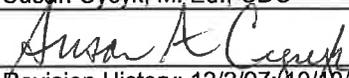




Division of Prevention and Behavioral Health Services
 Department of Services for Children Youth and Their Families
 State of Delaware

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| CS 005 | | DPBHS APPEAL POLICY | |
| Authored by: | Kelly Lovelace, LCSW | Title: Manager of Quality Improvement | |
| Approved by: | Susan Cczyk, M. Ed., CDC | Title: Division Director | |
| Signature: |  | Date Adopted: 9/17/97 | |
| | Revision History: 12/2/97; 10/10/03, 2/7/07, 4/10/08, 9/10/09, 11/30/11, 1/26/12, 2/12/13 | Reviewed: 12/13/10, 12/18/13 | Page: 1 of 6 |

PURPOSE

The Division of Prevention and Behavioral Health Services (DPBHS) establishes this policy to define formal appeals and state the process by which an appeal is to be made.

SCOPE

This policy applies to all DPBHS staff, substance abuse clients age fourteen years or older, parents/legal guardians, legal representative of the client, and service providers for DPBHS clients.

POLICY STATEMENT

It is the policy of the Division of Prevention and Behavioral Health Services to provide an appeal process through which DPBHS service providers, substance abuse clients age fourteen years or older, parents/legal guardians, or legal representatives for clients may request reconsideration of those decisions identified by this policy as appropriate for appeal. Appeals will be processed in a manner that is timely and safeguards the rights of the appellant. Staff shall ensure that no appellant will experience any form of retaliation for registering an appeal.

All appeals must be consistent with the Client Eligibility Policy (CS 001) and the Clinical Services Management Policy (CS 004). The appeal procedures for Psychiatric Hospitals and all other facilities certified by the Division of Prevention and Behavioral Health Services as Medicaid 'Psych Under 21' facilities will conform to Federal Medicaid regulations. Other appeal procedures shall be consistent with Federal Medicaid regulations and DSCYF policy.

It is the intent of the Division to resolve concerns about client care at the most suitable level. If the issue is not satisfactorily resolved at this point, an appeal, either written or oral must be submitted and will follow the DPBHS Appeal Procedure accompanying this policy.

Level of care decisions, denial of a continued stay, and eligibility may be appealed by a parent/legal guardian, legal representative for the client, by a substance abuse client age fourteen years or older, or by a provider with the consent and approval of the child's parent or legal guardian. Providers may assist clients and families as advocates in the submission of an appeal.

Services currently being provided to the child may be continued pending resolution of the appeal. However, if the appeal is denied the appellant may be required to pay the costs of the service provided from the date of DPBHS' denial of the appeal to the date of client discharge.

DPBHS staff have the obligation to explain to providers, substance abuse clients age fourteen years or older, parents or legal guardians their rights regarding appeals. Appeal rights for clients, parents or legal

guardians will be addressed in the Client Handbook and at any point that the appellant is clearly dissatisfied with services authorized by a clinical services treatment team leader or an eligibility decision.

When DFS or DYRS has legal custody, staff in disagreement with DPBHS decisions should use the DSCYF case dispute resolution procedures instead of the appeal procedures.

All appellants are to be informed of their right to receive assistance from the DPBHS Quality Improvement Unit in the formulation of a written appeal for DPBHS appeals. Appellants receiving Medicaid must be informed by DPBHS of their right to appeal directly to DHSS Medicaid Office at any point in the appeal process.

DOCUMENTATION

Copies of all formal appeals, formal responses, outcomes and notification letters will be maintained by the DPBHS Quality Improvement Unit.

OI/QA MEASURES

Aggregate reports on provider appeals are provided by the Manager of Quality Improvement to the Quality Management Committee at least annually. The report will identify significant findings and/or recommendations.



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| CS005 | DPBHS APPEAL PROCEDURE | | |
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| Approved by: | Susan Ccyk, M. Ed., CDC | Title: Division Director | |
| Signature: | | Date Adopted: 9/17/07 | |
| | Revision History: 12/2/97; 10/10/03, 3/14/07, 4/10/08, 3/17/09, 12/13/10, 11/30/11, 1/26/13, 2/12/13, 12/18/13 | Reviewed: 9 /17/97 | |

Use of this procedure assumes that informal attempts to resolve the issue with a treatment team leader, intake supervisor, or consulting psychiatrist have failed and that an appeal, either written or oral, has been received.

Matters appropriate for appeal are level of care decisions, continued stay, and eligibility determinations.

I. Provider appeals for reconsideration of continued stay authorization and level of care decisions are made as follows:

A. Psychiatric hospitals and all other facilities certified by the Division of Prevention and Behavioral Health Services as Medicaid 'Psych Under 21' facilities (42 CFR, Subpart 456.236).

An appeal of a continued stay denial must be made prior to the expiration of the client's current service authorization.

Step One:

In the course of routine business, CSMT procedures follow the steps below for authorization of services for Psych under 21 facilities:

- A subgroup of the Quality Management (QM) Committee that includes at least one physician automatically reviews all CSMT decisions in which a case does not meet clinical criteria for continued stay.
- If this QM subgroup determines that a continued stay is not needed, they notify the recipient's attending or staff physician and give him/her an opportunity to present additional information before finalizing the decision.
- If the provider physician does not present additional information or clarification of the need for continued stay within two (2) business days of notification, the decision of the subgroup is final.
- Written notification of the decision to the provider physician, prior to the expiration of the continued stay review date.

Step Two:

- If the provider physician presents additional information or clarification, at least two physicians appointed by the DPBHS Utilization Management Committee, one of whom is knowledgeable in the treatment of mental disease, will review the request for continued stay.

- If the appeal is denied, then the decision must be communicated to the provider, in writing, with a copy to the Quality Improvement Unit and the client or his/her parent or legal guardian. The notification letter is to be sent by certified mail.
- If the client for whom service is requested is Medicaid eligible, the notification is to include:
 - ▶ the appeal determination,
 - ▶ the reason for the decision,
 - ▶ the right to appeal this decision, in writing or orally, to the DPBHS Division Director within five (5) business days from the event or the denial precipitating the appeal,
 - ▶ the right to request a Fair Hearing with the DHSS Medicaid office at any time during the process,
 - ▶ contact information for the Medicaid Fair Hearing Office,
 - ▶ the right to have the service continue pending resolution of the appeal,
 - ▶ how to request continued service,
 - ▶ notification that the appellant may be required to pay the costs of this service if the appeal is denied,
 - ▶ the right to request assistance from the DPBHS Manager of Quality Improvement in the formulation of the appeal, and
 - ▶ the Manager of Quality Improvement's telephone number.
- For non-Medicaid eligible clients, the decision at Step Two is final.
- DPBHS may extend the timeframe of this appeal up to fourteen (14) calendar days of this appeal.
- In the event of an extension, written notice must be provided to the appellant and is to include:
 - ▶ the reason for the extension, and
 - ▶ the appellant's right to grieve the extension.

Step Three

- If the provider appeals the Step Two denial to the DPBHS Division Director, the Division Director or his/her designee will review the appeal and make a final decision.
- If the appeal is denied, then the decision must be communicated to the appellant, in writing, within five (5) business days of receipt of the appeal with a copy to the Quality Improvement Unit and the client or his/her parent or legal guardian. The notification letter is to be sent by certified mail.
- The notification is to include:
 - ▶ the appeal determination,
 - ▶ the reason for the decision,
 - ▶ the right to request a Fair Hearing with the DHSS Medicaid office at any time during the process,
 - ▶ contact information for the Medicaid Fair Hearing Office,
 - ▶ the right to have the service continue pending resolution of the appeal,
 - ▶ how to request continued service, and
 - ▶ notification that the appellant may be required to pay the costs of this service if the appeal is denied.
- DPBHS may extend the timeframe of this appeal up to fourteen (14) calendar days of this appeal
- In the event of an extension, written notice must be provided to the appeal and is to include:
 - ▶ the reason for the extension, and

- ▶ the appellant's right to grieve the extension.

B. Services at all other levels of care including facilities not certified as "Psych Under 21"

An appeal of a continued stay denial must be made within 10 days of receiving notification of the plan for discharge. A continued stay appeal can be made by a provider or the client/family. An appeal of a level of care decision must be made within 10 days of receiving notification of the treatment team's level of care decision. Level of care appeals can be made by the client/family.

The appellant is encouraged to attempt to resolve the dispute with the Clinical Services Management Team Leader prior to appealing formally, which is as follows:

Informal Appeal

The informal initial request for reconsideration of a service denial is presented to the DPBHS Clinical Services Management Team Leader. This appeal may be written or oral. In the event that a review of this appeal results in a denial, then the DPBHS Team Leader is to provide written notification to the appellant to include the following information:

- the appeal finding
- the right to appeal this decision to the DPBHS Manager of Quality Improvement within (10) business days from the denial precipitating the appeal,
- the reason for the decision
- For Medicaid eligible clients, the notification is also to include the appellant's right to:
 - ▶ request a Fair Hearing with the DHSS Medicaid office at any time during the process,
 - ▶ contact information for the Medicaid Fair Hearing Office,
 - ▶ the right to have the service continue pending resolution of the appeal,
 - ▶ how to request continued service,
 - ▶ notification that the appellant may be required to pay the costs of this service if the appeal is denied,
 - ▶ request assistance from the DPBHS Manager of Quality Improvement in the formulation of the appeal, and
 - ▶ the Manager of Quality Improvement's telephone number.

A copy of the denial letter is to be sent to the Manager of Quality Improvement at the time such notification is sent to the appellant.

Appeal

An appeal may be made either in writing or orally. Upon receipt of an appeal of the Team Leader's decision, the DPBHS Manager of Quality Improvement will appoint a review panel of at least two (2) DPBHS staff members licensed as mental health practitioners and not involved in the case. The panel review will include records review, discussion with the appellant, CSM staff, and provider as necessary.

The appeal review participants will advise the Manager of Quality Improvement of the finding and will, within ten (10) business days of receipt of the appeal, provide written notification to the appellant. The notification is to be sent by certified mail.

If the appeal is denied, for Medicaid eligible clients, the notification is to identify the appellant's right to request a Fair Hearing by DHSS Medicaid and include contact information for the DHSS Medicaid Fair Hearing Office. For non-Medicaid eligible clients, this decision is final.

A copy of the appeal finding letter is to be sent to the Manager of Quality Improvement at the time such notification is sent to the appellant.

II. Eligibility Appeals

When an applicant for DPBHS services is determined not to be eligible for those services, DPBHS Intake staff will provide written notification to the appellant to inform him/her of:

- the right to appeal the decision to the Manager of Quality Improvement within (90) days from the denial precipitating the appeal, and
- the right to request the assistance of the DPBHS Manager of Quality Improvement in the formulation of a written appeal.

Medicaid eligible clients will be informed of their right to request a Fair Hearing by DHSS Medicaid at any time during this process which is to include contact information for the Medicaid Fair Hearing Office.

Appeal:

Upon receipt of an Appeal, the Manager of Quality Improvement will convene a review panel consisting of at least two licensed mental health practitioners.

The decision of this panel will be provided in writing to the appellant within ten (10) business days of receipt of the appeal. The notification is to be sent by certified mail.

If the appeal is denied, for Medicaid eligible clients, the notification is to identify the appellant's right to request a Fair Hearing by DHSS Medicaid and include contact information for the DHSS Medicaid Fair Hearing Office. For non-Medicaid eligible clients, this decision is final.

A copy of the appeal finding letter is to be sent to the Manager of Quality Improvement at the time such notification is sent to the appellant.