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Owner	Mica Shattuck: Supervisor, Appeals & Grievances
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Applicability	EOCCO
References	Behavioral Health, Dental, Healthcare Services + 4 more

EOCCO OHA Contested Case Hearings Policy

I. Policy Statement and Purpose

EOCCO investigates and participates in the Oregon Health Authority (OHA) Health Systems Division contested case hearings requested by Medicaid members. The OHA Medicaid program affords one level of appeal to members and they must complete the appeal process with EOCCO prior to requesting a contested case hearing.

II. Definitions

A. **Adverse benefit determination:**

1. A denial or limitation by EOCCO of the following:

   a. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;

   b. The reduction, suspension, or termination of a previously authorized service;

c. The denial, in whole or in part, of payment for a service.

d. The failure to provide services in a timely manner, as defined by the State;

e. The failure of the CCO to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.

f. For a resident of a rural area with only one CCO, the denial of a member's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network.

g. The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

B. **Expedited Contested Case Hearing:** A member, or representative (including provider), who believes that taking the time for a standard resolution of a contested case hearing could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function may request an expedited contested case hearing.

1. A request for an expedited hearing for a service that has already been provided (post-service) to the member will not be granted.

C. **Contested Case Hearing**: A hearing requested by a Medicaid member or representative (including provider) with the member's written consent regarding an appeal decision by EOCCO that has denied benefits for requested services, payment of a claim or terminated, discontinued or reduced a course of treatment or any other adverse benefit determination. A member can also initiate a contested case hearing if EOCCO fails to adhere to the notice requirements, then the member is deemed to have exhausted the appeal process.

1. If a provider filed an appeal on behalf of a member, the provider may request a contested case hearing on behalf of the member. The hearing request must be filed with EOCCO or the Oregon Health Authority hearings unit no later than 120 days following the date of the EOCCO written appeal decision. A member may initiate a contested case hearing if EOCCO fails to adhere to notice and timing requirements. The member and representative, EOCCO, and the legal representative of a deceased member's estate are all parties to the contested case hearing. Contested case hearings (expedited or standard) are filed using Hearing request form (MSC 0443) or the Health Systems Division Service Denial Appeal and Hearing Request form (OHP 3302). Expedited hearings can also be requested orally, in writing or online.

D. **Representative:** A representative is an individual who can make Medicaid-related decisions for a member who is not able to make such decision themselves. In this policy a representative also includes the member's provider. A provider or the members authorized representative, with the member's written consent, has the authority to file an appeal, grievance, or contested case hearing with EOCCO. EOCCO considers the member, the member's representative, or the legal representative of a deceased member's estate as parties to an appeal. A representative

is allowed to request an appeal, file a grievance, or request a state fair hearing request. With respect to EOCCO's notification requirements, a separate notice must be sent to each individual who falls within this definition.

III. Procedure

A. Receiving and forwarding contested case hearing requests.

1. The OHA representative forwards the hearing request via email to EOCCO.
2. When EOCCO receives a hearing request that has been mailed directly to EOCCO in error, EOCCO does the following:
    a. Ensures there is a date stamp on the document or adds the appropriate date stamp.
    b. The hearing request is directed to the appropriate staff.
    c. EOCCO will date stamp the request prior to immediately emailing the hearing request and notice of adverse benefit determination (NOABD) to the OHA hearings unit.

B. Preparation of Hearing File

1. EOCCO prepares for the hearing and:
    a. Determines if the hearing request was previously reviewed as an appeal by EOCCO. If not previously processed as an appeal, EOCCO investigates and resolves the appeal in accordance with the EOCCO Medicaid Member Grievances and Appeals Policy and emails the OHA hearing unit the hearing request with the information that the appeal rights were not previously exhausted by the member.
    b. If the member has exhausted the EOCCO appeal process, EOCCO provides relevant information required for the hearing process to the OHA hearing unit, including chart notes from the current provider and other providers noted in history that may have information pertinent to the hearing within 2 working days from the date of receiving the relevant documentation applicable to the request. For expedited hearing requests OHA shall decide within 2 working days of the receipt of medical documentation if the hearing will be expedited.

C. Providing Hearing Information to OHA

1. EOCCO emails the following information to OHA upon receipt of the hearing request (standard or expediated) unless the hearing request was not previously reviewed as an appeal (see Section III.B.1). The required information will be submitted to OHA within two business days:
    a. All documents and records EOCCO relied upon to take its action, including those used as the basis for the initial action or the notice of appeal resolution, if applicable, and all other relevant documents and records
    b. .EOCCO claims payment history (from the date of service related to the hearing to present).

c. EOCCO grievance form or OHA complaint form and any member correspondence.

d. EOCCO appeal response to the member.

e. Medical/Dental consultant's review.

f. Medical/Dental chart notes.

g. Claim Inquiry Explanation of Benefits screen showing prior authorization or predetermination if applicable.

h. EOCCO acknowledgement of the appeal and the member authorization form.

i. Any other documents requested by OHA.

2. To be entitled to continuing benefits, the member can make a request by phone, letter, fax or by using the Review of Health Care Decision form and check the box requesting continuing benefits by:
    a. The tenth day following the date of the notice of adverse benefit determination or the notice of appeal resolution.
    b. The effective date of the action proposed in the notice, if applicable.
3. If at the member's request EOCCO continues or reinstates the member's benefits while the appeal is pending the benefits must be continued until one of the following occurs:
    a. The member withdraws the contested case hearing; or
    b. The member does not request a contested case hearing within 10 days calendar days from the date of the Notice of Appeal Resolution; or
    c. A final Contested Case Hearing decision adverse to the member is issued.
4. EOCCO will pay for disputed services received by the enrollee while the appeal was pending, unless state policy and regulation provide for the state to cover the cost of such services, when the CCO or state fair hearing officer reverses a decision to deny authorization of the services. EOCCO continues the member's benefits when requested if the member or member's representative files the hearing time, within 10 calendar days after EOCCO mails the notice of appeal resolution or the intended effective date of EOCCO's proposed notice of appeal resolution. In addition the request must:
    a. Involve the termination, suspension, or reduction of a previously authorized course of treatment;
    b. Involve services that were ordered by an authorized provider;
    c. The member timely files for continuation of benefits,
    d. Pertain to the original period covered by the original authorization that has not expired; and
    e. Include the member's request for extension of benefits.
    f. The member's right to the continuation of benefits pending an

administrative hearing:

g. If the member or their representative requests that EOCCO continue or reinstates their benefits while the appeal is pending and

h. The notice of appeal resolution is adverse to the member, the benefits continue pending the administrative hearing.

i. If the member received the disputed services while the appeal was pending, EOCCO pays for the services per the plan provisions.

D. Contested Case Hearing

1. The administrative law judge (ALJ) sends confirmation of the hearing along with the exhibit profile before the commencement of the hearing. EOCCO arranges the following:
    a. Reserves a telephone capable conference room.
    b. Schedules the medical/dental consultant to be present if the hearing involves medical or dental necessity.
2. An ALJ assigned from the state panel conducts and controls the hearing.
3. The ALJ conducts the hearing to include the following:
    a. Presentation by the OHA representative on the scope of the hearing and the issues to be addressed.
    b. Statement by the member
    c. Presentation by EOCCO on the appeal issues and reason for benefit determination
    d. Any rebuttal evidence
    e. Closing arguments
4. The ALJ, EOCCO, OHA, and the member or an authorized representative may question witnesses.
5. The hearing may be continued with recesses as determined by the ALJ.
6. Exhibits are marked and maintained by the ALJ as part of the record of the proceedings.
7. The ALJ makes an audio or stenographic record of the telephone hearing. EOCCO or the member may request a copy of the audio or stenographic record from the OHA representative.
8. Final orders
    a. The ALJ issues a final order, or the case is otherwise resolved by OHA, ordinarily within 90 days from the date the member requested an appeal (not including the number of days the Medicaid member took to subsequently file for the hearing, or the date the Medicaid member filed for direct access to an OHA hearing). The final order is the final decision of OHA.

b. The final order is in writing and states the action taken by the ALJ as a result of the facts found and the citation of the statutes under which the decision was reached.

c. The final order is signed by the ALJ.

d. The final order is served to each party.

e. If the final order reverses EOCCO's decision, EOCCO promptly requests an authorization or adjustment be completed up to the limit of the original request or authorization, retroactive to the date the action was taken, even if the member has lost eligibility after the date the action was taken. If the service have not been furnished, EOCCO will authorize the services as expeditiously as the member's health condition requires but no later than 72 hours from the date the notice is received from OHA, per OAR 410-141-3910. EOCCO will also:

    i. Notify the member, the member's representative (if applicable) both orally and in writing and the member's provider in writing of the available services and how to access them;

    ii. Enter the prior authorization into the system or adjust the encounter data claim representing the service.

f. If the final order upholds EOCCO's decision, EOCCO may recover the cost of the services furnished to the member while the hearing was pending in accordance with OHA general rule 410-120-1860 or OAR 410-141-3890 PHP's appeal procedures.

g. When the ALJ reverses the CCO's decision to deny authorization of services, MCE can file written exceptions or present argument to the Proposed and Final Order within ten working days after the date the Proposed Order is issued by the ALJ (see OAR 410-120-1860). If written exceptions are filed, the Order does not become a Final Order on the 11th work day and the services shall not be provided until the Final Order is issued by OHA. Once a Final Order is issued and if the decision remains overturned the services shall be authorized or provided to the member within 72 hours of the MCE receiving the Final Order.

h. EOCCO sends the ALJ final order to the subcontracted dental plan as necessary.

E. Statement of Confidentiality

1. All information and documentation received or created by EOCCO that includes protected health information (PHI) shall be maintained in a confidential manner in accordance with state and federal privacy laws. EOCCO will provide member assurance of confidentiality in all written, oral and posted material in grievance and appeal processes. If PHI is to be used for purposes other than as required for treatment, payment and/or operations, or as required by federal or state law, an authorization is obtained from the individual.

F. Logging/Reporting/Storage

1. Documentation of closed hearings are scanned and stored for a minimum of 7 years. The hearing request is logged into the processing system with the following information:
    a. All prior information necessary for the appeal
    b. Date the hearing was filed at EOCCO
    c. Date of Hearing
    d. Nature of hearing
    e. Continuing benefits were requested
    f. Continuing benefits provided
    g. Final order of the hearing (no show, not hearable, member withdrew, plan overturned prior to hearing, ALJ affirmed decision, ALJ overturned decision)

G. Contracts and handbooks
    1. EOCCO informs providers and subcontractors, at the time they enter into a contract, about the enrollee's right to request continuation of benefits that the CCO seeks to reduce or terminate during an appeal or state fair hearing filing, if filed within the allowable timeframes, although the enrollee may be liable for the cost of any continued benefits while the appeal or state fair hearing is pending if the final decision is adverse to the enrollee.
    2. EOCCO informs providers and subcontractors, at the time they enter into a contract, about:
        a. Enrollee grievance, appeal, and fair hearing procedures and timeframes as specified in 42 CFR 438.400 through 42 CFR 438.424 and described in the EOCCO Medicaid Member Grievances and Appeals Policy.
        b. The enrollee's right to file grievances and appeals and the requirements and timeframes for filing.
        c. The availability of assistance to the enrollee with filing grievances and appeals.
    3. EOCCO makes its written materials that are critical to obtaining services, including, at a minimum, provider directories, enrollee handbooks, appeal and grievance notices, and denial and termination notices available in the prevalent non-English languages in its particular service area. EOCCO provides information to members regarding the following: Member rights and responsibilities
    4. EOCCO provides information to members regarding the following:
        a. An explanation of how MCEs shall accept, process, and respond to grievances, appeals, and contested case hearing requests;
        b. Member rights and responsibilities; and
        c. How to file for a hearing through the state's eligibility hearings unit related to the member's current eligibility with OHP.

5. EOCCO utilizes an enrollee handbook approved by the state that:
    a. Includes the enrollee's right to file grievances and appeals.
    b. Includes the requirements and timeframes for filing a grievance or appeal.
    c. Includes information on the availability of assistance in the filing process for grievances.
    d. Includes information on the availability of assistance in the filing process for appeals.
    e. Includes the enrollee's right to request a state fair hearing after the CCO has made a determination on an enrollee's appeal which is adverse to the enrollee.
    f. Specifies that, when requested by the enrollee, benefits that the CCO seeks to reduce or terminate will continue if the enrollee files an appeal or a request for state fair hearing within the timeframes specified for filing, and that the enrollee may, consistent with state policy, be required to pay the cost of services furnished while the appeal or state fair hearing is pending if the final decision is adverse to the enrollee.

H. Reporting and Evaluation
    1. EOCCO reports the resolution of all closed OHA hearings to the EOCCO Quality Improvement Committee quarterly. EOCCO QIC reviews the reports, analyze issues raised by members and their resolution, and makes recommendations for improvement as necessary. Annually, a summary of the EOCCO grievance system results are presented to the EOCCO Governance Board.

IV. Related Policies & Procedures, Forms and References

A. 42 CFR 438.400 through 42 CFR 438.424
B. EOCCO Medicaid Member Grievances and Appeals Policy
C. OAR 410-120-1860
D. OAR 410-141-3890
E. OAR 410-141-3900
F. OAR 410-141-3905
G. OAR 410-141-3910
H. OAR 410-141-3915

V. Affected Departments:

A. Medicaid Services
B. Quality Programs

Attachments

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Approval Signatures

Step Description	Approver	Date
EOCCO QIC Policy Subcommittee	Becky Miller: GOBHI Policy Analyst	04/2024
	Mica Shattuck: Supervisor, Appeals & Grievances	04/2024

Applicability

EOCCO

References

Behavioral Health, Dental, Healthcare Services, Medical, Pharmacy, Submit to OHA upon material change, Submit to OHA within 5 business days of request