United Behavioral Health

Grievance and Appeal System: Medicaid Enrollee's Adverse Benefit Determination Notice			**Policy Identifier/Number:** CR-02C
Annual Review Completed Date: February 2018			
Policy Category: Government – Pierce Regional Support Network	**Applicable Lines of Business:** Medicaid	**Entity/Plan:** Optum Pierce Behavioral Health Organization	**State:** Pierce County, Washington
Approved by: Bea Dixon, Executive Director			**Signature:**

Policy Statement and Purpose

The Optum Pierce Behavioral Health Organization (BHO) ensures that all Medicaid enrollees receiving behavioral health services receive Adverse benefit determination notices from the Optum Pierce OPTUM PIERCE BHO that notify Enrollees about the right to appeal Adverse benefit determinations. Medicaid enrollees receive an Adverse benefit determination notice of the right to appeal when a request for prior authorization of a service is denied and when previously authorized services are reduced, suspended, or terminated.

To ensure that Adverse benefit determination notices and concomitant rights to appeal are provided in a manner that gives timely, clear, and easily understood information to Medicaid enrollees seeking and receiving behavioral health services.

Policy Audience and Applicability

This policy is applicable to the Optum Pierce OPTUM PIERCE BHO and benefits administered through the Washington State Department of Social and Health Services (DSHS) current Prepaid Inpatient Health Plan (PIHP).

Policy Definitions

- **Administrative Hearing**: a proceeding before an administrative law judge to review an adverse benefit determination or a BHO decision to deny or limit authorization of a requested non-Medicaid service communicated on a notice of determination.
- **Adverse Benefit Determination**: in the case of Medicaid services administered by the BHO, any one or more of the following:
    - The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
    - The reduction, suspension, or termination of a previously authorized service;
    - The denial, in whole or in part, of payment for a service;

Optum is responsible for adhering to all applicable state and/or federal laws governing activities within the scope of this policy, including the Mental Health Parity and Addiction Equity Act (MHPAEA) and the Health Insurance Portability and Accountability Act (HIPAA) privacy requirements, as well as the applicable requirements, standards and regulations as set forth by the Employee Retirement Income Security Act (ERISA), the Center for Medicare and Medicaid Services (CMS), the Department of Labor (DoL), and any applicable accrediting organizations.

- The failure to provide services in a timely manner, as defined by the state;
- The failure of a BHO to act within the grievance and appeal system time frames as provided in *WAC 388-877-0660 through 388-877-0670* regarding the standard resolution of grievances and appeals;
- For a resident of a rural area with only one BHO, the denial of and individual's request to exercise their right to obtain services outside the network;
- The denial of an individual's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

- **Appeal**: a review by the behavioral health organization (BHO) of an adverse benefit determination.
- **Grievance**: an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, an individual's right to dispute an extension of time proposed by the BHO to make an authorization decision, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a behavior health provider or employee, and failure to respect the individual's rights regardless of whether a specific action is requested by the individual.
- **Grievance and Appeal System**: the processes a BHO implements to handle appeals of adverse benefit determinations and grievances as well as the processes to collect and track information about them. The BHO must establish the grievance and appeal system and meet the requirements of *42 C.F.R. Sec. 438, Subpart F (2017)*.
- **Individual**: a person who applies for, is eligible for, or receives BHO-authorized behavioral health services from an agency licensed by the department as a behavioral health agency. For the purposes of accessing the grievance and appeal system and the administrative hearing process, when another person is acting on an individual's behalf, the definition of individual also includes any of the following:
  - In the case of a minor, the individual's parent or, if applicable, the individual's custodial parent;
  - The individual's legal guardian;
  - The individual's representative if the individual gives written consent;
  - The individual's behavioral health provider if the individual gives written consent, except that the behavioral health provider cannot request continuation of benefits on the individual's behalf.
- **Notice of Adverse Benefit Determination**: a written notice a BHO provides to an individual to communicate an adverse benefit determination.
- **Notice of Determination**: a written notice that must be provided to an individual to communicate denial or limited authorization of a non-Medicaid service offered by the BHO. A notice of determination must contain the following:
  - The reason for denial or offering of alternative services;
  - A description of alternative services, if available; and
  - The right to request an administrative hearing, how to request a hearing, and the time frames for requesting a hearing as identified in *WAC 388-877-0675.*

Policy Provisions

1. Notice of Adverse Benefit Determination

1.1. Optum Pierce BHO's notice of adverse benefit determination provided to an individual must be in writing and in an easily understood formal following *42 C.F.R. Sec. 438.10 (2017)*, which includes requirements that each notice:

1.1.1. Be written in the individual's non-English language, if applicable;

1.1.2. Lists the Optum Pierce BHO's toll-free and TTY/TDY telephone number; and

1.1.3. Explains the availability of free written translation, oral interpretation to include any non-English language, auxiliary aids such as American Sign Language, TTY/TDY telephone services, and alternative formats to include large print and Braille.

1.2. The notice of adverse benefit determination must at a minimum, explain the following, per *WAC 388-877-0665*:

1.2.1. The adverse benefit determination that the Optum Pierce BHO has made or intends to make;

1.2.2. The reasons for the adverse benefit determination, including citation of the rule(s) and criteria used for the basis of the decision;

1.2.3. The right of the individual to be provided reasonable access to and copies of all documents, records, and other information relevant to the individual's adverse benefit determination upon request and free of charge;

1.2.4. The individual's right to file an appeal of the adverse benefit determination with the Optum Pierce BHO, including information on exhausting the BHO's one level of appeal and the individual's right to request an administrative hearing;

1.2.5. The circumstances under which an expedited appeal process is available and how to request it; and

1.2.6. The individual's right to received behavioral health services while an appeal is pending, how to make the request, and that the individual may be held liable for the cost of services received while the appeal is pending if the appeal decision upholds the decision in the notice of adverse benefit determination.

1.3. When the Optum Pierce BHO or its contracted behavioral health agency does not reach service authorization decisions within the required time frame, or fails to provide services in a timely manner, it is considered an adverse benefit determination. In these cases, the Optum Pierce BHO sends a formal notice of adverse benefit determination that includes the individual's right to request an administrative hearing. When the Optum Pierce BHO does not act within the grievance and appeal system time frames, it is considered exhaustion of the appeals process and the individual has a right to request an administrative hearing.

1.4. For individuals receiving Wraparound with Intensive Services (WISe), Optum Pierce BHO must provide a written notice of adverse benefit determination to the individual or the authorized representative if:

1.4.1. A Children and Adolescent Needs and Strengths (CANS) screen results in the denial of a request for Wraparound with Intensive Services, or any other decision that meets the definition of an adverse benefit determination.

1.4.2. The individual expresses disagreement to the Optum Pierce BHO regarding a treatment decision or the individual service plan.

1.5. Is a Notice of Adverse Benefit Determination required when an individual disagrees with a specific service or treatment decision?

1.5.1. For non-WISe enrolled individuals:

1.5.1.1. Once medical necessity is established and services are authorized, ongoing treatment decisions should be mutually agreed upon between the

individual and the service provider during the Individual Service Planning process. Notices are not needed for an ongoing treatment decision mutually agreed upon by the client and the provider. However, if the consumer files a grievance with the Optum Pierce BHO expressing dissatisfaction with a treatment decision, the Optum Pierce BHO uphold the decision, and the decision is a denial, reduction, suspension, or termination of a previously authorized service , then the grievance is treated as an appeal and a Notice of Adverse Benefit Determination must be issued.

1.5.2. For WISe enrolled individuals:

1.5.2.1. The *T.R.* settlement agreement provides an additional due process right for individuals receiving Wraparound with Intensive Services (WISe) beyond those required by the CFR. Notices are not needed for an ongoing treatment decision that is mutually agreed upon by the consumer and provider. However, if a WISe enrolled youth (or parent or guardian if the youth is under age 13) expresses any dissatisfaction with a treatment decision or the individual service plan to the Optum Pierce BHO, then the grievance is immediately treated as an appeal (regardless if the Optum Pierce BHO upholds the decision) and a Notice of Adverse Benefit Determination must be issued.

Mailing Timeframes: Optum Pierce BHO or its agent must mail the Notices of Adverse Benefit Determinations within the following timeframes:

1.1. For Routine Service authorization decisions that deny or limit services, no longer than 14 calendar days from the request for service.

1.2. For terminations, suspensions, or reductions of previously authorized services, no longer than 10 calendar days before the date of the Adverse Benefit Determination.

1.3. For expedited authorization decisions in which Optum Pierce BHO determines or its contracted BHO indicates, or the Optum Pierce BHO determines, that following the standard timeframe could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function, Optum Pierce BHO must make an expedited authorization decision and provide notice as expeditiously as the Enrollee's health condition requires and no later than 72 hours after the receipt for the request for service.

1.4. Optum Pierce BHO may extend the 72 hour time period by up to 14 calendar days if the Enrollee requests an extension, or if Optum Pierce BHO is able to demonstrate to DSHS upon the department's request that it needs additional information and that the added time is in the Enrollee's interest.

1.5. For Actions that are issued because Optum Pierce BHO has verifiable information indication probably beneficiary fraud the notice can be provided in as few as 5 calendar days before the date of the Adverse Benefit Determination.

1.6. When an of the following occur Optum Pierce BHO must issue the notice by the date of the Adverse Benefit Determination:

1.6.1. The Enrollee has died.

1.6.2. The Enrollee submits a signed written statement requesting service termination.

1.6.3. The Enrollee submits a signed written statement including information that requires service termination or reduction and indicates that he or she understands that service termination or reduction will result.

1.6.4. The Enrollee has been admitted to an institution in which he or she is ineligible for Medicaid services.

1.6.5. The Enrollee's address is determined unknown based on returned mail with no forwarding address.

1.6.6. The Enrollee is accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth.

1.6.7. A change in the level of medical care is prescribed by the Enrollee's physician.

1.6.8. The Notice involves and adverse determination with regard to preadmission screening requirements of section 1919(e)(7) of the Act.

1.6.9. The transfer or discharge from a facility will occur in an expedited fashion as described in 42 CFR § 483.12(c)(3).

1.6.10. Denial of payment or at the time of any Adverse Benefit Determination directly affecting the claim.

1.7. Under the following circumstances, authorization decisions may be extended an additional 14 calendar days:

1.7.1. The Enrollee or the BHA requests an extension.

1.7.2. Optum Pierce BHO demonstrates the need for additional information to make an authorization decision and that the extension is in the Enrollee's best interest.

1.8. If Optum Pierce BHO extends the timeframe it must:

1.8.1. Give the Enrollee written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a Grievance if he or she disagrees with that decision; and

1.8.2. Issue and carry out its determination as expeditiously as the Enrollee's behavioral health condition requires and no later than the date the extension expires.

1.9. Optum Pierce BHO must provide a Notice on the date the timeframes expire, when service authorization decisions are not reached within the applicable timeframes for either standard or expedited service authorization

Related Policies, Procedures & Materials

- Pierce Behavioral Health Organization Policy: CR-01 - *Consumer Rights and Responsibilities*
- *CR-02A Grievance and Appeal System: Grievance Process CR-02B Grievance and Appeal System: Medicaid Enrollee's Right to Appeal Notices of Adverse Benefit Determination* Pierce Behavioral Health Organization Policy: CR-06 - *Ombuds Services*
- Pierce Behavioral Health Organization Policy: CM-05 - *UM/Resource Management Plan*
- Pierce Behavioral Health Organization Policy: CM-10 - *UM/Authorization and Concurrent Reviews*

Attachments

N/A

Approval History

A. Policy created and effective: 07/2009

B. Policy and Procedure Committee review and approval: 10/26/2009

C. Policy and Procedure Committee review and approval: 08/23/2010

D. Policy and Procedure Committee review and approval: 09/26/2011

E. Policy and Procedure Committee review and approval: 08/27/2012

F. Policy and Procedure Committee review and approval: 12/02/2013

G. Policy and Procedure Committee review and approval: 12/15/2014

H. Operational Procedures and Standards Committee reviewed and accepted: 01/25/2017

I. Optum Pierce BHO reviewed and accepted: February 2018