DAVIS BEHAVIORAL HEALTH
Community · Commitment · Change

Policies & Procedures

EXPEDITED APPEALS

Section: Grievance Policies

Pages: 3

Subject: Expedited Appeals

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POLICY

DBH will maintain a Grievance System which will allow an Enrollee, the Enrollee's legally authorized representative (including the legal representative of a deceased Enrollee's estate), or a provider with the Enrollee's written consent to file an expedited Appeal, either orally or in writing.

PROCEDURE

1. When DBH determines (from a request from an Enrollee) or a provider indicates (in making the appeal on the Enrollee's behalf or supporting the Enrollee's request) that the time frame for a standard resolution could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function, the DBH Grievance Officer will initiate an expedited review for appeals.

2. The request for an Expedited Appeal may be filed either orally or in writing by the Enrollee or a provider with the Enrollee's written consent. Oral inquiries seeking to appeal an Adverse Benefit Determination are treated as an Appeal, to establish the earliest possible filing date for the Appeal.

3. The Enrollee or provider may file an Appeal of an Adverse Benefit Determination within 60 days from the date on the Adverse Benefit Determination.

4. DBH will continue the Enrollee's benefits during the Appeal process if the Enrollee
   A. The appeal must be filed within 60 calendar days from the date on DBH's Adverse Benefit Determination.
   B. DBH will continue the enrollee's benefits/services during the appeal and state hearing process if the enrollee files for timely continuation of benefits defined as on or before the later of the following:
      1. Within 10 days of DBH mailing the Adverse Benefit Determination

2. The intended effective date of DBH's proposed Adverse Benefit Determination

This only applies to enrollees requesting continuation of benefits for previously authorized services proposed to be terminated, suspended or reduced.

C. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.
D. The services were ordered by an authorized provider.
E. The period covered by the original authorization has not expired.

5. When an Enrollee or provider requests an expedited resolution of an Appeal, DBH will provide reasonable opportunity, and the Enrollee or provider will be notified of the limited time available, for the Enrollee or provider to present evidence, testimony and allegations of fact or law, in person or in writing. DBH will provide the Enrollee and his or her legally authorized representative an opportunity, before and during the appeals process, to examine the Enrollee's case file, including medical records, and any other documents and records, and any new or additional documents considered, relied upon, or generated by DBH in connection with the appeal. This information will be provided free of charge and sufficiently in advance of the appeals resolution timeframe.
   A. Include as parties to the Appeal the Enrollee and his or her representative; or
   B. The legal representative of a deceased Enrollee's estate.
6. Punitive action will not be taken against a provider who either requests an expedited resolution to an Appeal or supports an Enrollee's Appeal.
7. DBH will provide the Enrollee with any reasonable assistance in taking procedural steps. Reasonable assistance includes, but is not limited to, auxiliary aids & services upon request, providing interpreter services and toll-numbers that have adequate TTY/TTD and interpreter capability. From anywhere in Davis County, the Enrollee may call toll-free (801) 447-8887 and ask for the Grievance Officer. For TTY/TTD, the Enrollee may call 711 or call 1-888-346-3162 for Spanish. If an Enrollee needs interpreter services or other assistance, the Enrollee may contact any DBH facility or call the Grievance Officer at (801) 447- 8887 and request an interpreter or other assistance.
8. The Grievance Officer will provide an acknowledgment, either orally or in writing, of the receipt of the request for an expedited Appeal resolution and will explain to the Enrollee the process that will be followed to resolve the Appeal.
9. DBH will maintain complete records of all Appeals and submit semi-annual reports summarizing Appeals using Department-specified reporting templates. The DBH Grievance Officer will maintain documentation for appeals including, but not limited to:
   A. Written Adverse Benefit Determination

B. A log of all oral Appeals and oral requests for expedited resolution of appeals, including:

1. date of the oral requests
2. date of acknowledgment of oral requests for expedited resolution of appeals and method of acknowledgment (e.g., orally or in writing)
3. date of denials of requests for expedited Appeal resolution
4. date of attempt to give prompt oral notice of denial of request for expedited Appeal resolution

C. Copies of written standard or written expedited Appeal requests.

D. Copes of written notices of denial of requests for expedited Appeal resolution

E. Date and acknowledgement of written standard and written expedited Appeal requests and method of acknowledgment (eg orally or in writing)

F. Copies of written notices when extending the time frame for adjudicating standard or expedited Appeals when DBH initiates the extension.

G. Copies of written Notices of Appeal Resolution.

H. Name of the individual(s) who made the decision on an Appeal. If the Appeal is regarding a denial that is based on lack of medical necessity or involves clinical issues, the title and credentials of the individual(s) who made the decision on the Appeal to demonstrate that DBH ensures that they are individuals who 1) were not involved in any previous level of review or decision-making and 2) are health care professionals who have the appropriate clinical expertise, as determined by the Utah Department of Health, in treating the Enrollee's condition or disease

I. For standard or expedited Appeals not resolved within the required time frames, copies of Adverse Benefit Determination letters informing enrollees they may request a State Fair Hearing.

J. All other pertinent documentation needed to maintain a complete record of all Appeals and to demonstrate that Appeals were adjudicated according to contractual provisions governing Appeals.

10. Individuals who make the decision on appeal are individuals who:

A. Take into account all comments, documents, records, and other information submitted by the members or their representative without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination.

B. were not involved in any previous level of review or decision-making

C. if deciding on an Appeal of a denial that is based on lack of medical necessity or an Appeal that involves clinical issues, are health care professionals who have the appropriate clinical expertise in treating the Enrollee's condition or disease.

11. If DBH or the State Fair Hearing Officer reverses a decision to deny, limit, or delay services that are not furnished while the appeal is pending, DBH will authorize or provide the disputed service promptly, and as expeditiously as the enrollee's health condition requires. If the DBH or the State Fair Hearing Officer reverses a decision to deny authorization of services, and the enrollee receives the disputed services while the appeal is pending, DBH will pay for those services in accordance with State regulations.