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I. Purpose:


To establish the Service Center's policy and procedures for the Clinical Appeal process, including decision and notification response standards.

II. Department(s) and Committee(s) Affected:

- A. Clinical Policy and Standards Committee (CPSC) and related Subcommittees
- B. Service Center Clinical/Quality/Compliance Committee and related Subcommittees
- C. Care Management and Medical Staff

III. Policy:

- A. Members or their designated representatives have the right to initiate the appeal of any adverse medical necessity determination up to 30 thirty calendar days from the date on the Notice of Action letter. A provider or facility, acting on behalf of the member as confirmed in writing, may file an appeal of any adverse medical necessity determination. Appeal requests can be made orally or in writing; however, an oral request to appeal must be followed up by a written, signed, appeal.
- B. As part of the appeals process, a member, designated representative, provider, or facility rendering service can submit written comments, documents, records, and other information relating to the case. *ValueOptions* takes all such submitted information into account in considering the appeal regardless of whether such information was submitted or considered in the initial consideration of the case.
- C. Appeals considerations are conducted by health professionals (Peer Advisors) who:
 - 1. Are clinical peers;

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2. hold a current active, unrestricted license to practice medicine or a health profession;
3. if medical doctors, are board-certified;
4. are in the same profession and in a similar specialty as typically manages the medical condition, procedure, or treatment as mutually deemed appropriate; and
5. are neither the individual who made the original non-certification, nor the subordinate of such individual.

D. Members may file a State Fair Hearing at any stage of the appeal process up to 30 calendar days from the Notice of Action. Kansas does not require Members to exhaust the *ValueOptions* appeals process before Members may request a State Fair Hearing.


E. Appeals records are maintained for the greater of the time of either ten years or six years after the expiration or termination of the contract.

IV. Definitions:

A. **Standard Appeal** - The first review of a medical necessity adverse determination conducted at the request of a member, designated representative, or the Provider of Record by a ValueOptions' Peer Advisor (PA) who is neither the individual who made the original non-certification decision nor the subordinate of such an individual for the purpose of determining medical necessity for authorization.


B. **Initiation of Appeal Process** – A valid appeal is initiated when:

1. The member, provider, facility rendering service, or the member's designated representative has requested the appeal with written confirmation if not a request for expedited appeal.
2. The request includes at least the member's name or identification number and the dates of service for which a denial of services or claims payment for services is the subject of the appeal request; and


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3. The request is received within 30 calendar days of the date on the Notice of Action.

- C. **Clinical Peer** - A physician or other health professional who holds an unrestricted license and is in the same or similar specialty as typically manages the medical condition, procedures, or treatment under review. Generally, as a peer in a similar specialty, the individual must be in the same profession, i.e., the same licensure category as the ordering provider.
 - D. **Expedited Appeal** - An expedited appeal is a request to review a decision concerning admission, continued stay, or other behavioral healthcare services for a member who has received urgent services but has not been discharged from a facility, or when a delay in decision-making might seriously jeopardize a Member's life, health, or ability to attain, maintain, or regain maximum function.
 - E. **Provider of Record** – The physician or other health care provider that has primary responsibility for the care, treatment, and services rendered to the member *or* the health care facility where treatment is requested on an inpatient or outpatient basis.
 - F. **Retrospective Appeal** - A review of relevant medical record documentation by a ValueOptions' Peer Advisor who is neither the individual who made the original noncertification decision nor the subordinate of such an individual, after a member has been discharged from the level of care or service under review.
 - G. **Urgent Services** – Level of care includes hospital detoxification, residential, reintegration, intermediate and social detoxification services.
- V. Procedure:
- A. Initiation of Appeal Process

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1. Providers and members are informed verbally and in writing about their rights of appeal and the appeal process, both standard and expedited, after an adverse determination is made.
2. Providers, facilities, members or designated representatives, may request a clinical appeal either verbally or in writing up to 30 calendar days after receipt of notification of a clinical non-certification. Oral requests to appeal must be followed by a written, signed, appeal. An appeal by the Provider on behalf of the Member must be confirmed in writing by the Member.
3. When *ValueOptions* receives a timely appeal request, the appropriate staff person verifies the type of appeal requested by referencing the clinical record and opens an appeal record, which is maintained either in electronic or paper-based format. The appeal record includes at a minimum:
 - a. The name of the requestor;
 - b. Date of request;
 - c. Names of member, provider and facility rendering services;
 - d. Copies of all correspondence between the member, provider, or facility rendering service, and *ValueOptions* regarding the appeal;
 - e. Dates of appeal reviews, documentation of actions taken, and final resolution;
 - f. Minutes or transcripts of appeal proceedings (if any).
4. Within five working days of receipt of the appeal, the date of appeal request is acknowledged in writing, and the requestor is informed of what information, if any, is required to conduct the appeal, and timeframes for submission. In addition, the requestor is informed that the member, provider, or facility rendering service can submit any written comments, documents, records, and other information relating to the case. Before and during the appeal process, the Member and/or the Member's representative may request to review the Member's case file, including clinical records, and any other documents. ValueOptions will also provide a reasonable opportunity for allegations of fact or law to be presented in person as well as in writing.

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5. When a request for an appeal of adverse determination is received orally, a one-page appeal form is sent to the appealing party at the time receipt of the appeal is acknowledged.
6. When an appeal is requested, but requested information is not received within the decision timeframe, the appeal is conducted based on whatever information is available and a decision is rendered within appropriate timeframes.
7. When the appeal process has been initiated within time standards, the Medical Director or designee assigns the case to an appropriate Peer Advisor or to the appropriate external review body as indicated to conduct the review based on the type of appeal.

B. Standard Appeal


1. Upon being assigned a case for appeal review, a *ValueOptions* Peer Advisor undertakes a full investigation of the substance of the appeal, including aspects of the clinical care involved. The Peer Advisor considers all documents, records, or other information submitted by the member, provider, or facility rendering care (regardless of whether such information was submitted or considered in the initial consideration of the case), and the clinical criteria and treatment guidelines used by ValueOptions. The Peer Advisor processes the appeal request as required (i.e. peer to peer conversation, or clinical peer review of the submitted documentation).
2. Based on consideration of all pertinent information, including relevant criteria and guidelines, the Peer Advisor makes a determination to reverse (i.e., overturn) the original adverse determination in whole or part, or to uphold the original adverse determination.
3. When the appeal review is completed, the Peer Advisor or designee verbally informs the provider of the decision including the length of authorization and the level of care authorized, and/or any alternatives/recommendations, which are clinically appropriate. The Member's UM record is updated to reflect the substance of the appeal and the actions taken.

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4. The Clinical Appeal is completed as expeditiously as the Member's health condition requires but no later than the 14 calendar days from the date appeal request was received.
5. Written notification of the appeals decision is sent within the determination timeframe for all Standard and Expedited Appeals.
6. Members may request an extension of 14 days for standard appeals if they need more time to submit information.
7. ValueOptions may request an extension of 14 days to complete a standard appeal resolution. The need for additional information and extension of time must be justified, show how the delay is in the Member's interest, and requires the approval of Kansas Social and Rehabilitation Services (SRS).

C. Expedited Appeal

1. An expedited appeal may be requested when the provider indicates, or ValueOptions determines, that following the standard appeal time frame could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function.
2. The Member or provider may file an expedited appeal either orally or in writing. No additional Member follow-up is required.
3. ValueOptions will inform the Member verbally of the limited time available for the Member to present evidence and allegations of fact or law, in person and in writing, in the case of an expedited resolution.
4. The expedited appeal will be completed and notice provided as expeditiously as required by the Member's condition, but, no later than 3 business days after the appeal is received.
5. Members may request an extension of 14 days for standard appeals if they need more time to submit information.
6. ValueOptions may extend the timeframes by up to 14 calendar days, with approval by SRS. ValueOptions must show that there is need for additional information and show how the delay is in the Member's interest. ValueOptions will notify the Member of the reason for the extension.

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7. If ValueOptions denies a request for expedited resolution of an appeal, efforts will be made to provide Member with prompt oral notice and written notice will follow within 2 calendar days. Furthermore, the appeal will be transferred to the standard appeal timeframe. Member may file a grievance in response to this decision.

D. Retrospective Appeal

1. When a member is discharged from the service or level of care under consideration prior to an initiation of the appeal process, the treating provider and/or the member has the right to request a Retrospective Appeal.
2. The member, provider of record or the facility rendering services is informed of the relevant medical record documentation needed to conduct the appeal review and the timeframe within which the documentation must be received.
3. A ValueOptions' Peer Advisor reviews the record to determine medical necessity of the services or days that were not certified as a result of the Peer Review decision. Such retrospective review will be based on written screening criteria established and periodically updated with appropriate involvement from physicians, including practicing physicians, and other health care providers.
4. This review is completed within 14 calendar days of the initiation of the appeals process. Written notification is issued to attending or ordering provider, facility and patient within the 14 calendar days determination timeframe.
5. The same 14 day extension requests as presented in the Standard appeal process may be applied in the Retrospective Appeal process.


E. For all types of appeals, Peer Advisors document their decision in the UM record, legibly if in hard copy, and according to Service Center standards, which include at a minimum:

- a. Timeliness information and data source of review
- b. Clinical criteria supporting the decision

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- c. Clinical rationale to support the decision
- d. Identification of contact and time
- e. Determination and reason for the determination
- f. Name and credentials of the clinical peer

- F. Fair Hearing – *ValueOptions* notifies members of their rights to a State Fair Hearing at the time the Notice of Action is given, as well as, at the time of decision for Standard or Expedited Appeals. *ValueOptions* provides assistance to the member or the member’s representative in accessing the fair hearing process, to the extent necessary.
1. Members may file a request for a State Fair Hearing at any stage of the appeal process and are not required to exhaust the ValueOptions’ appeal process first.
 2. The State Fair Hearing can be requested up to 30 calendar days from the date of the Notice of Action. Furthermore, a Member may seek a State Fair Hearing if not satisfied with ValueOptions’ decision in response to an appeal.
 3. A State Fair Hearing request must be made in writing, signed, and sent to the **Office of Administrative Hearings, 1020 S Kansas Avenue, Topeka, KS 66612-1311**. Fair Hearing Request forms can be accessed at <http://www.da.ks.gov/hearings/request.htm>.
- G. Continuation of Benefits
1. Services to the Member will be extended during an appeal if all of the following criteria are met:
 - a. the appeal is filed on or before the later of:
 - i. ten calendar days of the Notice of Action
 - ii. the intended effective date proposed in the Notice of Action
 - b. the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment (see policy C245 Reversal of Certification Determination)
 - c. the services were ordered by an authorized provider


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- d. the authorization period has not expired
- e. the Member requests continuation of benefits.

2. The benefits will be continued until one of the following occurs:
 - a. Member withdraws the appeal
 - b. Ten calendar days have passed since the date of the appeal resolution letter when the initial adverse decision is upheld (unless the member requested a Fair Hearing with continuation of benefits)
 - c. State Fair Hearing decision is issued that is adverse to the Member
 - d. authorization expires or authorization service limits are met
3. ValueOptions may recover the cost of the continuation of services furnished to the Member while the appeal was pending if the final resolution of the appeal upholds the adverse determination.

H. Notifications

1. ValueOptions will provide written notice of resolution for standard and expedited appeals within the decision timeframe.
2. Written resolution notice will include:
 - a. the results and date of the appeal resolution;
 - b. for decision not wholly in the Member's favor:
 - i. the right to request a State Fair Hearing
 - ii. how to request a State Fair Hearing
 - iii. the right to continue to receive benefits pending a hearing;
 - iv; how to request the continuation of benefits; and
 - v; notice that Member may be liable for costs of any continued benefits if the action of ValueOptions is upheld in hearing.
 - c. that in the State Fair Hearing the Member may represent him/herself or use legal counsel, a relative, a friend, or a spokesperson;
 - d. the specific regulations that support, or the change in federal or State law that requires the Action, and

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- e. an explanation of the individual’s right to request an evidentiary or State Fair Hearing in some cases if the Action is based on change in law


I. Monitoring and Reporting

1. Service Center staff monitors the appeals process to ensure all appeal requests are responded to within contractual guidelines and that all applicable appeal rights are made known to the appropriate individuals.
2. Compliance with appeals decision and notification policy and procedures is tracked and reported monthly to the Service Center Quality Management Committee and to the Corporate Quality Council on a quarterly basis.
3. Service Center staff maintains a monthly log of all appeals, including State Fair Hearings. The log minimally includes:
 - a. The VO-KS ID number for the member,
 - b. The Level of Care originally denied,
 - c. The provider
 - d. The date the appeal was received,
 - e. The type of appeal requested,
 - f. The date the appeal was completed,
 - g. The outcome of the appeal, and
 - h. The number of days required to complete the appeal
4. ValueOptions submits appeals reports to Kansas Social and Rehabilitation Services summarizing each appeal handled during the quarter.

VI. References

This policy is intended to comply with provisions relating to notice and Fair Hearings in the Medicaid Program, *ValueOptions* corporate policy C305P, URAC and NCQA standards.

VII. Attachment(s)

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- A. Standard Turnaround Time for Appeal Completion and Notice, by Type of Appeal
- B. *ValueOptions* Appeal Form