Policy:	GG.1814
Title:	**Appeals Process for Long Term Care Facility**
Department:	Grievance and Appeals Resolution Services
Section:	Not Applicable
CEO Approval:	*/s/ Michael Hunn 07/11/2024*
Effective Date:	09/01/2004
Revised Date:	07/01/2024
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This Policy defines the process by which a Long Term Care (LTC) Facility provider may Appeal a CalOptima Health post-service Level of Care decision to deny, modify, or recommend alternative options to a request for LTC Facility daily rate services for a Medi-Cal, OneCare, or OneCare Connect Member.

II. POLICY

A. Upon receipt of a Notice of Adverse Benefit Determination (NABD)/Notice of Action (NOA) or Notice of Denial informing an LTC Facility provider of a denial, modification, or recommendation for an alternative option to a requested Long Term Care Facility daily rate, the LTC Facility provider shall have the right to appeal the Level of Care decision in accordance with the provisions set forth in this Policy.

B. In order to appeal the decision, an LTC Facility provider shall request reconsideration of the decision by submitting a written request for an Appeal within sixty (60) calendar days after receiving the NABD/NOA or Notice of Denial from CalOptima Health.

C. If CalOptima Health denies an LTC Facility provider's Appeal for the Level of Care, the LTC Facility provider may submit an Appeal for the Level of Care decision, within the applicable timeframe, in accordance with CalOptima Health Policies HH.1101: CalOptima Health Provider Complaint and MA.9006: Provider Complaint Process.

III. PROCEDURE

A. An LTC Facility provider may request reconsideration of a Level of Care decision by submitting an Appeal, in writing, to the Grievance and Appeals Resolution Services (GARS) Department. The LTC Facility provider shall:

1. Submit the written request within sixty (60) calendar days after the date of the NABD/NOA or Notice of Denial;

2. Include all relevant materials, such as clinical documentation or other documentation supporting the request;

3. Clearly label the request with "Appeal;" and

4. Include a new LTC Authorization Request Form (ARF).

B. Acknowledgement of LTC Appeal

1. The CalOptima Health Grievance and Appeal Resolution Services (GARS) Department shall send an Acknowledgment Letter within five (5) calendar days after receipt of an LTC Appeal.

2. The letter shall indicate the receipt of the LTC Appeal and identify a GARS nurse who can be contacted if they choose to submit additional information, including written comments, documents, or other information relevant to the Appeal.

C. CalOptima Health shall reconsider the Level of Care decision based upon a review of medical records and other documentation, as submitted by the LTC Facility provider, to support the Level of Care, including, but not limited to nursing notes, physician notes, and other records.

D. A GARS nurse shall investigate, review, and summarize the Appeal history and documentation, including any aspects of clinical care involved; for submission to the Chief Medical Officer (CMO) or their Designee for review.

E. For Medical Necessity decisions, CalOptima Health's CMO or their Designee shall render a decision.

F. Resolution of LTC Appeal

1. CalOptima Health shall send to the Provider, as appropriate, an Appeal Resolution Letter within thirty (30) calendar days after receipt of the LTC Appeal.

G. CalOptima Health shall notify the LTC Facility provider, in writing, of the decision. If CalOptima Health upholds the Level of Care decision to deny, modify, or recommend an alternative option to a requested LTC Facility daily rate, the LTC Facility provider notification shall include information regarding the LTC Facility provider's right to file a Complaint in accordance with CalOptima Health Policies HH.1101: CalOptima Health Provider Complaint, and MA.9006: Provider Complaint Process.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health Contract for Health Care Services
C. CalOptima Health Policy GG.1503: CalOptima Health Hospice Coverage, Notification and Validation Requirements
D. CalOptima Health Policy GG.1800: Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from a Nursing Facility Level A (NF-A) and Level B (NF-B)

E. CalOptima Health Policy GG.1803: Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from a Subacute Facility-Adult/Pediatric
F. CalOptima Health Policy GG.1804: Admission to, Continued Stay in, and Discharge from Out-of-Network Subacute Facility, Nursing Facility Level A (NF-A) and Level B (NF-B)
G. CalOptima Health Policy HH.1101: CalOptima Health Provider Complaint
H. CalOptima Health Policy MA.9006: Provider Complaint Process
I. CalOptima Health Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
J. Title 22, California Code of Regulations (C.C.R.), §51003(g)
K. Title 22, California Code of Regulations (C.C.R.), §51334
L. Title 22, California Code of Regulations (C.C.R.), §51335

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
02/03/2016	Department of Health Care Services (DHCS)	Approved as Submitted
06/21/2017	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
03/07/2019	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	09/01/2004	GG.1814	Appeals Process for Long Term Care Facility Daily Rate Denial, Modification, or Recommendation	Medi-Cal
Revised	02/01/2007	GG.1814	Appeals Process for Long Term Care Facility Daily Rate Denial, Modification, or Recommendation	Medi-Cal
Revised	03/01/2008	GG.1814	Appeals Process for Long Term Care Facility Daily Rate Denial, Modification, or Recommendation	Medi-Cal
Revised	11/01/2015	GG.1814	Appeals Process for Long Term Care Facility Daily Rate Denial, Modification, or Recommendation	Medi-Cal OneCare Connect
Revised	06/01/2016	GG.1814	Appeals Process for Long Term Care Facility Daily Rate Denial, Modification, or Recommendation	Medi-Cal OneCare Connect
Revised	07/01/2017	GG.1814	Appeals Process for Long Term Care Facility	Medi-Cal OneCare Connect
Revised	03/07/2019	GG.1814	Appeals Process for Long Term Care Facility	Medi-Cal OneCare Connect
Revised	04/01/2022	GG.1814	Appeals Process for Long Term Care Facility	Medi-Cal OneCare Connect
Revised	07/01/2024	GG.1814	Appeals Process for Long Term Care Facility	Medi-Cal OneCare OneCare Connect

IX. GLOSSARY

Term	Definition
Appeal	For the purposes of this Policy, a request by a Provider for review of any decision to deny, modify, or recommend alternative options to a requested Level of Care decision.
Acknowledgement Letter	A written statement acknowledging receipt of a Complaint or Appeal.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Facility	For purposes of this policy, Long Term Care (LTC) facility, including a Nursing Facility Level A (NF-A) [Intermediate Care Facility (ICF) or Subacute Facility] and Nursing Facility Level B [Skilled Nursing Facility (SNF)].
Level of Care (LOC)	Criteria for determining admission to a LTC facility contained in Title 22, CCR, Sections 51334 and 51335 and applicable CalOptima Health Policies.
Medically Necessary or Medical Necessity	Medi-Cal: Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of medical necessity set forth in Section 1396d(r)(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under 21 years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima Health shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child. OneCare: Reasonable and necessary medical services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services includes Medi-Cal Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. OneCare Connect: Services must be provided in a way that provides all protections to the Member provided by Medicare and Medi-Cal. Per Medicare, services must be reasonable and necessary Covered Services for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. § 1395y. In accordance with Title XIX law and related regulations,

Term	Definition
	and per Medi-Cal, medical necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury under WIC Section 14059.5.
Member	A beneficiary enrolled in a CalOptima Health program.
Provider	Medi-Cal: A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, or other person or institution that furnishes Covered Services. OneCare: 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) 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. OneCare Connect: A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Health Network, physician group, or other person or institution who furnishes Covered Services.