



Introduction to Medicaid Appeals Involving Managed Care Organizations

This document provides you with step-by-step instructions for how to represent yourself during a mediation and hearing. The mediation and hearing process is what you use to argue that the decision to reduce, deny, or terminate your/your child's services was incorrect and should be reversed. This is general information provided only for educational purposes to help you understand the Medicaid appeals process and give you tools for self-advocacy.

What is a Medicaid Appeal?

Medicaid appeals are intended to allow a person to appeal a denial or reduction of a Medicaid service with or without an attorney. Although an attorney can be helpful, people are often successful in Medicaid appeals on their own or with the help of a trusted relative or friend. The keys to success are: knowing your rights, being organized, and presenting information to the Administrative Law Judge that shows your medical need for the services you are requesting.

When Do I Have a Right to Appeal?

The North Carolina Department of Health and Human Services (DHHS), Division of Medical Assistance (DMA) is the State agency in charge of the Medicaid program. However, the State delegates many responsibilities to the local Managed Care Organizations (MCOs) that manage all Medicaid and State-funded behavioral health services. Behavioral health services is a term that refers to all the mental health, developmental disability and substance abuse services. The MCOs are responsible for approving or denying requests for behavioral health services. Other contractors are responsible for approving or denying other requests, which is a different appeal process.

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If you receive a letter that says the Medicaid-funded **service or equipment** you asked for is denied, terminated, suspended, or reduced, you have the right to appeal the “action”¹ by the MCO. An “action” generally is related to services, such as a denial or limited authorization of a requested service. An appeal of an action is generally the appeals process for an MCO managed Medicaid-funded service which consists of Reconsideration Review and an opportunity to be heard through the state fair hearing process at the Office of Administrative Hearings (OAH).

Under the regulations, an MCO must also have a grievance process to accept complaints about any matter other than an “action”. Possible subjects for a grievance could include the quality of care or services provided, problems associated with interpersonal relationships such as rudeness, etc. Filing a grievance is important because not only does it generate a formal response to an issue, the grievances are part of the records the MCO must keep and how they report on customer satisfaction.

There may be a request, such as a request to be a parent-provider that is denied but is not a denial of services and is not covered by this appeal process. There is also an exception to the right to appeal when there is a statewide policy change, which may apply in limited circumstances. In such circumstances, you may be able to request an exception or modification to the policy; if your request is denied, you may appeal that adverse agency decision. Please pay close attention to the deadlines for the appeal as set out in the notification letter.

What Does the Medicaid Appeal Process Look Like?

Step 1: You must receive **Notice** that the services have been denied, terminated, suspended, or reduced. This notice must include:

- Your/your child's name;
- Which service was denied and why;
 - All Notices are required to provide a brief explanation for the denial typically referred to as the clinical rationale. The clinical rationale should explain the medical reason as to why the MCO did not approve the requested service. **However, you are often required to call the MCO to get the full clinical rationale/explanation.**
- When the service will end or change;
- What you need to do to appeal the decision;
- Contact information for Legal Aid of North Carolina or other legal services groups; and
- A Reconsideration Request Form.

You have thirty (30) days from the date of the Notice to request a Reconsideration Review.

Step 2: Reconsideration by the MCO

- Reconsideration is a required step that obligates the MCO to take a “second look” at the request for services and any documents submitted with it.
- The individuals involved in this review cannot be the same individuals who considered the initial request for services.
- Service recipients, guardians, and providers typically are not participants, but may submit additional information for the reviewers to consider.
- Some MCOs may allow peer-to-peer clinician review during this phase, allowing a treating clinician to discuss the appropriateness for the requested service with the reconsideration reviewer(s).
- This process must be completed within **45 days** after the MCO receives the request.
 - You may request an expedited reconsideration, which must be acted on within 3 business days from the date it is received **if** a standard resolution could seriously jeopardize the individual/enrollee's life, health, or ability to attain, maintain, or regain maximum function.
 - If the MCO denies a request for an expedited reconsideration, the MCO must make reasonable efforts to give the enrollee and affected parties oral notice and follow up with written notice by mail no later than 2 calendar days after receiving the request for an expedited appeal.²
 - **If the expedited reconsideration request is made by a provider on behalf of the enrollee, the MCO shall presume an expedited appeal is necessary and grant the request.**
- You will be notified whether the original decision was reversed or the original decision stands:
 - If the original decision stands, you will be informed of your right to appeal to OAH. You will have **30 days** to file the OAH appeal notice, but file the notice ASAP to avoid interruption of services. You must file the appeal with **OAH, NC DHHS, and the MCO**. Faxing the appeal to the three numbers may be the easiest way to ensure the appeal is filed properly.

Step 3: Mediation

- **Mediation** is an informal process in which both parties are guided through a discussion by a neutral, third-party mediator to see if the parties can reach a settlement.
- New information or evidence may be raised during mediation.
- Mediations are usually held by telephone.

- A settlement could result in the MCO reversing or modifying their decision, or an agreement to postpone the appeal until further documentation is submitted to or reviewed by the MCO.
- There is no requirement to reach an agreement at mediation, and admissions or settlement offers discussed at mediation are **confidential** and cannot be used at the hearing **by either side**.
- Even if no agreement is reached, mediation is beneficial because it:
 - Allows the parties to negotiate without fear that any statements would be later used against them;
 - Allows the parties to "brainstorm" other services that can meet the same need; and
 - Allows the enrollee to learn more about the basis for the denial or reduction and what the MCO will argue at a hearing.
- **You are not required to mediate, but if you agree and fail to participate (absent "good cause"), your appeal will be dismissed.**

Step 4: State Fair Hearing

- The **state appeal hearing** is before a single administrative law judge (ALJ) at OAH.
- The hearing involves presenting evidence, including introducing documents, witness testimony, and making arguments to the ALJ.

Can I Keep Services During the Appeal?

If you file your Reconsideration Request Form and then your OAH Appeal Form within 10 days from the date on the letters, there should be no break in your services. Your services should continue at the level you were receiving prior to your denial until a final decision is made at mediation or a hearing. If you file your OAH Appeal Form after 10 days, but before 30 days, you may have a break in services for a short period of time until your appeal is received by OAH, but then services should be reinstated.

The letter you received states that you may be required to pay for services that continue because of your appeal. While this is possible if you ultimately lose at a hearing, it does not generally occur. Voluntarily discontinuing services to avoid having to reimburse DMA may be a bad strategy because if you can live without services while you are appealing the decision, the judge may think you do not need the appealed services. MCOs interpret the federal Medicaid Managed Care regulations to mean that services do not have to be reinstated or continue during an appeal if the reduction or termination of services occurs at the end of an authorization period (for example, at the end of a plan year). The MCO treats each renewal as if it was an initial authorization request and argues that because it is a new request, services do not need to continue. This view is at odds with a Supreme

Court ruling in *Goldberg v. Kelly*,³ that entitles Medicaid recipients to a pre-termination hearing before a cut or termination goes into effect. However, the federal Centers for Medicare and Medicaid Services has proposed to change the Managed Care Regulations so that they are compatible with the Supreme Court ruling allowing enrollees to continue to receive services throughout the appeal process.

How Do I Prepare For Mediation?

After filing your appeal, you will be contacted by a mediator within 10 days (but no later than 25 days), to schedule a mediation with a representative from the MCO in an attempt to settle the appeal. Regardless of the date of the mediation, it is a good idea to prepare for the mediation as if it were the hearing as soon as you send in the OAH Appeal Form.

If you **are not** represented by an attorney, the parties at the mediation will include a neutral, third-party mediator, yourself, and a representative from the MCO. If you **are** represented by an attorney, an attorney representing the MCO will appear at the mediation. An Assistant Attorney General may also appear to represent the State of NC and its contractors. MCOs are usually represented by attorneys who do not work for the State. If you are represented by an attorney, you should let the mediator know that you have legal representation as soon as possible.

Here are steps you can take before the mediation to make the best use of this time:

- **Gather Documents** – Organize any information or records you have documenting your medical need for the service requested. **Be ready to explain what would happen if you or your child does not get the service you requested.** If you or your child's services were reduced in the past, which caused some negative consequences, also gather documentation of the effect it had on you or your child.
- **Request Documents** – You are entitled to see the information that was used when the decision was made to deny your request for a service. You can request a copy of your case file by contacting the MCO.
- **Share Documents** – If you have documents, such as a letter from your doctor, that you would like the MCO to see prior to mediation that will facilitate your discussions, you can provide a copy directly to the mediator. The mediator will give it to the representative for the MCO. If you want to give documents to the mediator, you should do so at least several days before the mediation. If you present new documents close to the hearing date, the Court may continue the case a minimum of 15 days, but no more than 30 days, to allow the MCO time to review the documents.⁴

- **Invite Others** – Medical professionals—such as your/your child’s doctor—or other individuals involved with your/your child’s care—such as direct care workers —will serve as the best witnesses regarding your/your child’s need for the service requested. If these individuals cannot attend the mediation, they can also write a letter explaining why you or your child has a medical need for services.
- **Talk With the State/MCO Attorney**—To find out the identity of this person, contact OAH and request a copy of any “Notices of Appearance” which contain the contact information for any attorneys representing any party in the appeal. When you contact this individual, request a copy of your file with the MCO. You can also request a copy of your file from the MCO, most likely from the section of the MCO that handles grievances. A copy of any correspondence or filings with OAH must be sent to each attorney involved in your case. If you do not have an attorney, the judge must make a reasonable effort to give you a fair hearing. This means that the judge does not expect you to know the law as well as an attorney, and should be as helpful as he or she can be during the hearing. **Very few people have attorneys for Medicaid appeals.**
- **Service Definition/Clinical Coverage Policy** – Service definitions and clinical coverage policies (CCPs) describe the criteria and factors evaluated in approving or denying requests for services. You should be familiar with the clinical coverage policy that governs the service you requested. The CCPs can be found on the MCO’s website or obtained by calling the MCO. For many MCOs, the policies are found under the provider section of the website. The State also makes the CCPs available at their website: <http://dma.ncdhhs.gov/document/clinical-coverage-policy-ccp-index>.
- **Have a Plan In Mind** – It may be that the MCO offers you a certain number of units of the service, but it is less than what you were requesting. This is called a **settlement offer**. Have in mind the number of units of the service you feel will meet your medical need. If you are willing to settle for a lesser number of units, you may be able to resolve the case at mediation and avoid a hearing. You may also be able to provide sufficient information to show that you need the originally requested amount of services.

How Do I Prepare For the Hearing?

Setting the Date/Location of the Hearing

If mediation is not successful, you will receive written notice of your hearing date by certified mail. If you need more time before your hearing, you can ask the judge for a “continuance” (later court date). You must show “good cause” for why you need a continuance. Examples of good cause include scheduled medical procedures or needing

additional time to review documents. To get a continuance, you must write a letter to the judge and send a copy to the attorney assigned to the case representing the MCO or State agency.

Most hearings will be done over the telephone. However, you can request an in-person hearing. If you request an in-person hearing, it will be in the county that contains the headquarters of the MCO.⁵ You can request the hearing be in your county of residence if you can show that the enrollee's impairment limits their travel.

You have a right to see your/your child's file with the State/MCO prior to the hearing. Contact the attorney representing the MCO to obtain a copy of this file. Any documents that the State/MCO intends to submit at the hearing must be sent to you within a reasonable time before the hearing.⁶ If these documents are not sent to you in a reasonable time before the hearing, you may request a continuation.⁷ "Reasonable time" is not a set number of days, but would be based on the amount of documents and the time before the hearing. **If documents are sent at least 5 business days before the hearing, it will likely be considered a reasonable time. Keep in mind that you are under the same obligation, so it is important to send a copy of any documents that you will use at the hearing to the State/MCO attorney in a reasonable time.**

What Do I Have to Prove?

For a denial of a request for a service, either new or previously received, **you** must show the judge that:

- The service you requested is medically necessary, **and**
- You should have received the service you asked for.

"Red Herrings" in an Appeal

A Medicaid appeal will **only** address whether the State/MCO was correct to reduce, deny, or terminate a service. However, many parents want to resolve other issues that they find important at the hearing. In Disability Rights NC's experience representing individuals at these appeals, it does not help to divert the judge's attention to issues that are **not** related to your/your child's need for a service or your/your child's need for a certain amount of a service.

Concerns that are unrelated to your/your child's need for a service should be directed to the MCO's internal grievance process. Issues that may be important to you, but are irrelevant to the appeal, often include:

- Who may be the provider or caregiver and the effect a cut to services may have on that provider of services;

- Grievances about the quality of a provider's care; and
- Personality conflicts between you and the State/MCO—i.e., the “rudeness” of someone involved in your/your child's care.

How Do I Prove My Case?

The objective in an appeal is to present evidence that will help you prove to the judge that the service or equipment you asked for is medically necessary and your request for a service should not have been reduced, denied, or terminated. Medicaid services will only be provided when they are medically necessary. “Evidence” includes witness testimony, records, documents, or any other objects that are shown to the judge during the trial. Your evidence should help the judge understand the type of service you need, the level or amount of hours you need, how the service has or will help you, and the consequences of you not getting the service.

- **Witnesses** can include your doctor, nurse, aide, case manager, caregivers, and anyone else who can testify to your medical need for services.
 - It is helpful to have your treating physician or other medical professional testify at the hearing. The medical professional should be prepared to describe the service requested and testify specifically as to how it helps you, the number of hours required, and the consequences for you without the service or level of service requested.
 - It is also helpful to have your service provider or community guide at the hearing to tell the judge why the Medicaid services you asked for are medically necessary, including if your Medicaid services have helped you get better or learn new things, or if you would deteriorate without the services.
 - Witnesses can testify by phone if they are not available to attend the hearing in person. You must provide the telephone number where your witness can be reached to the judge prior to the hearing. If your witness is only available to testify during a certain time of the day, you should notify the judge in advance.
 - You should check your witnesses' schedules to make sure they are available on the date of your hearing. If they are not, this may be good cause for requesting a continuance (later court date) from OAH.
- **Records/Documents** – This includes letters from your physician, medical records, school records, information about the service or equipment, or any other records that help the judge understand what the service/equipment is and why it is needed

in the requested amount. To speed up the process of obtaining these documents, be selective about which records you request. For example, a child's entire school record is usually not needed to prove a child's need for in-home skill building services, but a recent Occupational Therapy evaluation conducted as part of the child's IEP may be helpful.

- **Objects** – For example, if you requested a type of equipment, you could show the judge an example (like a picture) of the equipment you asked for.
- Make sure that you have **4 copies** of any evidence that you bring with you to the hearing – a copy for the judge, the attorney for the State/MCO, the witness, and yourself.

What Happens at the Hearing?

During the appeal, please act with the utmost courtesy and respect towards the judge and the other attorneys. For example:

- Address the judge as “your honor” or “judge” or “ma’am” or “sir.”
- Address the attorney representing the State and the MCO as “Mr.” or “Ms.” and their last name.
- Do not accuse witnesses of lying; however you can point out evidence that contradicts a witnesses’ testimony.
- Stand up when you are talking to the judge, and ask the judge’s permission when you need to move around (such as approaching a witness). If you are not able to stand up during the hearing, you can inform the judge and ask if you may remain seated.
- Do not interrupt. If you have a question or comment, please wait until the witness or the other attorney has finished speaking.
- Understand that the attorney and witnesses for the other side are trying to win their case and not make you mad or hurt your feelings. They will interpret facts to best support their argument, but it is important to remain calm and not accuse people of lying. Focus on your argument and proving your case.

What Happens After the Hearing?

The ALJ will issue a decision in your case that either agrees or disagrees with the decision to reduce, deny, suspend, or terminate services. The law says that the judge has to decide whether the State/MCO:

- “acted erroneously;”
- “acted arbitrarily or capriciously;”
- “failed to use proper procedure;”
- “failed to act (as required by law or rule);” or
- “exceeded its authority or jurisdiction.”

This means that the judge has to decide if the MCO: (a) did something wrong when they denied or changed your service; (b) had a good reason for its decision; and (c) followed all the laws when it made its decision. OAH is supposed to schedule and hear cases within 55 days of receipt of your request for a hearing.⁸

The ALJ’s decision is final and cannot be reversed by the State. However, if you disagree with the decision, you can appeal to Superior Court within **30 days** from the date of the Final Notice of Decision. This is done by filing a Petition for Judicial Review in the Superior Court in the county where you reside.. If you feel the need to appeal your case to Superior Court, it is recommended you contact an attorney to assist you with this process. However, you do not have to have an attorney to appeal your case to Superior Court.

The petition should state why you do not agree with the Final Decision, what has happened in your case up to this point, and what you want the Superior Court to do for you. All appeals are heard by a Superior Court judge, without a jury.

To file your petition in Superior Court, you have to pay a \$125 filing fee. If you cannot afford this fee, you can file a form to request that the filing fee be waived. This, and other required papers that must be filed, such as a “Civil Action Cover Sheet,” can be obtained at your local courthouse or online at www.nccourts.org.

Within 10 days after you file the petition, you must send a copy of your petition to all parties listed in the Final Decision. You can send the petition either by personal delivery or by U.S. mail.

In the Superior Court hearing, you are bound by the evidence shown to the judge at the administrative hearing, unless (a) the Superior Court judge says that more evidence is needed, **and** (b) you could not reasonably have shown the evidence to the judge at the administrative hearing.

Who Can Help Me with the Appeal Process?

Anyone you trust, such as a friend or relative can help you during your appeal. Your provider of the Medicaid service may be willing to assist you. You can also contact Legal Aid of North Carolina at 1-866-219-5262 to see if you can get legal assistance.

Disability Rights North Carolina is a 501(c)(3) nonprofit organization headquartered in Raleigh. It is a federally mandated protection and advocacy system with funding from the U.S. Department of Health and Human Services, the U.S. Department of Education, and the Social Security Administration.

Its team of attorneys, advocates, paralegals and support staff provide advocacy and legal services at no charge for people with disabilities across North Carolina to protect them from discrimination on the basis of their disability. All people with disabilities living in North Carolina are eligible to receive assistance from Disability Rights NC.

Contact us for assistance or to request this information in an alternate format.

Disability Rights North Carolina

3724 National Drive, Suite 100

Raleigh, North Carolina 27612

www.disabilityrightsncc.org

919-856-2195

877-235-4210 (toll free)

888-268-5535 (TTY)

919-856-2244 (fax)

¹ An “action” is defined as: “(1) The denial or limited authorization of a requested service, including the type or level of service; (2) The reduction, suspension, or termination of a previously authorized service; (3) The denial, in whole or in part, of payment for a service; (4) The failure to provide services in a timely manner, as defined by the State; (5) The failure of an MCO or PIHP to act within the timeframes provided in § 438.408(b); or (6) For a resident of a rural area with only one MCO, the denial of a Medicaid enrollee’s request to exercise his or her right, under § 438.52(b)(2)(ii), to obtain services outside the network.” 42 C.F.R. § 438.400(b).

² N.C. GEN. STAT. § 108D-13(d).

³ See 397 U.S. 254 (1970).

⁴ Previously a party had to submit documents at least 7 days before the hearing. Although there is no longer an exact requirement, this is probably still a good timeline. If there are a lot of documents, the earlier you submit the documents, the less likely it will be that the MCO will ask for a continuance.

⁵ N.C. GEN. STAT. § 108D-15(h)(2) (2013).

⁶ N.C. GEN. STAT. § 108D-15(h)(5)(a) (2013).

⁷ N.C. GEN. STAT. § 108D-15(h)(4). Continuances should be requested before the day of the hearing as continuances are rarely granted on the day of the hearing. If the person appealing fails to make an appearance at the hearing, OAH will dismiss the case unless the individuals moves to show good cause no later than three business days after the date of dismissal.

⁸ N.C. GEN. STAT. § 108D-15(h)(1) (2013).