MEDICAID RECIPIENT DUE PROCESS (APPEAL) RIGHTS

You, as a Medicaid recipient, have the constitutional right to due process because Medicaid is an entitlement program. Specifically, due process means that when a Medicaid service request is denied, reduced, terminated, or suspended, you (or your personal representatives) must receive written notice of the adverse decision and have an opportunity for a fair hearing (appeal) pursuant to the Social Security Act, 42 C.F.R. 431.200 *et seq.,* and N.C.G.S. §108A-70.9.

MAILING AND RECEIVING YOUR NOTICE

The letter will be mailed by trackable mail (United States Postal Service, United Parcel Services of America, Inc.---UPS, FedEx, etc.) to the last know address that you have on file with your county Department of Social Services (DSS**)** or the Social Security Administration (for Social Security Income, SSI, recipients). **If you move, it is important and your responsibility to update your address directly with DSS or the Social Security Administration (for SSI recipients).** If you do not update your address, it is unlikely you will receive communication from Medicaid about the Medicaid benefit or your services.

The adverse decision letter will come from the N.C. Division of Medical Assistance or one of its vendors. The vendors are ACS, The Carolinas Center for Medical Excellence, HP Enterprise Services, MedSolutions, the Murdoch Center, Piedmont Behavioral Healthcare, ValueOptions, Crossroads Behavioral Healthcare, The Durham Center, Eastpointe LME, and Pathways LME. The letter will describe the decision and why it was made and will contain instructions on how to appeal if you disagree with the decision. A pre-printed appeal request form with your name, address, and Medicaid identification number will be enclosed with the notice.

If you do not receive your notice on the initial delivery attempt, follow the instructions on the delivery notification so the letter will be delivered. For delivery to take place, you may be required to sign, date, and return a form.

APPEALING MEDICAID'S DECISION

If you decide to appeal Medicaid's decision to deny, terminate, reduce, or suspend the services requested by your provider, you or your personal representative must sign and date the appeal request form and send it to the Office of Administrative Hearings (OAH) by mail or facsimile (fax) within **30 days of the date the notice was mailed**. The mailing address and telephone and fax numbers for OAH are located on the appeal request form.

WHEN FILING AN APPEAL, YOU ARE REQUESTED TO ONLY USE THE COMPLETED, COMPUTER GENERATED APPEAL FORM PRE-PRINTED WITH YOUR NAME, ADDRESS, AND MEDICAID IDENTIFICATION NUMBER ENCLOSED IN YOUR MAILING. If you do not receive the adverse notice or have lost the appeal form that was provided in the adverse notice, contact the Medicaid Recipient Appeals Section at the numbers provided in the table below, and a new form will be provided to you or to another person named by you. If the notice was properly addressed to the correct person at the latest address on file with Medicaid, a new notice will be issued upon your or your legal guardian's request, but the date will not be updated. **If you or your legal guardian fails to notify DSS or the Social Security Administration (for**

SSI recipients) of a change in address or fails to accept service of a notice sent via trackable mail, the date of the notice is not updated and the time to appeal is not extended. If a notice is addressed to the incorrect person or address or if some other error is made by the utilization review (UR) vendor or Medicaid, a new notice with an updated date shall be issued.

Providers may not file appeals on your behalf unless you list the provider as your representative on the appeal request form. Providers may assist recipients in filing the appeal electronically or via fax.

NOTE: The Office of Administrative Hearings (OAH) may be contacted to validate that the appeal request has been received and the date it was received. It is not necessary to file duplicate appeal requests for the same service, same amount and frequency of service, same time period, same date of decision.

UNDERSTANDING THE MEDICAID RECIPIENT APPEAL PROCESS

Your case will begin as soon as the completed recipient hearing request form is **received** by the OAH. If you choose to appeal, you may represent yourself during the appeal process, hire an attorney, or ask a relative, friend, or other spokesperson to speak for you. You will be contacted by OAH or the Mediation Network of North Carolina to discuss your case and to be offered an opportunity for mediation in an effort to resolve the appeal. Contact is made by telephone or **trackable mail**. So, it is important to accept all **trackable mail** and telephone calls from OAH or the mediation center.

Mediation is an informal opportunity for you and your representatives to talk with Medicaid representatives about your need for the service in an effort to resolve your case without going to hearing. Mediations will not be recorded. **Mediation is confidential and legally binding.** If your personal representative attends the mediation and a settlement is reached, you will be legally bound by the settlement even if you are dissatisfied with the result. Best practice is always for you, your parent, or legal guardian to participate in the mediation and hearing processes. Medicaid is entitled to bring its attorneys to mediation, if needed.

If you do not accept the offer of mediation or the results of mediation, the case will proceed to hearing and will be heard by an administrative law judge with OAH unless you or your personal representative withdraw the request for hearing. You will be notified by **trackable mail** of the date, time, and location of the hearing. The administrative law judge will make a decision and will send it to Medicaid for a final agency decision. You will receive a written copy of both the administrative law judge's decision and Medicaid's final agency decision by **trackable mail**. You and your provider should not act on the administrative law judge's decision because Medicaid must review the decision and issue the final agency decision. If you do not agree with Medicaid's final agency decision, you may ask for a judicial review in superior court. The hearing process must be completed within 90 days of OAH's receipt of the completed Recipient Hearing Request Form.

You or your personal representative may present new evidence at the hearing or mediation. This includes medical records and written reports (even if obtained after Medicaid made its decision), testimony from physicians and other providers about why you need the service, and testimony by

family and friends. If new evidence is submitted at the hearing or mediation that Medicaid has not reviewed, DMA staff and/or their attorneys may request additional time for review. The administrative law judge shall continue or recess the hearing for a minimum of 15 days and a maximum of 30 days to allow for Medicaid's review.

YOU SHOULD NOTIFY THE PROVIDER WHEN THE FINAL AGENCY DECISION FROM MEDICAID IS RECEIVED. The final agency decision shall be implemented no later than three business days from the date the decision was mailed. If the service is approved, the notice will state the conditions under which the service will be provided and when new requests for services should be submitted.

PROVIDING SERVICES DURING THE APPEAL PROCESS FOR A CONTINUING SERVICE REQUEST THAT IS REDUCED, TERMINATED, OR SUSPENDED

Services may be provided during the pendency of the appeal under maintenance of service when the request is for a **continuing** service. A continuing request means a request for a service required to be authorized on the day immediately preceding the date the UR vendor received the next request for service.

Maintenance of service (MOS) means that you are entitled to receive services during the pendency of the appeal when a request for a **continuing** service is reduced, terminated, or suspended. MOS will be provided as described below as long as you remain otherwise Medicaid eligible, unless you give up this right.

- If you appeal within **10 days of the date the notice was mailed**, payment authorization for services will continue without a break in service. Authorization for payment must be at the level required to be authorized on the day immediately preceding the adverse determination or the level requested by the provider, whichever is less.

- If you appeal more than 10 calendar days but within 30 calendar days of the date the notice is mailed, authorization for payment must be reinstated, retroactive to the date the completed appeal request form is received by the Office of Administrative Hearings. Authorization for payment must be at the level required to be authorized on the day immediately preceding the adverse determination or the level requested by the provider, whichever is less.

- MOS will **not** be authorized if:
  - You appeal more than 30 days after the date the notice was mailed, regardless of whether OAH accepts the appeal.
  - Your provider submitted a **continuing** request for service after your current authorization for services expired. Medicaid will treat this request as an initial rather than a reauthorization or continuing request.

NOTE: MOS ends upon the issuance of a final agency decision that upholds the original Medicaid decision to reduce, terminate or suspend a continuing service.

CHANGING PROVIDERS

If you appeal an adverse decision, if your provider agency is going out of business, or you have changed providers for Community Alternatives Program (CAP) services or another service with an authorization period of six months or more, the current authorization for services will transfer to the new provider within five business days of notification by the new provider to the appropriate UR vendor and upon submission of written attestation that provision of the service meets Medicaid policy and your condition meets clinical coverage policy criteria, your provider's acceptance of all associated responsibility; **and either** your, your parent's, or your legal guardian's written permission for transfer **or** a copy of your discharge from the previous provider. Authorization will be effective the date your new provider submits a copy of the written attestation. You may change providers at any other time. However, the discharging provider and the new provider must follow all policy requirements and Medicaid's prior approval procedures, and the new provider will be required to submit a new request for authorization. The authorization will not transfer except in the situations described above.

OBTAINING FURTHER INFORMATION

For further information about Medicaid prior approval and recipient due process (appeals), please review the resources specified below.

- **Division of Medical Assistance's Policies and Procedures**
  Medicaid Recipient Due Process Rights and Prior Approval Policies and Procedures
  http://www.ncdhhs.gov/dma/provider/index.htm

- **Special Bulletin**
  New Due Process and Prior Approval Procedures Effective May 01, 2011, and implemented May 27, 2011
  http://www.ncdhhs.gov/dma/provider/library.htm

- **Due Process and Prior Approval Training Slides**
  http://www.ncdhhs.gov/dma

Questions concerning the Division's prior approval processes should be addressed to the Medicaid Recipient Appeals Section at the numbers below. Please address questions about the Medicaid recipient appeals process to the Office of Administrative Hearings or to the Medicaid Recipient Appeals Section as indicated below.

AGENCY	ADDRESS	TELEPHONE #	FAX #
Office of Administrative Hearings	Clerk 6714 Mail Service Center Raleigh, NC 27699-6714	919-431-3000	919-431-3100
Division of Medical Assistance, Medicaid Recipient Appeals Section	2501 Mail Service Center Raleigh, NC 27699-2501	919-855-4260 or 1-800-662-7030 Ask for your call to be transferred to the Medicaid Recipient Appeals Section	919-733-2796