

REVIEWS, RECONSIDERATIONS AND APPEALS

Colorado Health Partnerships, Foothills Behavioral Health Partners, and Northeast Behavioral Health Partnership are Colorado BHOs contracted with Colorado Medicaid to manage Medicaid behavioral health benefits and all three have delegated their utilization management programs to ValueOptions. Each of the three BHOs has an Office of Member and Family Affairs (OMFA) that is available to assist members in exercising their rights to appeal.

All authorization determinations are made within timeframes required by Medicaid standards. As the ValueOptions Service Center is also accredited by the Utilization Review Accreditation Commission, its timeframes meet the more stringent of the two standards. All notifications for authorizations and denials also comply with both Medicaid and URAC standards as do the content of Notice of Action letters. For requirements concerning initial and continued stay authorization of all levels of care, please refer to Section 4, Utilization Management Procedures. At the time of any review a BHO Medical Director or Peer Reviewer may deny authorization based on the diagnosis, the service requested, or medical necessity criteria. If a service is determined not to be a BHO covered service or a diagnosis is determined not to be a BHO covered diagnosis, the service or diagnosis may still be available to the member under Colorado Medicaid but not through the BHO. For assistance please contact the BHO's Office of Member and Family Affairs.

When a request for service is in whole or in part denied, providers may be asked by members to assist in the Medicaid appeal process. The State of Colorado Medicaid contract allows for an appeal process for its members who are denied any request for covered mental health services as well as under other circumstances referred to as Actions as defined at the end of this Section. The following information identifies the process for the Medicaid member to access his/her appeal rights. The provider is granted Reconsideration rights but the right to appeal is available only to the member, member's guardian, or member's Designated Client Representative (DCR). The provider may represent the member in all levels of appeal with the member's written consent, or if designated in writing as the member's DCR.

CONTACTING THE BHO OFFICES OF MEMBER AND FAMILY AFFAIRS AND VALUEOPTIONS COLORADO

To obtain assistance for a member to exercise his/her appeal rights:

For Colorado Health Partnerships contact the CHP Office of Member and Family Affairs at **1-800-804-5040**.

For Northeast Behavioral Health Partnership contact the NBHP Office of Member and Family Affairs at **1-970-347-2367**.

For Foothills Behavioral Health Partners, contact the FBHPartners Office of Member and Family Affairs at **303-432-5956 or 1-866-245-1959**.

CLINICAL GUIDELINES

Clinical services are authorized based upon diagnosis, service requested, medical necessity criteria, and the application of established treatment guidelines. Medical necessity criteria are defined by Colorado Medicaid. Treatment guidelines are adopted and revised by each BHO with input from members and families. Guidelines are developed using national standards, published research, expert opinions and local “best” practices. Treatment guidelines are continually reviewed and revised to reflect the growing knowledge of best practice standards.

These guidelines are made available at:

Colorado Health Partnerships - <http://www.chnpartnerships.com>

Foothills Behavioral Health Partners - <http://www.fbhpartners.com>

Northeast Behavioral Health Partnership - <http://www.nbhpartnership.com>

CLINICAL PEER REVIEW PROCESSES

The BHO medical staff (Medical Director or Clinical Peer Reviewer) will conduct a Clinical Peer Review before denying any service request. A Clinical Peer Review consists of a decision based on review of all available clinical information by an appropriately licensed behavioral health professional.

At the completion of a Clinical Peer Review, the BHO Peer Reviewer will inform the provider/facility if services will be authorized or denied. A denial of payment becomes effective at the completion of this review unless otherwise specified by the BHO Peer Reviewer. If a decision is made to deny authorization, written Notice of Action of this decision will be mailed to the member and provider/facility within the earlier of one (1) business day or three (3) calendar days.

PROVIDER’S REQUEST FOR RECONSIDERATION (PEER TO PEER REVIEW)

Reconsideration can be requested by the provider if the provider can offer clinically significant information that was not available to the Peer Reviewer at the time of an adverse determination by Clinical Peer Review. For an adverse determination for Urgent services, the provider has 24 hours following verbal notification of an initial denial to request a telephonic Reconsideration Peer-to-Peer Review. In the case of a facility, this time interval begins at the time of verbal notification to any member of the facility staff. This process is available for both prospective and concurrent requests. The provider who requests a Reconsideration Peer-to-Peer Review for Urgent services or an appropriate representative of the facility requesting Reconsideration must be available for telephonic consultation within 24 hours of notification that the request for Reconsideration has been received; otherwise a final determination will be made based on the Clinical Peer Review. The re-decision to authorize or deny the request for services will be made at the completion of the Reconsideration Peer-to-Peer Review.

For an adverse determination for non-Urgent services, the provider has 14 calendar days following verbal notification of an initial denial to request a Reconsideration Peer-to-Peer Review. In the case of a facility, this time interval begins at the time of verbal notification to any member of the facility staff. This process is available for both prospective and concurrent

requests. The provider who requests a Reconsideration Peer-to-Peer Review for non-Urgent services or an appropriate representative of the facility requesting Reconsideration must be available for telephonic consultation within two (2) calendar days of notification that the request for Reconsideration has been received; otherwise a final determination will be made based on the Clinical Peer Review. The re-decision to authorize or deny the request for services will be made at the completion of the Peer-to-Peer Review. No further reconsideration is available to the provider following a Peer-to-Peer Review. The member/guardian/DCR may request an appeal.

A request for Reconsideration must be made telephonically to a ValueOptions Clinical Care Manager at the Access to Care line (1-800-804-5008). If the denial of the requested service is upheld at the time of the Peer-to-Peer Review, the provider will be notified verbally. Both provider and member will also receive written notification of the decision. Upon conclusion of Reconsideration, any further appeal is a formal appeal and can only be initiated by the member/guardian/DCR. The member may name the provider as his/her DCR but must do so in writing.

RETROSPECTIVE AUTHORIZATION PROCESS

Requests for retrospective authorization will be considered in the following circumstances:

- Member is made Medicaid eligible retroactively;
- Member's condition at the time of initiation of treatment interfered with the member providing accurate verification of insurance;
- Member provided inaccurate information concerning eligibility for Medicaid.

Providers have ninety (90) calendar days from the first day of non-authorized services, or from the date of the member's notice confirming retroactive Medicaid eligibility, to request a retrospective review.

To obtain consideration the provider/facility must submit a written request including documentation supporting the basis for the request. A retrospective authorization determination requires the submission of the medical records covering the span of the request, which will be considered complete and final at the time of submission of the request for Retrospective Authorization. ValueOptions will make determinations on Retrospective Authorization Requests within 30 calendar days. If granted, retroactive authorization may cover all or only part of a given episode of care depending upon a determination of medical necessity throughout the episode. The member/guardian/DCR may appeal a denial of payment for all or any part of the episode of care. The provider may appeal only if designated in writing to appeal on the member's behalf or if designated by the member as the member's DCR.

MEMBER'S REQUEST FOR APPEAL OF AN ACTION

A member/guardian/DCR may appeal any of the Actions listed in the Definition at the end of this Section. An appeal (Standard or Expedited; see definition at end of this section) may be implemented at the member's/guardian's/DCR's request within 20 calendar days of the date of a Notice of Action. The appeal request may be verbal but must be followed up in writing. The BHO's Office of Member and Family Affairs is available to assist members with this appeal process, including helping a member put their appeal in writing. The appeal request must be submitted to the Grievance and Appeals Coordinator, ValueOptions, 7150 Campus Drive, Suite

300, Colorado Springs, Colorado 80920, by fax to 719-538-1433, or telephonically at 800-804-5008 for CHP and NBHP, or 866-245-1959 for FBHPartners. A psychiatric physician who was not involved in the initial denial will re-evaluate the original decision based on information received in the appeal letter, any subsequent information the member/guardian/DCR may provide, and on the original clinical documentation. For a Standard Appeal a determination will be made and resolution mailed to the member within 10 working days of the receipt of the appeal. In the case of an Expedited Appeal, determination and notification will be made within 3 working days of the receipt of the appeal.

A member/guardian/DCR may also file a request for a State Fair Hearing simultaneously to filing an appeal with the BHO, or a member or DCR may file directly for a State Fair Hearing without first filing an appeal with the BHO. Instructions for filing for a State Fair Hearing are also included in the Notice of Action.

MEMBER'S REQUEST FOR STATE FAIR HEARING APPEAL

The member/guardian/DCR may request, in writing or telephonically, a State Fair Hearing with an Administrative Law Judge (ALJ) of any Medicaid action as listed in the Definitions at the end of this Section. A member/guardian/DCR may skip the BHO appeal step and go directly to an appeal to an Administrative Law Judge for a State Fair Hearing upon notification of an action, or may file an appeal with the BHO and the ALJ at the same time (recommended in order to preserve the member's appeal rights as either appeal must be filed with the same 20 calendar day timeframe. A member's/guardian's/DCR's request for either type of appeal must be submitted within 20 calendar days from the date of the Notice of Action. The individual may represent him/herself or use legal counsel, a relative, a friend, or other spokesperson at the hearing. The member or his/her authorized representative shall be entitled to examine the complete case file and any other documents to be used at hearing at a reasonable time before the hearing or during the hearing. Documents and information that are confidential as a matter of law shall be exempt from this requirement unless they are to be offered as evidence during the hearing. Conference telephone hearings may be offered as an alternative to face-to-face hearings. All applicable provisions of the face-to-face hearing shall apply to telephone hearings. The hearing shall be private unless the applicant or recipient requests, on the record, that the hearing be open to the public. If the member/member's guardian/designated representative is not fluent in English or has a language difficulty, the Court will arrange to have present at the hearing a qualified interpreter who will be sworn to translate correctly. An ALJ decision is the final decision in the member/member's guardian/designated representative appeal process. To initiate this process, the member/guardian/DCR can contact the Office of Administrative Courts at 633 17th Street, Suite 1300, Denver, CO 80202, 303-866-2000, fax 303-866-5909. Assistance with this process is available for member/member's guardian/designated representative from the BHO Office of Member and Family Affairs at the numbers above, or from the Ombudsman for Medicaid Managed Care at 1-877-435-7123, (TTY: 1-888-876-8864) 303 E 17th Ave, Suite 105, Denver, CO, 80203, e-mail: help123@maximus.com.

Appeal of Termination, Suspension or Reduction of Previously Authorized Services

An appeal in this category follows the same procedure as a standard appeal except that the timeframe for filing the appeal is 10 calendar days instead of 20 calendar days. This timeframe applies to both the appeal to the BHO as well as for the State Fair Hearing. Appeals in the category also may include a request for services during the appeal process. The timeframe for

sending the appeal decision is the same as a standard appeal, within ten(10) working days from receiving the appeal.

Special Circumstances under which Services May be Continued at BHO Expense during the Course of an Appeal

Upon member/guardian/DCR request, services will be continued during the appeal of the termination, suspension, or reduction of a *previously* authorized service. For example, if a valid authorization for 30 days of residential services is terminated after only 15 days. In order to obtain continued services, a member's appeal must be filed on or before the later of the following:

- Within ten (10) days of the BHO mailing the Notice of Action; or
- Within ten (10) days of the intended date of the BHO's proposed action (i.e., before services actually terminate).

Previously authorized services may be continued only if ALL the following criteria are met:

- The member/guardian/DCR or provider with written consent of the member files the appeal timely;
- The services were ordered by an authorized provider;
- The original period covered by the original authorization has not expired; and
- The Member requests extension of benefits (services).

If the requested service continues it is for a limited time until one of the following occurs:

- The member withdraws the appeal;
- Ten (10) days pass after the BHO mails the notice providing the resolution of the appeal upholding the original BHO termination, suspension, or reduction of services, unless the member, within a ten (10) day timeframe makes a request for a State Fair Hearing with continuation of services until a State Fair Hearing decision is reached;
- A State Fair Hearing Office issues a hearing decision adverse to the member; or
- The time period of the previous authorization of the services expires.

Definitions

Actions

An appeal may be filed for events categorized as Actions. Actions include:

1. The denial or limited authorization of a requested service, including the type or level of service;
2. The reduction, suspension, or termination of a previously authorized service.
3. Denial of payment for a service, in whole or in part.
4. Failure of the BHO to provide a service in a timely manner.
5. Failure of the BHO to act within approved timeframes for grievances or appeals.
6. Denial of a request by a member in a rural area to obtain treatment outside of the ValueOptions Medicaid Provider Network.

Clinical Peer Review

This process involves a desk review of clinical information provided verbally or in writing by an appropriately qualified and licensed BHO Peer Reviewer.

Peer-to-Peer Review

This process involves telephonic discussion of pertinent clinical information by a provider and an appropriately qualified and licensed BHO Medical Director or Peer Reviewer. The Peer Reviewer has the authority to deny authorization should the member not have a covered diagnosis or not meet medical necessity criteria for the service being requested.

Standard Appeal

A member may appeal any Action, as defined above. The standard appeal process is the most often requested appeal and is initiated when the denial of services does NOT jeopardize the life or health of the member. The standard appeal must be completed within a 10 working day timeframe. When this determination is made, notification will be mailed to the member. This process can be used for any prospective, concurrent or retrospective appeal.

Expedited Appeal

When a denial of services may jeopardize the life or health of a member, an expedited appeal process may be requested. The expedited appeal is to insure a more timely decision than the ten (10) working day standard appeal process. The expedited appeal occurs most frequently at higher levels of care (i.e., inpatient requests, ATU requests etc). In the case of an expedited appeal, determination will be made and a resolution letter mailed to the member within three (3) working days of the request for appeal.