Policy:	MA.9008
Title:	**Appeal Process for Coverage Termination of SNF, Home Health, or CORF Services**
Department:	Grievance and Appeals Resolutions Services
Section:	Not Applicable
CEO Approval:	*/s/ Michael Hunn 12/14/2023*
Effective Date:	08/01/2005
Revised Date:	12/01/2023
Applicable to:	☐ Medi-Cal ☒ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines the process by which a Member may appeal an Organization Determination involving termination of Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF) Covered Services.

II. POLICY

A. CalOptima Health, or a Health Network, shall issue a Notice of Medicare Non-Coverage (NOMNC), in accordance with CalOptima Health Policy MA.6023: Notice of Medicare Non-Coverage and Notice of a Detailed Explanation of Non-Coverage.

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B. Upon receipt of a NOMNC, a Member, or the Member's Authorized Representative, may request fast-track review of CalOptima Health's, or a Health Network's, decision by the Quality Improvement Organization (QIO), in accordance with this Policy.

C. If a Member or the Member's Authorized Representative fails to request fast-track review by the QIO in accordance with this policy, the Member, the Member's Authorized Representative, or physician may request an expedited review from CalOptima Health, in accordance with CalOptima Health Policies MA.9004: Expedited Pre-Service Appeal, as appropriate.

D. CalOptima Health shall process a request for an expedited review, in accordance with CalOptima Health Policies MA.9004: Expedited Pre-Service Appeal , as appropriate.

E. CalOptima Health shall notify a Member of the expedited Appeal process:

1. Upon initial enrollment and annually thereafter;

2. In the OneCare Evidence of Coverage (EOC), OneCare Connect Member Handbook, and periodic Member newsletters;

3. In all notices of adverse Organization Determination and non-coverage; and

4. Upon a Member's request.

III. PROCEDURE

A. Review by the Quality Improvement Organization (QIO)

1. A Member, or the Member's Authorized Representative, may request fast-track review by the QIO within the following timeframes:

    a. By noon of the calendar day following receipt of the NOMNC; or

    b. By noon of the calendar day before coverage ends, if the Member receives the NOMNC more than two (2) calendar days prior to the date coverage ends.

2. A Member, or the Member's Authorized Representative, shall request fast-track review by the QIO in writing, by facsimile, or by telephone.

3. If CalOptima Health receives a Member's, or the Member's Authorized Representative's, request for fast-track review by the QIO, it shall immediately forward such request to the QIO.

4. The QIO shall notify CalOptima Health upon receipt of a Member's, or a Member's Authorized Representative's, request for fast-track review.

    a. CalOptima Health, or the Health Network, shall issue a Detailed Explanation of Non-Coverage (DENC) to the Member and provide a copy to the QIO and the Grievance and Appeals Resolution Services (GARS) staff, no later than the close of business of the date it receives QIO notification that the Member requested fast-track review by the QIO, or the close of business one (1) calendar day before the effective date of coverage termination, whichever is later.

    b. The DENC shall include the following:

        i. A specific and detailed explanation why services are either no longer reasonable and necessary, or otherwise no longer covered;

        ii. A description of any applicable Medicare coverage rule, instruction, or other Medicare policy, including citations to the applicable Medicare policy rules, or information about how the Member may obtain a copy of the Medicare policy from CalOptima Health;

        iii. Any applicable CalOptima Health policy, contract provision, or rationale upon which the termination decision was based; and

        iv. Facts specific to the Member and relevant to the coverage determination, that are sufficient to advise the Member of the applicability of the coverage rule, or policy, to the Member's case.

    c. CalOptima Health, or a Health Network, shall make best efforts to use the most expeditious method of delivering the DENC to the Member, including personal delivery, courier, facsimile, or electronic mail.

    d. CalOptima Health, or a Health Network, shall provide information requested by the QIO by the close of business of the calendar day it receives such request from the QIO.

e. If the QIO delays its decision due to CalOptima Health's failure to provide necessary information, or records, in a timely manner, CalOptima Health, or the Health Network, shall accept liability for the costs of any additional coverage required by the delayed decision.

f. If the QIO defers the decision until receipt of requested information from CalOptima Health, the Member's coverage shall continue until the QIO makes a decision.

5. If the QIO returns, or forwards, a Member's request for review to CalOptima Health due to the Member's failure to file a request for QIO review within the timeframe specified in Section III.A.1. of this policy, CalOptima Health shall process the request as an expedited Appeal, in accordance with CalOptima Health Policies MA.9004: Expedited Pre-Service Appeal, as appropriate.

6. The QIO will make an official determination of the Medical Necessity of continued services, and notify the Member and CalOptima Health within forty-eight (48) hours after receipt of a request for review.

   a. If the QIO upholds CalOptima Health's, or a Health Network's, initial Organization Determination:

      i. GARS staff shall complete documentation in the Appeals tracking system, and close the case; and

      ii. The Member, the Member's Authorized Representative, or physician may appeal the QIO's decision to the QIO, in accordance with Section III.B. of this policy. The Member has the right to appeal the decision to an Administrative Law Judge (ALJ), the Medicare Appeals Council (MAC), or a federal court, in accordance with Section III.B, Section III.C, and Section III.D of this policy, respectively.

   b. If the QIO overturns CalOptima Health's, or a Health Network's, initial Organization Determination:

      i. CalOptima Health, or the Health Network, shall authorize, or provide, the service as expeditiously as the Member's health requires, but not later than seventy-two (72) hours after receipt of notice of the QIO's decision;

      ii. GARS, or the Health Network staff, shall send a notice of reinstatement of coverage to the Member and the QIO; and

      iii. GARS staff shall complete documentation in the Appeals tracking system, and close the case.

7. Financial Liability

   a. The Member shall not incur additional financial responsibility for Covered Services if:

      i. The QIO overturns CalOptima Health's, or a Health Network's, initial Organization Determination; or

      ii. The Member stops receiving care no later than the effective date stated on the Member's NOMNC.

b. The Member may incur at least one (1) calendar day of financial responsibility for Covered Services if:

i. The QIO upholds CalOptima Health's, or a Health Network's, initial Organization Determination; or

ii. The Member continues to receive Covered Services until the calendar day after the effective date stated on the NOMNC.

iii. If the QIO upholds CalOptima Health's, or a Health Network's, initial Organization Determination, the Member shall accept financial responsibility for continued SNF, HHA, or CORF Covered Services received after the effective date of termination, unless the QIO decision is reversed on Appeal, in accordance with Sections III.B, C, and D of this policy.

iv. If the QIO decision is reversed on Appeal, in accordance with Sections III.B, C, and D of this policy, CalOptima Health shall reimburse the Member, in accordance with the appealed decision, for the costs of any Covered Services for which the Member already paid the SNF, HHA, or CORF Provider.

B. Administrative Law Judge (ALJ) Hearing

1. A Member, the Member's Authorized Representative, or physician has the right to a hearing before an ALJ if the disputed service meets the threshold amount specified in the Medicare Managed Care Manual.

2. A Member, the Member's Authorized Representative, or physician shall request an ALJ hearing by submitting such request:

a. In writing to CalOptima Health, a Social Security Administration (SSA) office, a Railroad Retirement Board (RRB) office (if applicable), or the Independent Review Entity (IRE); and

b. Within sixty (60) calendar days after the notice from the QIO of its Appeal decision. The Member, or the Member's Authorized Representative, may request an extension to this timeframe for good cause by submitting a written request for such extension that includes the reason the Member, or the Member's Authorized Representative, cannot meet the timeframe, in accordance with Title 20, Code of Federal Regulations, Section 404.911.

3. If CalOptima Health receives a request for an ALJ hearing from a Member, a Member's Authorized Representative, or a physician, GARS staff shall forward the Member Request for ALJ Hearing to the IRE. The IRE shall compile and forward the Member's file to the ALJ.

4. Although CalOptima Health shall not have the right to request an ALJ hearing, it may participate as a party to the hearing.

5. If the ALJ reverses CalOptima Health's, or the Health Network's, initial adverse Organization Determination, in whole, or in part, CalOptima Health, or the Health Network, shall:

a. Authorize, or provide, the service under dispute as expeditiously as the Member's health condition requires, but no later than sixty (60) calendar days after the date it receives notice from the ALJ reversing the Organization Determination, unless it requests MAC review of the ALJ decision, in accordance with Section III.C. of this policy. If CalOptima Health

requests MAC review of the ALJ decision, it may wait for the MAC's decision before it authorizes, or provides, the disputed service; and

b. Inform the IRE when it effectuates the decision.

C. Medicare Appeals Council (MAC) Review

1. Any party that is dissatisfied with the ALJ hearing decision, including CalOptima Health, may request a MAC review of the ALJ decision, or dismissal, by filing a written request to the MAC.

2. A party requesting a MAC review shall submit such request:

   a. In writing directly to the MAC; and

   b. Within sixty (60) calendar days after the date of receipt of the ALJ hearing decision, or dismissal. The MAC may grant an extension if the requesting party can demonstrate good cause.

3. If CalOptima Health receives a Member's, or the Member's, Authorized Representative's, request for a MAC review, it shall forward a copy of the Member's request, the Member's complete case file, and a cover letter to the MAC.

4. If CalOptima Health requests a MAC Review, it shall:

   a. Submit a CalOptima Health request for MAC hearing and a complete case file to the MAC;

   b. Concurrently notify the Member of CalOptima Health's request by sending the Member a copy of the request and all information submitted to the MAC; and

   c. Notify the IRE of CalOptima Health's request.

5. The MAC may initiate a review on its own motion within sixty (60) calendar days after the date of an ALJ hearing decision, or dismissal. The MAC will notify all parties, in writing, of its decision to initiate such review.

6. If the MAC reverses CalOptima Health's, or the Health Network's, initial adverse Organization Determination, in whole, or in part, CalOptima Health, or the Health Network, shall:

   a. Authorize, or provide, the service under dispute as expeditiously as the Member's health condition requires, but no later than sixty (60) calendar days after the date it receives notice from the MAC reversing the initial adverse Organization Determination; and

   b. Inform the IRE when it effectuates the decision.

D. Judicial Review

1. Any party, including CalOptima Health, may request judicial review of an ALJ decision if:

   a. The MAC denied the party's request for review; and

   b. The amount in controversy meets the threshold amount specified in the Medicare Managed Care Manual.

2. Any party, including CalOptima Health, may request judicial review of a MAC decision if:

    a. The MAC denied the party's request for review; or

    b. It is the final decision of CMS; and

    c. The amount in controversy meets the threshold amount specified in the Medicare Managed Care Manual.

3. A party may not obtain judicial review unless the MAC has acted on the case.

4. In order to obtain judicial review, a party shall file a civil action in a district court of the United States, in accordance with Section 205(g) of the Social Security Act.

5. CalOptima Health shall notify all other parties to an Appeal prior to requesting judicial review.

6. If the judicial review reverses CalOptima Health's, or the Health Network's, initial adverse Organization Determination, in whole, or in part, CalOptima Health, or the Health Network, shall:

    a. Authorize, or provide, the service under dispute as expeditiously as the Member's health condition requires, but no later than sixty (60) calendar days after the date it receives notice from the judicial review reversing the Organization Determination; and

    b. Inform the IRE when it effectuates the decision.

E. Appeals Data

1. The Quality Improvement Committee (QIC) shall track, trend, and analyze Appeals data, taking into account information from other sources, including, but not limited to, Grievances, Member satisfaction survey results, and disenrollment forms.

2. The QIC shall present aggregate information to the CalOptima Health Board of Directors, with recommendations for interventions, as appropriate.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Health Policy MA.6023: Notice of Medicare Non-Coverage and Notice of a Detailed Explanation of Non-Coverage
C. CalOptima Health Policy MA.9004: Expedited Pre-Service Appeal
D. Medicare Managed Care Manual, Chapter 13
E. Social Security Act, §205(g)
F. Title 20, Code of Federal Regulations (C.F.R.), §404.911
G. Title 42, Code of Federal Regulations (C.F.R.), §422.560 et. seq.

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	08/01/2005	MA.9008	Appeal Process for Coverage Termination of SNF, Home Health, or CORF Services	OneCare
Revised	10/01/2012	MA.9008	Appeal Process for Coverage Termination of SNF, Home Health, or CORF Services	OneCare
Revised	11/01/2016	MA.9008	Appeal Process for Coverage Termination of SNF, Home Health, or CORF Services	OneCare
Revised	12/01/2016	MA.9008	Appeal Process for Coverage Termination of SNF, Home Health, or CORF Services	OneCare OneCare Connect
Retired	12/13/2016	CMC.9008	Appeal Process for Coverage Termination of SNF, Home Health, or CORF Services	OneCare Connect
Revised	01/01/2018	MA.9008	Appeal Process for Coverage Termination of SNF, Home Health, or CORF Services	OneCare OneCare Connect
Revised	04/01/2022	MA.9008	Appeal Process for Coverage Termination of SNF, Home Health, or CORF Services	OneCare OneCare Connect
Revised	12/01/2023	MA.9008	Appeal Process for Coverage Termination of SNF, Home Health, or CORF Services	OneCare

IX. GLOSSARY

Term	Definition
Appeal	As defined at 42 CFR §422.561 and §423.560, the procedures that deal with the review of adverse initial determinations made by the plan on health care services or benefits under Part C or D the enrollee believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the enrollee) or on any amounts the enrollee must pay for a service or drug as defined in 42 CFR §422.566(b) and §423.566(b). These appeal procedures include a plan reconsideration or redetermination (also referred to as a level 1 appeal), a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (Council), and judicial review.
Authorized Representative	An individual who is the legal representative or otherwise legally able to act on behalf of an enrollee, as the law of the State in which the beneficiary resides may allow, in order to execute an enrollment or disenrollment request; e.g., court appointed legal guardians, persons having durable power of attorney for health care decisions, or individuals authorized to make health care decisions under state surrogate consent laws, provided they have the authority to act for the beneficiary in this capacity (see §40.2.1). Form CMS-1696 may not be used to appoint an authorized representative for the purposes of enrollment and disenrollment. This form is solely for use in the claims adjudication or claim appeals process and does not provide broad legal authority to make another individual's healthcare decisions.
Comprehensive Outpatient Rehabilitation Facility (CORF)	A CORF is a facility established and operated at a single fixed location exclusively for the purpose of providing diagnostic, therapeutic, and restorative services to outpatients by or under the supervision of a physician.
Covered Services	Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract.
Health Network	A Physical Hospital Consortium (PHS), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Home Health Agency (HHA)	A public or private agency or organization that offers home care services including skilled nursing services and at least one other therapeutic service in the residence of the client through physicians nurses, therapists, social workers, and homemakers whom they recruit and supervise.
Member	A beneficiary enrolled in a CalOptima Health program.

Term	Definition
Organization Determination	Any determination made by CalOptima Health with respect to any of the following: 1. Payment for temporarily Out-of-Area renal dialysis services, Emergency Services, post-stabilization care, or urgently needed services; 2. Payment for any other health services furnished by a Provider that the Member believes: a. Are covered under Medicare; or b. If not covered under Medicare, should have been furnished, arranged for, or reimbursed by CalOptima Health. 3. CalOptima Health's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the Member believes should be furnished or arranged for by CalOptima Health; 4. Reduction or premature discontinuation of a previously authorized service; 5. CalOptima Health's failure to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the Member with timely notice of an adverse determination, such that a delay would adversely affect the Member's health.
Provider	Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B.
Quality Improvement Organization (QIO)	An organization comprised of practicing doctors and other health care experts under contract to the Federal government to monitor and improve the care given to Medicare enrollees. A QIO reviews Complaints raised by enrollees about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Medicare managed care plans, Medicare Part D prescription drug plans, and ambulatory surgical centers. A QIO also reviews continued stay denials for enrollees receiving care in acute inpatient hospital facilities as well as coverage terminations in Skilled Nursing Facilities (SNFs), Home Health Agencies (HHAs) and Comprehensive Outpatient Rehabilitation Facilities (CORFs).
Skilled Nursing Facility (SNF)	A facility that meets specific regulatory certification requirements that primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.