ITASCA MEDICAL CARE (IMCare)
POLICY AND PROCEDURE

Title: MHCP-MC Appeals	**Index:** Grievances and Appeals
NCQA Standard #: UM8: Policies for Appeals; UM9: Appropriate Handling of Appeals; RR2: Policies for Complaints and Appeals	
Statute/CFR#: MN Statute, Sections 62M.06, 62M.09, 42 CFR 438, Subpart F	
Effective Date: 07/01/85	**Policy Number:** 2.05.01
Written by: QI/UM Staff	**Reviewed/Revised Date:** 05/01/2018
Attachments:	

Definitions:

Action (Adverse Benefit Determination): An action (Adverse Benefit Determination) is:

1. the denial or limited authorization of a requested service, including the level or type of service;
2. the reduction, suspension, or termination of a previously authorized service;
3. the denial, in whole or in part of payment for a service;
4. the failure to provide services in a timely manner;
5. the failure to act within timeframes;
6. for a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right to obtain services out of network.;
7. the denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, or other enrollee financial liabilities.

Appeal: A request to change a previous decision (adverse benefit determination) made by IMCare. An enrollee or authorized representative of an enrollee may appeal any adverse decision (denial/DTR). An appeal is an oral or written request from the enrollee, or the Provider acting on behalf of the enrollee with the enrollee's written consent, to IMCare for review of an action. Effectuation**:** Compliance with a reversal of IMCare's original adverse utilization management determination. Compliance may entail payment of a claim, authorization for a service, or provision of services.

Expedited Appeal: A request to change a denial for urgent care. Urgent care is any request for medical care treatment with respect to which the application of the time period for making non-urgent care decisions could result in the following circumstances:

- Could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function, based on a prudent layperson's judgment, or
- In the opinion of the practitioner with knowledge of the enrollee's medical condition, would subject the enrollee to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

For expedited appeals, IMCare must allow a provider with knowledge of the enrollee's condition to act as the enrollee's authorized representative.

Pre Service Appeal: A request to change a denial for care or service that IMCare must approve, in whole or in part, in advance of the enrollee obtaining the care or services.

Post Service Appeal: A request to change a denial for care or services that have already been received by the enrollee.

Subsequent Appeal: When an enrollee appeals a decision from a previous appeal on the same issue.

POLICY:
Itasca Medical Care (IMCare) must have written policies and procedures for thorough, appropriate and timely resolution of enrollee appeals; and have a thorough and consistent process for addressing enrollee service and payment appeals. IMCare may only have one level of appeal for enrollees.

IMCare's policies and procedures for registering and responding to oral and written appeals must include:

1. Documentation of the substance of appeals and actions taken.
2. Investigation of the substance of appeals, including any aspect of clinical care involved.
3. Notification to enrollees of the disposition of appeals and the right to further appeal, as appropriate.
4. Standards for timeliness, including standards for clinically urgent situations.
5. Provisions of language services for the appeal process.

Itasca Medical Care (IMCare) views enrollee appeals seriously and has written procedures in place for a thorough and consistent investigation and response to appeals, including appeals filed with participating providers. IMCare will handle all appeals in a respectful manner and will maintain the confidentiality of its enrollees at all times throughout and after the appeal process is completed. It is the responsibility of the Health Plan Compliance Coordinator to ensure that confidentiality is maintained, documentation is complete and accurate, and the appeal process is implemented and completed according to policies and procedures.

Enrollees or providers acting on behalf of an enrollee with the enrollee's written consent may file an appeal within 60 days of the date of the DTR Notice of Action, or for any other action taken by IMCare. An attending health care professionals may appeal a utilization review decisions to IMCare without the written signed consent of the enrollee in accordance with Minnesota Statutes, § 62M.06 (medical necessity). Appeals to IMCare may be filed orally or in writing. Unless an enrollee requests an expedited appeal The initial filing determines the timeframe for resolution.

IMCare tracks appeals and monitors trends in order to initiate corrective action as necessary. Appeal data is reported to and evaluated by the Provider Advisory Subcommittee and the Quality Improvement/Utilization Review Committee. IMCare's appeal procedures are designed to be in compliance with NCQA Guidelines, Federal Regulations, Minnesota Statutes and Minnesota Department of Human Services contract requirements.

IMCare's Grievance System (which includes appeals) is subject to approval of the State.

(A) Any proposed changes to the Appeal System must be approved by the State prior to implementation.

(B) IMCare will send written notice to enrollees of significant changes to the Appeal System at least 30 days prior to implementation.
(C) IMCare will provide information specified in 42 CFR 438.10(g)(1) about the Appeal System to providers and subcontractors at the time they enter into a contract.
(D) Within 60 days after the extension of a contract with a Provider (e.g. hospitals, individual Providers, and clinics) IMCare must inform the Provider of the programs under this Contract, and specifically provide an explanation of the Notice of Rights and Responsibilities, and Grievance, Appeal and State Appeal (State Fair Hearing) Rights of enrollees and Providers under this contract.

Filing Requirements
If the appeal is filed orally, IMCare must assist the enrollee, or provider filing on behalf of the enrollee, in completing a written signed appeal.

Once the oral appeal is reduced to writing by IMCare, and pending the enrollee's signature, IMCare must:

a) May promptly resolve the appeal in favor of the Enrollee, regardless of receipt of a signature, or

b) If no signed Appeal is received within thirty (30) days, the MCO may resolve the Appeal as if a signed appeal were received

Timeframe for Resolution of Appeals

Type of Appeal	**Time frame, no extension**	**Time frame, with extension**
Expedited		
Oral and Written	Oral and written notice within 72 hours	14 days* with extension letter**
Denial of Expedited Appeal Request	Orally within 24 hours, and follow with written notice within two (2) calendar days	
Standard	Within thirty (30) calendar days	14 days* with extension letter

*** Extension of time frame**: If IMCare cannot make a determination within thirty (30) days due to circumstances outside the control of IMCare, IMCare make take an extension of the timeframes for resolution of appeals of up to fourteen (14) days for standard and expedited appeals if the enrollee requests the extension, or if IMCare justifies both the need for more information and that an extension is in the enrollee's interest. IMCare must provide written notice to the enrollee and the attending health care professional of the reason for the decision to extend the time frame if IMCare determines that an extension is necessary, prior to extending the timeframe. IMCare's extension notice must notify the enrollee of their right to file a grievance if he or she disagrees with IMCare's decision to extend. IMCare must issue a determination no later than the date the extension expires. The State may review IMCare's justification.

- ***Expedited*** **Appeals:**
  (1) IMCare must resolve and provide written notice of resolution for both oral and written appeals as expeditiously as the enrollee's health condition requires, but

not to exceed seventy-two (72) hours after receipt of the appeal, consistent with 42 CFR § 438.408(b)(3).

(2) If IMCare denies a request for expedited appeal, IMCare shall transfer the denied request to the standard appeal process, consistent with 42 CFR § 438.410(c), preserving the first filing date of the expedited Appeal. IMCare must notify the enrollee of that decision orally within twenty-four (24) hours of the request and follow up with a written notice within two (2) days.

(3) When a determination not to certify a health care service is made prior to or during an ongoing service, and the attending health care professional believes that an expedited appeal is warranted, IMCare must ensure that the enrollee and the attending health care professional have an opportunity to appeal the determination over the telephone. In such an appeal, IMCare must ensure reasonable access to the MCO's consulting physician as authorized by Minnesota Statutes § 62M.06, subd.2(a).

- ***Standard*** **Appeals:**
  - IMCare must resolve each appeal as expeditiously as an enrollee's health requires, not to exceed 30 calendar days after receipt of the appeal.

- **Subsequent Appeals:**
  - If an enrollee appeals a decision from previous appeal on the same issue, and IMCare decides to hear it, for purposes of the timeframes for resolution, this will be considered a new appeal.

- **Deemed Exhaustion of Appeals:**
  - In the event IMCare fails to adhere to the notice and timing requirements, the enrollee is deemed to have exhausted the appeals process, and may proceed to a State Appeal (State Fair Hearing).

The documentation required by IMCare may include copies of part or all of the medical record and a written statement from the attending health care professional.

Prior to upholding an initial determination not to certify for clinical reasons, IMCare will ensure that a review of the documentation is reviewed by a physician who did not make the initial determination not to certify.

When a determination not to certify a health care service is made prior to or during an ongoing service, and the attending health care professional believes that an expedited appeal is warranted, IMCare must ensure that the enrollee and the attending health care professional have an opportunity to appeal the determination over the telephone. In such an appeal, IMCare must ensure reasonable access to IMCare's consulting physician or health care provider.

If a determination not to certify is not reversed through the appeal process, IMCare must inform the enrollee and the attending health care professional, in writing, of their right to appeal to the Minnesota Department of Health.

An attending health care professional or enrollee who has been unsuccessful in an attempt to reverse a determination not to certify must be provided the following:

- A complete summary of the review findings;
- Qualifications of the reviewer(s), including any license, certification, or specialty designation; and
- The relationship between the enrollee's diagnosis and the review criteria used as the basis for the decision, including the specific rationale for the reviewer's decision.

In cases of appeal to reverse a determination not to certify for clinical reasons, IMCare must ensure that a physician of IMCare's choice in the same or a similar specialty as typically manages the medical condition, procedure, or treatment under discussion is reasonable available to review the case.

Handling of Appeals

(A) All oral inquiries challenging or disputing a DTR Notice of Action or any action shall be treated as an oral appeal.

(B) IMCare must send a written acknowledgment within ten days of receiving the request for an appeal and may combine it with the notice of resolution (Acknowledge & Resolved Letter – Appeal) if a decision has been made within the ten days.

(C) IMCare must give enrollees any reasonable assistance required in completing forms and taking other procedural steps, including but not limited to, providing interpreter services and toll-free numbers that have adequate TTY and interpreter capability.

(D) IMCare must ensure that the individual making the decision was not involved in any previous level of review or decision-making, nor are subordinates of the person making the previous decision.

(E) If IMCare is deciding an appeal regarding denial of a service based on 1) lack of Medical Necessity, 2) a Grievance regarding denial of expedited resolution of an Appeal, or 3) a Grievance or Appeal that involves clinical issues; then, IMCare must ensure that the individual making the decision was not involved in any previous level of review or decision-making, and is a Health Care Professional with appropriate clinical expertise, in a same or similar specialty as typically manages the medical condition, procedure, or treatment under discussion, in treating the enrollee's condition or disease. IMCare must ensure that its reviewers are reasonably available to review cases. Prior to upholding a denial for clinical reasons, IMCare must ensure that there is review of the documentation by a physician who did not make the initial determination to deny.

(F) A peer of the treating mental health or substance abuse provider, a doctoral-level psychologist, or a physician must review requests for outpatient services in which

IMCare has concluded that a determination not to certify a mental health or substance abuse service for clinical reasons is appropriate.

(G) A chiropractor must review all cases in which IMCare has concluded that a determination not to certify a chiropractic service or procedure for clinical reasons is appropriate and an appeal has been made by the attending chiropractor, enrollee, or designee.

(H) IMCare must provide the enrollee with a reasonable opportunity to present evidence and allegations of fact or law, in person, by telephone, as well as in writing. For expedited appeal resolutions, IMCare must inform the enrollee of the limited time available to present evidence in support of their appeal.

(I) IMCare must provide the enrollee, and his or her representative, an opportunity, before and during the appeal process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeal process. Enrollees may obtain copies of all documents relevant to their appeal, free of charge, and upon request.

(J) IMCare must include as parties to the appeal the enrollee, his or her representative, or the legal representative of a deceased enrollee's estate.

(K) IMCare must not take punitive action against a provider who requests an expedited resolution or supports an enrollee's appeal.

(L) IMCare may require copies of part or all of the medical record and a written statement from the attending health care professional as documentation for their review.

Notice of Resolution of Appeal

(A) IMCare must provide written notice of the resolution of all appeals, and must include in the text of the notice:
1. The results of the resolution process and date it was completed; and
2. The enrollee's right to request a State Appeal (State Fair Hearing) if the resolution was not wholly favorable to the enrollee. IMCare must include with the notice a copy of the State's Notice of Rights, language block and complaints block notice.

(B) For appeals of Utilization Management (UM) decisions, the written notice of resolution shall be sent to an enrollee, the attending health care professional, and the primary care physician (when not the attending health care professional).

(C) IMCare must notify the enrollee and attending health care professional by telephone of its determination on an expedited appeal as expeditiously as the enrollees medical condition requires, but not later than seventy-two (72) hours after receiving the expedited appeal.

(D) If an enrollee or attending health care professional is unsuccessful in an appeal of the UM determination, IMCare must provide:
1. A complete summary of the review findings,

2. Qualifications of the reviewer, including any license, certification, or specialty designation; and,
3. The relationship between the enrollee's diagnosis and the review criteria used as the basis for the decision, including the specific rationale for the reviewer's decision.

Reversed Appeal Resolutions
If a decision by IMCare is reversed by the appeal process, IMCare:
(A) Must comply with the appeal decision promptly and as expeditiously as the enrollee's health condition requires; and
(B) Must pay for any services the enrollee already received that are the subject of the appeal or State Appeal (State Fair Hearing).

External Review Request
An enrollee may request an external review. In addition, if a determination not to certify is not reversed through the expedited appeal, IMCare must include in the notification the right to submit the appeal to the external appeal process described in 62Q.73 and the procedure for initiating the process. This information must be provided in writing to the enrollee and the attending health care professional as soon as practical. If an enrollee requests an external review, the Minnesota Department of Human Services (DHS) randomly assigns an external review entity. The assigned external review entity must provide immediate notice of the review to IMCare. Upon notification of an external review, IMCare must adhere to the timelines and follow the process outlined in Minnesota Statutes, Section 62Q.73, subd. 6.

Appeal records are made available to the State upon request.

PROCEDURE:

Utilization Management (UM) Appeals

1. The Health Plan Compliance Coordinator will:
   a. Retrieve the original authorization paperwork, duplicates the original authorization request on CaseTrakker indicating the duplication is the result of an appeal.
   b. Forward the service authorization to the Medical and/or Dental Director for determination of who will review the appeal.

2. The Medical and/or Dental Director will:
   a. Determine who will review the appeal.
   b. Ensure that the individual making the decision was not involved in any previous level of review or decision-making, and is a health care professional with appropriate clinical expertise, in a same or similar specialty as typically manages the medical condition, procedure or treatment under discussion, in treating the enrollee's condition or disease.
   c. Document the determination on CaseTrakker.
   d. Forward the appeal/service authorization to the Health Plan Compliance Coordinator.

3. The Health Plan Compliance Coordinator will:

a. Send documentation to the assigned reviewer, indicating the appeal status (expedited vs. standard, timelines, etc).
b. Track the appeal process for timeliness.

4. The Physician/Specialty Reviewer (including mental health providers and chiropractors, as appropriate – see Handling of Appeals (F) and (G) above) will:
   a. Review the appeal, processes the request in the appropriate time frame. Requests additional information if needed, e.g. contact enrollee or person acting on behalf of the enrollee, contact attending health care professional, and/or request applicable medical records. Documents additional information request.
      i. IMCare must provide the enrollee with a reasonable opportunity to present evidence and allegations of fact or law, in person, by telephone, as well as in writing. If expedited, IMCare must inform the enrollee of the limited time available for this to happen.
      ii. IMCare must provide the enrollee, and his or her representative, an opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeal process.
   b. Investigate the issue(s) identified in the appeal, including review of all relevant information, e.g. medical records.
   c. Document review findings and determination, as well as the date of completion, and the reasons for the determination on CaseTrakker.
   d. Sign and date the documentation.
   e. Forward the original request and all documentation to the Compliance Coordinator.

5. The Health Plan Compliance Coordinator will:
   a. Inform the Medical Secretary if the denial has been overturned, so that the appropriate referral letters can be generated, as referenced below.
   b. Ensure that the appeal resolution letters include:
      i. A complete summary of the review findings,
      ii. Qualifications of the reviewer, and
      iii. The relationship between the enrollee's diagnosis and the review criteria used, including the specific rationale for the reviewer's decision.

Payment/Other Appeals

1. The Health Plan Compliance Coordinator will:
   a. Review the appeal, processes the request in the appropriate time frame, and documents the investigation and process used to resolve the issue.
   b. Follow the appropriate timeframes.
   c. Determine the issue of the appeal: no referral on file, receiving bills after IMCare paid, premiums, co-pays, other insurance, etc.
   d. Work with the enrollee to get the information needed to resolve the issue.
   e. Verify the issue internally, for example:
      i. For those claims that deny for "no referral on file", ensure that a referral is required, and that it is not a system issue.

ii. For those claims that denied for other insurance, verify that the information is correct.

f. Requests referral from the primary care provider for those claims that denied appropriately. Tracks the referral through the process, and if approved, notifies the claims department to reprocess the claim.

g. Determine the source of other insurance. Verifies other insurance information with the Financial Worker, if needed, and compares that information to the claims system. Contact the insurance carrier, if needed, to verify coverage. If no longer covered, shares information with the Financial Worker, if needed, and/or the claims processor to update the claims system. Request the claim to be reprocessed if appropriate.

h. Generate the appropriate appeal letters as indicated below. Provides a complete summary of the appeal, the investigation, and the resolution.

All Appeals

1. The enrollee, authorized representative (or the provider acting on behalf of the Enrollee with the enrollee's written consent) may initiate an appeal by:
   a. Contacting the IMCare Health Plan Compliance Coordinator via telephone, in person, by fax, in writing, etc.
      - NOTE: The enrollee, or the provider acting on behalf of the enrollee, with the enrollee's written consent, may initiate an appeal within 60 days of a DTR Notice of Action or for any other action taken by IMCare. Attending Health Care Professionals may appeal utilization review decisions at the MCO level without written, signed consent of the enrollee in accordance with MN Statutes, section 62M.06.
   b. Describing the nature of the appeal to the IMCare Health Plan Compliance Coordinator.
   c. Requesting an expedited review of the matter, if the appeal is regarding an urgently needed service.

2. IMCare Health Plan Compliance Coordinator will:
   a. Document receipt of the appeal, indicating if the appeal is oral or written.
   b. Record the appeal information in the CaseTrakker system promptly. Includes a descriptive explanation of the appeal issue. Document all actions taken on an appeal including, but not limited to, the issue, investigation, resolution and effectuation, based on the outcome.
   c. Determine if an expedited review is indicated either by request or by the nature of the appeal.
      i. An expedited appeal can be requested if the enrollee was denied a service requested under the expedited pre service process, or if the enrollee was denied an expedited grievance that was requested due the extension of the time frame on the request for service.
      ii. If an expedited review is requested or indicated, forward to the QI/UM nurse.
   d. Offer to assist in completing a written appeal, if the appeal is filed orally, and is not an expedited request.

i. This includes repeating the issue to the enrollee, authorized representative or provider, and informs them that the written appeal will be mailed, along with a self addressed stamped envelope, for review, signature, and return to IMCare.
ii. Then generates the Oral Appeal Acknowledgement Letter on CaseTrakker, allowing ten days for receipt of the signed letter. Includes enrollee rights, language block, and self addressed stamped envelope with the letter.

NOTE: **If the oral request is an expedited appeal prior to or during an ongoing service from an attending health care professional,** all information will be taken over the telephone, confirmed and documented on CaseTrakker, forgoing the need for reducing the appeal to writing. The attending health care professional will also be informed in the initial telephone interaction or through follow up interaction of their right to access to the consulting physician assigned to review the appeal.

e. Pending the enrollee's signature on the Oral Appeal Acknowledgment Letter:
   i. Resolve the appeal in favor of the enrollee, regardless of receipt of a signature, or;
   ii. Resolve the appeal as if a signed appeal was received, if no signed appeal is received within 30 days.
f. Track for receipt of the signed appeal (Oral Appeal Acknowledgement Letter),
g. Document the appeal process on CaseTrakker, including the issue, the investigation, the resolution and any other information that is pertinent to the issue.
h. When the determination is adverse to the enrollee, include further appeal rights with the notification letter. If the determination is initially communicated by telephone, the enrollee or the provider acting on behalf of the enrollee must be notified of appeal rights at that time. Notification must include their right to request a State Appeal (State Fair Hearing).
i. Within 72 hours of receipt of an expedited appeal, informs the enrollee (or representative), primary care physician, and attending health care professional (if not the primary care physician) of the findings and determination regarding the appeal, and follows up with written notice generating the Resolution Letter – Appeal on CaseTrakker. Includes enrollee rights and language block in the mailing.
j. Within ten days of receipt of an oral appeal, documents the investigation and resolution on CaseTrakker and generates the Acknowledged–Appeal letter to the enrollee on CaseTrakker, and copies the primary care physician, and attending health care professional (if not the primary care physician). If the appeal can be resolved within ten days, may generate the combined Acknowledged & Resolved-Appeal Letter on CaseTrakker. Includes a descriptive explanation of the appeal issue, the investigation, and the resolution. Includes enrollee rights and language block in the mailing.
k. Generate the 14 day extension letter on CaseTrakker if the appeal cannot be resolved in the time frame, and if the enrollee (or representative) requested the extension or an extension is in the best interest of the enrollee. Includes in the letter that the enrollee may file an expedited grievance if they do not agree with the extension of the time frame. The extension notice is mailed to the enrollee and the attending health care professional.
l. Resolve the appeal within 14 days of the extension, and generates the Resolution – Appeal letter on CaseTrakker. Includes a descriptive explanation of the appeal issue, the investigation, and the resolution. Includes enrollee rights and language block in the mailing.

m. Resolve the standard appeal within 30 days of receipt of the appeal by generating the Resolved-Appeal Letter on CaseTrakker. Includes a descriptive explanation of the appeal issue, the investigation and the resolution.
n. Provide for effectuation of the appeal outcome.
o. Documents effectuation of the appeal outcome on CaseTrakker.
p. Maintain a complete file on each appeal.
q. Generate the Oral and Written Appeal Reports on CaseTrakker, and submits them to DHS quarterly.
r. Maintain copies of any additional documentation and CaseTrakker entry for additional reporting to the Provider Advisory Committee, the Service Advisory Committee, and External QI/UR. Appeal data is also reported periodically to the Itasca County Board of Commissioners and is aggregated for the annual Program Evaluation.
s. Prepare appeal files for MDH and other external audits.
t. Provide appeal records to the State upon request.
u. Monitor the appeal activity to determine if there are constant variables that require additional training and/or education of staff or contracted and/or delegated providers, or possible corrective action to be taken.

External Reviews

1. **The Health Plan Compliance Coordinator will:**
   a. Facilitate a response to the external review request following the process outlined in Minnesota Statutes, Section 62Q.73, subd. 6.
   b. Maintain a copy of all documentation resulting from the external review.