

---

## SECTION 14

# DUE PROCESS

### Learning Objectives

1. Describe the importance of due process.
2. Describe how due process impacts prior approval and how it differs from DMA's current business rules to process prior approval requests.
3. Explain how non-covered services may be requested.

NC DMA 10/2009

# PROPER PRIOR APPROVAL REQUEST

---

Must be submitted by a provider in accordance with DMA's published procedures.

NC DMA 10/2009

## PROPER PROVIDER APPROVAL REQUEST, CONT'D.

---

See the clinical medical coverage policies and the PA section of the Basic Medicaid Billing Guide on DMA's website at:

<http://www.ncdhhs.gov/dma/medbillcaguide.htm>

NC DMA 10/2009

## PROPER PRIOR APPROVAL REQUEST, CONT'D.

---

- Recipient's name and address, MID number, and DOB
- Date of request
- Provider contact information, including signatures, if required
- The service that is being requested

NC DMA 10/2009

## IMPROPER PRIOR APPROVAL REQUEST

---

If the request is missing required information, it will be considered improper.

The request will be returned to provider.

NC DMA 10/2009

## IMPROPER PRIOR APPROVAL REQUEST, CONT'D.

---

The recipient will be notified by EDS or the DMA consultant that the request was returned to the provider.

No further action is required by DMA or the vendor/contractor.

NC DMA 10/2009

# ACTING UPON A REQUEST

---

Acting upon a request means:

- Approving the request
- Denying the request
- Reducing the request
- Requesting additional information

NC DMA 10/2009

## ACTING UPON A REQUEST, CONT'D.

---

DMA staff and vendors or contractors must act upon a request no later than 15 business days of receipt of the request, unless there is a more stringent requirement.

An emergent request must be reviewed and acted upon within two business days of receipt of the request, unless there is a more stringent requirement.

NC DMA 10/2009

## ACTING UPON A REQUEST, CONT'D,

When a proper request for prior approval may be made verbally and it can be approved, the caller will be notified that the request for prior approval:

- is approved effective the date of the call contingent upon receipt of the written request within 15 business days of the call, unless there is a more stringent requirement, and
- will be denied if the written request is not received within 15 business days of the call, unless there is a more stringent requirement.

NC DMA 10/2009

## ADDITIONAL INFORMATION

---

The provider will be notified in writing if additional information is required, and the recipient will receive a copy of the notice.

The provider will be allowed 15 business days from the date of the request to submit the additional information or to request an extension of time (verbally or in writing).

NC DMA 10/2009

## ADDITIONAL INFORMATION, CONT'D.

---

DMA staff and vendors/contractors must act upon the request within 15 business days of receipt of the additional information, unless there is a more stringent requirement.

If there is no response, the recipient will be notified in writing that the request was denied for insufficient information.

NC DMA 10/2009

## ADDITIONAL INFORMATION, CONT'D.

---

The provider will receive a copy of the recipient's notification.

NC DMA 10/2009

## DUE PROCESS

If a recipient's service is denied, reduced, or terminated, the recipient must receive a written explanation that:

- states why the service was denied, reduced, or terminated,
- identifies the citation(s) supporting the decision or adverse action, and
- describes how to appeal the decision.

NC DMA 10/2009

Citation Sources include:

Federal or state law

Federal or state rules

Waivers

Promulgated policies

State Medicaid plan

# REQUESTING NON-COVERED SERVICES

---

The provider may submit a Non-Covered Services Request form on behalf of the recipient to:

Assistant Director for Clinical Policy and Programs  
Division of Medical Assistance  
2501 Mail Service Center  
Raleigh, NC 27699-2501  
FAX: 919-715-7679

NC DMA 10/2009

## REQUESTING NON-COVERED SERVICES, CONT'D.

---

The Non-Covered Services Request form may be found on DMA's website at:

<http://www.ncdhhs.gov/dma/forms/forms.html>

NC DMA 10/2009

## REQUESTING NON-COVERED SERVICES, CONT'D.

---

All due process procedures apply in their entirety.

The recipient is notified in writing if the request is denied or if more information is requested from the provider.

NC DMA 10/2009

## REQUESTING TO EXCEED LIMITATIONS OF COVERED SERVICES

---

The DME provider must send a written request to DMA, along with a letter of medical necessity from the prescribing physician, physician's assistant or nurse practitioner. Consideration will be given to the request and a written decision will be returned to the provider. Recipients will be notified in writing if the request is denied.

NC DMA 10/2009

## MORE INFORMATION ABOUT DUE PROCESS

---

- Special Medicaid Bulletins, December 2005 and January 2006

NC DMA 10/2009

## CAP/C APPEAL RIGHTS

---

The following are not considered CAP/C appeals:

- Appeals regarding determination of Medicaid eligibility (these are done at DSS)

NC DMA 10/2009

## CAP/C APPEAL RIGHTS, CONT'D.

The following also are not considered CAP/C appeals:

- A provider's termination or denial of services
- A physician's level of care recommendation
- A physician's order for services

NC DMA 10/2009

### A provider's termination or denial of services

A provider of CAP/C services and other Medicaid services may refuse to serve a CAP/C client. The provider's decision may not be appealed to Medicaid.

EXAMPLE: Suzie's mother has been verbally abusive to the personal care aides who have provided care for Suzie. The provider agency has worked with the case manager in trying to alleviate the problem, but the child's mother continues to be abusive. The provider agency refuses to continue serving the client.

### A physician's level of care recommendation

EXAMPLE: Mrs. Brown wants CAP/C services for her son, Johnnie. However, Johnnie's physician states that he does not need the level of care provided in a nursing facility. Mrs. Brown's only option is to pursue the matter with Johnnie's physician.

### A physician's order for services

Medicaid only pays for services recommended by a physician. If the client's physician recommends termination or denial of a service, the physician's recommendation may not be appealed to Medicaid.

EXAMPLE: Mrs. Frazier believes that her daughter would benefit from physical therapy and requests that this service becomes a part of her Plan of Care. The client's physician states physical therapy is not needed and refuses to order the service. Mrs. Frazier's only option is to pursue the issue with her daughter's physician.

## CAP/C APPEAL RIGHTS, CONT'D.

---

The following actions MAY be appealed to CAP/C:

- Denial of CAP/C participation
- Termination of CAP/C participation
- A reduction of a CAP/C service in the Plan of Care
- A termination of a CAP/C service in the Plan of Care
- A denial of a request to increase an existing CAP/C service in the Plan of Care
- A denial of a request to add a CAP/C service to the Plan of Care

NC DMA 10/2009

## CAP/C APPEAL HEARINGS

---

- Hearings are conducted by an Administrative Law Judge with the Office of Administrative Hearings (OAH).
- The family must request the hearing by completing a form enclosed with their letter. They must file their request within 30 days.
- The family will be offered mediation.
- If mediation is unsuccessful, or if the family refuses mediation, the case proceeds to hearing.
- The judge will make a decision and send that decision to Medicaid for a final agency decision.
- If the family disagrees with the final agency decision, they may ask for a judicial review in Superior Court.

NC DMA 10/2009

## CASE MANAGER ROLE IN HEARINGS

---

### YOU DO NOT

- Take sides
- Present your own testimony

### YOU DO

- Assist both the family and DMA in preparing for the hearing, as needed
- Attend the hearing
- Remain a neutral party between DMA and the recipient
- Answer the questions that you are asked during the hearing

NC DMA 10/2009

## CONTINUATION OF SERVICES DURING AN APPEAL

---

If the child is currently receiving services, the appeal is filed appropriately, and the child continues to remain otherwise eligible, the child may keep his/her services at the CURRENT or at a LOWER level until the appeal is resolved.

However, if the family loses the appeal, they may be required to pay for services that continued as a result of the appeal.

NC DMA 10/2009

## SUMMARY

---

- DMA has 15 business days to respond to a request.
- DMA's response will be to approve, deny, or reduce the request, or to request additional information.
- If DMA requests more information, the provider has 15 business days to provide the information or to ask for an extension. One extension of an additional 15 business days is allowed.
- Recipients are given appeal rights with any decision to deny, reduce, or terminate.
- Decisions made by the child's physician or by Medicaid eligibility can only be appealed to those parties.
- CAP/C decisions are appealed to the office of Administrative Hearings. Mediation is offered, and the hearing is held if mediation is refused or unsuccessful.
- CAP/C case managers are expected not to take sides, but rather to be a neutral party and act as a liaison between DMA and the recipient.
- In some cases, recipients may continue their current services at the current or reduced level until the hearing has been resolved.

NC DMA 10/2009

## REVIEW QUESTIONS

Please make sure you can answer the following questions before proceeding to the next section.

1. The time frame for response from DMA regarding a service or supply request is
  - A. 15 calendar days
  - B. 15 business days
  - C. immediately
  - D. there is no time frame specified
  
2. The time frame for response to DMA regarding a request for additional information is
  - A. 15 calendar days
  - B. 15 business days
  - C. immediately
  - D. there is no time frame specified
  
3. Explain the role of the case manager during a CAP/C appeal.

## REVIEW ANSWERS

1. B, 15 business days
2. B, 15 business days
3. The case manager maintains a neutral stance during the appeals process. She acts as a liaison between the recipient and DMA. He helps the recipient and DMA as needed to prepare for the hearing. In some cases, she continues the child's services at their current or lower level until the appeal is over. The case manager attends the hearing and answers any questions she is asked.