DAVIS BEHAVIORAL HEALTH
Community · Commitment · Change

Policies & Procedures

STANDARD APPEALS

Section: Grievance Policies

Pages: 4

Subject: Standard Appeals

Effective Date: 1/2009

Revision Date: 08/19/2021

POLICY

DBH will maintain an appeals process whereby an Enrollee, his/her legally authorized representative (including the representative of a deceased enrollee's estate), or provider acting on behalf of the enrollee with the enrollee's written consent, may file an Appeal of an Adverse Benefit Determination:

PROCEDURE

1. An appeal may be filed either orally or in writing by either the enrollee, his/her legally authorized representative (including the representative of a deceased enrollee's estate), or a provider acting on behalf of the enrollee and with the enrollee's written consent.
    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:
        i. Within 10 days of DBH mailing the Adverse Benefit Determination

ii. 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.

2. Oral inquiries seeking to appeal an Adverse Benefit Determination are treated as an Appeal to establish the earliest possible filing date for the Appeal. Written, signed Appeals should be sent to the DBH Grievance Officer at 934 South Main Street Layton, UT 84041. If an Enrollee or his or her provider requests an Appeal orally, DBH will inform or remind the Enrollee or provider of the following:
   a. If the Enrollee wants a continuation of benefits when the decision is to terminate, suspend or reduce a previously authorized course of treatment, this must be requested.

3. DBH will give Enrollees any reasonable assistance in completing required forms for submitting a written Appeal or taking other procedural steps. Reasonable assistance includes, but is not limited to, auxiliary aids & services upon request, 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, 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.

4. Each Enrollee and his or her legally authorized representative who has filed an Appeal will be entitled to the following.
   a. An acknowledgement of the receipt of the Appeal (either orally or in writing by a form entitled "Notice of Receipt of Appeal") and an explanation of the process that will be followed to resolve the Appeal.

b. Reasonable opportunity to present evidence, testimony, and allegations of fact or law, in person as well as in writing. The enrollee will be informed of the limited time available for this sufficiently in advance of the resolution timeframe in case of expedited resolution.
c. An opportunity, before and during the appeals process, to examine the Enrollee's case file, including medical record, any other documents or record and any new or additional documents considered, relied upon or generated by DBH in connection with the appeal, will be considered during the appeals process:
    1. Include as partied to the Appeal the Enrollee and his or her representative; or
    2. The legal representative of a deceased Enrollee's estate.

    This information will be provided at no cost and sufficiently in advance of the appeal resolution time frame.

5. DBH will ensure that Individuals who make the decision on an Appeal (Standard or Expedited), see also Expedited Appeals policy) are individuals who
    a. Take into account all comments, documents, records and other information submitted by the enrollee 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.

6. If the Grievance Officer determines that the required Appeal time frame will not be met, the Enrollee will be mailed a Notice of Appeal Extension informing him/her that DBH will need another 14 days to make the decision and providing the reason for the delay.
7. DBH will maintain complete records of all Appeals and submit the 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:
        i. Date of the oral requests
        ii. Date of acknowledgment of oral requests for expedited

resolution of Appeals and method of acknowledgment (e.g. orally or in writing)

iii. Date of denials of requests for expedited appeal resolution
iv. 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. Copies 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 (e.g.,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 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.

8. 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 pendin, 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.