CENCAL HEALTH POLICY AND PROCEDURE (P&P)	
Title: Member Appeals	**Policy No.:** MS-23
Department: Member Services	
Cross Functional Departments: Provider Services, Medical Management, Quality	
Effective Date: 07/2023	**Last Revised Date:** 10/2023
P&P Require DHCS Approval? Y ☒ N ☐	
Director or Officer Signature: Eric Buben Director of Member Services	**Officer Signature:** Van Do-Reynoso, MPH, PhD Chief Customer Experience Officer and Chief Health Equity Officer

I. Purpose:

To ensure CenCal Health's Member Appeals system establishes organizational accountability for properly addressing and processing Member Appeals.

II. Policy:

A. CenCal Health maintains a Member Appeals system to ensure Member Appeals are responded to, and resolved, in a timely and appropriate manner, and are not unduly delayed when a Member's medical condition requires time sensitive services. CenCal Health's Appeals system enables the Member, or their authorized representative, the opportunity to disagree with the Plan's decision regarding the authorization process.

B. CenCal Health's Appeals system provides Members or their appointed representatives the right to:

1. Request an Appeal of an Adverse Benefit Determination within sixty (60) calendar days from the date on the Notice of Adverse Benefit Determination (NABD). CenCal Health shall relay to Members how to continue benefits during the in-plan appeal process through the State Fair Hearing, when applicable.

C. Appeals filed by a provider on behalf of a Member must be accompanied by the Member's written consent.

D. All Member Services staff involved in the receipt of an Appeal have the responsibility to:

1. Document all Appeals into CenCal Health's on-line tracking system as soon as either is identified. The on-line tracking system populates from the HIS eligibility data and provides demographic information of the member such as aid code and SPD identification, for appropriate reporting and compliance with regulatory and contract requirements.

2. Immediately alert the appropriate Grievance and Appeal (G&A) staff of

any Expedited Appeal requests pursuant to the G&A training manual.

3. Provide Members with assistance in completing Appeal forms.
4. Coordinate with the Grievance & Appeals Team to deliver all documents requested by a filing Member or their representative, that CenCal Health reviewers used to make a decision.
5. Coordinate auxiliary aid, translation of materials, alternative format selection needs or connect with interpreter services or provide CenCal Health's toll-free number for TTY/TDD 1-833-556-2560.
6. All Appeal cases with the initial documentation of Member's issues are forwarded to the Plan's Medical Management Team/ Licensed Clinical Professional reviewer within two (2) business days of receipt (unless the Appeal is an expedited request, which is forwarded immediately) from Member or provider on their behalf. This process facilitates the review of documentation by the clinical nurse reviewer to ensure guidance regarding appropriate coding of case by the G&A coordinator and the procurement of appropriate medical records, chart notes and associated documentation to be requested for review by the Plan's physician reviewer.

E. CenCal Health retains responsibility for the Member Appeal system and does not delegate this responsibility to its provider network.

F. Appeals received by CenCal Health staff from its Members regarding Specialty Mental Health (also known as Mental Health Plans, or "MHP") provided through Santa Barbara County Alcohol, Drug, and Mental Health Services (Santa Barbara County Behavioral Wellness Department), and Mental Health Services of San Luis Obispo County (MHS-SLO) are forwarded to these agencies immediately and the Member is advised accordingly. If the Member wishes to provide the Plan's Member Services Representative (MSR) with full details of their Appeal, the MSR will document their issue, offer a warm transfer to the appropriate agency, and advise the Member that the Plan will be forwarding their Appeal to the appropriate entity for resolution. In addition, the Appeal will be forwarded to the Plan's G&A staff to ensure that the Member's concern is addressed by the appropriate mental/behavioral health entity.

G. Appeals received by CenCal Health staff from its Members regarding pharmacy benefits are no longer processed by CenCal Health. The new Department of Health Care Services (DHCS) Program in the State of California known as "Medi-Cal Rx" assumed grievance and appeal responsibilities on January 1, 2022.

III. **Procedure**:

A. Initiation of an Appeal

1. All Member Appeals that are the result of a disagreement with benefit-related decisions, such as coverage disputes, disagreeing with and seeking reversal of a request for Prior Authorization involving medical necessity, etc., that are associated with a Notice of Action (NOA), are

initiated by CenCal Health. The initial review policies and procedures are as outlined in Health & Safety Code section 1367.01 and included in CenCal Health's pre-service review process Policy & Procedure (HS-UM07: Notification of UM Determinations and Timeliness).

2. CenCal Health's Member Appeal system procedure and process allows an Appeal to be initiated from any of the following:
    a. A Member or their appointed representative (if the Member wishes to have a representative act on their behalf regarding the Appeal, he/she must provide at minimum, verbal authorization, or complete and send their Appointment of Representative Form if not on file with the Plan);
    b. A provider on behalf of a Member, with Member's participation, which must include written consent if Member has granted provider the authority to act on their behalf in filing the Appeal; only then will the Appeal be initiated.
3. CenCal Health is currently not responsible for initiating Member Appeals related to Medi-Cal pharmacy benefits.
    a. For pharmacy-related pre-service Member Appeals involving disagreement with benefit-related decisions (such as coverage disputes, disagreeing with and seeking reversal of a request for prior authorization involving medical necessity, etc.) that are associated with a NOA, will be adjudicated through the existing State Fair Hearing (SFH) process already in use by DHCS.
    b. Members maintain the right to contact the Medi-Cal Rx Customer Service Center (CSC) to ask questions, seek clarification on the NOA contents, or provide additional information. Such contact will not impact the Member's right to pursue a State Fair Hearing.
    c. For more information about the Medi-Cal Rx SFH appeals process, please see DHCS' existing SFH policy and processes which are available on the DHCS and California Department of Social Services' (CDSS) websites, respectively at: https://www.dhcs.ca.gov/services/medi-cal/Pages/Medi-CalFairHearing.aspx and https://www.cdss.ca.gov/hearing-requests.
    d. The Medi-Cal Rx Call Center at Magellan Rx (the pharmacy benefits manager for Medi-Cal Rx) will not be involved in resolving member appeals. However, CenCal Health will provide Magellan Rx with any assistance requested as may be applicable.
    e. If a Member calls CenCal Health to file an Appeal related to their pharmacy benefits, CenCal Health's Member Services Department will transfer the Member, or the appointed representative, to the Medi-Cal Rx CSC through Magellan Rx directly at 1-800- 541-5555, TTY 1-800-430-7077.

B. Intake, Documentation and Registering of Member Appeals

1. Appeals may be presented either through a telephone call, Appeals form, in-person, or other correspondence. The MSR is the primary intake for Member-generated Appeals.
2. The MSR obtains the necessary information from the Member, including but not limited to the Member's reason for appealing the original decision and any clinical or other information provided with the appeal request, or by their appointee, or provider (with the Member's written consent required before initiation of the provider-filed Appeal) on their behalf and confirms that the Member wishes to file an Appeal.
3. Members may present evidence, testimony, or make arguments etc., via phone call or in writing in support of their Appeal. All information gathered will be presented to the non-clinical or clinical reviewers at the time the investigation completes.
4. Members may follow up a verbal Appeal with a written Appeal but are not required to do so. CenCal Health will process and adjudicate the verbal appeal commencing on the date the oral request for an Appeal is received.
5. CenCal Health advises of the provisions to ensure Aid Paid Pending (APP) via the Notice of Action template language (as supplied by DHCS), and forwards requests from Members for APP to the Plan's Legal Department for approval during the timeframe of the Appeal processing of the Adverse Benefit Determination and regardless of whether the Member makes a separate request to CenCal Health when the Member timely files an Appeal of a decision to terminate, suspend, or reduce services.
6. Should a person other than the Member, provider, or appointed representative contact CenCal Health, the MSR will document the information presented. At no time will the MSR divulge a Member's confidential information to the individual that files the complaint on behalf of the Member. The MSR will refer the issue to the Member Services Supervisor, or designee, who will contact the Member to validate the issue and ask if the Member wishes to file an Appeal.
7. Upon receipt of a written Appeal, the Grievance & Appeals Coordinator will call the Member, or their appointed representative, within one business day to discuss the Appeal. All requests for CenCal Health Appeal forms are to be mailed no later than the next business day from the date of the request. All Appeals received either written or via the toll-free telephone number for the Member Services Department, are entered into and tracked on CenCal Health's on-line tracking system.
8. Members can appeal a Notice of Action (NOA) or Notice of Adverse Benefit Determination (NABD) within sixty (60) calendar days from the date on the NOA or NABD. The Grievance & Appeals Coordinator will educate Member on how to continue benefits during the in-plan appeal process through the State Fair Hearing, when applicable.

C. Member Services Grievance & Appeals Coordinator Research; Verification of Coding

1. The Member Services Grievance & Appeals Coordinator (G&A Coordinator) reviews the documentation and contacts the appropriate provider office(s) to validate date(s) of service and other information given by the Member.

2. The G&A Coordinator reviews each Appeal, including all information from the provider office(s) and any other pertinent research, and then refers the case to a Health Services Nurse within two (2) calendar days for verification of the accuracy of the G&A Coordinator's appeal coding and confirmation of appropriate medical records, charts, and other documentation that the G&A Coordinator will be obtaining for physician review.

    a. All prior authorizations that have resulted in an Adverse Benefit Determination that would include TARs and RAFs are automatically considered clinical review necessity and processed appropriately for review by a physician reviewer who was not involved in the original decision(s).

    b. If the Appeal is regarding the discontinuance of benefits, the Plan must provide for the continuation of noted denied benefits until the resolution of the Appeal has been determined. The Health Services Nurse will coordinate these services with the Health Services UM staff.

3. Every Appeal is reviewed by a Health Services Nurse who is a Registered Nurse with an active license to practice nursing in California. The Health Services Nurse verifies the appropriateness of the G&A Coordinator's coding determination. This verification is based on clinical experience and application of clinical criteria. The Health Services Nurse notifies the G&A Coordinator of his/her decision and determines whether any additional information is required to process the Appeal. Additional information may or may not include medical records.

D. Non-Clinical Review Process

1. If the G&A Coordinator categorizes an Appeal as non-clinical, for administrative reviews such as billing disputes, the Health Services Nurse reviews the Appeal documentation on CenCal Health's on-line tracking system and verifies that the Appeal has no clinical component within two (2) business days of receipt of the Appeal. If the Health Services Nurse determines that the Appeal may involve a clinical concern, the Nurse will notify the G&A Coordinator. The G&A Coordinator will correct the coding and proceed, if necessary, with the collection of documentation required by Health Services to process the Appeal for clinical review by a designated physician reviewer.

2. The Member Services Grievance-QI Manager reviews and oversees all Appeal documentation and research. The Member Services Grievance-QI Manager completes the non-clinical appeal review, documents

findings, and follows-up with appropriate staff when necessary to address identified quality improvement opportunities regarding quality of service issues.

E. Clinical Review Process

1. When the G&A Coordinator determines that the Appeal requires clinical review, the G&A Coordinator completes the required documentation, including all pertinent information needed for the review by a physician reviewer, including previous denial and appeal history, current medical records and provider responses and any previous actions taken prior to the appeal in follow-up to the previous denial (if applicable). A complete packet is presented to the Medical Management team/ licensed clinical professional nurse.
2. For Appeals that require a physician reviewer, the Medical Management team/ licensed clinical professional nurse reviews the completed packet and prepares a review summary for the Medical Management physician reviewer.
3. The physician reviewer must be different than the physician who reviewed the initial request or had any part in any prior decisions. The physician reviewer will also not be a subordinate of someone who participated in the initial review or decision.
4. The physician reviews the packet and consults with or directs the review, to a practitioner in the same or similar specialty who typically treats the condition, who provides recommendation to assist the physician completing the review. The physician reviewer then directs appropriate departments to perform follow-up when necessary to address identified quality improvement opportunities.
5. All research of clinical issues that are part of the physician reviewer's findings are considered peer review protected via state statute.
6. The physician reviewer notifies the G&A Coordinator in writing of the completion of each clinical review for Appeals.

F. Expedited Appeal Process

1. The Expedited Appeal process requires resolution within 72 hours. The Member Services G&A Coordinator reviews Members' or providers' requests on behalf of the Member (with the Member's written consent) for Expedited Appeals immediately upon receipt and forwards to the Medical Management team/ licensed clinical professional Nurse and to the Chief Medical Officer or Medical Director for review to determine if the request meets DHCS criteria for Expedited Appeals.
    a. If the request meets criteria, in accordance with the DHCS guidelines, the Expedited Appeal is resolved, and an outcome is provided to the requestor within the 72-hour (3 calendar day) allowable review period.

b. If it does not meet criteria, the Appeal then follows the standard 30-day Appeal process and the requestor is notified that the request did not meet expedited criteria verbally, followed by written notice of the downgrade from expedited to standard 30-day Appeal review. The acknowledgement letter sent to Member shall also advise the Member that he/she may file a Grievance against the downgrade.

2. For Expedited Appeals , the Medical Management team/ licensed clinical professional nurse reviews the completed packet and prepares a review summary for the Medical Management physician reviewer.
3. The physician reviewer must be different than the physician who reviewed the initial request or had any part in any prior decisions. The physician reviewer will also not be a subordinate of someone who participated in the initial review or decision.
4. The physician reviews the packet and directs appropriate departments to perform follow-up when necessary to address identified quality improvement opportunities.
5. All research of clinical issues that are part of the physician reviewer's findings are considered peer review protected via state statute.
6. The G&A Coordinator calls the Member or appointed representative within the 72-hour time frame to advise of the outcome, and the final letter is mailed.

G. Mental/Behavioral Health Appeals

1. The G&A Coordinator summarizes and forwards documentation of all specialty mental/behavioral health clinical and non-clinical Appeals to Santa Barbara County Behavioral Wellness Department or MHS of San Luis Obispo (MHS-SLO) for specialty mental health services if the Appeal is pertaining to specialty mental health services. For all mild to moderate behavioral health Appeals, CenCal Health staff will initiate and investigate these Appeals and enter into our on-line tracking system.
2. Within one (1) business day, the Santa Barbara County Behavioral Wellness Department or MHS - SLO QA Manager will acknowledge receipt of the complaint by secure e-mail to the G&A Coordinator. The QA Managers for Santa Barbara Behavioral Wellness or MHS-SLO researches and resolves Appeals directly with the Member.

H. Experimental/Investigational Clinical Appeal Process

1. This process is applicable to CenCal Health's Knox-Keene licensed programs; however, there are currently no Members enrolled in CenCal Health products that are Knox-Keene licensed.
2. If CenCal Health has denied a treatment procedure or service as being experimental or investigational, Members may request a face-to-face meeting or hearing with CenCal Health's Medical Director and/or their physician designee to be held within five (5) calendar days. Otherwise,

the appeal is processed within the normal thirty (30) calendar daytime frame.

3. These denials are subject to the Independent Medical Review (IMR) process and Members will be notified of their right to request this process with the appropriate IMR Form and envelope within five (5) calendar days of the Plan's decision to deny. Members are not required to first file an Appeal with CenCal Health before requesting an Independent Medical Review.
4. Additional information about CenCal Health's coverage of experimental or investigational treatment services or technology is included in CenCal Health's Policy & Procedure (HS-UMXX - Experimental and Investigational Authorization Process).

I. Notification to Member of Disposition of Appeal

1. The G&A Coordinator acknowledges receipt of Members' Appeals, in writing, within five (5) calendar days. Members may submit additional comments, documents and other information relating to their Appeal. The acknowledgement letter is sent on Plan letterhead and contains the date the Appeal was received, a summary of the issue, advising them that their issue will be resolved within thirty (30) calendar days, the G&A Coordinator's name, phone number and the Plan address noted on the bottom of the official Plan letterhead.
2. The G&A Coordinator notifies Members, in writing that CenCal Health has finished its review of their Appeal and provides a clear and concise explanation of the Plan's decision no later than thirty (30) calendar days from its receipt. CenCal Health has 30 calendar days to resolve Appeals regardless of whether the oral appeal is followed by a written Appeal.
3. For clinical Appeals, the Medical Management team/ licensed clinical professional nurse notifies the G&A Coordinator of the Chief Medical Officer/ physician designee's Appeal decision and provides the documentation and/or reason for the denial including the specific criterion used to make the decision, or an excerpt of the criterion, is included in the final letter to the Member, which are noted in the Notice of Appeal Resolution (NAR). The NAR letter also identifies all reviewer clinical credentials (such as MD, DO, PhD, physician) and specialty (e.g., pediatrician, general surgeon, neurologist, clinical psychologist) who participated in making the appeal decision, including the same-or-similar specialist reviewer, when applicable, as they provide specific clinical knowledge and experience that affects the decision. The G&A Coordinator prepares the final resolution letter (which includes the Member's right to a state hearing), obtains the Chief Medical Officer/ physician designee's signature, and mails the Member the Appeal decision, in writing, no later than thirty (30) calendar days from receipt. If the Plan fails to adhere to the noted time requirements, the Member is deemed to have exhausted the Plan's Appeal process and may initiate

the State Fair Hearing process within 120 calendar days of the Plan's failure to comply with the time frames noted above.

4. The Member is also notified of their right to receive, upon request, reasonable access, and copies of all documents relevant to their Appeal in accordance with HIPAA requirements noted in the Member Handbook at no cost. Requests for documents must be approved by CenCal Health's Chief Medical Officer and the HIPAA Privacy Officer. The Member is also notified of their right to request a copy of the actual benefit provision, guideline, protocol, and other similar criterion on which the Appeal decision was based, and they may obtain a list of titles and qualifications of individuals participating in the Appeal review.
5. If the Appeal decision is favorable to the Member, Medical Management UM, CM or clinical designee will ensure that the authorization for services is approved in CenCal Health's Health Information System (HIS) that same business day and will coordinate with the G&A Coordinator in order to ensure the health care services are scheduled as promptly and as expeditiously as the Member's condition requires (not to exceed 72-hours from the date of the overturned decision). Should the Member require services within seventy-two (72) hours, this will be coordinated with the appropriate physician, facility, or pharmacy. The Member is notified both orally and in writing via the NAR template language requirements.
6. For Expedited Appeals, within seventy-two (72) hours of receipt, the Health Services Nurse notifies the G&A Coordinator of the physician reviewer or physician designee's determination if the case does/does not meet expedited criteria and the G&A Coordinator notifies the Member by telephone, and in writing in a clear and concise manner, of the outcome of CenCal Health's expedited review determination. Written notification is sent by certified U.S. mail. If the request did not meet expedited criteria for handling, the standard 30-day appeal review is initiated.
7. The G&A QI Manager reviews all final letters prepared by the G&A Coordinators to ensure the Appeal's final documentation to the Member or their representative clearly explains the decision and provides the criteria used to make the decision. This process of seeking the Member Services G&A QI Manager's review and approval of final letter documentation occurs for all appeal cases.

J. Mandated Language with Member Notification

1. For Knox-Keene Licensed programs (currently none under CenCal Health), Department of Managed Health Care (DMHC) mandated language, including the DMHC's toll-free telephone number, the DMHC's TDD line for the hearing and speech impaired, CenCal Health's telephone number, and the DMHC's internet address, would be included on CenCal Health's website and in all of the following documents:
    a. CenCal Health's contracts with its providers;
    b. All Evidence of Coverage/Member Handbooks;

c. CenCal Health's Member Grievance and Appeal System Policy and Procedure;

d. Grievance and Appeal Forms,

e. All written responses to Grievances and Appeals; and

f. All written notices to Members required under the Appeal process of CenCal Health, including any written communications to Member that offer the Member the opportunity to participate in CenCal Health's Grievance and Appeal process.

2. Pursuant to the Code of California Regulations Title 22 requirements, DHCS, and Code of Federal Regulations Title 42, mandated language must be included in all of the letters and/or Member notification listed above.

3. When sending the required Appeals notifications to Members, CenCal Health must comply with the nondiscrimination, language assistance requirements, and accessibility standards as outlined in APL 21-004 and APL 21-011, including translation, font, and format requirements, and any subsequent updates or revisions to the APL and attach the required documents to all NOA and NAR notifications. The content of the notice must also comply with applicable state and federal law and all requirements of the contract between DHCS and CenCal Health.

K. Department of Social Services (DSS) State Hearings

1. The Department of Social Services is the county agency that determines eligibility for public assistance programs, such as Medi-Cal, Cal Works, Aid to Families with Dependent Children, Cal Fresh, and general assistance. Members that disagree with the Plan's decisions regarding a denial, termination, or modification of a request for services for prior authorization, may request a State Hearing within 120 calendar days from the date of the Plan's Notice of Appeal Resolution Letter. In the event that the Plan denial is regarding a discontinuation of a benefit, the Plan will provide for the continuation of benefits those services pending the State Hearing resolution. In cases of deemed exhaustion, the Member has 120 days from 1) the expiration date of the timeframe in which CenCal Health should have sent a NAR to the Member; 2) the expiration date of the timeframe in which CenCal Health should have sent a NOA to the Member; or 3) the date of the Member's receipt of CenCal Health's deficient written NAR/NOA to request a State Hearing. This information is supplied in the language within the DHCS approved, Evidence of Coverage/Member Handbook language for how to file a State Hearing.

2. CenCal Health will notify Members that the state must issue a final decision within 90 calendar days of the date of request for State Hearing (3 working days for expedited State Hearings), as explained in the Member's Evidence of Coverage/Member Handbook.

3. CenCal Health's Legal Department is CenCal Health's primary contact for State Hearing notification. Upon receipt of the State Fair Hearing request,

the Legal Department will review the case, prepare a position statement with the Health Services physician reviewer, and represent the health plan at the State Fair Hearing with appropriate clinical staff. See CenCal Health Policy & Procedure LGL-02: Member State Fair Hearings for further explanation of CenCal Health's State Hearing Process.

IV. Definitions: See G&A Definition Addendum

V. References:

A. DHCS APL 22-012: Governor's Executive Order N-01-19, Regarding Transitioning Medi-Cal Pharmacy Benefits from Managed Care to Medi-Cal Rx

B. DHCS APL 21-004: Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services

C. DHCS APL 21-011: Grievance and Appeal Requirements, Notice, and "Your Rights" Templates

VI. Cross References:

A. Policy and Procedures (P&Ps):

1. HS-UM07: Notification of UM Determinations and Timeliness
2. HS-UMXX: Experimental and Investigational Authorization Process
3. LGL-02: Member State Fair Hearing
4. MS-22: Member Grievances
5. MS-24: Communication and Education of Grievance and Appeals Process
6. MS-25: Monitoring and Oversight of Grievance and Appeals System

B. Standard Operating Procedure (SOP):

1. MSSOP-062: Intake of Grievance or Appeal by MSR
2. MSSOP-84: Expedited Appeals Process
3. MSSOP-86: Pharmacy Grievances & Appeals
4. MSSOP-85: Provider-Filed Appeals Process
5. MSSOP-83: Standard Appeals Process

C. Program Documents:

1. Grievances & Appeals Definition Addendum
2. Provider Manual – Grievance & Appeals Section

VII. Attachments: N/A

Revision History:

P&P Revision Date	Leaders who Reviewed and Approved P&P Revisions	Reason for P&P Revisions	P&P Revision Effective Date (date P&P is operationalized)	DHCS P&P Approval Date
10/2023	Eric Buben, Director of Member Services; Van Do-Reynoso, MPH, PhD Chief Customer Experience Officer and Chief Health Equity Officer	Checked-Out for 2024 Integration and updated to new template	07/2023	12/2023
07/2023	Eric Buben, Director of Member Services	Restructuring of MS-20 resulted in a number of more specific P&Ps, including this one, which focuses on member grievances. Minimal, if any, changes to content.	Upon DHCS Approval	10/2023