

Purpose:

To properly document and record information pertaining to and the final results of appeal decisions in accordance with state and federal guidelines. The appeals process is implemented after a service or benefit is denied, limited, reduced, suspended or terminated and a review of the decision is requested. The procedure outlines the process for administering appeal requests.

Procedures:

- I. When the service or benefit denial, reduction or termination is issued, a Notice of Action letter is sent to the member and practitioner. The Notice of Action letter provides both parties with their rights to an appeal and outlines the appeal process.
- II. Oral inquiries seeking to appeal a decision must be confirmed in writing by the member or their representative, unless:
 - a. The person making the appeal requests an expedited resolution, or
 - b. The appeal is sent from DMAP as part of a requested Administrative Hearing appeal.
- III. If the appeal is originally received in writing, THA Staff will date stamp the request upon receipt. This is entered into the Complaint Log under the appeal tab.
- IV. The appeal request along with relevant member information including, but not limited to, chart notes, labs, studies, etc. used in the original denial will be provided to the Case Manager who is preparing the appeal file.
- V. The THA Case Manager will notify the member, member representative and / or physician of receipt of the appeal by phone, fax or letter and request any additional documentation necessary that pertains to the substance of the appeal and any actions taken.
- VI. A full investigation of the essence of the appeal, including aspects of clinical care involved will be reviewed by THA Case Management. If the original denial was not based on medical appropriateness (benefit or administrative denials), the Nurse Case Manager will forward the appeal to the THA Medical Director for review and consideration.

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- A. As part of the review process the THA Medical Director may contact the Primary Care Physician (PCP) or specialist, involved to discuss the case.
 - B. A second THA Medical Director will review any appeal that was the result of an initial medical appropriateness denial decision from the THA Medical Director that originally made the review decision.
 - C. The Medical Director may also consult with a disinterested medical specialist consultant if appropriate.
 - D. The procedure outlined above ensures that the Case Managers or Medical Directors who make decisions on appeals are staff who were not involved in any previous level of review or decision making; and are health care professionals who have the appropriate clinical expertise in treating the member's condition or disease.
- VII. THA will make a decision within 14 calendar days (45CFR 438.210 {d}) of the date the appeal was received.
- VIII. If the request is for an expedited appeal, THA will make an expedited appeal decision and notify the DMAP member and the practitioner(s) via telephone or fax the same day as the determination, and follow up in writing within three (3) working days of the receipt of the appeal request.
- IX. Once a decision is made regarding service coverage, a Notice of Appeal Resolution will be completed by the Nurse Case Manager. The Notice of Appeal Resolution will be reviewed by an alternate Case Manager or other designated staff for accuracy. The Notice of Appeal Resolution will include:
- A. Relevant information as specified by DMAP;
 - B. Applicable OAR citation documenting reasons for the decision;
- X. A copy of the determination is faxed to the providers involved on the day the Appeal determination is made.
- XI. The original Notice is mailed to the member. Should the determination be of an adverse outcome, the Notice of Hearing Rights (Forms DMAP 3030 and DHS 443) is included in the written decision.

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- XII. All appeals are recorded in the Complaint/Appeal Log. Documentation will include whether continuation of benefits was requested and whether the continuation of benefits was provided.
- XIII. The out come of the appeal (denial upheld or denial reversed and approved) is documented in Plexis under the appeal category as an appeal upheld or overturned.
- XIV. THA staff or case managers may assist the DMAP member with filing an appeal and providing interpreter services and toll-free numbers with adequate TTY/TTD and interpreter capacity if needed.
- A. Interpreter services are obtained through Tuality Healthcare contracted interpreters.
 - B. TTY services are obtained by calling Tuality Healthcare contracted providers.
- XV. Expedited Appeals
- A. An expedited appeal or hearing request may be initiated if the provider, member or member representative indicates that taking the time for a standard resolution could seriously jeopardize the member's life, health or ability to attain, maintain or regain maximum function.
 - B. Resolution of the appeal and written notice to the member must occur no later than 2 business days after receipt of the appeal. This may be extended if one of the following occurs:
 - 1. Additional information is required and the delay is in the member's best interest and/or
 - 2. The member requests the extension
 - C. Both the providers and member will be notified by fax, or telephone and a written notice of the decision is sent to the member the same day as the determination.
 - D. The Member, the Member Representative or the practitioner must be informed of the limited time available in the case of an expedited Administrative Hearing request.
- XVI. Continuation of Benefits pending Appeal Resolution and Administrative Hearing
- A. Filing on or before the later of the following:

1. Within 10 calendar days after THA mails the Notice of action
 2. The intended effective date of THA's proposed Action
- B. THA will continue the member's benefits if:
1. The THA member or member representative files the Appeal or Administrative Hearing Request within 10 calendar days of the date on the Notice of Action
 2. The appeal or Administrative Hearing Request involves the termination, suspension, or reduction of a previously authorized course of treatment
 3. The services were ordered by a THA provider or a provider that member has been referred to by a THA provider.
 4. The original period covered by the original authorization has not expired
 5. The member requests the extension of the benefits
- C.
- If the THA member requests, THA will continue or reinstate the benefits while the appeal or Administrative Hearing is in process. Continuation of services will be noted in Plexis. If the final resolution is adverse to the member, they will be responsible for any costs incurred.
- D All results and time line from administrative hearings are documented in the complaint/appeal log. Also document if THA provided the member with other options or services and what they are.
- E. The final outcome from an administrative hearing will be included in the Quarterly Complaint/Appeal Log report.
- XVII. THA maintains the confidentiality of the THA member during all aspects of the appeal process.

Refer: 45CFR 438.210
45CFR 164.501
OAR 410-141-0266
OAR 410-210-1360 (4)
OAR 410-120-1860
OAR 410-120-1865

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THA Plan Director

THA Medical Director