DATE: May 24, 2017

TO: ALL MEDI-CAL DENTAL MANAGED CARE (DMC) PLANS

SUBJECT: APL 17-003: GRIEVANCE AND APPEAL REQUIREMENTS; REVISED NOTICE TEMPLATES AND “YOUR RIGHTS” ATTACHMENTS

PURPOSE:
The purpose of this Dental All Plan Letter (APL) is for the Department of Health Care Services (DHCS) to provide Medi-Cal Dental Managed Care (DMC) plans with clarification and guidance regarding the application of new federal and existing state regulations for processing grievances and appeals.

BACKGROUND:
On May 6, 2016, the Centers for Medicare and Medicaid Services published the Medicaid and Children’s Health Insurance Program Managed Care Final Rule\(^1\), which aimed to align Medicaid managed care regulations with requirements of other major sources of coverage. The final rule stipulated new requirements for the handling of grievances and appeals that become effective July 1, 2017.\(^2\)

This APL provides all-encompassing guidance to DMC plans regarding grievance and appeal requirements. In addition to clarifying the application of new federal regulations and addressing discrepancies with existing state regulations\(^3\), this APL also includes revised notice templates for each type of Notice of Action (NOA) or Notice of Appeal Resolution (NAR) that DMC plans may decide, including revised “Your Rights” attachments that must be sent in conjunction with member notifications. The annual “Member Reminder Template” shall include a “Notice of New Appeal Procedure” statement. Requirements pertaining to Independent Medical Reviews (IMRs) remain unchanged.

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\(^1\) Federal Register (FR), Volume 81, No. 88, 27497 (May 6, 2016)
\(^2\) Title 42, Code of Federal Regulations (CFR), Part 438
\(^3\) Title 22, California Code of Regulations (CCR), Section 53858; Title 28, CCR, Section 1300.68
REQUIREMENTS:

I. DEFINITIONS

A. Notice of Action

The term “Notice of Action” (NOA) has been replaced with “Notice of Adverse Benefit Determination” (NABD)\(^4\) for unfavorable or untimely decisions. However, because this new terminology may be confusing for beneficiaries, DHCS will retain the use of “NOA” for ease of understanding. Therefore, a “NOA” that is a NABD shall consequently be defined as a formal letter informing a member of an adverse benefit determination.

B. Adverse Benefit Determination

Under new federal regulations, the definition of an “Adverse Benefit Determination” encompasses all previously existing elements of an “Action” that is not wholly in favor of the beneficiary. Additional language clarifies the inclusion of determinations involving medical necessity, appropriateness, setting, covered benefits, and financial liability. An “Adverse Benefit Determination” is defined to mean any of the following actions taken by the DMC plan:

1. 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 benefit.
2. The reduction, suspension, or termination of a previously authorized service.
3. The denial, in whole or in part, of payment for a service.
4. The failure to provide services in a timely manner.
5. The failure to act within the required timeframes for standard resolution of grievances and appeals.
6. The denial of a member’s request to dispute financial liability.

C. Grievance

The state definition\(^5\) does not specifically distinguish “grievances” from “appeals,” however, federal regulations\(^6\) have redefined “Grievance and Appeal System” to mean processes the DMC plan implements to handle grievances and appeals. The terms “grievance” and “appeal” are separately defined. Due to distinct processes delineated for the handling of each, DMC plans shall adopt the federal definition but also incorporate applicable sections of the existing state definition that do not pose conflicts.

\(^4\) Title 42, CFR, Section 438.404
\(^5\) Title 28, CCR, Section 1300.68(a)(1)(2)
\(^6\) Title 42, CFR, Section 438.400(b)
1. A grievance is an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, and the member’s right to dispute an extension of time proposed by the DMC plan to make an authorization decision.\(^7\)

2. A complaint is the same as a grievance. Where the DMC plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.\(^8\)

3. An inquiry is a request for information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other DMC plan processes.

DMC plans shall not discourage the filing of grievances. A member need not use the term “grievance” for a complaint to be captured as an expression of dissatisfaction, and therefore a grievance. If a member expressly declines to file a grievance, the complaint shall still be categorized as a grievance and not an inquiry. The DMC plans may still protect the identity of the member, however, the complaint shall be aggregated for tracking and trending purposes as with other grievances.

D. Appeal

Under new federal regulations, an “appeal” is defined as a review by the DMC plan of an adverse benefit determination.\(^9\) While state regulations\(^10\) do not explicitly define the term “appeal”, they do delineate specific requirements for the new federal definition of an appeal. Requests for an appeal involve the modification or denial of services based on medical necessity, a determination that the requested service was not a covered benefit, or another criteria for an adverse benefit determination as listed above. The DMC plan shall treat these requests for review as appeals under federal regulations.

DMC plans shall adopt the formal definition of “appeal” in accordance with new federal regulations but still comply with all existing state regulations as it pertains to appeal handling as applicable. These requirements are further delineated in Section IV of this APL.

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\(^7\) Title 42, CFR, Section 438.400(b)
\(^8\) Title 28, CCR, Section 1300.68(a)(1)(2)
\(^9\) Title 42, CFR, Section 438.400(b)
\(^10\) Title 28, CCR, Section 1300.68(d)(4) and (5)
II. ADVERSE BENEFIT DETERMINATIONS

A. Authorization Timeframes

1. Standard Requests
DMC plans must approve, delay, modify, or deny a provider’s prospective or concurrent request for dental services in a timeframe which is appropriate for the nature of the member’s condition, but no longer than five business days from the DMC plan’s receipt of information reasonably necessary to make a determination. The DMC plan’s written response, a NOA, shall be dated and postmarked no later than 14 calendar days from the date of receipt of the request. An extension of 14 calendar days may be granted if either the member or provider requests the extension, or the DMC plan justifies a need for additional information and how the extension is in the member’s best interest. If the DMC plan fails to issue a NOA within the required timeframe, it shall be considered a denial and therefore constitutes an adverse benefit determination. The member would then have the right to request an appeal with the DMC plan.

2. Retrospective Requests
DMC plans must approve, delay, modify, or deny a provider’s retrospective request for dental services within 30 calendar days from receipt of information that is reasonably necessary to make a determination.

3. Expedited Requests
In instances where a provider indicates, or the DMC plan determines, that the standard timeframe may seriously jeopardize the member’s health, causing severe pain or impairing function, the DMC plan must approve, delay, modify, or deny a provider’s prior authorization or concurrent request for dental services, and send the appropriate NOA in a timeframe which is appropriate for the nature of the member’s condition, but no longer than 72 hours from the receipt of the request. An extension of 14 calendar days may be granted if the member requests the extension, or upon DHCS satisfaction, the DMC plan justifies a need for additional information and how the extension is in the member’s best interest. If the DMC plan fails to issue a NOA within the required timeframe, it shall be considered a denial and therefore constitutes an adverse benefit determination. The member would then have the right to request an appeal with the DMC plan.

11 Health & Safety Code, Section 1367.01 (h)(1)
12 Title 42, CFR, Section 438.210(d)(1)
13 Title 42, CFR, Section 438.404(c)(5)
14 Health & Safety Code, Section 1367.01(h)(1)
15 Title 42, CFR, Sections 438.210(d)(2) and 438.404(c)(5); Health & Safety Code, Section 1367.01(h)(2)
4. Deferrals
In instances where the DMC plan cannot make a decision to approve, modify, or deny a request for authorization within the required timeframe because it is not in receipt of information reasonably necessary and requested, the DMC plan shall send out a delay NOA to the provider and member within the required timeframe or as soon as the DMC plan becomes aware that it will not meet the timeframe. A delay NOA is warranted if the DMC plan extends the timeframe an additional 14 calendar days because either the member or provider requests the extension, or upon DHCS satisfaction, the DMC plan justifies a need for additional information and how the extension is in the member's best interest. The delay NOA shall specify the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required. The DMC plan shall also include the anticipated date when a decision will be rendered.16

5. Terminations
For terminations, suspensions, or reductions of previously authorized services, DMC plans must notify members at least ten days before the date of the action with the exception of circumstances permitted under Title 42, CFR, Sections 431.213 and 431.214.17

B. Notice of Adverse Benefit Determination (NABD)
Members must receive written notice of an approval or of an adverse benefit determination. DMC plans currently utilize DHCS-developed standardized NOA templates for scenarios that are commonly used (approval, denial, modification, termination). DHCS continues to provide standardized templates for use and has revised the templates for NOAs that are NABDs and corresponding “Your Rights” attachments to comply with new federal regulations. The following distinct NOA templates accommodate actions that DMC plans may commonly take:

1. Denial of a treatment or service
2. Modification of a treatment or service
3. Termination or reduction of the level of treatment or service currently underway

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16 Health & Safety Code, Section 1367.01(h)(5)
17 Title 42, CFR, Section 438.404(c)(1)
“Your Rights” attachments, only if they meet the new federal rule requirements

1. Language access and formatting consistent with Title 42, CFR, Section 438.10.
2. The adverse benefit determination.
3. The reasons for the adverse benefit determination, including the member’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 member’s adverse benefit determination. This information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits.
4. The member’s right to request an appeal of the DMC plan’s adverse benefit determination, including information on exhausting the DMC plan’s one level of appeal described at Title 42, CFR, Section 438.402(b) and the right to request a State fair hearing consistent with Title 42, CFR, Section 438.402(c).
5. The procedures for exercising the rights specified in this paragraph (3).
6. The circumstances under which an appeal process can be expedited and how to request it.
7. The member’s right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances, consistent with state policy, under which the member may be required to pay the costs of these services.

C. Translation of Notices

The DHCS contract additionally requires DMC plans to fully translate member-informing materials into the required threshold languages. DHCS acknowledges the challenges associated with the timely translation of clinical rationale that must be inserted into the NOA. If translating the clinical rationale will jeopardize a DMC plan’s ability to comply with the mailing timeframes, DHCS will accept NOAs where the rationale is written in English. However, the body of the NOA must be translated into required threshold languages and a sentence in the member’s preferred language must be inserted to explain how the member can obtain a verbal translation of the clinical rationale. The body of the NOA constitutes the entire content of the NOA with the exception of the clinical rationale. DMC plans must also provide a written translation of the clinical rationale if specifically requested by the member.

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18 Title 42, CFR, Sections 438.404(a) and 438.404(b)(1-6)
19 Exhibit A, Attachment 13, Section 4(C)(1)
III. GRIEVANCES

A. Timeframes for Filing
   Timeframes for filing grievances are delineated in both federal\(^{20}\) and state\(^{21}\) regulations. While existing state regulations establish a timeframe of at least 180 calendar days from the date of the incident subject to the member’s dissatisfaction, new federal regulations allow grievances to be filed at any time. DMC plans shall adopt the standard which is least restrictive to members and allow grievances to be filed at any time in accordance with new federal regulations.

B. Method of Filing
   In accordance with both existing federal\(^{22}\) and state\(^{23}\) regulations, a grievance may be filed by a member, a provider acting on behalf of the member, or an authorized representative either orally or in writing.

C. Standard Grievances
   1. Acknowledgment
      In accordance with existing state regulations\(^{24}\), DMC plans shall provide written acknowledgment to the member that is dated and postmarked within five calendar days of receipt of the grievance. The acknowledgment letter shall advise the member that the grievance has been received, the date of receipt, and provide the name, telephone number, and address of the representative who may be contacted about the grievance.

   2. Resolution
      Timeframes for resolving grievances and sending written resolution to the member are delineated in both federal\(^{25}\) and state\(^{26}\) regulations. Federal regulations, which remain unchanged, allow the State to establish a timeframe for grievance resolution that does not exceed 90 calendar days from the date of receipt of the grievance. The State’s established timeframe is 30 calendar days. DMC plans shall continue to comply with the State’s established timeframe of 30 calendar days for grievance resolution.

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\(^{20}\) Title 42, CFR, Section 438.400(b)
\(^{21}\) Title 28, CCR, Section 1300.68(b)(9)
\(^{22}\) Title 42, CFR, Section 438.402(c)(3)(i)
\(^{23}\) Title 28, CCR, Section 1300.68(a)(1)
\(^{24}\) Title 28, CCR, Section 1300.68(d)(1)
\(^{25}\) Title 42, CFR, Section 438.408(b)(1)
\(^{26}\) Title 28, CCR, Sections 1300.68(a) and (d)(3)
a. Resolved" means that the grievance has reached a final conclusion with respect to the member’s submitted grievance as delineated in existing state regulations.27

b. The DMC plan’s written resolution shall contain a clear and concise explanation of the DMC plan’s decision.28

c. Federal regulations29 allow for a 14-calendar day extension for standard and expedited appeals. This allowance does not apply to grievances. However, in the event that resolution of a standard grievance is not reached within 30 calendar days as required, the DMC plan shall notify the member in writing of the status of the grievance and the estimated date of resolution in accordance with existing state regulations.

D. Exempt grievances
DMC plans shall continue to comply with all state regulations30 pertaining to exempt grievance handling as follows:

Grievances received over the telephone that are not coverage disputes, and are resolved by the close of the next business day, are exempt from the requirement to send a written acknowledgment and response. The DMC plan shall maintain a log of all such grievances containing the date of the call, the name of the complainant, member identification number, nature of the grievance, nature of the resolution, and the representative's name who took the call and resolved the grievance. The DMC plan shall periodically review the information contained in this log.

The DMC plan shall ensure exempt grievances are incorporated into the quarterly grievance and appeal report that is submitted to DHCS.

E. Expedited grievances
State regulations31 delineate processes for expedited grievance handling and require resolution within three calendar days. Congruent with state regulations, DHCS acknowledges that there are instances that may involve an imminent and serious threat to the health of a member, including, but not limited to, severe pain, or impairment of bodily function that do not involve the appeal of an adverse benefit determination, yet are “urgent” or “expedited” in nature. For consistency, DMC plans shall apply the revised federal timeframe for resolving expedited appeals (72 hours) to expedited grievances. The 72-hour timeframe would require DMC plans to additionally record the time of grievance receipt, and

27 Title 28, CCR, Section 1300.68(a)(4)
28 Title 28, CCR, Section 1300.68(d)(3)
29 Title 42, CFR, Section 438.408(b) and (c)
30 Title 28, Section 1300.68(d)(8)
31 Title 28, CCR, Section 1300.68.01
not just the date, as the specific time of receipt would drive the timeframe for resolution.

Federal regulations\textsuperscript{32} require DMC plans to make reasonable efforts to provide oral notice to the member of the resolution. DMC plans shall apply this requirement of oral notice for expedited appeals to expedited grievances.

DMC plans shall comply with all other existing state regulations pertaining to expedited grievance handling in accordance with Section 1300.68.01, Title 28, of the California Code of Regulations (CCR).

IV. APPEALS

A. Timeframes for Filing

Timeframes for filing appeals are delineated in the DHCS contract\textsuperscript{33}, as well as in both state\textsuperscript{34} and federal\textsuperscript{35} regulations.

Existing federal regulations allow members 90 days from the date on the NOA to file an appeal. By contrast, existing state regulations, which do not distinguish grievances from appeals, allow at least 180 calendar days to file grievances, which are inclusive of appeals. Currently, DMC plans comply with the 90-day timeframe in accordance with the DHCS contract.

New federal regulations require members to file an appeal within 60 calendar days from the date of the NOA. The DMC plan shall adopt the 60-calendar day timeframe in accordance with the new federal regulations. Members must also exhaust the DMC plan’s appeal process prior to requesting a state hearing.

B. Method of Filing

In accordance with existing federal\textsuperscript{36} and state\textsuperscript{37} regulations, appeals may be filed by a member, a provider acting on behalf of the member, or an authorized representative either orally or in writing. Appeals filed by the provider on behalf of the member require written consent from the member.\textsuperscript{38} DMC plans shall continue to comply with this existing requirement in accordance with the DHCS contract and federal regulations.\textsuperscript{39}

\textsuperscript{32} Title 42, CFR, Section 438.408(d)(2)(ii)
\textsuperscript{33} Exhibit A, Attachment 14, Section 4(B)(1)
\textsuperscript{34} Title 28, CCR, Section 1300.68(b)(9)
\textsuperscript{35} Title 42, CFR, Section 438.402(c)(2)(ii)
\textsuperscript{36} Title 42, CFR, Section 438.402(c)(2)(ii)
\textsuperscript{37} Title 42, CFR, Section 438.402(c)(3)(ii)
\textsuperscript{38} Title 28, CCR, Section 1300.68(a)(1)
\textsuperscript{39} Title 42, CFR, Section 438.402(a)(1)(ii)
\textsuperscript{30} Exhibit A, Attachment 14, Section 5(A)
In addition, an oral appeal (excluding expedited appeals) shall be followed by a written, signed appeal.\(^{40}\) The date of the oral appeal establishes the filing date for the appeal. DMC plans shall request that the member’s oral request for a standard appeal be followed by written confirmation in accordance with federal regulations. DMC plans shall assist the member in preparing a written appeal, including notifying the member of the location of the form on the DMC plan’s website or providing the form to the member upon request. DMC plans shall also advise and assist the member in requesting continuation of benefits during the appeal of the adverse benefit determination in accordance with federal regulations.\(^{41}\) In the event that the DMC plan does not receive a written, signed appeal from the member, the DMC plan shall neither dismiss nor delay resolution of the appeal without making a reasonable effort to provide assistance to the member.

C. **Standard appeals**

1. **Acknowledgment**
   The DMC plan shall provide written acknowledgment to the member that is dated and postmarked within five calendar days of receipt of grievance, which is inclusive of appeals.\(^{42}\) The acknowledgment letter shall advise the member that the appeal has been received, the date of receipt, and provide the name, telephone number, and address of the representative who may be contacted about the appeal.

2. **Resolution**
   Federal regulations revise the timeframe for resolving appeals from 45 to 30 calendar days.\(^{43}\) DMC plans may extend the timeframe for appeals resolution by 14 calendar days in accordance with federal regulations delineated below.

D. **Expedited appeals**
   State regulations\(^{44}\), which do not distinguish grievances from appeals, require expedited resolution of grievances within three calendar days, which is inclusive of appeals. Federal regulations\(^{45}\) revise the timeframe for resolving appeals from three working days to 72 hours. DMC plans shall comply with the 72-hour timeframe in accordance with new federal regulations. The 72-hour timeframe would require DMC plans to additionally record the time of appeal receipt, and not just the date, as the specific time of receipt would drive the timeframe for

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\(^{40}\) Title 42, CFR, Sections 438.402(c)(3)(ii), 438.406(a) and 438.406(b)(3)
\(^{41}\) Title 42, CFR, Section 438.420
\(^{42}\) Title 28, CCR, Section 1300.68(d)(1)
\(^{43}\) Title 42, CFR, Section 438.408(b)(2)
\(^{44}\) Title 28, CCR, Section 1300.68.01
\(^{45}\) Title 42, CFR, Section 438.408(b)(3)
resolution. DMC plans may extend the timeframe for expedited appeals resolution by 14 calendar days in accordance with federal regulations delineated below.

Additionally, DMC plans are required to make reasonable efforts to provide oral notice to the member of the resolution. DMC plans shall comply with all other existing state regulations pertaining to expedited appeal handling in accordance with Section 1300.68.01 of Title 28 CCR.

E. Extension of Timeframes

1. DMC plans may extend the resolution timeframes for either standard or expedited appeals by up to 14 calendar days if any of the two conditions apply:
   a. The member requests the extension.
   b. The DMC plan demonstrates to the satisfaction of DHCS upon request, that there is a need for additional information and how the delay is in the member’s best interest.

2. DMC plans shall give the member written notice within two calendar days of the reason for the decision to extend the timeframe, and inform the member of the right to file a grievance if he or she disagrees with that decision.

3. In the event the DMC plan fails to adhere to the notice and timing requirements, the member is deemed to have exhausted the DMC plan’s internal appeal process and may initiate a state hearing.

F. Upheld Decisions

Federal definitions separately define NOA and Notice of Appeal Resolution (NAR), which in turn trigger a separate set of appeal rights, necessitating the need for unique notices for denials and appeals. DHCS has, therefore, created distinct notice templates to inform members of their appeal rights depending on whether a NOA or NAR is issued.

For appeals not resolved wholly in favor of the member, DMC plans shall utilize the DHCS template packet for upheld decisions which is comprised of two components: 1) the NAR and 2) “Your Rights” attachments. These revised documents are viewed as a “packet” and must be sent in conjunction to comply with all requirements of the NAR.

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46 Title 42, CFR, Section 438.408(d)(2)(ii)
47 Title 42, CFR, Section 438.408(c)(1)(i)
48 Title 42, CFR, Section 438.408(c)(1)(ii)
49 Title 42, CFR, Section 438.408(c)(2)(ii)
50 Title 42, CFR, Section 438.408(c)(3)
1. **Notice of Appeal Resolution (NAR)**  
DMC plans shall comply with federal and State regulations in sending written response to appeals as follows:

a. The results of the resolution and the date it was completed.  

b. If the DMC plan’s determination is based in whole or in part that the service is not medically necessary, the DMC plan shall include in its written response the reasons for its determination and clearly state the criteria, clinical guidelines, or dental policies used in reaching the determination.

c. If the DMC plan’s determination specifies the requested service is not a covered benefit, the DMC plan shall include in its written response the provision in the Contract, Evidence of Coverage, or Member Handbook that excludes the service. The response shall either identify the document and page where the provision is found, direct the member to the applicable section of the contract containing the provision, or provide a copy of the provision and explain in clear concise language how the exclusion applied to the specific dental service or benefit requested.

d. If the appeal is not resolved wholly in favor of the member, the NAR shall include a “cc” to DHCS either by USPS mail, or electronically to dmcdeliverables@dhcs.ca.gov.

2. **“Your Rights” Attachment**  
In accordance with federal and state regulations, the written NAR, shall at a minimum, include all of the following requirements:

a. The member’s right to request a state hearing no later than 120 calendar days from the date of the DMC plan’s written appeal resolution, and how to request a state hearing.

b. The member’s right to request and receive continuation of benefits while the state hearing is pending and how to request continuation of benefits, including the timeframe in which the request shall be made in accordance with Title 42, CFR, Section 438.420.

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51 Title 42, CFR, Section 438.408(e)(1)  
52 Title 28, CCR, Section 1300.68(d)(4)  
53 Title 28, CCR, Section 1300.68(d)(5)  
54 Title 42, CFR, Section 438.408(e)(2)(i); Title 22, CCR, Section 53858(e)(5)  
55 Title 42, CFR, Section 438.408(e)(2)(ii)
c. For Knox-Keene licensed DMC plans, the member’s right to request an
IMR from the Department of Managed Health Care (DMHC) if the DMC
plan’s determination is based in whole or in part that the service is not
medically necessary. The DMC plan shall include the IMR application,
instructions, the DMHC’s toll-free telephone number, and an envelope
addressed to DMHC.56

G. Overturned Decisions
For appeals resolved in favor of the member, written notice to the member shall
include the results of the resolution and the date it was completed. DMC plans
shall also ensure that the written response contain a clear and concise
explanation of the reason, including the reason for why the decision was
overturned.57 DMC plans shall utilize the DHCS template packet for appeals
which contains the NAR for overturned decisions.

DMC plans must authorize or provide the disputed services promptly and as
expeditiously as the member’s condition requires if the DMC plan reverses the
decision to deny, limit, or delay services that were not furnished while the appeal
was pending. DMC plans shall authorize or provide services no later than 72
hours from the date reversing the determination.58

V. STATE HEARINGS
A member has the right to request a state hearing when a claim for dental services
is denied or is not acted upon with reasonable promptness.59

A. Timeframes for Filing
Existing federal regulations60 and state laws61 currently require members to
request a state hearing within 90 days from the date the NOA. However, new
federal regulations require members to request a State Hearing within 120
calendar days from the date of the NAR, which informs the member that the
Adverse Benefit Decision has been upheld. This presents a significant change for
members who previously did not have to exhaust the DMC plan’s appeal process
prior to requesting a state hearing. DHCS has updated all “Your Rights”
attachment templates so that members are informed of the revised 120-calendar
day requirement in accordance with new federal regulations.

The parties to state hearing include the DMC plan as well as the member and his
or her representation or the representative of a deceased member’s estate.

56 Title 28, CCR, Section 1300.68(d)(4)
57 Title 28, CCR, Section 1300.68(d)(3)
58 Title 42, CFR, Section 438.424(a)
59 Title 42, USC, Section 1396a(a)(3); Welfare & Institutions Code, Section 10950
60 Title 42, CFR, Section 438.408(f)
61 Welfare & Institutions Code, Section 10951
B. **Standard Hearings**
DMC plans shall notify members that the State must reach its decision within 90 calendar days of the date of the request.  

C. ** Expedited Hearings**
The DMC plan shall notify members that the State must reach its decision within three working days of the date of the request.

D. **Overturned Decisions**
DMC plans shall authorize or provide the disputed services no later than 72 hours from the date reversing the determination.

VI. **GRIEVANCE AND APPEAL SYSTEM OVERSIGHT**
DMC plans shall establish, implement, and maintain a Grievance and Appeal System to ensure the receipt, review, and resolution of grievances and appeals. The System shall operate in accordance with all applicable federal regulations, state laws, and state regulations.

A. The DMC plan shall operate in accordance with its written procedures. These procedures shall be submitted to DHCS prior to use.  

B. The DMC plan shall designate an officer that has primary responsibility for overseeing the System. The officer shall continuously review the operation of the System to identify any systemic patterns in the handling of grievances and appeals.

C. The DMC plan shall notify members about its Grievance and Appeal System and shall include information on the DMC plan’s procedures for filing and resolving grievances and appeals, the toll-free telephone or a local telephone number in each service area, and the address for mailing grievances and appeals. The notice shall also include information regarding the DMC plan’s review process, the IMR system, and the DMC plan’s toll-free telephone number and website address.

D. The DMC plan shall notify members of the process for obtaining grievance and appeals forms. A description of the procedure for filing grievances and appeals

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62 Title 42, Section 431.244(f)(1)
63 Title 42, CFR, Section 431.244(f)(2)
64 Title 42, CFR, Section 438.424(a)
65 Title 42, CFR, Section 438
66 Health and Safety Code, Section 1368
67 Title 22, CCR, Section 53858; Title 28, CCR, Section 1300.68
68 Title 22, CCR, Section 53858
69 Title 22, CCR, Section 1300.68(b)(1)
70 Title 22, CCR, Section 53858(b); Title 28, Sections 1300.68(b)(2) and (4)
shall be readily available at each facility of the DMC plan, on the DMC plan’s website, and from each contracting provider’s office or facility. The DMC plan shall ensure that assistance in filing grievances and appeals will be provided at each location where grievances and appeals are submitted. Grievance and appeal forms shall be provided promptly upon request.71

E. The DMC plan shall ensure adequate consideration of grievances and appeals and rectification when appropriate. If multiple issues are presented by the member, the DMC plan shall ensure that each issue is addressed and resolved.72

F. The DMC plan shall maintain a written record for each grievance and appeal received by the DMC plan. The record of each grievance and appeal shall be maintained in a log and include the following information73:

1. The date and time of receipt of the grievance or appeal.

2. The name of the member filing the grievance or appeal.

3. The representative recording the grievance or appeal.

4. A description of the complaint or problem.

5. A description of the action taken by the DMC plan or provider to investigate and resolve the grievance or appeal.

6. The proposed resolution by the DMC plan or provider.

7. The name of the DMC plan provider or staff responsible for resolving the grievance or appeal.

8. The date of notification to the member of resolution.

G. As required in DHCS Contract Exhibit A, Attachment 15 C74, the DMC plan shall submit quarterly grievance and appeal reports in the required format to DHCS no later than thirty (30) calendar days following the end of the reporting quarter, to include, but not limited to, the required elements set forth in Title 28, CCR, 1300.68(f).

H. The written record of grievances and appeals shall be submitted, at least quarterly to the DMC plan’s quality assurance committee for systematic aggregation and analysis for quality improvement. Grievances and appeals reviewed shall include, but not be limited to, those related to access to care, quality of care, and denial of services. Appropriate action shall be taken to remedy any problems identified.75

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71 Title 22, CCR, Sections 53858(c), (d), and (f); Title 28, CCR, Sections 1300.68(d)(6) and (7)
72 Health & Safety Code, Section 1368(a)(1)
73 Title 22, CCR, Section 53858(e)(1); Title 28, CCR, Section 1300.68(d)(5)
74 Exhibit A, Attachment 15, Section C(2) and (3)
75 Title 22, CCR, Section 53858(e)(3) and (4)
I. The written record of grievances and appeals shall be reviewed periodically by

the governing body of the DMC plan, the public policy body, and by an officer of
the DMC plan or designee. The review shall be thoroughly documented.76

J. The DMC plan shall ensure the participation of individuals with authority to
require corrective action. All grievances and appeals related to dental quality of
care issues shall be immediately submitted to the DMC plan’s dental director for
action.77

K. The DMC plan shall address the linguistic and cultural needs of its member
population as well as the needs of members with disabilities. The DMC plan shall
ensure all members have access to and can fully participate in the Grievance
and Appeal System by assisting those with limited English proficiency or with a
visual or other communicative impairment. Such assistance shall include, but is
not limited to, translations of grievance and appeal procedures, forms, and DMC
plan responses to grievances and appeals, as well as access to interpreters,
telephone relay systems and other devices that aid disabled individuals to
communicate.78

L. The DMC plan shall assure that there is no discrimination against a member on
the grounds that the member filed a grievance or appeal.79

M. The DMC plan shall establish and maintain a system of aging grievances and
appeals that are pending and unresolved for 30 days or more and shall include a
brief explanation of the reasons each grievance and appeal is pending and
unresolved.80

N. The DMC plan shall ensure that the person making the final decision for the
proposed resolution of a grievance or appeal based has not participated in any
prior decisions related to the grievance or appeal and is a health care
professional with clinical expertise in treating a member’s condition or disease if
any of the following apply81:

1. An appeal of an adverse benefit determination that is based on lack
of medical necessity.
2. A grievance regarding denial of an expedited resolution of an
appeal.
3. Any grievance or appeal involving clinical issues.

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76 Title 28, CCR, Section 1300.68(b)(5)
77 Title 22, CCR, Section 53858(e)(2)
78 Title 22, CCR, Section 53858(e)(6); Title 28, CCR, Section 1300.68(b)(3)
79 Title 28, CCR, Section 1300.68(d)(8)
80 Health & Safety Code, Section 1368(b)(8)
81 Title 42, CFR, Section 438.406(b)(2)
O. The DMC plan shall ensure that individuals making decisions on clinical appeals take into account all comments, documents, records, and other information submitted by the member or member’s designated representative, regardless of whether such information was submitted or considered in the initial adverse benefit determination.82

P. The DMC plan shall provide the member or member’s designated representative the opportunity to review the member’s case file, including dental records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the DMC plan in connection with any standard or expedited appeal of an adverse benefit determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe.83

Q. The DMC plan shall provide the member a reasonable opportunity, in person and in writing, to present evidence and testimony. The DMC plan must inform the member of the limited time available for this sufficiently in advance of the resolution timeframe for appeals as specified and in the case of expedited resolution.84

VII. ANNUAL MEMBER REMINDER TEMPLATE

The annual “Member Reminder” shall include the following language to inform members of the new DMC plan appeal procedure effective July 1, 2017:


Beginning on July 1, 2017, you will be required to use your dental plan’s appeal procedures before you will be able to file for a state fair hearing. Federal law has changed and now requires this new process.

You are not losing your right to a state fair hearing.

Enclosed is the notice “Your Rights Under Dental Managed Care” telling you what these new rights will be.

82 Title 42, CFR, Section 438.406(b)(2)(iii)
83 Title 42, CFR, Section 438.406(b)(5)
84 Title 42, CFR, Section 438.406(b)(4)
If you have any questions regarding this APL or the sample notices, please contact Mr. Ruben Romero, Chief, Provider and Beneficiary Services Section, at (916) 445-8385, or by email at ruben.romero@dhcs.ca.gov.

Sincerely,

ORIGINAL SIGNED BY:

Anastasia Dodson
Acting Chief, Medi-Cal Dental Services Division
Department of Health Care Services

Enclosure (s)