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DATE: December 10, 2020

**ALL PLAN LETTER 20-003
SUPERCEDES ALL PLAN LETTER 17-003E**

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

SUBJECT: CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) FINAL
RULE REVISIONS EFFECTING GRIEVANCE AND APPEAL
REQUIREMENTS; REVISED “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 (CMS) published the Medicaid and Children’s Health Insurance Program Managed Care Final Rule¹, 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 became effective July 1, 2017.² On November 13, 2020, CMS published revisions to the Final Rule regulations with the intent to ensure states’ feasibility and flexibility in implementing requirements without undue administrative burden.³ Amended regulations⁴ which pose an impact to members’ grievances and appeals rights become effective December 14, 2020.

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 regulations⁵, 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”

¹ Federal Register (FR), Volume 81, No. 88, 27497 (May 6, 2016)

² Title 42, Code of Federal Regulations (CFR), Part 438

³ FR, Volume 85, No. 220, 72754 (November 13, 2020)

⁴ Title 42, CFR, Sections 438.400(b)(3), 438.402(c)(3)(ii), and 438.408(f)(2)

⁵ Title 22, California Code of Regulations (CCR), Section 53858; Title 28, CCR, Section 1300.68

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.

REQUIREMENTS:

I. DEFINITIONS

A. Adverse Benefit Determination

Under new federal regulations, the term “Action” has been replaced with “Adverse Benefit Determination.”⁶ The definition of an “Adverse Benefit Determination” encompasses all previously existing elements of an “Action” under federal regulations with the addition of language that 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.⁷
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.

B. Notice of Action

Under new federal regulations, the term “Notice of Action” (NOA) has been replaced with “Notice of Adverse Benefit Determination.”⁸ However, because this new terminology may be confusing for members, DHCS will retain the use of “NOA” for ease of understanding. Therefore, a NOA shall be redefined as a formal letter informing a member of an adverse benefit determination.

⁶ Title 42, CFR, Section 438.400(b)

⁷ A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a “clean claim” per Title 42, CFR, Section 447.45(b) is not an adverse benefit determination.

⁸ Title 42, CFR, Section 438.404

C. Grievance

The state definition⁹ does not specifically distinguish “grievances” from “appeals,” however, federal regulations¹⁰ 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.

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.¹¹
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.¹²
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.¹³ While state regulations¹⁴ 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

⁹ Title 28, CCR, Section 1300.68(a)(1)(2)

¹⁰ Title 42, CFR, Section 438.400(b)

¹¹ Title 42, CFR, Section 438.400(b)

¹² Title 28, CCR, Section 1300.68(a)(1)(2)

¹³ Title 42, CFR, Section 438.400(b)

¹⁴ Title 28, CCR, Section 1300.68(d)(4) and (5)

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.

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.¹⁵ 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.¹⁶ 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 on the date that the timeframe expires.¹⁷ The member would then have the right to request an appeal with the DMC plan.

The DMC plan’s written response to the member (NOA) shall be dated and postmarked within two business days of the decision.¹⁸

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.¹⁹

¹⁵ Health & Safety Code, Section 1367.01 (h)(1)

¹⁶ Title 42, CFR, Section 438.210(d)(1)

¹⁷ Title 42, CFR, Section 438.404(c)(5)

¹⁸ Health & Safety Code, Section 1367.01(h)(3)

¹⁹ Health & Safety Code, Section 1367.01(h)(1)

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.²⁰ The member would then have the right to request an appeal with the DMC plan.

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.²¹ 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.²² 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.²³

Upon receipt of all information reasonably necessary and requested by the DMC plan, the DMC plan shall approve, modify, or deny the request for authorization within five business days or 72 hours for standard and expedited requests, respectively.

²⁰ Title 42, CFR, Sections 438.210(d)(2) and 438.404(c)(5); Health & Safety Code, Section 1367.01(h)(2)

²¹ HSC Section 1367.01(h)(5)

²² Title 42, CFR, Section 438.210(d)(1)(i)(ii) and (2)(ii)

²³ Health & Safety Code, Section 1367.01(h)(5)

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 431.214.²⁴

B. Notice of Action (NOA)

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 NOA templates 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, or
3. Termination or reduction of the level of treatment or service currently underway.

Effective July 1, 2017, DMC plans shall utilize the revised NOA templates and corresponding “Your Rights” attachments included in this APL. DMC plans shall not make any changes to the NOA templates or “Your Rights” attachments without prior review and approval from DHCS, except to insert information specific to members as required.

C. Contents of Notice

Content requirements of the NOA are delineated in federal regulations²⁵, state laws²⁶, and state regulations.²⁷ The DHCS standardized templates are comprised of two components: 1) the NOA 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 NOA.

1. NOA

New federal regulations necessitate minimal changes to the existing NOA template. DHCS has added a clarifying statement to indicate that members may request, free of charge, copies of all documents and records relevant to the NOA, including criteria or guidelines used.²⁸

²⁴ Title 42, CFR, Section 438.404(c)(1)

²⁵ Title 42, CFR, Section 438.404(b)

²⁶ Health & Safety Code, Section 1367.01

²⁷ Title 22, CCR, Sections 51014.1, 51014.2, and 53894

²⁸ Title 42, CFR, Section 438.404(b)(2)

DMC plans shall comply with all other existing state laws and regulations in determining whether to approve, modify, or deny requests by providers prospectively, concurrently, or retrospectively. For decisions based in whole or in part on medical necessity, the written NOA shall contain all of the following:

- a. A statement of the action the DMC plan intends to take.²⁹
- b. A clear and concise explanation of the reasons for the decision.³⁰
- c. A description of the criteria or guidelines used. This includes a reference to the specific regulation or authorization procedures that support the decision, as well as an explanation of the criteria or guideline.³¹
- d. The clinical reasons for the decision. The DMC plan shall explicitly state how the member's condition does not meet the criteria or guidelines.³²
- e. For written notification to the provider, the name and direct telephone number or extension of the decision maker. Decisions shall be communicated to the member in writing. In addition, decisions shall be communicated to the provider initially by telephone or facsimile, and then in writing, except for decisions rendered retrospectively.³³

If the DMC plan can substantiate through documentation that effective processes are in place to allow the provider to easily contact the decision-maker through means other than a direct phone number (e.g., telephone number to the specific unit of the Utilization Management Department that handles provider appeals directly), a direct telephone number or extension shall not be required. However, the DMC plan must conduct ongoing oversight to monitor the effectiveness of this process.

The above requirements shall only pertain to decisions based in whole or in part on medical necessity. For all other adverse benefit determinations (e.g., denials based on a lack of information, or benefit denials, etc.) that are not based on medical necessity, DMC plans shall ensure that the NOA still provides a clear and concise explanation of the reasons for the decision.

2. "Your Rights" Attachment

New federal regulations warrant substantial revision to the "Your Rights"

²⁹ Title 22, CCR, Sections 51014.1(c)(1) and 53894(d)(1)

³⁰ Health & Safety Code, Section 1367.01(h)(4); Title 22, CCR, Sections 51014.1(c)(2) and 53894(d)(2)

³¹ Health & Safety Code, Section 1367.01(h)(4); Title 22, CCR, Sections 51014.1(c)(3) and 53894(d)(3)

³² Health & Safety Code, Section 1367.01(h)(4)

³³ Health & Safety Code, Section 1367.01(h)(4)

attachment, which informs members of critical appeal rights. Currently, existing federal and state regulations permit a member to file an appeal and request a State Hearing at the same time. New federal regulations require members to exhaust the DMC plan's internal appeal process and receive notice that the adverse benefit determination has been upheld prior to proceeding to a State Hearing. If the DMC plan fails to adhere to the required timeframe when resolving the appeal, the member is deemed to have exhausted the DMC plan's internal appeal process and may request a State Hearing.

In accordance with both new and existing federal regulations, the written NOA shall, at a minimum, meet all language and accessibility standards set forth in Title 42, CFR, Section 438.10, Health & Safety Code, Section 1367.01, and Title 28, CCR, Section 1300.67.04, and include all of the following requirements:

- a. The member's or provider's right to request an internal appeal with the DMC plan within 60 calendar days³⁴ from the date on the NOA.³⁵
- b. The member's right to request a State Hearing only after filing an internal appeal with the DMC plan and receiving notice that the adverse benefit determination has been upheld.³⁶
- c. The member's right to request a State Hearing if the DMC plan fails to send a resolution notice in response to the appeal within the required timeframe.³⁷
- d. Procedures for exercising the member's rights to request an appeal.³⁸
- e. Circumstances under which an expedited review is available and how to request it.³⁹
- f. The member's right to have benefits continue pending resolution of the appeal and how to request a continuation of benefits in accordance with Title 42, CFR, Section 438.420.⁴⁰

Due to the significant impact that these new changes have on members' appeal rights, DHCS has deemed it necessary to create two distinct "Your Rights" attachments to accommodate the following scenarios: 1) members who receive a NOA and 2) members who receive a Notice of Appeal Resolution (NAR). A NAR is a formal letter informing a member that an adverse benefit determination has been overturned or upheld.

³⁴ New federal regulations (Title 42, CFR, Section 438.402(c)(2)(ii)) revise the timeframe that members have to request an appeal from 90 to 60 calendar days.

³⁵ Title 42, CFR, Section 438.404(b)(3)

³⁶ Title 42, CFR, Section 438.404(b)(3)

³⁷ Title 42, CFR, Section 438.408(c)(3)

³⁸ Title 42, CFR, Section 438.404(b)(4)

³⁹ Title 42, CFR, Section 438.404(b)(5)

⁴⁰ Title 42, CFR, Section 438.404(b)(6)

While the “Your Rights” attachment sent out to members who receive a NOA will contain general information on State Hearing and IMR rights, the notice will primarily inform the member on how to request an appeal with the DMC plan. A State Hearing form need not be attached, as the member would need to exhaust the DMC plan’s appeal process first. Similarly, an IMR form need

not be attached, as the member would also need to exhaust the DMC plan’s appeal process prior to requesting an IMR unless the Department of Managed Health Care (DMHC) determines that an expedited review is warranted due to extraordinary and compelling circumstances.⁴¹ Requirements pertaining to IMRs remain unchanged.

Conversely, the “Your Rights” attachment sent out to members who receive a NAR that upholds the original adverse benefit determination will not contain information on how to file a request for an appeal as the member will have already exhausted the DMC plan’s appeal process. The notice will primarily inform the member on how to request a State Hearing and/or IMR. State Hearing and IMR application forms will be attached as appropriate. Current versions of State Hearing and IMR⁴² forms shall be used when sending the NAR. It is the DMC plan’s responsibility to ensure use of the most updated State Hearing and IMR forms.

DMC plans shall use the revised NOA/NAR and “Your Rights” attachments contained in this APL, selecting the appropriate packet for use depending on whether the DMC plan is issuing a NOA or NAR. As all DMC plans are Knox-Keene licensed, DMC plans must additionally comply with state laws⁴³ and include verbatim IMR language required in all notices sent to members. This required IMR paragraph is already incorporated into the templates and requires no action by the DMC plan.

D. Translation of Notices

The DHCS contract⁴⁴ 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

⁴¹ Health & Safety Code, Section 1368.03(a); Title 28, CCR, Section 1300.74.30(b)

⁴² The IMR form can be accessed at the following link: <http://www.dmhc.ca.gov/>

⁴³ Health & Safety Code, Section 1368.02(b)

⁴⁴ Exhibit A, Attachment 13, Section 4(C)(1)

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.

III. GRIEVANCES

A. Timeframes for Filing

Timeframes for filing grievances are delineated in both federal⁴⁵ and state⁴⁶ 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 federal⁴⁷ and state⁴⁸ 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 laws⁴⁹ and regulations⁵⁰, 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 federal⁵¹ and state⁵² 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

⁴⁵ Title 42, CFR, Section 438.400(b)

⁴⁶ Title 28, CCR, Section 1300.68(b)(9)

⁴⁷ Title 42, CFR, Section 438.402(c)(3)(i)

⁴⁸ Title 28, CCR, Section 1300.68(a)(1)

⁴⁹ Health & Safety Code, Section 1368(a)(4)(A)

⁵⁰ Title 28, CCR, Section 1300.68(d)(1)

⁵¹ Title 42, CFR, Section 438.408(b)(1)

⁵² Title 28, CCR, Sections 1300.68(a) and (d)(3)

30 calendar days. DMC plans shall continue to comply with the State's established timeframe of 30 calendar days for grievance resolution.

- 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.⁵³
- b. The DMC plan's written resolution shall contain a clear and concise explanation of the DMC plan's decision.⁵⁴
- c. Federal regulations⁵⁵ 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 laws⁵⁶ and regulations⁵⁷ 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.

Under new federal regulations, coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment would qualify as appeals and not grievances. Therefore, appeals are not exempt from written acknowledgment and resolution and must be processed as standard appeals.

⁵³ Title 28, CCR, Section 1300.68(a)(4)

⁵⁴ Title 28, CCR, Section 1300.68(d)(3)

⁵⁵ Title 42, CFR, Section 438.408(b) and (c)

⁵⁶ Health & Safety Code, Section 1368(a)(4)(B)

⁵⁷ Title 28, Section 1300.68(d)(8)

E. Expedited Grievances

State laws⁵⁸ and regulations⁵⁹ 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 not just the date, as the specific time of receipt would drive the timeframe for resolution.

Federal regulations⁶⁰ 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 contract⁶¹, as well as in both state⁶² and federal⁶³ 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.

⁵⁸ Health & Safety Code, Section 1368.01(b)

⁵⁹ Title 28, CCR, Section 1300.68.01

⁶⁰ Title 42, CFR, Section 438.408(d)(2)(ii)

⁶¹ Exhibit A, Attachment 14, Section 4(B)(1)

⁶² Title 28, CCR, Section 1300.68(b)(9)

⁶³ Title 42, CFR, Section 438.402(c)(2)(ii)

B. Method of Filing

In accordance with existing federal⁶⁴ and state⁶⁵ 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.⁶⁶ DMC plans shall continue to comply with this existing requirement in accordance with the DHCS contract⁶⁷ and federal regulations. 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.⁶⁸

C. Standard Appeals

1. Acknowledgment

In accordance with existing state laws⁶⁹ and regulations⁷⁰, DMC plans shall provide written acknowledgment to the member that is dated and postmarked within five calendar days of receipt of the appeal.⁷¹ 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.⁷² DMC plans may extend the timeframe for appeals resolution by 14 calendar days in accordance with federal regulations delineated under Section IV(E) below.

D. Expedited Appeals

State laws⁷³ and regulations⁷⁴, which do not distinguish grievances from appeals, require expedited resolution of grievances within three calendar days, which is inclusive of appeals. Federal regulations⁷⁵ 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

⁶⁴ Title 42, CFR, Section 438.402(c)(3)(ii)

⁶⁵ Title 28, CCR, Section 1300.68(a)(1)

⁶⁶ Title 42, CFR, Section 438.402(c)(1)(ii)

⁶⁷ Exhibit A, Attachment 15, Section A

⁶⁸ Title 42, CFR, Section 438.420

⁶⁹ Health & Safety Code, Section 1368(a)(4)(A)

⁷⁰ Title 28, CCR, Section 1300.68(d)(1)

⁷¹ Title 28, CCR, Section 1300.68(d)(1)

⁷² Title 42, CFR, Section 438.408(b)(2)

⁷³ Health & Safety Code, Section 1368.01(b)

⁷⁴ Title 28, CCR, Section 1300.68.01

⁷⁵ Title 42, CFR, Section 438.408(b)(3)

receipt, and not just the date, as the specific time of receipt would drive the timeframe for resolution. DMC plans may extend the timeframe for expedited appeals resolution by 14 calendar days in accordance with federal regulations delineated under Section IV(E) below.

Additionally, DMC plans are required to make reasonable efforts to provide oral notice to the member of the resolution.⁷⁶ 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.⁷⁷
 - 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.⁷⁸
2. For any extension not requested by the member, DMC plans are required to provide the member with written notice of the reason for the delay. New federal regulations delineate the following additional requirements that DMC plans must comply with:
 - a. The DMC plan shall make reasonable efforts to provide the member with oral notice of the extension.⁷⁹
 - b. The DMC plan shall provide written notice of the extension within two calendar days and notify the member of the right to file a grievance if the member disagrees with the extension.⁸⁰
 - c. The DMC plan shall resolve the appeal as expeditiously as the member's health condition requires and in no event extend resolution beyond the initial 14-calendar day extension.⁸¹
 - d. In the event that 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.⁸²

⁷⁶ Title 42, CFR, Section 438.408(d)(2)(ii)

⁷⁷ Title 42, CFR, Section 438.408(c)(1)(i)

⁷⁸ Title 42, CFR, Section 438.408(c)(1)(ii)

⁷⁹ Title 42, CFR, Section 438.408(c)(2)(i)

⁸⁰ Title 42, CFR, Section 438.408(c)(2)(ii)

⁸¹ Title 42, CFR, Section 438.408(c)(2)(iii)

⁸² Title 42, CFR, Section 438.408(c)(3)

F. Upheld Decisions

Federal definitions separately define Notice of Adverse Benefit Determination (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.

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.⁸³
- 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.⁸⁴
- 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.⁸⁵
- 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 dentalmanagedcare@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:

⁸³ Title 42, CFR, Section 438.408(e)(1)

⁸⁴ Title 28, CCR, Section 1300.68(d)(4)

⁸⁵ Title 28, CCR, Section 1300.68(d)(5)

- a. The member's right to request a State Hearing no more than 120 calendar days from the date of the DMC plan's written appeal resolution, and how to request a State Hearing.⁸⁶
- 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 438.420.⁸⁷
- c. For Knox-Keene licensed DMC plans, the member's right to request an IMR from the DMHC if the DMC plan's determination is based in whole or in part that the service is not medically necessary, is experimental/investigational, or is an emergency service.⁸⁸ The DMC plan shall include the IMR application, instructions, the DMHC's toll-free telephone number, and an envelope addressed to DMHC.⁸⁹

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.⁹⁰ 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.⁹¹

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.⁹²

⁸⁶ Title 42, CFR, Section 438.408(e)(2)(i); Title 22, CCR, Section 53858(e)(5)

⁸⁷ Title 42, CFR, Section 438.408(e)(2)(ii)

⁸⁸ Health & Safety Code, Sections 1370.4 and 1374.30(d); Title 28, CCR, Section 1300.74.30(a)

⁸⁹ Title 28, CCR, Section 1300.68(d)(4)

⁹⁰ Title 28, CCR, Section 1300.68(d)(3)

⁹¹ Title 42, CFR, Section 438.424(a)

⁹² Title 42, USC, Section 1396a(a)(3); Welfare & Institutions Code, Section 10950

A. Timeframes for Filing

Existing federal regulations⁹³ and state laws⁹⁴ require members to request a State Hearing no more than 120 calendar days from the date of the NAR, which informs the member that the *Adverse Benefit Decision* has been upheld.

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.

B. Standard Hearings

The Department of Social Services (DSS) will ordinarily reach its decision within 90 calendar days of the date of the request.⁹⁵

C. Expedited Hearings

The DSS will reach its decision as expeditiously as the member's health condition requires, but no later than within three working days of receipt of the case file from the DMC plan.⁹⁶

D. Overturned Decisions

DMC plans shall authorize or provide the disputed services no later than 72 hours from the date reversing the determination.⁹⁷

VI. NONDISCRIMINATION NOTICE AND LANGUAGE ASSISTANCE TAGLINES

Section 1557 of the Affordable Care Act (ACA), which builds on long-standing federal civil rights laws⁹⁸, prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities. On May 18, 2016, the United States Department of Health and Human Services (HHS), Office for Civil Rights (OCR) issued the Nondiscrimination in Health Program and Activities Final Rule⁹⁹ to clarify existing nondiscrimination requirements and set forth new standards to implement Section 1557. Effective July 18, 2016, federal regulations¹⁰⁰ required DMC plans to post a nondiscrimination notice and language assistance taglines (in at least the top 15 non-English languages spoken) in significant communications to members. Senate Bill (SB) 223 (Atkins, Chapter 771, Statutes of 2017) subsequently codified certain requirements of Section 1557 and Government Code Section 11135 expanded the list of protected characteristics to additionally include religion, ancestry, ethnic group identification, mental and physical disability, medical condition, genetic information, marital status, and sexual orientation.

⁹³ Title 42, CFR, Sections 438.408(f)(1) and (2)

⁹⁴ Welfare & Institutions Code, Section 10950

⁹⁵ Title 42, Section 431.244(f)(1)

⁹⁶ Title 42, CFR, Section 431.244(f)(2)

⁹⁷ Title 42, CFR, Section 438.424(a)

⁹⁸ Title VI, Civil Rights Act of 1964; Title IX, Education Amendments of 1972; Section 504, Rehabilitation Act of 1973; Age Discrimination Act of 1975

⁹⁹ 81 FR 31375

¹⁰⁰ Title 45, CFR, Section 92.8

To incorporate all of these requirements, DHCS created a sample “Nondiscrimination Notice” and “Language Assistance” taglines (in the top 16 non-English languages spoken in California), which are available for DMC plan use. These templates must be sent to members in conjunction with each of the following significant notices: NOA, grievance acknowledgment letter, grievance resolution letter, appeal acknowledgment letter, and NAR. DMC plans may utilize the templates provided by DHCS, make unsubstantial modifications to the templates, or create new templates with the same content requirements.

VII. 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 regulations¹⁰¹, state laws¹⁰², and state regulations.¹⁰³

- A. The DMC plan shall operate in accordance with its written procedures. These procedures shall be submitted to DHCS prior to use.¹⁰⁴
- 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.¹⁰⁵
- 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.¹⁰⁶
- 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 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.¹⁰⁷

¹⁰¹ Title 42, CFR, Section 438

¹⁰² Health and Safety Code, Section 1368

¹⁰³ Title 22, CCR, Section 53858; Title 28, CCR, Section 1300.68

¹⁰⁴ Title 22, CCR, Section 53858

¹⁰⁵ Title 28, CCR, Section 1300.68(b)(1)

¹⁰⁶ Title 22, CCR, Section 53858(b); Title 28, Sections 1300.68(b)(2) and (4)

¹⁰⁷ Title 22, CCR, Sections 53858(c), (d), and (f); Title 28, CCR, Sections 1300.68(d)(6) and (7)

- 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.¹⁰⁸
- 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 information¹⁰⁹:
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(C)¹¹⁰, the DMC plan shall submit quarterly grievance and appeal reports in the required format no later than thirty (30) calendar days following the end of the reporting quarter, to include, but not be limited to, the required elements set forth in 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.¹¹¹
- 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.¹¹²
- 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

¹⁰⁸ Health & Safety Code, Section 1368(a)(1)

¹⁰⁹ Title 22, CCR, Section 53858(e)(1); Title 28, CCR, Section 1300.68(d)(5)

¹¹⁰ Exhibit A, Attachment 15, Section C(2) and (3)

¹¹¹ Title 22, CCR, Section 53858(e)(3) and (4)

¹¹² Title 28, CCR, Section 1300.68(b)(5)

care issues shall be immediately submitted to the DMC plan's dental director for action.¹¹³

- 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.¹¹⁴
- 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.¹¹⁵
- 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.¹¹⁶
- 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 apply¹¹⁷:
 - 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.
- 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.¹¹⁸

¹¹³ Title 22, CCR, Section 53858 (e)(2)

¹¹⁴ Title 22, CCR, Section 53858(e)(6); Title 28, CCR, Section 1300.68(b)(3)

¹¹⁵ Title 28, CCR, Section 1300.68(d)(8)

¹¹⁶ Health & Safety Code, Section 1368(b)(8)

¹¹⁷ Title 42, CFR, Section 438.406(b)(2)

¹¹⁸ Title 42, CFR, Section 438.406(b)(2)(iii)

- 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.¹¹⁹
- 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.¹²⁰

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.

If you have any questions regarding this APL or the sample notices, please contact dmcdeliverables@dhcs.ca.gov.

Sincerely,

Original signed by C. Brookins for

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

Enclosure(s)

¹¹⁹ Title 42, CFR, Section 438.406(b)(5)

¹²⁰ Title 42, CFR, Section 438.406(b)(4)