Senior Care Partners P.A.C.E.

Appeals

Section: Participant Rights	**Policy Number: 05**
Policy Name: Appeals	**Dept. Owner: Quality**
Federal Reg. Reference:§460.122 and §460.124	
Date Adopted: 01/11/2013	**Last Review/Revision Date: 02/01/2019**

Purpose: Participants of Senior Care Partners P.A.C.E. PACE program who disagree with denial of services, non-payment of services, termination of services, or reduction of services can file a formal complaint, referred to as an appeal. A participant may file an appeal either verbally or in writing.

Definitions:

Appeal: A participant's action taken with respect to Senior Care Partners P.A.C.E.'s non-coverage of or non-payment for, a service including denials, reductions, or termination of services.

Policy: It is the policy of Senior Care Partners P.A.C.E. to provide participants the opportunity to appeal a decision. Senior Care Partners P.A.C.E. provides for an internal appeals process and may assist participants in an external appeals process through Medicare or Medicaid.

The Medicaid covered participant may request an external appeal at any time during the appeal process. The Medicare only covered participant must follow the internal appeal process first.

Procedure:

Confidentiality

- All requests for an appeal will be treated in a confidential manner and in compliance with the program's confidentiality/privacy policy.
- All staff will review the Appeal Policy and Procedure at the time of orientation.
- All staff will review the Confidentiality/Privacy Policy and Procedure at the time of orientation and annually thereafter.
- All staff will sign a confidentiality acknowledgment form.
- Violations of the Confidentiality/Privacy Policy will result in disciplinary action.

Appeals

1. The appeal process and applicable policy/procedures will be reviewed both orally and in writing with the participant/family/representative by the designated staff member at the time of enrollment, at least annually at the time of annual review, when Senior Care Partners P.A.C.E. denies, reduces or terminates services, or when Senior Care Partners P.A.C.E. denies payment for services.

2. A participant will be notified in writing of denial of coverage or payment and the designated staff member will document the circumstances in the EMR.
3. The written notice of denial will be included in the participant's electronic health record.
4. The participant will be informed that staff is available to assist with the appeals process as needed.
5. The appeal policy and procedure will be made available upon request to the participant/family member/representative.

Standard Appeal Procedure

1. An appeal may be expressed either orally or in writing to the designated Senior Care Partners P.A.C.E. staff.
2. An appeal must filed within 30 calendar days of the written denial of services, notification of non-payment, termination, or reduction in services.
3. Upon receipt of an appeal, the designated staff will discuss with and provide all parties involved in writing, the specific steps, including the time frame, for response that will be necessary to resolve the appeal.
4. All parties involved will be notified of and given a reasonable opportunity to present evidence related to the dispute, in person, as well as in writing.
5. If the participant/family member/representative wishes to file an appeal during non-center hours, the administrator on call will be responsible for receiving the appeal and relaying it to the proper staff the following business day.
6. All requests to appeal a decision will be documented by the designated compliance staff in the appeal log and maintained in a confidential location. In addition, a summary of the participant's appeal will be documented in the participant's electronic health record.
7. Non-expedited requests will be resolved as expeditiously as the participant's health requires, but no later than thirty (30) calendar days after receipt of the appeal.
8. There shall be no discrimination against a participant because he/she has filed an appeal and the program will continue to furnish the disputed service until issuance of the final determination if the participant acknowledges that he/she may be liable for the costs of the contested services if the decision is not made in his/her favor.
9. The service in question will be reviewed by the external appeal committee for appropriateness taking into consideration the medical, social, and functional needs of the participant.
10. In order to ensure the review of the appeal and subsequent determination is made by an objective third party appropriately credentialed and not involved in the original decision and having no stake in the outcome, the appeal will be reviewed by a "Board" of appeal reviewers.
    a. The Board of appeal reviewers will be comprised of a minimum of three (3) professionals from the various MI PACE programs selected by the MI PACE

program Executive Directors. The individuals selected will be a member of one of the MI PACE programs.

b. A member of the Board of appeal reviewers must recuse him/herself from the review of an appeal involving the PACE program in which the individual is employed.

11. For a determination made in favor of a participant, the PACE program will advise the participant and furnish the disputed service as expeditiously as the participant's health condition requires. All related correspondence will be documented in the participant's electronic health record.
12. Regarding determinations that are adverse to the participant either wholly or in part, the PACE program will notify the participant in writing of his/her appeal rights under Medicare or Medicaid. Should the participant elect to appeal, the program shall assist the participant in choosing which option of appeal to pursue. The program will forward the appeal to the appropriate external entity. All related correspondence will be documented in the participant's electronic health record.
13. In the case where Senior Care Partners P.A.C.E. is proposing to terminate or reduce services currently being provided to a Medicaid covered participant, Senior Care Partners P.A.C.E. will continue to furnish the disputed service(s) until issuance of the final determination if the participant requests continuation with the understanding that he or she may be liable for the costs of the contested services if the determination is not made in his or her favor.
14. During the appeals process, Senior Care Partners P.A.C.E. will continue to furnish all other Medicare and Medicaid covered services as well as other services determined necessary by the interdisciplinary team to improve or maintain the participant's overall health status.
15. For a determination that is wholly or partially adverse to the participant at the same time the decision is made, a representative from the program's compliance department will notify:
    a. CMS, and
    b. The State Administering Agency

All related correspondence will be documented in the participant's electronic health record.

<u>Expedited Appeal Procedure</u>

1. If participant/family member/representative believes that his/her life, health, or ability to regain maximum function would be seriously jeopardized without the services in question, the participant/family member/representative can request an expedited appeal.
2. If the participant/family member/representative does not request an expedited appeal, the designated program staff will determine if the appeal requires an expedited review process.
3. If the participant requests an expedited appeal, but it is determined that the participant's health or ability to regain or maintain maximum function would NOT be

seriously jeopardized without the services in question, the participant will be informed that the appeal request does not meet the criteria for expedition and will be processed according to standard format.

4. In the case of an expedited appeal, the following apply:
    a. Senior Care Partners P.A.C.E. must respond to the expedited appeal as expeditiously as the participant's health requires, but not to exceed seventy-two (72) hours after the program receives the appeal.
    b. Senior Care Partners P.A.C.E. may extend the 72 hour time period by up to 14 calendar days for either of the following reasons:
        i. The participant requests the extension.
        ii. Senior Care Partners P.A.C.E. justifies to MDHHS the need for additional information and how the delay is in the interest of the participant.

<u>Submitting Appeal Information to Appeal Board and Documentation of Appeal Consideration</u>

1. Expedited appeal requests will be submitted to the point of contact for the appeal Board on the same day (or within 24 hours) the request for appeal has been received from the participant.
2. The following documentation must be provided to the appeal Board:
    a. Participant's name;
    b. Item or service appealed;
    c. Dates the item or service has been received by the participant;
    d. A copy of the written denial of service authorization/coverage and/or payment;
    e. A written summary of the reason the participant/family member/representative does not agree with the denial of service authorization/coverage and/or payment.
    f. IDT documentation supporting the denial of service authorization/coverage and/or payment. Only documentation supporting the denial determination should be submitted.
3. The point of contact for the appeal Board will disseminate the relevant information to all members of the appeal Board for review and schedule a phone conference to review the appeal and make a determination.
4. The process of reviewing the appeal and considering the relevant information will be documented by a member of the appeal Board. All documentation submitted and summarizing the appeal Board's decision will be maintained in a secure location.
5. The appeal Board's decision will be communicated to the program within twenty four (24) hours of the date the appeal documentation was submitted.

External Appeals

1. An appeal may be made to Medicare or Medicaid, but not both. All Medicaid appeals must be requested in writing. The designated staff will assist the participant with the process chosen.
2. A Medicaid participant may make an external appeal, at any time. Information can be obtained by calling or writing:

State Office of Administrative Hearings and Rules
Department of Community Health
Administrative Tribunal
PO Box 30763
Lansing, MI 48909
(877) 833-0870

3. If the participant chooses the Medicare Appeals Process, the participant must complete the PACE program's internal process first. The designated program staff will forward the appeal externally to the Medicare's independent review entity.

Data Collection and Reporting

1. A record of all appeals shall be maintained by the designated compliance staff. The record shall include the initial date, identification of the appeal, the date of resolution and a summary of the resolution itself.
2. The designated staff will maintain, aggregate, and analyze information on the appeal proceedings.
    a. Data is reviewed quarterly for trends and presented to the QAPI committee on a quarterly basis.
        i. Committee members are alert to trends posing high safety risks or those that may need immediate investigation and identified trends and patterns will be incorporated as a formal part of the program's QAPI program
    b. The information shall be reviewed with the governing body on a routine basis.
3. Appeal information is included in the quarterly HPMS data collection.

Reviewed and Approved by:

Review Date	Reviewed By		Review Date	Reviewed By
01/11/2013			02/01/2019	M Bozell
07/12/2016	L. Ferrara			
10/23/2017	M Bozell			
02/09/018	L Ferrara			

03/25/2019

Signature Executive Director Date