CORPORATE POLICY & PROCEDURE

	Policy Name: Adverse Benefit Determinations
Department: Clinical Engagement	Policy Number: CE21
Version: 6	Creation Date: 8/14/18
Revised Date: 4/1/19, 10/23/19, 7/24/20, 8/6/20	Review Date: 7/23/19

Line of Business: ☐ All

☒ Umpqua Health Alliance	☐ Umpqua Health Management
☐ Umpqua Health - Newton Creek	☐ Physician eHealth Services
☐ UHA Community Activities	☐ Umpqua Health Network
☐ Professional Coding and Billing Services	☐ ACE Network

Signature:

Approved By: F. Douglas Carr, MD, Chief Medical Officer Date: 8/10/2020

POLICY STATEMENT

Umpqua Health Alliance (UHA) issues written notification to members when it has made or intends to make an adverse benefit determination. UHA shall maintain its policies in accordance with the Coordinated Care Organization (CCO) Contract between UHA and the Oregon Health Authority (OHA, Authority, or State), Oregon Administrative Rules (OAR) 410-141-3835 through 410-141-3915, and Code of Federal Regulations (CFR) 42 CFR §§ 438.400 through 438.424. This policy is applied in conjunction with the policies for prior authorizations, grievances, appeals, hearings and member services (i.e. Member Handbook).

PURPOSE

To provide all members with opportunity to appeal an adverse benefit determination.

RESPONSIBILITY

Clinical Engagement

DEFINITIONS

Adverse Benefit Determination (ABD): The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit; the reduction, suspension, or termination of a previously authorized service or the denial of payment for a service; failure to provide services in a timely manner, as defined by the State; the failure of UHA to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals; the denial of a member's request to exercise his or her right, under § 438.52(b)(2)(ii), to obtain services outside the network if they are a resident of a rural area with only one managed care organization; and the denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

Appeal: A request for review of an adverse benefit determination issued by UHA. Members have

one level of appeal with UHA.

Grievance: An expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. Grievances include the member's right to dispute an extension proposed by the CCO to make an authorization decision.

Grievance System: The overall system that includes grievances and appeals handled at UHA and access to the OHA administrative hearing process.

Member Representative: A person who can make Oregon Health Plan (OHP) related decisions for a member who lacks the ability to make and communicate health care decisions to health care providers, including communication through person's familiar with the principal's manner of communicating if those persons are available. A member representative may be, in the following order of priority, a person who is designated as the member's health care representative as defined in Oregon Revised Statutes (ORS) 127.505(13) (including an attorney-in-fact or a court-appointed guardian), a spouse, or other family member as designated by the member, the Individual Service Plan Team (for members with developmental disabilities), parent or legal guardian of a minor below the age of consent, a Department of Human Services (DHS) or OHA case manager or other DHS or OHA designee. For members in the care or custody of DHS Children, Adults, and Families (CAF) or Oregon Youth Association (OYA), the member representative is DHS or OYA. For members placed by DHS through a Voluntary Child Placement Agreement (SCF form 499), the member representative is his or her parent or legal guardian.

PROCEDURES

1. UHA issues a written notification approved by OHA for an ABD, for any of the following:
    a. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
    b. The reduction, suspension, or termination of a previously authorized service.
    c. The denial, in whole or in part, of payment for a service.
    d. The failure to provide services in a timely manner, as defined by the State.
    e. The failure of UHA to act within the timeframes provided in § 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.
    f. For a resident of a rural area with only one managed care organization, the denial

of a member's request to exercise his or her right, under § 438.52(b)(2)(ii), to obtain services outside the network.

g. The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

2. The ABD notifies the member and requesting provider in writing by meeting the notice requirements of 42 CFR § 438.404 and OAR 410-141-3885 by including the Appeal and Hearing Request Form (OHP 3302) and including the following:
    a. Date of the notice;
    b. UHA's name, address, and telephone number;
    c. Name of the member's Primary Care Practitioner (PCP), Primary Care Dentist (PCD), or behavioral health professional, as applicable;
    d. Member's name, address, and member ID number;
    e. Service requested or previously provided and the ABD UHA made or intends to make, including whether UHA is denying, terminating, suspending, or reducing a service or denial of payment;
    f. Date of the service or date service was requested by the provider or member;
    g. Name of the provider who performed or requested the service;
    h. Effective date of the ABD if different from the date of the notice;
    i. Whether UHA considered other conditions such as co-morbidity factors if the service was below the funding line on the OHP Prioritized List of Health Services; statement of intent governing the use and application of the Prioritized List to requests for health care services, and other coverage for services addressed in the State's 1115(a) Waiver;
    j. Clear and thorough explanation of the specific reasons for the adverse benefit rules including specific sections of the statues and administrative rules to the highest level of specificity for each reason and specific circumstance identified in the notice that includes, but is not limited to:
        i. The item requiring prior authorization but not authorized;
        ii. The services or treatment requested not meeting medically necessary or medically appropriate criteria as defined in OAR 410-120-0000;
        iii. The service specifically not a covered service or that does not meet requirements based on the Prioritized List of Health Services;
        iv. The service or item received in an emergency care setting that does not qualify as an emergency service;
        v. The person is not a member at the time of the service or not a member at the time of the requested service;
        vi. Except in the case of an Indian Health Care Provider (HCP) serving an Indian (AI/AN) member of the CCO, the provider not on the

contractor's panel;

vii. Prior approval not obtained (except as allowed in OAR 410-141-3840); or

viii. UHA's denial of member's disenrollment request and findings that there is no good cause for the request.

k. Language clarifying that oral interpretation is available for all languages and how to access it.

3. The ABD and attached Appeal and Hearing Request Form (OHP 3302) also explain the following to the member:
   a. The member's right to be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's ABD. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits.
   b. Circumstances under which an appeal process can be expedited and how to request it.
   c. The member's right to have benefits continue pending the resolution of the appeal, how to request that benefits be continued, and the circumstances, consistent with state policy, under which the member may be required to pay the costs of continued services.
   d. The member's right to have benefits continue pending the resolution of the appeal [to be entitled to continuing benefits, the member shall complete a UHA appeal request or an Authority contested case hearing request for continuing benefits no later than:
      i. The tenth day following the date of the notice of ABD or the notice of appeal resolution (NOAR); and
      ii. The effective date of the ABD proposed in the notice, if applicable.
   e. The member's right to request an appeal within 60 days from the date of notice on the ABD.
   f. The member's right to request a hearing within 120 days from the date of notice on the NOAR.
4. The notice must comply with the OHA's formatting and readability standards in OARs 410-141-3580, 410-141-3585 and 42 CFR § 438.10, including, without limitation, translating a notice of adverse benefit determination (ABD) for those members who speak prevalent non-English language and be written in language sufficiently clear that a layperson could understand the notice and make an informed decision about appealing and following the process for requesting an appeal.
5. UHA provides notice of an ABD expeditiously as the member's condition requires within state-established timeframes for authorization requests consistent with OAR

410-141-3835:

a. For standard authorization requests for services not previously authorized, provide notice as expeditiously as the member's condition requires and no later than 14 days following receipt of the request for service with a possible extension of up to 14 additional days if the following applies:
    i. The member, the member's representative, or provider requests an extension; or
    ii. UHA justifies to the Authority upon request a need for additional information and how the extension is in the member's interest. UHA must provide its justification to OHA via administrative notice to the email address identified by OHA in its request, within five (5) days of OHA's request.
b. For notice of ABDs that affect services previously authorized, UHA shall mail the notice at least ten days before the date the ABD takes effect:
    i. UHA shall make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than 72 hours after receipt of the request for service;
    ii. UHA may extend the 72-hour time period up to 14 days if the member requests an extension or if UHA justifies to the Authority upon request a need for additional information and how the extension is in the member's interest. UHA must provide its justification to OHA via Administrative Notice to the email address identified by OHA in its request, within five (5) days of OHA's request.
c. If UHA extends the ABD timeframe for standard or expedited authorization decisions that deny or limit services, it must:
    i. Give the member written notice and make reasonable effort to give oral notice of the reason for the extension and inform the member of the right to file a grievance if he/she disagrees with the decision.
    ii. Issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.
d. UHA mails the notice of ABD by the date of the action when any of the following occur:
    i. The recipient has died.
    ii. The member submits a signed written statement requesting service termination.
    iii. The member submits a signed written statement including information that requires service termination or reduction and indicates that he understands that service termination or reduction will result.
    iv. The member has been admitted to an institution where he or she is

ineligible under the plan for further services.

v. The member's whereabouts unknown based on returned mail with no forwarding address.
vi. The member is accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth.
vii. A change in the level of medical care is prescribed by the member's physician.
viii. The notice involves an adverse determination with regard to preadmission screening requirements for LTPC admissions.
ix. The transfer or discharge from a facility will occur in an expedited fashion.
x. The denial of payment.
xi. Any service authorization decision not reached within the timeframes specified in this rule shall constitute a denial and becomes an ABD. A notice of ABD shall be issued on the date the timeframe expires.
xii. For ABDs for long term psychiatric care (LTPC) transfers, the safety or health of individuals in the facility would be endangered, the member's health improved sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the member's urgent medical needs, or a member has not resided in the LTPC for 30 days.

e. UHA mails the notice of ABD at least 10 days before the date of ABD, when the ABD is a termination, suspension, or reduction of previously authorized Medicaid-covered services. UHA may mail the ABD as few as five (5) days prior to the date of ABD if the agency has facts indicating that ABD should be taken because of probable fraud by the member, and the facts have been verified, if possible, through secondary sources.

6. UHA will give notice on the date that the timeframes expire when service authorization decisions are not reached within the applicable timeframes for either standard or expedited service authorizations.
7. UHA maintains a record of each ABD, appeal, and grievance in a manner accessible to the state and available upon request to the Centers for Medicare & Medicaid Services. Records shall be retained for ten years (CO23 – Record Retention & Destruction Policy).
8. In addition to the content of the ABD and the Appeal and Hearing Request Form (OHP 3302), members may also access information regarding their rights to an appeals, hearing, and grievance on the UHA website and in the Member Handbook.
9. If a member expresses that they need assistance in filling out any forms, requests a notice in a different language or format, or would like an interpreter, they may contact UHA member services for assistance.

10. UHA annually reviews and updates its grievance systems policies and procedures and its member notifications. Written notification of updates to these procedures and timeframes within 5 business days after approval of such updates by OHA.

Subcontracted Entities

1. If UHA subcontracts the prior authorization, appeal, or grievance process to a subcontractor, it must:
    a. Provide to OHA all subcontracts for grievance services to be approved prior to such subcontracts being implemented (CCO Contract Exhibit B, Part 3, Section 14(c)(4).
    b. Ensure the subcontractor meets the requirements consistent with this rule and OAR 410-141-3835 through 410-141-3915 and 42 CFR §§ 438.400 through 438.424;
    c. Monitor the subcontractor's performance on an ongoing basis;
    d. Perform a formal compliance review annually to assess performance, deficiencies, or areas for improvement, including but not limited to, updates to the grievance systems policies and procedures and its member notifications; and
    e. Ensure the subcontractor takes corrective action for any identified areas of deficiencies that need improvement.
2. Subcontractors must also comply with the following guidelines:
    a. Maintain a log according to the criteria specified by OHA and submit to UHA no later than 21 days after the end of each quarter.
    b. ABD, NOAR, and grievance resolution notices (as applicable) will be sent by the subcontractors on UHA's behalf. Copies of notices issued will be submitted to UHA no later than 21 days after the end of each quarter.
3. For hearings, subcontractors will forward all documentation to OHA and UHA and coordinate schedules to be available as expert witness during the hearing process.
4. UHA shall not subcontract to a subcontractor or participating provider the adjudication of an appeal, in accordance with OAR 410-141-3875(14).