

Nursing Facility Provider Manual — internal appeal, external medical review, and state fair hearing processes

Effective May 1, 2022, Medicaid members will have the option of an external medical review in addition to a state fair hearing for medical appeals. These updates to the *Nursing Facility Provider Manual* give information about the external medical review and state fair hearing processes and also include other updates to our internal appeal process.

Chapter 2 *Quick Reference – Member medical appeal information-* address for submitting written appeals is changed to:

**Amerigroup Appeals
P.O. Box 62429
Virginia Beach, VA 23466-2429**

Section 8.2 *Member Rights and Responsibilities – Member Rights, item 5, is revised as follows:*

5. You have the right to use each available complaint and appeal process through the managed care organization and through Medicaid, and get a timely response to complaints, appeals, external medical reviews and state fair hearings. That includes the right to:
 - a. Make a complaint to your health plan or to the state Medicaid program about your health care, your provider, or your health plan.
 - b. Get a timely answer to your complaint.
 - c. Use the plan's appeal process and be told how to use it.
 - d. Ask for an external medical review and state fair hearing from the state Medicaid program and get information about how that process works.
 - e. Ask for a state fair hearing without an external medical review from the state Medicaid program and get information about how that process works.

Chapter 9 *Complaints, Appeals and Provider Disputes - sections are updated as follows:*

9.1.3 Member Medical Appeal Process and Procedures

Amerigroup has established and maintains a system for resolving dissatisfaction with actions regarding the denial or limitation of coverage of health care services filed by a member or a provider acting on behalf of a member. This process is called a member appeal.

Note: Medical appeals do not apply to nonmedical issues. Nonmedical concerns are classified as complaints.

<https://provider.amerigroup.com/TX>

Amerigroup members in the Medicaid Rural Service Area and the STAR Kids program are served by Amerigroup Insurance Company; all other Amerigroup members in Texas are served by Amerigroup Texas, Inc.

What can I do if the MCO denies or limits my member's request for a covered service?

Medicaid Appeal Process — the following language or similar information describing the appeals process appears in our member handbook:

What can I do if my doctor asks for a service or medicine for me that's covered but Amerigroup denies it or limits it?

There may be times when Amerigroup says we will not pay for all or part of the care that has been recommended. You have the right to ask for an appeal. An appeal is when you or your designated representative asks Amerigroup to look again at the care your doctor asked for and we said we will not pay for. A designated representative can be a family member, your provider, an attorney, a friend or any person you choose.

If you ask someone (a designated representative) to file an appeal for you, you must also send a letter to Amerigroup to let us know you have chosen a person to represent you. Amerigroup must have this written letter to be able to consider this person as your representative. We do this for your privacy and security.

You can appeal our decision orally or in writing:

- You can call Member Services at **800-600-4441 (TTY 711)**.
- You can send us a letter or the request form included with our decision letter to:

Amerigroup Appeals
P.O. Box 62429
Virginia Beach, VA 23466-2429

How will I find out if services are denied?

If we deny services, we will send you a letter at the same time the denial is made.

What are the time frames for the appeals process?

You or a designated representative can file an appeal. You must do this within 60 days of the date of the first letter from Amerigroup saying we will not pay for or cover all or part of the recommended care.

When we get your letter or call, we will send you a letter within five business days. This letter will let you know we got your appeal. We will also let you know if we need any other information to process your appeal. Amerigroup will contact your doctor if we need medical information about the service.

A doctor who has not seen the case before will look at your appeal. He or she will decide how we should handle the appeal.

We will send you a letter with the answer to your appeal. We will do this within 30 calendar days from when we get your appeal unless we need more information from you or the person you

asked to file the appeal for you. If we need more information, we may extend the appeals process for 14 days if the delay is in your best interest. If we extend the appeals process, we will let you know in writing the reason for the delay. You may also ask us to extend the process if you know more information that we should consider.

How can I continue receiving services that were already approved?

You have 60 days to file an appeal from the date of the decision letter. To continue receiving services that have already been approved by Amerigroup but may be part of the reason for your appeal, you must file a request for continuation of benefits on or before the later of:

- Ten days after we send the notice to you to let you know we will not pay for or cover all or part of the care.
- The date the notice says the service will end.

If the decision on your appeal upholds our first decision, you may be asked to pay for the services you received during the appeals process.

If the decision on your appeal reverses our first decision, Amerigroup will pay for the services you received while your appeal was pending.

Can someone from Amerigroup help me file an appeal?

Yes, a member advocate or Member Services representative can help you file an appeal with Amerigroup or with the appropriate state program. Please call Member Services toll-free at **800-600-4441 (TTY 711)**.

Can members request an external medical review and state fair hearing?

Yes, you can ask for an external medical review and state fair hearing after the Amerigroup internal appeal process is complete. Your request must be made within 120 days of the date of our appeal decision letter. An external medical review cannot be requested without a state fair hearing but you can withdraw your request for the hearing after you get the external medical review decision.

Can members request a state fair hearing only?

Yes, you can ask for a state fair hearing without an external medical review after the Amerigroup internal appeal process is complete. Your request must be made within 120 days of the date of our appeal decision letter.

9.1.4 Emergency Medical Appeals

An emergency medical appeal will be performed when appropriate. A member can request an emergency medical appeal in cases where time expended in the standard resolution could

jeopardize the member's life, health or ability to attain, maintain or regain maximum function. An emergency medical appeal concerns a decision or action by Amerigroup that relates to:

- Health care services including but not limited to procedures or treatments for a member with an ongoing course of treatment ordered by a health care provider, the denial of which, in the provider's opinion, could significantly increase the risk to a member's health or life.
- A treatment referral, services, procedure or other health-care service that if denied could significantly increase risk to a member's health or life.

The following language or similar information appears in our member handbooks:

What is an emergency appeal?

An emergency appeal is when the health plan has to make a decision quickly based on the condition of your health and taking the time for a standard appeal could jeopardize your life or health.

How do I ask for an emergency appeal? Does my request have to be in writing?

You or the person you ask to file an appeal for you can request an emergency appeal. You can request an emergency appeal orally or in writing.

- You can call Member Services at **800-600-4441 (TTY 711)**.
- You can send us a letter or the request form included with our decision letter to:
Amerigroup Appeals
P.O. Box 62429
Virginia Beach, VA 23466-2429

What are the time frames for an emergency appeal?

After we get your letter or call and agree your request for an appeal should be expedited, we will call and send you a letter with the answer to your appeal. We will do this within 72 hours from receipt of your appeal request.

If your appeal relates to an ongoing emergency or hospital stay, we will call you with an answer within one business day or 72 hours, whichever is shorter. We will also send you a letter with the answer to your appeal within 72 hours.

What happens if Amerigroup denies the request for an emergency appeal?

If we do not agree that your request for an appeal should be expedited, we will call you right away. We will send you a letter within two calendar days to let you know how the decision was made and that your appeal will be reviewed through the standard review process.

Who can help me file an emergency appeal?

A member advocate or Member Services representative can help you file an emergency appeal. Please call Member Services toll-free at **800-600-4441 (TTY 711)**.

9.1.5 State Fair Hearing and External Medical Review Information

Can a member ask for a state fair hearing?

If a member, as a member of the health plan, disagrees with the health plan's internal appeal decision, the member has the right to ask for a state fair hearing. The member may name someone to represent them by contacting the health plan in writing and giving the name of the person the member wants to represent him or her. A provider may be the member's representative. The member or the member's representative must ask for the state fair hearing within 120 days of the date on the health plan's letter that tells of the decision being challenged. If the member does not ask for the state fair hearing within 120 days, the member may lose his or her right to a state fair hearing. To ask for a state fair hearing, the member or the member's representative should send a letter to the health plan at:

Amerigroup State Fair Hearing/EMR Coordinator
P.O. Box 62429
Virginia Beach, VA 23466-2429

Or call Member Services at **800-600-4441 (TTY 711)**.

If the member asks for a state fair hearing within 10 days from the time the health plan mails the appeal decision letter, the member has the right to keep getting any service the health plan denied, at least until the final hearing decision is made. If the member does not request a state fair hearing within 10 days from the time the health plan mails the appeal decision letter, the service the health plan denied will be stopped.

If the member asks for a state fair hearing, the member will get a packet of information letting the member know the date, time, and location of the hearing. Most state fair hearings are held by telephone. At that time, the member or the member's representative can tell why the member needs the service the health plan denied.

HHSC will give the member a final decision within 90 days from the date the member asked for the hearing.

Can a member ask for an external medical review?

If a member, as a member of the health plan, disagrees with the health plan's internal appeal decision, the member has the right to ask for an external medical review. An external medical review is an optional, extra step the member can take to get the case reviewed for free before the state fair hearing. The member may name someone to represent him or her by writing a letter to the health plan telling the MCO the name of the person the member wants to represent him or her. A provider may be the member's representative if the provider is named as the member's

authorized representative. The member or the member's representative must ask for the external medical review within 120 days of the date the health plan mails the letter with the internal appeal decision. If the member does not ask for the external medical review within 120 days, the member may lose his or her right to an external medical review. To ask for an external medical review, the member or the member's representative should either:

- Fill out the *State Fair Hearing and External Medical Review Request Form* provided as an attachment to the member notice of MCO internal appeal decision letter and mail or fax it to Amerigroup by using the address or fax number at the top of the form;
- Call Amerigroup at **800-600-4441 (TTY 711)**.

If the member asks for an external medical review within 10 days from the time the health plan mails the appeal decision letter, the member has the right to keep getting any service the health plan denied, based on previously authorized services, at least until the final state fair hearing decision is made. If the member does not request an external medical review within 10 days from the time the health plan mails the appeal decision letter, the service the health plan denied will be stopped.

The member, the member's authorized representative, or the member's LAR may withdraw the member's request for an external medical review before it is assigned to an Independent Review Organization or while the Independent Review Organization is reviewing the external medical review request. The member, the member's authorized representative, or the member's LAR must submit the request to withdraw the external medical review using one of the following methods: 1) in writing, via United States mail, email, or fax; or 2) orally, by phone or in person. An Independent Review Organization is a third-party organization contracted by HHSC that conducts an external medical review based on functional necessity or medical necessity. An external medical review cannot be withdrawn if an Independent Review Organization has already completed the review and made a decision.

Once the external medical review decision is received, the member has the right to withdraw the state fair hearing request. If the member continues with the state fair hearing, the member can also request the Independent Review Organization be present at the state fair hearing. The member can make both of these requests by contacting Amerigroup at **800-600-4441 (TTY 711)** or the HHSC Intake Team at EMR_Intake_Team@hhsc.state.tx.us.

If the member continues with a state fair hearing and the state fair hearing decision is different from the Independent Review Organization decision, it is the state fair hearing decision is final. The state fair hearing decision can only uphold or increase member benefits from the Independent Review Organization decision.

Can a member ask for an emergency external medical review?

If a member believes that waiting for a standard external medical review will seriously jeopardize the member's life or health, or the member's ability to attain, maintain, or regain maximum function, the member or member's representative may ask for an emergency external

medical review and emergency state fair hearing by writing or calling Amerigroup. To qualify for an emergency external medical review and emergency state fair hearing, the member must first complete the Amerigroup internal appeals process.

9.1.6 Medicaid Continuation of Benefits

Amerigroup members may request a continuation of their benefits during the medical appeal process by contacting Amerigroup Member Services at **800-600-4441 (TTY 711)**. To ensure continuation of currently authorized services, the member (or person acting on behalf of the member) must file an appeal with continuation of benefits request by the later of:

- Ten days following the date Amerigroup sends the notice of adverse benefit determination.
- The intended effective date of the adverse benefit determination as stated in the letter.

Amerigroup will continue the member's coverage of benefits if all the following conditions are met:

- The member or the member's representative files the appeal timely (within 60 days of the date of the initial notice of adverse benefit determination).
- The appeal involves the termination, suspension or reduction of previously authorized services.
- The services were ordered by an authorized provider.
- The period covered by the original authorization has not expired.
- The member or the member's representative timely requests continuation of benefits as defined in the previous paragraph.

If, at the member's request, Amerigroup continues or reinstates the benefits while the appeal is pending, the benefits will be continued until one of the following occurs:

- The member withdraws the appeal or request for the state fair hearing.
- Ten days pass after Amerigroup mails the appeal determination letter unless the member has, within the 10 days, requested a state fair hearing with continuation of benefits either with or without an external medical review.
- A State Fair Hearing Officer issues a hearing decision adverse to the member.

The member may be responsible for the continued benefits if the final determination of the appeal or state fair hearing is not in his or her favor. If the final determination of the appeal or state fair hearing is in the member's favor, Amerigroup will authorize coverage of and arrange for disputed services as expeditiously as the member's health condition requires but no later than 72 hours after receipt of notice reversing the determination. If the final determination is in the member's favor and the member received the disputed services, Amerigroup will pay for those services.