Chapter 9: Grievances and Appeals

The grievance procedure is set forth in Maryland Law (COMAR 10.09.70.08). This chapter of the provider manual describes the process for complying with COMAR regulations. A *grievance* is a request made for re-review of a previous medical necessity determination that resulted in non-authorization of a service request. A consumer or a provider/advocate, with consumer's consent may request a grievance. ValueOptions® Maryland provides for two internal levels of grievance following an initial medical necessity review that resulted in non-authorization of a service request. Consumers may appeal to the CSA at any point in the process, except in circumstances when the CSA is the provider of service. Medical Assistance (MA) recipients may have the State of Maryland's Office of Administrative Hearings (OAH) review the decision for MA services, at any stage, as the final authority. The Mental Hygiene Administration (MHA) is the final authority for consumers who are uninsured eligible.

Definitions

A **consumer** is a Maryland Medicaid (MA) recipient, uninsured eligible individual or the consumer's legal guardian who requests mental health services. For this chapter of the provider manual, a parent of the child is considered the consumer.

A **complaint** is an expression of dissatisfaction with some aspect of the Public Mental Health System (PMHS).

A **grievance** is a process available to MA recipients and uninsured eligible individuals to request a re-review of a non-authorization of requested services for reasons of medical necessity.

An **appeal** is a formal process available to MA recipients to request the CSA, MHA and/or the Office of Administrative Hearings (OAH) to review the decision.

A **Care Manager (CM)** is a mental health professional responsible for reviewing, coordinating, and approving the mental health treatment of individuals served by the Maryland PMHS.

A **Physician Advisor (PA)** is a board-certified psychiatrist who reviews authorization requests and performs medical necessity determinations.

Clinical service non-authorization is defined as a determination by a ValueOptions® Maryland PA that the mental health services requested are not medically necessary.

An **administrative or technical denial** is based on the failure to meet administrative requirements set forth by the PMHS and the MHA, such as not following the rules for pre-authorization of services or not requesting continued authorization of existing

services on or before the last authorized day or service.

An **urgent request** is defined as a request for pre-authorization for admission to an acute inpatient facility, or a service level in which the consumer, or provider of service believes that waiting 24 hours for a decision would potentially be harmful to the consumer.

A **non-urgent request** is defined as a request for continued acute inpatient services or any other service level other than a request for pre-authorization of an acute inpatient admission.

Level I – ValueOptions® Maryland Grievance - Summary

The initial review of an authorization request submitted by a provider on behalf of a consumer is completed by a ValueOptions® Maryland CM. A CM may only authorize service requests. When a CM cannot authorize services based on the information submitted via ProviderConnect, or submitted telephonically, the CM may ask the provider for additional information. When the additional information is received, the CM will authorize the services requested or suggest an alternative level of care. If the CM is not able to authorize the requested services or negotiate an alternative level of care, the CM will refer the case to the ValueOptions® Maryland Medical Director or PA.

A non-authorization of services results when the ValueOptions® Maryland Medical Director or PA reviews a service request, and cannot approve the request because it does not meet the medical necessity criteria established for that level of service. Following the initial non-authorization of service, a consumer, or a provider or advocate with the consumer's consent, may file a Level I Grievance to have the service request reviewed by another ValueOptions® Maryland PA. If the decision to non-authorize the service request is upheld, ValueOptions® Maryland forwards a non-authorization letter to the consumer and provider. If the consumer continues to disagree with the continued non-authorization decision, a Level II Grievance may be requested.

Level I Grievance: Pre-certification of Inpatient Admissions and Urgent Requests

A Level I Grievance must be filed within 10 business days of the initial non-authorization of service. The Level I Grievance review is completed telephonically between a ValueOptions® Maryland PA and the provider. The Level I Grievance will be completed within one hour of receiving the request.

- Direct contact with the provider is required in order to make timely decisions.
- If the provider is not available within the time frame allotted, the provider or consumer may request that ValueOptions® Maryland place the request on hold for up to 72 hours.
- The ValueOptions® Maryland PA will make reasonable attempts to reach the provider

or designated clinical contact for additional clinical information. If he/she cannot be reached, the ValueOptions® Maryland PA will make a decision based on the available information.

- ValueOptions® Maryland may request documentation from the treatment record when the telephonic information is unclear or incomplete.

- If the ValueOptions® Maryland PA concludes that services are medically necessary, ValueOptions® Maryland authorizes the requested service and forwards a Level I Grievance authorization letter to the consumer and the provider within two business days. The authorization is also entered into ProviderConnect and is available to the provider via download.

- If the ValueOptions® Maryland PA concludes that the non-authorization or partial non-authorization is appropriate, ValueOptions® Maryland informs the provider of the decision and grievance rights during the telephonic review. A Level I Grievance non-authorization letter that includes information about the next level of grievance available to the consumer is sent to the provider and consumer within two business days.

Level I Grievance: Other Services or Non-Urgent Requests

Level I Grievances for all other services in which the *consumer is actively in care* will be completed within 24 hours of the grievance being filed. A Level I Grievance must be filed within 10 business days following the initial non-authorization of service. The Level I Grievance is completed telephonically between a ValueOptions® Maryland PA and the provider.

- Direct contact with the provider is required in order to make timely decisions.

- If the provider is not available within the time frame allotted, the provider or consumer may request that ValueOptions® Maryland place the request on "Holding for Provider Information" status for up to 72 hours.

- The ValueOptions® Maryland PA will make reasonable attempts to reach the provider or designated clinical contact for additional clinical information. If he/she cannot be reached, the ValueOptions® Maryland PA will make a decision based on the available information.

- ValueOptions® Maryland may request documentation from the treatment record when the telephonic information is unclear or incomplete.

- If the ValueOptions® Maryland PA concludes that services are medically necessary, ValueOptions® Maryland authorizes the requested service and forwards a Level I Grievance authorization letter to the consumer and the provider within two business days. The authorization is also entered into ProviderConnect and is available to the

provider via download.

- If the ValueOptions® Maryland PA concludes that the non-authorization or partial non-authorization is appropriate, ValueOptions® Maryland informs the provider of the decision and grievance rights during the telephonic review. The provider and consumer will be forwarded a Level I Grievance non-authorization letter, within two business days, that includes the next level of grievance available to the consumer.

Level II Grievance: Pre-certification of Inpatient Admissions and Urgent Requests

A Level II Grievance must be filed within three business days following the notification of Level I Grievance non-authorization of service. The Level II Grievance is completed telephonically between a ValueOptions® Maryland PA and the provider. The Level II Grievance will be completed by ValueOptions® Maryland within one hour of receiving the request when a consumer is waiting for admission to an acute inpatient service level.

- Direct contact with the provider is required in order to make timely decisions.

- If the provider is not available within the time frame allotted, the provider or consumer may request that ValueOptions® Maryland place the request on hold for up to 72 hours.

- The ValueOptions® Maryland PA will make reasonable attempts to reach the provider or designated clinical contact for additional clinical information. If he/she cannot be reached, the ValueOptions® Maryland PA will make a decision based on the available information.

- ValueOptions® Maryland may request documentation from the treatment record when the telephonic information is unclear or incomplete.

- If the ValueOptions® Maryland PA concludes that services are medically necessary, ValueOptions® Maryland authorizes the requested service and forwards a Level II Grievance authorization letter to the consumer and the provider within two business days. The authorization is also entered into ProviderConnect and is available to the provider via download.

- If the ValueOptions® Maryland PA concludes that the non-authorization or partial non-authorization is appropriate, ValueOptions® Maryland informs the provider of the decision and grievance rights during the telephonic review. A Level II Grievance non-authorization letter that includes the next level of grievance available to the consumer is forwarded to the provider and consumer within two business days.

Level III - CSA Appeals

When the consumer does not agree with the determination made by the ValueOptions® Maryland PA following the Level II Grievance, the consumer may contact the CSA Director of his/her county of residence to appeal the decision.

Pre-authorization of Inpatient Admissions and Urgent Requests
A review of Level III appeals for inpatient admissions or urgent care will be completed and the decision communicated to the consumer, provider and ValueOptions® Maryland by the CSA within five business days of the request.

All Other Services
Appeals for all other services will be completed and the decision communicated to the consumer, provider MHA and ValueOptions by the CSA within 10 business days of the request.

Process for Level III Appeals:

- Within 10 business days of the notification of Level II non-authorization, a Level III appeal may be submitted to the CSA of the county in which the consumer resides.

- When requested, ValueOptions® Maryland will forward to the CSA all the documentation regarding the decision within one business day.

- The CSA may contact the appropriate provider for any additional information needed to re-evaluate medical necessity.

- The CSA may request that the consumer or provider follow the grievance process with ValueOptions® Maryland if he/she has not already done so.

- When the CSA authorizes services, they will inform the consumer and the provider, telephonically, of the determination within one business day. The CSA will notify ValueOptions® Maryland, MHA, and the provider, in writing, within two business days of the decision, using an approved form letter which must be signed by the Physician Advisor.

- When the CSA upholds ValueOptions® Maryland non-authorization, the CSA must inform the consumer and provider by phone or fax within one business day of the decision. The CSA will notify ValueOptions® Maryland, MHA, and the provider, in writing within two business days of the decision, using the approved form letter which must be signed by the CSA Director.

- Consumers must also be informed by the CSA of their right to appeal to the Mental Hygiene Administration.

Level IV - MHA Appeal

Regarding appeals submitted for MHA review:

- Appeals must be requested in writing to MHA within 5 business days after receipt of a CSA's decision.
- MHA may perform an investigation of the appeal which must be accomplished within 10 business days.
- MHA may refer the appeal to either ValueOptions® Maryland or the CSA for re-review when grievance levels have not been utilized.
- MHA must make its determination and provide written notification to the consumer within 15 business days.
- Medical Assistance (MA) recipients will be informed by the MHA of their right to appeal to the OAH.
- The MHA is the final authority for consumers who are uninsured eligible.
- MHA will notify ValueOptions® Maryland, in writing, of the outcome to all appeals.

To file a Level IV Appeal with the MHA via mail:

Attn: Grievances and Appeals
Mental Hygiene Administration
Spring Grove Hospital Center-Dix Building
55 Wade Avenue, Catonsville, MD 21228

Level V – OAH Appeals

If a consumer with MA wishes to appeal the MHA's decision, he/she must file a notice, in writing, to the Office of Administrative Hearings (OAH) within 45 business days of MHA's decision to not authorize services.

Requests for appeal hearings should be submitted via mail to:

Office of Administrative Hearings
11101 Gilroy Road
Hunt Valley, Maryland 21031-1301
Voice: (410) 229-4100, Fax: (410) 229-4111

Administrative Denials

Administrative denials most frequently occur when:

1) The provider fails to obtain preauthorization

2) Timely filing requirements are not met

3) Services are provided by a provider who is not participating in the primary coverage carrier's network.

4) The consumer is not a Medicaid beneficiary

5) The consumer was admitted to a medical unit or for a primary medical diagnosis, including substance abuse. This must be appealed directly to the consumer's Managed Care Organization (MCO).

Administrative denials may be appealed to the Mental Hygiene Administration (MHA) when the claimant believes that an exception to Medicaid rules is justified.

To file an Administrative Appeal with the MHA via mail:

Attn: Administrative Grievances
Mental Hygiene Administration
Spring Grove Hospital Center – Dix Building
55 Wade Avenue
Catonsville, MD 21228

Administrative denials may be appealed to ValueOptions® Maryland if, and only if, the claimant believes the administrative denial was due to an error on the part of ValueOptions® Maryland.

To file an Administrative Appeal with ValueOptions® Maryland via mail:

ValueOptions®
Attn: Claims Appeals Dept.
P.O. Box 1950
Latham, NY 12110