Section: [insert section title]

Policy Number:
Creation Date:
Effective Date:
Revision Date:

Policy Name: Appeals Process

Purpose:

To provide for responses to, and resolution of appeals as expeditiously as the participant's health condition requires, while maintaining confidentiality, in accordance with regulatory and contractual requirements.

Policy:

[PACE Program] is committed to ensuring that a participant, a participant's representative or a treating provider has the right to appeal **[PACE Program's]** decision to deny, defer or modify a particular care-related service or its decision not to pay for a service received by a participant.

[PACE Program] will handle all appeals in a respectful manner and will maintain the confidentiality of a participant's appeal at all times throughout and after the appeals process is completed. Information pertaining to appeals will not be disclosed to program staff or contract providers, except where appropriate to resolve the appeal.

Contract providers are accountable for all appeal procedures established by **[PACE Program]**. **[PACE Program]** will monitor contracted providers for compliance with this requirement on an annual basis or on an as needed basis.

Definitions:

An **appeal** is defined as a participant's action taken with respect to the PACE organization's noncoverage of, or nonpayment for, a service including denials, reductions or termination of services.

An appeal may be filed verbally, either in person or by telephone or in writing. The appeals process may take one of two following forms:

- A ***standard* appeal** means a standard review process for response to, and resolution of, appeals as expeditiously as the participant's health requires, but no later than 30 calendar days after the PACE organization receives an appeal.

- An ***expedited* appeal** occurs when a participant believes that his or her life, health, or ability to regain maximum function would be seriously jeopardized, absent provision of the service in dispute. The PACE organization will respond to the appeal as expeditiously as the participant's health condition requires, but no later than 72 hours after it receives the appeal. The 72-hour timeframe may be extended by up to 14 calendar days for either of the following reasons:
    1. The participant requests the extension.
    2. The PACE organization justifies to the State administering agency the need for additional information and how the delay is in the interest of the participant.

Disputed health care service means any health care service eligible for payment under the enrolled participant's contract with **[PACE Program]** that has been denied, modified or delayed by a decision of **[PACE Program]** in whole or in part due to the finding that the service is not necessary.

Necessary or **Necessity** means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury.

Representative means a person who is acting on behalf of or assisting a participant, and may include, but is not limited to, a family member, a friend, a PACE employee, or a person legally identified as Power of Attorney for Health Care/Advanced Directive, Conservator, Guardian, etc.

General Information:

1. The **[PACE Program's designee]** has primary responsibility for maintenance of the procedures, review of operations, and utilization of any patterns of appeals to formulate policy changes and procedural improvements in the administration of the plan.

2. **[PACE Program]** will continue to furnish the participant with all services at the frequency provided in the current plan of care during the appeals process.

3. **[PACE Program]** will not discriminate against a participant solely on the grounds that an appeal has been filed.

4. **[PACE Program]** will ensure that a participant is able to access and participate in the appeals process by addressing the linguistic and cultural needs of its participants, as well as the needs of participants with disabilities. **[PACE Program]** will ensure the following:

    a. If the person filing the appeal does not speak English, a bilingual staff member will be available to facilitate the process. If a staff person is not available, translation services/interpreter will be made available.
    b. All written materials describing the appeal process are available in the following languages: **[insert applicable languages]**
    c. **[PACE program]** maintains a toll-free number **(insert number)** for the filing of appeals *[Note: Only applicable in the event that a PACE participant and/or his/her representative would incur long distance charges if calling from within the plan's service area].*
    d. [*Insert other relevant procedures for addressing any cultural, linguistic or access requirements (such as TTY/TDD number) related to the filing or processing of appeals*]

5. **[PACE Program]** will provide written information about the appeal process to a participant and/or his/her representative upon enrollment, at least annually thereafter, and whenever the interdisciplinary team denies, defers, or modifies a request for services or refuses to pay for a service. Information includes, but is not limited to:

    a. Procedures for filing an appeal, including participant's external appeal rights under Medicare and Medicaid (in California, Medi-Cal).

    b. Telephone numbers for the filing of appeals received in person or by telephone: [**insert** specific staff titles authorized to receive appeals; include toll free number

and TTY/TDD number for each specific PACE site, if applicable; days and hours of operation]

c. Location where written appeals may be filed: [**insert** specific staff titles authorized to receive appeals; provide an address for each specific PACE site, if applicable]

6. Any method of transmission of appeals information from one **[PACE Program]** staff to another shall be done with strictest confidence, in adherence with HIPAA regulations.

7. **[PACE Program]** will assist the participant in choosing which external appeals process to pursue if both are applicable, and forward the appeal to the appropriate external entity.

Procedure:

A. Receiving Requests to Provide a Service or Pay for a Service

1. A participant or his/her representative may request to initiate, eliminate, or continue a particular service or pay for a service. A participant or his/her representative may submit the request to **[PACE Program]** either verbally, by telephone or in person, or in writing.

2. In the event a participant or his/her representative requests provision of or payment for a particular service, the interdisciplinary team (IDT) will determine whether the requested service is necessary, based on the assessed needs of the participant.

3. **[PACE Program]** will notify the participant or his/her representative of its decision to approve, deny, defer or modify the request as expeditiously as the participant's condition requires, but no later than 72 hours of receiving the participant's request.

   a. If the decision is to *approve* the requested service, without deferring or modifying provision of the service, or payment for a service, the participant or his/her representative will be notified verbally and/or in writing. The service will be furnished to the participant as determined by the interdisciplinary team's revised plan of care.

   b. If the decision is to deny, defer or modify a request for service or deny payment of a service, the participant or his/her representative will be notified verbally **and** in writing. If the participant or his/her representative appeals the denial for reconsideration, **[PACE Program]** will initiate the Appeal Process as outlined in this policy and procedure.

B. Notification of a Decision to Deny, Defer or Modify a Request for Service or Deny Payment of a Service

1. At the time of the decision, **[PACE Program]** informs the participant, and as appropriate, the treating provider of the reason for denial, deferral or modification of a service or denial of payment for a service.

2. Notification of the denial, deferral or modification of service or denial of payment is made both verbally; either in person or by telephone, ***and*** in writing, using the *"Notice of Action for Service Request"* (NOA) Form (see Attachment 1).

3. The **[PACE Designee]** will document in the medical record that a denial, deferral or modification of service or denial or payment has been made, using "Denial of Service" in the title of the progress note.

4. **[PACE Program]** will notify the participant in writing of their right to appeal the denial for reconsideration by **[PACE Program]** and of their external appeal rights, using the *"Information for Participants about the Appeals Process"* notice (see Attachment 2).

5. If the interdisciplinary team fails to provide the participant with timely notice of the resolution of the request or does not furnish the services required by the revised plan of care, this failure constitutes an adverse decision, and the participant's request must be automatically processed by **[PACE Program]** as an appeal.

C. Filing an Appeal

1. The appeal process is available to any participant, his/her representative or treating provider who disputes denial of payment for a service or the denial, deferral or modification of a service by the primary care physician (PCP) or any member of the interdisciplinary team (IDT) who is qualified to make referrals.

2. An appeal for denial, deferral or modification of a service or payment for a service may be filed verbally or in writing.
   a. A participant and/or his/her representative may verbally request an appeal by speaking to the Director, Center Manager, Social Worker or other IDT member.
   b. At the time of denial or at anytime upon request, **[PACE Program]** provides a participant and/or his/her representative with an "Appeal for Reconsideration of Denial" form (see Attachment 3). The participant and/or his/her representative completes the form, which constitutes a written request to appeal **[PACE Program]** decision.
   c. The **[Social Worker or designee]** will assist the PACE participant and/or his/her representative in filing an appeal in the event assistance is required.

3. An appeal may be filed as a **"standard appeal"** or an **"expedited appeal"**, depending on the urgency of the case:

   a. A **standard appeal** may be filed verbally or in writing with any **[PACE program]** staff within 180 calendar days of a denial of service or payment. The 180-calendar day limit may be extended for good cause by **[PACE Program]**.

   b. An **expedited appeal** may be filed verbally or in writing to **[PACE Program]** if the participant or a treating physician believes that the participant's life, health or ability to regain maximum function would be seriously jeopardized without provision of the service in dispute.

   c. In the case of an expedited appeal, the **[QA Department or designee]** will immediately contact the Medical Director by telephone at **{insert number}** or **{pager number}**.

4. The **[QA Department or designee]** notifies either the **[Program Director or designee]** or the Medical Director of the appeal:
   a. Appeals related to disputed health care services should be directed to the Medical Director.

b. Appeals related to disputed health care services or payment issues should be directed to the **[Program Director or designee].**

5. For **[PACE Program]** participants enrolled in Medi-Cal, the **[PACE Program]** will continue to furnish the disputed service if the following conditions are met:

   a. **[PACE Program]** is proposing to terminate or reduce services currently being furnished to the PACE participant.
   b. The participant requests continuation of the service with the understanding that he/she may be liable for the cost of the contested service if the determination is not made in his/her favor. (See "Appeal for Reconsideration of Denial" for participant's decision.)

6. If the above conditions are met, **[PACE Program]** will not discontinue the disputed service for which an appeal has been filed until the appeals process has concluded.

D. Acknowledgement of Receipt of Appeal

1. The **[Medical Director]** or **[Program Director]** will acknowledge a standard appeal in writing (see Attachment 4, *"Acknowledgement of Receipt of Appeal"*) within **five** (5) working days of the initial receipt of appeal by **[PACE Program]**.

2. For an expedited appeal, the **[QA Manager or designee]** informs the participant or representative within one (1) business day by telephone or in person that the request for an expedited appeal has been received and explains his/her additional appeal rights, as applicable.

E. Documentation of Receipt of Appeal

1. All appeals expressed either verbally and/or in writing, will be documented on the day that it is received or as soon as possible after the event or events that precipitated the appeal, in an Appeal Log (see Attachment 7, *"Appeal Log"*).

2. Appeals are documented on the *"Appeal for Reconsideration of Denial"* (Attachment 3) form by the participant, his/her representative or by a treating provider, on behalf of the participant. Complete information must be provided so that the appeal can be resolved in a timely manner.

3. In the event of insufficient information, the **[Designee]** will take all reasonable steps to contact the participant, and/or his/her representative or other appropriate parties to the appeal to obtain missing information in order to resolve the case within the designated timeframes for an expedited and standard appeal.

F. Reconsideration of Decision for Service Request or Payment of a Service

1. An appeal will be reviewed and decided by an appropriately credentialed and impartial third party who was not involved in the original action and who does not have a stake in the outcome of the appeal. At **[PACE Program]**, [insert information regarding who this is and how the person(s) is/are selected].

2. All individuals involved with the appeal, including the participant or their representative, will be given written notice of the appeals process and reasonable

opportunity to present evidence or submit relevant facts for review to **[PACE Program]**, either verbally or in writing.

3. For a "**standard appeal**", the designated **[Medical Director or Program Director]** will inform the participant in writing of the decision to reverse or uphold the decision within 30 calendar days of receipt of an appeal, or more quickly if the participant's health condition requires.

4. For an "**expedited appeal**" supported by a physician, the **[PACE Program]** will make a decision regarding the appeal as promptly as the participant's health condition requires, but no later than 72 hours after receipt of the request for appeal.

    a. If a participant's request for expedited appeal is not supported by a physician, the **[PACE Program] [Medical Director]** decides if the participant's health situation requires making a decision within 72 hours.
        i. If the participant's health does not warrant an expedited appeal process, **[PACE Program/ Medical Director]** notifies the participant within 72 hours that the appeal will be treated as a standard appeal.
    b. The **[Medical Director or Program Director]** will provide the participant and/or his/her representative and the Department of Health Care Services with a written statement of the final disposition or pending status of an expedited appeal within 72 hours of receipt of an appeal.
    c. In the event the 72-hour timeframe must be extended, **[PACE program]** will provide justification to the DHCS for need of the extension. **[PACE Program]** will notify participant both verbally and in writing of the pending status and reason for the delay in resolving the appeal. The participant will be notified of the anticipated date by which the appeal decision will be determined.

G. Determination of an Appeal

1. When the decision of an appeal is ***in favor of a participant***, that is, the Director's decision to deny, defer, or modify a service or payment of a service is reversed, the following applies:

    a. **[Medical Director/Program Director]** provides a written response to the participant and/or representative, sent by mail, within 30 calendar days of receiving a standard appeal or sooner if the participant's health condition requires (see Attachment 5, *"Notice of Appeal Resolution"*).
    b. **[PACE Program]** will provide authorization to get the disputed service or provide the service as quickly as the participant's health condition requires, but no later than 30 calendar days from the receipt of the request for a standard appeal.
    c. For an expedited appeal, **[PACE Program]** will provide the participant permission to obtain the disputed service or provide the service as quickly as the participant's health condition requires, but no later than 72 hours from the receipt of a request for an expedited appeal.
    d. If the decision to deny payment for a service is reversed by **[PACE Program],** then payment will be made within 60 calendar days of receiving the participant's or representative's request for a standard or expedited appeal.

2. When the decision of an appeal is ***not in favor of the participant***, that is, the **[Director's]** decision to deny, defer or modify provision or payment of a service is upheld, or if the participant is not notified of the decision within the specified time

frame for a standard or expedited appeal, the **[QA Coordinator or designee]** will do the following:

a. Notify in writing, at the time the decision is made, and within 30 calendar days from the date of the request for a standard appeal and within 72 hours for an expedited appeal (see Attachment 6, *"Notice of Appeal Decision"*):
    1. The participant and/or his/her representative
    2. Health Plan Management System (HPMS)
    3. Integrated Systems of Care Division, Department of Health Care Services.
b. Notify the participant and/or his/her representative in writing of his/her appeal rights through the Medicare or Medi-Cal program, or both, depending on the participant's eligibility (See Attachment 2, *"Information for Participants about the Appeal Process"*).
c. Offer to assist the participant or participant's representative in choosing which external appeal route to pursue (if desired) and to assist in preparation of appeal.
d. Forward the appeal to appropriate external entity.

H. External Review Options for Appeal

Medi-Cal External Appeal Process

1. This option for external appeal is available to participants enrolled in Medi-Cal, that is, "Medi-Cal only" or "both Medi-Cal and Medicare":

   If the participant and/or representative chooses to appeal using the Medi-Cal external appeal process, **[designate PACE staff]** will assist the participant and forward the appeal to:

   California Department of Social Services
   State Hearings Division
   P.O. Box 944243, Mail Station 19-37
   Sacramento, CA 94244-2430
   Telephone: 1-800-952-5253
   Facsimile: (916) 229-4410
   TDD: 1-800-952-8349

2. **[PACE Program]** will not discontinue services for which an external appeal has been filed until the external appeal process has concluded. However, if **[PACE Program's]** initial decision to deny, discontinue or reduce a service is upheld, the participant may be financially responsible for the cost of the disputed service provided during the external appeal process.

3. If a participant and/or his/her representative want a State hearing, he or she must ask for it within 90 calendar days from the date of the NOA (Attachment 1). A participant and/or his/her representative may speak at the State hearing or have someone else speak on the participant's behalf, including a relative, friend or an attorney.

    a. For legal assistance, the participant and/or his/her representative may be able to get free legal help. To facilitate this, the **[QA Staff or designee]** will provide a listing of *"Legal Services Listing"* to the participant and/or his/her representative (Attachment 8).

b. **[PACE Program]** is required to provide written position statements whenever notified by DHCS that a participant has requested a State hearing. The [PACE Program] will designate staff **[insert which staff, e.g. Medical Director, Program Manager, etc.]** to make testimony at State hearings whenever notified by DHCS of the scheduled time and place for a State hearing.

c. If the Administrative Law Judge (ALJ) decision is in favor of the participant's appeal, [PACE Program] will follow the judge's instruction as to the timeline for provision of services to the participant or payment for services for a standard or expedited appeal.

d. If the ALJ's decision, adopted by the Director as final, is not in favor of the participant's appeal, the participant may request a re-hearing with the Director within 30 calendar days after receiving the final decision.

e. Within one year after receiving notice of the Director's final decision, the participant may file a petition with the superior court, under the provisions of Section 1094.5 of the Code of Civil Procedure.

2. The following option for external appeal is available to participants enrolled in Medicare, that is, "Medicare only" or "both Medicare and Medi-Cal":
    a. A Medicare enrollee may choose to appeal **[PACE Program's]** decision using Medicare's external appeals process. **[PACE Program]** will send the appeal to the current contracted Medicare appeals entity

    b. The contracted Medicare appeals entity maintains a standard and expedited appeal process. Standard appeals will be resolved within 30 calendar days after filing of the appeal; expedited appeals will be resolved with 72 hours (with a possible 14 calendar day extension).
    c. The contracted Medicare appeals entity will contact **[PACE Program]** with the results of the review. The contracted Medicare appeals entity will either maintain **[PACE Program's]** original decision or change **[PACE Program's]** decision and rule in the participant's favor.
    d. If the contracted Medicare appeals entity's decision is not in the participant's favor, there are further levels of external appeal, and if requested by the participant and/or representative, **[Social Worker]** will assist a participant in further pursuing the appeal.

I. Documentation, Tracking, Analysis and Reporting

1. All appeals related information shall be marked "confidential".

2. All Appeal-related information and correspondence, including the appeals log will be stored in locked cabinets in the **[Quality Assurance Department or as designated]**.

3. The *Appeals Log* (Attachment 7) will contain, at a minimum, the following information:
    a. Name and telephone number of the staff person recording the appeal
    b. Date the appeal was filed
    c. Participant's and/or her/her representative's name and/or person filing the appeal
    d. Description of the appeal
    e. Action taken

f. Description and date of the final resolution.

4. **[Quality Assurance Coordinator or designee]** is responsible for maintaining, aggregating, and analyzing information related to appeals to identify trends or patterns. On a quarterly basis, this information will be forwarded to **[Program staff/designated committees]**.

5. **[PACE Program]** will submit a summary of all grievances in the quarterly report to the DHCS, Integrated Systems of Care Division and Centers for Medicare and Medicaid Services. The DHCS appeals summary is due 45 calendar days from the date of the end of the reporting quarter.

6. A written summary of appeals including number, type, location, and disposition are reported to the **[Quality Management Team, as applicable]**, **[Quality Assurance and Improvement Committee, as applicable]**, and the **[Board of Directors]** on a quarterly basis.

7. Records of all appeals will be held confidentially and made available as needed to State and Federal agencies upon request.

8. **[PACE Program]** shall maintain in its files copies of all appeals, the responses and recording of log for ten (10) years from the date the appeal was filed.

9. To ensure timeliness and accuracy in the appeals process, **[PACE Program]** shall perform regular audits of the appeals log and files to ensure they correspond with other data reporting systems (i.e. HPMS reports).

J. Annual Review

1. The appeals process will be reviewed with participants and/or their representative, contract providers and all employees of **[PACE Program]** on an annual basis. [Identify who will have responsibility for coordinating the annual review and how this will be coordinated; insert organization's procedure, specifically responsibility for coordinating the annual review process and how this will be done.]

Attachments:

1. Notice of Action for Service or Payment Request
2. Information for Participants about the Appeals Process
3. Appeal for Reconsideration of Denial
4. Acknowledgement of Receipt of Appeal
5. Notice of Appeal Resolution
6. Notice of Appeal Decision
7. Appeals Log
8. Legal Services Listing

Regulatory Citation:

Department of Health and Human Services, CMS, Federal Register Volume 64, No. 226, 42CFR Part 460.122, 124; California Department of Health Services Contract (2008), Exhibit A, Attachment 14, Number 5-6