Section 9

REVIEWS, RECONSIDERATIONS AND APPEALS

Colorado Health Partnerships and Foothills Behavioral Health Partners are Colorado Behavioral Health Organizations (BHO) contracted with the Colorado Department of Health Care Policy and Financing (HCPF) to manage Health First Colorado behavioral health benefits through the Colorado Community Behavioral Health Services Program, and have delegated their utilization management programs to Beacon Health Options. 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 Health First Colorado standards. As the Beacon Health Options Engagement 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 Health First Colorado and URAC standards, as does the content of Notice of Adverse Benefit Determination 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 the 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 Health First Colorado, 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 Health First Colorado appeal process. The State of Colorado Health First Colorado contract allows for an appeal process for its members who are denied any request for covered behavioral health services as well as under other circumstances referred to as Adverse Benefit Determinations and is defined at the end of this section. The following information identifies the process for the Health First Colorado 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 they are designated in writing as the member’s DCR.
CONTACTING THE BHO OFFICES OF MEMBER AND FAMILY AFFAIRS AND BEACON HEALTH OPTIONS

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 ext., 361-483.

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 Health First Colorado contract established by the HCPF. 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

Foothills Behavioral Health Partners - 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 authorization 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 Adverse Benefit Determination 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)

Following a clinical denial, a Reconsideration Peer to Peer Review 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. Preferably, this request will be made within 24 hours of a denial. A request for Reconsideration Peer to Peer Review should be made telephonically to a Beacon Health Options Clinical Care Manager (CCM) via the Access to Care line (1-800-804-5008). The Clinical Care Manager will then give the provider instructions on how to complete the review. A Clinical Peer Reviewer will be available within one business day to complete the review. The re-decision to authorize or deny the request for services will be made at the completion of the Peer to Peer Review. If the denial of the requested services is upheld at the time of the Peer to Peer Review, the provider will be notified verbally. Both the provider and the member will also receive written notification of the decision. Upon conclusion of the Reconsideration, any further review must be made through the process of a formal appeal.

A formal appeal 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 Health First Colorado 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 Health First Colorado eligibility via the Health First Colorado Web Portal

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

Requesting a Retrospective Review

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 Health First Colorado 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 Health First Colorado.

To obtain consideration, the provider/facility must submit a written request including documentation supporting the basis for the request. A retrospective review 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 review. Beacon Health Options will make determinations on a retrospective request within 30 calendar days. If the request is approved, then dates of service retroactively authorized 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 Adverse Benefit Determination 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 OF AN APPEAL**

A member/guardian/DCR may file an appeal for any of the adverse benefit determinations listed in the definition at the end of this section. In most cases, appeals (standard or a quick appeal; see definition at end of this section) must be filed by the member/guardian/DCR within 60 calendar days of the date of a Notice of Adverse Benefit Determination. However, if a member is appealing an adverse benefit determination to reduce, suspend or terminate a previously authorized service AND the member wants to continue the service during the appeal, the appeal must be filed within 10 days of the Notice of adverse benefit determination or by the date that the adverse benefit determination would take effect, whichever is later. Also, the services must have been ordered by an authorized provider; the original period covered by the original authorization must not have expired, and the member must ask that services be continued during the appeal. Appeals received outside of required timeframes will not be processed. (See section below, HOW LONG WILL PREVIOUSLY AUTHORIZED SERVICES CONTINUE WHEN AN ADVERSE BENEFIT DETERMINATION IS APPEALED?)

The appeal request may be verbal but must be followed up in writing in order to complete the appeal. 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, Beacon Health Options, 9925 Federal Drive, Suite 100, Colorado Springs, Colorado 80921, by fax to 719-538-1433, or telephonically at 800-804-5040 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 a quick appeal, determination and notification will be made within 3 calendar days (72 hours) of the receipt of the appeal.

**MEMBER’S REQUEST FOR A STATE FAIR HEARING**

A member/guardian/DCR may also file a request for a State Fair Hearing in writing to review any Health First Colorado adverse benefit determination as listed in the definitions at the end of this section. A State Fair Hearing can only be requested after all appeal options have been completed.
The Member/Guardian/DCR must ask for the State Fair Hearing within 120 calendar days from the date of the appeal decision letter sent by Beacon Health Options. If, however, the adverse benefit determination involves a reduction, suspension or termination of a previously authorized service AND the member wants the service continued during the State Fair Hearing, the member must request the State Fair Hearing within ten (10) days of the Notice of Adverse Benefit Determination letter or by the date the adverse benefit determination would take effect, whichever is later. The member must also ask that the services be continued during the State Fair Hearing process. If, prior to receiving an unfavorable decision from the BHO on the member’s appeal AND the member wants to continue previously authorized services during the State Fair Hearing, the member/guardian/DCR may request a State Fair Hearing within 10 days of the BHO’s decision on the appeal. (See section below, HOW LONG WILL PREVIOUSLY AUTHORIZED SERVICES CONTINUE WHEN AN ADVERSE BENEFIT DETERMINATION IS APPEALED?)

A member may represent him/herself or use legal counsel, a relative, a friend, the Health First Colorado 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 the 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/DCR 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 Administrative Law Judge decision is the final decision in the member’s 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, 303-866-5626, 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 Health First Colorado Managed Care at 1-877-435-7123, (TTY: 1-888-876-8864) 303 E 17th Street, Denver, CO, 80203, e-mail: help123@maximus.com.

**HOW LONG WILL PREVIOUSLY AUTHORIZED SERVICES CONTINUE WHEN AN ADVERSE BENEFIT DETERMINATION IS APPEALED?**

If the member/guardian/DCR has requested that previously authorized services continue during an appeal, services will continue only until **one** of the following occurs:

- The member withdraws the appeal
- 10 days pass after the BHO mails its decision on the appeal and the decision is against the member UNLESS the member, within the 10 day timeframe, has requested a State Fair Hearing with continuation of benefits until a State Fair Hearing decision is reached
- A State Fair Hearing officer makes a decision that is adverse to the Member
- Or, the time period covered by the original authorization ends.
Member Responsibility for Services Furnished while an Appeal or State Fair Hearing is Pending

If the BHO’s decision on a member’s appeal is adverse to the member, and the member has not filed for a State Fair Hearing, the BHO may recover the cost of the services furnished to the member while the appeal is pending, if the reason why the services were furnished was solely because of the requirements listed above. (This does not apply if the member received services because of medical necessity.) Similarly, if the State Fair Hearing decision is adverse to the member and services were furnished while the Hearing was pending, the BHO may recover the cost if the service furnished solely because of the requirements listed above.

BHO Responsibility for Services Furnished while the Appeal is Pending

If the BHO’s decision on a member’s appeal upholds the member’s appeal and the member has not filed for a State Fair Hearing, the BHO must pay for the services that were furnished while the appeal is pending, if the reason why the services were furnished was solely because of the requirements listed above. Similarly, if the State Fair Hearing decision upholds the member’s appeal and services were furnished while the Hearing was pending, the BHO must pay for the services that were furnished solely because of the requirements listed above. If the services were not provided, the BHO must provide the services as quickly as possible.

An Example of Termination, Suspension or Reduction of a Previously Authorized Service

An example of termination, suspension or reduction of a previously authorized service would be when the BHO authorizes 30 days of residential treatment, but terminates the services after 15 days, and the termination is not due to a change in Health First Colorado eligibility.

DEFINITIONS

Adverse Benefit Determination

An appeal or State Fair Hearing may be filed for events categorized as adverse benefit determinations. Adverse benefit determinations 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 Beacon Health Options Health First Colorado 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 adverse benefit determination, 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.

Quick Appeal

When a denial of services may jeopardize the life or health of a member, a quick appeal process may be requested. The quick appeal is to insure a more timely decision than the ten (10) working day standard appeal process. The quick appeal occurs most frequently at higher levels of care (i.e., inpatient requests, ATU requests etc). In the case of a quick 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.