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POLICY AND PROCEDURE

POLICY TITLE: EEU Provider Appeal Process	**POLICY #:** DSAMH003
PREPARED BY: DSAMH Policy Committee	**DATE ISSUED:** 3/1/2019
RELATED POLICIES: DSAMH001 GH Admissions DSAMH002 GH Discharge	**REFERENCE:** EEU manual, DSAMH contracts (community and in-patient), 42 CFR 438.400: 5000 Fair Hearing Practice and Procedures 5000 Fair Hearing Practice and Procedures
DATES REVIEWED: 2/15/2019 5/2/2022 6/1/2023	**DATES REVISED:** 4/16/2020 5/24/2022 2/22/2023
APPROVAL: DocuSigned by: Joanna Champney 1B71C05196B24CA... 6/14/2023 | 10:06 AM PDT	**NOTES:** ☐DSAMH Internal Policy ☒DSAMH Operated Program ☒DSAMH State Providers ☐Delaware Psychiatric Center ☐Targeted Use Policy (Defined in scope)

I. **PURPOSE:**

The purpose of this policy is to outline the appeals process through the Division of Substance Abuse and Mental Health (DSAMH) Eligibility and Enrollment Unit (EEU) for all PROMISE programs and all programs requiring authorization from the EEU Utilization Review (UR) team. Providers may appeal decisions made by the DSAMH regarding DSAMH or Medicaid payor approvals. Appeals may include level of care admission, referral, denials of authorization, or discharge decisions.

II. **POLICY STATEMENT:**

DSAMH is responsible to ensure that the public behavioral health system serves all Delaware residents over 18 years of age in need of such services. While DSAMH EEU makes every effort to ensure client and provider satisfaction, there may be disagreements between the EEU and the provider. This policy provides an avenue for those times when the provider disagrees with the decision made by the EEU, elevating the decision to the Appeals Committee. DSAMH has the authority to deny appeals and in those cases the provider must adhere to the original decision by the EEU.

III. **DEFINITIONS:**

"ACT" means Assertive Community Treatment team.

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"Appeals Committee" means the body that reviews Level 2 appeals from the EEU. The committee includes the DSAMH Medical Director and other designees from DSAMH Bureaus.

"Beneficiary" means an individual who is approved for PROMISE services.

"CRISP" means Community Reintegration Support Program.

"Day" means calendar day unless business day is specified.

"Delaware resident" means either:

1. An individual who is domiciled in Delaware for any part of the tax year or maintains an abode in Delaware and spends more than 183 days in the State.
2. A person who possesses a valid Delaware-issued identification card such as driver's license or non-driver identification card.

"Discharge" means closure from the contracted provider services or from PROMISE services.

"DSAMH" means the Division of Substance Abuse and Mental Health.

"EEU" means the DSAMH Eligibility and Enrollment Unit.

"Group Home (GH)" means a residential facility licensed as a Group Home for Persons with Mental Illness by the Division of Health Care Quality (DHCQ), together with the legal entity to which the license was issued.

"ICM" means Intensive Case Management team.

"PAC" means the PROMISE Assessment Center, a DSAMH facilitated program.

"PROMISE Program" means Promoting Optimal Mental Health for Individuals through Supports and Empowerment (PROMISE) Home and Community-Based Services (HCBS) waiver program under DSAMH. PROMISE assesses clients for level of care needs and monitors services to ensure the client receives appropriate care from contracted providers.

"SUD" means substance use disorder.

IV. **SCOPE:**

The EEU is responsible for reviewing decisions regarding all PROMISE services and completes UR for Fee-for-Service Medicaid, state-pay private psychiatric hospital clients, and SUD residential facilities for state-pay clients. This policy applies to all contracted providers and clients served by DSAMH EEU UR.

V. **PROCEDURE:**

A. PROMISE Appeals:

1. The DSAMH Appeal process is to be utilized once all other options have been explored.
    a. It is the expectation of DSAMH that the EEU staff, the PAC staff, community providers, partners, and beneficiaries, have exhausted all attempts to define services that both meet medical-necessity criteria and attempt to meet beneficiaries' preferences.

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b. The appeal process is utilized when these efforts have been exhausted, beneficiary and provider are given education on decision, and beneficiary or provider decide to pursue DSAMH appeal.
c. Beneficiaries under Managed Care Organizations (MCOs) also have an additional appeal process under the Division of Medicaid and Managed Care and may appeal directly through the Medicaid appeals process.

2. When a beneficiary is discharged from PROMISE, the EEU shall do the following:
   a. Send the individual, or guardian as applicable, a Notice of Action (NOA) stating the reason for the closure;
   b. Pursuant to the NOA, the beneficiary has 90 days from the date of the NOA to file an appeal and have a hearing;
   c. If the beneficiary contacts the EEU to return to services within 14 days, the beneficiary can return to services without having to restart the intake process;
   d. If the beneficiary contacts the EEU after 14 days, the individual shall complete a brief screen and initial assessment with PROMISE; and
   e. When clinically appropriate, EEU leadership and PROMISE leadership may reverse an administrative closure up to 60 days after notification.
   f. Beneficiaries with Medicaid have the right to appeal a closure from PROMISE through the Fair Hearing Practice and Procedure set forth by Medicaid.
3. An ACT, ICM, CRISP, GH provider, or any other PROMISE service may disagree with a referral sent by the EEU, a level of care change recommended by PROMISE, or a discharge recommendation, including EEU/PROMISE stating not to discharge a beneficiary.
   a. Referral:
      i. If the provider disagrees with a referral sent by the EEU after assessing the beneficiary and clinical documentation, the provider team lead or other designee, may submit the PROMISE Appeal Request Form (DSAMH003A) to the DSAMH EEU appeals email at DHSS_DSAMH_EEU_Appeals@delaware.gov to state their reasons. This must be submitted within five (5) business days of the receipt of the referral.
      ii. The EEU Utilization Review supervisor will review all initial appeals and respond within three (3) business days of decision.
      iii. The EEU leadership will elevate appeals to the Appeals Committee as needed.
      iv. Once the committee has made a decision, the EEU will respond to the request within five (5) business days of decision.
      v. If it is determined that the appeal is approved by the committee, the referral will be sent to another provider.
      vi. If it is determined that the appeal is denied by the committee, the provider must accept the beneficiary.
      vii. All committee decisions are final.

   b. Level of care:
      i. For existing beneficiaries, the provider shall communicate concerns regarding level of care (LOC) or ability to continue to provide services to the beneficiary with PROMISE. This may include decreased or increased services.
      ii. PAC staff shall complete a reassessment and submit to the EEU for review.
      iii. If the EEU staff does not agree with the LOC recommendation, they will collaborate with PAC staff and obtain additional information.
      iv. If EEU staff have not reached agreement with the LOC recommendation after obtaining additional information from PAC staff, it will not be approved, and the

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PAC and the provider will be notified.

v. If the provider disagrees with this decision, the provider team lead, or other designee, may submit the PROMISE Appeal Request Form to the Chief of Clinical Services, or designee, to state their reasons. This must be submitted within three (3) business days of the notification of LOC denial.

vi. The Chief of Clinical Services, or designee, and the PROMISE Administrator will review the appeal request, the PROMISE care packet with the LOC recommendation, the assurances form completed by EEU staff, and other supporting documentation. A decision will be made and relayed to the provider within five (5) business days of receipt.

vii. If the provider disagrees with this decision, the provider can appeal this decision in writing to the Chief of Clinical Services, or designee, within two (2) business days. The Chief of Clinical Services, or designee, will present the case to the Appeals Committee. A response will be sent within ten (10) business days of receipt and the decision is final.

c. Discharge

i. Community providers are expected to make good faith efforts to engage beneficiaries in services. The provider must contact PROMISE prior to discharge to discuss the appropriateness of the discharge and coordinate the discharge date.

ii. If an agreement cannot be reached regarding the appropriateness of discharge or the date, a PROMISE Appeal Request Form may be submitted to the Chief of Clinical Services, or designee, within five (5) business days of receipt.

iii. The Chief of Clinical Services, or designee, will meet with the PROMISE Administrator to review the beneficiary file and make a decision regarding the discharge within five (5) business days of receipt.

iv. The provider can appeal this decision in writing to the Chief of Clinical Services, or designee, within two (2) business days. The Chief of Clinical Services, or designee, will consult with the DSAMH Medical Director to review all information. A response will be sent within ten (10) business days of receipt, and the decision is final.

B. Inpatient Appeals:

1. The EEU staff completes utilization review (UR) for Fee-for-Service Medicaid, state-pay private psychiatric hospital clients, and substance use disorder (SUD) residential facilities for state-pay clients. If the facility disagrees with the EEU's decision to no longer authorize payment for services, the facility may appeal the decision.

a. Private psychiatric hospitals and SUD residential facilities must meet continued care criteria. An Inpatient Appeal Request Form (DSAMH003B) may be completed by UR staff or designee from the facility and submitted to the Chief of Clinical Services, or designee. The appeal shall be filed within two (2) business days of the last authorized day or within two (2) business days of receipt of notification of the last covered day. Included with the appeal shall be documentation supporting the need for continued care including but not limited to, the client not being safe to discharge to the community, the inability to stabilize symptoms, and the continued need for services which cannot be provided in a less restrictive setting. The appeal forms and supporting documentation shall be submitted to DHSS_DSAMH_EEU_Appeals@delaware.gov. The Chief of Clinical Services, or designee, and other EEU staff not involved in the initial denial will review the documentation.

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b. The provider will be notified in writing of the decision within five (5) business days. If the denial is reversed, UR by EEU staff will continue.
c. If the denial is upheld, the provider may initiate a second level appeal by submitting the Inpatient Appeal Request Form and the entire client record for review within five (5) business days of the determination to DHSS_DSAMH_EEU_Appeals@delaware.gov. Chief of Clinical Services, or designee, shall submit the appeal and documentation to the DSAMH Medical Director.
d. The Medical Director will convene a panel to review all information and submit a written decision to the provider within thirty (30) business days of receipt. The decision is final.

VI. **POLICY LIFESPAN:** This policy will be reviewed annually by EEU and policy committee.

VII. **RESOURCES:**
A. DSAMH003A PROMISE Appeal Form
B. DSAMH003B Inpatient Appeal Request Form