State of California—Health and Human Services Agency

Department of Health Care Services

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ALL PLAN LETTER 22-006
SUPERCEDES ALL PLAN LETTER 20-003

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

SUBJECT: CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) FINAL RULE REVISIONS AFFECTING 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 federal and state legal requirements for processing grievances and appeals. This APL supersedes APL 20-003 and includes member notification templates and updated template attachments that must accompany member notifications.

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 Rule (Final Rule)[1] which aligned 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] In December 2020, DHCS issued APL 20-003 to provide plans with guidance regarding referral and state grievance and appeal requirements, including the Final Rule requirements. As part of APL 20-003, DHCS provided revised notice templates for use when notifying members of a denial, limitation, delay, or modification of benefits and for the "Your Rights" attachments that are sent in conjunction with member notifications.

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[1]Federal Register (FR), Volume 81, No. 88, (May 6, 2016)
[2]Title 42, Code of Federal Regulations (CFR), Part 438, Subpart F

REQUIREMENTS:

I. DEFINITIONS

A. Grievance

While state regulations do not specifically distinguish “grievances” from “appeals”, federal regulations define “grievance and appeal system” to mean the processes implemented by the plan to handle grievances and appeals, with the terms “grievance” and “appeal” each separately defined.[3] Due to distinct processes delineated for the handling of each, plans must 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 or care of 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.[4]
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.[5]
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 must 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 processed as a grievance by the plan. If a member expressly declines to file a grievance, the complaint shall still be categorized as a grievance and not an inquiry.

B. Adverse Benefit Determination

An “adverse benefit determination” is defined to mean any of the following actions taken by the DMC plan: [6]

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.

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[3] Title 28 of the California Code of Regulations (CCR) 1300.68(a)(1) and (2); and 42 CFR 438.400(b).
[4] 42 CFR 438.400(b)
[5] 28 CCR 1300.68(a)(1)-(2)
[6] 42 CFR 438.400 (b)

3. The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for service solely because the claim does not meet the definition of a “clean claim” per 42 CFR section 447.45(b) is not an adverse benefit determination.
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. For a resident of a rural area with only one DMC plan, the denial of the member’s request to obtain services outside the network.
7. The denial of a member’s request to dispute financial liability.

C. Notice of Action

A “notice of action” (NOA) is defined as a formal letter from a DMC plan informing a member of an “adverse benefit determination”.

D. Appeal

An “appeal” is federally defined as a review by the DMC plan of an adverse benefit determination.[7] While state regulations do not explicitly define the term “appeal,” they do delineate specific requirements for certain types of grievances that would fall under the federal definition of appeal because they involve the delay, modification, or denial of services based on medical necessity, or a determination that the requested service is not a covered benefit.[8] The DMC plan must treat these grievances as appeals under federal regulations.

DMC plans must use the federal definition of “appeal” and comply with all existing state regulations as they pertain to the handling of appeals. These requirements are delineated in section IV of this APL.

E. Notice of Appeal Resolution

A “notice of appeal resolution” (NAR) is a formal letter from a plan informing a member of the outcome of the appeal of an adverse benefit determination.[9] The NAR informs the member whether the plan has overturned or upheld its decision on the adverse benefit determination.

II. AUTHORIZATION TIMEFRAMES AND ADVERSE BENEFIT DETERMINATIONS

A. Authorization Timeframes

DMC plans must render a decision on a provider’s request for authorization of dental care services for a member, and notify the provider and the member using the appropriate NOA template within the timeframes outlined below and in accordance with notification requirements in federal and state law. For purposes of auditing, the postmark on the plan’s notice to the member will be used to confirm compliance with all prior authorization request timeframes and notice requirements set forth below.

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[7] 42 CFR 438.400(b)
[8] 28 CCR 1300.68(d)(4)-(5)
[9] 42 CFR 438.408(d)(2)

1. **Standard Requests**
DMC plans must approve, delay, modify, or deny a provider's prospective or concurrent request for dental services for a member within the shortest applicable timeframe which is appropriate for the member's condition, but no longer than five business days from the DMC plan's receipt of information reasonably necessary and requested by the plan to make a determination, not to exceed 14 calendar days following the plan's receipt of the request for service[10]. Decisions to approve, modify, or deny requests, must be communicated by the plan to the provider within 24 hours of the decision and to the member within two business days using the appropriate NOA template[11]. The plan's written notice to the member must also be sent with sufficient time to allow the member to request Aid Paid Pending (i.e., continuation of benefits), if applicable.

Federal law permits an extension of the initial 14-calendar day authorization timeframe by up to 14 days if the member or the provider requests an extension, or if the plan can justify its need for additional information and demonstrate how the extension is in the member's interest.

If the plan requires an extension of the initial 14-calendar day authorization timeframe, the plan must either deny the authorization request or immediately notify the requesting provider to request all specific information the plan still needs to make its authorization decision. The plan must also document its justification in the member's medical record of the need for the extension to obtain additional information and demonstrate how the extension is in the member's interest.[12] DMC plans must provide this documentation to DHCS upon request.

The plan's written notice requesting additional information must specify the information the plan requested but did not receive, the expert reviewer to be consulted, or the additional examinations or tests required before the service can be approved or denied.

The plan must also include the anticipated date when its decision will be made, make a decision on the request as expeditiously as the member's health condition requires, and advise the member that they have a right to file a grievance to dispute the delay.[13] The plan must send this written notice within the required timeframe, or as soon as the plan becomes aware that it will not meet the initial authorization timeframe, whichever is earlier.[14] Following the plan's notification and request for additional and specific information, the plan must approve, delay, modify, or deny a

[10] Health and Safety Code (HSC) 1367.01(h)(1); 42 CFR 438.210(d)(1); and 42 CFR 438.404(c)(3).
[11] HSC 1367.01(h)(3)
[12] 42 CFR 438.210(d)(1)
[13] HSC 1367.01(h)(5), HSC 1367.01(h)(4)
[14] HSC 1367.01(h)(5)

provider's retrospective request within the shortest applicable timeframe that is appropriate for the nature of the member's condition, but no longer than five business days from the plan's receipt of information reasonably necessary and requested by the plan to make a determination, not to exceed the additional 14 calendar days.[15]

Decisions to approve, modify, or deny requests, must be communicated by the plan to the provider within 24 hours of the decision and to the member within two business days using the appropriate NOA template.[16]

A plan's failure to render a decision for standard authorization requests within the required timeframes above is considered a denial and therefore constitutes an adverse benefit determination on the date that the timeframe expires.[17] In this situation, the member has the right to request an appeal with the plan and the plan must send the member written notice of all appeal rights.[18]

2. **Expedited Requests**

In instances where a provider indicates, or the DMC plan determines, that the standard request timeframe may seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the DMC plan must approve, modify, or deny a providers prior authorization or concurrent request 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 for a member, and notify the provider and the member, using the appropriate NOA template, in a timeframe which is appropriate for the nature of the member's condition, but is no longer than 72 hours after the plan's receipt of all information needed to make an authorization decision for the request for service.[19]

Federal law permits an extension of the initial 72-hour authorization timeframe by up to 14 calendar days if the member requests the extension, or upon DHCS satisfaction, the DMC plan can justify its need for additional information and can demonstrate how the extension is in the member's best interest.[20]

If the plan requires an extension of the initial 72-hour authorization timeframe, the plan must either deny the authorization request or document its justification in the member's medical record of the need for the extension to obtain additional information and demonstrate how the extension is in the member's interest.[21] If the plan requires the extension, it must send written

[15] 42 CFR 438.210(d)(1); 42 CFR 438.404(c)(5), HSC 1367.01(h)(1)
[16] HSC 1367.01(h)(3)
[17] 42 CFR 438.404(c)(5)
[18] 42 CFR 438.404(b)(3-6)
[19] HSC 1367.01(h)(2); 42 CFR 438.210(d)(2)(i)
[20] 42 CFR 438.210(d)(2)(ii)
[21] 42 CFR 438.210(d)(2)(ii)

notice to the member and the provider, using the appropriate NOA template, to request the specific information it needs to determine if the service is medically necessary. This notice must be sent within the required timeframe, or as soon as the plan becomes aware that it will not be able to meet the initial timeframe, whichever is earlier.[22]

The written notice must specify the information the plan needs but did not receive, the expert reviewer to be consulted, or the additional examinations or tests required before the service can be approved or denied. The plan must also include the anticipated date when its decision will be made, make a decision on the request as expeditiously as the member's health condition requires, and advise the member that they have a right to file a grievance to dispute the delay.[23]

Following this notification and request for specific information, the plan must approve, modify, or deny the request within the shortest applicable timeframe that is appropriate for the nature of the member's condition, but is no longer than 72 hours from the plan's receipt of the additional information reasonably necessary and requested by the plan to make a determination, not to exceed the additional 14 calendar days.[24] The plan's written response to the member must be sent with sufficient time to allow the member to request Aid Paid Pending, if applicable.

A plan's failure to render a decision for standard authorization requests, within the required timeframes above is considered a denial and therefore constitutes an adverse benefit determination on the date that the timeframe expires.[25]

In this situation, the member has the right to request an appeal with the plan and the plan must send the member written notice of all appeal rights.[26]

3. **Retrospective Requests**
   In cases where the review is retrospective, the plan must communicate its decision to the member who received services, or to the member's designee, within 30 days of the receipt of information that is reasonably necessary to make the retro-authorization determination. The plan is also required to communicate the decision to the provider in a manner that is consistent with current law.[27]

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[22] HSC 1367.01(h)(5)
[23] HSC 1367.01(h)(5)
[24] 42 CFR 438.210(d)(2)
[25] 42 CFR 438.404(c)(5)
[26] 42 CFR 438.404(a-b)
[27] HSC 1367.01(h)(1)

4. **Suspensions or Reductions**[28]
   For suspensions or reductions of previously authorized services, DMC plans must notify members at least ten days prior to the date of the action pursuant to Title 42 CFR section 431.211 to ensure there is adequate time for members to timely file for Aid Paid Pending, with the exception of circumstances permitted under Title 42, CFR, sections 431.213 and 431.214.[29]

B. Notice of Action (NOA)

DMC plans must provide members with written notice of an adverse benefit determination using the DHCS-developed, standardized NOA template and the NOA "Your Rights" template. The following five distinct NOA templates accommodate actions that DMC plans may commonly take:

1. Denial of a treatment of service;
2. Delay of a treatment or service;
3. Modification of a treatment or service;
4. Suspension or reduction of the level of treatment or service currently underway; and

DMC plans are not permitted to make any changes to the NOA templates or NOA "Your Rights" templates without prior review and approval from DHCS, except to insert information specific to the member as required.

C. Contents of Notice

Content requirements of the NOA are delineated in federal and state law.[30] The written NOA must meet all language and accessibility standards, including translation, font, and format requirements, as set forth in APL 21-001, Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services, federal and state law, and all requirements in the DHCS contract.[31]

The NOA is comprised of two components: 1) the appropriate DHCS standardized NOA template and 2) The DHCS standardized NOA "Your Rights" template. DMC plans are required to send the documents together any time a NOA is issued.

1. **Written Notice of an Adverse Benefit Determination (NOA Template)**
   DMC plans must comply with all federal and state law in determining whether to approve, modify, or deny requests by providers prospectively, concurrently, or retrospectively. Members may request, free of charge,

[28]42 CFR 438.404(c)(1)
[29]42 CFR Part 431
[30] 42 CFR 438.404(b); HSC 1367.01; 22 CCR 51014.1, 51014.2, and 53894
[31] Title 42 CFR sections 438.10, 438.402, 438.404, and 438.408; Title 45 CFR, Part 92; WIC 10951(b)(1)(A) and 14029.91; Exhibit A, Attachment 11 Provision H, Linguistic Services

copies of all documents and records the plan relied on to make decisions, including any clinical criteria or guidelines used.[32]

For decisions based in whole or in part on medical necessity, the written NOA must contain all of the following:

a. A statement of the action the plan intends to take.[33]
b. A clear and concise explanation of the reasons for the decision.[34]
c. A description of the criteria or guidelines used. This includes a reference to the specific regulation or authorization procedure(s) that supports the decision, as well as an explanation of the criteria or guideline.[35]
d. The clinical reasons for the decision. The DMC plan must explicitly state how the member's condition does not meet the criteria or guidelines.[36]
e. For written notification to the provider, the name and direct telephone number or extension of the decision maker. Decisions must be communicated to the member in writing. In addition, with the exception of decisions rendered retrospectively, decisions must be communicated to the provider initially by telephone or facsimile, and also in writing.[37]

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 is not required. However, the plan must conduct ongoing oversight to monitor the effectiveness of this process.

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

2. **NOA "Your Rights" Template(s)**
The NOA "Your Rights" attachment informs members of critical appeal and hearing rights.

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[32] 42 CFR 438.404(b)(2)
[33] 22 CCR 51014.1(c)(1) and 53894(d)(1)
[34] HSC 1367.01(h)(4); 22 CCR 51014.1(c)(2) and 53894(d)(2)
[35] HSC 1367.01(h)(4); 22 CCR 51014.1(c)(3) and 53894(d)(3)
[36] HSC 1367.01(h)(4)
[37] HSC 1367.01(h)(4)

Federal and state law require that members exhaust the plan's internal appeal process and receive notice that the adverse benefit determination has been upheld prior to proceeding to a state hearing. However, if the DMC plan fails to adhere to federal and state notice and timeframe requirements, the member is deemed to have exhausted the plan's internal appeal process and may request a state hearing.[38]

The DHCS-developed NOA "Your Rights" attachment template includes all of the following required elements:

a. The member's or provider's right to request an internal appeal with the plan within 60 calendar days from the date on the NOA.[39]
b. The member's right to request a state hearing after filing an internal appeal with the plan and receiving notice that the adverse benefit determination has been upheld.[40]
c. The member's right to request a state hearing without having to exhaust the plan's internal appeal process, in instances of deemed exhaustion.[41]
d. Procedures for exercising the member's rights to request an appeal.[42]
e. Circumstances under which an expedited review is available and how to request one.[43]
f. The member's right to Aid Paid Pending and instructions on how to timely file for an appeal (i.e., within 10 days of the NOA or before the effective date of the intended action) of a decision to terminate, suspend or reduce services. DMC plans must provide Aid Paid Pending regardless of whether the member makes a separate request to the plan when the member timely files an appeal of a decision to terminate, suspend or reduce services.[44]

Plans must use the NOA "Your Rights" templates enclosed to this APL. The NOA "Your Rights" template for Knox-Keene licensed plans provides information for members about how to request an Independent Medical Review (IMR). Knox-Keene licensed plans are subject to additional state laws, including the requirement that certain written notices to members contain prescribed language advising members of additional rights and directing them to contact the Department of Managed Health Care (DMHC) to request an IMR.[45] This required mandatory paragraph is already incorporated into the template and requires no action by the plans.

[38] 42 CFR 438.402, 438.404, 438.408, and 438.10; WIC 14197.3.
[39] 42 CFR 438.402(c)(2)(ii) and 438.404(b)(3)
[40] 42 CFR 438.402(c)(1)
[41] 42 CFR 438.402(c)(1)(i)(A) and 438.408(c)(3); WIC 10951(b)(1)(B)
[42] 42 CFR 438.404(b)(4)
[43] 42 CFR 438.404(b)(5)
[44] 42 CFR 438.404(b)(6) and 438.420, 22 CCR 51014.1 and 51014.2
[45] HSC 1368.02(b)

When sending the "Your Rights" attachment to members as part of the NOA, plans must include the most current version of the state hearing form enclosed with this APL. Knox-Keene licensed plans must also include the IMR form, application instructions, DMHC's toll-free telephone number, and an envelope addressed to DMHC.[46] Knox-Keene licensed plans are required to check the DMHC website periodically to ensure use of the most current IMR form.[47] Plans may include state hearing and IMR forms that contain tracking numbers to more easily identify and administer member rights. Such tracking numbers should contain initials, acronyms, or names that identify the plan.

III. GRIEVANCES

A. Timeframes for Filing

Timeframes for filing grievances are delineated in both federal and state law.[48] While 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 must adopt the standard that 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 and state law, a grievance may be filed either orally or in writing by a member, a provider acting on behalf of the member, or an authorized representative.[49]

C. Standard Grievances

1. Acknowledgment

In accordance with state law, DMC plans must provide written acknowledgment to the member that is dated and postmarked within five calendar days of receipt of the grievance.[50] The acknowledgment letter must advise the member that the grievance has been received, and the date of receipt, and it must 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 and state law.[51] Federal regulations 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 must comply with the state's established timeframe of 30 calendar days for grievance resolution.

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[46] 28 CCR 1300.68(d)(4)
[47] IMR form: http://www.hmohelp.ca.gov/
[48] 42 CFR 438.402(c)(2)(i); 28 CCR 1300.68(b)(9)
[49] 42 CFR 438.402(c)(3)(i); 28 CCR 1300.68(a)(1); 42 CFR 438.402(c)(1)(ii)
[50] HSC 1368(a)(4)(A); 28 CCR 1300.68(d)(1)
[51] 42 CFR 438.408(b)(1); HSC 1368.01(a); 28 CCR 1300.68(a) and (d)(3)

a. “Resolved” means that the grievance has reached a final conclusion withrespect to the member’s submitted grievance as delineated in existing state regulations.[52]
b. The DMC plan’s written resolution must contain a clear and concise explanation of the DMC plan’s decision.[53]
c. Even though federal regulations allow for a 14-calendar day extension for standard and expedited appeals, this allowance does not apply to grievances.[54] In the event that resolution of a standard grievance is not reached within 30 calendar days as required, the plan must notify the member in writing of the status of the grievance and the estimated date of resolution.

D. Exempt Grievances

DMC plans must comply with all state laws pertaining to exempt grievance handling.[55] 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 must 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 name of the representative who took the call and resolved the grievance. The information contained in the log must be reviewed by the plan.

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

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

E. Expedited Grievances

State law delineates processes for expedited grievance handling and require resolution within three calendar days.[56] 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 must apply the federal timeframe for resolving expedited appeals (72 hours) to expedited grievances. The 72-hour timeframe requires plans to record not just the date of the grievance receipt, but also the time, as the specific time of receipt dictates the timeframe for resolution.

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[52] 28 CCR 1300.68(a)(4)
[53] HSC 1368(a)(5); 28 CCR 1300.68(d)(3)
[54] 42 CFR 438.408(c)
[55] HSC 1368(a)(4)(B); 28 CCR 1300.68(d)(8)
[56] HSC 1368.01(b); 28 CCR 1300.68.01(a)(2)

Federal regulations require DMC plans to make reasonable efforts to provide the member with oral notice of the expedited resolution.[57] Plans must apply this requirement of oral notice for expedited appeals to expedited grievances.

DMC plans must comply with all other state requirements pertaining to expedited grievance handling in accordance with state law.[58]

IV. APPEALS

A. Timeframes for Requesting an Appeal

Timeframes for filing appeals are delineated in the DHCS contract, as well as in federal law.[59] Members must file an appeal within 60 calendar days from the date of the NOA. Members must exhaust the plan's appeal process prior to requesting a state hearing, except in instances of deemed exhaustion.[60]

B. Method of Requesting an Appeal

In accordance with federal and state law, appeals may be filed either orally or in writing by a member, a provider acting on behalf of the member, or an authorized representative.[61] Appeals filed by the provider on behalf of the member require written consent from the member.[62] DMC plans must continue to comply with this requirement in accordance with the DHCS contract and federal regulations.[63]

The date of the oral appeal establishes the filing date for the appeal.[64] Plans must accept a written appeal following the member's oral request for a standard appeal. However, plans only have 30 calendars days to resolve the appeal regardless of whether the oral appeal is followed by a written appeal. If the plan fails to respond within 30 calendar days of receipt of an oral request for an appeal, the member is deemed to have exhausted the plan's internal appeal requirement and can request a state hearing.

Failure to submit a written appeal is not a basis for the plan to disregard the oral appeal. Plans are required to assist any member wishing to file an appeal. This includes assisting the member with navigating the plan's website or providing the appeal form to the member upon request. DMC plans must also advise and assist the member to ensure the provision of Aid Paid Pending during the appeal of the adverse benefit determination, in accordance with federal and state law.[65] Plans

[57] 42 CFR 438.408(d)(2)(ii)
[58] HSC 1368.01(b); 28 CCR 1300.68.01
[59] Exhibit A, Attachment 15; 42 CFR 438.402(c)(2)(ii)
[60] 42 CFR 438.402, 438.404, 438.408, and 438.10; WIC 10951 and 14197.3.
[61] 42 CFR 438.402(c)(3)(ii); 28 CCR 1300.68(a)(1)
[62] 42 CFR 438.402(c)(1)(ii)
[63] Exhibit A, Attachment 15, Section A
[64] 42 CFR 438.406(b)(3)
[65] 42 CFR 438.420; 22 CCR 51014.1 and 51014.2.

must provide Aid Paid Pending regardless of whether the member makes a separate request to the plan when the member timely files an appeal (i.e., within 10 days of the NOA, or before the effective date of the intended action) of a decision to terminate, suspend or reduce services. In the event the plan does not receive a written, signed appeal from the member, the plan is prohibited from dismissing or delaying the resolution of the appeal.

C. Standard Appeals

1. Acknowledgment

In accordance with state law, DMC plans shall provide the member with written acknowledgment within five calendar days of receipt of the appeal. The acknowledgment letter must advise the member that the appeal has been received, the date of receipt, and it must provide the name, telephone number, and address of the representative who may be contacted about the appeal.[66]

2. Resolution

The timeframe for resolving appeals is within 30 calendar days.[67]

3. Deemed Exhaustion

In the event that the plan fails to adhere to the state and federal notice and timeframe requirements for either NOA or NAR, including the plan's failure to provide a fully translated notice, the member is deemed to have exhausted the plan's internal appeal process and may initiate a state hearing.[68]

D. Expedited Appeals

In accordance with federal law, the timeframe for resolving expedited appeals must be no longer than 72 hours.[69] DMC plans must comply with the 72-hour timeframe. The 72-hour timeframe requires plans to record the time of appeal receipt, and not just the date, as the specific time of receipt dictates the timeframe for resolution.

Additionally, plans are required to make reasonable efforts to provide the member with oral notice of the expedited appeal resolution.[70] DMC plans must comply with all other existing state regulations pertaining to expedited appeal handling.[71]

E. Notice of Appeal Resolution

DMC plans must provide members with a written NAR using the appropriate DHCS- developed, standardized NAR template. There are two NAR template options:

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[66] HSC 1368(a)(4)(A); 28 CCR 1300.68(d)(1)
[67] 42 CFR 438.408(b)(2); 28 CCR 1300.68; HSC 1368.01
[68] Title 42 CFR section 438.10, 42 CFR 438.402(c)(1)(i)(A), 438.404; and 438.408(c)(3) and(i); WIC 10951(b)(1)(B) and 14029.91); Title 45 CFR, Part 92
[69] 42 CFR 438.408(b)(3)
[70] 42 CFR 438.408(d)(2)(ii)
[71] 28 CCR 1300.68.01

1. Uphold: for appeals not resolved wholly in favor of the member; or
2. Overturned: for appeals resolved in favor of the member

For appeals upholding the original adverse benefit determination, the NAR must also include the NAR “Your Rights” attachment.

DMC plans are not permitted to make any changes to the NAR templates or “Your Rights” templates without prior review and approval from DHCS, except to insert information specific to the member as required.

F. Content of Notice

Content requirements for the NAR are delineated in federal and state law. The written NAR must meet all language and accessibility standards, including translation, font, and format requirements, as set forth in APL 21-001, Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services, federal and state law, and all requirements in the DHCS contract.[72]

For appeals not resolved wholly in favor of the member, the NAR is comprised of two components: 1.) The NAR “Uphold” template and 2.) The NAR “Your Rights” template. DMC plans must send the member both of these documents to comply with all requirement of the NAR.

For appeals resolved in favor of the member, the NAR only consists of the NAR “Overturned” template; the “Your Rights” attachment is not included with the NAR when the appeal overturns the original adverse benefit determination.

1. **Notice of Appeal Resolution (NAR Template)**
   DMC plans must comply with federal and state law in determining whether to uphold or overturn an adverse benefit determination in response to member appeals. The written NAR must contain the following:

   a. The results of the resolution process and the date it was completed.[73]
   b. For decisions to uphold a denial determination that is based in whole or in part on medically necessity, the reasons for its determination and clearly stated criteria, clinical guidelines, or dental policies used in reaching the determination.[74]
   c. For decisions to uphold a denial based on a determination that the requested service is not a covered benefit, the provision in the DHCS contract, or in the evidence of coverage/member handbook, that excludes the service. The response must either identify the document and page where the provision can be found, direct the member to the applicable section of the contract containing the provision, or provide a

[72] 42 CFR 438.408(e)(2)(iii)
[73] 42 CFR 438.408(e)(1)
[74] HSC 1367.01(b); 28 CCR 1300.68(d)(4)

copy of the provision and explain in clear concise language how the exclusion applied to the specific dental service or benefit requested.[75]

d. For appeals resolved in favor of the member: a clear and concise explanation of why the decision was overturned.[76]
e. 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. **NAR "Your Rights" Attachment Template(s)**

The NAR "Your Rights" template informs members of their rights following an adverse benefit determination that has been upheld on appeal. It does not contain information on how to file a request for an appeal, as the member will have already exhausted the plan's appeal process.

The DHCS-developed NAR "Your Rights" templates include all of the following elements:

a. The member's right to request a state hearing no later than 120 calendar days from the date of the plans written NAR and instructions how to request a state hearing.[77]
b. The members right to Aid Paid Pending and instructions on how to timely file for a state hearing (i.e., within 10 days of the NAR) regarding a decision to terminate, suspend or reduce services. DMC plans must provide Aid Paid Pending regardless of whether the member makes a separate request to the plan when the member timely files for a state hearing regarding a decision to terminate, suspend or reduce services.[78]
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 a disputed emergency service.[79]

DMC plans must use the NAR "Your Rights" templates enclosed with this APL. The NAR "Your Rights" template for Knox-Keene licensed plans provides information for members on how to request an IMR. Knox-Keene licensed plans are subject to additional state laws, including the requirement that certain written notices to members contain prescribed language advising members of additional rights and directing them to contact DMHC to request an IMR.[80] This mandatory paragraph is already incorporated into the template and requires no action by plans. When sending the "Your Rights" attachment to members as part of the NAR, plans must include the most current version of

[75] HSC 1363.5 and 1367.01; 28 CCR 1300.68(d)(5)
[76] HSC 1368(a)(5); 28 CCR 1300.68(d)(3)
[77] 42 CFR 438.408(e)(2)(i); 22 CCR 53858(e)(5)
[78] 42 CFR 438.408(e)(2)(ii) and 42 CFR 438.420; 22 CCR 51014.1 and 51014.2
[79] HSC 1370.4 and 1374.30(d); 28 CCR 1300.74.30(a)
[80] HSC 1368.02(b)

the state hearing form, which is provided as an attachment to this APL. Knox-Keene licensed plans must also include the IMR form, application instructions, DMHC's toll-free telephone number, and an envelope addressed to DMHC.[81] Knox-Keene licensed plans are required to check the DMHC website periodically to ensure use of the most current form.[82] Plans may include state hearing and IMR forms that contain tracking numbers to more easily identify and administer member rights. Such tracking numbers should contain initials, acronyms, or names that identify the plan.

G. Overturned Decisions

DMC plans must authorize or provide the disputed services promptly and as expeditiously as the member's condition requires if the plan reverses its decision to deny, limit, or delay services that were not furnished while the appealwas pending. DMC plans shall authorize or provide services no later than 72 hours from the date the determination is reversed.[83]

V. TRANSLATION OF GRIEVANCE AND APPEALS NOTICES

Federal and state law, the DHCS contract, and APL 21-001 require plans to fully translate and provide written member information in a member's required language, as specified, including all grievance and appeals notices referenced in this APL.[84]

Specifically, plans must fully translate NOAs/NARs, including the clinical rationale for the plan's decision that must be included in the NOA/NAR. While DHCS has made it clear that immediate translation of the entire NOA/NAR is required by federal and state law, DHCS acknowledges that plan Trade Associations have advised that some plans do not currently have sufficient technological or contractual processes in place to ensure immediate translation of the clinical rationale.

DMC plans that are not currently in compliance with immediate, full translation of the entire NOA/NAR are expected to come into compliance with full translation within six months of the issuance date of this APL. Failure to come into compliance will subject non-compliant plans to corrective action and imposition of monetary sanctions.

Plans that mail a partially translated NOA/NAR with the clinical rationale written in English must ensure all of the following requirements are met during the six month compliance period: 1) the body of the NOA/NAR (i.e., non-clinical NOA/NAR template language) must be translated into the member's required language; 2) a sentence must be inserted in the NOA/NAR in the member's required language explaining how the member can obtain oral interpretation of the clinical rationale on an expedited basis; 3) the plan must make every effort to provide the member with an explanation of the clinical rationale regarding the requested service, which includes assisting the member in exercising all grievance rights

[81] 28 CCR 1300.68(d)(4)
[82] The IMR form can be accessed at the follow link: http://www.hmohelp.ca.gov./
[83] 42 CFR 438.424(a)
[84] 42 CFR 438.10(d)(3), 438.404(a), and 438.408(d)(2)(i); 22 CCR 53876; WIC 14029.91(e); Exhibit A, Attachment 11.H, Linguistic Services

pursuant to federal and state law; 4) provide a fully translated written notice, including a fully translated clinical rationale, as soon as possible but not later than 30 calendar days from the date the partially translated notice was sent; and, 5) the plan is prohibited from requesting dismissal of a state hearing in all cases where it failed to provide a fully translated notice because this qualifies as deemed exhaustion of the plan's internal appeal and the member can immediately request a state hearing.[85]

VI. STATE HEARINGS

A member has a due process right to request a state hearing when a claim for medical assistance is denied or is not acted upon with reasonable promptness.[86] A member may also initiate a state hearing if the member is deemed to have exhausted the plan's appeal process because the plan failed to comply with notice and timing requirements.[87] The parties to a state hearing include the plan as well as the member and, if applicable, the member's representative or the representative of a deceased member's estate.[88] To ensure a member's right to due process during the state hearing process, the plan must ensure that a statement of position is timely filed with the California Department of Social Services (DSS) State Hearings Division and that a witness is available and prepared to present the plan's position and to be cross-examined at the state hearing.[89]

A. Timeframes for Filing

Federal regulations require members to request a state hearing no less than 90 calendars days and no more than 120 calendar days from the date of the NAR, informing the member that an adverse benefit decision has been upheld.[90] The DHCS templates for the "Your Rights" attachments inform members of this requirement.

In cases of deemed exhaustion, the member has 120 days from: 1) the expiration date of the timeframe in which the plan should have sent a NAR to the member; 2) the expiration date of the timeframe in which the plan should have sent a NOA to the member; or 3) the date of the member's receipt of the plan's deficient written NAR/NOA (e.g., in cases where the plan failed to provide a fully translated NOA).[91]

B. Standard Hearings

The plan must notify members that the state must issue a final decision within 90 calendar days of the date of the request. [92]

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[85] 42 CFR 438.68, 438.402, and 438.408
[86] 42 CFR 431.205 and 431.242 and *Goldberg v. Kelly*, 397 US 254 (1970);
[87] 42 CFR 438.10, 438.402, 438.404 and 438.408
[88] 42 CFR 438.408(f)(3)
[89] 42 CFR 431.205 and 431.242; Goldberg v. Kelly, 397 US 254, *supra;* CDSS Manual of Policies and Procedures, Manual Letter No. CFC-16-01, section 22-049.
[90] 42 CFR 438.408(f)(2)
[91] 42 CFR 438.408
[92] 42 CFR 431.244(f)(1)

C. Expedited Hearings
The plan must notify members that the state must issue a final decision within three working days of the date of the request.[93]

D. Overturned Decisions
The DMC plans must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires, no later than 72 hours from the date the plan receives notice of the hearing decision reversing the plan's adverse benefit determination.[94]

VII. NONDISCRIMINATION NOTICE AND LANGUAGE ASSISTANCE TAGLINES[95]

When sending the required grievance and appeals notifications to members, plans must comply with the nondiscrimination and language assistance requirements as outlined in APL 21-001, including any subsequent updates or revisions to this APL.

VIII. GRIEVANCE AND APPEAL SYSTEM OVERSIGHT

DMC plans must establish, implement, maintain, and oversee a grievance and appeal system to ensure the receipt, review, and resolution of grievances and appeals. The grievance and appeal system must operate in accordance with all applicable federal, and state laws.[96]

A. The DMC plan must operate in accordance with its written procedures for grievance and appeals. Theseprocedures must be submitted to DHCS prior to use.[97]

B. The DMC plan must designate an officer that has primary responsibility for overseeing the grievance and appeal system. The officer must continuously review the operation of thegrievance and appeal system to identify any emergent or systemic issues with grievance and appeals and/or patterns of improper service denials. The grievance and appeal system must include reporting procedures in order to improve plan's policies and procedures. [98]

C. The DMC plan must notify members about its grievance and appeal system and shall include information for members on how the plan's procedures for filing and resolving grievances and appeals work, a toll-free telephone or a local telephone number in each service area, and the address for mailing grievances and appeals. The notice must also include information regarding DMHC's review process, the IMR system, and DMHC's toll-free telephone number and website address, as appropriate. [99]

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[93] 42 CFR 431.244(f)(2)
[94] 42 CFR 438.424(a)
[95] APL 21-001
[96] 42 CFR Part 438, Subpart F; HSC 1368; 22 CCR 53858; 28 CCR 1300.68
[97] 22 CCR 53858(a)(1)
[98] 28 CCR 1300.68(b)(1)
[99] 22 CCR 53858(b); 28 CCR 1300.68(b)(2) and (4)

D. The DMC plan must notify members of the process for obtaining grievance and appeals forms. A description of the procedure for filing grievances and appeals must be readily available at each facility of the plan, on the plan's website, and at each contracting provider's office or facility. The plan must ensure that assistance in filing grievances and appeals will be provided at each location where grievances and appeals are submitted. Grievance and appeal forms must be provided promptly upon request.[100]

E. The plan must ensure adequate consideration of grievances and appeals and rectification when appropriate. If multiple issues are presented by the member, the DMC plan must ensure that each issue is addressed and resolved.[101]

F. The plan must maintain a written record for each grievance and appeal received by the plan. The record of each grievance and appeal must be maintained in a log and include the following information:[102]

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 plan or provider toinvestigate and resolve the grievance or appeal.
6. The proposed resolution by the plan or its medical professional responsible for making utilization management decisions.
7. The name of the plan provider or staff responsible forresolving 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), 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). The written record of grievances and appeals must be submitted, at least quarterly to the plan's quality assurance committee for systematic aggregation and analysis for quality improvement. Grievances and appeals reviewed must include, but not be limited to, those related to access to care, quality of care, and denial of services. DMC plans must take appropriate action to remedy any problems identified.[103]

H. The written record of grievances and appeals must be reviewed periodically by the governing body of the DMC plan, the public policy body, and by an officer ofthe DMC plan or designee. The review must be thoroughly documented.[104]

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[100] 22 CCR 53858(c), (d), and (f); 28 CCR 1300.68(b)(6) and (7)
[101] HSC 1368(a)(1)
[102] 22 CCR 53858(e)(1); 28 CCR 1300.68(b)(5)
[103] 22 CCR 53858(e)(3) and (4)
[104] 28 CCR 1300.68(b)(5)

I. The plan must 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.[105]

J. The DMC plan must address the linguistic and cultural needs of its member population as well as the needs of members with disabilities. The DMC plan mustensure all members have access to and can fully participate in the Grievance and Appeal System by assisting those with limited English proficient members or those with a visual or other communicative impairment. Such assistance includes, 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.[106]

K. The DMC plan must assure that there is no discrimination against a member on the grounds that the member filed a grievance or appeal.[107]

L. The DMC plan must establish and maintain a system of aging grievances and appeals that are pending and unresolved for 30 calendar days or more and include a brief explanation of the reasons for each pending and unresolved grievance and each appeal .[108]

M. The DMC plan must ensure that the person making the final decision for the proposed resolution of a grievance or appeal has not participated in any prior decisions related to the grievance or appeal. Additionally, the decision maker must be a dental professional with clinical expertise in treating a member's condition or disease ifany of the following apply:[109]

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

N. The DMC plan must 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.[110]

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[105] 22 CCR 53858(e)(2)
[106] 22 CCR 53858(e)(6); 28 CCR 1300.68(b)(3)
[107] 28 CCR 1300.68(b)(8)
[108] HSC 1368(b)(8)
[109] 42 CFR 438.406(b)(2)
[110] 42 CFR 438.406(b)(2)(iii)

O. The DMC plan must 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.[111]

P. 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.[112]

All templates referenced in this APL may be viewed in PDF format on the DHCS website as attachments to this APL. To obtain copies of any template referenced in this APL in Word format, or to obtain translated state hearing forms, please send a request via email to: dmcdeliverables@dhcs.ca.gov.

If the requirements contained in this APL, including any updates or revisions to this APL, necessitate a change in a plan's P&Ps, the plan must submit its updated P&Ps 90 days from the release of this APL. If a plan determines that no changes to its P&Ps are necessary, the plan must submit an e-mail confirmation within 90 days of the release of this APL, stating that the plan's P&Ps have been reviewed and no changes are necessary. The e-mail confirmation must include the title of this APL as well as the applicable APL release date in the subject line.

DMC plans are responsible for ensuring that their subcontractors and network providers comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters. These requirements must be communicated by each plan to all subcontractors and network providers.

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

Sincerely,

Original signed by:

Adrianna Alcala-Beshara, JD, MBA
Chief, Medi-Cal Dental Services Division
Department of Health Care Services

Enclosures

[111] 42 CFR 438.406(b)(5)
[112] 42 CFR 438.406(b)(4)