Ohio Administrative Code

Rule 5160-26-08.4 Managed care: appeal and grievance system.

Effective: January 1, 2023

(A) This rule does not apply to MyCare Ohio plans as defined in rule 5160-58-01 of the Administrative Code.

(B) Notice of action (NOA) by a managed care organization (MCO) or the single pharmacy benefit manager (SPBM).

(1) When an adverse benefit determination has occurred or will occur, the MCO or SPBM shall provide the affected member with a NOA.

(2) The language and format of the NOA shall comply with the requirements listed in 42 CFR 438.10 (October 1, 2021), and the NOA shall explain:

(a) The adverse benefit determination the MCO or SPBM has taken or intends to take;

(b) The reasons for the adverse benefit determination, including the right of the member to be provided, upon request and free of charge, reasonable access to copies of all documents, records, and other relevant determination information;

(c) The member's right to file an appeal to the MCO or SPBM;

(d) Information related to exhausting the MCO or SPBM appeal process;

(e) The member's right to request a state hearing through the state's hearing system upon exhausting the MCO or SPBM appeal process;

(f) Procedures for exercising the member's rights to appeal the adverse benefit determination;

(g) Circumstances under which expedited resolution is available and how to request it;

(h) If applicable, the member's right to have benefits continue pending the resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay for the cost of these services; and

(i) The date the notice is issued.

(3) NOAs shall be issued within the following time frames:

(a) For a decision to deny or limit authorization of a requested service the MCO or SPBM shall issue a NOA simultaneously with the MCO or SPBM's decision.

(b) For reduction, suspension, or termination of services prior to the member receiving the services previously authorized by the MCO or SPBM, the MCO or SPBM shall give notice at least fifteen calendar days before the effective date of the adverse benefit determination except:

(i) If probable recipient fraud has been verified, the MCO or SPBM shall give notice five calendar days before the effective date of the adverse benefit determination.

(ii) Under the circumstances set forth in 42 CFR 431.213 (October 1, 2021), the MCO or SPBM shall give notice on or before the effective date of the adverse benefit determination.

(c) For denial of payment for a non-covered service, the MCO or SPBM shall give notice simultaneously with the MCO or SPBM's determination to deny the claim, in whole or part, for a service not covered by medicaid, including a service determined through the MCO or SPBM's prior authorization process as not medically necessary.

(d) For untimely prior authorization, appeal, or grievance resolution, the MCO or SPBM shall give notice simultaneously with the MCO or SPBM becoming aware of the untimely resolution. Service authorization decisions not reached within the time frames specified in rule 5160-26-03.1 of the Administrative Code constitutes a denial and is thus considered to be an adverse benefit determination. Notice shall be given on the date the authorization decision time frame expires.

(C) Grievances.

(1) A member may file a grievance with the MCO or SPBM orally or in writing at any time. An authorized representative must have the member's written consent to file a grievance on the member's behalf.

(2) The MCO or SPBM shall acknowledge the receipt of each grievance to the member filing the grievance. Oral acknowledgment by the MCO or SPBM is acceptable. If the grievance is filed in writing, written acknowledgment shall be made within three business days of receipt of the grievance.

(3) The MCO or SPBM shall review and resolve all grievances as expeditiously as the member's health condition requires. Grievance resolutions, including member notification, shall meet the following time frames:

(a) Within two business days of receipt if the grievance is regarding access to services.

(b) Within thirty calendar days of receipt for non claims-related grievances except as specified in paragraph (C)(3)(a) of this rule.

(c) Within sixty calendar days of receipt for claims-related grievances.

(4) At a minimum, the MCO or SPBM shall provide oral notification to the member of a grievance resolution. If the MCO or SPBM is unable to speak directly with the member, or the resolution includes information that must be confirmed in writing, the resolution shall be provided in writing simultaneously with the MCO or SPBM's resolution.

(5) If the MCO or SPBM's resolution to a grievance is to uphold the denial, reduction, suspension, or termination of a service or billing of a member due to the MCO or SPBM's denial of payment for that service, the MCO or SPBM shall notify the member of his or her right to request a state hearing as specified in paragraph (G) of this rule, if the member has not previously been notified.

(D) Standard appeals.

(1) A member, a member's authorized representative, or a provider may file an appeal orally or in writing within sixty calendar days from the date that the NOA was issued. An oral appeal filing must be followed with a written appeal. The MCO or SPBM shall:

(a) Immediately convert an oral appeal filing to a written appeal on behalf of the member; and

(b) Consider the date of the oral appeal filing as the filing date.

(2) Any provider acting on the member's behalf shall have the member's written consent to file an appeal. The MCO or SPBM shall begin processing the appeal upon receipt of the written consent.

(3) The MCO or SPBM shall acknowledge receipt of each appeal to the member filing the appeal. At a minimum, acknowledgment shall be made in the same manner the appeal was filed. If an appeal is filed in writing, written acknowledgment shall be made by the MCO or SPBM within three business days of receipt of the appeal.

(4) The MCO or SPBM shall provide the member reasonable opportunity to present evidence and allegations of fact or law, in person as well as in writing, and inform the member of this opportunity sufficiently in advance of the resolution time frame. Upon request, the member and/or member's authorized representative shall be provided, free of charge and sufficiently in advance of the resolution time frame, the case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon or generated by the MCO or SPBM, or at the direction of the MCO or SPBM, in connection with the appeal of the adverse benefit determination.

(5) The MCO or SPBM shall consider the member, the member's authorized representative, or an estate representative of a deceased member as parties to the appeal.

(6) The MCO or SPBM shall review and resolve each appeal as expeditiously as the member's health condition requires, but the resolution time frame shall not exceed fifteen calendar days from the receipt of the appeal unless the resolution time frame is extended as outlined in paragraph (F) of this rule.

(7) The MCO or SPBM shall provide written notice of the appeal's resolution to the member, and to the member's authorized representative if applicable. At a minimum, the written notice shall include the resolution decision and date of the resolution.

(8) For appeal resolutions not resolved wholly in the member's favor, the written notice to the member shall also include the following information:

(a) The right to request a state hearing through the state's hearing system;

(b) How to request a state hearing; and if applicable:

(i) The right to continue to receive benefits pending a state hearing;

(ii) How to request the continuation of benefits; and

(iii) If the adverse benefit determination is upheld at the state hearing, the member may be liable for the cost of any continued benefit.

(c) Oral interpretation is available for any language;

(d) Written translation is available in prevalent non-English languages as applicable;

(e) Written alternative formats may be available as needed; and

(f) How to access interpretation and translation services as well as alternative formats that can be provided by the MCO or SPBM.

(9) For appeal resolutions decided in favor of the member, the MCO or SPBM shall:

(a) Authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires, but no later than seventy-two hours from the appeal resolution date, if the services were not furnished while the appeal was pending.

(b) Pay for the disputed services if the member received the services while the appeal was pending.

(E) Expedited appeals.

(1) The MCO and SPBM shall establish and maintain an expedited review process to resolve appeals when the member requests and the MCO or SPBM determines, or the provider indicates in making the request on the member's behalf or supporting the member's request, that the standard resolution time frame could seriously jeopardize the member's life, physical or mental health or ability to attain, maintain, or regain maximum function.

(2) In utilizing an expedited appeal process, the MCO and SPBM shall comply with the standard appeal process specified in paragraph (D) of this rule, except the MCO and SPBM shall:

(a) Determine within one business day of the appeal request whether to expedite the appeal resolution;

(b) Make reasonable efforts to provide prompt oral notification to the member of the decision to expedite or not expedite the appeal resolution;

(c) Inform the member of the limited time available for the member to present evidence and allegations of fact or law in person or in writing;

(d) Resolve the appeal as expeditiously as the member's health condition requires, but the resolution time frame shall not exceed seventy-two hours from the date the MCO or SPBM received the appeal unless the resolution time frame is extended as outlined in paragraph (F) of this rule;

(e) Make reasonable efforts to provide oral notice of the appeal resolution in addition to the required written notification; and

(f) Ensure punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal.

(3) If the MCO or SPBM denies a member's request for expedited resolution of an appeal, the MCO

or SPBM shall:

(a) Transfer the appeal to the standard resolution time frame of fifteen calendar days from the date the appeal was received unless the resolution time frame is extended as outlined in paragraph (F) of this rule;

(b) Make reasonable efforts to provide the member prompt oral notification of the decision not to expedite, and within two calendar days of the receipt of the appeal, provide the member written notice of the reason for the denial, including information that the member can grieve the decision.

(F) Grievance and appeal resolution extensions.

(1) A member may request the time frame for the MCO or SPBM to resolve a grievance or a standard or expedited appeal be extended up to fourteen calendar days.

(2) The MCO or SPBM may request the time frame to resolve a grievance or a standard or expedited appeal be extended up to fourteen calendar days. The following requirements apply:

(a) The MCO or SPBM shall seek such an extension from ODM prior to the expiration of the standard or expedited appeal or grievance resolution time frame;

(b) The MCO or SPBM request shall be supported by documentation of the need for additional information and that the extension is in the member's best interest; and

(c) If ODM approves the extension, the MCO or SPBM shall make reasonable efforts to provide the member prompt oral notification of the extension and, within two calendar days, provide the member written notice of the reason for the extension and the date by which a decision shall be made.

(3) The MCO and SPBM shall maintain documentation of any extension request.

(G) Access to state's hearing system.

(1) Except as set forth in paragraph (G)(2) of this rule, and in accordance with 42 CFR 438.402

(October 1, 2021), members may request a state hearing only after exhausting the MCO or SPBM's appeal process. If the MCO or SPBM fails to adhere to the notice and timing requirements for appeals set forth in this rule, the member is deemed to have exhausted the appeal process and may request a state hearing.

(2) In accordance with rule 5160-20-01 of the Administrative Code, members proposed for enrollment or currently enrolled in the coordinated services program (CSP) are afforded state hearing rights in accordance with division 5101:6 of the Administrative Code and are not subject to the requirement of first appealing to the MCO.

(3) When required by paragraph (D)(8) of this rule, and in accordance with division 5101:6 of the Administrative Code, the MCO or SPBM shall notify members, and any authorized representatives on file with the MCO or SPBM, of the right to a state hearing subject to the following requirements:

(a) If an appeal resolution upholds the denial of a request for the authorization of a service, in whole or in part, the MCO or SPBM shall simultaneously issue the "Notice of Denial of Medical Services By Your Managed Care Entity" (ODM 04043).

(b) If an appeal resolution upholds the decision to reduce, suspend, or terminate services prior to the member receiving the services as previously authorized by the MCO or SPBM, the MCO or SPBM shall issue the "Notice of Reduction, Suspension or Termination of Medical Services By Your Managed Care Entity" (ODM 04066).

(c) If the MCO or SPBM learns a member has been billed for services received by the member due to the MCO or SPBM's denial of payment, and the MCO or SPBM upholds the denial of payment, the MCO or SPBM shall immediately issue the "Notice of Denial of Payment for Medical Services By Your Managed Care Entity" (ODM 04046).

(4) The member or member's authorized representative may request a state hearing within ninety calendar days from the date of an adverse appeal resolution by contacting the ODJFS bureau of state hearings or local county department of job and family services (CDJFS).

(5) There are no state hearing rights for a member terminated from the MCO pursuant to an MCO-

initiated membership termination in accordance with rule 5160-26-02.1 of the Administrative Code.

(6) Following the bureau of state hearing's notification to the MCO or SPBM that a member has requested a state hearing, the MCO or SPBM shall:

(a) Complete the "Appeal Summary for Managed Care Entity" (ODM 01959) with appropriate supporting attachments, and file it with the bureau of state hearings at least three business days prior to the scheduled hearing date. The appeal summary shall include all facts and documents relevant to the issue, in accordance with rule 5160-26-03.1 of the Administrative Code, and be sufficient to demonstrate the basis for the MCO or SPBM's adverse benefit determination;

(b) Send a copy of the completed ODM 01959 to the member and the member's authorized representative, if applicable, the CDJFS, and the designated ODM contact; and

(c) If benefits were continued through the appeal process in accordance with paragraph (H)(1) of this rule, continue or reinstate the benefit(s) if the MCO or SPBM is notified that the member's state hearing request was received within fifteen days from the date of the appeal resolution.

(7) The MCO or SPBM shall participate in the state hearing, in person or by telephone, on the date indicated on the "Notice to Appear for a Scheduled Hearing" (JFS 04002) sent by the bureau of state hearings.

(8) The MCO or SPBM shall comply with the state hearing decision provided via the "State Hearing Decision" (JFS 04005). If the state hearing decision sustains the member's appeal, the MCO or SPBM shall submit the information required by the "Order of Compliance" (JFS 04068) to the bureau of state hearings. The information, including applicable supporting documentation, is due to the bureau of state hearings and the designated ODM contact by no later than the compliance date specified in the hearing decision. If applicable, the MCO or SPBM shall:

(a) Authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires, but no later than seventy-two hours from the date it receives notice reversing the adverse benefit determination if services were not furnished while the appeal was pending.

(b) Pay for the disputed services if the member received the services while the appeal was pending.

(H) Continuation of benefits while an appeal or state hearing are pending.

(1) Unless a member requests that previously authorized benefits not be continued, the MCO or SPBM shall continue a member's benefits when all the following conditions are met:

(a) The member requests an appeal within fifteen days of the MCO or SPBM issuing the NOA;

(b) The appeal involves the termination, suspension, or reduction of services prior to the member receiving the previously authorized services;

(c) The services were ordered by an authorized provider; and

(d) The authorization period has not expired.

(2) If the MCO or SPBM continues or reinstates the member's benefits while the appeal or state hearing are pending, the benefits shall be continued until one of the following occurs:

(a) The member withdraws the appeal or the state hearing request;

(b) The member fails to request a state hearing within fifteen days after the MCO or SPBM issues an adverse appeal resolution; or

(c) The bureau of state hearings issues a state hearing decision upholding the reduction, suspension or termination of services.

(3) If the final resolution of the appeal or state hearing upholds the MCO or SPBM's original adverse benefit determination, at the discretion of ODM, the MCO or SPBM may recover the cost of the services furnished to the member while the appeal and/or state hearing was pending.

(I) Additional provisions regarding appeals and grievances.

(1) The MCO and SPBM shall give members all reasonable assistance filing a grievance, an appeal, or a state hearing request including but not limited to:

(a) Explaining the MCO or SPBM's process to be followed in resolving the member's appeal or grievance;

(b) Completing forms and taking other procedural steps as outlined in this rule; and

(c) Providing oral interpretation and oral translation services, sign language assistance, and access to the appeals and grievance system through a toll-free number with text telephone yoke (TTY) and interpreter capability.

(2) The MCO and SPBM shall ensure the individuals who make decisions on appeals and grievances are individuals who:

(a) Were neither involved in any previous level of review or decision-making nor a subordinate of any such individual; and

(b) Are health care professionals who have the appropriate clinical expertise in treating the member's condition or disease if deciding any of the following:

(i) An appeal of a denial based on lack of medical necessity;

(ii) A grievance regarding the denial of an expedited resolution of an appeal; or

(iii) An appeal or grievance involving clinical issues.

(3) In reaching an appeal resolution, the MCO and SPBM shall take into account all comments, documents, records, and other information submitted by the member or their authorized representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.