

WASATCH BEHAVIORAL HEALTH
SPECIAL SERVICE DISTRICT

Medicaid Enrollee Notice of Adverse Benefit Determination (ABD), Appeal and State Fair Hearing – C – 3.08B

Purpose:

To ensure that Wasatch Behavioral Health Special Service District (WBH) adheres to all provisions contained within its current contract with the Utah State Department of Health regarding prompt resolution of Enrollee appeals whenever (1) Enrollee is denied services from an outside provider (2) services are denied, reduced or terminated (3) denial of payment for services (4) failure to provide timely services (5) timely decision regarding a complaint. In addition, to ensure Medicaid Enrollees are provided with access to the State Fair Hearing process if an appeal is not resolved wholly in favor of the Enrollee.

Definitions:

Adverse Benefit Determination (ABD): A written notice informing the Enrollee of a ABD WBH has taken and of their right to appeal the ABD. ABD's are defined by the following categories:

ABD 1: Denial or limited authorization of a requested service, including the type or level of service. (Example: When WBH denies request to see an outside provider or non-panel provider). (See related policy C-4.31)

ABD 2: Reduction, suspension, or termination of a previously authorized service. (Example: Decrease the number of services or end a service WBH had previously approved and the client does not agree). (See related policies C-4.30 and C-4.31)

ABD 3: Denial in whole or in part of payment for services. (Example: WBH denies a payment to an outside provider). (See related policy F-1.07)

ABD 4: Failure to provide first face-to-face services in a timely manner, due to Center limitations, and resulting in client dissatisfied. (Example: WBH did not provide an intake appointment within the required amount of time for emergency, urgent or non-urgent care). (See related policy C-3.06 Client Access/Performance Standards)

ABD 5: ABD regarding grievances Failure to act within the required time frames for solution and notification of appeals and grievances. (Example: WBH did not settle a grievance in the required time frame (45 calendar days). (See related policy C-3.08 Medicaid Grievances)

Appeal - Standard:

An Enrollee's or his/her authorized representative or provider, will have 60 days from Adverse Benefit Determination (ABD) to request an appeal/review of a WBH ABD. Appeals may be submitted to WBH orally or in writing. The oral Appeal must be confirmed in writing within 60 calendar days of the date of the ABD, or within 5 working days from the date of the oral Appeal request, whichever is the longer Appeal request timeframe. (SEE PAGE 55 of MEDICAID CONTRACT) Appeals may be made in behalf of an Enrollee by a provider or authorized agent with the Enrollee's consent. A representative of the deceased Enrollee's estate may also make an Appeal. WBH must resolve the appeal/review with 30 calendar days from receipt of the written Appeal. WBH may extend the time frame for an additional 14 calendar days under certain circumstances. WBH's failure to process an appeal within the required time frames constitutes an ABD. Client will have the right to ask for a Medicaid State Fair Hearing.

Appeal - Expedited:

The Enrollee, or authorized representative or provider, may request an expedited Appeal when the time for a standard resolution (60 days) could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function. Expedited Appeal request maybe be submitted to WBH orally or in writing. Oral requests for expedited Appeals do not require a follow-up written request. WBH must give a decision on an expedited Appeal as soon as possible and no later than 72 hours after WBH received the expedited Appeal request. Under certain circumstances WBH may extend the resolution timeframe by up to 14 additional calendar days. If WBH denies a request for an expedited Appeal, WBH shall complete the Appeal using the standard time frame of no longer than 30 calendar days from the day WBH received the Appeal request, with a possible 14 calendar day extension for resolving the Appeal and Providing Notice of Appeal resolution to affected parties.

State Fair Hearing:

A formal hearing held by the Utah State Dept. of Health (Department) in behalf of a Enrollee and/or, a provider in behalf of the Enrollee, when the Enrollee is dissatisfied with the Appeal decision given by their local mental health provider and they have exhausted WBH's internal Appeals process. The Enrollee must request a State fair hearing within 30 calendar days from the date of WBH's Notice of Appeal Resolution. If an Enrollee wants to continue benefits pending the outcome of the State fair hearing, when they have previously been suspended, reduced, or terminated, they must request continuation of benefits and a hearing within 10 days of WBH mailing its Notice of Appeal Resolution. The Department shall reach a decision within 90 days of the Enrollee's request for a hearing. The Department shall follow prescribed standards when an Enrollee requests an expedited State fair hearing.

Policy:

- A. Enrollees, at the time of their admission, shall be given a Medicaid Handbook and informed of their rights including the right to appeal a WBH ABD.
- B. WBH shall inform Medicaid Enrollees both orally and in writing of their right to appeal if they are dissatisfied with an ABD taken by WBH.

- C. The information provided to the Enrollee shall be stated in simple, clear, language and include information needed for the Enrollee and/or the provider to file an appeal of WBH's ABD. WBH shall provide reasonable assistance as needed.
- D. Care Management Services (CMS) and its Enrollee Customer Service Representative (CSR) shall exercise oversight responsibility for ensuring all policy, procedure, and processes associated with ABDs are adhered to including tracking, report preparation and writing, timeliness compliance, and records documentation as per PMHP Medicaid Contract requirements.
- E. WBH shall maintain complete records of all ABDs and Appeals including decisions for a period of six years.
- F. WBH shall submit written summaries of ABDs and Appeals to the Utah State Department of Health, using department templates as required by the PMHP Medicaid contract.
- G. WBH's CSR shall monitor and report to the Quality Improvement Committee all ABDs and Appeals for quality improvement purposes including, the determination of trends, and any systemic issues that need to be addressed. Enrollee Protected Health Information (PHI) shall be de-identified and data analysis shall be accomplished through limited data sets whenever possible.
- H. WBH shall ensure that during the Appeal process, Enrollees and/or their legally authorized representative or provider have the opportunity to:
 - 1) Address the Appeals Review Committee in person or in writing with evidence and allegations of fact or law.
 - 2) Examine their case file including medical records and any other documents and records considered during the Appeal process.
- I. WBH shall not retaliate, inhibit, or take any discriminatory ABD against an Enrollee or Enrollee's provider who files an Appeal or requests an expedited Appeal. Appeals shall be received in confidence and discussed only with persons involved in the resolution process.
- J. The Enrollee, at their request, may continue to receive treatment services during their WBH Appeal, or the State fair hearing process, with the understanding that if the outcome of their Appeal or State fair hearing is not in their favor, they may be responsible for the payment of those services.
- K. WBH shall make ABD and Appeal informational and instructional materials available in the prevalent non-English language. Information and instruction materials shall also be made available to Enrollees who are visually limited or have limited reading proficiency.
- L. WBH shall provide oral interpreter and oral translation services, sign language assistance and access to the grievance system through a toll-free number with TTY/TDD and interpreter capability.

ABD Procedures:

ABD #1: Denial or limited authorization of a requested service, including the type or level of service:

(See Flowchart 1 ABD Process for ABD #1, Flowchart 2, Expedited Process for ABD #1)

1. When an Enrollee requests at intake to see an outside provider, the intake staff person shall notify the manager of the request and inform the Enrollee that the program manager shall review the Enrollee's request with the Enrollee. The program manager shall notify the Enrollee of the decision within 14 calendar days of their request. The manager may under certain circumstances, described below, request up to an additional 14-day extension.
2. When an Enrollee's selected provider initiates a request for the Enrollee to be treated by the selected provider, the program manager shall make a decision and provide notice to the selected provider and Enrollee as expeditiously as the Enrollee's health condition requires, but no later than 14 calendar days from receipt of the outside providers request for a service authorization. The program manager shall also consult, as appropriate, with the requesting provider.
3. WBH shall inform the Enrollee that they will need to complete WBH's intake process. When the selected provider is contracted with WBH, the program manager shall follow Service Authorization Request Review procedures in policy C-4.31 Intake, Recovery Planning...Outside Providers. When a selected provider is not contracted with WBH, The program manager shall follow the Outside Provider Contract Process see policy C-4.31 Intake, Recovery Planning...Outside Providers.
4. When an Enrollee/ or the Enrollee's selected provider indicates that adhering to the 14 day standard time frame could seriously jeopardize the Enrollee's life, or health, or ability to attain, maintain, or regain maximum function, the program manager shall make an expedited authorization decision and provide notice as expeditiously as the Enrollee's health condition requires. The program manager must make an expedited decision no later than 3 working days after receipt of the request for Service Authorization. (See flow chart page 2 Expedited Service Authorization Request ABD #1: Denial or Limited Authorization Requested Service).
5. When the program manager denies a service authorization request, or authorizes a service in an amount, duration, or scope that is less than requested, including the type or level of service, this constitutes an ABD unless the Enrollee agrees with the services offered. When an ABD is constituted, the program manager shall:
 - 1) Notify the requesting provider verbally or in writing, and give the Enrollee written ABD that includes his /her right to Appeal, and the right to receive reasonable assistance with the appeal process (use form 7.59b-N2a ABD and Appeal Rights). The ABD shall clearly indicate the ABD that has been taken and provide a clear statement of the basis for the ABD. The notice must be individualized to the Enrollee's case and medical and legal terms must be explained if the terms cannot be simplified. The notice shall also be

written in easily understood language and format (See policy C-3.10 Readability of Documents for testing procedures).

- 2) Notify the Outside Provider Contract Coordinator who shall monitor service authorization requests and report any ABDs to the Customer Service Representative (CSR).
6. The CSR shall log the ABD information, as per PMHP Medicaid Contract requirements, in the Grievance, ABD, Appeal Spreadsheet. The CSR shall maintain a copy of the ABD, Extension, and any other pertinent documentation needed to maintain a complete record.
7. Should the Enrollee or other affected parties decide to appeal an ABD. (See Appeal Process).
8. When WBH fails to reach a decision on a standard or expedited service authorization request within the required time frames, this constitutes an ABD. The program manager shall:
 - 1) Notify the requesting provider verbally or in writing, and give the Enrollee written ABD, that includes his /her right to Appeal, and the right to receive reasonable assistance with the appeal process by or on the date the applicable time frame for making the decision expires. (use form 7.59b-N2a ABD and Appeal Rights)
 - 2) Forward verbal and/or written notice information to the CSR.
9. The CSR shall log the ABD information, as per PMHP Medicaid Contract requirements, in the Grievance, ABD, and Appeal spreadsheet. The CSR shall maintain a copy of the ABD, Extension, and any other pertinent documentation needed to maintain a complete record.

Extensions for EXPEDITED Service Authorization Requests:

1. The manager may extend the 3 working day time period by up to a total of 14 calendar days if:
 - a) The Enrollee requests an extension; or
 - b) The program manager needs an extension for additional information, the extension is in the Enrollee's interest, and the manager can justify his/her reason to the Utah State Department of Health upon their request.
2. Should the program manager extend the time frame to make an expedited service authorization decision, the manager shall, within the allocated time period, make a decision and provide notice to the Enrollee and all affected parties.
3. The Customer Service Representative (CSR) shall log information, as per PMHP Medicaid Contract requirements, in the Enrollee Grievance, ABD, Appeal spreadsheet. The CSR shall maintain a copy of the Request for Extension and any other pertinent documentation needed to maintain a complete record.

Extensions for STANDARD Service Authorization Requests:

1. When the manager extends the time frame for making a standard service authorization decision, the program manager shall:
 - 1) Give the Enrollee/provider written notice of the reason for the decision to extend the time frame (use form 7.59a-N1a Notice of Extension for Service Authorization Request).
 - 2) Inform the Enrollee of his/her right to file a Grievance, and how to do so, if the Enrollee disagrees with the decision to extend the time frame (See Grievance Procedures, page 4).
 - 3) Issue and carry out the determination as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires.
2. The CSR shall log the ABD information, as per PMHP Medicaid Contract requirements, in the Grievance, ABD, and Appeal spreadsheet. The CSR shall maintain a copy of the Request for Extension and any other pertinent documentation needed to maintain a complete record.

ABD #2: Reducing, Suspending, or Terminating Previously Authorized Services:

(See Flowchart 3 ABD Process for ABD #2)

1. When a program manager terminates, suspends or reduces previously authorized Medicaid-covered services, and the Enrollee agrees with the change, the Enrollee's provider shall make the change in the Enrollee's treatment plan.
2. When a program manager terminates, suspends or reduces previously authorized Medicaid-covered services, and the Enrollee informs the program manager that he/she disagrees with the change in his/her treatment plan, this constitutes an ABD.
3. If the covered services were provided by a Subcontractor (Outside Provider), the program manager shall notify the provider and send a written ABD for Decreasing or Ending Services explaining the ABD, the date the ABD shall take effect and what led to the ABD to either decrease, suspend, or end services, the Enrollee's right to appeal, and explain that he/she may receive reasonable assistance with the appeal process from staff (use form 7.59b-N3a ABD for Decreasing or Ending Services and Appeal Rights).
4. The ABD shall clearly indicate the ABD that has been taken and provide a clear statement of the basis for the ABD. The notice must be individualized to the Enrollee's case and medical and legal terms must be explained if the terms cannot be simplified. The notice shall also be written in easily understood language and format (See policy C-3.10 Readability of Documents for testing procedures).
5. The program manager must mail the notice to the Enrollee as expeditiously as the Enrollee's health condition requires and within the following time frames:
 - a) at least 10 days before the date of the ABD; or
 - b) 5 days before the date of the ABD if the program manager has facts indicating that ABD should be taken because of probable fraud by the

Enrollee, and the facts have been verified, if possible, through secondary sources; or

- c) by the date of the ABD if:
 - 1) the program manager has factual information confirming the death of the Enrollee;
 - 2) the program manager receives a clear written statement signed by the Enrollee that:
 - a) he/she no longer wishes services; or
 - b) he/she gives information that requires termination or reduction of services and indicates that he/she understands that this must be the result of supplying that information;
 - c) the Enrollee has been admitted to an institution where he is ineligible for further services;
 - d) the Enrollee's whereabouts are unknown and the post office returns mail directed to him indicating no forwarding address. In this case any discontinued services must be reinstated if his/her whereabouts become known during the time is eligible for services;
 - e) the Enrollee has been accepted for Medicaid services by another local jurisdiction; or;
 - f) the Enrollee's physician or other licensed mental health therapist authorized to prescribe mental health treatment under Utah law prescribes the change in the level of medical (mental health) care.
6. The ABD shall clearly indicate the ABD that has been taken and provide a clear statement of the basis for the ABD. The notice must be individualized to the Enrollee's case and medical and legal terms must be explained if the terms cannot be simplified. The notice shall also be written in easily understood language and format (See policy C-3.10 Readability of Documents for testing procedures).
7. The program manager shall forward a copy of the ABD to the CSR.
8. The CSR shall log information, as per PMHP Medicaid Contract requirements, in the Grievance, ABD, and Appeal spreadsheet. The CSR shall maintain a copy of the ABD and any other pertinent documentation needed to maintain a complete record.

ABD #3: Denial of Claims Payment in Whole or Part:

(See Flowchart page 4 ABD process and related policy F-1.07 Denial of Claims Payment in Whole or Part)

1. WBH's Claims Review Auditors shall initiate the first review of claims sent to WBH by contracted providers and make a recommendation to WBH's Administrative Services (AS) Cost Accountant to pay, partially pay, or not pay, including his/her reason for partial or nonpayment using the following criteria.

2. The AS cost accountant shall notify the CSR of any WBH denial of Medicaid Enrollee provider payments for the following five reasons. The CSR shall then initiate a ABD:
 - 1) A Claims Review Committee denial.
 - 2) The provider was not a WBH contracted provider during the time services were rendered.
 - 3) The provider's service was not prior-authorized by WBH, and/or
 - 4) The Enrollee was not eligible for Medicaid when services were provided.
 - 5) The Enrollee requested continued services during an appeal or State fair hearing, and the appeal or State fair hearing decision was adverse to the Enrollee.
3. The CSR shall send the Enrollee, and all affected parties, a written Denial Letter, a ABD letter with an explanation of the problem(s) associated with the claim, the Enrollee's right to appeal, and offer assistance regarding the claim if requested. (use form 7.59q Claim Error and form 7.59-N2a ABD).
Note: Denials due to technical problems does not constitute an ABD.
4. The ABD shall clearly indicate the ABD that has been taken and provide a clear statement of the basis for the ABD. The notice must be individualized to the Enrollee's case and medical and legal terms must be explained if the terms cannot be simplified. The notice shall also be written in easily understood language and format (See policy C-3.10 Readability of Documents for testing procedures).
5. The CSR shall log information, a per PMHP Medicaid Contract requirements, in the Grievance, ABD, and Appeal spreadsheet. The CSR shall maintain a copy of the ABD.
6. Should the Enrollee or other affected parties, decide to appeal the ABD. (See Appeal Process).

ABD #4 Failure to Meet Performance Standards for First Face-to-Face Services:

(See Flowcharts 5 ABD Process and related policy C – 3.06 Enrollee Access to Treatment – Performance Standards)

1. When WBH cannot offer the first face-to-face service within the required time frame, this constitutes an ABD. If the Enrollee is not satisfied with waiting beyond the required time frame, the Intake Program Manager shall notify the CSR.
2. The CSR shall send the Enrollee, and all affected parties, a written ABD letter explaining the reason why WBH could not offer an appointment within the performance standard, the Enrollee's right to appeal, and explain that they may receive reasonable assistance with the appeal process from staff (use form 7.59b-N2a ABD and Appeal Rights).
3. The ABD shall clearly indicate the ABD that has been taken and provide a clear statement of the basis for the ABD. The notice must be individualized to the Enrollee's case and medical and legal terms must be explained if the terms cannot

be simplified. The notice shall also be written in easily understood language and format (See policy C-3.10 Readability of Documents for testing procedures).

4. Should the Enrollee or other affected parties, decide to Appeal the ABD. (**See Appeal Process in this policy**).
5. The CSR shall log information, as per PMHP Medicaid Contract requirements, in the Grievance, ABD, and Appeal spreadsheet. The CSR shall maintain a copy of the ABD.

NOTE: The following situations do not constitute an ABD:

- **The Enrollee agrees to and is not dissatisfied with waiting beyond the required time frame,**
- **WBH determines the Enrollee should not be at risk as a result of waiting, and The Enrollee is told to contact WBH if his or her situation changes.**

ABD #5 Failure to Resolve Grievance within Required Time Frame

(See Flowchart 6 ABD Process)

1. When a program manager or administrator does not notify the Enrollee of the grievance decision within the 45-day Medicaid required time frame and the additional 14 calendar day extension, the program manager or administrator shall notify the CSR.
2. The CSR shall send the Enrollee, and all affected parties, a written ABD letter explaining the reason why WBH did not make a decision about the grievance within the required time frame, the Enrollee's right to appeal, and explain that they may receive reasonable assistance with the Appeal process from staff (use form 7.59b-N2a ABD and Appeal Rights).
3. The ABD shall clearly indicate the ABD that has been taken and provide a clear statement of the basis for the ABD. The notice must be individualized to the Enrollee's case and medical and legal terms must be explained if the terms cannot be simplified. The notice shall also be written in easily understood language and format (See policy C-3.10 Readability of Documents for testing procedures).
4. Should the Enrollee or other affected parties decide to appeal the ABD, the program manager or administrator shall be excluded from the review of the appeal. The program manager or administrator must continue to try to resolve the grievance.
5. Should the Enrollee or other affected parties, decide to Appeal the ABD. (See Appeal Procedures).
6. The CSR shall log information, as per PMHP Medicaid Contract requirements, in the Grievance, ABD, and Appeal spreadsheet. The CSR shall maintain a copy of the ABD.

Appeal Procedures:

(See flowcharts 7-11 Appeals Process)

Standard Appeals Process

1. Appeals may be made in behalf of an Enrollee by an authorized representative or provider.
2. An Enrollee or his/her authorized representative or provider, will have 60 calendar days from the date on WBH's written notice of ABD to request an appeal/review of a WBH ABD. If an Appeal is filed orally, the Enrollee or his/her authorized representative or provider, must submit a written, signed Appeal request within 60 calendar days from the date on the notice of ABD, or within 5 working days from the date of the oral Appeal request, whichever is the longer Appeal request timeframe.
3. A legal representative of the deceased Enrollee's estate may also make an Appeal. WBH must resolve the appeal/review with 30 calendar days from receipt of the written signed Appeal request. WBH may extend the time frame for resolving the Appeal and providing notice by up to 14 calendar days if:
 - (1) The Enrollee or his/her authorized representative or provider requests the extension; or
 - a. (2) WBH shows that there is a need for additional information and how the delay is in the best interest of the Enrollee. .
 3. If WBH extends the time frame, and the extension was not requested by the Enrollee, WBH shall:
 - (1) Make reasonable efforts to give the Enrollee prompt oral notice of the delay;
 - (2) Give the Enrollee written notice within 2 calendar days of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a Grievance about the decision; and
 - (3) Complete the Appeal as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires.

WBH's failure to process an appeal within the required time frames constitutes an ABD. Client will have the right to ask for a Medicaid State Fair Hearing.

2. When an Enrollee or his/her authorized representative or provider calls and files an Appeal orally, the CSR shall:
 1. Provide that Enrollees making oral inquires and seeking to Appeal an ABD are treated as an Appeal to establish the earliest possible filing date for the Appeal.
 2. Inform or remind the Enrollee or provider of the following:
 - a) That the oral filing of an Appeal must be confirmed in writing within 60 calendar days of the date of the ABD, unless the Enrollee or his/her

authorized representative or provider requests an expedited resolution to the Appeal. (**See Expedited Appeals Process**).

- b) The authorized representative or provider can file the written Appeal only with the Enrollee's attached written consent.
 - c) How the Enrollee or his/her authorized representative or provider , can obtain a copy of the standardized form used to submit the Appeal in writing (use form 7.59I-N11 Appeal Request Form). NOTE: The Enrollee may select the option of an expedited appeal on the appeal request form.
 - d) If Enrollee or his/her authorized representative or provider does not send the written Appeal request form to WBH within 60 calendar days from the ABD, the Enrollee, authorized representative or provider shall lose the right to Appeal.
 - e) If the Enrollee wants continuation of benefits when the ABD is to terminate, suspend or reduce a previously authorized course of treatment, that this maybe be requested.
 - f) To whom or where to send the written, signed Appeal.
 - g) The Enrollee or his/her authorized representative or provider has the opportunity, before and during the appeals process, to examine the Enrollee's case file, including medical records, and any other documents and records considered during the appeals process:
 - i). Include as parties to the Appeal the Enrollee or his/her authorized representative or provider, or
 - ii). the legal representative of a deceased Enrollee's estate.
3. Provide, if needed, reasonable assistance in taking procedural steps. Reasonable assistance includes, but is not limited to, providing interpreter services and toll free numbers that have adequate TTY/TTD and interpreter capability.
 4. Acknowledge receipt of the request for Appeal resolution either orally or in writing and explain to the Enrollee/provider the process that shall be followed to resolve the Appeal. (use form 7.59g-N6a Notice of Receipt of Standard Appeal).
 5. Forward a copy of the Appeal to WBH's Appeals Review Committee (ARC). The core review committee shall consist of the Youth and Adult Services Division Directors, the Medical Director, and the CMS Director. The CSR shall act as the committee's secretary.
 6. The CSR shall log information, as per PMHP Medicaid Contract requirements, in the Grievance, ABD, and Appeal spreadsheet. The CSR shall maintain documentation of receipt and request.
 7. The ARC members shall:
 1. Review the request for Appeal and ensure that any committee member(s) or parties involved earlier in the process be excluded as an ARC reviewer. ARC members shall include others who have the appropriate clinical expertise in treating the Enrollee's condition or disease.

2. Make a decision and give written notification to the Enrollee and other authorized parties of its decision as expeditiously as the Enrollee's health condition requires, but no later than 14 calendar days from the oral or written Appeal (use form 7.59d-N4a Notice of Appeal Decision). The ARC shall include in its Notice of Appeal Decision letter to the Enrollee, and other affected parties, all information needed to request a State fair hearing with the Utah State Department of Health. WBH shall provide reasonable assistance to the Enrollee as needed. The Notice shall include information regarding their opportunity to:
 - a. Examine prior to the hearing the content of their WBH case file and all documents and records to be used by WBH in the hearing;
 - 1) Bring witnesses;
 - 2) Establish all pertinent facts and circumstances;
 - 3) Present an argument without undue interference;
 - 4) Question or refute any testimony or evidence, including confronting and cross-examining adverse witnesses.

8. Should WBH fail to provide resolution of the Appeal within the required timeframe, the ARC members shall notify the enrollee of their right to file a request for a State fair hearing as the Enrollee has already exhausted WBH's internal Appeal process.

9. The CSR shall log information, as per PMHP Medicaid Contract requirements, in the Grievance, ABD, and Appeal spreadsheet. The CSR shall maintain a copy of the Appeal decision and any other pertinent documentation needed to maintain a complete record.

Expedited Appeals Process:

(See flowcharts 8, 10, 11 Expedited Appeals Process)

1. When the Enrollee or provider indicates that the time for a standard resolution for an Appeal could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function, the Enrollee or provider with the Enrollee's written consent, may file an expedited Appeal either orally or in writing. When the Enrollee requests an expedited Appeal orally, the CSR shall acknowledge receipt that a decision shall be made in 3 working days. (Expedited Appeal requests do not require a written follow-up request. The oral Appeal must be confirmed in writing within 60 calendar days of the date of the ABD.

2. If the ARC Committee agrees to the expedited Appeal request, the CSR shall:
 1. Give a written decision to the Enrollee within 3 working days of the request (use form 7.59h-N7a Notice of Receipt of Expedited Appeal Request).
 2. Inform the Enrollee or provider of the limited time available for the Enrollee to present evidence and allegations of fact or law, in person and in writing.
 3. Ensure that punitive ABD is not taken against a provider who either requests and expedited resolution to an Appeal or supports an Enrollee's Appeal.

4. Provide, if needed, reasonable assistance in taking procedural steps. Reasonable assistance includes, but is not limited to, providing interpreter services and toll free numbers that have adequate TTY/TTD and interpreter capability.
 5. Allow Enrollee to review medical records, etc. as per contract requirements.
 6. Acknowledge receipt of the request for expedited Appeal resolution either orally or in writing and explain to the Enrollee the process that shall be followed to resolve the Appeal (use form 7.59g-N6a Notice of Receipt of Standard Appeal).
 7. Log information, as per PMHP Medicaid Contract requirements, in the Grievance, ABD, Appeal Spreadsheet. The CSR shall maintain documentation of receipt and request.
 8. Forward a copy of the Appeal to WBH's Appeals Review Committee (ARC). The core review committee shall consist of the Youth and Adult Services Division Directors, the Medical Director, and the CMS Director. The CSR shall act as the committee's secretary.
3. The ARC members shall:
1. Review the request for Appeal and ensure that any committee member(s) or parties involved earlier in the process be excluded as an ARC reviewer. ARC members shall include others who have the appropriate clinical expertise in treating the Enrollee's condition or disease.
 2. Make decision/resolution within 72 hours from the oral or written Appeal.
 3. Make reasonable effort to provide oral notice of the expedited resolution in addition to providing a written Notice of Appeal to the Enrollee and other authorized parties of its decision within 72 hours from the oral or written Appeal (use form 7.59d-N4a Notice of Appeal Decision). The ARC shall include in its Notice of Appeal Decision letter to the enrolled Enrollee, and other affected parties, all information needed to request a State fair hearing with the Utah State Department of Health. WBH shall provide reasonable assistance to the Enrollee as needed. The Notice shall include information regarding their opportunity to:
 - a) Examine prior to the hearing the content of their WBH case file and all documents and records to be used by WBH in the hearing;
 - b) Bring witnesses;
 - c) Establish all pertinent facts and circumstances;
 - d) Present an argument without undue interference;
 - e) Question or refute any testimony or evidence, including confronting and cross-examining adverse witnesses.
4. The CSR shall log information, as per PMHP Medicaid Contract requirements, in the Grievance, ABD, and Appeal spreadsheet. The CSR shall maintain a copy of the Appeal receipt, decision, and any other pertinent documentation needed to maintain a complete record.

Denial of a Request for Expedited Appeal Resolution

If the ARC Committee denies a request for an expedited resolution of an Appeal, the CSR shall:

1. Transfer the Appeal to the standard time frame of no longer than 30 calendar days from the day the ARC receives the Appeal, with a possible 14 calendar day extension for resolving the Appeal and providing Notice of Appeal Resolution to affected parties.
2. Make reasonable effort to give the Enrollee and affected parties prompt oral notice of the denial.
3. Mail written notice within 2 calendar days explaining the denial, specifying the standard time frame that shall be followed, and informing the affected parties that the Enrollee may file a Grievance regarding this denial of expedited resolution of the Appeal.
4. Log information, as per PMHP Medicaid Contract requirements, in the Grievance, ABD, Appeal spreadsheet. The CSR shall maintain a copy of the Appeal receipt, decision, and any other pertinent documentation needed to maintain a complete record.

Appeal Extension:

WBH's Appeals Review Committee (ARC) members may extend the time frame for resolving the Appeal and providing notice by up to 14 calendar days if: (use form 7.59f-N5 Notice of Appeal Extension)

1. The Enrollee requests the extension; or
2. ARC members show that there is need for additional information and how the delay is in the Enrollee's interest (upon Medicaid request).
3. When the ARC members extend the time frame, and the extension was not requested by the Enrollee, the CSR shall send the Enrollee written notice of the reason for the delay within 2 calendar days. The notice shall include the reason for the delay and inform the enrollee of the right to file a grievance if he or she disagrees with the decision to extend the timeframes.
4. When the ARC members do not resolve an Appeal within the required time frame, this constitutes an ABD. The Enrollee may now file a request for a State fair hearing as the Enrollee has already exhausted the internal appeals process. The Enrollee shall then file a request for a State fair hearing. **(See State Fair Hearing Process)**.
6. The CSR shall send the Enrollee and affected parties a ABD (use form 7.59-N2a ABD), log information, as per PMHP Medicaid Contract requirements, in the ABD and Appeal spreadsheet. The CSR shall maintain a copy of the ABD, extension, and any other pertinent documentation needed to maintain a complete record.

Continuation of Benefits During the Appeal or State Fair Hearing Process:

WBH shall continue the Enrollee's benefits during the Appeal process if:

1. The ABD being appealed is to terminate, suspend or reduce a previously authorized course of treatment;

2. The services were ordered by an authorized provider;
3. The original period covered by the original authorization has not expired;
4. The Enrollee files the Appeal timely, which means filing the Appeal on or before the later of the following:
 - a) Within 10 days of the mailing the ABD; or
 - b) By the intended effective date of the proposed ABD; and
5. The Enrollee requests extension of benefits in the Appeal.

Duration of Continued or Reinstated Services:

1. When WBH continues or reinstates the Enrollee's services, WBH shall continue services until one of the following occurs:
 - a) The Enrollee withdraws the Appeal;
 - b) The Enrollee or his/her authorized representative or provider fails to request a State Fair Hearing within 10 calendar days after WBH send the notice of an adverse resolution;
 - c) An Enrollee or his/her authorized representative or provider fails to request continuation of disputed services within 10 calendar days after WBH send the notice of an adverse resolution;
 - d) A State fair hearing officer issues a hearing decision adverse to the Enrollee
 - e)
2. If the final resolution of the Appeal is adverse to the Enrollee, that is, it upholds WBH's ABD, WBH may recover the cost of the services furnished to the Enrollee while the Appeal or State fair hearing was pending, to the extent that they were furnished solely because of the requirements of the regulation set forth in 42 CFR 431.230(b).

Reversed Appeal Resolutions:

1. **Services Not Furnished While the Appeal is Pending**
 If WBH or State fair hearing officer reverses an ABD to deny, limit, or delay services that were not furnished while the Appeal was pending, WBH's Intake Program Manager shall authorize the provision of the disputed services promptly, and as expeditiously as the Enrollee's health condition requires but no later than seventy-two (72) hours from the date it receives notice reversing the determination. .
2. **Services Furnished While the Appeal is Pending**
 If WBH or the State fair hearing officer reverses a decision to deny authorization of services and the Enrollee received the disputed services while the Appeal was pending, WBH shall pay for those services in accordance with State policy and regulations.

State Fair Hearing Process:

(See flowchart 12 State Fair Hearing Process)

1. When an Enrollee or provider is not satisfied with WBH's ARC's Appeal decision, the Enrollee or provider has the right to ask for a Medicaid State fair hearing. The Utah State Department of Health requires exhaustion of WBH's Appeal procedures before the Enrollee may request a State fair hearing.

2. When ARC members make the final Appeal decision, and it is not wholly in favor of the Enrollee, or the ARC members are not able to make a decision on the Appeal within the required time frame, the Utah State Department of Health shall permit the Enrollee, or a provider acting on the Enrollee's behalf, to request a Medicaid State fair hearing within 120 calendar days from the date of the ERC members notice of Appeal decision. WBH's CSR shall send the Notice of Appeal Decision letter to the Enrollee and affected parties along with State Fair Hearing Rights And Hearing request form. (use form # 7.59d-N4a Notice of Appeal Decision, form #7.59n Request for a *Standard* State Fair Hearing, form # 7.59p Request for an *Expedited* State Fair Hearing).
3. When the Enrollee wants to continue benefits pending the outcome of the State fair hearing, when a previously authorized course of treatment has been terminated, suspended or reduced, the services were ordered by an authorized provider and the original period covered by the original authorization has not expired, the Enrollee/provider must submit a request for a State fair hearing and continuation of benefits within 10 calendar days after the CSR mails the Notice of Appeal Decision letter. WBH's CSR shall send the Notice of Appeal Decision letter to the Enrollee and affected parties along with State Fair Hearing Rights and Hearing request form. (use form # 7.59d-N4a Notice of Appeal Decision, form 7.59m Request for a *Standard* State Fair Hearing or form # 7.59o Request for an *Expedited* State Fair Hearing).
4. The parties to the State fair hearing include the ARC members as well as the Enrollee and his or her representative(s) which may include legal counsel, a relative, a friend or other spokesman, or the representative of a deceased Enrollee's estate.
5. The Enrollee, his or her authorized representative(s) or provider shall be given an opportunity to examine at a reasonable time before the date of the hearing and during the hearing, the content of the Enrollee's case file and all documents and records to be used by the ARC members.
6. The Enrollee shall also be given the opportunity to:
 - 1) Bring witnesses;
 - 2) Establish all pertinent facts and circumstances;
 - 3) Present an argument without undue interference; and
 - 4) Question or refute any testimony or evidence, including opportunity to confront and cross-examine adverse witnesses.
7. The State fair hearing with the Utah State Department of Health is a de novo hearing. If the Enrollee or provider requests a State fair hearing with the WBH ARC members, all parties to the hearing are bound by the Utah State Department of Health's decision until any judicial reviews are completed and are in the Enrollee's or provider's favor. Any decision made by the Utah State Department of Health pursuant to the hearing shall be subject to appeal rights as provided by State and Federal laws and rules.

8. The Enrollee shall be notified by the Utah State Department of Health Board in writing of the State Fair Hearing decision and any appeal rights as provided by State and Federal laws and rules.
9. The CSR shall log information, as per PMHP Medicaid Contract requirements, in the Grievance, ABD, Appeal spreadsheet. The CSR shall maintain a copy of the State Fair Hearing request, decision, and any other pertinent documentation needed to maintain a complete record.

Standard State Fair Hearing requests:

The Utah State Department of Health shall reach its hearing decision within 90 calendar days from the date the Enrollee filed the Appeal with WBH, not including the days the Enrollee takes to file the request.

Expedited State Fair Hearing requests:

Expedited State Fair Hearings occur when 1) WBH's ARC committee fails to resolve the expedited appeal within the required time frame or 2) The ARC committee's decision on the expedited appeal was wholly or partially adverse to the Enrollee. The Utah State Department of Health shall reach its hearing decision within 3 working days from the date the Utah State Department of Health receives from WBH all needed information, including information from the Enrollee's medical record, for a State fair hearing request for a denial of a service that:

- a) Meets the criteria for the expedited Appeal process but was not resolved using the WBH required expedited Appeal time frames; or
- b) Was resolved wholly or partially adversely to the Enrollee using the WBH's expedited Appeal time frames.

Right to Change and/or Terminate Policy:

Reasonable efforts shall be made to keep employees informed of any changes in the policy; however, WBH reserves the right, in its sole discretion, to amend, replace, and/or terminate this policy at any time.

Appeal Log

Wasatch Behavioral Health Appeal Log											
Reporting Period:											
Client Name:											
Client Number:											
Affected Parties:											
Reason For Appeal:											
Date of Oral Appeal:											
Date of Written Appeal:											
Type of Appeal:											
Date of Acknowledgment (Receipt):											
Date reviewed by ARC:											
Appeal receipt type:											
Expedited appeal approved?:											
Date Expedited appeal request											
Date of attempt to give prompt oral											
Continue benefits?:											
Decision date:											
Oral decision date:											
14 Day extension needed?:											
Date Enrollee notified of extention:											
Other pertinent appeal information in file Y/N?											
<p style="color: red;">NOTE: 1. An Enrollee's or his/her authorized representative, will have 60 days from the ABD to request an appeal/review of a WMH ABD. Appeals may be submitted to WMH orally or in writing. Appeals may be made in behalf of an Enrollee by a provider or authorized representative with the Enrollee's consent. A legal representative of the deceased Enrollee's estate may also make an Appeal. WMH must resolve the appeal/review with 30 calendar days from receipt of the Appeal. WMH may extend the time frame for an additional 14 calendar days under certain circumstances. WMH must resolve an expediated appeal within 72 hours from receipt of the Appeal</p>											
ABD Type Key (reason for appeal)											
1 - Denial or limited authorization of a requested service, including the type or level of service.											
2 - Reduction, suspension, or termination of a previously authorized service.											
3 - Denial in whole or in part of payment for services.											
4 - Failure to provide first face-to-face services in a timely manner, due to Center limitations, and resulting in client dissatisfaction.											
5 - Failure to act within the required time frames for solution and notification of appeals and grievances.											

State Fair Hearing Log

Wasatch Behavioral Health State Fair Hearing Log											
Reporting Period:											
Client Name:											
Client Number:											
Affected Parties:											
Reason For Hearing:											
Date of Request											
Standard/Expedited:											
Continue Benefits?											
Date Sent to State											
State Decision Date											
Other pertinent documentation information for State Fair Hearing											

Form # 7.59b-N2a Adverse Benefit Determination (ABD)

If you need this letter in Spanish, call the Wasatch Behavioral Health customer service representative at 801- 373-4760.

Si usted necesita esta carta en español, llame a un representante de Wasatch Behavioral Health al 801- 373-4760.

Delete all information in Red before sending letter to client...Use 12 pt font

(The ABD shall clearly indicate the ABD that has been taken and provide a clear statement of the basis for the ABD. The notice must be individualized to the Enrollee's case and medical and legal terms must be explained if the terms cannot be simplified. The notice shall also be written in easily understood language and format. See policy C-3.10 Readability of Documents for testing procedures)

"[Click here and type date]"

"[Click here and type recipient's name]"

"[Click here and type recipient's address]"

**Example
Form**

Dear "[Click here and type recipient's name]" ,

On "[Click here and type date]" Wasatch Behavioral Health took the following Adverse Benefit Determination (ABD);

We denied or limited approval of your requested service/provider.

(Explain why services were limited or denied. If limited, explain the details of the request and the limited approval. Limited approvals may include: a. provider asked for certain number of sessions, you approve less with no chance for approval of the remaining sessions requested; or b). provider asks for certain number of sessions and services are approved in segments and you do not end up approving the original amount requested.)

We denied payment for a service you received that you may have to pay for.

(Explain what led to the ABD, individualized to the Enrollee. Refer to your handbook section on payment liability and provide information to the Enrollee as to which reason fits their situation.)

We did not offer your first appointment within the required amount of time, and you were unhappy with this.

(Explain what led to the ABD, individualized to the Enrollee)

We did not make a decision about your request service within the required amount of time (14 days for a standard request or 3 days for an expedited (quick) request).

(Summarize request and explain why you were not able to make a decision within the required time frame and when you plan to make decision by- may reduce likelihood they'll appeal.)

We did not make a decision about your Grievance within the required amount of time (90 days.)

(Explain why you were not able to make a decision within the required time frame and when you plan to make decision by- may reduce likelihood they'll appeal.)

If you are unhappy with this ABD, you have the right to appeal. The rest of this letter explains how to file an Appeal.

You must file your Appeal within 60 calendar days from the date on this letter.

You, your authorized representative or your provider may file your Grievance. If you need help filing your Grievance, call the Wasatch Behavioral Health customer services representative at 801- 373-4760.

Interpreters are free of charge and are available in all languages, including sign language. If you need an interpreter to help you file your Grievance, call Wasatch Behavioral Health customer services representative at 801- 373-4760. Outside of Utah County call 866-366-7987.

To file an Appeal:

1. You may file your appeal by calling us at 801- 373-4760 and asking for the Wasatch Behavioral Health customer service representative.
2. If you call us to file your appeal, you must confirm your oral appeal in writing within 60 calendar days of your oral appeal. Please use the enclosed written appeal request form.
3. If you do not want to call first, you must send us your written appeal within 60 calendar days of the date on the ABD. Send us your appeal using the enclosed written appeal form.
4. If your authorized representative or your provider files your Appeal, the Appeal must include your written permission. You may give your written permission by completing and signing the bottom of the enclosed written appeal request form or by sending us a separate note. This is important. If we do not receive your written permission, your provider may not appeal the ABD.
5. Send the complete written appeal to:

Wasatch Behavioral Health
c/o Care Management Department
750 North 200 West, Suite 300
Provo, UT 84601

If you call us first to file your Appeal, we plan to make a decision within 30 **calendar days** from the date **we get your written Appeal request.** If you send us your Appeal in writing, **we plan to make a decision within 30 calendar days from the date we get your written Appeal request.**

Sometimes we'll need more time to make a decision, or you may ask us to take more time. If so, we may take an additional 14 calendar days to make our decision. If we need to take extra time, we will send you a letter telling you that.

EXPEDITED (QUICK) APPEALS

If you or your provider or authorized representative believes taking this amount of time could place your life or health in danger, or that you might have a permanent setback, you may ask for an expedited (quick) Appeal.

To file an expedited appeal:

1. You may ask for an expedited appeal by calling the Wasatch Behavioral Health customer services representative at 801- 373-4760. You do not also have to send your Appeal in writing.
2. If you do not want to call first, check the “expedited Appeal” box on the enclosed Appeal form and send it to us.
3. If your provider or authorized representative files your appeal, the appeal must include your written permission. You may give your written permission by completing and signing the bottom of the enclosed written appeal request form or by sending us a separate note. This is important. If we do not receive your written permission, your provider may not appeal the ABD.

If we agree the decision needs to be made quickly, we will make a decision in **72 hours after we receive your expedited Appeal request.** If you or we need more time to make the decision, we can take up to another **14 calendar days.** If we need more time, we will send you a letter telling you why.

If your appeal is denied, we will send you a letter explaining the reason why it was denied and tell you how to ask for a State Fair Hearing.

Again if you have any questions please contact the Wasatch Behavioral Health customer services representative at 801- 373-4760.

Sincerely,

[Click **here** and type your name]

Cc: **Private provider (if applicable)**
Affected Parties (if applicable)

Enclosure: Appeal Request Form

**Wasatch Behavioral Health
APPEAL REQUEST FORM**

1. Is the client or a provider requesting this **Appeal**? Client? Or Provider? (Circle)
2. Name of Client: _____
Client's Address: _____
3. Name of Provider Involved: _____
Provider's Address: _____
4. The reason you are requesting the Appeal: _____

5. You may ask for an expedited (quick) decision on your Appeal if you believe taking the regular amount of time could place your life or health in danger, or that you might have a permanent setback.

___ Check here if you want an expedited Appeal.
6. If the Appeal is about decreasing or ending services, do you want these services continued during the Appeal process? Please remember if the Appeal decision is not in your favor, you may have to pay for these services. Also use form Form # 7.59c-N3a ABD for Decreasing or Ending Services

___ Check here if you want these services continued.
7. If you need help filling out this form, an interpreter, or have any questions about the Appeal process please call (name or title) at (phone number).
8. **REMINDER!!** If you are **not** asking for an expedited (quick) Appeal, and you call us first to file your Appeal, you must confirm your oral appeal in writing within 60 calendar days of the ABD.
9. If you have evidence or additional documentation to submit. Please attached to this form or attach a statement explaining what you intend to submit and when you intend to submit it. You may also submit additional evidence or documentation at a later time.

Provider Permission Statement

If your provider is filing the Appeal for you, you must give your written permission.

I _____ (your name) give my permission for
_____ (provider's name) to file this Appeal for me.

Client's Signature

Date

Form # 7.59I-N11

Form # 7.59a-N1a: Notice of Extension for Service Authorization Request

If you need this letter in Spanish, call the Wasatch Behavioral Health customer service representative at 801- 373-4760.
Si usted necesita esta carta en español, llame a un representante de Wasatch Behavioral Health al 801- 373-4760.

Delete all information in Red before sending letter to client... Use 12 pt font

"[Click here and type date]"

"[Click here and type recipient's name]"

"[Click here and type recipient's address]"

Dear "[Click here and type recipient's name]" ,

*On "[Click here and type date]" you asked for approval to get **(name of service)** from **(name of therapist)** or **(name of therapist)** asked for approval to provide **(name of service)** to you. We are supposed to make a **decision in 14 days. If we cannot make a decision in that time, we can take up to 14 more days.** We are letting you know that we need more time to make a decision.

We need more time because **(explain reason for the delay *and why it'll help them in the long run, including type of information needed and from whom, if applicable)**

*If you are unhappy that we need more time, you may file a grievance with us.

You, your authorized representative or your provider may file your Grievance. If you need help filing your Grievance, call the Wasatch Behavioral Health customer services representative at 801- 373-4760.

Interpreters are free of charge and are available in all languages, including sign language. If you need an interpreter to help you file your Grievance, call Wasatch Behavioral Health customer services representative at 801- 373-4760. Outside of Utah County call 866-366-7987.

To file a grievance:

You may file your grievance by calling us, talking to a center staff member in person or by giving it to us in writing. If you want to mail it, please mail it to:

Wasatch Behavioral Health
c/o Care Management Department
750 North 200 West, Suite 300
Provo, UT 84601

Once we get the grievance, we will give you a decision within **45 calendar days**. We will either talk to you about our decision, or we will send you a letter.

Sincerely,

[Click **here** and type your name]

Cc: **Private provider (if applicable)**
Affected Parties (if applicable)

Form # 7.59c-N3a ABDAverse Benefit Determination (ABD) for Decreasing or Ending Services

If you need this letter in Spanish, call the Wasatch Behavioral Health customer service representative at 801- 373-4760.
Si usted necesita esta carta en español, llame a un representante de Wasatch Behavioral Health al 801- 373-4760.\

Delete all information in Red before sending letter to client...Use 12 pt font

(The ABD shall clearly indicate the ABD Effective date needs to be added here that has been taken and provide a clear statement of the basis for the ABD. The notice must be individualized to the Enrollee's case and medical and legal terms must be explained if the terms cannot be simplified. The notice shall also be written in easily understood language and format. See policy C-3.10 Readability of Documents for testing procedures)

"[Click here and type date]"

"[Click here and type recipient's name]"

"[Click here and type recipient's address]"

Dear "[Click here and type recipient's name]"

On "[Click here and type date]" Wasatch Behavioral Health decided to **(Explain the ABD, the date your ABD will take effect and what led to the ABD to either decrease, suspend or end services, individualized to the Enrollee. Describe the Enrollee's unique situation.)**

If you are unhappy with our decision, you have the right to Appeal. The rest of this letter explains how to file an Appeal.

You, your authorized representative or your provider may file your Grievance. If you need help filing your Grievance, call the Wasatch Behavioral Health customer services representative at 801- 373-4760.

Interpreters are free of charge and are available in all languages, including sign language. If you need an interpreter to help you file your Grievance, call Wasatch Behavioral Health customer services representative at 801- 373-4760. Outside of Utah County call 866-366-7987.

If you decide to file an Appeal, you may choose to keep getting the services discussed above during your Appeal. If you choose to get these services during your Appeal, and the Appeal is not decided in your favor, you may have to pay for them.

- If you choose to get these services during your Appeal, you must file your Appeal
 - **Within 10 days from the date** on your ABD letter, or
 - By the date we plan to change the services discussed above, whichever is later.
- If you do NOT choose to get these services during your Appeal, you must file your Appeal within **10 calendar days from the date on your ABD letter.**

To file an Appeal:

1. You may file your Appeal by calling us at 801- 373-4760 and asking for the Wasatch Behavioral Health customer service representative.
2. If you call us to file your Appeal, you must confirm your oral appeal in writing within 10 calendar days of your oral appeal. Please use the enclosed written Appeal request form.

3. If you do not want to call first, just send us your Appeal using the enclosed written Appeal form.
4. If your provider files your Appeal, the Appeal must include your written permission. You may give your written permission by completing and signing the bottom of the enclosed written Appeal request form or by sending us a separate note. This is important. If we do not receive your written permission, your provider may not Appeal the ABD.
5. Send the complete written Appeal to:

Wasatch Behavioral Health
 c/o Care Management Department
 750 North 200 West, Suite 300
 Provo, UT 84601

Sometimes we'll need more time to make a decision, or you may ask us to take more time. If so, we may take an additional **14 calendar days to make our decision.** If we need to take extra time, we will send you a letter telling you that.

EXPEDITED (QUICK) APPEALS

If you or your provider believes taking this amount of time could place your life or health in danger, or that you might have a permanent setback, you may ask for an expedited (quick) Appeal.

To file an expedited Appeal:

1. You may ask for an expedited Appeal by calling the Wasatch Behavioral Health customer service representative at 801- 373-4760. You do not also have to send your Appeal in writing.
2. If you do not want to call first, check the “expedited Appeal” box on the enclosed Appeal form and send it to us.
3. If your provider files your Appeal, the Appeal must include your written permission. You may give your written permission by completing and signing the bottom of the enclosed written Appeal request form or by sending us a separate note. This is important. If we do not receive your written permission, your provider may not Appeal the ABD.

If we agree the decision needs to be made quickly, we will make a decision in **72 hours.** If you or we need more time to make the decision, we can take up to another **14 calendar days.** If we need more time, we will send you a letter telling you why.

Again, if you have any questions, please contact the Wasatch Behavioral Health customer service representative at 801- 373-4760.

Sincerely,

[Click **here** and type your name]

Cc: **Private provider (if applicable)**
Affected Parties (if applicable)

Enclosure: Appeal Request Form

Form # 7.59d-N4a Notice of Appeal Decision

If you need this letter in Spanish, call the Wasatch Behavioral Health customer service representative at 801- 373-4760.
Si usted necesita esta carta en español, llame a un representante de Wasatch Behavioral Health al 801- 373-4760.

Delete all information in Red before sending letter to client...Use 12 pt font

"[Click here and type date]"

"[Click here and type recipient's name]"

"[Click here and type recipient's address]"

Dear "[Click here and type recipient's name]" ,

On "[Click here and type date]" Wasatch Behavioral Health took the following ABD;

- We denied or limited approval of your requested service/provider.
(Explain what led to the ABD, individualized to the Enrollee)
- We denied payment for a service you received.
(Explain what led to the ABD, individualized to the Enrollee)
- We did not offer your first appointment within the required amount of time as you were unhappy with this.
(Explain what led to the ABD, individualized to the Enrollee)
- We decreased or ended services we had previously approved and you did not agree with the change.
(Explain what led to the ABD, individualized to the Enrollee.)
- We did not make a decision about your request for service within the required amount of time
(Explain reason)

We received your appeal of this ABD on "[Click here and type date]" .

(If it was a standard Appeal and the Enrollee first filed the Appeal orally, give the date of the oral filing – NOT the date you receive the follow-up written Appeal.)

- Your Appeal was a standard Appeal.
 - Your Appeal was an expedited (quick) Appeal.
- If your Appeal was about our plan to decrease or end services:

- During the Appeal, you received the services we had planned to decrease or end.
- During the Appeal, you did not get the services we had planned to decrease or end.

APPEAL DECISION:

- Our decision on your Appeal is in your favor.

Since we have made a decision in your favor, the rest of this letter does not apply to you.

- Our decision on your appeal is not in your favor.

(Explain decision. You must also inform the Enrollee that this is WBH's last and final decision.)

Since our decision on your Appeal is not in your favor, you have the right to ask for a Medicaid State Fair Hearing.

We were not able to make a decision on your Appeal within the required amount of time.

(List reasons)

We plan to make our decision by **(date)**. If you are unhappy about this, you have the right to ask for a Medicaid State Fair Hearing.

You must file a written request for a Medicaid State Fair Hearing by using the enclosed form. Be sure to send your completed form within the time frame that fits your situation as described on the enclosed form. This is especially important if you want to keep getting these services during the Medicaid State Fair Hearing process.

Delete all information in Red before sending letter to client...

The Enrollee must request a State Fair Hearing within 120 calendar days from the date of the Notice of Appeal Resolution. If the Enrollee chooses to continue disputed services, the Enrollee must, within 10 calendar days after WBH send the notice of an adverse resolution, request a State Fair Hearing. The Enrollee or his/her authorized representative or provider must within 10 calendar days after WBH send the notice of adverse resolution; submit to the State Fair Hearing office a written request to continue the disputed services during the State Fair Hearing.

You, your authorized representative or your provider may file your Grievance. If you need help filing your Grievance, call the Wasatch Behavioral Health customer services representative at 801- 373-4760.

Interpreters are free of charge and are available in all languages, including sign language. If you need an interpreter to help you file your Grievance, call Wasatch Behavioral Health customer services representative at 801- 373-4760. Outside of Utah County call 866-366-7987.

To ask for a Medicaid State Fair Hearing;

1. Complete the enclosed Medicaid State Fair Hearing Request form.
2. Mail the completed form to the following address:

**DIVISION OF HEALTH CARE FINANCING
DIRECTOR'S OFFICE/FORMAL HEARING UNIT
BOX 143105
SALT LAKE CITY, UTAH 84114-3105**

This address is also on the hearing request form.

If you have any questions, please contact the Wasatch Behavioral Health customer service representative at 801- 373-4760.

Sincerely,

[Click **here** and type your name]

Cc: **Private provider (if applicable)**
Affected Parties (if applicable)

Enclosure: **either Standard or Expedited Medicaid State Fair Hearing Form (7.59m - 7.59p)**

Form # 7.59f-N5a Notice of Appeal Extension

If you need this letter in Spanish, call the Wasatch Behavioral Health customer service representative at 801- 373-4760.

Si usted necesita esta carta en español, llame a un representante de Wasatch Behavioral Health al 801- 373-4760.

Delete all information in Red before sending letter to client...Use 12 pt font

"[Click here and type date]"

"[Click here and type recipient's name]"

"[Click here and type recipient's address]"

Dear "[Click here and type recipient's name]"

On "[Click here and type date]" Wasatch Behavioral Health took the following ABD:

- We denied or limited approval of your requested service/provider.
(Explain what led to the ABD, individualized to the Enrollee – is this necessary?)
- We denied payment for a service you received.
(Explain what led to the ABD, individualized to the Enrollee – is this necessary?)
- We did not offer your first appointment within the required amount of time and you were unhappy with this.
- We decreased or ended services we had previously approved and you did not agree with the change
(Explain what led to the ABD, individualized to the Enrollee.)
- We did not make a decision about your request for service within the required amount of time (14 days for a standard request or 72 hours for an expedited (quick) request.)
- We did not make a decision about your grievance within the required amount of time (45 days).
(Explain why)

We received your Appeal of this ABD on **(date)**.

(NOTE: If it was a standard Appeal, and the Enrollee first filed the Appeal orally, specify this date – NOT the date you received the follow-up written Appeal request.)

- Your Appeal was a standard Appeal.
- Your Appeal was an expedited (*quick*) Appeal.

We have not been able to make a decision on your Appeal yet. As we said in your ABD letter, we can take up to another 14 calendar days. We need to take this extra time.

We need more time because **(explain reason for the delay, including type of information needed and from whom, if applicable)**

We will give you our decision in writing within 14 days.

Sincerely,

[Click **here** and type your name]

Cc: **Private provider (if applicable)**
Affected Parties (if applicable)

Form # 7.59g-N6a Notice of Receipt of Standard Appeal

If you need this letter in Spanish, call the Wasatch Behavioral Health customer service representative at 801- 373-4760.
Si usted necesita esta carta en español, llame a un representante de Wasatch Behavioral Health al 801- 373-4760.

Delete all information in Red before sending letter to client...Use 12 pt font

"[Click here and type date]"

"[Click here and type recipient's name]"

"[Click here and type recipient's address]"

Dear "[Click here and type recipient's name]" ,

On "[Click here and type date]" we received your Appeal regarding (explain details).

(If the Enrollee first filed the Appeal orally, specify that date- NOT the date you received their follow-up written appeal request. It is the date of the oral filing from which you have 60 calendar days to make a decision.)

(Add the paragraph below if the ABD was to decrease, suspend or end services and the Enrollee asked for continuation of benefits during the appeal process.)

You asked to keep getting the services you are appealing during the appeal process. Keep in mind you may have to pay for these services if our decision on your appeal is not in your favor.

We have 30calendar days from the date we received your Appeal to give you our decision in writing.

To help us make the best decision possible you have the opportunity to give us information about anything that will help us understand why you are making this appeal. You, or your authorized representative or provider, have the right to review information, including your medical record. Your review of this information may be limited by federal regulation.

If you need help during the appeal, including an interpreter, call the Wasatch Behavioral Health customer service representative at 801- 373-4760.

Sincerely,

[Click **here** and type your name]

Cc: **Private provider (if applicable)**
Affected Parties (if applicable)

Form # 7.59h-N7a Notice of Receipt of Expedited Appeal Request

If you need this letter in Spanish, call the Wasatch Behavioral Health customer service representative at 801- 373-4760.
Si usted necesita esta carta en español, llame a un representante de Wasatch Behavioral Health al 801- 373-4760.

Delete all information in Red before sending letter to client...Use 12 pt font

"[Click here and type date]"

"[Click here and type recipient's name]"

"[Click here and type recipient's address]"

Dear "[Click here and type recipient's name]"

On "[Click here and type date]" we received your Appeal regarding (explain details). You your authorized representative or provider asked for an expedited (or quick) decision on your Appeal.

- We agree that a decision should be made quickly. We will give you our decision within 72 hours from the date of your Appeal.
- We do not agree that a decision should be made quickly.

(Explain why you do not think their situation warrants an expedited decision that is why taking the standard time frame will not jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function).

*Instead, we will make a decision on your Appeal within 30 calendar days from the date **we get your written Appeal.**

*If you are unhappy about this, you may file a *Grievance with us.

You, your authorized representative or your provider may file your Grievance. If you need help filing your Grievance, call the Wasatch Behavioral Health customer services representative at 801- 373-4760.

Interpreters are free of charge and are available in all languages, including sign language. If you need an interpreter to help you file your Grievance, call Wasatch Behavioral Health customer services representative at 801- 373-4760. Outside of Utah County call 866-366-7987.

To file a Grievance:

You may file your Grievance by calling us, talking to a center staff member in person or by giving it to us in writing. If you want to mail it, please mail it to:

Wasatch Behavioral Health
c/o Care Management Department
750 North 200 West, Suite 300
Provo, UT 84601

Once we get the Grievance, we will give you a decision within **45 calendar days**. We will either talk to you about our decision, or we will send you a letter. If you gave us your Grievance in writing, we will always send you a letter back.

Sincerely,

[Click **here** and type your name]

Cc: **Private provider (if applicable)**
Affected Parties (if applicable)

Form # 7.59k-N10a Notice of Grievance Decision Right to Appeal (did not resolve in time)

If you need this letter in Spanish, call the Wasatch Behavioral Health customer service representative at 801- 373-4760.
Si usted necesita esta carta en español, llame a un representante de Wasatch Behavioral Health al 801- 373-4760.

**Delete all information in Red before sending letter to client...Use 12 pt font
(Centers – This form is only required for written grievances. You may use it for decisions on oral grievances if you want.)**

"[Click here and type date]"

"[Click here and type recipient's name]"

"[Click here and type recipient's address]"

Dear "[Click here and type recipient's name]"

We received your grievance on "[Click here and type date]" . At that time, the grievance was regarding **(summarize grievance)**.

Wasatch Behavioral Health has decided or WBH wants you to know **(summarize resolution)**.
Since we have made a decision on your grievance the rest of this letter does not apply to you.

Wasatch Behavioral Health was not able to make a decision on your grievance within the total amount of time Medicaid requires, including the 14 calendar days.
(List reasons)

Since we were not able to make a decision on your grievance, you have the right to appeal. You must file your appeal within **60calendar days from the date on this letter**.

You, your authorized representative or your provider may file your Grievance. If you need help filing your Grievance, call the Wasatch Behavioral Health customer services representative at 801- 373-4760.

Interpreters are free of charge and are available in all languages, including sign language. If you need an interpreter to help you file your Grievance, call Wasatch Behavioral Health customer services representative at 801- 373-4760. Outside of Utah County call 866-366-7987.

To file an appeal:

1. You may file your appeal by calling the Wasatch Behavioral Health customer service representative at 801- 373-4760.
2. If you call us to file your appeal, you must confirm your oral appeal in writing within 60 calendar days of the notice of ABD. Please use the enclosed written appeal request form. Y
3. If you do not want to call first, send us your appeal using the enclosed written appeal form.
4. If your provider files your appeal, the appeal must include your written permission. You may give your written permission by completing and signing the bottom of the enclosed written appeal request form or by sending us a separate note. This is important. If we do not receive your written permission, you lose the right to appeal.

5. Send the complete written appeal to:

Wasatch Behavioral Health
c/o Care Management Department
750 North 200 West, Suite 300
Provo, UT 84601

Delete all information in Red before sending letter to client...Use 12 pt font

If you call us first to file your appeal, we plan to make a decision within 30 calendar days from the date **we get your written Appeal.**

If you do not call us first to file your Appeal, but send us a written Appeal request, we plan to make a decision within 30 calendar days from the date **we get your written Appeal request.**

Sometimes we may need more information, or you may ask us to take more time. If so, we may take an additional **14 calendar days** to make our decision. **If we need to take extra time, we will send you a letter telling you that.**

If you or your provider believes your life or health is in danger, you may ask for an **expedited** (quick) appeal.

To file an expedited appeal:

1. You may ask for an expedited appeal by calling 801- 373-4760. You do not also need to send us a written appeal.
2. Or if you want, you don't need to call us--you may just check the expedited appeal box on the enclosed written appeal request form and send it to us.
3. If your provider files your appeal, the appeal must include your written permission. You may give your written permission by completing and signing the bottom of the enclosed written appeal request form or by sending us a separate note. This is important. If we do not receive your written permission, you lose the right to appeal.

If we agree the decision needs to be made quickly, we will make a decision in **72 hours**. If you or we need more time to make the decision, we can take up to another **14 calendar days**. If we need more time, we will send you a letter telling you why.

Again if you have any questions please contact the Wasatch Behavioral Health customer services representative at 801- 373-4760.

[Click **here** and type your name]

Cc: **Private provider (if applicable)**
Affected Parties (if applicable)

Sincerely,

Enclosure: Appeal Request Form

REQUEST FORM FOR A STANDARD MEDICAID STATE FAIR HEARING

If you are appealing the Prepaid Mental Health Plan's (PMHP's) decision to decrease or stop a service(s) that the PMHP had previously approved, does the Medicaid client want the services continued during the State Fair Hearing? Please check one of the boxes:

- YES, the client wants the services continued during the State Fair Hearing*
NO, the client does not want the services continued during the State Fair Hearing

*If the State Fair Hearing decision is the same as the PMHP's, the PMHP may require the client to pay for the services.

If the client wants the services continued during the State Fair Hearing, the 'Yes' box must be checked and this form must be mailed to the address below WITHIN 10 CALENDAR DAYS from the date the PMHP mailed its decision on the Appeal. If it is not mailed within 10 calendar days, the PMHP does not have to keep giving the services after the 10 days.

If the form is not mailed within 10 calendar days, or the 'NO' box above has been checked, or the hearing is about any other Appeal decision the PMHP has made, this form must be mailed to the address below WITHIN 30 CALENDAR DAYS from the date on the PMHP's written decision on the Appeal. A copy of the PMHP's decision on the Appeal must be attached to this form or we cannot proceed with a State Fair Hearing.

- 1. IS THE CLIENT OR PROVIDER REQUESTING THIS STATE FAIR HEARING? Client? or Provider? (Circle) If the provider is filing this request on behalf of the client, the client's written consent must be attached.
2. NAME OF CLIENT: CLIENT'S MEDICAID ID #: CLIENT'S ADDRESS:
3. NAME OF PROVIDER INVOLVED: PROVIDER'S ADDRESS:
4. NAME OF PMHP
5. The reason you are requesting this hearing is:
6. The results you would like to have from this hearing are:



You must mail a copy of this form to each person who has a direct interest in this hearing request. List the names and addresses of all people to whom you are sending a copy of this request.

Name: Address: State: Zip:
Name: Address: State: Zip:

If you will be represented by an attorney, tell the attorney to file A Notice of Appearance to the address below. If the Division of Medicaid and Health Financing does not receive A Notice of Appearance at least 10 calendar days before any scheduled hearing, the Division will assume that an attorney will not be present at the hearing.

Will you be represented by an attorney? Yes No (Circle)

NAME OF ATTORNEY: ATTORNEY'S PHONE #:
ATTORNEY'S ADDRESS: State: Zip:

Signature of person requesting the State Fair Hearing Phone # Date

SEND THIS REQUEST TO: Via U.S. Post Office Director's Office/Formal Hearings Division of Medicaid and Health Financing PO Box 143105 Salt Lake City, UT 84114-3105
Via UPS or FedEx Director's Office/Formal Hearings Division of Medicaid and Health Financing 288 North 1460 West Salt Lake City, UT 84116-3231

Rev 12/2011 Or fax to: 801-536-0143

FORM TO REQUEST A STATE FAIR HEARING

Are you asking for a State fair hearing because of a decision made by the Medicaid agency or by a managed care plan?

*Check one: Medicaid Agency Managed Care Plan - Name of Plan: _____

(A managed care plan can be a Medicaid physical health plan, Medicaid prepaid mental health plan, Medicaid dental plan, CHIP dental plan, or CHIP physical and mental health plan.)

This form must be submitted by the deadlines shown on the next page.

Please enclose a copy of the Medicaid Agency's denial notice or the Managed Care Plan's notice of its appeal decision or we cannot proceed with this hearing request.

If waiting for a decision about this hearing request could endanger the member's life, health or ability to attain, maintain, or regain maximum function, call Administrative Hearings (801-538-6576) to request an expedited hearing.

*1. Name of person requesting hearing: _____ *Phone #: _____

*Street Address: _____

Email Address: _____ Fax #: _____

*2. Member's name: _____ *Medicaid ID #: _____ Date of birth: _____

3. Provider's name: _____ Provider's PI: _____

4. Reason for hearing request: _____

5. Service(s) or procedure code(s): _____ Date(s) of service(s): _____

Providers: Submit any medical records that support your position, otherwise the hearing may be delayed.

You may represent yourself or have another person represent you. If an attorney represents you, the attorney must file a Notice of Appearance to the address below. *Will an attorney represent you? Yes No

Name of representative or attorney: _____ Phone #: _____

Address: _____ State: _____ Zip: _____

*Signature of person requesting hearing _____ Date _____

Name and address of additional person(s) you would like to be notified of your hearing request: _____

All asterisked (*) items above must be completed to proceed with this hearing request.

SEND THIS FORM TO:

Via U.S. Post Office Director's Office/Administrative Hearings Division of Medicaid and Health Financing PO Box 143105 Salt Lake City, UT 84114-3105	Via UPS or FedEx Director's Office/Administrative Hearings Division of Medicaid and Health Financing 288 North 1460 West Salt Lake City, UT 84116-3231	Email or Fax Email: administrativehearings@utah.gov Fax: 801-536-0143
---	---	---

Administrative Hearings Telephone #: 801-538-6576

Notice of Adverse Benefit Determination (ABD)
Inpatient Authorization Denial
(Junction form 7.59b-N2a)

Provider: Provider Name
 Address
 City, State Zip

Patient Name: Patient Name
 Address
 City, State Zip

Dates of Service: MM/DD/YYYY – MM/DD/YYYY

Account Number: 1234567899-1

If you are unhappy with this decision, you have the right to file an Appeal by calling Wasatch Behavioral Health’s Claims Review Auditor, Sheila Foster, at 801-852-3324. The attached document explains how to file an Appeal and what to do if you need help filing the Appeal. Your provider may also file the Appeal if you give your written consent. You must send the completed Appeal Request Form to Wasatch Behavioral Health’s Associate Director within 30 calendar days from the date on this letter.

Wasatch Behavioral Health Services Special Service District provides an interpreter, if needed. Interpreters are free of charge for Medicaid enrollees, and are available in all languages, including sign language. If you need interpreter services, please call the Claims Review Auditor at 801-852-3324.

Sincerely,

Sheila Foster
Claims Review Auditor

Cc: Provider
 Address
 City, State Zip

Enclosure

The rest of this letter explains how to file an Appeal.
