Appeals Procedures

Medical Necessity Appeals of Non-Certification Determinations

Medicaid

Standard Medical Necessity Appeals of Non-Certification Determinations
An appeal is defined as a formal request by a member or provider, including facilities or other health care entities on behalf of a member or provider for a review of a determination or action. Medical necessity appeals of non-certification determinations must be submitted to CareSource within 180 calendar days of the original denial date. Medical necessity appeals filed by members or providers on behalf of a member with written authorization to appeal on their behalf in writing will be resolved within 30 calendar days of receipt or as expeditiously as the member's condition warrants.

Medical necessity appeals of non-certification determinations must be submitted to CareSource within 180 calendar days of the original denial date.

Expedited Appeals
An expedited appeal request may be a verbal request and should be submitted to our Medical Management Department by calling **1-800-390-7102** and following the appropriate menu prompts **within 10 days of the date of the determination.**

The member's authorized representative or a provider acting on the member's behalf may request an expedited clinical appeal when taking the time for a standard appeal resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. An oral filing must be followed with a written appeal. The member's authorized representative or a provider acting on the member's behalf must have the member's written consent to file an appeal. CareSource will begin processing the appeal pending receipt of the written consent. CareSource will make a determination within one working day of the expedited appeal request to expedite the appeal resolution. CareSource will make reasonable efforts to provide prompt verbal notification to the member of the decision to expedite or not expedite the appeal resolution. This attempt will be made by phone. If the member is in a facility, the provider or facility will be notified on the same business day of the decision. The member will be informed of the limited time available for presentation of evidence and allegations of fact or law in person or in writing.

The member and provider will be notified in writing of the determination to process as a standard appeal within two calendar days of receipt of the appeal, including information that the member can grieve the decision.

In the event that CareSource denies the request for an expedited appeal, the appeal will be resolved within the MDCH-mandated timeframes for a standard appeal.

Expedited appeals will be resolved and verbal notification will be made within 72 hours of receipt of the appeal or as expeditiously as the medical condition requires unless the resolution timeframe is extended.

CareSource will verbally notify the provider/facility of the appeals resolution if the member is in an inpatient setting. CareSource will send written notification to both the provider and member on the same business day of the decision.

Expedited appeals are not tolled. Any request for an expedited appeal that is not approved will be processed as a standard appeal. The member will receive notice within two business days of that decision not to expedite the request.

A member can verbally request that CareSource extend the timeframe to resolve a standard or expedited appeal up to 14 calendar days. CareSource may request that the timeframe to resolve a standard or expedited appeal be extended up to 14 calendar days. CareSource must submit documentation that the extension is in the member's best interest to MDCH for prior approval. If MDCH approves the extension, CareSource must immediately give the member written notice of the reason for the extension and the date that a decision must be made.

Submitting a Member Clinical Appeal

If the member is dissatisfied with any medical necessity decision made by CareSource, we offer one level of appeal. Members have the right to an Administrative Hearing as a first or second level of appeal. Members are provided with the necessary information via the initial denial notification.

Provider Clinical Appeal

MDCH identifies a Provider Clinical Appeal as one that is filed by the provider without the member's involvement, and the provider only communicates directly with the Plan. In addition, the provider has not contacted the member regarding the adverse action, nor has the member contacted the Plan regarding the adverse action. Provider pre-service appeals will be resolved (e.g. written notification of the appeal decision is issued) within 14 calendar days. Provider post-service appeals will be resolved (e.g., written notification of the appeal decision is issued) within 30 calendar days.

You can now submit appeals through our secure Provider Portal on our website at **https://providerportal.caresource.com/MI/**.

*You can now submit appeals through our secure Provider Portal on our website at **https://providerportal.caresource.com/MI/**.*

To submit an appeal in writing please use the Provider Claim Appeal Request Form located in this manual. Please include:

- The member's name, CareSource member ID number and date of birth
- The provider's name and CareSource provider billing number
- The place, date and type of service that had a non-certification determination
- The reason why the determination should be reconsidered
- Any additional available medical information to support your reasons for reversing the determination

The Appeals Department may request additional information from you to document medical necessity. All clinical appeal requests and associated information are reviewed by clinicians previously uninvolved with the case. You will be notified in writing of the outcome of your appeal request.

Please submit appeal requests in writing by mailing or faxing to:

CareSource
Attn: Provider Appeals
P.O. Box 2008
Dayton, OH 45401-2008

Fax: (937) 531-2398

Appeals of Claims Denials or Adverse Decisions *(Medicaid and Medicare)*
An adverse decision regarding payment for a claim for services rendered to a CareSource member can be appealed if the request for an appeal is made within 365 days of the date of service or discharge. If the appeal is denied, providers will be notified in writing. If the appeal is approved, payment will show on the providers Explanation of Payment (EOP).

Written Appeals
Please use the Provider Claim Appeal Request Form located in this manual. Please include:

- The member's name and CareSource member ID number
- The provider's name and ID number
- The code/s and reason why the determination should be reconsidered
- If submitting a Timely Filing appeal, you must send proof of original receipt of the appeal by fax or EDI for reconsideration
- If the appeal is regarding a clinical edit denial, the appeal must have all the supporting documentation as to the justification of the edit

Please submit written appeal requests by mailing or faxing to:

CareSource
Attn: Provider Appeals
P.O. Box 2008
Dayton, OH 45401-2008

Fax: (937) 531-2398

Medicare

Member, Provider or Provider Appealing on Behalf of a Member
Standard Medical Necessity Appeals of Non-Certification Determinations
For appeals on behalf of the member please refer to the CareSource Advantage Member's Evidence of Coverage. The Evidence of Coverage is located on our website at **www.caresource.com**. Search Evidence of Coverage.

Level 1: Appeal – Reconsideration

A member starts the appeal process by making an appeal. It is called the first level of appeal or a Level 1 Appeal.

The member contacts CareSource and makes the appeal. If their health requires a quick response, they must ask for a fast appeal. To start an appeal the member, their representative, or in some cases their doctor must contact CareSource. Appeal request must be within 60 calendar days from the date on the written notice sent concerning a coverage decision. If the member wishes, their doctor may give additional information to support the appeal.

A standard appeal must be in writing and completed within 30 calendar days after being received by CareSource.

A fast appeal is also called an expedited appeal. An expedited appeal can be a verbal or written request and must be completed within 72 hours after being received by CareSource

Level 2: Independent Review Entity – IRE

If CareSource says no to the Level 1 Appeal, the case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, the Independent Review Organization reviews the decision made during the first appeal. This organization decides whether the decision made should be changed.

Step 1: The Independent Review Organization reviews the appeal. The Independent Review Organization is an outside independent organization that is hired by Medicare. This organization is not connected with CareSource and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work. CareSource will send information about the appeal to this organization. This information is called the "case file." The member has the right to ask for a copy of the case file. The member has a right to give the Independent Review Organization additional information to support their appeal. Reviewers at the Independent Review Organization will take a careful look at all of the information related to the appeal.

If there was a "fast" appeal at Level 1, there will also be a "fast" appeal at Level 2.

Level 3: Administrative Law Judge – ALJ

The notice received from the Independent Review Organization will tell the member in writing if the case meets the requirements for continuing with the appeals process. For example, to continue and make another appeal at Level 3, the dollar value of the medical care coverage being requested must meet a certain minimum. If the dollar value of the coverage being requested is too low, the member cannot make another appeal, which means that the decision at Level 2 is final.

Level 4: The Medicare Appeals Council

The Medicare Appeals Council will review the member's appeal and give the member an answer. The Medicare Appeals Council works for the Federal government.

If the member's Level 4 appeal is approved, or if the Medicare Appeals Council denies CareSource's request to review a favorable Level 3 Appeal decision, the appeals process *may* or *may not* be over. CareSource will decide whether to appeal this decision to Level 5. Unlike a decision at Level 2 (Independent Review Organization), CareSource has the right to appeal a Level 4 decision that is favorable to the member. If CareSource decides *not* to appeal the decision, CareSource must authorize or provide the member with the service within 60 days after receiving the Medicare Appeals Council's decision. If CareSource decides to appeal the decision, CareSource will let the member know in writing.

If the member's Level 4 appeal is denied or if the Medicare Appeals Council denies the review request, the appeals process *may* or *may not* be over. If the member decides to accept this decision, the appeals process is over. If the member does not want to accept the decision, the member might be able to continue to the next level of the review process. If the Medicare Appeals Council says no to the member's appeal, the notice the member receives will tell the member whether the rules allow the member to go on to a Level 5 Appeal. If the rules allow the member to go on, the written notice will also tell the member who to contact and what to do next if the member choose to continue with the next level of review.

Level 5: A Judge at the Federal District Court

A judge at the Federal District Court will review your appeal if permitted based on the Level 4 response. This is the last stage of the appeals process.