

SECTION 7 APPEALS

CHAPTER 55 The Appeals Process

FH
Fair
Hearings

Everything in this chapter deals with the assurance of Fair Hearings.

WHAT DECISIONS MAY BE APPEALED?

Any decision made by DMA or one of its vendors to

- deny a service/supply,
- reduce a service/supply,
- deny an increase in a service/supply,
- suspend a service/supply, or
- terminate a service/supply

of a recipient or applicant may be appealed. 'Service' may refer to a program (such as CAP/C) or to a service within the program (such as CAP/C Nursing Services). DMA's vendors include HP, Value Options, ACS, and CSC.

ARE THERE ANY DECISIONS THAT MAY NOT BE APPEALED?

Decisions not made by Medicaid or one of its vendors may not be appealed to Medicaid. The following are some examples:

1. Decisions made by the recipient's physician

A physician's level of care recommendation may not be appealed to Medicaid.

EXAMPLE: Mrs. Brown wants CAP/C services for her son, Johnnie.

However, Johnnie's physician states that he does not need the level of

care provided in a nursing facility. Mrs. Brown's only option is to pursue the matter with Johnnie's physician.

2. Decisions made by a provider

A provider of CAP/C services and other Medicaid services may refuse to serve a CAP/C client. The provider's decision may not be appealed to Medicaid.

EXAMPLE: Suzie's mother has been verbally abusive to the personal care aides who have provided care for Suzie. The provider agency has worked with the case manager in trying to alleviate the problem, but the child's mother continues to be abusive. The provider agency refuses to continue serving the client.

3. Decisions made by the recipient/legal guardian

A decision made voluntarily by a recipient or guardian may not be appealed, but they can always reapply for the service.

EXAMPLE: Mrs. Smith withdrew her daughter Cathy from CAP/C because Mrs. Smith needed to move out of state because of her job. However, the job fell through, and they did not move after all. The termination of CAP/C may not be appealed, but depending upon the length of time that had elapsed, the termination could be rescinded or Mrs. Smith could reapply.

4. When a reduction or termination of a service is the result of a federal or state action requiring an automatic change that adversely affects some or all recipients. DMA will inform the local lead agencies when this exception applies as part of the notice of any such action. Normally, it would apply only to recipients 21 years of age or older or to non-EPSTD eligible services for recipients under 21.

WHO MAY APPEAL A DECISION?

Only a recipient or a recipient's legal representative may appeal a decision.

A case manager may not appeal for a recipient. The case manager may assist the recipient through the process, but may not make the decision or request the appeal (unless the family designates the case manager as their legal representative).

A provider may not appeal a decision regarding a recipient's services; for example, a nursing agency may not appeal a reduction of hours (again, unless the family designates someone in the agency as their legal representative).

WHO IS RESPONSIBLE FOR NOTIFYING A RECIPIENT OF HIS OR HER APPEAL RIGHTS?

The agency or vendor that made the decision will send a certified letter to the recipient. The letter will explain why the decision was made, what other options may be available, the appeals process, and how to file an appeal.

OVERVIEW OF THE APPEALS PROCESS

Below is the information regarding the appeal process that is given to the recipient/family in their adverse decision letter:

- Hearings are conducted by an administrative law judge with the Office of Administrative Hearings (OAH).
- To file for a hearing, you must submit **a completed hearing request form** (enclosed in this mailing). You can also obtain a hearing request form by calling the Division of Medical Assistance at the number specified above, or you can call the Office of Administrative Hearings at 919-431-3000.
- Mail or fax the completed hearing request form to Clerk, Office of Administrative Hearings **AND** General Counsel, North Carolina Department of Health and Human Services at the addresses or fax numbers on the enclosed hearing request form. **The completed form must be filed within 30 days of the date this decision letter was mailed**. As the mailing date is located on the envelope, **please keep the envelope containing this decision letter**.
- The Office of Administrative Hearings or the Mediation Network of North Carolina will contact you to discuss your case and to offer an opportunity for mediation in an effort to resolve your appeal. If mediation resolves your case, your hearing will be dismissed, and services will be provided as specified by the Mediation Network of North Carolina.
- If you do not accept the offer of mediation or the results of mediation, your case will proceed to hearing. You will be notified by mail of the date, time, and location of your hearing.

- The administrative law judge will make a decision and will send that decision to Medicaid for a final agency decision. You will receive a written copy of both the administrative law judge's decision and Medicaid's final agency decision.
- If you do not agree with Medicaid's final agency decision, you may ask for a judicial review in superior court.
- You may represent yourself in the hearing process, hire an attorney, or ask a relative, friend, or other spokesperson to speak for you.
- If a **continuing** request for services is denied and you submit a request for hearing within **30 days of the date this decision letter was mailed** and as long as you remain otherwise Medicaid eligible, unless you give up this right, you are entitled to receive services during the pendency of the appeal. **This right to receive services applies even if you change providers.** Services will be provided at the same level you were receiving the day before the decision or the level requested by your provider, whichever is less. The services that continue must be based on your current condition and must be provided in accordance with all applicable state and federal statutes and rules and regulations.
- If you lose your appeal, you may be required to pay for the services that continue because of the appeal.

WHAT ARE THE TIMEFRAMES?

- The effective date of the adverse action
 - if it was an initial request (initial meaning that the services were not authorized during the 10 days prior to the request), is the date the letter was mailed
 - if it was a continuing request (continuing meaning services were authorized on the day before the adverse decision), is 10 days from the date the notice was mailed
- The appeal must be filed within 30 days of the date the adverse decision letter was mailed to the recipient.
- Maintenance of Services
 - If the recipient appeals within 10 days of the date the notice was mailed, payment for services and service provision will not be interrupted.
 - If the recipient appeals within 30 days of the date the notice was mailed and services were stopped or reduced, services will be reinstated.

- The recipient will be contacted by the mediator within five days of receipt of case from OAH.
- If there is a mediation, it must be completed within 25 days of receipt of the hearing request by OAH.
- If there is no mediation or if the case proceeds to hearing, 15 days notice of hearing must be given.
- The entire OAH proceeding, including mediation, must be completed within 55 days of receipt of the hearing request by OAH
- 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.
- The ALJ (Administrative Law Judge) may allow brief extensions of the timeline on fair hearings for good cause to ensure the record of the proceeding is complete.
- 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.
- The final agency decision will be completed within 20 days of receipt of the case from OAH.

- The effective date of the decision
 - If it upholds the original adverse decision, is three business days from the date the decision was mailed to the recipient and/or the legal guardian
 - If it reverses the original adverse decision, in whole or in part, is specified in the decision, and is usually 20 days after the date of decision
- The final agency decision also states when the next service request must be submitted (usually 15 business days from decision).
- The final agency decision may be appealed to Superior Court within 30 days of the date the final agency decision was mailed.

WHAT IS MAINTENANCE OF SERVICES?

Maintenance of services is the right of the recipient to continue their services during the pendency of the appeal. This right applies to decisions on *continuing* requests, when the recipient remains otherwise Medicaid eligible, and when the appeal was filed within 30 days of the date the adverse decision letter was mailed.

Services are provided at the same level the recipient was receiving the day before the adverse decision, or the level requested by the provider, whichever is less. Any changes requested to the Plan of Care during this time are reviewed on a case-by-case basis, balancing the above with the child's health, safety, and welfare needs.

The recipient may change providers and still keep their maintenance of services. The recipient may give up this right and elect to not receive the services during the pendency of the appeal.

If the recipient loses the appeal, he/she may be required to pay for the services that continue because of the appeal.

WHAT IS THE CASE MANAGER'S ROLE IN THE APPEAL PROCESS?

Case Managers may assist both the recipient and DMA in preparation for the appeal process. It is recommended that the case manager remain a neutral party so as to maintain an effective working relationship with both parties regardless of the outcome of the appeal.

Case Managers generally do not need to attend the mediation or hearing, but may need to do so at the request of the parent or DMA.

For more information about the hearing process, visit the websites indicated below.

Adults: <http://www.ncdhhs.gov/dma/Forms/abd.pdf>

Children: <http://www.ncdhhs.gov/dma/Forms/famchild.pdf>



CHAPTER REVIEW**🔑 Key Points**

1. Only decisions made by DMA or one of its representatives may be appealed. Decisions made by physicians, providers, families, or other entities can not be appealed to DMA.
2. Recipients have the right to appeal any adverse action including denial, reduction, suspension, or termination of services.
3. A recipient may choose to continue his/her current services at the current or at a lower level during the pendency of the appeal. To do so, he/she must remain otherwise Medicaid eligible and file the appeal within 30 days.
4. Only the recipient/legal guardian or someone else appointed by that person to be the recipient's legal representative may file an appeal.
5. Appeals are heard by the Office of Administrative Hearings. Mediation is offered, and is voluntary. The OAH decision is considered advisory to the Director (of DMA), and the Director issues the final decision. The Director's decision may be appealed to Superior Court.
6. Stringent timelines exist for filing, hearing, deciding, and implementing the decisions of the appeals process.
7. The Case Manager may be asked by both the recipient and DMA for assistance in preparing for the appeal process. The Case Manger should remain a neutral party during the process.

 **Test Your Knowledge/Section Review**

1. Fill in the blank: A recipient has ____ days from the date their letter was mailed to file their appeal.
2. Mediation is
 - a. required.
 - b. voluntary.
3. James is applying to CAP/C and his initial plan of care contains 16 hours per day of CAP/C Nursing. DMA denies the CAP/C Nursing. James' family plans to appeal. Can James have the 16 hours of nursing until his appeal is over?
 - a. Yes
 - b. No.
4. True or False: If the case goes to hearing, the judge's decision is final.
5. DMA reduced Suzy's nurse aide hours. The agency that provides the nurse aide disagrees with the decision. You advise them:
 - a. to file an appeal within 30 days.
 - b. that only the recipient/legal guardian may decide to appeal.
 - c. that there is nothing at all that can be done.

1.30; 2. b; 3. b;4. False; 5. b

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