Chapter 10
Grievances and Appeals

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Grievances and Appeals

The regulations for grievances and appeals are outlined in COMAR 10.09.36. This chapter of the provider manual describes the process for complying with COMAR regulations. A grievance is a request made for review of a previous medical necessity determination that resulted in non-authorization of a service request. A participant or a provider/advocate, with participant’s consent, may request a grievance.

10.1. Definitions

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<th>TERM</th>
<th>DEFINITION</th>
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<td>Administrative or Technical Denial</td>
<td>Failure to meet administrative requirements set forth by the Public Behavioral Health System (PBHS) and the BHA such as not following the rules of pre-authorization of services or not requesting continued authorization for existing services before the last authorized day of service.</td>
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<td>Appeal</td>
<td>A formal process available to Medicaid recipients to request the OAH to review the decision.</td>
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<td>Care Manager</td>
<td>A behavioral health professional responsible for reviewing, coordination, and approving the mental health treatment of individuals served by the Maryland PBHS.</td>
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<td>Clinical Service Non-Authorization</td>
<td>A determination by a Beacon Maryland Physician Advisor that the behavioral health service requested is not medically necessary.</td>
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<td>Complaint</td>
<td>An expression of dissatisfaction with some aspect of the Maryland PBHS.</td>
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<td>Grievance</td>
<td>A process available to Medicaid recipients and uninsured eligible individuals to request a re-review of a non-authorization of requested services for reasons of medical necessity.</td>
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<td>Non-Urgent Request</td>
<td>A request for continued acute inpatient services or any other service level other than a request for pre-authorization of an acute inpatient admission.</td>
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<td>Participant</td>
<td>A Maryland Medicaid recipient, uninsured eligible individual, or the participant’s legal guardian who requests behavioral health services. For this chapter of the provider manual, a parent of the child is considered the participant.</td>
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<td>Physician Advisor</td>
<td>A board-certified psychiatrist who reviews authorization requests and performs medical necessity determinations.</td>
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<td>Reconsideration</td>
<td>A reconsideration for a clinical service non-authorization due to a lack of medical necessity is a request for a peer-to-peer review between the provider and a Beacon Maryland Physician Advisor. This is available to the provider when the initial non-authorization of service was conducted without the benefit of a peer-to-peer review. A reconsideration for an administrative denial is a submission of documentation from the provider evidencing that the denial was made due to an error by Beacon.</td>
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10.2. Initial Review and Reconsideration Process

The initial review of an authorization request is performed by a Beacon Care Manager. A Care Manager is responsible for reviewing authorization requests. If a Care Manager cannot authorize services based on the information provided in ProviderConnect or submitted by phone, then the Care Manager will request additional information from the provider. When all of the necessary information is present the Care Manager will either authorize the service or suggest an alternate level of care. If the Care Manager denies the service request and is unable to negotiate an alternate level of care the case will be referred to the Beacon Maryland Medical Director or Physician Advisor.

The Beacon Medical Director or Physician Advisor will review the authorization request and make a decision to approve or deny the request based on the medical necessity criteria for that service.

A provider, participant or advocate may request reconsideration in the event that the service is not authorized. A provider is eligible for reconsideration if the authorization denial was done without the benefit of a peer-to-peer review.

A reconsideration request must be made within 3 business days of the date on the initial denial notification letter. Beacon will make the reconsideration decision within 24 hours or by the close of the next business day from when the reconsideration was received. If the decision to not authorize a service request is upheld, then Beacon will verbally notify the provider. If the reconsideration results in an overturn of the denial, the provider will be notified verbally and a letter will be sent to the provider and participant.

10.3. Grievances

GRIEVANCE REVIEW LEVEL 1 – BEACON HEALTH OPTIONS

If the provider or participant continues to disagree with the decision regarding authorization requests, they can ask that another Beacon Physician Advisor review the service request as a Grievance Review Level 1. A letter will be sent to the participant and provider regarding the decision after the Grievance Review Level 1.

Grievance Review Level 1 Time Frames

A Grievance Review Level 1 must be filed within 10 business days of the initial decision or completion of the reconsideration process. Grievance Review Level 1 determinations will be made by Beacon within 24 hours or by the close of the next business day for expedited (fast) urgent requests and five calendar days for a non-urgent request.

Direct contact with the provider or participant is required to make a timely decision. If the provider is not available during the allotted timeframe, the provider or participant may put the request on hold for up to
72 hours. Beacon may request documentation from the treatment record when the submitted information is unclear or incomplete.

If the Beacon Physician Advisor concludes that services are medically necessary, Beacon will authorize the request and forward a Grievance Review Level 1 authorization letter to the participant and provider within three calendar days. The authorization will also be available via ProviderConnect. If the Beacon Physician Advisor concludes that medical necessity criteria is not met and non-authorization is appropriate, Beacon will inform the provider of the decision by telephone. A Grievance Review Level 1 non-authorization letter will be to the participant and provider within three calendar days.

To submit a Grievance Review Level 1 case, you can:

- Fax: 877-381-5571
- Mail to:
  Beacon Health Options
  ATTN: Grievances and Appeals Department
  1099 Winterson Road, Suite 200
  Linthicum, MD 21090

GRIEVANCE REVIEW LEVEL 2 – BEHAVIORAL HEALTH ADMINISTRATION (BHA)

If the participant or provider continues to disagree with the outcome of the Grievance Review Level 1 process the case can be submitted to the Grievance Review Level 2 process.

Limitations

Grievance Review Level 2 submissions will not be reviewed if the claim was denied due to an administrative denial as outlined in section 10.5 of this chapter.

Submission Requirements

Submissions to Grievance Review Level 2 are only considered when they are deemed complete. All of the following documents are required before the grievance will be considered complete:

- The Grievance Submission Form with all sections completed. The form is available at http://maryland.beaconhealthoptions.com/provider/forms/admin/BHA-Appeal-Form.pdf
- Beacon Health Options Remittance Report evidencing the completion of Grievance Review I;
- Grievance Response from Beacon Health Options
- Claim Denial information associated with the grievance process at Beacon Health Options;
- The patient’s CMS 1500 or UB04 form; and
- The patient’s medical record for the date(s) in question including admission and discharge note.

Failure to include the required documents or properly complete the submission form may result in significant delay or denial to review the case.

BHA’s review process may include input from the Core Service Agency (CSA) and/or Local Addictions Authority (LAA). BHA will notify the provider and participant, in writing, of the outcome. BHA is the final authority for participants who are uninsured eligible. Medicaid recipients will be informed by BHA of their rights to appeal to the OAH.
To submit a Grievance to BHA you can:

- Fax: 410-402-8441
- Mail to:
  Behavioral Health Administration
  ATTN: Administrative Grievances
  Spring Grove Hospital – DIX Building
  55 Wade Avenue
  Catonsville, MD 21228

10.4. Appeals

A provider or participant may request a hearing at the Office of Administrative Hearings (OAH) at any time within 90 days from receipt of the notification of denial. The OAH is the final authority with regards to decisions about Medicaid services. Further information is available in COMAR 10.01.04. A request for a Medical Assistance Fair Hearing shall be made to:

Office of Administrative Hearings
11101 Gilroy Road
Hunt Valley, MD 21031-1301
Phone: 410-229-4100
Fax: 410-229-4111

10.5. Administrative Denials

An administrative denial means the claim is denied due to one of the reasons below:

- The provider fails to obtain a pre-authorization.
- The timely filing requirements are not met.
- Services are provided by a provider who is not participating in the primary coverage carrier’s network.
- The participant is not a Medicaid beneficiary.
- The participant does not meet uninsured eligibility requirements.

A provider can request a reconsideration of an administrative denial within 90 days of the initial notification of the denial. If your organization believes this administrative denial has resulted from an error, technical or otherwise made by Beacon Health Options, then feel free to call customer service at 1-800-888-1965, reference the inquiry number on the denial letter and discuss the technical error within 30 days from the date of the administrative denial notice.

Reconsideration for failure to obtain a pre-authorization are only eligible for submission if the participant has retroactive Medical Assistance.

10.5. Complaints

To report your dissatisfaction with some aspect of the Maryland PBHS, you can:

- Call to: 800.888.1965 or TTY 866.835.2755
- Fax to: 877.381.5571
- Email to: grievances@beaconhealthoptions.com
- Mail to:
  Beacon Health Options, Inc.
  ATTN: Complaints Department
  1099 Winterson Road, Suite 200
  Linthicum, MD  21090

If you include your name and address Beacon will confirm receipt of your complaint within 5 days and a letter informing you of the resolution status of your complaint within 30 days. If you are not satisfied with the resolution you may request a resolution review. Instructions for this will be included with the resolution letter.