



State of California—Health and Human Services Agency
Department of Health Care Services



EDMUND G. BROWN JR.
GOVERNOR

DATE: January 3, 2018

TO: ALL MEDI-CAL DENTAL MANAGED CARE PLANS

SUBJECT: **APL 18-001: REVISED GRIEVANCE AND APPEAL REPORT**

PURPOSE:

This 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 regarding compliance with a new template for the Grievance and Appeal Report. This APL provides instructions to the DMC plans regarding the Grievance and Appeal Report that will be due quarterly, forty-five (45) calendar days after the end of each quarter. For the quarters ending September 30, 2017 and December 31, 2017, these reports are due February 15, 2018.

BACKGROUND:

Federal and state laws establish state-specified Grievance and Appeal Reports which DMC plans are required to meet as set forth under the DMC contracts. The May 24, 2017, [Dental APL 17-003: Grievance and Appeal Requirements; Revised Notice Templates and "Your Right" Attachments](#) addressed changes to grievance and appeal definitions, processes, notices, and timeframes. This letter addresses DMC Plan compliance with regard to Grievance and Appeal Reports, formerly called Grievance Reports, and related requirements. Specifically, 2016 Title 42 Code of Federal Regulations (CFR)¹ have been incorporated into Assembly Bill 205 (Chapter 738, Statutes of 2017) and Assembly Bill 1688 (Chapter 738, Statutes of 2017). Assembly Bill 2207 (Chapter 613, Statutes of 2016) also states grievance and appeal requirements. Assembly Bills 205, 1688, and 2207 codify grievance and appeal requirements in Welfare and Institutions Code (WIC) Sections 10950, 10951, 10951.5, 10952, 14197.3, 14102.5, 14149.8, 14459.6, and 14132.915. Grievance and appeal requirements have been memorialized in the current DMC plan contract in Exhibit A, Attachment 9, Provider Relations; Exhibit A, Attachment 14, Member Services and Beneficiary Support; and Exhibit A, Attachment 15, Member Grievance and Appeal System. These new provisions became effective July 1, 2017.

¹ Title 42 CFR §§ 431.200, 438.2, 438.228, 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.424, 431.200, 431.220 and 431.244.

January 3, 2018

The following definitions should be used to differentiate between a grievance, an appeal, and an inquiry. Further information can be found in Dental APL 17-003.

- **Appeal:** Under new federal regulations, an “appeal” is defined as a review by the DMC plan of an adverse benefit determination. 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.

- **Grievance/complaint:** 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. A complaint is the same as a grievance, and either term may be used for publication or in a conversation, for example, a member may fill out a written “complaint” form or file a grievance by telephone. An inquiry is different than a grievance. Where the DMC plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.

- **Inquiry:** 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.

REQUIREMENTS:

Forty-five (45) calendar days after the end of each quarter, DMC plans must submit a completed Grievance and Appeal Report utilizing the attached template to the DHCS Medi-Cal Dental Secured File Transfer Platform (SFTP) inbox.

The completed Grievance and Appeal Report template shall include data for the quarter which ended prior to the 45 day period. Please note this reporting must include all cases

January 3, 2018

received in the specific quarter, even if the grievance or appeal was not resolved in the same quarter. Also for this report only, plans should report both member- and provider-initiated grievances and appeals related to a specific member. Member information on the attached template for the Grievance and Appeal Report shall include the state fiscal year, state fiscal year quarter, county and plan name, date reported, date resolved, member initials (no full names), member gender, member ethnicity, member age, member primary language, and if the grievance and/or appeal was provider- or member- initiated.

For grievances, plans shall enter information on the grievances tab and indicate whether the member has filed a grievance only, a grievance and an appeal, or an exempt grievance only; the grievance timeframe (standard or expedited); and grievance details. Plans shall indicate details of the grievance by choosing a type (a number) for all categories (columns) that apply. Plans shall not choose only one category if more than one category of grievance was described by the member or provider. If a grievance category is marked, the corresponding resolved grievance category shall also be marked. If a grievance category does not apply, no type will be chosen for that category. Plans shall indicate the types for accessibility grievance, quality of care/service grievance, and other grievance. The other grievance category is for grievances that do not fall into any of the pre-defined categories. If the other grievance category is chosen, the grievance type(s) must be defined. For each other grievance type, assign a number and specify (as concisely as possible) the grievance type in the second cell under the other grievance column. If more than three other grievance types are included in the report, add more numbers with a definition for each number.

For appeals, plans shall enter information on the appeals tab and indicate whether the member has filed an appeal only, or a grievance and an appeal; the appeal timeframe; and the details of the appeal. Plans shall indicate details of the appeal by choosing a type (a number) for all categories (columns) that apply. Plans shall not choose only one category if more than one category of appeal was described by the member or provider. If an appeal category is marked, the corresponding resolved appeal category shall also be marked. If an appeal category does not apply, no type will be chosen for that category. The appeal category choices are orthodontics appeal, removable prosthodontics appeal, fixed prosthodontics appeal, endodontics appeal, preventive services appeal, periodontics appeal, and other appeal. If the other appeal category is chosen, the appeal type(s) must be defined. For each other appeal type, assign a number and specify (as concisely as possible) the appeal type in the second cell under the other appeal column. If more than three other appeal types are included in the report, add more numbers with a definition for each number.

If a member presents a grievance and an appeal on the same date, information will be entered on both the grievances tab and the appeals tab; and type 2 (Grievance and Appeal) will be marked for the Grievance/Appeal category. The instructions tab provides information about filling out the Grievance and Appeal Report.

DENTAL ALL PLAN LETTER 18-001

PAGE 4

January 3, 2018

DMC plans who submit insufficient or inaccurate data will receive written notification from DHCS. DMC plans shall ensure that corrected data is resubmitted within fifteen (15) calendar days of receipt of DHCS' notice.

Sincerely,

A large black rectangular redaction box covers the signature area. Faint blue ink scribbles are visible above the box.

Alani C. Jackson, MPA
Chief, Medi-Cal Dental Services Division
Department of Health Care Services