

Home Health Services - Reconsideration/Appeals Process

Objective: To provide any beneficiary, home health agency (HHA) or physician/physician assistant/nurse practitioner who receives an equipment or admission review denial notice and disagrees with the determination, the opportunity to request and receive a reconsideration/appeal of the determination.

Performed By: Medical Director (MD)
Associate Medical Director (AMD)
Physician Advisor (PA)
Denial/Reconsideration Coordinator (DRC)

Policy:

HSM advises beneficiaries/representative, HHA providers and physician/physician assistants/nurse practitioners in writing of all denial determinations. All parties are notified of the right to request a reconsideration/appeal and the timeframes for submitting a request. Any party who receives a denial notice and disagrees with the determination may request a reconsideration/appeal of the determination.

The request may be submitted to HSM by telephone, mail, or by FAX, within thirty (30) business days of the date of the denial notice for a non-expedited reconsideration or within three (3) business days for an expedited reconsideration/appeal. Only one type of reconsideration may be requested from HSM. HSM has developed a form (**HealthSystems of Mississippi Medicaid Home Health Reconsideration/Appeal Request Form**) for beneficiaries/representatives, HHA and physicians/physician assistants/nurse practitioners to use for this purpose.

HSM will conduct the reconsideration/appeal review for all timely requests and make a decision to perform the reconsideration/appeal review on a case-by-case basis for untimely requests. Upon receipt of a non-expedited reconsideration/appeal request, HSM notifies all parties in writing that a request has been received and allows ten (10) calendar days for submission of any additional information which may affect the reconsideration/appeal determination. Reconsiderations/appeals will be performed whether or not additional information is supplied.

HSM will ensure that the Physician Advisor (PA) performing the appeal review is a Mississippi licensed, board certified, actively practicing peer physician (i.e., same specialty) to the requesting physician and a different PA than originally reviewed and denied the review request. HSM completes review and notification within one (1) business day of receipt of requests and all necessary information for expedited reconsiderations and within twenty (20) business days of receipt of requests for non-expedited reconsiderations and all necessary information.

Procedure: Reconsideration/Appeals Process

1. Upon receipt of a request for reconsideration/appeal, the TC will:
 - Track the request via HSM's internal tracking system,
 - Record the tracking number on the request,
 - Retrieve the medical record from the file room, and
 - Forward the case to the Denial/Reconsideration Coordinator (DRC)
2. The DRC will:
 - Create a record of the request within HSMPURS
 - Determine if the request is timely
 - Ascertain whether additional clinical information was included in the request, and
 - Issue written notification indicating the reason why reconsideration/appeal review will not be performed on all untimely requests. This notification will be sent to the requester.
3. After creating a record of the request in HSMPURS, the DRC will process each timely request for an reconsideration/appeal as follows:
 - **Non-expedited Reconsideration:** send/mail notification (Acknowledgment of Receipt of a Request for Reconsideration) to the requester and other parties that a request has been received and that a comment period of ten (10) calendar days for submitting additional information is available. The notice indicates that additional information must be received by HSM within ten (10) calendar days of the notice date. The DRC places the case in a tickler file during the comment period.
 - **Expedited Reconsideration:** Contact the HHA/attending physician to obtain additional information and continue with step four (4). **Ten (10) day comment period does not apply.**
4. Upon expiration of the ten-day (10-day) comment period, the RAC will forward the medical record file, any additional information, the review documentation, and an HSMPURS generated reconsideration/appeal worksheet to the Medical Director, Associate Medical Director or designated Physician Advisor (PA) for a determination.
5. The reconsideration review is performed by the Medical Director/Associate Medical Director or Physician Advisor (PA) selected by the Medical Director/Associate Medical Director who is:
 - Not associated with the original denial;
 - Not related to the beneficiary;
 - Not responsible for the care of the beneficiary;
 - A physician licensed in Mississippi who is board certified or board eligible in the specialty that matches the type of care under review and has active admitting privileges at one or more hospitals in Mississippi, and

- A different physician from the one making the initial denial determination.
6. The PA will review the information that led to the denial determination, the complete medical record, and any additional information submitted. For expedited reconsiderations/appeals, the PA may contact the attending physician by phone to obtain additional information.
 7. After a reconsideration/appeal determination (i.e., the denial was upheld, modified, or reversed,) has been made by the Medical Director or PA, written notification is sent to the parties involved within the following timeframes:
 - Within one (1) business day after receipt of a request for reconsideration/appeal if the Medicaid beneficiary requested an expedited reconsideration/appeal
 - Within twenty (20) business days after receipt of a request for a non-expedited reconsideration/appeal.
 8. Following reconsideration review, the review record is returned to the DRC for processing. The DRC updates data fields as appropriate. The DRC drafts verbiage for appropriate notification letters and forwards to the Medical Director for review prior to issuance.
 9. All involved parties are notified in writing of reconsideration review determination within one (1) business day of receipt of request and all necessary information for expedited and within twenty (20) business days for non-expedited determinations (i.e., denial upheld, reversed, or modified).

The DRC provides verbal notification within the same timeframe.

 - the principal and clinical rationale for the “original” denial determination;
 - the principal and clinical rationale for the reconsideration determination; and
 - information for the facility and physician that the **Medicaid beneficiary** has the right to request an Administrative Appeal to DOM within thirty (30) calendar days of the notification date and directions for how the beneficiary may request such an appeal.
 10. The DRC ensures that all data fields and documentation of results are completed. The DRC files copies of notifications issued and the Review Worksheet and forwards the case to the medical records file room.
 11. The DRC also enters results of cases that go to DOM for Administrative Appeals in the appropriate data screens when the information is received from DOM.