



MEDICAID RECIPIENT DUE PROCESS RIGHTS AND PRIOR APPROVAL POLICIES AND PROCEDURES

OBJECTIVES

- **Explain the importance of due process.**
- **Explain how due process impacts the prior approval/ prior authorization process.**
- **Explain how covered and non-covered state Medicaid plan services may be requested.**
- **Explain the Medicaid recipient appeal process.**

OUTLINE

- 1. Importance of Due Process.**
- 2. Types of PA Requests.**
- 3. Developing and Submitting the Request for PA.**
- 4. Reviewing the PA Request.**
- 5. Acting on the PA Request.**
- 6. Types of Notices, including Adverse Notices.**
- 7. Content of Notices.**
- 8. Mailing Notices.**
- 9. Authorizations During the Appeal Process.**
- 10. Changing Providers.**
- 11. Understanding the Appeal Process.**
- 12. Implementing the Final Agency Decision.**

IMPORTANCE OF DUE PROCESS

- **Medicaid recipients (or their *authorized* personal representatives) have the right to appeal adverse decisions of the State Medicaid agency and receive a fair hearing pursuant to the Social Security Act, 42 C.F.R. 431.200 *et seq.* and N.C.G.S. §108A-70.9.**
- **Medicaid recipients have a constitutional right to due process because Medicaid is an entitlement program.**
- **Due process means notice and an opportunity for a hearing when a Medicaid service is denied, reduced, terminated, or suspended.**

TYPES OF PRIOR APPROVAL (PA) REQUESTS

- ***Initial request*** means a request for a service that the recipient was not authorized to receive on the day immediately preceding the date of the utilization review (UR) vendor's receipt of the request.
- ***Reauthorization or continuing or concurrent request*** means a request for a service required to be authorized for that recipient on the day immediately preceding the date of the utilization review vendor's receipt of the request.

DEVELOPING THE REQUEST FOR PRIOR APPROVAL

- **It is the responsibility of the provider to document medical necessity.**
- **Requests for prior approval of Medicaid services should be fully documented by the provider and treating clinicians to demonstrate medical necessity.**
- **Providers are encouraged to supplement the information requested on prior approval forms and plan of care forms with other recent clinical information the provider believes will document medical necessity if the provider believes the information requested on the form is not sufficient to fully document medical necessity for the requested service.**
- **This additional documentation may include, but is not limited to, recent evaluation reports from clinicians, recent treatment records, and letters signed by treating clinicians which explain why the service is medically necessary.**

DEVELOPING THE REQUEST FOR PA (CONT.)

Requests MUST include the following minimum information in order to be reviewed for medical necessity:

- **Recipient's name and address, MID number, and date of birth**
- **Identification of service requested or procedure code**
- **Provider name/NPI/Provider number who is to perform service or procedure**
- **All required signatures on forms required by law**
- **Date the service is requested to begin or be performed**
- **Documents or forms required by state or federal statute**
- **Example: Session Law 2009-451, Section 10.68.A.(a)(7) mandates that a psychiatric assessment and discharge plan be submitted as part of any request for Child Level III and IV Residential Services.**

DEVELOPING THE REQUEST FOR PA (CONT.)

- **Requests that do not include this minimal information will be returned as unable to process.**
- **An unable to process notice will not include appeal rights.**

DEVELOPING THE REQUEST FOR PA (CONT.)

- **Providers must complete and submit requests for prior approval using forms and fields required by applicable clinical coverage policy and vendor, and must submit all necessary attachments (e.g., person centered plans, x-rays, etc.) for request to be considered complete.**
- **Requests that do not include minimum required clinical coverage information are incomplete.**
- **Such requests will not be reviewed for medical necessity and may be denied without first requesting additional information.**
- **Notice of Denial for an incomplete request will be sent and will include appeal rights.**

DEVELOPING THE REQUEST FOR PA (CONT.)

- **Early and Periodic Screening, Diagnosis and Treatment (EPSDT) entitles Medicaid recipients under the age of 21 to medically necessary screening, diagnostic and treatment services that are needed to “correct or ameliorate defects and physical and mental illnesses and conditions,” regardless of whether the requested service is covered in the N.C. State Plan for Medical Assistance.**
- **All requests for prior authorization for covered state plan services for children under the age of 21 will be reviewed under EPSDT by the appropriate vendor or DMA.**
- **All requests for PA for 1905(a) services that are not covered under the NC State Plan for Medical Assistance will be reviewed under EPSDT by DMA.**

DEVELOPING THE REQUEST FOR PA (CONT.)

- **For children under 21, the PA request should also include documentation to show how the service will correct or ameliorate a defect, physical or mental illness, or a condition [health problem] and meet all other EPSDT criteria.**
- **This includes:**
 - **documentation showing that policy criteria are met;**
 - **documentation to support that all EPSDT criteria are met; and**
 - **evidence-based literature to support the request, if available.**
- **EPSDT criteria are found on the EPSDT Provider Page at <http://www.ncdhhs.gov/dma/epsdt/> and will be covered in the EPSDT training.**
Basic criteria include:
 - **Must be determined to be medical in nature.**
 - **Must be generally recognized as an accepted method of medical practice or treatment.**
 - **Must not be experimental or investigational.**
 - **Must be safe.**
 - **Must be effective.**

DEVELOPING THE REQUEST FOR PA (CONT.)

- **UR vendors will fully comply with EPSDT (or refer to DMA staff for EPSDT review if consistent with their contract).**
- **UR vendors will review requests for services for Community Alternatives Program (CAP) waiver recipients under 21 years of age using EPSDT criteria if the service in question can be covered under EPSDT. EPSDT covers diagnostic, screening, preventive and rehabilitative services and other treatment but does not cover habilitative services.**

**REQUESTING NON-COVERED SERVICES FOR RECIPIENTS
UNDER 21 YEARS OF AGE**

- **Providers may submit a Non-Covered Services Request for Recipients under 21 Years of Age form on behalf of the recipient to:**

**Assistant Director for Clinical Policy and Programs
Division of Medical Assistance
2501 Mail Service Center
Raleigh, NC 27699-2501
FAX: 919-715-7679**

- **The Non-Covered State Medicaid Plan Services for Recipients under 21 Years of Age Request form may be found on DMA's website at:**

<http://www.ncdhhs.gov/dma/epsdt/>

DEVELOPING THE REQUEST FOR PA (CONT.)

- **For more information, see the medical (clinical) coverage policies, the PA website, and the PA section of the Basic Medicaid Billing Guide on DMA's website at:**
 - **Policies:** <http://www.ncdhhs.gov/dma>
 - **Prior Approval:**
<http://www.ncdhhs.gov/dma/provider/priorapproval.htm>
 - **Guide:** <http://www.ncdhhs.gov/dma/basicmed/>

SUBMITTING THE REQUEST FOR PRIOR APPROVAL

- **All requests for prior approval must be submitted electronically, via facsimile or, in instances where such transmittal is not possible, via U.S. mail or hand delivery to the appropriate vendor.**
- **It is the provider's responsibility to maintain documentation evidencing the date the request was made.**
- **Requests submitted to the wrong vendor will be forwarded to the appropriate vendor if there is enough information on the request to do so. Sending requests to the wrong vendor may delay the decision.**

REVIEWING THE REQUEST FOR PA (CONT.)

- UR Vendors will consider all relevant information that is submitted in addition to the information provided on required forms and in required fields, regardless of whether the additional information is included on a particular form.
- UR Vendors will make individualized medical necessity decisions based on the individual representations of each prior authorization request and the applicable law and policy, will use publicly available utilization review and best practice guidelines, and will allow case-by-case exceptions to those guidelines and policies as required by EPSDT. For more information on the best practice guidelines used by DMA's Vendors refer to <http://www.ncdhhs.gov/dma/provider/priorapproval.htm>.

REVIEWING THE REQUEST FOR PA (CONT.)

- **Prior to the decision on a request for prior approval, contacts with the requesting provider or recipient (including telephone and email contacts) will be limited to those needed to obtain more information about the service request and/or to provide education about Medicaid-covered services.**
- **Providers and recipients will not be asked to withdraw or modify a request for prior approval of Medicaid services in order to accept a lesser number of hours, or less intensive type of service, or to modify a SNAP score or other clinical assessment discussions.**

REVIEWING THE REQUEST FOR PA (CONT.)

- **Material misinformation to or intimidation of providers or recipients that has the foreseeable effect of significantly discouraging requests for Medicaid services, continuation of Medicaid services, or the filing or prosecution of OAH appeals is prohibited.**
- **These requirements should not be construed to prevent clinical or treatment discussions.**
- **UR Vendors will read from a script at the outset of any verbal contact with a provider or recipient in connection with a request for prior approval.**

VENDOR SCRIPT

- *When speaking with Providers:*

“We have received a prior authorization request for [NAME OF RECIPIENT] and would like to discuss it with you. Nothing in this conversation is intended to discourage you from continuing with the request you have submitted. Your patient has the right to a written notice and a hearing if we deny the request and to authorization for payment for services during the appeal process if this request involves a service your patient is currently receiving. I cannot ask you to withdraw the request you have submitted or to modify the request to accept a lower amount, level, or type of service. I am calling because, at this time, we do not have enough information to approve this request. If you have additional information that you have not submitted that you think would support your request, please tell me about it now.”

VENDOR SCRIPT

- **When speaking with Recipients:**

“We have received a prior authorization request submitted on your behalf and would like to discuss it with you. Nothing in this conversation is intended to discourage you from continuing with the request you submitted. You have the right to a written notice and a hearing if we deny the request and to authorization for payment for services during the appeal process if this request involves a service you are currently receiving. I cannot ask you to withdraw the request you have submitted or to modify the request to accept a lower amount, level, or type of service. I am calling because, at this time, we do not have enough information to approve this request. If you or your provider has additional information that has not been submitted that you think would support your request, please tell me about it now.”

REVIEWING THE REQUEST FOR PA (CONT.)

COMPLETE REQUEST

- **Contains the minimum requirements specified in the applicable clinical coverage policy. That is, the request includes documentation or clinical information specifically required by the applicable clinical coverage policy such as a person centered plan or x-ray, etc.**
- **Will be reviewed for medical necessity.**
- **Appeal rights apply.**

INCOMPLETE REQUEST

- **Does *not* contain the minimum requirements specified in the applicable clinical coverage policy.**
- ***Cannot* be reviewed for medical necessity because minimum policy requirements were missing.**
- **Notice of Denial will be issued.**
- **Appeal rights apply.**

REVIEWING THE REQUEST FOR PA (CONT.)

Examples of Incomplete Requests:

- PCP missing or required signature on PCP missing
- Required credentials not included with signature
- Checked boxes not checked
- Signatures without dates
- Required discharge plan missing
- SOC (Systems of Care Coordinator) signature missing
- Risk assessment missing
- Change of provider request without required attestation

ADDITIONAL INFORMATION

- **Even though a request was complete, new or additional information, at the discretion of the UR vendor, may be needed to make a decision on the request. The provider will be notified in writing or verbally if additional information is required.**

If requesting additional information verbally:

- The caller will read a statement indicating that additional information is being requested verbally and that this is not an attempt to have the provider withdraw or modify the request but an opportunity to provide needed information.
- Most often, additional information requested verbally can be provided verbally at the time of the call.

ADDITIONAL INFORMATION (CONT.)

- **If additional information is requested in writing or electronically, the provider will be allowed 10 business days from the date of the request to submit the additional information.**
- **If the provider fails to respond, an adverse notice must be issued that will contain appeal rights.**
- **DMA staff and vendors/contractors must act upon the written request within 15 business days of receipt of the additional information, unless there is a more stringent requirement.**

REAUTHORIZATION REQUESTS

- **NEW REQUIREMENT: Must request re-authorization or continuation of services at least 10 calendar days *PRIOR* to the end of the current authorization period in order for services to continue without interruption.**
- **If request is submitted at least 10 calendar days before end of current authorization period but the vendor does not make a decision prior to the end of the current authorization period, retroactive authorization will be entered when the vendor makes a decision on the request.**

Note: Does not apply to unable to process requests. In other words, unable to process requests will not serve as a “placeholder” for purposes of the 10-day requirement.

Exception: Requests for CAP, inpatient or emergent services are not subject to the 10 day calendar requirement. Requests must be submitted in accordance with current policy. If submitted prior to the expiration of the authorization period, services continue without interruption.

REAUTHORIZATION REQUESTS (CONT.)

- **Providers should continue to provide services beyond the end of the authorization period if reauthorization was timely requested.**
- **Providers will be paid for services provided when the authorization request is submitted timely as specified by these instructions.**
- **If a vendor fails to authorize services as specified by these instructions, please contact the DMA Appeals Unit at 919-855-4260.**

REAUTHORIZATION REQUESTS (CONT.)

- **If the provider does not request reauthorization of a service at least 10 calendar days prior to the end of the current authorization period, there may be a break in authorization.**

***EXAMPLE:* Recipient is authorized to receive 8 units of a service each week beginning on June 1 through August 30. If the provider believes that it is medically necessary for the service to continue beyond August 30, the request for prior approval must be submitted no later than 10 calendar days prior to August 30 in order for services to continue without interruption**

REAUTHORIZATION REQUESTS (CONT.)

- **If the provider submits the request at least 10 calendar days prior to the end of the current authorization period and the request is *APPROVED*, there must be no break in service and the service must be authorized beginning on the first day after the end of the authorization period.**

***EXAMPLE:* Recipient is authorized to receive 8 units of a service each week beginning on June 1 through August 30. Request for prior approval of 8 units per week of service for an additional 90 days is submitted on August 15. UR vendor reviews and issues decision approving the request on September 4. Authorization for 8 units per week will be entered into the system retroactive to September 1.**

REAUTHORIZATION REQUESTS (CONT.)

- **Requests for prior approval to continue authorization of a service the recipient is currently receiving that are received *LESS* than 10 calendar days prior to the end of the authorization period will, if possible, be processed within the UR Vendor's required turnaround time according to the vendor's contract, and if *APPROVED*, will be authorized beginning on the date of the decision. Authorization will *NOT* be backdated to account for late requests unless the exception in slide 25 (for CAP, inpatient, and emergent services) applies.**

EXAMPLE: Recipient is authorized to receive 8 units of a service each week beginning on June 1-August 30. Request for prior approval of 8 units per week of service for an additional 90 days is submitted on August 28. UR Vendor reviews and issues decision approving the request on September 4. Authorization for 8 units per week will be entered into the system on September 4 for 90 days and the service will not be authorized from September 1 – 3.

REAUTHORIZATION REQUESTS (CONT.)

- **If provider submitted request at least 10 calendar days prior to end of current authorization period and request is *DENIED* or *REDUCED*, effective date of change in services shall be no sooner than 10 days after date notice is mailed.**

***EXAMPLE:* Recipient is authorized to receive 8 units of a service each week beginning on June 1 through August 30. Request for prior approval of 8 units per week of service for an additional 90 days is submitted on August 15. UR vendor reviews, asks for additional information and issues decision denying the request on September 4. Authorization for 8 units per week will be entered into the system effective retroactive to September 1 through September 14 (10 days from the date of the notice).**

REAUTHORIZATION REQUESTS (CONT.)

- **Requests for prior approval to continue authorization of a service recipient is currently receiving that are received *LESS* than 10 calendar days prior to the end of the authorization period, *if DENIED OR REDUCED*, authorization at prior level of service will be entered for 10 days beginning date of decision. If recipient files timely appeal, authorization will continue through the appeal period. There is no retroactive authorization unless the exception in slide 25 (for CAP, inpatient or emergent services) applies.**
- (Example on next slide.)

REAUTHORIZATION REQUESTS (CONT.)

EXAMPLE: Recipient is authorized to receive 8 units of a service each week beginning on June 1 through August 30. Request for prior approval of 8 units per week of service for an additional 90 days is submitted on August 28. UR Vendor reviews and issues decision authorizing 4 units per week on September 4. Authorization for 8 units per week will be entered into the system effective September 4 for 10 days, and authorization for 4 units per week for 90 days will be entered effective September 15. If an appeal is requested within 10 calendar days of the decision, authorization for 8 units must continue without further interruption. If an appeal is requested more than 10 calendar days after the date of the notice but within 30 days, MOS must be entered at 8 units per month effective with the date of the appeal and continuing until there is a final agency decision. The service will not be authorized from September 1 – 3.

REAUTHORIZATION REQUESTS (CONT.)

- **If UR vendor cannot issue a decision within 15 business days on a request to *CONTINUE* authorization of a service, on day 16 the UR vendor must enter authorization for the service to continue at the prior level until the effective date of its decision on the request. This applies as long as the request was submitted before the authorization period expired.**
- ***EXAMPLE:* Recipient is authorized to receive 8 units of a service each week beginning on June 1 through August 30. Request for prior approval of 8 units per week of service for an additional 90 days is submitted on August 27. UR Vendor reviews but is unable to issue decision on the request by September 20, which is the 15th business day after August 27. Authorization for 8 units per week will be entered into the system on September 21 to continue until 10 days after a decision is issued on the request. The service will not be authorized from September 1 – 20.**

REAUTHORIZATION REQUESTS (CONT.)

- **If the request is submitted MORE THAN ONE DAY after the end of the current authorization period, the request will be treated as an initial request.**

REAUTHORIZATION REQUESTS (CONT.)

EXAMPLE: 20 hours per month of a service authorized through May 31.

Provider requests reauthorization of 20 hours per month on June 2. The UR Vendor will treat the request for services as an initial request:

- If the UR Vendor approves the re-authorization request, payment for service stops on May 31. Authorization resumes effective the date of the notice because re-authorization was not requested prior to the end of the current authorization period.
- If the UR Vendor reduces the re-authorization request, payment for service stops on May 31. Authorization for the service at the new level will begin effective the date of the notice, and payment will be made at the amount approved by the UR Vendor. If an appeal is requested, services are authorized at the new level pending appeal because re-authorization was not requested prior to the end of the current authorization period.
- If the UR Vendor denies the re-authorization request, payment for service stops on May 31. There is no authorization for services pending appeal because re-authorization was not requested prior to the end of the current authorization period.

REAUTHORIZATION REQUESTS (CONT.)

- **Providers should continue to provide services at the prior level beyond the end of the authorization period if the provider timely requested reauthorization even though there may be a delay of up to 15 business days after the request was submitted before the UR vendor enters authorization into the system.**
- **A provider who provides documentation that a request for reauthorization was timely and properly requested shall be entitled to seek correction of the authorization from DMA if the UR vendor fails to properly authorize continuation of services.**

ACTING UPON A REQUEST

- **DMA staff and vendors or contractors must act upon a request no later than 15 business days of receipt of the request, unless there is a more stringent requirement.**
 - Acting upon a request means:
 - Approving the request
 - Denying an initial request
 - Reducing/terminating a continuing or concurrent request
 - Requesting additional information
- **An emergent request must be reviewed and acted upon within two business days of receipt of the request, unless there is a more stringent requirement. For example, a vendor is required to issue a decision on a request for mental health crisis services within four hours of the request (i.e. when patient suicidal).**

VERBAL REQUEST

- **When a proper request for prior approval may be made verbally and it can be approved, the caller will be notified that the request for prior approval:**
 - is approved effective the date of the call contingent upon receipt of a written request matching the verbal request within 10 business days of the call, unless there is a more stringent requirement; and
 - will be denied if the written request is not received within 10 business days of the call, unless there is a more stringent requirement, or if the written request does not match the verbal request.

EXAMPLE: FL-2 Level of Care requests

TYPES OF NOTICES

- **Unable to Process Notice**
- **Notice of Approval of Service Request**
- **Notice of Receipt of Duplicate Request**
- **Notice of Prior Approval when Request Exceeds Policy Maximum (Adults Only)**
- **Notice of Denial or Change Notice for Incomplete Request**
- **Notice of Denial of Initial Request**
- **Notice of Change in Services**

TYPES OF NOTICES

Appeal Rights Not Included

- Unable to Process Notice

This notice is mailed or electronically transmitted to the provider and/or recipient when a request is received that lacks required information necessary for the UR vendor to recognize and process it as a request for prior approval.

TYPES OF NOTICES

Appeal Rights Not Included (CONT.)

- Notice of Approval of Service Request

This notice is mailed or electronically transmitted to the provider and/or recipient when DMA or the UR Vendor has approved a covered service for a recipient or a non-covered state Medicaid plan service for a recipient under 21 years of age.

TYPES OF NOTICES

Appeal Rights Not Included (CONT.)

- Notice of Receipt of Duplicate Request

This notice is mailed or electronically transmitted to the provider when an identical or duplicate request for service has been received and the time limit to appeal an earlier adverse decision has not expired.

- **Example 1: Two different providers submit identical requests for the same recipient.**
- **Example 2: A provider submits a request for a recipient and then submits an identical request before the vendor has acted on the first request or while an appeal period is still pending for the first request.**

TYPES OF NOTICES

- **Notice Asking for Additional Information**

This notice is mailed or electronically transmitted to the provider requesting new or additional information at the discretion of the UR vendor. The provider is asked to respond by submitting the needed information within 10 business days of the date of the notice. If the provider fails to respond, an adverse notice with appeal rights must be issued.

TYPES OF NOTICES

- Notice of Prior Approval when Request Exceeds Policy Maximum
This notice is mailed or electronically transmitted to the provider when a request that exceeds policy limits has been received for a recipient 21 years of age and older and approved at policy limit based on medical necessity. The notice educates provider about policy limits and reminds provider that all requests must be submitted in accordance with policy requirements.

NOTE: If recipient is over 21 years of age and request is approved at:

- **Policy Limit:** Notice issued without appeal rights via trackable mail.
- **Below Policy Limit:** Notice issued with appeal rights via trackable mail.

If recipient is under 21 years of age, request must be reviewed under EPSDT and an adverse decision with appeal rights issued even if approved at policy limit.

TYPES OF NOTICES

Appeal Rights Included (CONT.)

- Notice of Denial or Change Notice for Incomplete Request

This notice is mailed by trackable mail to the recipient and first class mail to the provider when an incomplete request is submitted for review.

***EXAMPLE:* The provider submits a request that is able to be processed, but fails to include a copy of the X-ray (or other document) required by the applicable clinical coverage policy. The request will be denied without further review and will identify any missing information, but the provider will not be reminded to submit additional information in any subsequent notice.**

TYPES OF NOTICES

Appeal Rights Included (CONT.)

- Notice of Denial of Initial Request

This notice is mailed by trackable mail to the recipient and first class mail to the provider when an adverse decision is made on a request for authorization for payment for a service that recipient was not authorized to receive on day immediately preceding date of request. A recipient who appeals a denial of an initial request is not entitled to maintenance of service during the appeal period.

***EXAMPLE:* Recipient was authorized to receive 8 units/week of service for which authorization ended July 31. On August 2, provider submits request for 8 units of service per week to continue for 90 more days. If the request is denied, recipient will NOT be entitled to maintenance of service because it was an initial request (the previous authorization had expired).**

TYPES OF NOTICES

Appeal Rights Included (CONT.)

- Notice of Change in Services
 - **This notice is mailed by trackable mail to the recipient and first class mail to the provider when an adverse decision is made on a request for authorization for payment for a service recipient was authorized to receive on day immediately preceding date of request (i.e. a continuing or concurrent request).**
 - **Effective date of change shall be no sooner than 10 days after date notice is mailed.**
 - **If a lower level or amount of the requested service is approved, beginning date for this service is same date as notice's effective date (10 days after mailing).**
 - **Maintenance of Service (MOS) applies to requests for reauthorization if an appeal of a change in services is timely filed. (MOS) means the continuation of authorization during the appeal period when a recipient appeals a decision to reduce or terminate a Medicaid covered service that was authorized on the day immediately preceding the date of the request for PA.**
 - **If a decision both denies authorization for a new service and changes authorization for an existing service, the UR vendor shall either issue a Change Notice or shall issue both a Change Notice and an Initial Denial Notice.**

CONTENT OF NOTICES

- **If a recipient's service is denied, reduced, or terminated, the recipient or the recipient's legal guardian (if under 18 or adjudicated incompetent) must receive written explanation that clearly identifies decision taken on each service requested and a reasonable explanation of decision.**
- *A statement that medical necessity was not met or the EPSDT standard was not met is not a sufficient explanation.*
- **UR vendors must properly complete all fields in Notice Templates.**

CONTENT OF NOTICES (CONT.)

- **Notices must include:**

- The requested service, frequency, and time periods for which each service was requested and approved or denied/ reduced/ terminated;
- The effective date (initial and continuing or concurrent request);
- The legal authority supporting the decision in that case;
- A correct webpage where legal authority may be found;
 - Federal or state law
 - Federal or state rules
 - (CAP) Waivers or Manuals
 - Medical (Clinical) Coverage Policies
 - State Medicaid Plan
- For children under 21, a statement that an EPSDT review occurred and a reasonable explanation of why the EPSDT standard was not met or was not applicable; and
- A telephone number of a contact person who can answer questions about the reasons for the decision in this case.

CONTENT OF NOTICES (CONT.)

- **UR vendors will not identify or offer any alternative services in adverse notices, including but not limited to evaluations, team meetings, or non-Medicaid covered services.**
- **If an Unable to Process Notice or Notice of Denial for Incomplete Request is issued, the notice will identify what information was missing from the request.**

MAILING NOTICES

- **The recipient or parent or legal guardian shall be notified in writing of an adverse decision and right to appeal. Notice shall be mailed on date indicated on notice as date of decision.**
- **UR vendors shall establish a mail cutoff time after which notices shall be dated the following business day.**
- **Effective dates of adverse notices are indicated below.**
 - **Initial Request** (services were not required to be authorized on the day immediately preceding the request for reauthorization): later of the requested start date or the date the notice is mailed
 - **Continuing Request** (services were required to be authorized on the day immediately preceding the request for reauthorization): at least 10 calendar days after the date the notice was mailed.

MAILING NOTICES (CONT.)

- **Notices shall be mailed to the last known address given by the recipient or his/her legal guardian to the county Department of Social Services or the U.S. Social Security Administration (for SSI recipients), as provided to the UR vendor by DMA.**

It is the responsibility of the recipient and/or his/her legal guardian to update this address.

- **If the notice is returned undelivered and it was properly addressed to the latest address on file in EIS/ NC FAST/ SSI, a copy of the notice shall be forwarded to the Department of Social Services office associated with the last address on file in EIS so that DSS can take appropriate action.**

MAILING NOTICES (CONT.)

- **For recipients under 18 years of age or for recipients who have been adjudicated incompetent, notices shall be mailed to the provider and the parent or guardian listed in the North Carolina Eligibility Information System/ NC FAST/ SSI Database. If any recipient or parent/ guardian notifies Medicaid that the recipient's notice was not received, a duplicate notice will be issued.**
- **Any recipient who believes he or she did not receive notice of a decision on a request for prior approval should contact the CARE-LINE Information and Referral Service at 1-800-662-7030 (English/Spanish) or 1-877-452-2514. (Note: this is a TTY number that is only answered for deaf or hearing impaired callers). The CARE-LINE is open from 8:00 a.m. until 5:00 p.m., Monday - Friday.**
- **Duplicate copies of notices may also be obtained by calling the UR Vendor or the DMA Appeals Unit at 919-855-4260.**

MAILING NOTICES (CONT.)

- **Should the notice have been addressed to the wrong person or address, or for some other error made by the UR Vendor or DMA, a new notice with an updated date MUST be issued.**
- **Should the notice have been properly addressed to the right person at the latest address on file in EIS/ NC FAST/ SSI, a new notice will be issued upon request by the recipient or his/her legal guardian, but the date will not be updated.**

MEDICAID RECIPIENT APPEAL REQUEST FORM

- **Prior to mailing, the UR Vendor shall complete the top portion (header) of the hearing request form, the recipient's name, address, Medicaid identification number, and identification of the service about which an adverse decision was made.**
- **The hearing request form and the hearing instructions and information sheet must be enclosed in the recipient's notice.**
- **The provider will receive a copy of the adverse notice only.**
- **The appeal request form shall be a one page stand-alone form, and it cannot be duplexed.**

APPEALING THE DECISION

- **Recipient and/or legal guardian must:**
 - Request a hearing within 30 days of the date of the notice was mailed.
 - Send the request by U.S. mail, e-mail or facsimile to the Office of Administrative Hearings (OAH). The statute also requires that a copy be sent to the Department of Health and Human Services (DHHS).

OAH

Clerk of Court

Medicaid Recipient Appeals

6714 Mail Service Center

Raleigh, NC 27699-6714

FAX: 919-431-3100

Office #: 919-431-3000

oah.clerks@oah.nc.gov

DHHS

Medicaid Recipient Appeals

2501 Mail Service Center

Raleigh, NC 27699-2501

FAX: 919-733-2796

Office #: 919-855-4260

- **Providers may not file appeals on behalf of recipients unless the recipient lists the provider as the representative on the appeal request form.**

QUESTIONS ABOUT THE ADVERSE DECISION OR APPEAL PROCESS

- **DMA and the UR Vendor may provide answers about the decision or the appeal process or may refer questions about the appeal process to the Office of Administrative Hearings (OAH) at 919-431-3000. If you need to know if a recipient you provide services to has filed an appeal, OAH will not provide this information unless you are identified as the personal representative on the appeal request form.**
- **For questions regarding legal assistance, please refer the recipient to Legal Aid of North Carolina at 919-856-2564 or toll-free at 1-866-369-6923.**
- **Recipients with disabilities should be referred to Disability Rights of North Carolina at 1-877-235-4210.**

AUTHORIZATIONS DURING THE APPEAL PROCESS

- **Within five (5) business days after the UR vendor is notified of the filing of a Hearing Request with OAH that occurs within 10 calendar days after the date the Change Notice is mailed, MOS authorization in the computer system must be entered beginning with the effective date of the decision and authorization at the prior level of service (or the amount requested if less) must continue without interruption until the UR Vendor is notified that the appeal has been resolved, either through mediation, dismissal, or a final agency decision, as long as the recipient does not give up this right and as long as he/she remains otherwise eligible for the service and the Medicaid program. This right exists regardless of whether the provider submitted the reauthorization request 10 days before the end of the authorization period so long as the request was made by the end of the authorization period.**
- (Examples on next slide.)

AUTHORIZATIONS DURING THE APPEAL PROCESS (CONT.)

- ***EXAMPLE 1:*** Recipient was authorized to receive 8 units per week of a service for which the authorization ended on July 31. On July 31, the provider submits a request for 8 units of the service per week to continue for 90 more days. The request is denied in a change notice dated August 10 to be effective August 20. The recipient appeals on August 20. The UR vendor must enter MOS authorization within 5 business days for 8 units per week effective August 20, the effective date of the change notice.
- ***EXAMPLE 2:*** Recipient was authorized to receive 8 units per week of a service for which the authorization ended on July 31. On July 20, the provider submits a request for 8 units of the service per week to continue for 90 more days. The request is denied in a change notice dated August 3 and authorization is entered for August 1 through August 13. The recipient appeals on August 13. The UR vendor must enter MOS authorization within 5 business days for 8 units per week effective August 13, the effective date of the change notice.

AUTHORIZATIONS DURING THE APPEAL PROCESS (CONT.)

- **Within five (5) business days after the UR Vendor is notified of the filing of a Hearing Request with OAH that occurs more than 10 calendar days but within 30 calendar days of the date the Change Notice is mailed, authorization for payment must be reinstated, retroactive to the date the completed appeal request form is received by the OAH. Authorization for payment must be at the level required to be authorized on the day immediately preceding the adverse determination or the level requested by the provider, whichever is less.**
- (Examples on next slide.)

AUTHORIZATIONS DURING THE APPEAL PROCESS (CONT.)

- ***EXAMPLE 1:*** Recipient was authorized to receive 8 units per week of a service for which the authorization ended on July 31. On July 31, the provider submits a request for 8 units of the service per week to continue for 90 more days. The request is denied in a change notice dated August 10 to be effective August 20. The recipient appeals on August 31. The UR vendor must enter MOS authorization for 8 units per week effective August 31, the date of the appeal request.
- ***EXAMPLE 2:*** Recipient was authorized to receive 8 units per week of a service for which the authorization ended on July 31. On July 20, the provider submits a request for 8 units of the service per week to continue for 90 more days. The request is denied in a change notice dated August 3 and authorization is entered for August 1 through August 13. The recipient appeals on August 25. The UR vendor must enter MOS authorization within 5 business days for 8 units per week effective August 25, the date of the appeal request.

AUTHORIZATIONS DURING THE APPEAL PROCESS (CONT.)

Maintenance of Service (MOS) will not apply in the following situations:

- **Initial Requests**
- **Continuing requests where the recipient and/or legal representative filed an appeal more than 30 days after the date of the notice.**

CHANGING PROVIDERS

For Medicaid recipients who:

- have appealed an adverse decision, or
- whose provider agency is going out of business, or
- have changed providers for CAP services or
- are changing providers for another service with an authorization period of six months or more,

the current authorization for services will transfer to the new provider within five (5) business days of notification by the new provider to the appropriate UR vendor and upon submission of written attestation that provision of the service meets Medicaid policy and the recipient's condition meets coverage criteria and acceptance of all associated responsibility; and either

- Written permission of recipient or legal guardian for transfer; or
- Copy of discharge from previous provider .

CHANGING PROVIDERS (CONT.)

- **Authorization will transfer/ be effective the date the new provider submits a copy of the written attestation.**
- **Following the appeal or prior to the end of the current authorization period, the new provider must submit a request for reauthorization of the service in accordance with the medical (clinical) coverage policy requirements and these procedures.**
- **Medicaid recipients may change providers at any time. In all other situations where a recipient changes providers, the new provider will be required to submit a new request for authorization. The existing authorization will not transfer and the discharging provider and the new provider must follow all policy requirements and these procedures.**

UNDERSTANDING THE FAIR HEARING (APPEAL) PROCESS

- **Fair Hearing Process (OAH and Final Agency Decisions)—** must be completed in 90 days from the date hearing request received by OAH. There is a new law that governs Medicaid appeals in North Carolina: **G.S. 108A-70.9A.**

Three Phases

- **Mediation (voluntary)**—completed within 25 days of receipt of hearing request by OAH
- **OAH Proceeding**—completed within 55 days of receipt of hearing request by OAH
- **Final Agency Decision**—completed within 20 days of receipt of case from OAH

UNDERSTANDING THE APPEAL PROCESS

Mediation:

- Informal process to explore options for a mutually acceptable resolution to the recipient's appeal.
- Voluntary and may be accepted or declined by the recipient.
- Free and may resolve the case more quickly than a fair hearing.
- Case referred to the Mediation Network of North Carolina.

UNDERSTANDING THE APPEAL PROCESS (CONT.)

- **The recipient will be contacted by the mediator within five days of receipt of case from OAH.**
- **The mediator serves as a neutral party whose role is to guide the mediation process, facilitate communication, and assist the parties to generate and evaluate possible outcomes.**
- **The recipient may invite anyone to participate in the mediation as long as all parties involved in the mediation agree.**

UNDERSTANDING THE APPEAL PROCESS (CONT.)

- **The recipient and their representatives may participate in person or by telephone. Medicaid staff/vendors participate by phone. If the recipient is represented by an attorney, DMA may ask an attorney from the AG's Office to participate.**
- **New evidence may be presented at the mediation that has not been seen or heard by the Medicaid agency before. Medicaid representatives may need a recess to review and respond to the new information.**

UNDERSTANDING THE APPEAL PROCESS (CONT.)

- **The UR vendor represents Medicaid in the mediation process.**
- **The UR vendor shall not exceed its authority in negotiating a settlement, and shall not provide material misinformation to recipient(s) or mediator(s). Examples: The UR vendor shall not ask the recipient or provider to withdraw or modify a request, or threaten sanctions against a provider, or state that a provider will be required to pay for services if the recipient loses the appeal.**
- **Providers who participate in mediations as the properly designated personal representative of a recipient shall not provide material misinformation to agency staff or mediator(s).**

UNDERSTANDING THE APPEAL PROCESS (CONT.)

- **The recipient does not have to accept any offer made during mediation.**
- **If recipient agrees to mediation and if mediation resolves the case, the appeal will be dismissed, and services will be provided as agreed to during the mediation.**
- **Mediation must be completed within 25 days of receipt of appeal request by OAH.**
- *Mediation is confidential and legally binding. Example: Provider attended mediation as personal representative without parent of recipient. Provider reached binding mediation agreement, but parent was later unhappy with the settlement. OAH found that the mediation was legally binding.*

UNDERSTANDING THE APPEAL PROCESS (CONT.)

- **If the recipient does not accept the offer of mediation or if the mediation does not succeed and the recipient still wishes to proceed with a hearing, the case will be scheduled for hearing.**
- **Mediator must report to OAH that the case was not resolved, recipient rejected the offer of mediation, or recipient failed to appear.**
- **OAH will not hold a hearing until the recipient has been given an opportunity to resolve the case through mediation, but recipients are not required to participate in mediation.** *(Completed within 55 days of receipt of hearing request by OAH and includes 25 days for mediation)*

UNDERSTANDING THE APPEAL PROCESS (CONT.)

- **The hearing will be held by an administrative law judge (ALJ).**
- **Recipient may represent himself/herself or may hire an attorney or use a legal aid attorney, or ask a relative, friend, or other spokesperson (including provider or case manager) to speak for them.**
- **The Department will be represented by an Assistant Attorney General.**

UNDERSTANDING THE APPEAL PROCESS (CONT.)

Settlements after mediation or on the day of the hearing:

- Even if the recipient and the UR Vendor cannot reach an agreement at the mediation, recipients can still reach a settlement of their appeal prior to hearing or on the day of the scheduled hearing.
- If the recipient has new medical evidence to present at the hearing, let the Assistant Attorney General assigned to the case know.
- The AAG and/or the UR Vendor may talk to the recipient or the recipient's personal representative about settlement options.
- When a settlement agreement is reached outside of mediation or hearing, the terms of the settlement will be put in writing by the UR Vendor, including the service, level of service approved, effective date, end date, provider, billing code, if known/if needed, and a statement specifying why the agreed upon service, amount, or frequency is medically necessary.
- The UR Vendors have contractual deadlines in which to enter the agreed-upon authorization into the system.

UNDERSTANDING THE APPEAL PROCESS (CONT.)

- **The recipient or personal representative will be notified in advance of the day and time of the hearing.**
- **Continuances will not be granted on the day of the hearing except for good cause, which is not defined in the Medicaid appeals law. The ALJ decides what constitutes good cause.**
- **If the hearing is properly noticed by OAH and the petitioner (recipient) fails to make an appearance, the hearing will be IMMEDIATELY DISMISSED unless the recipient presents good cause explaining why they failed to appear for the hearing within three business days of the date of the dismissal.**

UNDERSTANDING THE APPEAL PROCESS (CONT.)

- **The hearing will be held by telephone unless the recipient specifically requests an in-person or videoconference hearing.**
- **If the recipient chooses a telephone hearing, OAH can call the recipient's witnesses and representative at different telephone numbers to participate in the hearing. Even if the recipient has an in person hearing, he/she can ask that a witness such as their physician participate by telephone.**
- **To have a videoconference hearing, the recipient must have access to a computer with a camera and videoconference software (such as Skype).**
- **The recipient can request an in-person hearing in their county of residence even if they filed the appeal form asking for a telephone hearing. To do so, the recipient needs to contact OAH.**

UNDERSTANDING THE APPEAL PROCESS (CONT.)

- ❖ **An in-person hearing will be held at OAH in Wake County (Raleigh) unless the recipient can show good cause why he/she cannot come to Wake County for the hearing. (Good cause includes, but is not limited to, the recipient's impairments limiting travel or the unavailability of the recipient's treating professional witnesses.) The ALJ will make the determination regarding good cause.**
- **If a hearing is held outside of Raleigh, it will be held at one of the OAH sites listed below that is closest to the recipient's county of residence.**
 - **Newton/Asheville**
 - **Charlotte**
 - **High Point**
 - **Fayetteville**
 - **Wilmington**
 - **Elizabeth City/Halifax**
 - **New Bern**

UNDERSTANDING THE APPEAL PROCESS (CONT.)

- **Burden of Proof**
 - ***Initial Request:*** Petitioner has burden of proof to show entitlement to requested benefit or service when request denied.
 - ***Continuing or Concurrent Request:*** Medicaid has burden of proof when decision is to reduce, terminate, or suspend previously requested benefit or service.

UNDERSTANDING THE APPEAL PROCESS (CONT.)

- **The recipient may present new evidence at the hearing. This includes medical records and written reports (even if obtained after Medicaid made its decision), testimony from physicians and other providers about why the recipient needs the service, and testimony by family and friends.**
- **If new evidence is submitted at the hearing that Medicaid has not reviewed, Medicaid may request additional time for review.**
- **The administrative law judge shall continue or recess the hearing for a minimum of 15 days and a maximum of 30 days to allow for Medicaid's review.**

UNDERSTANDING THE APPEAL PROCESS (CONT.)

- **The recipient has a right to review all of the documents in Medicaid's file about his/her case before the hearing date.**
- **The AAG will mail all documents that DMA intends to use at the hearing to the recipient or personal representative before the hearing.**
- **Copies of the case file will be provided to the AAG by the UR Vendor in advance of the hearing so that they can be mailed by trackable mail to the recipient if requested.**

UNDERSTANDING THE APPEAL PROCESS (CONT.)

- **Two or more DHHS witnesses will testify at the hearing.**
 - The Medicaid witness will discuss the clinical coverage policy.
 - The vendor witness will discuss the clinical decision.
- **Witnesses are sworn or may affirm, exhibits are entered into evidence, hearings are recorded and can be transcribed.**
- **The assistant attorney general will ask questions of the Medicaid and vendor witnesses as well as the recipient or legal guardian and his/her witnesses.**
- **The recipient or his/her representative can ask questions of his/her witnesses and of the witnesses who testify for the Medicaid agency.**
- **The administrative law judge can also ask questions.**

UNDERSTANDING THE APPEAL PROCESS (CONT.)

- **The administrative law judge can also request a medical assessment that will be paid for by Medicaid and will be made a part of the record.**
- **Qualifying circumstances include those in which:**
 - a hearing involves medical issues, such as a diagnosis, an examining physician's report, or a medical review team's decision; and
 - the administrative law judge considers it necessary to have a medical assessment other than that performed by the individual in making the original decision.

UNDERSTANDING THE APPEAL PROCESS (CONT.)

Administrative Law Judge must decide if Medicaid:

- Exceeded its authority or jurisdiction
- Acted erroneously
- Failed to use proper procedure
- Acted arbitrarily or capriciously or
- Failed to act as required by law or rule

UNDERSTANDING THE APPEAL PROCESS (CONT.)

- **After the hearing, the administrative law judge will make a decision within 20 days of the date of completion of the hearing and will send that decision to the recipient and to the Medicaid agency.**
- **ALJ may allow brief extensions of the timeline on fair hearings for good cause to ensure the record of the proceeding is complete. N.C. General Statute § 108A – 70.9B(b)(4) defines good cause to include delays from untimely receipt of documentation to render a decision and other unavoidable and unforeseen circumstances.**
- **This is NOT the final agency decision, and it will not be implemented by the UR Vendor unless upheld by the final agency decision.**

FINAL AGENCY DECISION

- The Medicaid agency will make the final agency decision within 20 days of receipt of the case from OAH.
- Each party is given an opportunity to provide written exceptions by telling why they agree/disagree with the decision made by the ALJ.
- If the final agency decision reverses the OAH decision, the decision must provide information that supports reversal of the decision.
- The final agency decision will be mailed to the petitioner(s) and any personal representative(s) identified in the appeal request form by trackable mail.

FINAL AGENCY DECISION (CONT.)

- Decisions That Uphold Agency Action

A final agency decision that upholds the agency action shall be implemented no later than three business days from the date the decision is mailed to the petitioner or representative at the addresses provided on the recipient appeal request form.

UNDERSTANDING THE APPEAL PROCESS (CONT.)

- Decisions that Reverse the Agency Action (UR Vendor Decision) in Part or in Full
 - **If the final agency decision or a mediated settlement holds that all or part of the requested services were medically necessary, payment for those services as approved in the final agency decision or settlement will be authorized within three business days for at 20 prospective calendar days after the date of the decision.**
 - **A copy of the final agency decision will be electronically transmitted to the appropriate UR Vendor, and will be mailed to the recipient and any personal representative identified in the appeal request form.**

FINAL AGENCY DECISION (CONT.)

- **The final agency decision shall include a notification that a new request for prior authorization is required to be received by the UR Vendor within 15 calendar days of the decision in order to avoid an interruption in services.**
- **Upon receipt by the vendor of a request for service authorization within 15 calendar days from the date of a final agency decision which holds that all or part of the requested services were medically necessary, authorization for payment will remain in effect without interruption for at least 10 calendar days following the mailing of the notice of decision on the new request for prior authorization.**

FINAL AGENCY DECISION (CONT.)

- **If the request is denied or reduced, it will be treated as a timely request for reauthorization and MOS pending appeal will apply.**
- **Final agency decisions will notify the recipient of the importance of immediately informing the provider of the decision.**
- **The final agency decision may be appealed to Superior Court within 30 days of the date of the final agency decision.**
- **The recipient, legal guardian, or attorney must file a Petition for Judicial Review with Clerk of Superior Court, Civil Division, Wake County or county of residence. A personal representative who is not an attorney cannot file an appeal in Superior Court.**

FINAL AGENCY DECISION (CONT.)

- **Medicaid may seek repayment for services provided during the pendency of the appeal if the recipient loses the appeal.**
- **Only the recipient, spouse of the recipient, or parent of a minor recipient will be held responsible for repayment.**
- **Neither providers nor parents or legal guardians of adult recipients nor non-parent guardians of minor recipients will be held responsible for repayment of services provided during the pendency of an appeal.**

MEDICAID RECIPIENT FAIR HEARING TIMELINE

