attachments noted in Appendix A
6. If an Expedited Review is requested and the issue(s) do not meet criteria for Expedited Review, the HOI QR RN or HOI Grievance Coordinator/Specialist make reasonable attempts to provide prompt oral notice to the member that the Appeal will be processed within the standard timeframe of 30 calendar days from receipt. This is done within two (2) calendar days of receipt of the Appeal.
    a. The member is informed of their right to file a Grievance if they are unhappy with the decision to downgrade the Appeal from expedited to standard timeframe for investigation.
    b. The HOI QR RN or HOIGrievance Coordinator/Specialist informs the member of the right to concurrently notify the DMHC about the Appeal, and provides the member with DMHC's contact information.
7. Within two (2) calendar days of receipt of the Appeal, the HOI Grievance Coordinator/Specialist also sends the member an Acknowledgement Letter informing the member their Appeal was received, that the Appeal was downgraded to a standard Appeal, and will be resolved within 30 calendar days. ("Downgrade Acknowledgement Letter").
    a. An Acknowledgement Letter (any type) is sent to the provider if the provider submitted the Appeal on the member's behalf

g. Investigation

1. SFHP fully investigates the content of the Appeal and documents findings. SFHP does not give deference to the initial denial, modification or deferral decision.
2. If multiple issues are presented by the member, the HOI Grievance Coordinator/Specialist, Customer Service Manager (for Non-Clinical Appeals), and/or a SFHP Medical Director (for Clinical Appeals) ensure that each issue is addressed and resolved.
3. The member has the opportunity to submit evidence and testimony relating to the Appeal, in person and in writing.

4. SFHP considers all comments, documents, records, and other information submitted by the member, regardless of whether such information was submitted or considered in the initial Adverse Benefit Determination.
5. Members have reasonable access to all documents relevant to the Appeal upon request and may request copies free of charge.
6. Standard documents and correspondence are available in the Medi-Cal, Healthy Workers HMO, and Healthy Kids HMO threshold languages in accordance with the member's written and spoken language.
7. Appeal notices are based on templates reviewed and approved by DHCS and DMHC. Please reference Appendix A for a list of Appeal notices and the enclosures sent with each notice.
8. A member also has the right to interpreter services during any part of the Appeal process. SFHP provides access to telephone relay systems and other devices that aid disabled individuals to communicate. SFHP's policy, CLS-02, details SFHP's system for addressing cultural and linguistic requirements.

h. Clinical Review

The following requirements apply to Clinical Appeals only:

1. The reviewer of the Clinical Appeal must be a physician who was not involved in the initial determination and who is not the subordinate of any physician involved in the initial determination.
2. At least one of the physician reviewers should be a practitioner in the same or similar specialty if the Appeal involves:
    a. an Adverse Benefit Determination that is based on the lack of medical necessity;
    b. denial of an expedited resolution of an Appeal; or
    c. any clinical issues.
3. To be considered a same-or-similar specialist, the reviewing specialist's training and experience must meet the following criteria:
    a. Includes treating the condition.
    b. Includes treating complications that may result from the service or procedure.
    c. Is sufficient for the specialist to determine if the service or procedure is medically necessary or clinically appropriate.
4. If the Adverse Benefit Determination is not overturned upon initial review as an Appeal, a SFHP Medical Director may send the Appeal to an external ndependent medical review organization appropriately qualified to review the medical issue for a final decision. The external reviewer may recommend overturning or upholding the initial decision.

i. Non-Clinical Post Service Appeals

The following requirements apply to Non-Clinical Post-Service Appeals only:

1. The HOI QR RN identifies Appeals that are both non-clinical and involve services already rendered to the member (Post-Service).

2. Non-Clinical Post-Service Appeals do not originate from decisions to deny, modify or delay authorization requests. Instead, Non-Clinical Post-Service Appeals originate from a Notice of Action involving a denied claim where the reason for denial was not based on medical necessity.
3. Non-Clinical Post-Service Appeals involve claim decisions that were not made by a physician, and thus, do not require review by a physician.
4. The reviewer of a Non-Clinical Post- Service Appeal must be someone who was not involved in the initial determination and who is not the subordinate of any person involved in the initial determination.
5. The Customer Service Grievance Coordinator/Specialist processes, investigates and resolves Non-Clinical Post Service Appeals in accordance with the Appeal requirements stated in this Policy and Procedure.
6. The Customer Service Grievance Coordinator/Specialist consults with the Claims Department, Provider Relations, and Customer Service Manager, as applicable, to reach a resolution for the Non-Clinical Post-Service Appeal.

j. Clinical Post Service Appeals

The following requirements apply to Clinical Post-Service Appeals only:

1. The HOI QR RN identifies Appeals that are clinical and involve services already rendered to the member (Post-Service).
2. Clinical Post-Service Appeals originate from decisions to deny, modify or delay authorization requests.
3. Clinical Post-Service Appeals involve utilization management decisions made by a physician, and thus, require review by a physician.
4. The Access and Care Experience Team Grievance Coordinator/Specialist processes, investigates and resolves Clinical Post-Service Appeals in accordance with the Appeal requirements stated in this Policy and Procedure.
5. The Grievance Coordinator/Specialist consults with the Utilization Management Department, Provider Relations, and Claims Department as applicable, to reach a resolution for the Clinical Post-Service Appeal.

k. Resolution

Unless otherwise specified, the following requirements apply to both standard and Expedited Appeals:

1. The Appeal is resolved once a final conclusion is reached with respect to the submitted Appeal, and there are no pending Appeals for the same member within SFHP's Grievance system, including entities with delegated authority.
2. Except for Expedited Appeals, SFHP resolves the Appeal and sends a Notice of Appeal Resolution (NAR) within 30 calendar days of receipt of the appeal.
3. The disposition of the Appeal is communicated through the NAR. The NAR includes:
    a. The resolution, date it was completed, and a clear and concise explanation of SFHP's decision.
    b. Culturally and linguistically appropriate language.

c. A complete explanation of the grounds for the denial written in plain language that a layperson can understand and does not include abbreviations or acronyms that are not defined or health care procedure codes that are not explained.
d. If SFHP's denial determination is based in whole or in part on medical necessity; the determination clearly states the criteria, clinical guidelines, or medical policies used to reach the determination.
e. A list of titles and qualifications, including specialties of the individuals participating in the appeal review.
f. If SFHP's denial determination is that the requested service is not a covered benefit, the determination includes the provision in the DHCS Contract, Evidence of Coverage (EOC), or Member Handbook that excludes the service.
    i. The document and page where the provision is found, directs the member to the applicable section of the DHCS contract containing the provision, or provides a copy of the provision and explains how the exclusion applies to the service requested.
g. Notification that the member can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based, upon request.
h. A list of titles and qualifications, including specialties, of individuals participating in the appeal review.
i. Additional information for further appeal rights (See Appendix A).

4. HOI Grievance Coordinator/Specialist coordinates with the Marketing Department to translate SFHP's NAR decision to a threshold language if time allows prior to the expiration of the applicable resolution timeframe.
5. If an Appeal is resolved in favor of the member (i.e., results in an overturn of SFHP's previous decision), the decision is communicated to the member by a written NAR.
    a. SFHP authorizes the services promptly and as expeditiously as the member's condition requires, but no later than 72 hours from the date it reverses the determination.
6. If the provider submitted the Appeal on the member's behalf, a copy of the NAR is sent to the provider,
7. If resolution cannot be provided within the required timeframe, the HOI Grievance Coordinator/Specialist contacts the member to notify them of their right to contact DMHC and pending status of the Appeal resolution. This is documented in the Appeal case file.
8. NAR is reviewed by the HOI QR RN to ensure all clinical aspects of the Appeal is clear and concise, and reflects decisions made by a SFHP Medical Director.
9. A SFHP Medical Director reviews and signs the NAR.

III. Requirements for Expedited Appeals (except Appeals about Non-Formulary Drugs for Healthy Workers/Health Kids)

The following requirements apply to Expedited Appeals only, but not to Expedited Appeals about Non-Formulary Drugs:

1. Pursuant to CS-13, members requesting Expedited Review of an Appeal are immediately informed of the right to contact the DMHC about their Appeal.
2. The Expedited Review is initiated immediately upon receipt, and is resolved as soon as possible, but no later than 72 hours from the time of receipt.
3. SFHP monitors the clinical status of the patient throughout the process and acts as expeditiously as the member's health requires.
4. The HOI Grievance Coordinator/Specialist communicates the disposition of the Appeal in a written NAR to the member and requesting provider within 72 hours of receipt of the Appeal.
5. The HOI Grievance Coordinator/Specialist or the HOI QR RN makes reasonable efforts to provide the the member and provider with verbal notification of the resolution by phone.
6. The HOI Grievance Coordinator/Specialist notifies the Supervisor, Regulatory Affairs, or designee, of receipt and resolution of an Expedited Appeal. The Supervisor, Regulatory Affairs, or designee, provides a written statement to the DMHC about the disposition or pending status of the Expedited Appeal within three calendar days of receipt of the Appeal.

IV. Requirements for Appeals about Non-Formulary Drugs

The following process applies when a Healthy Workers HMO or Healthy Kids HMO member disputes the denial of a non-formulary drug. This section does not apply to appeals of denial about formulary drugs. This section does not apply to Medi-Cal members.

1. Healthy Workers HMO (HW) and Healthy Kids HMO (HK) members may request coverage of non-formulary drugs (also known as an "exception request").
2. If the member receives an NOA denying a request for a non-formulary drug, the NOA provides the member with information about how to file an non-fomulary drug appeal (also known as a "grievance seeking an external exception request review").
3. The member has one hundred and eighty (180) days from the date of the NOA to file an Appeal about a non-formulary drug.
4. Upon receipt of an Appeal about a non-formulary drug, a SFHP Pharmacist determines whether the Appeal should be overturned. If the SFHP Pharmacist determines upon initial review that the Appeal should be upheld, SFHP forwards the Appeal and all applicable documentation to an external review organization for review.
5. If the original request was processed as a standard prior authorization request ("standard exception request"), SFHP provides the member or authorized representative of the decision no later than 72 hours following the receipt of the Appeal. If the exception request is granted, SFHP covers the drug for the duration of the prescription.
6. If the original request was processed as an expedited prior authorization request where exigent circumstances exist ("expedited exception request"), SFHP provides the member or authorized representative of the decision no later than 24 hours

following the receipt of the Appeal. If the expedited exception request is granted, SFHP covers the drug for the duration of the exigency.
7. The decision is communicated to the member by phone in a culturally and linguistically appropriate manner and a written NAR. The written NAR is translated to a HW or HK threshold language if time allows prior to the expiration of the 72-hour or 24-hour timeframe.
8. The NAR serves as both the written acknowledgement of receipt and resolution of the Appeal. A copy of the NAR is sent to the provider, if the provider appeals on the member's behalf.

V. Special Considerations

If an Appeal involves one of the following issues, the Appeal is subject to additional review and/or classification as described below:

a. Delegated Appeals

1. SFHP delegates the responsibility for processing Appeals to certain Knox-Keene licensed health care service plans. SFHP fully delegates the Appeal process to one (1) health plan, Kaiser Health Plan Foundation.
2. SFHP partially delegates the responsibility for processing Appeals to Beacon Health Options ("Beacon"). Under partial delegation, a SFHP Medical Director and/ or QR RN reviews the Appeal prior to Beacon finalizing the Notice of Appeal Resolution.
3. Per CS-13, if SFHP receives an Appeal, the processing of which is delegated, the Customer Service Representative still performs intake of the Appeal.
4. A SFHP Medical Director and/ or HOI QR RN determines whether the Appeal should be processed by SFHP or forwarded to the delegated entity for processing. For more information, see the Desktop Procedures for Delegated Grievances.

b. Cultural and Linguistic Requirements

The HOI Grievance Coordinators/Specialists are trained by the Program Manager, Population Health on cultural and linguistic requirements. This procedure ensures the Grievance Coordinators/Specialists are able to identify any cultural and linguistic issues raised in Appeals.

The Program Manager, Population Health performs a review of all Appeals involving cultural and/or linguistic concerns including alleged discrimination by SFHP providers or staff to ensure accurate identification and resolution of issues. For more information, see HECLS Desktop Procedure (DTP).

SFHP reports Appeals alleging discrimination against Medi-Cal members because of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, or disability to DHCS for review and appropriate action. The Grievance Coordinator/Specialist sends the member's CIN number, copies of the case notes, provider response (if any), and resolution letter to the Supervisor,

Regulatory Affairs, or designee, for forwarding to DHCS. This is documented in SFHP's Care Management System.

VI. State External Review of an Appeal

1. SFHP has one internal level of Appeal resolution. Members may contact SFHP Customer Service to have a previously issued resolution for an Appeal reconsidered; however, Members are not required to participate in SFHP's Appeal process for more than 30 calendar days and are encouraged to seek external review.
2. If the Member does not agree with SFHP's decision on an Appeal, members may:
    a. Contact the DMHC and apply for an Independent Medical Review (IMR). An outside reviewer not affiliated with SFHP will review the member's Appeal.
    b. Ask for a State Fair Hearing (Medi-Cal members only). A Department of Social Services (DSS) administrative law judge will review the member's Appeal.
3. SFHP informs members of no-cost external review options in the NAR or, if the member is a Medi-Cal member, the "Your Rights" document.
4. Medi-Cal members may contact the State Ombudsman's Office. The Ombudsman Office is reached toll-free at 1-888-452-8609. The TDD number is 1-800-952-8349. Its office hours are Monday-Friday, 8am to 5 pm, closed on State holidays.
5. Members may designate an authorized representative to speak on their behalf in IMR cases and/or State Fair Hearings.
6. Medi-Cal members may request both an IMR and a State Fair Hearing at the same time. A Medi-Cal member cannot ask for an IMR if the issue was presented for resolution at a State Fair Hearing.

a. DMHC Independent Medical Review (IMR)

1. Member must ask for an IMR within 180 days of the date of the NAR.
2. Members may qualify for IMR if SFHP's decision was based in whole or in part on a determination that the service is not medically necessary, the requested service is experimental/investigational, or the case involves an emergency service. Denials based on a determination that the requested service was not a covered benefit are not eligible for IMR.
3. Medi-Cal members are eligible for IMR if the issue has not yet been presented at a State Fair Hearing.
4. Members are required to exhaust SFHP's Appeal process prior to seeking an IMR, except when the DMHC determines that extraordinary and compelling circumstances exist. Extraordinary and compelling circumstances might include when an imminent and serious threat to the health of the member.
5. The Supervisor, Regulatory Affairs, or designee, responds to DMHC requests for information about IMRs pursuant to Policy and Procedure CRA-24.
6. If SFHP's decision is overturned by an IMR, SFHP authorizes the previously denied service or pays the associated claim within the timeframes set by DMHC.

b. State Fair Hearing

1. Medi-Cal members may request a State Fair Hearing within 120 days of the date of the NAR.
2. Members may request a State Fair Hearing by contacting the California Department of Social Services, State Hearings Division, P.O. Box 944243, Mail Station 19-37, Sacramento, California 94244-2430, 1-800-952-5253, TTY/TDD 1-800-952-8349.
3. The member has the right to request and receive continuation of services that were previously authorized but terminated by SFHP while the State Fair Hearing is pending (Aid Paid Pending). To request continuation of services that were previously authorized but terminated by SFHP (Aid Paid Pending), members must request a State Fair Hearing within 10 days of the NAR or prior to the effective date of the termination of services. If Aid Paid Pending is requested timely, SFHP authorizes the previously terminated services within 5 working days of receipt of the hearing request.
4. Medi-Cal members are required to exhaust SFHP's Appeal process prior to seeking a State Fair Hearing. SFHP's Appeal process is exhausted if the member submits an Appeal to SFHP and receives a written response or NAR within 30 days.
5. SFHP's Appeal process may be deemed exhausted if SFHP fails to meet notice or timeliness requirements, including failure to respond to an Appeal within 30 days or providing incorrect information about the Appeal process to the member.
6. The Supervisor, Regulatory Affairs, or designee, responds to State Fair Hearing requests from DHCS and/or DSS pursuant to Policy and Procedure CRA-24.
7. If SFHP and the member are able to resolve the member's issue prior to a State Fair Hearing, and the member agrees to withdraw his/her request for a State Fair Hearing, SFHP's Customer Service assists the member in accordance with the procedure detailed below:
    a. State Fair Hearing requests can only be withdrawn by the member, not by SFHP.
    b. Customer Service conducts a conference call with the member and the Department of California Social Services Office by calling 1-800-743-8525.
8. An administrative law judge may take up to 90 days from the date of the hearing request to decide the member's case. Members may request an expedited hearing if the member believes waiting for up to 90 days will seriously harm their life, health or their ability to attain, maintain, or regain maximum function. An expedited hearing is decided within three working days of the hearing request.
9. When SFHP receives the final disposition of the case, SFHP acts to implement the order within the deadlines set by the order, when indicated. If a previously denied request for a service is overturned, SFHP authorizes the service within 72 hours. If the service has already been rendered, any outstanding claims are reimbursed within 30 days.

VII. Oversight Roles and Responsibilities

1. The Chief Medical Officer has primary responsibility for SFHP's Appeal process and system.

2. The SFHP Quality Improvement Committee oversees the Appeal process. The SFHP Director of Health Outcomes Improvement is responsible for maintaining Appeal procedures, reviewing the operation of the process, and leading SFHP's quality committee in identifying emergent patterns of Appeals in order to initiate systemic improvements in SFHP operations.
3. The Governing Board may direct SFHP to improve the quality and efficiency of the grievance process, or to initiate improvement activities that directly address the individual or systemic issues raised.

MONITORING

1. SFHP reviews Appeal data and Appeal internal audit results at the Grievance Program Leadership Team (PLT).
2. HOI Grievance Analyst compiles a quarterly grievance report for all Medical Groups. Provider Network Operations designee submits a quarterly grievance report to all Medical Groups.
3. On a monthly basis, the Utilization Management Committee (UMC) reviews Appeals, IMRs, and State Fair Hearings resulting in overturn of an authorization decision made by SFHP or one of its delegated medical groups. The UMC recommends corrective action and/or identifies where the Clinical Operations Department or Pharmacy Department can revise the authorization process, if necessary, to improve the member experience, to address any barriers, and ensure the utilization management criteria are consistent with current industry and evidence-based practices.The Quality Improvement Committee reviews an Appeals report every quarter regarding the activity of pharmacy and medical authorizations and overturned and upheld appeals.
4. HOI Grievance Analyst and Delegation Oversight designee conducts annual audits of entities delegated for the processing of Appeals.
5. SFHP monitors entities delegated processing of Grievances and Appeals pursuant to DO-08 Oversight of Delegated Grievances.
6. Pursuant to CLS-02, the Program Manager, Population Health, performs annual oversight reviews of Appeals to ensure that cultural and linguistic issues are being identified, logged and appropriately addressed.
7. SFHP completes an annual Grievance and Appeals report according to NCQA requirements and submits to PLT for review.
8. The Supervisor, Compliance Program, or designee, performs an internal audit of Grievances and Appeals on a quarterly basis.
9. At least quarterly, the Governing Board reviews the activities of all quality committees. SFHP also conducts a review and analysis on at least a quarterly basis, of all recorded grievances and appeals related to access to care, quality of care and denial of services, and takes appropriate action to remedy any system problems identified in such reviews. Annually, the Governing Board reviews the Quality Improvement Evaluation, which includes tabulated grievance data, an evaluation of grievance and complaint trends, member satisfaction survey results and related data. The Quality Improvement Evaluation also proposes priority areas for improvement, and related activities and goals.

DEFINITIONS

Administrative Appeals: an appeal of a decisions that are not about coverage or medical necessity. Administrative Appeals are subject to the requirements in NCQA RR 2. SFHP classifies and processes Administrative Appeals as Grievances. Please see policies and procedures QI-06 Clinical Member Grievances and CS-14 Non-Clinical Member Grievances and Non-Clinical Decline-to-File Grievances.

Adverse Benefit Determination: any of the following actions taken by SFHP:

a. Denial or limited authorization of a requested service, including determinations based on the type or level of service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
b. Reduction, suspension, or termination of a previously authorized service.
c. Denial, in whole or in part, of payment for a service.
d. Failure to provide services in a timely manner.
e. Failure to act within required timeframes for resolution of Grievances and Appeals.
f. Denial of a beneficiary's request to dispute financial liability.

Appeal: a request by a member for review of an Adverse Benefit Determination, including, delay, modification or denial of services based on medical necessity, or a determination that the requested service was not a covered benefit. Appeals are subject to the requirements in NCQA UM 8 and UM 9.

Disputed Health Care Service: any health care service that is eligible for coverage and payment by SFHP or medical group that has been delayed, denied, or modified by a decision of SFHP or one of its medical groups. The decision to delay, deny or modify must be made, in whole or in part, due to a finding that the service is not medically necessary.

Expedited Review: an accelerated review and reporting process for grievances involving an imminent and serious threat to the member's health. An "imminent and serious threat to health" includes, but is not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of the health of the member.

Grievance: an expression of dissatisfaction by a member about an issue other than an Adverse Benefit Determination, including but not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employees, and the member's right to dispute an extension to make an authorization decision. A Grievance is also known as an Administrative Appeal.

Independent Medical Review (IMR): The expert review of disputed health care services by an outside organization that contracts with the Department of Managed Health Care (DMHC).

Notice of Action (NOA): a formal letter telling members that a medical service has been denied, deferred, or modified.
Notice of Adverse Benefit Determination (NABD): same definition of NOA. DHCS has retained use of NOA for ease of understanding by members.

Notice of Appeal Resolution (NAR): appeal resolution letter determining if the appeal will be overturned or upheld.

Post-Service Appeal: a request to change an Adverse Benefit Determination for care or services that have been received by the member.

Potential Quality Issue (PQI): an identified adverse variation from expected clinical standard of care requiring further investigation. A PQI can lead to a confirmed provider or system quality issue or opportunity for improvement.

State Fair Hearing: a review by a California Department of Social Services administrative law judge of a Medi-Cal member's complaint about how Medi-Cal benefits or services were handled or a denial or modification of Medi-Cal benefits or services.

AFFECTED DEPARTMENTS/PARTIES

Claims
Clinical Operations
Compliance & Regulatory Affairs
Customer Service
Performance & Process Improvement
Pharmacy
Provider Relations

RELATED POLICIES AND PROCEDURES, DESKTOP PROCESS and PROCESS MAPS

1. Acknowledgement Letter
2. Authorization Requests (CO-22)
3. Clinical Member Grievances (QI-06)
4. DTP Beacon Grievances
5. DTP Carved Out Services
6. DTP Cultural, Linguistic and Health Education Grievance Process
7. DTP Delegated Grievances
8. DTP Grievance Review Committee
9. DTP Grievance Review Committee
10. DTP HECLS
11. Grievance Form
12. Member Grievances and Appeals: Rights, Intake and Case Creation (CS-13)

13. Member Handbook and/or Evidence of Coverage and Disclosure Form
14. Non-Clinical Grievances and Non-Clinical Decline-to-File Grievances (CS-14)
15. Notice of Appeal Resolution Letter
16. Oversight of Delegated Grievances (DO-08)
17. Pharmacy Prior Authorization (PHARM-02)
18. Potential Quality Issues (QI-18)Responding to State Inquiries about Member Complaints (CRA-24)
19. UM Authorization and NOA Letters (CO-01)
20. Use of Interpreter Service and Bilingual Staff (CLS-02)

REVISION HISTORY

Effective Date: July 2, 2019
Approval Date: June 20, 2019; August 23, 2019
Revision Date(s): August 23, 2019

REFERENCES

1. APL 17-006 Grievance and Appeal Requirements
2. Code of Federal Regulations, Title 42, Section 438.406 (b)3, 438.420
3. Health and Safety Code, Sections 1367.01, 1367.27, 1368, 1368.01, 1368.02, 1368.03, 1368.04, 1370.4, 1374.30, 1374.31, 1374.32, 1374.33, 1374.35, and 1374.36
4. MMCD All Plan 03008: Submission of Quarterly Logs
5. MMCD All Plan 03009: Expedited State Hearings
6. MMCD Policy Letter 09-006: Timeframes for Member Grievances
7. NCQA Standards UM9 Member Appeals
8. Title 22, California Code of Regulations, Section 53858, 53893, 51014
9. Title 28, California Code of Regulations, Section 1300.68
10. Welfare and Institutions Code 10961

APPENDIX A

Medi-Cal

Letter Type	Attachments
Appeal Acknowledgment	Language Assistance Taglines and Nondiscrimination Notice
Appeal Acknowledgement and Downgrade of Expedited to Standard Appeal	Language Assistance Taglines and Nondiscrimination Notice; NAR Your Rights, State Fair Hearing Form, IMR form, envelope addressed to DMHC
Notice of Appeal Resolution (NAR) – Uphold	Language Assistance Taglines and Nondiscrimination Notice, NAR Your Rights, State Fair Hearing Form, IMR form, envelope addressed to DMHC
Notice of Appeal Resolution (NAR) – Overturn	Language Assistance Taglines and Nondiscrimination Notice, NAR Your Rights
Grievance/Appeal Withdrawal	Language Assistance Taglines and Nondiscrimination Notice

Healthy Workers HMO and Healthy Kids HMO

Letter Type	Attachments
Appeal Acknowledgment	Language Assistance Taglines and Nondiscrimination Notice
Appeal Acknowledgement and Downgrade of Expedited to Standard Appeal	Language Assistance Taglines and Nondiscrimination Notice; IMR form, envelope addressed to DMHC
Notice of Appeal Resolution (NAR) – Overturn	Language Assistance Taglines and Nondiscrimination Notice
Notice of Appeal Resolution (NAR) – Uphold	Language Assistance Taglines and Nondiscrimination Notice, IMR form, envelope addressed to DMHC
Grievance/Appeal Withdrawal	Language Assistance Taglines and Nondiscrimination Notice

Appendix B

Grievance Type	Member Acknowledgement	Member Resolution
Expedited		Oral notice within 72 hours
Downgraded from Expedited to Standard	Oral notice within 2 days Written notice within 2 days	Written notice within 30 days of receipt
Standard	Written notice within 5 days	
Redirected to Delegate	Written notice of redirection within 5 days	