

**STANDARD OPERATING PROCEDURES MANUAL**

**FOR**

**INPATIENT PSYCHIATRIC AND**

**DETOXIFICATION SERVICES**

**CONCURRENT REVIEW**

**Department of Vermont Health Access**

**Vermont Agency of Human Services**

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**Table of Contents**

I. Introduction.....Page 3

II. Criteria for Inpatient Hospitalization.....Page 3

III. Admission Process

- Children and Adolescents.....Page 4
- Adults Ages 18 – 22 at Brattleboro Retreat.....Page 4
- Adults Ages 18 and Over Out-of-State.....Page 5
- Adults Admitted for Medically Managed Detoxification.....Page 5
- Involuntary Admissions.....Page 5

IV. Concurrent Review

- Procedure.....Page 6
- Secondary Review.....Page 7
- Awaiting Placement Days.....Page 7
- Retrospective Review.....Page 8

V. Appeal of Payment Denial.....Page 9

VI. Inter-Rater Reliability.....Page 9

VII. Attachments

- Attachment 1: Mental Health 24 Hour Emergency Services.....Page 11
- Attachment 2: OVHA Child and Adolescent Inpatient  
Notification Form.....Page 12
- Attachment 3: OVHA Non-CRT Adults Age 18-21  
Admission to Brattleboro Retreat  
Admission Form.....Page 14
- Attachment 4: Vermont Medicaid Admission Notification  
Form for Out-Of-State Inpatient Facility  
Psychiatric Inpatient Services.....Page 16
- Attachment 5: Medicaid Payment Secondary Review Request.....Page 17
- Attachment 6: OVHA Appeals Process for Patients and Families....Page 18

## **I. Introduction**

Acute inpatient mental health treatment is the most intensive level of psychiatric care. Treatment is provided in a 24-hour secure and protected, medically staffed environment with a multimodal approach. The goal of the inpatient stay is to stabilize the individual who is experiencing an acute psychiatric condition with a relatively sudden onset, severe course, or a marked decompensation due to a more chronic condition.

“Detoxification” means the planned withdrawal of an individual from a state of acute or chronic intoxication, under qualified supervision and with or without the use of medication.

Detoxification is monitoring and management of the physical and psychological effects of withdrawal, for the purpose of assuring safe and rapid return of the individual to normal bodily and mental function. (Vermont Statutes, Title 33 §702). Inpatient detoxification refers to the medically managed treatment regimen used to support the withdrawal of the addictive substance.

This manual describes processes to be followed by the Department of Vermont Health Access (DVHA) when the following Medicaid primary populations are hospitalized on a psychiatric floor or in a psychiatric inpatient facility:

- Children and adolescents to age 18 (excluding Community & Rehabilitation Services [CRT] enrollees)
- Adults ages 18 – 22 at the Brattleboro Retreat (excluding VHAP covered beneficiaries and CRT)
- Adults in facilities outside the State of Vermont (excluding Border Hospitals and CRT)
- Adults admitted for medically managed detoxification services to a psychiatric unit or psychiatric facility.

## **II. Criteria for Inpatient Hospitalization:**

To ensure that mental health services are provided at an appropriate level of care and within the appropriate utilization of resources the DVHA has adopted the LOCUS (adults) and CALOCUS (children & adolescents) instruments for determining authorization for psychiatric inpatient level of care.

The LOCUS and CALOCUS guidelines represent a resource efficient evidenced based approach to the management of inpatient admissions and continued length of stay. The CALOCUS provides a framework for defining the appropriate intensity of services and resources to meet the needs of children and adolescents. The instrument is a method of quantifying the clinical severity and service needs of three quite different populations of children and adolescents. It may be used in children with psychiatric disorders, substance use disorders, or developmental disorders.

The LOCUS is an instrument that is sufficiently sensitive to distinguish appropriate needs and services. It provides clear, reliable, and consistent measures that are succinct, but sufficient to make care or quality monitoring judgments.

To ensure that the medically managed detoxification services are provided at an appropriate level of care and with the appropriate utilization of resources, the DVHA has adopted the American Society of Addiction Medicine (ASAM) Patient Placement Criteria for the Treatment of Substance-Related Disorders for determining authorization for inpatient level of care.

The ASAM Patient Placement Criteria represents a resource efficient evidenced based approach to the management of inpatient admissions and continued length of stay.

For the specific cases of eating disorders, the DVHA will also utilize the APA Level of Care Guidelines for Patients with Eating Disorders

<http://www.psychiatryonline.com/content.aspx?aID=138866#139460>).

### **III. Admission Process:**

#### **Children and Adolescents to Age 18 (excluding CRT)**

Youth whose primary insurance is Vermont Medicaid are screened by designated staff from the local Community Mental Health Center (CMHC) prior to being admitted to a psychiatric inpatient facility (*Attachment 1*). The purpose of screening prior to an inpatient admission is for continuity of care, identification of intervention strategies, and appropriate determination for involuntary hospitalization. This would include assessment for less restrictive alternatives and review of any existing crisis plan for the youth. An inpatient psychiatric admission may be recommended or supported by the CMHC screener when:

- The youth is in need of hospitalization based on admission criteria, and
- Community and support system resources are exhausted, and
- A less restrictive alternative is not available

CMHC screeners are provided with an initial screening form that includes a list of available resources that must be contacted in order to make decisions related to appropriate level of care and treatment options (*Attachment 2*). This admission data form must be faxed to the Department of Vermont Health Access (DVHA) by the next business day following an admission and reflects inpatient criteria met, as well as alternatives considered and reasons for ruling them out. The CMHC screener also arranges for transportation and admission to a psychiatric inpatient facility.

Children and adolescents who are out-of-state at the time of the admission will be screened by the admitting facility. All emergent and urgent admissions will require notification to the DVHA within 24 hours or the next business day of admission. All elective admissions will require notification prior to admission. The admitting facility will fax to the DVHA the *Vermont Medicaid Admission Notification Form for Out-of-State Hospital Psychiatric Inpatient Services (Attachment 4)* (<http://ovha.vermont.gov/for-providers/forms-1>).

#### **Adults Ages 18 – 22 to the Brattleboro Retreat (excluding VHAP covered beneficiaries and CRT)**

Adults ages 18 – 22 whose primary insurance is Vermont Medicaid must be screened by designated staff from the local CMHC prior to being admitted to the Brattleboro Retreat. The

purpose of screening prior to an inpatient admission is for continuity of care, identification of intervention strategies, and appropriate determination for involuntary hospitalization. This would include assessment for less restrictive alternatives and review of any existing crisis plan. An inpatient psychiatric admission may be recommended or supported by the CMHC screener when:

- The individual is in need of hospitalization based on admission criteria, and
- Community and support system resources are exhausted, and
- A less restrictive alternative is not available

CMHC screeners are provided with an initial screening form that includes a list of available resources that must be contacted in order to make decisions related to appropriate level of care and treatment options (*Attachment 3*). This admission data form must be faxed to the Department of Vermont Health Access (DVHA) following an admission and reflects inpatient criteria met, as well as alternatives considered and reasons for ruling them out. The CMHC screener also arranges for transportation and admission to the Brattleboro Retreat.

#### Adults Ages 18 and Over to an Out-of-State Facility (excluding CRT)

Adults whose primary insurance is Vermont Medicaid admitted to an out-of-state facility for psychiatric inpatient services will be screened by the admitting facility. All emergent and urgent admissions will require notification to the DVHA within 24 hours or the next business day of admission. All elective admissions will require notification prior to admission. The admitting facility will fax to the DVHA the *Vermont Medicaid Admission Notification Form for Out-of-State Hospital Psychiatric Inpatient Services (Attachment 4)* (<http://ovha.vermont.gov/providers/forms-1>).

#### Adults Admitted to a Psychiatric Unit or Psychiatric Facility for Medically Managed Detoxification

All adults (ages 18 and over) whose primary insurance is Vermont Medicaid admitted to a psychiatric unit or psychiatric facility, both in-state and out-of-state, for medically managed detoxification services will be screened by the admitting facility. All emergent and urgent admissions will require notification to the DVHA within 24 hours or the next business day of admission. All elective admissions will require notification prior to admission. The DVHA Care Manager may be contacted at (802)879-8232 for notification and to begin the concurrent review process.

#### Involuntary Admissions

All involuntary admissions and court evaluations, regardless of provider or pay source, must be done by a Department of Mental Health Qualified Mental Health Professional (QMHP).

## **IV. Concurrent Review**

### **Procedure**

The admitting inpatient facility will contact the DVHA Concurrent Review Care Manager (CRCM) within 24 hours or the next business day of the admission to begin the concurrent review process. All reviews will be performed over the phone with additional documentation faxed to the DVHA upon request. Based on information provided, the DVHA CRCM will assign authorization in increments of 24 hours up to 7 days based upon the beneficiary's acuity level, unless extenuating circumstances exist and care providers agree to an exception. The DVHA CRCM will render an authorization decision to the inpatient facility within 24 hours or 1 business day of receipt of the clinical information. Upon determination that clinical criteria for inpatient level of care are no longer met, the DVHA CRCM will inform the inpatient facility of the last covered day. If the inpatient facility disagrees with this decision they may request a Secondary Review (see page 6). The DVHA will generate a payment authorization in the MMIS.

If, following completion of the medically managed detoxification process, the patient demonstrates evidence of significantly acute psychiatric co-morbidity requiring inpatient care, the inpatient facility will be responsible for ensuring that the continued inpatient care is billed using the appropriate diagnosis. The hospital must notify the DVHA CRCM of the request for continued inpatient stay on the last authorized day of the medically managed detoxification process. All admissions (excluding CRT) will continue the concurrent review process throughout the inpatient stay. For beneficiaries enrolled in the CRT program, the inpatient facility will contact the beneficiary's designated Community Mental Health Center for authorization.

The DVHA CRCM is available Monday – Friday, 7:45am – 4:30pm (excluding holidays). All decisions regarding payment authorization for nights, weekends and holidays will be made during regular business hours. Should the situation arise outside of the regular business hours in which the clinical presentation of a patient changes and additional days are needed, the inpatient facility will notify the DVHA CRCM on the next business day and provide the clinical justification for the additional days needed. Every effort will be made to render an authorization decision at that time, but no later than the end of the business day.

The CALOCUS and LOCUS instruments will be utilized in performing concurrent review and for assigning authorization for inpatient mental health services. The ASAM criteria will be utilized in performing concurrent review and for assigning authorization for medically managed detoxification. Any cases that do not meet criteria; or where there is a potential to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested will be referred to a health care professional who has appropriate clinical expertise in treating the member's condition or disease for determination. This would include currently licensed mental health professionals such as a LCSW, Licensed Psychologist, LCMHC or a physician. The DVHA will have in effect inter-rater reliability mechanisms to ensure consistent application of review criteria for concurrent review decisions.

### Secondary Review

In the event an inpatient facility requests payment authorization from the DVHA for a particular beneficiary and the DVHA denies payment authorization, the inpatient facility may request a secondary review by contacting the DVHA Quality Improvement Director. This process is not an appeals process; however, it does allow the providers to supply the DVHA with additional information. It is not a process for a review of the DVHA policy or for review of any decision other than a decision by the DVHA not to authorize payment for a particular beneficiary. Requests for a secondary review must be made no later than 14 days after the DVHA first gives notice, either written or verbal, to the inpatient facility that payment for that particular beneficiary will not be authorized beyond a certain date. The secondary review will consist of a review of current information, any new information, as well as documentation from the inpatient facility as to why they believe the DVHA should authorize payment in that particular case. All clinical data must be submitted within the 14-day notice period (*Attachment 5*).

Upon receipt of the request and all relevant, timely-submitted clinical information, the DVHA will undertake a good-faith review of the records in its possession, and the reasons supporting the provider's request for a secondary review. The inpatient facility may request a verbal discussion between clinicians involved in the care of the beneficiary and the DVHA clinical staff in order to further clarify the clinical information. The DVHA Quality Improvement Director, or their designee, will review the records, consider the discussion and undertake the reconsideration. This review may also include the DVHA Medical Director. The inpatient facility's physician and/or Medical Director may also request to speak with the DVHA Medical Director. This will be organized by the DVHA CRCM or the DVHA Quality Improvement Director and the conversation may include the inpatient facility physician and/or Medicaid Director, inpatient facility discharge planner, the DVHA Medical Director or his/her designee, the DVHA CRCM and the DVHA Quality Improvement Director. The DVHA will make its best efforts to notify the provider of its secondary review decision within 28 days of receipt of notice of the request. There is no additional review after the DVHA has made a decision on the secondary review, except in the sole discretion of the DVHA Division Director.

All requests for a secondary review must be addressed to:

DVHA Quality Improvement Director  
Office of Vermont Health Access  
312 Hurricane Lane, Suite 201  
Williston, VT 05495

### Awaiting Placement Days

Awaiting Placement days are those days approved at an acute inpatient facility when beneficiaries are awaiting placement to a lower level of care.

Procedure:

1. The DVHA Concurrent Review Care Manager (CRCM) will consult with the DVHA Quality Improvement Director (QID) when there is a potential delay in discharge due to the complicating factors of the case.
2. The DVHA CRCM will notify the Department of Mental Health (DMH), the Department of Disability, Aging and Independent Living (DAIL) or the Department for Children and Families (DCF) of the potential delay and request their assistance in the discharge planning, if deemed appropriate.
3. If necessary, the DVHA CRCM will request of the inpatient facility social worker that a phone conference be scheduled. Phone conferences are to include the DVHA CRCM, inpatient facility treatment team representatives, local treatment team representatives, DCF, DAIL or DMH as appropriate, and others as deemed necessary.
4. If a resolution to the discharge problem is not obtained after the phone conference, or a meeting was previously held between the inpatient facility and the parties responsible for discharge planning with no resolution, the inpatient facility may request a consultation with the DVHA Medical Director (or his designee), and others as deemed necessary, prior to the decision for awaiting placement status.
5. Subsequent team phone conferences for discharge planning may be scheduled as determined by the phone conference team.
6. The decision to change a beneficiary's level of care to awaiting placement status will be made when the patient no longer meets criteria for acute inpatient level of care based on the utilization of the CALOCUS, LOCUS or ASAM instrument for determining authorization. Awaiting placement status will be utilized only after the DVHA Medical Director (or his designee) has reviewed the case.
  - a. Upon specific request of the inpatient facility following the DVHA's decision, the DVHA Medical Director (or his designee) will coordinate a consultation with an appropriate specialist. The inpatient facility may request a three-way conversation with the DVHA Medical Director and the consultant.
7. The DVHA CRCM will notify the inpatient facility utilization reviewer no later than 24 hours or one business day prior to the change to awaiting placement status. Awaiting placement designation will not be assigned until such time.

The inpatient facility must initiate adequate placement efforts prior to the termination of acute care coverage and shall document such efforts and contacts. Once awaiting placement status begins the inpatient facility must continue placement efforts until placement occurs. The facility may be required to submit their documentation to the DVHA.

Retrospective Review

The DVHA will not perform retrospective reviews for the purpose of reviewing authorization decisions and recoupment of payments except in the case of material misrepresentation or fraud. Retrospective reviews will be performed in the case of a lack of notification to the DVHA of an admission.

## **V. Appeal of Payment Denial**

Vermont Medicaid beneficiaries may request an internal MCO appeal for any level-of-care DVHA Medicaid payment authorization decision that results in a denial or reduction of services. Appeals are made by telephone or in writing to DVHA (*Attachment 6*). An expedited appeal can be requested if a delay would adversely affect the beneficiary's health. An appeal occurs only after all means to come to agreement about the most appropriate course of treatment are exhausted. Appeal responses are issued in writing and state the reviewer's understanding of the issues under review, reference to the information used to make the determination and the clinical criteria used to render the decision. If a beneficiary disagrees with the decision from the appeal, they may ask the department that made the decision for a fair hearing. They have 90 days from the date of the original notice of decision or action, or 30 days from the date of an appeal decision, to ask for a fair hearing. The beneficiary may ask for both an appeal and a fair hearing at the same time, just an appeal, or just a fair hearing. They can also call the Office of Health Care Ombudsman at 1-800-917-7787 for help with any part of this process or for help in deciding what to do.

## **VI. Inter-Rater Reliability**

The DVHA will have in place inter-rater reliability mechanisms to ensure consistent application of review criteria for inpatient review decisions. All utilization reviewers, program administrators, or any designated staff responsible for authorization of psychiatric or detoxification inpatient services will complete the manuals and the Criteria Competency Training for use of the LOCUS and CALOCUS instruments as well as the ASAM PPC-2R manual prior to reviewing cases. The inter-rater reliability tool will be utilized to review staff on a quarterly basis for the first year of implementation of the concurrent review system. After the first year, yearly ratings will be completed except when an outlier is identified. If an outlier is identified, all staff as noted above will be reviewed quarterly until consistency is achieved. A minimum standard rating of 80% is expected. If after three quarters consistency is not achieved additional training will be provided to staff with a corrective action plan if deemed necessary. Any new hires will be reviewed quarterly for the first year.

For the review three sample cases will be given to each staff to rate using the LOCUS, CALOCUS, and ASAM instruments.

## VII. ATTACHMENTS

**MENTAL HEALTH 24 HOUR EMERGENCY SERVICES**

Clara Martin Center <i>(Orange County)</i>	(800) 639-6360
Counseling Service of Addison County <i>(Addison County)</i>	(802) 388-7641
Health Care and Rehabilitation Services of Southeastern VT <i>(Windham and Windsor Counties)</i>	(800) 622-4235
HowardCenter – First Call <i>(Chittenden County)</i>	(802) 488-7777
Lamoille County Mental Health Services <i>(Lamoille County)</i>	(802) 888-4635 <i>After Hours-</i> (802) 888-4231
Northeast Kingdom Human Services, Inc. <i>(Essex, Caledonia and Orleans Counties)</i>	<i>St. Johnsbury -</i> (802) 748-3181 <i>Newport-</i> (802) 334-6744
Northwestern Counseling and Support Services <i>(Franklin and Grand Isle Counties)</i>	(802) 524-6554
Rutland Mental Health Services <i>(Rutland County)</i>	(802) 775-1000
United Counseling Service <i>(Bennington County)</i>	<i>Manchester -</i> (802) 362-3950 <i>Bennington -</i> (802) 442-5491
Washington County Mental Health Services <i>(Washington County)</i>	(802) 229-0591

**DVHA Child & Adolescent**  
**Inpatient Admission Notification Form**

The following information and justification must be provided to the **Department of Vermont Health Access, (fax #802-879-5963)** at the time of the hospital admission:

- 1.) Admission date: \_\_\_\_\_ Admit facility \_\_\_\_\_
- 2.) Child/adolescent name: \_\_\_\_\_
- 3.) Address: \_\_\_\_\_
- 4.) SS#/Medicaid Unique ID: \_\_\_\_\_ Date of Birth \_\_\_\_\_
- 5.) Parent/guardian name: \_\_\_\_\_  
Parent/guardian consent on file? \_\_\_yes \_\_\_no  
DCF custody? \_\_\_yes \_\_\_no  
If in DCF custody, name of social worker assigned to case, district and telephone number  
\_\_\_\_\_
- 6.) CMHC active client? \_\_\_yes \_\_\_no
- 7.) Status: \_\_\_voluntary \_\_\_involuntary
- 8.) Referral source: \_\_\_\_\_
- 9.) Screener name: \_\_\_\_\_ CMHC: \_\_\_\_\_

- |   |  |
|---|--|
| 10.) Alternatives considered:                     | Name of person who refused admission and reason for refusal: |
| ___ The Baird Center<br>802-488-6600              | _____  |
| ___ Home Intervention<br>802-479-1339             | _____  |
| ___ Northeastern Family Institute<br>802-655-8833 | _____  |
| ___ Crisis Respite Beds                           | _____  |
| ___ Kinship care                                  | _____  |
| ___ In-home support                               | _____  |
| ___ Other (please specify)                        | _____  |

**(If no alternatives were considered, the reason must be clearly explained in item #11.)**

- 11.) Assessment narrative to include clinical justification that satisfies criteria for hospitalization:
  - Evidence of mental illness (previous diagnosis or need for diagnostic clarity)



**DVHA Non-CRT Adults Age 18 - 21**  
**Admission to Brattleboro Retreat Notification Form**

The following information and justification must be provided to the **Office of Vermont Health Access (fax #802-879-5963)** at the time of a hospital admission to **Brattleboro Retreat for non-CRT adults, ages 18 through 21:**

- 13.) Date of admission: \_\_\_\_\_
- 14.) Client name: \_\_\_\_\_
- 15.) Address: \_\_\_\_\_
- 16.) SS#/Medicaid Unique ID: \_\_\_\_\_ Date of Birth \_\_\_\_\_
- 17.) CMHC active client? yes no
- 18.) Status: voluntary involuntary
- 19.) Referral source: \_\_\_\_\_
- 20.) Screener name: \_\_\_\_\_ CMHC: \_\_\_\_\_

- |                                    |  |
|------------------------------------|--|
| 21.) Alternatives considered:      | Name of person who refused admission and reason for refusal: |
| _____ In-home support              | _____  |
| _____ Assist (488-6411)            | _____  |
| _____ Alternatives (463-1987)      | _____  |
| _____ Battelle House (442-5491)    | _____  |
| _____ Home Intervention (479-1339) | _____  |
| _____ Other                        | _____  |

(If no alternatives were considered, the reason must be clearly explained in #10.)

If hospitals that are closer to the patient's residence refused admission, complete the following as above:

- \_\_\_\_\_ CVMC \_\_\_\_\_
- \_\_\_\_\_ FAHC \_\_\_\_\_
- \_\_\_\_\_ RRMC \_\_\_\_\_
- \_\_\_\_\_ Windham Center \_\_\_\_\_

- 22.) Assessment narrative to include clinical justification that satisfies criteria for inpatient hospitalization:

- Evidence of mental illness (previous diagnosis or need for diagnostic clarity)
- Description of current and recent behavior(s) and level of dangerousness to self or others (i.e., violence, suicidal plan and means, disorganized thinking and/or functioning)
- Medical information (physical health, medications and compliance, complicating medical factors or medication issues)





**REQUEST FOR SECONDARY REVIEW OF INPATIENT PSYCHIATRIC SERVICES**  
**DEPARTMENT OF VERMONT HEALTH ACCESS**

This request must be submitted by the provider no later than 14 days after DVHA first gives notice, either written or verbal, to the inpatient facility that payment for that particular patient will not be authorized.

Date of Request:

Name of Provider:

Name of Patient:

Patient Medicaid ID Number:

Date of Admission:

Secondary Review Dates of Service:

Documented evidence that substantiates continued stay criteria must include:

1. A narrative signed by a clinical staff that provides a brief background of the case and the reasons why the provider believes DVHA should authorize payment.
2. Clinical data that supports the request for a secondary review. **Do not send the entire chart.**

The secondary review will consist of a review of current information, any new information, as well as documentation from the inpatient facility as to why they believe DVHA should authorize payment in that particular case. The inpatient facility may request a verbal discussion between clinicians involved in the care of the patient and DVHA clinical staff in order to further clarify the clinical information.

## **DVHA APPEALS PROCESS FOR PATIENTS AND FAMILIES**

(Excerpt from the DVHA Health Care Programs Handbook)

### **When You Don't Agree with an Action**

An “action” is one of the following:

- ❖ Denial or limit of a covered service or eligibility for service, including the type, scope or level of service;
- ❖ Reduction, suspension or termination of a previously approved covered service or a service plan;
- ❖ Denial, in whole or in part, of payment for a covered service;
- ❖ Failure to provide a clinically-indicated covered service, when the MCO provider is a DA/SSA;
- ❖ Failure to act in a timely manner when required by state rule;
- ❖ Denial of your request to obtain covered services from a provider who is not enrolled in Medicaid (note that the provider who is not enrolled in Medicaid cannot be reimbursed by Medicaid).

If you don't agree with an action, you may ask for that action to be reviewed. If the Department of Vermont Health Access made the decision, you can ask Member Services for your appeal or fair hearing (described below) by calling 1-800-250-8427, or writing to the address below. Call the customer service number on the back of your employer-sponsored insurance plan ID card for information about how to appeal a decision made by that plan.

Health Access Member Services  
Department of Vermont Health Access  
101 Cherry Street, Suite 320  
Burlington, VT 05401

### **Appeal**

Appeals are heard by a qualified person who did not make the original decision. You have 90 days from the decision date to ask the department that made the decision for an appeal. Your provider may ask for the appeal if you wish. In most cases we try to make a decision in 30 days, however it can take up to 45 days. You and the state can also request up to 14 more days but only if it might help you (for example, your provider needs more time to send information or you can't get to a meeting or appointment in the original time frame). The longest it will ever take is 59 days for a decision to be made.

If your need for the denied benefit is an emergency, you may ask for an **expedited**

**appeal.** If it is decided that your appeal is an emergency, you will get a decision within three working days. If you are told your benefit is changed because of a change in a federal or state law, you may not ask for an appeal but may ask for a fair hearing.

## **Fair Hearing**

If you disagree with the decision from the appeal, you may ask the department that made the decision for a fair hearing. You have 90 days from the date of the original notice of decision or action, or 30 days from the date of an appeal decision to ask for a fair hearing. **At a fair hearing, you may represent yourself or ask a lawyer, a relative, a friend, or other spokesperson to represent you. Your Choice:** You may ask for both an appeal and a fair hearing at the same time, just an appeal, or just a fair hearing. When a Fair Hearings is requested, the first hearing will be scheduled between 7 and 30 days. Federal rules say that your fair hearing will be resolved within 90 days of the date you asked for an appeal or for a fair hearing, whichever comes first. However this timeframe is often longer in order to get more information or review new information. Fair hearings generally end up taking several months.

## **Continuation of Benefits**

If a benefit has been ended or reduced based on your individual situation and you have asked for an appeal or a fair hearing :

- ❖ depending on when you requested an appeal or fair hearing, you may ask for the benefit to continue until your appeal or hearing is decided. If you paid for your benefits, you will be paid back the amount you paid if the appeal or hearing is decided in your favor. If the State paid for the continuing benefits and the denial is upheld, you may have to pay the cost of any benefits you get while the appeal was pending.
- ❖ you need to ask for continuing benefits at the same time you request the appeal and/or fair hearing from Member Services (phone number and address on page 23).
- ❖ the service cannot continue if your appeal or hearing is about a benefit that has ended or been reduced because of a change in federal or state law.

If your fair hearing is about your premium, you must pay your premium by the premium due date or your coverage will end. You will be paid back the amount you over paid if the appeal or hearing is decided in your favor.



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