Section 9

REVIEWS, RECONSIDERATIONS AND APPEALS

Colorado Health Partnerships and Foothills Behavioral Health Partners are Colorado BHOs contracted with the Colorado Department of Health Care Policy and Financing (HCPF) to manage Medicaid behavioral health benefits through the Colorado Community Behavioral Health Services Program, and have delegated their utilization management programs to ValueOptions. Each of these 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 Colorado Medicaid standards. As the ValueOptions Service Center is also accredited by the Utilization Review Accreditation Commission (URAC), its timeframes meet the more stringent of the two standards where they differ from one another. All notifications for authorizations and denials also comply with both Medicaid and URAC standards as does 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. In addition, when a BHO Medical Director or Peer Reviewer is reviewing a case, a provider may be asked to participate in a phone call to discuss service, or to provide a written copy of the member’s treatment plan. Clinical Care Managers or any other staff members do not have the authority to deny a service. Denials may only be issued by a BHO Medical Director or Peer Reviewer. 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. In addition, there may be other funding sources for particular services, depending on the member’s situation. 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 and is 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, the member’s guardian, or the member’s Designated Client Representative (DCR). The provider may represent the member in all levels of appeal with the member’s written consent, 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 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 the BHO and aligned with the Medicaid contract established by the Colorado Department of Health Care Policy and Financing. 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 periodically reviewed and revised to reflect the growing knowledge of best practice standards. These guidelines are made available at no cost, at:

Colorado Health Partnerships – [http://www.coloradohealthpartnerships.com](http://www.coloradohealthpartnerships.com)

Foothills Behavioral Health Partners - [http://www.fbhpartners.com](http://www.fbhpartners.com)

**Clinical Peer Review Processes**
When a Clinical Care Manager receives a request for authorization and there is any question as to whether the information provided meets criteria for authorization, the case is referred for a Clinical Peer Review with the BHO medical staff. The BHO medical staff consists of a psychiatrist Medical Director for all 24 hour levels of care and a clinical psychologist Peer Advisor for specific non-urgent, outpatient levels of care. Medical staff 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 (physician or clinical psychologist).

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 complete 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 of denial; 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 made it impossible for the provider/facility to obtain enough identifying information to determine Medicaid eligibility via the Colorado Medicaid Web Portal;

Providers are expected to check the Colorado Medicaid Web Portal for Medicaid eligibility prior to admission of presumed medically indigent patients. In addition, for members who have Medicaid at admission to a service often have frequent changes to Medicaid eligibility. Therefore, it is recommended that eligibility is checked prior to each outpatient service, and frequently throughout any higher level of care service to insure payment. Authorizations are dependent upon eligibility. If a member becomes ineligible for Medicaid, claims for those dates of service cannot be paid.

Requesting a retrospective authorization:
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. Note that BHO responsibility for payment of services does not extend greater than 90 days prior to the date of the eligibility determination. For consideration of
payment for services more than 90 days prior to the date eligibility is finally determined, please contact Colorado Medicaid.

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. For any dates of services that are not authorized, a Notice of Action letter will be sent to the provider and the member/guardian. 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 30 calendar days of the date of a Notice of Action. Appeals received outside of this timeframe will not be processed. 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, 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 calendar days (72 hours) 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 30
calendar day timeframe. A member’s/ guardian’s/DCR’s request for either type of appeal must be submitted within 30 calendar days from the date of the Notice of Action. The individual may represent him/herself or use legal counsel, a relative, a friend, the Medicaid Ombudsman 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 1525 Sherman Street, 4th Floor, Denver, CO 80203, 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 Street, 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 30 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. An example of termination, suspension or reduction of a previously authorized service would apply in the following type of situation: A valid authorization for 30 days of residential services is given, but is terminated after only 15 days, it would fall into this category. Authorizations begin on the first date of service authorized, and end on the expiration date of the initially authorized review period. Care is re-reviewed for additional authorization at the end of each authorization period. In the example given, the case would be scheduled for a review, where the provider is required to call ValueOptions to request additional days beyond day 30. If the authorization is ended before day 30, due to reasons other than a change in Medicaid eligibility, this would constitute a reduction or termination of a previously authorized service.

The timeframe between reviews for additional requested services by a provider depends on the clinical situation of the member. For authorization to continue, the provider must request
additional days by contacting ValueOptions at the end of each authorization period. If a member wants to appeal this type of denial, 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.

It’s important to note that if services are provided during the appeal or State fair hearing, and if the final decision is adverse to the member, the member may have to pay for those services.

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 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) calendar days (72 hours) of the request for appeal.