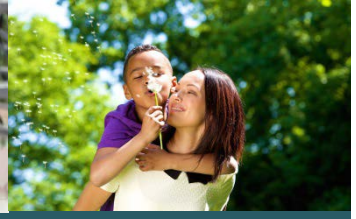

Smoky Mountain LME/MCO

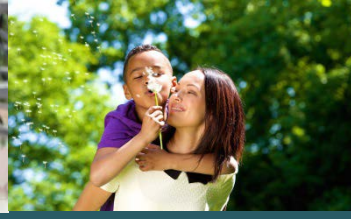
The Basics of LME/MCO Authorization and Appeals

Tracy Hayes, JD

General Counsel and Chief Compliance Officer

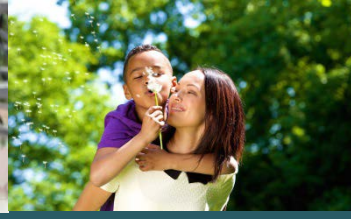
July 17, 2014

DSS Attorneys Summer Conference ▪ Asheville, NC

What is Smoky Mountain?

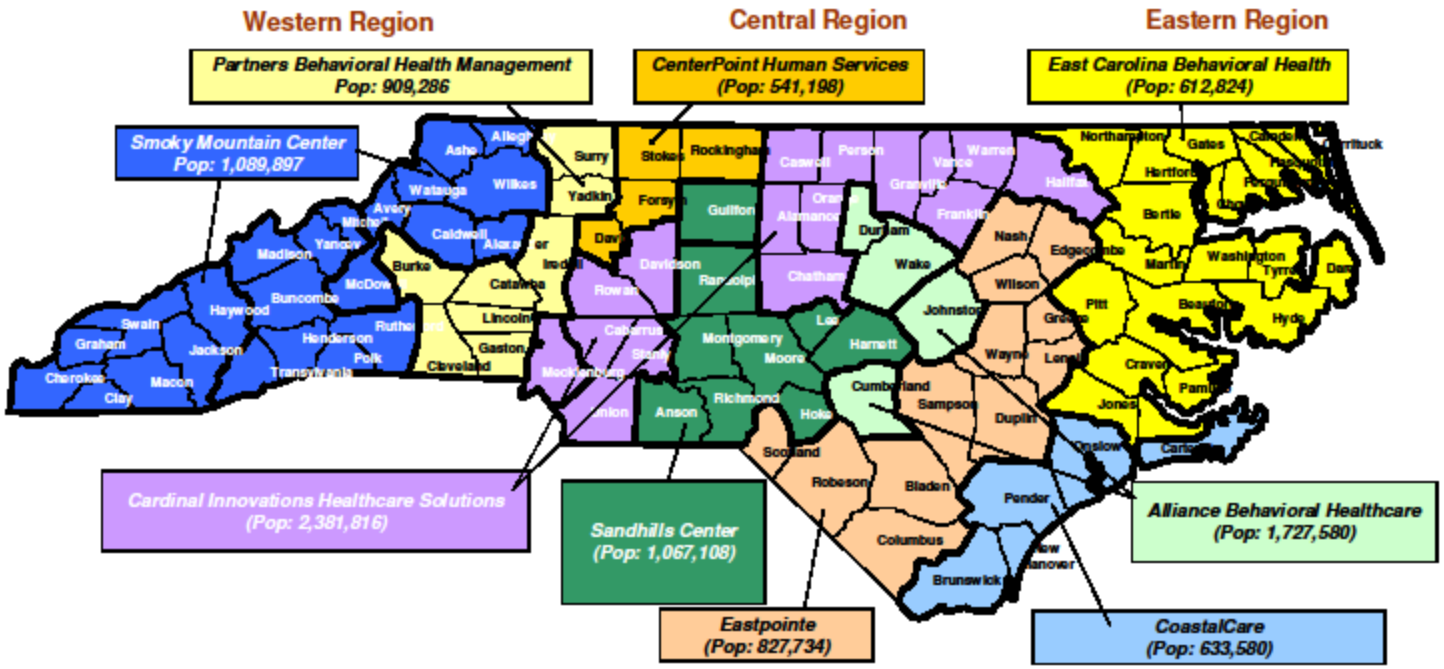
- Area Authority –area mental health, developmental disabilities, and substance abuse authority for 23 counties.
  - "An area authority or county program is the locus of coordination among public services for clients of its catchment area." N.C.G.S. § 122C-101
- Local Management Entity (LME)
- LME/MCO

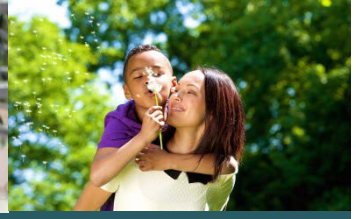
What are LME/MCOs?

- Local Political Subdivision of the State, N.C.G.S. § 122C-116
- Not Service Providers
- Medicaid Managed Care Organization
  - Care Coordination
  - Care Management (Authorizations)
  - Closed Provider Network

April 17, 2014
DHHS currently has -- Nine -- LME-MCOs operating under the 1915 b/c Waiver



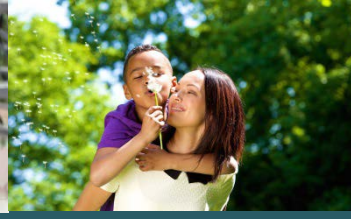
- *SMC now manages WHN catchment area*
- *Cardinal Innovations now managing Mecklenburg County catchment area*
- *Cardinal Innovations is the first of the four regions coming together*

Smoky Mountain LME/MCO

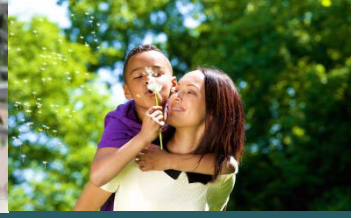
"The Medicaid statute (as is true of other parts of the Social Security Act) is an aggravated assault on the English language, resistant to attempts to understand it. The statute is complicated and murky, not only difficult to administer and to interpret but a poor example to those who would like to use plain and simple expressions."

Friedman v. Berger, 409 F. Supp. 1225, 1226 (S.D.N.Y. 1976).

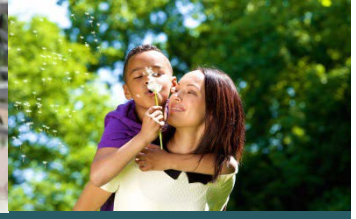
What is the "Waiver"?

- 1915(b) Waiver – Managed Care
- 1915(c) Waiver – Home and Community Based Services (Innovations, formerly CAP-MR/DD)
- Called a "Waiver" because it "waives" certain requirements of Social Security Act
- Governed by 42 CFR Part 438

AUTHORIZATIONS

Toll-free access to services: 1-800-849-6127 / Relay NC TTY-711

- Does service require prior authorization?
  - 22 unmanaged visits for adult E/M, unlimited for children
  - 8 unmanaged visits for adult psychotherapy/ testing, 16 for children*
  - Enhanced, Residential, Inpatient all require PA
- Identify applicable LME/MCO and contact the 24 hour Call Center for Provider Referral

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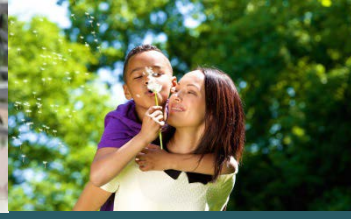
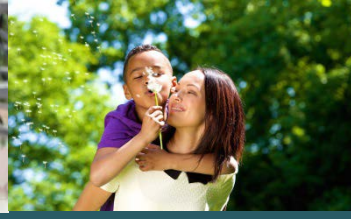
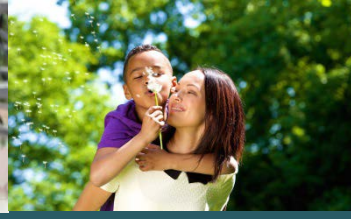


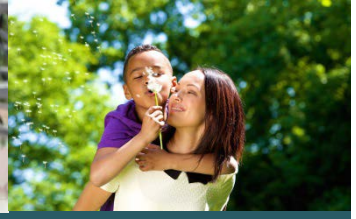
- Ask Provider to Submit a Service Authorization Request (SAR) or Treatment Authorization Request (TAR)
- Requests are submitted electronically
- Note: If consumer is an Innovations Waiver Participant, process will involve assigned LME/MCO Care Coordinator

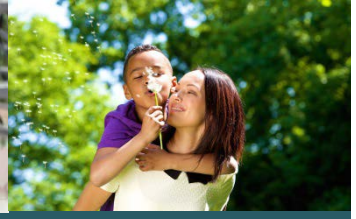
- Provider must be enrolled in the LME/MCO Network unless the service or treatment is not available through an in-network provider
  - Specialized treatment (e.g., anorexia, sexual offender)
  - Out of catchment area/ Out of state
  - **Still requires Prior Authorization**
- LME/MCO can limit provider participation so long as there are sufficient numbers of providers to serve consumers in region
- Exception: Emergency and “post-stabilization”

- LME/MCO receives request for prior authorization
- Is the service in LME/MCO Benefit Plan?
- Is it a valid request?
  - Name, Medicaid ID number, Birthdate
  - Provider name and NPI number
  - Service ID/ code and frequency
  - Date service or treatment requested to start
- If not, provider will receive Unable to Process Notice (no appeal rights)

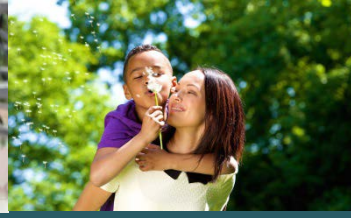



- Does it meet all requirements of Waiver and DMA Clinical Coverage Policy for requested service?
  - Person-centered plan, crisis plan, all necessary signatures, doctor's order, etc.
- If not, provider and consumer will receive formal administrative denial notice with appeal rights.
- LME/MCO has option to contact provider and request additional information but is not required to do so.
- Provider has responsibility to demonstrate medical necessity.

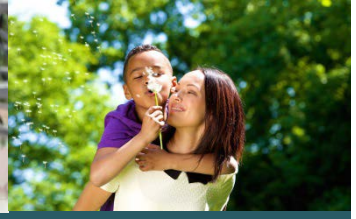
Medical Necessity/ EPSDT Review

- LME/MCO may place appropriate limits on services:
  - based on established criteria such as medical necessity
  - not budget or cost-cutting goals (no incentives to deny)
- Medical necessity criteria can be no more restrictive than Clinical Coverage Policies, NC State Plan, and 1915 (b)/(c) Waiver
- Request cannot be denied solely because of diagnosis, type of illness, or condition

Medical Necessity Review

- Initial Review by “health care professional with appropriate clinical expertise in consumer’s condition”
  - Waiver and/or Clinical Coverage Policy criteria
  - LOCUS, CALOCUS, ASAM scores
  - Clinical Practice Guidelines
- If recommendation to deny, second level review by peer-level reviewer (Ph.D. psychologist, M.D.)

Smoky Mountain LME/MCO

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) entitles Medicaid beneficiaries under the age of 21 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 State Plan.

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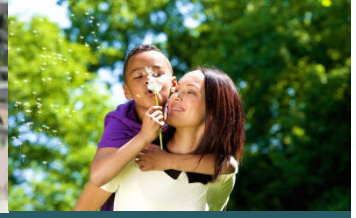
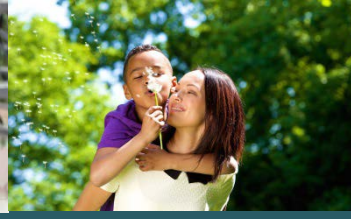
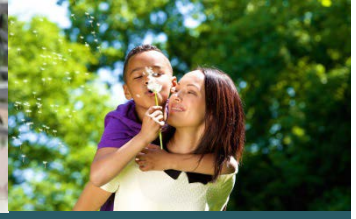


EPSDT Criteria

- Applies to scope of services covered by 1915 (b)/(c) Waiver (i.e. MH/DD/SA) and listed in the Social Security Act
- Must be accepted method of medical practice or treatment
- Cannot be unsafe, ineffective, experimental or investigational

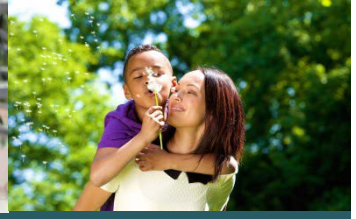



- If decision made to deny, reduce or terminate:
  - Formal notice with appeal rights*
  - Peer-to-Peer Conversation
- New request must be submitted for each authorization period

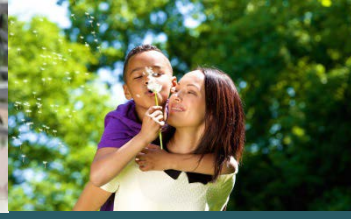
Standard Authorization Timeframe

- Within 14 calendar days following receipt of the service request
  - Can be extended 14 additional calendar days if additional information is required to make the decision

Expedited Authorization Timeframe

- Within three working days following receipt of the service request
  - Required when the standard timeframe seriously jeopardizes the enrollee's life or health or ability to attain, maintain, or regain maximum function
  - Can also be extended 14 additional calendar days
  - Inpatient requests generally receive decision within 24 hours

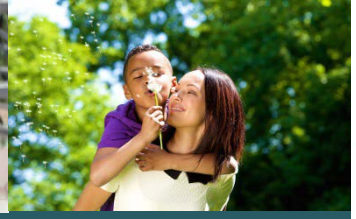
LME/MCO Reconsideration Review

State Fair Hearing (OAH)

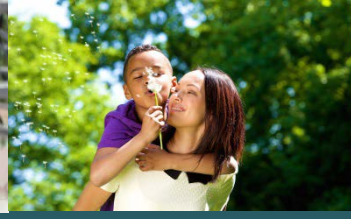
Superior Court

APPEAL PROCESS

Toll-free access to services: 1-800-849-6127 / Relay NC TTY-711

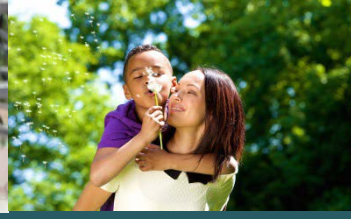



- Medicaid beneficiaries have a constitutional right to due process because Medicaid is an entitlement program. *Goldberg v. Kelly*, 397 U.S. 254 (1970).
- Governed by N.C. Gen. Stat. Chapter 108D (NC Session Law 2013-397) and 42 CFR Part 438, Subpart F

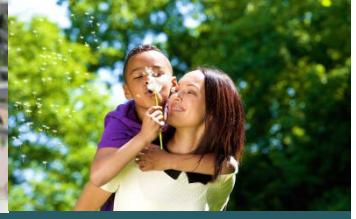
What can be appealed?

- "Managed Care Action" – decision to deny, reduce, terminate or suspend a request for Medicaid services, or failure to act with reasonable promptness on request (i.e. 14 calendar days)
- Cannot appeal Grievances or Complaints

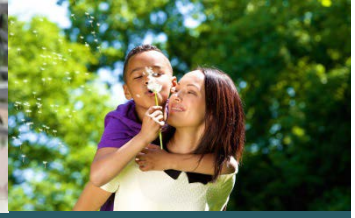
Notice of Managed Care Action

- Must include basis for decision, appeal rights and appeal form
- Mailed to consumer or guardian
- Provider receives electronic or mailed notification (does not receive appeal form)

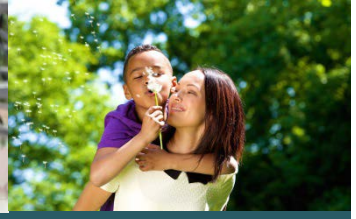
Requesting LME/MCO Reconsideration

- 30 calendar days to file appeal with LME/MCO
- Provider can only file appeal with written consent of consumer or guardian
- Cannot go straight to OAH, must go through LME/MCO reconsideration process

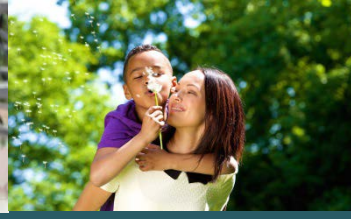
Reconsideration Process

- Right to review medical record
- Can submit additional information
- Reviewed by clinician who was not involved in original decision

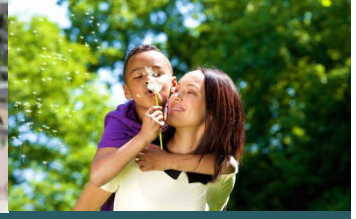
Notice of Resolution

- LME/MCO has 30 calendar days to issue decision*
- Decision mailed to consumer or guardian
- If original decision upheld, must include appeal rights and OAH appeal form
- Provider receives electronic or mailed notification (does not receive appeal form)

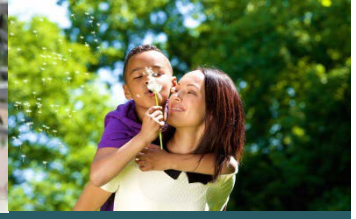
Filing appeal with OAH

- 30 calendar days
- Provider can only file appeal with written consent of consumer or guardian
- Must meet filing requirements

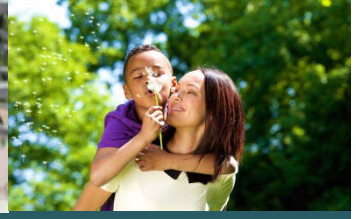
Office of Administrative Hearings Process

- First step: Mediation conducted by Mediation Network of North Carolina
- If not resolved at mediation, hearing will be scheduled before Administrative Law Judge
- Usually conducted by telephone
- Can submit new evidence
- 55 days to conduct hearing

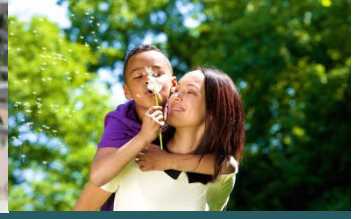
OAH Decision

- If either party dissatisfied, can file appeal to Superior Court within 30 days
- LME/MCO may impose cost of services on consumer or parent/ guardian if decision upheld
- No Maintenance of Service in managed care.

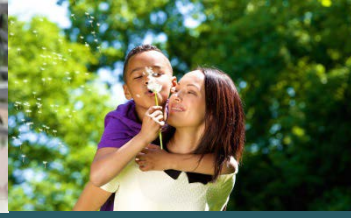



Continuation of Benefits

- LME-MCO is only required to pay for continuation of service during appeal if requested and **all** of the following conditions are met:
  - The appeal is timely; and
  - The appeal involves the termination, suspension, or reduction of a currently authorized service; and
  - The service was ordered by an authorized provider; and
  - The current service authorization has not expired.

- The service must continue until:
  - Appeal is withdrawn; or
  - Ten days after LME/MCO issues reconsideration decision, unless appeal filed at OAH within those 10 days; or
  - State Fair Hearing upholds LME/MCO action; or
  - The service authorization expires.

Questions?

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