North Carolina
Medicaid Special Bulletin

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Division of Medical Assistance
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Attention: All Providers
New Due Process and Prior Approval Procedures

Effective Date: May 01, 2011
Implementation Date: May 27, 2011

Introduction

The purpose of this Special Bulletin is to highlight for providers the significant changes in Medicaid's prior approval (PA) process for providers. The Division of Medical Assistance (DMA) is implementing new due process and prior approval procedures applicable to all provider types and to all medical services, procedures and supplies which require prior approval. The goal of these procedures is to provide uniformity across the Medicaid program, eliminate situations where a Medicaid recipient experiences an inadvertent break in service for Medicaid recipients, ensure that Medicaid recipients are provided with the due process to which they are entitled under federal and state law, and ensure that when providers submit timely requests for reauthorization, an authorization will be entered into the system until DMA or its utilization review vendor makes a decision on the request.

Prior Approval Procedures

The N.C. Department of Health and Human Services' (DHHS) Medicaid Recipient Due Process and Prior Approval Policies and Procedures were posted to the DMA prior approval webpage, http://ncdhhs.gov/dma/provider/priorapproval.htm, on January 26, 2011, and are attached to this Special Bulletin. DMA offered free live training sessions in five locations throughout the state during the months of January and February 2011, and the training slides are also available on the DMA prior approval webpage found at http://ncdhhs.gov/dma/provider/priorapproval.htm. Additional live sessions will be offered in Raleigh, Wilmington, and Morganton in June 2011 if DMA receives enough interest from providers. Dates, times, location, and registration instructions will appear in the monthly May and June 2011 Medicaid bulletins. To register, please visit the web address below.

http://www.ncdhhs.gov/dma/semreg/appeal_2011_seminar.aspx

Significant Changes

Below is a list of significant changes to DMA's prior approval procedures. This list highlights important points for providers to remember regarding requests for prior authorization and Medicaid recipient due process.

- **Submission of Requests**—All requests for prior approval must be submitted electronically, via facsimile or, in instances where such transmittal is not possible, via U.S. mail or hand delivery to the appropriate vendor. **It is the**

provider's responsibility to maintain documentation evidencing the date the request was made. Requests submitted to the incorrect vendor will be forwarded to the appropriate vendor if there is enough information on the request to do so. The effective date of receipt is the day the request is received by the correct vendor.

- **Unable to Process Requests**— Requests that lack any of the following will be returned to the provider via facsimile, electronically or U.S. mail as unable to process and the recipient will not have a right to appeal: recipient name/ address, recipient Medicaid identification (MID) number, date of birth (DOB), identification of service or procedure code requested, provider name, NPI number and Medicaid provider number of the provider who is to perform the service or procedure, date the service is requested to begin or be performed, all required signatures on forms required by statute, and/or any documents or forms required by state or federal statute in order to commence a review for prior authorization. The notice will identify the information that is missing from the request. The information in the request must be internally consistent, i.e. the name and MID number must match or the request will be returned as unable to process. If the request is submitted by a provider who is not authorized to deliver the service requested, it will also be returned as unable to process.

  NOTE: If the request identifies a service but fails to request the frequency of the service, DMA or the utilization review (UR) vendor will approve whatever frequency is medically necessary (if any), and the recipient will not be entitled to appeal the amount approved. Additionally, the provider identification information requirements may change occasionally based on federal requirements. Providers will be notified of any changes via the monthly Medicaid Bulletin.

  Example of forms required by statute: N.C. Session Law 2009-451, Section 10.68.A.(a)(7) mandates that a psychiatric assessment and discharge plan be submitted as part of any request for Child Level III and IV Residential Services.

- **Initial Requests**— means a request for a service that the recipient was not authorized to receive on the day immediately preceding the date that DMA (for requests that are reviewed by DMA Clinical Policy) or the correct UR vendor RECEIVED the request for prior approval. **This means that if the request is submitted MORE THAN ONE DAY after the end of an**

existing (current) authorization period, the request will be treated as an initial request and the recipient will NOT be entitled to maintenance of service pending appeal if the request is denied or reduced. If approved, authorization for initial requests will be effective on the requested start date, but no earlier than the date the request was received by the applicable utilization review vendor or DMA Clinical Policy.

NOTE: A request that is unable to be processed will not serve as a "placeholder" for purposes of determining whether a request is an initial or reauthorization request.

- **Incomplete Requests**—Requests that do not meet the minimum requirements of the applicable clinical coverage policy (e.g. fails to include a person centered plan, x-ray or other specific document required by the policy) may be returned to the provider as incomplete. The request will be denied, and the recipient will be notified of his or her right to appeal. Vendors are not required to request additional information from providers upon receipt of an incomplete request. The adverse notice will identify the information that was missing from the request. If the vendor exercises its discretion to request additional information, the provider shall have 10 business days from the date the notice was mailed to respond to the request for additional information. The request may be made verbally or in writing. If the provider fails to respond within 10 business days, the request will be denied.

- **Duplicate Requests** will be returned as unable to be processed in the circumstances specified below.
  - If two providers submit identical requests for the same recipient, the later of the two requests will be returned.
  - If a request is submitted when the time period to appeal an earlier adverse decision on an identical request has not expired.

- **Requests for Reauthorization**—All requests for reauthorization or continuation of a service must be submitted at least 10 calendar days **PRIOR** to the end of the current authorization period in order for services to continue without interruption. If the request is submitted at least 10 calendar days before the end of the authorization period but the UR vendor or Medicaid does not make a decision prior to the end of the current authorization period, retroactive authorization will be entered when the UR vendor makes a decision on the request.

NOTE: Requests that are returned as unable to process do not meet this requirement. That is, an unable to process request will not serve as a "placeholder" for the 10-day requirement.

EXCEPTION: Requests for a Community Alternatives Program (CAP), inpatient or emergent services, or any service with an authorization period of less than 10 days are not subject to this 10 calendar day requirement. Requests for prior approval for these services must be submitted in accordance with the applicable clinical coverage policy or CAP manual. If submitted prior to the expiration of the authorization period, services must continue without interruption.

Other important points about reauthorization requests appear below.

1. If a request is received **less** than 10 calendar days prior to the expiration of the current authorization, there may be a break in authorization. Authorizations will not be backdated to account for gaps created by the submission of an untimely request.
   a. An approved request will be authorized beginning the date of the decision.
   b. For a request that is denied or reduced, the effective date of the change in services shall be no sooner than 10 calendar days after the date the notice is mailed. Authorization will be entered for 10 days beginning the date of the decision.
2. If the request is submitted more than one day following the end of the current authorization period, the request will be processed as an initial rather than as a reauthorization request. This means that:
   a. The current authorization will end on its end date.
   b. The 10 day effective date on the notice does not apply. The effective date is the date of the notice.
   c. Maintenance of services is not available during the pendency of the appeal.

Detailed examples of how this policy applies in specific situations are included in the due process and prior approval policies and procedures

- ***Providers should continue to provide services at the prior level beyond the end date of the authorization period if the provider timely requested reauthorization even though there may be a delay of up to 15 business days after the request was submitted before the UR vendor enters authorization into the system. A provider who provides documentation that a request for reauthorization was timely and properly requested shall be entitled to seek correction of the authorization from DMA if the UR vendor fails to properly authorize continuation of services.***

- **Mailing Notices**— Notices are mailed to the last known address given by the recipient or his/her legal guardian to the county Department of Social Services or the U.S. Social Security Administration (for SSI recipients). It is the responsibility of the recipient and/or his/her legal guardian to update this address. Adverse notices are mailed via trackable mail. If a notice was properly addressed to the correct person at the latest address on file with DMA, a new notice will be issued upon request by the recipient or his/her legal guardian, but the date will not be updated. **If a recipient fails to notify DSS or the Social Security Administration (for Social Security Income, 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 UR vendor or Medicaid, a new notice with an updated date shall be issued.

- **Filing Appeals**—Providers may not file appeals on behalf of recipients unless the recipient lists the provider as the representative on the appeal request form. Providers may assist recipients in filing the appeal electronically or via facsimile. **WHEN FILING AN APPEAL, RECIPIENTS ARE REQUESTED TO ONLY USE THE COMPLETED, COMPUTER GENERATED APPEAL FORM PRE-PRINTED WITH THE RECIPIENT'S NAME, ADDRESS, AND MEDICAID IDENTIFICATION NUMBER ENCLOSED IN THEIR MAILING.** If the recipient did not receive the adverse notice or has lost the appeal form that was provided in their adverse notice, contact the DMA Appeals Section at 919-855-4260, and a new form will be provided to the recipient or to another person with the recipient's consent. If the request is for a continuing service, the appeal MUST be filed within 30 days of the date of the adverse notice. Maintenance of service will NOT be provided to recipients who file appeals more than 30 days after the date of an adverse notice, regardless of whether OAH accepts the appeal.

  NOTE: The Office of Administrative Hearings (OAH) may be contacted to validate that the recipient's 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.

- **Maintenance of Services (MOS)—**While the Division's instruction about MOS is unchanged, this information is provided for the convenience of the provider.

  Maintenance of service means that a recipient is 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 the recipient remains otherwise Medicaid eligible, unless he/she gives up this right.

  - If the recipient appeals 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 the recipient appeals 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:
    - The recipient appeals more than 30 days after the date the notice was mailed.
    - The recipient's service request was submitted after his/her 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.

- **Final Agency Decisions Which Reverse in Part or in Full the Agency Action**—If the final agency decision or a mediated settlement holds that all or part of the requested services were medically necessary, payment for those services will be authorized within three business days for 20 prospective calendar days after the date of the decision. A new request for

prior authorization is required to be received by the UR vendor within 15 calendar days of the decision in order to avoid an interruption in services. Upon receipt by the vendor of a request for service authorization within 15 calendar days from the date of a final agency decision which holds that all or part of the requested services were medically necessary, authorization for payment will remain in effect without interruption for at least 10 calendar days following the mailing of the notice of decision on the new request for prior authorization. If the request is denied or reduced, it will be treated as a timely request for reauthorization and maintenance of service pending appeal will apply.

- **Changing Providers—**For Medicaid recipients who have appealed an adverse decision, or whose provider agency is going out of business, or have changed providers for 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 the recipient's condition meets clinical coverage policy criteria and acceptance of all associated responsibility; **and either** written permission of recipient or legal guardian for transfer **or** a copy of the discharge from the previous provider. Authorization will be effective the date the new provider submits a copy of the written attestation. Medicaid recipients may change providers at any other time. However, the discharging provider and the new provider must follow all policy requirements and these 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.

- **Mediations—**Providers who participate in mediations as the properly designated personal representative of a recipient shall not provide material misinformation to agency staff or mediator(s). Mediations will not be recorded. DMA is entitled to bring its attorneys to mediation. **Mediation is confidential and legally binding.** If you attend as the recipient's personal representative and reach a settlement, the recipient will be bound by the settlement even if they are dissatisfied with the result. Best practice is always to include the recipient or the recipient's parent/ legal guardian in the mediation and hearing processes.

- **Presenting New Information During Hearings and Mediations**—The recipient 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 the recipient needs 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.

IMPORTANT POINTS

- ***Providers are <u>NEVER</u> required to pay for services if the recipient loses the appeal. This does not mean that services provided during the appeal period cannot be audited.***
- ***Providers must still comply with all policies and requirements governing documentation, staff qualifications, state licensure and federal certification requirements, if applicable, etc.***
- ***DMA Program Integrity can recoup for services paid during an appeal if there is no documentation to support that services were provided in accordance with policy.***

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Tec~~hnical denials will be issued for recipients who cannot be reached using contact~~ information on file with Medicaid or after two missed IA appointments.

Please visit the IA website, <u>http://www.qireport.net</u>, for further information.

Carolina Centers for Medical Excellence (CCME)—Specialized Therapies

While a re-authorization request must be submitted "at least 10 days PRIOR to the end of the current authorization period in order for services to continue without interruption", CCME's website accepts "Reauthorization" PA requests for up to six months after the previous authorization has ended to minimize data re-entry by providers.

All PA requests for specialized therapies must include the recipient's MID number. Providers will no longer be able to obtain PA for therapy patients who are awaiting Medicaid eligibility (pending MID). If Medicaid eligibility is retroactive,

PA may be requested for eligible service dates retrospectively.

PA requests are not considered **received** by CCME until the date that the completed request is submitted to CCME. The start date is the date requested by the provider but no sooner than the date a completed request is submitted to CCME.

Private Duty Nursing

Initial Requests

All requests for private duty nursing (PDN) prior approval will be reviewed by the DMA PDN nurse consultant. In addition to the items specified in the definition of unable to process, the requestor must submit the information specified below.

- Name and address of authorized PDN agency
- Requested start of care (SOC) date or note of pending hospital discharge
- Requested number of PDN hours per day and expected duration of PDN services
- Diagnoses and skilled nursing interventions required
- Physician's Request Form or letter of medical necessity (signed by the physician)
- If applicable, recent hospital admission and discharge summary
- Other information such as insurance coverage, caregiver availability and teaching required

Retroactive authorizations will no longer be approved by Medicaid. If PDN services are started prior to approval, the agency does so at its own risk. However, in the instance of weekend/holidays, initial requests for services may be submitted the next business day, and retroactive active coverage will be considered for that period only.

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The following information is required for reauthorization of PDN services:

- In addition to the requirements specified in the section entitled "Unable to Process", **either** the physician signed CMS 485 (Home Health Certification and Plan of Care) for the corresponding certification period **OR** a Documented Verbal Order detailing the date order received frequency, scope and duration of services to include nursing interventions required. Both the verbal order and the CMS 485 – Locator 23 must clearly indicate the nurse, title, and date of the verbal order.

- The agency must also submit a "Medical Update" summary of the recipient's clinical condition, including any recent changes to document the need for continuous, complex and substantial nursing care. In addition, any changes in insurance coverage or other formal nursing coverage such as in the school system must also be documented. Refer to the DMA website for forms at http://www.ncdhhs.gov/dma/services/pdn.htm or the Community Care Manual, Section 9 for additional information. Please note the updated PDN Prior Approval Form on the DMA website.
- Medicaid may require nursing notes, medication administration records, or other documentation before an approval can be generated.

For further information about re-authorization requests, please see the section entitled "Requests for Reauthorization".

Approval Notices and MMIS Claims Information

The approval letter and MMIS claims information will be generated once the physician-signed CMS 485 has been received by DMA. Per Home Care Licensure Rules, agencies have 60 days to secure a physician signature.

Transfers between PDN Service Providers

In keeping with newly revised Medicaid prior approval and due process procedures, transfers between agencies will be considered as new initial requests **unless** the provider is going out of business **or** the recipient has filed a contested case petition (appeal). Please see the section above entitled "Changing Providers" for further detail. If the recipient's case does meet either of these requirements, the new PDN provider must process the case as an initial request.

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID RECIPEINT DUE PROCEESS RIGHTS AND PRIOR APPROVAL POLICIES AND PROCEDURES

I. INTRODUCTION.

This document is intended to provide clear instruction on Medicaid recipient due process rights and prior approval procedures for North Carolina Medicaid providers and all agency staff and contractors that perform utilization review functions on behalf of DMA. The goal of these procedures is to provide uniformity across the Medicaid program, eliminate situations where a Medicaid recipient experiences an inadvertent break in service, and ensure that Medicaid recipients are provided with the due process to which they are entitled under federal and state law.

II. DEFINITIONS.

Adverse decision means a decision to deny a request for Medicaid covered service(s), or to reduce or terminate Medicaid covered service(s) for a Medicaid recipient.

EPSDT means the Early Periodic Screening, Diagnosis, and Treatment ("EPSDT") program. Children under age 21 who have Medicaid are entitled to medically necessary screening, diagnostic and treatment services that are needed to "correct or ameliorate defects and physical and mental illnesses and conditions," regardless of whether the requested service is covered in the North Carolina State Plan for Medical Assistance. EPSDT does not apply to children who have NC Health Choice. (For more information about EPSDT, refer to http://www.dhhs.state.nc.us/dma/epsdt/index.htm.)

Incomplete Request means a request that cannot be reviewed for medical necessity because it does not meet the minimum requirements of the applicable Clinical Coverage Policy. In other words, the request does not include documentation or clinical information specifically required by the applicable Clinical Coverage Policy such as a Person Centered Plan (PCP) or X-ray.

Initial Request means a request for a service that the recipient was not authorized to receive on the day immediately preceding the date of the UR Vendor's receipt of the request.

Maintenance of service (MOS) means the continuation of authorization during the appeal period when a recipient appeals a decision to reduce or terminate Medicaid covered service(s) that were authorized on the day immediately preceding the date of the request for prior approval.

Medicaid recipient means a Medicaid eligible recipient, or, in the case of a minor or adjudicated incompetent recipient, the recipient's parent or legal guardian.

Reauthorization or Continuing or Concurrent Request means a request for a service required to be authorized for that recipient on the day immediately preceding the date of the UR Vendor's receipt of the request. This means that a request received on the next day following expiration of the authorization is a concurrent request.

Unable to Process Request means a request that lacks any of the following: Recipient Name/ Address, MID, DOB, Identification of Service or Procedure Code requested, Provider Name and Medicaid provider number who is to perform the Service or Procedure, date the service is requested to begin or be performed, all required signatures on forms required by statute, and/or any documents or forms required by state or federal statute in order to commence a review for prior authorization.

III. DMA, UR VENDOR, AND PROVIDER RESPONSIBILITIES.

A. The provider must document medical necessity in the prior approval request.

B. Requests for prior approval of Medicaid services should be fully documented by the provider and treating clinicians to demonstrate medical necessity. Providers must complete and submit requests for prior approval (1) to the correct Utilization Review (UR) Vendor using the forms and fields required by the applicable Clinical Coverage Policy and UR Vendor, and (2) must submit all necessary attachments (for example, PCPs, X-rays) in order for the request to be considered complete.

C. Providers should supplement the information requested on prior approval forms and plan of care forms with other recent clinical information the provider believes will document medical necessity if the provider believes the information requested on the form is not sufficient to fully document medical necessity for the requested service. This additional documentation may include recent evaluation reports from clinicians, recent treatment

records, and letters signed by treating clinicians which explain why the service is medically necessary.

D. UR Vendors will consider all relevant information that is submitted in addition to the information provided on required forms and in required fields, regardless of whether the additional information is included on a particular form. UR Vendors will make individualized medical necessity decisions based on the individual representations of each prior authorization request and the applicable law and policy, will use publicly available utilization review and best practice guidelines, and will allow case-by-case exceptions to those guidelines and policies as required by EPSDT. For more information on the best practice guidelines used by DMA's Vendors refer to http://www.ncdhhs.gov/dma/provider/priorapproval.htm.

E. UR Vendors will perform EPSDT reviews, or refer to DMA staff for EPSDT review where appropriate. UR Vendors will review requests for services for Community Alternatives Program (CAP) waiver recipients under 21 years of age using EPSDT criteria if the service in question can be covered under EPSDT. EPSDT covers diagnostic, screening, preventive and rehabilitative services and other treatment but does not cover habilitative services.

F. Prior to the decision on a request for prior approval, contacts with the requesting provider or recipient (including telephone and email contacts) will be limited to those needed to obtain more information about the service request and/or to provide education about Medicaid-covered services. Providers and recipients will not be asked to withdraw or modify a request for prior approval of Medicaid services in order to accept a lesser number of hours, or less intensive type of service, or to modify a SNAP score or other clinical assessment. Material misinformation to or intimidation of providers or recipients that has the foreseeable effect of significantly discouraging requests for Medicaid services, continuation of Medicaid services, or the filing or prosecution of OAH appeals is prohibited. Nothing in this paragraph should be construed to prevent clinical or treatment discussions.

G. The following script shall be read or provided in writing at the beginning of contacts with a provider or recipient about a prior approval request which occur prior to making the decision on the request.

When speaking with Providers: "We have received a prior authorization request for [NAME OF RECIPIENT] and would like to

discuss it with you. Nothing in this conversation is intended to discourage you from continuing with the request you have submitted. Your patient has the right to a written notice and a hearing if we deny the request and to authorization for payment for services during the appeal process if this request involves a service your patient is currently receiving. I cannot ask you to withdraw the request you have submitted or to modify the request to accept a lower amount, level, or type of service. I am calling because, at this time, we do not have enough information to approve this request. If you have additional information that you have not submitted that you think would support your request, please tell me about it now."

> **NOTE**: If you ask for additional documents in this telephone conversation, you MUST follow-up with a written request.

When speaking with Recipients: "We have received a prior authorization request submitted on your behalf and would like to discuss it with you. Nothing in this conversation is intended to discourage you from continuing with the request you submitted. You have the right to a written notice and a hearing if we deny the request and to authorization for payment for services during the appeal process if this request involves a service you are currently receiving. I cannot ask you to withdraw the request you have submitted or to modify the request to accept a lower amount, level, or type of service. I am calling because, at this time, we do not have enough information to approve this request. If you or your provider has additional information that has not been submitted that you think would support your request, please tell me about it now."

H. When participating in mediations, the UR Vendor shall not exceed its authority in negotiating a settlement, and shall not provide material misinformation to recipient(s) or mediator(s). Providers who participate in mediations as the properly designated personal representative of a recipient shall not provide material misinformation to agency staff or mediator(s).

I. UR Vendors will issue a written notice of the decision on all requests for prior approval with reasonable promptness.

IV. REQUESTS FOR PRIOR APPROVAL.

A. All requests for prior approval must be submitted electronically, *via* facsimile or, in instances where such transmittal is not possible, *via* U.S. mail or hand delivery, to the appropriate UR Vendor. It is the responsibility of the provider to maintain documentation evidencing the date the request was submitted.

B. All requests for prior approval must include all information necessary for the UR Vendor to recognize it as a request: Recipient Name/ Address, MID, DOB, Identification of Service or Procedure Code requested, Provider Name and Medicaid provider number who is to perform the Service or Procedure, date the service is requested to begin or be performed, all required signatures, and/or any documents or forms required by state or federal law. Requests that do not include this information will be returned as **unable to process** and the notice will not include appeal rights.

C. Assuming the request is not returned as **unable to process** (see definitions above), all requests for prior approval must also include completion of the minimum forms and fields required by the applicable clinical coverage policy. Requests that do not include the minimum required clinical coverage information will be denied without first requesting further information and the notice will include appeal rights.

V. REAUTHORIZATION REQUESTS.

A. All requests for reauthorization or continuation of a service must be submitted at least 10 calendar days **PRIOR** to the end of the current authorization period in order for services to continue without interruption. If the request is submitted at least 10 calendar days before the end of the authorization period but the UR Vendor does not make a decision prior to the end of the current authorization period, retroactive authorization will be entered when the UR Vendor makes a decision on the request.

> **NOTE**: Requests that are returned as unable to process do not meet this requirement.
>
> **EXCEPTION:** Requests for CAP, inpatient or emergent services are not subject to this 10 calendar day requirement. Requests for prior approval for these services must be

submitted in accordance with the applicable Clinical Coverage Policy or CAP Manual. If submitted prior to the expiration of the authorization period, services must continue without interruption.

B. All requests for prior approval to continue authorization of a service the recipient is currently receiving MUST be submitted no later than ten calendar days prior to the end of the current authorization period in order to prevent a break in service (but see exception in the preceding paragraph). If the provider does not request reauthorization of a service at least 10 calendar days prior to the end of the current authorization period, there may be a break in authorization.

> **EXAMPLE**: Recipient is authorized to receive 8 units of a service each week beginning on June 1 through August 30. If the provider believes that it is medically necessary for the service to continue beyond August 30, the request for prior approval must be submitted no later than ten calendar days prior to August 30 in order for services to continue without interruption.

C. If the provider submits the request at least ten calendar days prior to the end of the current authorization period and the request is APPROVED, there must be no break in service and the service must be authorized beginning on the first day after the end of the authorization period.

> **EXAMPLE**: Recipient is authorized to receive 8 units of a service each week beginning on June 1 through August 30. Request for prior approval of 8 units per week of service for an additional 90 days is submitted on August 15. UR Vendor reviews and issues decision approving the request on September 4. Authorization for 8 units per week will be entered into the system retroactive to September 1.

D. Requests for prior approval to continue authorization of a service the recipient is currently receiving that are received LESS than 10 calendar days prior to the end of the authorization period will, if possible, be processed within the UR Vendor's required turnaround time according to the vendor's contract, and if APPROVED, will be authorized beginning on the date of the

decision. Authorization will NOT be backdated to account for late requests unless the exception in V.A. applies.

> **EXAMPLE**: Recipient is authorized to receive 8 units of a service each week beginning on June 1 through August 30. Request for prior approval of 8 units per week of service for an additional 90 days is submitted on August 28. UR Vendor reviews and issues decision approving the request on September 4. Authorization for 8 units per week will be entered into the system on September 4 for 90 days and the service will not be authorized from September 1 – 3.

E. If the provider submitted the request at least ten calendar days prior to the end of the current authorization period and the request is DENIED or REDUCED, the effective date of the change in services shall be no sooner than 10 days after the date the notice is mailed.

> **EXAMPLE**: Recipient is authorized to receive 8 units of a service each week beginning on June 1 through August 30. Request for prior approval of 8 units per week of service for an additional 90 days is submitted on August 15. UR Vendor reviews, asks for additional information and issues decision denying the request on September 4. Authorization for 8 units per week will be entered into the system effective retroactive to September 1 through September 14 (ten days from the date of the notice).

F. Requests for prior approval to continue authorization of a service the recipient is currently receiving that are received LESS than 10 calendar days prior to the end of the authorization period, if DENIED OR REDUCED, authorization at the prior level of service will be entered for ten days beginning on the date of the decision. If the recipient files a timely appeal, authorization will continue through the appeal period. There is no retroactive authorization unless the exception in V.A. applies.

> **EXAMPLE**: Recipient is authorized to receive 8 units of a service each week beginning on June 1 through August 30. Request for prior approval of 8 units per week of service for an additional 90 days is submitted on August 28. UR Vendor reviews and issues decision authorizing 4 units per week on

September 4. Authorization for 8 units per week will be entered into the system effective September 4 for ten days, and authorization for 4 units per week for 90 days will be entered effective September 15. If an appeal is requested within 10 calendar days of the decision, authorization for 8 units must continue without further interruption. If an appeal is requested more than 10 calendar days after the date of the notice but within 30 days, MOS must be entered at 8 units per month effective with the date of the appeal and continuing until there is a final agency decision. The service will not be authorized from September 1 – 3.

G. If the UR vendor cannot issue a decision within 15 business days on a request to CONTINUE authorization of a service, on day 16 the UR vendor must enter authorization for the service to continue at the prior level until the effective date of its decision on the request. This applies as long as the request was submitted before the authorization period expired.

EXAMPLE: Recipient is authorized to receive 8 units of a service each week beginning on June 1 through August 30. Request for prior approval of 8 units per week of service for an additional 90 days is submitted on August 27. UR Vendor reviews but is unable to issue decision on the request by September 20, which is the 15th business day after August 27. Authorization for 8 units per week will be entered into the system on September 21 to continue until 10 days after a decision is issued on the request. The service will not be authorized from September 1 – 20.

H. If the request is submitted on the next day after the end of the current authorization period, the request will be treated as an initial request.

EXAMPLE: 20 hours per month of a service authorized through May 31. Provider requests reauthorization of 20 hours per month on June 2 which is 2 calendar days after the expiration of the authorization. The UR Vendor will treat the request for services as an initial request because it was received more than 1 day after the expiration of the authorization:

1. If the UR Vendor approves the re-authorization request, payment for service stops on May 31. Authorization resumes effective the date of the notice because re-authorization was not requested prior to the end of the current authorization period.

2. If the UR Vendor reduces the re-authorization request, payment for service stops on May 31. Authorization for the service at the new level will begin effective the date of the notice, and payment will be made at the amount approved by the UR Vendor. If an appeal is requested, services are authorized at the new level pending appeal because re-authorization was not requested prior to the end of the current authorization period.

3. If the UR Vendor denies the re-authorization request, payment for service stops on May 31. There is no authorization for services pending appeal because re-authorization was not requested prior to the end of the current authorization period.

I. Providers will be regularly reminded that they should continue to provide services at the prior level beyond the end of the authorization period if the provider timely requested reauthorization even though there may be a delay of up to fifteen business days after the request was submitted before the UR vendor enters authorization into the system. A provider who provides documentation that a request for reauthorization was timely and properly requested shall be entitled to seek correction of the authorization from DMA if the UR vendor fails to properly authorize continuation of services.

VI. EDUCATIONAL NOTICES (DO NOT INCLUDE APPEAL RIGHTS)

A. Unable to Process Notice

This notice is mailed or electronically transmitted to the provider and/or recipient when a request is received that lacks required information necessary for the UR Vendor to recognize and process it as a request for prior approval: Recipient Name/ Address, MID, DOB, Identification of

Service or Procedure Code requested, Provider Name and Medicaid provider number who is to perform the Service or Procedure, date the service is requested to begin or be performed, all required signatures on forms required by state or federal statute, and/or any documents or forms required by state or federal statute.

B. **Notice of Approval of Service Request**

This notice is mailed or electronically transmitted to the provider and/or recipient when DMA or the UR Vendor has approved a covered service for a recipient or a non-covered state Medicaid plan service for a recipient under 21 years of age.

C. **Notice of Receipt of Duplicate Request**

This notice is mailed or electronically transmitted to the provider when an identical or duplicate request for service has been received and the time limit to appeal an earlier adverse decision has not expired.

D. **Notice of Prior Approval when Request Exceeds Policy Maximum**

This notice is mailed or electronically transmitted to the provider when a request that exceeds policy limits has been received for a recipient 21 years of age and older and approved at the policy limit based on medical necessity. The notice educates the provider about the policy limit and reminds the provider that all requests must be submitted in accordance with policy requirements.

> **<u>NOTE</u>: If the recipient is over 21 years of age and the request is approved at the policy limit, the notice does not include appeal rights. If the recipient is over 21 years of age and the request is approved at an amount less than the policy limit, an adverse notice with appeal rights must be issued via trackable mail. If the recipient is under 21 years of age, the request must be reviewed under EPSDT and an adverse decision with appeal rights must be issued even if approved at policy limit.**

E. **Notice Asking for Additional Information**

This notice is mailed or electronically transmitted to the provider requesting new or additional information because, even though the request was complete, at the discretion of the UR Vendor, the reviewer needs more information in order to make a decision on the request. The provider is asked to respond by submitting the needed information within 10 business days of the date of the notice. **If the provider fails to respond, an adverse notice shall be issued.**

VII. ADVERSE NOTICES (INCLUDE APPEAL RIGHTS)

A. Notice of Denial or Change Notice for Incomplete Request

This notice is mailed by trackable mail to the recipient and first class mail to the provider when an incomplete request is submitted for review.

> **EXAMPLE**: The provider submits a request that is able to be processed, but fails to include a copy of the X-ray (or other document) required by the applicable Clinical Coverage Policy. The request will be denied without further review, and the provider will not be reminded to submit additional information.

B. Notice of Denial of Initial Request

This notice is mailed by trackable mail to the recipient and first class mail to the provider when an adverse decision is made on a request for authorization for payment for a service that the recipient was not authorized to receive on the day immediately preceding the date of the request. A recipient who appeals a denial of an initial request is not entitled to maintenance of service during the appeal period.

> **EXAMPLE**: Recipient was authorized to receive 8 units per week of a service for which the authorization ended on July 31. On August 2, the provider submits a request for 8 units of the service per week to continue for 90 more days. If the request is denied, the recipient will NOT be entitled to maintenance of service because it was an initial request (the previous authorization had expired).

C. Notice of Change in Services

1. This notice is mailed by trackable mail to the recipient and first class mail to the provider when an adverse decision is made on a request for authorization for payment for a service the recipient was authorized to receive on the day immediately preceding the date of the request.

2. If an alternative or lower level service is approved, the beginning date of the period for this service must be the same date as the notice's effective date (10 days after mailing).

3. The effective date of the change shall be no sooner than 10 days after the date the notice is mailed.

4. Maintenance of Service (MOS) applies to requests for reauthorization if an appeal is requested.

5. If a decision both denies authorization for a new service and changes authorization for an existing service, the UR Vendor shall either issue a Change Notice or shall issue both a Change Notice and an Initial Denial Notice.

VIII. CONTENT OF NOTICE

A. Adverse notices will clearly identify the decision taken on each service that was requested and a reasonable explanation of the decision. A statement that medical necessity was not met or the EPSDT standard was not met is not a sufficient explanation. UR Vendors must properly complete all fields in Notice Templates, must identify what service (if any) and how much of it is approved. A notice must indicate the requested service and the requested frequency. The time periods for which each service was requested and/or approved must be clearly stated.

B. If an **Unable to Process** Notice or Notice of Denial for **Incomplete Request** is issued, the notice will identify what information was missing from the request.

C. If the request is for a child under age 21, the notice will indicate that a review under EPSDT occurred and include a reasonable explanation of why the EPSDT standard is not met or is not applicable.

D. Notices must include the legal authority supporting the decision in that case. This shall include a citation to the appropriate clinical coverage policy for the service requested and the correct webpage where that policy may be found. An adverse notice for services requested under any of the CAP Programs will cite the appropriate CAP waiver as legal authority for the decision.

E. UR Vendors will not identify or offer evaluations, team meetings, or non-Medicaid covered services as alternative services.

F. Notices must include the phone number of a contact person who can answer questions about the reasons for the decision in this case.

IX. MEDICAID RECIPIENT APPEAL REQUEST FORM

Prior to mailing, the UR Vendor shall complete the top portion of the hearing request form (header), the recipient's name, address, Medicaid identification number, and identification of the service about which an adverse decision was made. The hearing request form and the hearing instructions and information sheet must be enclosed in the recipient's notice. The provider will receive a copy of the adverse notice only. The appeal request form shall be a one page stand-alone form, and it cannot be duplexed.

X. MAILING THE NOTICES

A. The recipient or parent or legal guardian shall be notified in writing of an adverse decision and the right to appeal. The notice shall be mailed on the date indicated on the notice as the date of the decision. UR Vendors shall establish a mail cutoff time after which notices shall be dated the following business day. The effective dates of adverse notices are indicated below.

1. **Initial Request** (services were not required to be authorized on the day immediately preceding the request for reauthorization): later of the requested start date or the date the notice is mailed

2. **Continuing Request** (services were required to be authorized on the day immediately preceding the request for reauthorization): at least 10 calendar days after the date the notice was mailed.

B. Notices shall be mailed to the last known address given by the recipient or his/her legal guardian to the county Department of Social Services or the U.S. Social Security Administration (for SSI recipients), as provided to the UR vendor by DMA. It is the responsibility of the recipient and/or his/her legal guardian to update this address.

C. For recipients under 18 years of age or for recipients who have been adjudicated incompetent, notices shall be mailed to the provider and the parent or guardian listed in the North Carolina Eligibility Information System/ NC FAST/ SSI Database. If any recipient or parent/ guardian notifies Medicaid that the recipient's notice was not received, a duplicate notice will be issued.

1. If a notice is addressed to the wrong person or address, or if some other error is made by the UR Vendor or DMA, a new notice with an updated date shall be issued.

2. If a notice was properly addressed to the right person at the latest address on file in EIS/NC FAST/SSI, a new notice will be issued upon request by the recipient or his/her legal guardian, but the date will not be updated.

D. If the notice is returned undelivered and it was properly addressed to the latest address on file in EIS/NC FAST/SSI, a copy of the notice shall be forwarded to the Department of Social Services office associated with the last address on file in EIS so that DSS can take appropriate action.

E. Any recipient who believes he or she did not receive notice of a decision on a request for prior approval should contact the CARE-LINE Information and Referral Service at 1-800-662-7030 (English/Spanish) or 1-877-452-2514. (Note: this is a TTY number that is only answered for deaf or hearing impaired callers). In the Triangle area, call 919-855-4400 (English/Spanish) or 919-733-4851 (TTY for hearing impaired). The CARE-LINE is open from 8:00 a.m. until 5:00 p.m., Monday - Friday.

XI. QUESTIONS ABOUT THE ADVERSE DECISION OR APPEAL PROCESS

DMA and the UR Vendor may provide answers about the decision or the appeal process or may refer questions about the appeal process to the Office of Administrative Hearings (OAH) at 919-431-3000. For questions regarding legal assistance, please refer the recipient to Legal Aid of North Carolina at 919-856-2564 or toll-free at 1-866-369-6923. Recipients with disabilities also will be informed they may contact Disability Rights of North Carolina at 1-877-235-4210.

XII. RIGHT TO APPEAL

Medicaid recipients or their personal representatives have the right to appeal adverse decisions of the State Medicaid agency and receive a fair hearing pursuant to the Social Security Act, 42 C.F.R. 431.200 *et seq.* and N.C.G.S. §108A-70.9. Providers may not file appeals on behalf of recipients unless the recipient lists the provider as the representative on the appeal request form.

XIII. AUTHORIZATIONS DURING THE APPEAL PROCESS

A. Within five (5) business days after the UR vendor is notified of the filing of a Hearing Request with OAH that occurs within 10 calendar days after the date the Change Notice is mailed, MOS authorization in the computer system must be entered beginning with the effective date of the decision and authorization at the prior level of service (or the amount requested if less) must continue without interruption until the UR Vendor is notified that the appeal has been resolved, either through mediation, dismissal, or a final agency decision, as long as the recipient does not give up this right and as long as he/she remains otherwise eligible for the service and the Medicaid program. This right exists regardless of whether the provider submitted the reauthorization request 10 days before the end of the authorization period so long as the request was made by the end of the authorization period.

> **EXAMPLE 1**: Recipient was authorized to receive 8 units per week of a service for which the authorization ended on July 31. On July 31, the provider submits a request for 8 units of the service per week to continue for 90 more days. The request is denied in a change notice dated August 10 to be effective August 20. The recipient appeals on August 20. The UR vendor must enter MOS authorization within 5 business days for 8

units per week effective August 20, the effective date of the change notice.

EXAMPLE 2: Recipient was authorized to receive 8 units per week of a service for which the authorization ended on July 31. On July 20, the provider submits a request for 8 units of the service per week to continue for 90 more days. The request is denied in a change notice dated August 3 and authorization is entered for August 1 through August 13. The recipient appeals on August 13. The UR vendor must enter MOS authorization within 5 business days for 8 units per week effective August 13, the effective date of the change notice.

B. Within five (5) business days after the UR Vendor is notified of the filing of a Hearing Request with OAH that occurs more than ten calendar days but within 30 calendar days of the date the Change Notice is mailed, authorization for payment must be reinstated, retroactive to the date the completed appeal request form is received by the OAH. 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.

EXAMPLE 1: Recipient was authorized to receive 8 units per week of a service for which the authorization ended on July 31. On July 31, the provider submits a request for 8 units of the service per week to continue for 90 more days. The request is denied in a change notice dated August 10 to be effective August 20. The recipient appeals on August 31. The UR vendor must enter MOS authorization for 8 units per week effective August 31, the date of the appeal request.

EXAMPLE 2: Recipient was authorized to receive 8 units per week of a service for which the authorization ended on July 31. On July 20, the provider submits a request for 8 units of the service per week to continue for 90 more days. The request is denied in a change notice dated August 3 and authorization is entered for August 1 through August 13. The recipient appeals on August 25. The UR vendor must enter MOS authorization within 5 business days for 8 units per week effective August 25, the date of the appeal request.

XIV. IMPLEMENTING THE FINAL AGENCY DECISION

A. **Decisions which uphold the agency action**:

A final agency decision which dismisses the Petitioner's appeal or upholds the agency action shall be implemented no later than three business days from the date the decision was mailed to the petitioner(s) identified by OAH at the time the appeal was filed and electronically transmitted to the appropriate UR Vendor.

B. **Decisions which reverse in part or in full the agency action**:

If the final agency decision or a mediated settlement holds that all or part of the requested services were medically necessary, payment for those services as approved in the final agency decision or settlement will be authorized within three business days for at least twenty (20) prospective calendar days after the date of the decision.

A copy of the final agency decision will be electronically transmitted to the appropriate UR Vendor, and will be mailed to the petitioner(s) identified by OAH at the time the appeal was filed.

The final agency decision shall include a notification that a new request for prior authorization is required to be received by the UR Vendor within 15 calendar days of the decision in order to avoid an interruption in services. Upon receipt by the vendor of a request for service authorization within 15 calendar days from the date of a final agency decision which holds that all or part of the requested services were medically necessary, authorization for payment will remain in effect without interruption for at least 10 calendar days following the mailing of the notice of decision on the new request for prior authorization. If the request is denied or reduced, it will be treated as a timely request for reauthorization and MOS pending appeal will apply.

Final agency decisions will notify the recipient of the importance of immediately informing the provider of the decision.

XV. CHANGING PROVIDERS

A. During the Appeal Process, Going Out of Business, CAP services, Other Long Term Services

1. For Medicaid recipients who:

    a. have appealed an adverse decision, or

    b. whose provider agency is going out of business, or

    c. have changed providers for CAP services or

    d. are changing providers for another service with an authorization period of six months or more,

the current authorization for services will transfer to the new provider within five (5) 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 the recipient's condition meets coverage criteria and acceptance of all associated responsibility; and either

    (i) Written permission of recipient or legal guardian for transfer; or

    (ii) Copy of discharge from previous provider.

2. Authorization shall be effective the date the new provider submits a copy of the written attestation.

3. Following the appeal or prior to the end of the current authorization period, the new provider must submit a request for reauthorization of the service in accordance with the clinical coverage policy requirements and these procedures.

B. **At Any Other Time**

Medicaid recipients may change providers at any other time. However, the discharging provider and the new provider must follow all policy requirements and these procedures.