Policy:	MA.9007
Title:	**Appeal Process for Member Discharge from Inpatient Facility**
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 to discharge the Member from an inpatient facility.

II. POLICY

A. An inpatient facility shall issue the Important Message from Medicare (IM) Notice, in accordance with CalOptima Health Policy MA.6024: Notification of Inpatient Facility Discharge Appeal Rights.

B. Upon receipt of the IM Notice, a Member, or a Member's Authorized Representative, may request immediate review of CalOptima Health, or a Health Network's, Organization Determination by the Quality Improvement Organization (QIO), no later than midnight of the day of discharge.

C. .Upon QIO notification that a Member, or a Member's Authorized Representative, has requested an immediate review, CalOptima Health shall directly, or by delegation, deliver a Detailed Notice of Discharge (DND) to the Member as soon as possible, but no later than noon of the day after the QIO's notification.

D. Upon QIO notification that a Member, or a Member's Authorized Representative, has requested an immediate review, CalOptima Health and its delegates shall supply all information that the QIO needs to make its determination, including copies of both the IM Notice and DND, as soon as possible, but no later than noon of the day after the QIO notifies the inpatient facility of the request for immediate review.

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

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

III. PROCEDURE

A. Review by the Quality Improvement Organization (QIO)

1. Upon receipt of the IM Notice, a Member, or a Member's Authorized Representative, may request immediate review by the QIO. The Member, or the Member's Authorized Representative, shall submit such request:

    a. In writing, by facsimile, or by telephone;

    b. To the QIO that has an agreement with the inpatient facility; and

    c. Before midnight of the discharge calendar day, and before the Member leaves the inpatient facility.

2. The Member shall not incur additional financial responsibility for the inpatient stay, except for applicable coinsurance and deductibles, if he or she requests immediate review by the QIO, in accordance with Section III.A. of this policy, and remains in the inpatient facility. CalOptima Health, or the Health Network, shall be financially responsible for the costs of the inpatient stay until noon of the calendar day following the day the QIO notifies the Member of its review determination.

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

4. The QIO shall notify CalOptima Health and the inpatient facility upon receipt of a Member's request for immediate review.

    a. Upon notice from the QIO that a Member requested immediate review, Grievance and Appeals Resolution Services (GARS) staff shall:

        i. Request a copy of the IM Notice, by facsimile, from the inpatient facility; and

        ii. Notify CalOptima Health's Utilization Management Department, or the Health Network, and the inpatient facility to provide the Member with a Detailed Notice of Discharge (DND) as soon as possible, but no later than noon of the day after the QIO notifies CalOptima Health and the inpatient facility of the request.

    b. CalOptima Health, the Health Network, and the inpatient facility shall provide information requested by the QIO, as soon as possible, but no later than noon of the calendar day after the QIO notifies CalOptima Health and the inpatient facility of the request.

    c. In response to a request from CalOptima Health or the QIO, the inpatient facility shall submit a copy of the IM Notice, a copy of the DND, Medical Records, and other pertinent information to the QIO by no later than noon of the day after CalOptima Health, or the QIO, makes such a request.

    d. At the request of the Member, CalOptima Health, or the inpatient facility, shall furnish the Member with a copy of, or access to, any documentation that it sends to the QIO, including written records of any information provided by telephone, no later than close of business of the first (1st) day after the Member request for such material. CalOptima Health, or the inpatient facility, may charge the Member a reasonable amount to cover the costs of duplicating the documentation and delivering it to the Member.

e. If the QIO delays its determination due to CalOptima Health's failure to provide necessary information, or records, in a timely manner, CalOptima Health, or the Health Network, shall be liable 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 determination.

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.c. of this policy, CalOptima Health shall process the request as an Expedited Service Appeal, in accordance with CalOptima Health Policies MA.9004: Expedited Pre-Service Appeal, as appropriate.

6. If, after receipt of an IM Notice, a Member chooses to leave the inpatient facility, or, discontinue receipt of service on, or before, the proposed termination date, the Member may not later assert his or her right to request immediate review by the QIO relative to the services, or expect the services to resume, even if the Member requests an Expedited Appeal before the discontinuation date in the termination notice.

7. The QIO will make an official determination of whether or not continued hospitalization is Medically Necessary, and notify the Member, the inpatient facility, the physician, and CalOptima Health by close of business of the first (1st) calendar day after it receives all necessary information from the inpatient facility, CalOptima Health, or both.

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

      i. CalOptima Health shall no longer be liable for continued services, beginning at noon of the next calendar day after the QIO notifies the Member of the upheld decision.

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

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

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

      i. CalOptima Health, or a Health Network, shall authorize and continue to provide inpatient service until CalOptima Health, with the concurrence of the delegated Health Network, and the inpatient facility determines again that the Member no longer requires inpatient care. The inpatient facility notifies the Member again of the discharge, and issues a follow-up copy of the IM Notice.

      ii. GARS, or Health Network staff, shall send a Notice of Compliance to the QIO which includes a reinstatement notice, extension of the authorization, or a physician's order to cancel the discharge and notify the Member, in writing; and

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

8. The QIO determination is binding on the Member, the Health Network, CalOptima Health, and the inpatient facility, unless the Member requests a QIO Appeal.

B. QIO Appeal

1. A Member, a Member's Authorized Representative, or a physician may appeal the QIO's determination to the QIO within sixty (60) calendar days after receipt of notice of such determination. If the Member is no longer an inpatient in the hospital, and is dissatisfied with the QIO's determination, the Member may appeal directly to an ALJ, the MAC, or a federal court.

2. The QIO shall make a Appeal determination as expeditiously as the Member's health condition requires, but no later than fourteen (14) calendar days after the receipt of the Member's request for Appeal.

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

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

   b. The Member, the Member's Authorized Representative, or a physician may appeal the QIO's Reconsideration determination to an Administrative Law Judge (ALJ), the Medicare Appeals Council (MAC), or a federal court, in accordance with Sections III.C., III.D., and III.E. of this policy.

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

   a. CalOptima Health, or a Health Network, shall reimburse the Member, consistent with the QIO's determination, for the costs of any Covered Services for which the Member has already paid CalOptima Health, or the Health Network, no later than sixty (60) calendar days after the date it receives notice from the QIO, ALJ, MAC, or a federal court reversing the Organization Determination;

   b. GARS, or Health Network staff, shall send a notice of compliance to the QIO that includes a reinstatement notice, and extension of the authorization or a physician's order to cancel the discharge, and notify the Member, in writing; and

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

C. Administrative Law Judge Hearing

1. A Member, the Member's Authorized Representative, or a 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 QIO; 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.

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

ii. Although CalOptima Health does not have a right to request an ALJ hearing, it may be a party to the hearing.

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

a) Authorize, or reimburse the Member, consistent with the ALJ decision, for the costs of any Covered Services for which the Member has already paid CalOptima Health, or the Provider, unless it requests MAC review of the ALJ decision, in accordance with Section III.D. of this policy. If CalOptima Health requests MAC review of the ALJ decision, it may wait for the MAC's decision before it authorizes, reimburses the Member for, or provides the disputed service; and

b) Inform the QIO, in writing, when it effectuates the decision.

D. 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.

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

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

a. Submit a CalOptima Health Request for MAC Review 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 CalOptima Health Request for MAC Review and all information submitted to the MAC; and

c. Notify the QIO, in writing, of CalOptima Health's request.

4. 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.

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

    a. Authorize, and reimburse the Member, consistent with the MAC decision, for the costs of any Covered Services for which the Member has already paid CalOptima Health, or the Provider, 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 QIO, in writing, when it effectuates the decision.

E. 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 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 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 a 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 a 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 shall:

    a. Authorize, or reimburse the Member, consistent with the judicial review decision, for the costs of any Covered Services for which the Member has already paid CalOptima Health, or the Provider, 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 QIO, in writing, when it effectuates the decision.

F. 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. R EFERENCE(S)

A. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Health Policy MA.6024: Notification of Inpatient Facility Discharge Appeal Rights
C. CalOptima Health Policy MA.9004: Expedited Pre-Service Appeal
D. Social Security Act, §205(g)
E. Title 20, Code of Federal Regulations (C.F.R.), §404.911
F. Title 42, Code of Federal Regulations (C.F.R.), §422.560, 422.620-422.622, 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.9007	Appeal Process for Member Discharge from Acute Inpatient Facility	OneCare
Revised	10/01/2012	MA.9007	Appeal Process for Member Discharge from Acute Inpatient Facility	OneCare
Revised	12/01/2016	MA.9007	Appeal Process for Member Discharge from Acute Inpatient Facility	OneCare OneCare Connect
Retired	12/01/2016	CMC.9007	Appeal Process for Member Discharge from Acute Inpatient Facility	OneCare Connect
Revised	01/01/2018	MA.9007	Appeal Process for Member Discharge from Acute Inpatient Facility	OneCare OneCare Connect
Revised	04/01/2022	MA.9007	Appeal Process for Member Discharge from Acute Inpatient Facility	OneCare OneCare Connect
Revised	12/01/2023	MA.9007	Appeal Process for Member Discharge from Inpatient Facility	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.
Health Network	A Physical Hospital Consortium (PHS), Physician Medical Group (PMG) 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.
Member	A beneficiary enrolled in a CalOptima Health program.
Organization Determination	OneCare: Any determination made by CalOptima Health, or its delegated entity with respect the following: 1. Payment for temporarily out-of-area renal dialysis services, emergency services, post-stabilization care, or urgently needed services; CalOptima Health Policy MA.1001: OneCare Glossary of Terms. 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. Refusal to authorize, provide or pay for services, in whole or in part, including the type or level of services, which the Member believes should be furnished or arranged by CalOptima Health; 4. Reduction or premature discontinuation, of a previously authorized ongoing course of treatment; or **5.** Failure to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide timely notice of an adverse determination, such that a delay would adversely affect the health of the Member.

Term	Definition
Provider	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, 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).