POLICY AND PROCEDURE

POLICY TITLE: 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 http://regulations.delaware.gov/AdminCode/title16/Dep artment%20of%20Health%20and%20Social%20Services/Division%20of%20Social%20Services/Delaware%20Social%20Services%20Manual/5000.shtml
DATES REVIEWED: 2/15/2019 5/2/2022	**DATES REVISED:** 4/16/2020 5/24/2022
APPROVAL: DocuSigned by: Joanna Champney 1B71C05196B24CA... 5/24/2022 | 8:16 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 process for contracted providers to appeal decisions made by the Division of Substance Abuse and Mental Health (DSAMH).

II. POLICY STATEMENT

DSAMH is responsible to ensure that the public behavioral health system serves all Delaware adults in need of such services. For that reason, DSAMH requires that its contracted provider system accept referrals that DSAMH assigns to them. While DSAMH's Eligibility and Enrollment Unit (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 a provider believes a referral may not be appropriate for a particular program. DSAMH has the authority to deny appeals and, in those cases, the provider is responsible for admitting the client.

III. DEFINITIONS:

"ACT" means Assertive Community Treatment team.

"CRISP" means Community Reintegration Support Program.

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

"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.

"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.

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

"SUD" means Substance Use Disorder.

IV. SCOPE

All contracted providers and clients served by DSAMH EEU.

V. PROCEDURE

A. PROMISE Appeals:

1. The DSAMH Appeal process is to be utilized once all other options have been explored. It is the expectation of DSAMH that the EEU staff, the PAC staff, community providers, partners, and clients, have exhausted all attempts to define services that both meet medical-necessity criteria and attempt to meet client preferences. The appeal process is utilized when these efforts have been exhausted, client and provider are given education on decision, and client or provider decide to pursue DSAMH appeal. Clients 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 client is discharged from the PROMISE program, 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 client has 90 days from the date of the NOA to file an appeal and have a hearing;
c. If the client contacts the EEU to return to services within 14 days, the client can return to services without having to restart the intake process;
d. If the client contacts the EEU after 14 days, the individual shall complete a brief screen and initial assessment with the PROMISE program; and
e. When clinically appropriate, EEU leadership and PROMISE leadership may reverse an administrative closure up to 60 days after notification.
f. Clients 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 client.

a. Referral:
   i. If the provider disagrees with a referral sent by the EEU after assessing the client and clinical documentation, the provider team leader 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 leadership will present to the appeals committee which includes the DSAMH Medical Director.
   iii. Once the committee has made a decision, the EEU will respond to the request within five (5) business days.
   iv. If it is determined that the EEU agrees with the provider, the referral will be sent to another provider.
   v. If it is determined that provider should accept the referral, the provider must accept the client.
   vi. All committee decisions are final.

b. Level of care:
   i. For existing clients, the provider shall communicate concerns regarding level of care (LOC) or ability to continue to provide services to the client 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 PAC and the provider will be notified.

v. If the provider disagrees with this decision, the provider team leader 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.

vii. 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 and the decision is final.

c. Discharge
   i. Community providers are expected to make good faith efforts to engage clients in services. However, there are a number of possible reasons why a provider may discharge a client from services. Regardless of the reason, 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.
   iii. The Chief of Clinical Services, or designee, will meet with the PROMISE Administrator to review the client file and make a decision regarding the discharge within five (5) business days.
   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, and the decision is final.

B. <u>Inpatient Appeals:</u>

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 form 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.

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. The decision is final.

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

VII. **RESOURCES/REFERENCES: See table above**

A. DSAMH003A Provider Appeal Referral Form
B. DSAMH003B Inpatient Appeal Request
C. NOA – specific to circumstance – not attached here