

Due Process Instructions for LME/MCOs

Section I: Due Process Instructions

1. Discouragement Protections:

LME staff, including care coordinators, are strictly prohibited from discouraging requests for services by a family or provider, appeals of adverse decisions, or requests for maintenance of service pending appeal. Examples of prohibited discouragement include:

- Telling a member or provider there is no point in making the request because it will be denied;
- Providing materially incorrect or incomplete information about available services or appeal rights;
- Stating or suggesting that services over the individual's assigned budget will not be approved;
- Stating or suggesting to a member or provider that services should be requested in a lower amount or for a shorter duration (unless required by clinical policy);
- Stating that a service not managed by the LME should be requested instead of services managed by the LME;
- Threatening or suggesting retaliation may occur if the request is made or the appeal is filed;
- Encouraging a member to withdraw an appeal and submit a new request for the service;
- Informing a member that he or she cannot make a new request for services while an appeal is pending;
- Informing a member that because the period for which the service was originally requested (e.g. June 1 to June 30) has expired, the appeal is moot, and a new request must be made;
- Informing a member that new or additional information not provided with the original request or a change in the member's condition cannot be considered on appeal;
- Telling a member that a pending appeal must be withdrawn before the LME can consider a request for an alternative service;
- Threatening or suggesting to a provider that requesting a service or assisting a member with an appeal will trigger an audit.
- This section does not preclude clinical or treatment discussions with a family or provider or providing accurate information about waiver or clinical policy limits or requirements.

2. Processing Requests for Service

- If the request for service has been sent to the LME but the service requested is managed by another contractor, the LME must forward the request.
- 'Unable to process' vs. 'Missing information'
 - **Unable to process:** LME cannot process a request for a service because the request is missing critical identifiers, including, but not limited to:
 - Member's name and address, MID number, and date of birth
 - Identification of service requested or procedure code
 - Provider name/NPI/Provider number who is to perform service or procedure
 - All required signatures on forms required by law
 - Date the service is requested to begin or be performed
 - Documents or forms required by state or federal statute

- If a request for service cannot be processed because it is missing critical identifiers, the request should be returned marked as 'unable to process', identifying what necessary information is missing.
 - **Missing information:** a request is missing information needed to determine medical necessity.
 - If a request is missing information needed to determine medical necessity, the LME must request additional information.
 - If the additional information is not provided:
 - LME must make a decision based on the information available at the time of the request, if possible.
 - If the LME is unable to make a decision based on the information available at the time of the request, the LME is to issue form "LME Initial 2001", denying the request for 'additional information requested was not received'. Specify the information that was not provided.
- The LME must follow time frames for processing requests set out in federal regulations:
 - For standard authorization decisions, provide notice as expeditiously as the member's condition requires and within State-established timeframes that may not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if the member or the provider requests an extension or the MCO justifies (to the state agency upon request) a need for additional information and how the extension is in the member's interest.
 - If a provider indicates, or the MCO determines, that following the standard timeframe could seriously jeopardize the member's life, health or ability to attain, maintain, or regain maximum function, the MCO must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than 72 hours after receipt of the request for service.
 - For a notice of change in services, notice must be mailed at least 10 days before the proposed effective date of the change in services

3. APPEAL REQUESTS

- Appeal requests must be received within 60 days either in person or by mail, fax, email or telephone. If the member or authorized representative calls or emails within 60 days to request an appeal, the LME must have a process for receiving and recording these appeals. Be sure to inform the member that he/she must also submit a signed appeal request form within 14 days after the call or email.
- Inform the member that LME assistance in completing the form is available. This assistance also must be provided when requested during other steps of the appeal process. The LME must have a procedure for receiving and acting on requests for assistance with the appeal process.
- A provider or a representative can file the appeal request with the written permission of the member.
- An appeal request can also be filed based on a failure of the LME to act within the required timeframes. There is no deadline for such a request if no notice of decision was sent.

- The LME must mail a letter to the member and any named representative confirming that the appeal request was received. The letter must provide ten days to submit information in support of the appeal and information about the process for doing so, including that more time can be requested if needed. The LME need not wait on this information if able to reverse its initial decision without additional information.

4. EXPEDITED APPEAL:

- On the appeal request form or by phone, the member may ask for the appeal to be decided on an expedited basis if the member (or provider) states that waiting thirty (30) days could seriously jeopardize the member's life, physical or mental health, or ability to function. If the provider states in writing that the standard for an expedited review is met, the LME must process the appeal on an expedited basis. If the member requests an expedited review without a provider statement, the LME must determine as soon as possible whether to expedite the appeal.
- If the appeal is expedited, it must be processed within seventy-two (72) hours after the LME receives the request.
- If the request to expedite the appeal is denied, make reasonable efforts to inform the member by phone immediately following that decision. Also mail a written notice within two calendar days after that decision, informing the member that the request was not approved for an expedited review. If a request for expedited appeal is denied, it must be resolved within the standard timeline (30 days).

5. PROCESSING THE APPEAL REQUEST

- The appeal decision must be made by a professional who has the appropriate clinical expertise in treating the member's condition or disease. The reviewer must not have made or have been involved in making the initial decision or be a subordinate of any employee who was involved in making the initial decision.
- The member and their representative, family or provider have the right to meet in person with the reviewer to provide information in support of the appeal. The LME must have a procedure for accepting requests by phone or in writing for such a meeting and scheduling the meeting.
- The member and their team also can present new or additional information in writing to support the appeal. The LME must have a procedure for receiving this information and forwarding it to the reviewer.
- The member or representative also can request, by phone or in writing, a free copy of the member's entire case file at the LME (or a portion of the case file), including any documents and records that were used to make a decision about services. The member or representative can also request access to the member's medical records. Other information can also be requested, including medical necessity criteria and any processes or standards used in setting coverage limits. The LME must have a procedure for receiving these requests and promptly mailing a copy of the information requested without charge to the member or representative to the extent allowed by HIPAA. A signed release may be required from the member.
- The member or representative also can request by phone or in writing more time to gather information. This request should be granted if reasonable, but the member should be informed that the extension of time will be added to the 30-day time frame.

- The 30-day time frame also can be extended if the reviewer determines that it is necessary to request additional information. This can be done only if the additional information may help to approve the service request. Notify the member promptly in writing if an extension is necessary, including the reason for the extension, and that the member may file a grievance if he or she disagrees with the reason for the extension.

6. STATE FAIR HEARINGS

- The State Fair Hearing must be requested within 120 days of the date of the LME Notice of Decision. The member should fax, e-mail, mail, or hand deliver a copy of the Hearing Request Form to the LME and the Office of Administrative Hearings (OAH).
- The member may choose anyone as a representative during the appeal. The representative does not need to be an attorney.
- The member can request a State Fair Hearing by fax, by mail, by phone or in-person.
- Unless the member declines mediation, the LME will be contacted by the NC Mediation network to schedule a telephone mediation.
- The member or representative can request by, phone or in writing, a free copy of the member's entire case file at the LME (or a portion of the case file), including any documents and records that were used to make a decision about services. The member or representative can also request access to the member's medical records, Other information can also be requested, including medical necessity criteria and any processes or standards used in setting coverage limits. The LME must have a procedure for receiving these requests and promptly mailing a copy of the information requested free of charge to the member or representative to the extent allowed by HIPAA. A signed release may be required from the member.
- The member can present new information at the mediation which must be considered by the LME. The mediation communications are confidential and may not be used at a fair hearing.
- The LME must implement the ALJ decision or settlement within 72 hours unless otherwise ordered or agreed. If the decision or settlement approves a service for a period of time (e.g. 3 months), the LME must approve that authorization period beginning with the date the decision or settlement is implemented unless the member requests retroactive authorization or unless otherwise agreed to.

7. REQUESTING AN EXPEDITED STATE FAIR HEARING

- If the member needs a faster decision because their life, physical or mental health, or their ability to attain, maintain or regain maximum function is in danger, the member can request an expedited State Fair Hearing.
- When requesting an expedited State Fair Hearing, the request must include information from an appropriately licensed medical professional explaining the need for an expedited hearing.

8. CONTINUATION OF BENEFITS PENDING APPEAL (COB)

- This applies only to changes during an authorization period (LME 2002). This does not apply when there is a denial to take effect following the expiration of an authorization period.
- The member/representative must ask for services to continue at the prior level within 10 days from the date of the Notice, or the effective date of the proposed change in services, whichever is later.

- Once COB is in place, it must continue until the appeal is decided, withdrawn or otherwise resolved, even if the authorization period expires before the appeal is decided.
- If the appeal decision upholds or partially upholds the initial decision, the member or representative must request a State Fair Hearing AND ask for services to continue within 10 days of the mailing date of the Notice of Decision for services to continue pending the State Fair Hearing.
- If COB is requested and the appeal upholds the initial decision, the LME may ask the member to repay the cost of the services that were terminated or reduced and then continued during the appeal. Do NOT ask a parent (unless the member is under age 18) or a legal guardian or a provider to repay.
- If the member changes providers while the appeal is pending, transfer the COB authorization to the new provider.

9. General Instructions for Adverse Decision Templates

- All decisions on requests for services or to change or stop an existing service must be in writing using, department developed NABD templates. **Verbal denials are strictly prohibited.**
- The LME must provide a notice with appeal rights, even if the request is for an adult and is being denied because it exceeds clinical policy or waiver limits.
- Denials of requests for out-of-network or out of state services trigger notice and appeal rights for all members under age 21.
- Each CPT/Service Code and Service Description (showing amount of service requested, denied, approved) must appear for each requested service
- The reason for decision must include, as applicable, a detailed clinical rationale for this case, and any information requested and not provided.
- The rationale must address each service denied or partially denied or reduced but may also discuss the array of services as a whole.
- If an Adverse Benefit Determination discontinues or reduces any continuing service, provide a detailed explanation of the change in medical condition or social circumstances since the previous authorization was made, or the other reason why discontinuing or reducing the authorization is appropriate.
- If the Adverse Benefit Determination is to deny an out-of-network referral based on training/experience or availability of providers in-network, the decision must demonstrate that in-network providers are available and have appropriate training and experience to meet the member's particular needs.
- If the Adverse Benefit Determination is to deny or reduce requested Innovations Waiver services and the requested services exceed the member's resource allocation level budget, the notice must state that if an appeal is requested and if the service request is found on appeal to be medically necessary, the services will be approved.
- Legal authority must list the specific clinical policy section or regulation that was not met for each denied service.
- If the member is under age 21, the notice must include the required EPSDT language. Choose the EPSDT options that apply and specify why the ESPDT criteria are not met.
- Be sure correct phone numbers are on notices and all enclosures
- A nondiscrimination notice must be enclosed with all adverse decision notices.
- For Spanish speakers, be sure to send Spanish versions of notices and all enclosures. The LME must have a system for tracking which beneficiaries are Spanish speakers and must assure that the LME phone number on the notice and enclosures can be easily accessed by Spanish speakers. Language

line or another qualified interpreting service must be used for non-English speakers other than Spanish.

- The LME must provide accurate information about the appeal process in its member handbook and to providers.
- New service requests (even for the same service) must be accepted and processed during an appeal. All approved services must be provided during an appeal.

10. Dating and Mailing of Notice:

- Ensure that an envelope with proper postage was placed in custody of the postal service on the date that appears on the Notice.
- For an initial decision on a service, the Notice must be mailed as expeditiously as possible and no later than 14 days after the date of the request (unless extended), or within 72 hours for expedited service authorizations.
- For a decision that changes an existing service, the Notice must be mailed at least 10 days before the proposed effective date of the change in services.
- A copy of the notice should be sent to the provider who requested the service.
- If the notice is returned undelivered, make reasonable efforts to contact the member by telephone to verify the address and resend the notice.