# INSTRUCTIONS FOR LOGGING MCO APPEALS

The MCO quarterly appeal log, F-02466, is the standard format managed care organizations (MCOs) must use to submit member appeal information to the Department of Health Services (DHS). Refer to the DHS-MCO or the DHS-PO contract for the report requirements, reporting periods, due dates, and submission email address.

## Personal Information

Under Wis. Stat. § 49.45(4), personally identifiable information is kept confidential and is only used for the direct administration of the Family Care, Family Care Partnership, and PACE programs.

## General Instructions

1. This is an annual appeal log divided by quarters. The MCO is to enter each quarterly report on the corresponding quarter tab. **Only enter information on the 1st Quarter, 2nd Quarter, 3rd Quarter and 4th Quarter tabs.** The spreadsheet will tabulate the data on the corresponding quarterly analysis tab.

2. **Do not make any changes to the spreadsheet layout or formulas except to enter appeal information**. Do not reorder the columns, change column labels, or dropdown options. Please submit any suggestions for categories or corrections to the report format to the Bureau of Quality Oversight (BQO).

3. There are several drop-down menus included in the spreadsheet. Some of these menus contain "other" as an available selection. If the MCO needs to select "other," add additional detail in the *Comments* column. **Note**: The narrative sections are limited to a maximum of 350 characters.

4. **Log <u>every</u> appeal the MCO becomes aware of, including:**
   - Internal MCO appeal
   - Division of Hearing and Appeals (DHA) request for state fair hearing
   - DHA request for rehearing

   **Even if the hearing is regarding a decision made by an agency other than the MCO (for example, Income Maintenance), please include the appeal on the log and provide as much information as the MCO has available**.

5. If a member filed an appeal (i.e., request for fair hearing or internal MCO appeal) but the appeal has not been resolved by the time the MCO submits the report, select Pending/In Process for the applicable columns. **If there is a resolution within the 45 day period for the submission of the report, update the appeal log to reflect this.**

## Instructions for Header:

1. **MCO Name (cell B3)**
   Enter the name of the MCO.

2. **Program (cell B4)**
   Enter the program (Family Care, Family Care Partnership, or PACE). If the MCO offers more than one program, complete a separate Appeal Log for each program.

3. **MCO Census on Last Date of Quarter (cell G2)**
   Enter the total number of members enrolled on the last day of the previous quarter.

## Instructions for Columns:

1. **Appeal # (column A):**
   Number individual appeals consecutively for ease of reference, starting with number 1 for the first appeal of the calendar year.

2. **Member Name (column B):**
   Enter member's name using the following format: **Last name, First name, Middle initial**. If necessary, you may need to add a full middle name to distinguish members.

3. **MCO ID (column C):**
   Enter the MCO's unique identifier. This column is optional for MCOs.

4. **Medicaid ID (column D):**
   Enter member's Medicaid ID.

5. **Target Group (column E):**
   Select an entry from the drop-down menu. If the person is in more than one target group, select the primary target group. Identify additional target groups in the *Comments* column.

6. **Appeal Type (column F):**
   Select an entry from the drop-down menu. **If the member files more than one type of appeal regarding the same issue, enter information about the subsequent appeal or appeals on separate lines** and select the appropriate appeal type on each line.
   - **DHA:** Request for fair hearing with the Division of Hearings and Appeals
   - **DHA - Rehearing:** Request for rehearing with the Division of Hearings and Appeals
   - **MCO:** Internal/Local MCO appeal

7. **Date Appeal Filed/Date of Appeal Notice (column G):**
   Enter the date using the following format: MM/DD/YYYY. Record the date according to appeal type:
   - **DHA**: Enter the date on the DHA Appeal Notice memo.
   - **DHA - Rehearing:** Enter the date of the scheduled rehearing
   - **MCO:** Enter the date the member requests an internal MCO appeal. If a member requests an internal MCO appeal both orally and in writing, enter the earlier of those two dates.

**8. Date MCO was Notified of DHA Appeal, if applicable (column H):**
Enter the date the MCO received the DHA appeal notice using the following format: MM/DD/YYYY.

**9. Continuing Benefits (column I)**
Select an entry from the drop-down menu:
- Select "yes" if benefits were continued.
- Select "no" if benefits were not continued.
- Select "N/A" if the appeal does not involve the reduction, suspension, or termination of a service.

**10. If Benefits Not Continued, Why? (column J)**
Select an entry from the drop-down menu:
- Member did not request continuation of services
- Member requested continuation of services, but the request was not timely
- Services to be continued were not ordered by an authorized provider
- The period covered by the original service authorization had expired
- Other - Explain briefly in the *Comments* column.
- N/A - The appeal does not involve the reduction, suspension, or termination of a service

**11. If Benefits Continued But Have Now Stopped, Why? (column K)**
Select an entry from the drop-down menu:
- Member withdrew appeal or subsequent request for fair hearing
- Member did not timely request a fair hearing after receiving an adverse resolution to the appeal
- For DHA hearings-Member continued services during MCO level appeal but did not timely request continuation of services during fair hearing
- DHA issued a hearing decision adverse to the Enrollee
- Other - explain briefly in the *Comments* column.
- N/A - Continued services have not stopped
- N/A - The appeal does not involve the reduction, suspension, or termination of a service

**12. Date MCO Appeal Acknowledged/Date DHA Summary Sent (column L):**
Enter the date using the following format: MM/DD/YYYY. Record the date according to appeal type:
- **Date MCO Appeal Acknowledged:** Enter the date **the MCO sent written acknowledgment to the member** of the request for an internal MCO appeal. (Each MCO must send a written acknowledgment of every request for internal MCO appeal to the member and/or member's representative within five business days of receiving the request.)
- **Date DHA Summary Sent:** If the MCO is the named party of the state fair hearing, **enter the date the "Summary of Action Leading to Appeal" was sent** to DHA.
    - **Note:** The MCO should log every request for fair hearing it is aware of; however, the MCO will not return a Summary of Action to DHA for every fair hearing request (for example, a summary is not returned if the issue is loss of financial eligibility) In these instances, enter "None" in this line.

**13. Assisting Representation (column M):**
Select an entry from the drop-down menu. You do not need to indicate when a family member, friend, neighbor, or provider is present with the member in this column.
- If the MCO would like to keep track of appeals in which a provider and/or the member's legal decision maker is present, select **"Other"** and add the information in the *Comments* column.

- Acronyms:
  - BOALTC: Board on Aging and Long Term Care
  - DBS: Disability Benefit Specialist
  - DRW: Disability Rights Wisconsin
  - EBS: Elder Benefit Specialist

**14. Issue Type (column N):**

Select an entry from the drop-down menu. Definitions for each Issue Type can be found in the table below:

| Issue Type | Definition |
|---|---|
| Denial of Enrollee's right to request out-of-network care | The denial of a member's request to receive out-of-network care for a resident of a rural area with only one managed care entity. |
| Denial, in whole or in part, of payment for a service already rendered | The denial, in whole or in part, of payment for a service that falls within the benefit package specified in Addendum VI of the MCO-DHS contract. |
| Failure to resolve appeal/grievance timely | The failure of the MCO to act within the standard and expedited timeframes in Article XI of the DHS-MCO contract regarding the resolution of appeals and grievances). |
| Failure to timely provide MCP service | The failure to provide MCP services in a timely manner. |
| Family Care start date | Appeal of start date of Family Care services due to delayed Family Care eligibility processing. |
| Financial liability | The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities. |
| Functional eligibility | The loss of functional eligibility as a result of the administration of the LTCFS, including a change in level of care to non-nursing home level of care. |
| Involuntary disenrollment | The decision to involuntarily disenroll the member from the MCO, Family Care or PACE. |
| Not appealable per DHS contract | The issue is not an appealable issue per the DHS-MCO contract. |
| Self-directed supports (SDS) - denied or limited | The denial of a member's request to self-direct a service or the limitation of a member's existing level of self-direction. |
| Service denial or limited authorization | The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. |
| Service reduction | The reduction of a previously authorized service, unless the service was only authorized for a limited amount or duration and that amount or duration has been completed. |
| Service suspension | The suspension of a previously authorized service, unless the service was only authorized for a limited amount or duration and that amount or duration has been completed. |
| Service termination | The termination of a previously authorized service, unless the service was only authorized for a limited amount or duration and that amount or duration has been completed. |

| | |
|---|---|
| State/Federal law change | The issue is related to a change in state or federal law. (Not appealable unless the Enrollee believes they do not fall in the category of enrollees affected by the change). |
| Unacceptable MCP | The development of a MCP that is unacceptable to the member because it 1) requires the member to live in a place that is unacceptable to the member, 2) does not provide sufficient care, treatment or support to meet the member's needs or outcomes, or 3) requires the member to accept care, treatment, or support items that are unnecessarily restrictive or unwanted by the member. |

**15. Service Category, if applicable (column O)**

Select an entry from the drop-down menu. Enter "N/A" if:

- The appeal does not involve a service; or
- The appeal involves a service, but the service is not a general inpatient service, general outpatient service, inpatient behavioral health service, or outpatient behavioral health service.
    - General Inpatient Services (FCP/ P only): Applies (only) to Family Care Partnership and PACE appeals.

**16. Service Type, if applicable (column P):**

Select an entry from the drop-down menu.

- If the service type is not listed in the drop-down, select **"Other"** and enter the service type into the *Summary of Issue* column.
- Enter "N/A" if the appeal does not involve a service.

Abbreviations:

- Acute/Primary Medical Services (FCP/P only): Applies (only) to Family Care Partnership and PACE appeals
- AODA: Alcohol and other drug abuse
- DME/DMS: Durable medical equipment/Durable medical supplies
- ONS: Oral Nutritional Supplement
- OT/PT/SLP: Occupational therapy/physical therapy/speech language pathology
- PC: Personal care
- SHC: Supportive home care
- SNF: Skilled nursing facility

**17. Summary of Issue (column Q):**

Briefly describe the adverse benefit determination the member is appealing. Include the service type (if applicable) and a narrative description of the issue. Entries are limited to 350 words.

**18. Date(s) of Formal or Informal Reviews or Meetings (column R):**

Enter the date(s) using the following format: MM/DD/YYYY. Record the date(s) of any formal or informal reviews or meetings related to the member's appeal. Provide a brief summary of reviews or meetings in the *Comments* column.

**19. Date of Resolution (column S):**

Enter the date the appeal was resolved using the following format: MM/DD/YYYY. Record the date according to appeal type:

- DHA Fair Hearings: Use the date the Administrative Law Judge (ALJ) signs the hearing decision, which is located on the last page of the decision.

- Internal MCO Appeal: Use the date of the **decision**. Do not use the date of the MCO Grievance and Appeal Committee **meeting** unless that happens to be the same as the date of the written decision. For appeals resolved by mediation, use the date the MCO believes the appeal to be resolved.

**Note**: Leave this column blank if the appeal is Pending/In Process

**20. Date Internal MCO Appeal Resolution Letter Sent, if applicable (column T)**

Enter the date using the following format: MM/DD/YYYY. Record the date the MCO Grievance and Appeal Committee mailed or hand delivered the written notice of its appeal decision to the member.

**21. Timely Resolution Provided by MCO (column U)**

Select an entry from the drop-down menu:

- Select **"yes - standard"** if written resolution of the member's appeal was provided to the member within the standard resolution timeframe.
- Select **"yes - standard-extended"** if written resolution of the member's appeal was provided to the member within the standard-extended resolution timeframe, and the MCO followed all applicable extension requirements.
- Select **"yes - expedited"** if written resolution of the member's appeal was provided to the member within the expedited resolution timeframe.
  Select **"yes - expedited-extended"** if written resolution of the member's appeal was provided to the member within the expedited-extended resolution timeframe and the MCO followed all applicable extension requirements.

- Select **"no - standard"** if written resolution of the member's appeal was not provided to the member within the standard resolution timeframe.
- Select **"no - standard-extended"** if written resolution of the member's appeal was not provided to the member within the standard-extended resolution timeframe and the MCO followed all applicable extension requirements.
- Select **"no - expedited"** if written resolution of the member's appeal was not provided to the member within the expedited resolution timeframe.
- Select **"no - expedited-extended"** if written resolution of the member's appeal was not provided to the member within the expedited-extended resolution timeframe and the MCO followed all applicable extension requirements.

For all "no" responses, provide a brief explanation for failing to meet the applicable deadline in the *Comments* column.

Note: Select **"Pending/In Process"** if a member filed an internal MCO appeal, but a decision has not been issued by the end of the quarter being reported. The pending status should be removed, and updated information should be entered in subsequent quarterly reports. If there is a resolution within the 45 day period for the submission of the report, update the Appeal Log to reflect this.

**22. Resolution Type (column V):**

Select an entry from the drop-down menu.

- Select **"DHA - upheld MCO decision/dismissed"** if the ALJ dismissed the appeal or upheld the MCO's decision regarding the adverse benefit determination in its entirety.

- Select **"DHA - overturned MCO decision/remanded"** if the ALJ overturned the MCO's decision regarding the adverse benefit determination in its entirety.
- Select **"DHA - partially upheld MCO decision/remanded"** or **"MCO Committee – partially upheld"** when the ALJ or MCO Committee has partially upheld the adverse benefit determination.
    - For example- A MCO Committee decides to partially uphold a service termination by allowing a limited amount or duration of a service rather than the full amount or duration desired by the member.
- Select **"MCO Committee - upheld"** if the MCO Committee upheld or maintained the adverse benefit determination in its entirety.
- Select **"MCO Committee - overturned"** if the MCO Committee overturned the adverse benefit determination in its entirety.
- Select **"Member withdrew"** when a member chooses to withdraw or not participate in the formal appeal process after the formal process has been initiated, such as in the following types of situations:
    - The member requested a withdrawal of theDHA fair hearing request or MCO internal appeal.
    - The member was absent from a scheduled DHA fair hearing, so the hearing was dismissed.
    - The MCO could not contact the member to process a request for internal appeal (for example, unable to reach a member to schedule a time with the MCO Grievance and Appeal Committee meeting).
- Select **"Mediation - resolved"** if the issue was informally resolved through internal MCO review, negotiation, or mediation.
- Select **"Member Did Not Pursue"** if the member did not pursue the formal appeal process and the appeal was not otherwise resolved. Select this option when:
    - The member did not timely submit required documents, such as an appeal request form.
    - The member chooses not to file a formal appeal after dissatisfaction with mediation.

  If known, include information in the *Comments* column to briefly explain why the member chose this option.
- Select **"Disenrolled"** if the member disenrolled. If known, include information in the *Reason for Disenrollment* column to briefly explain why the member disenrolled.

**Note:** Select **"Pending/In Process"** from the drop-down menu if a member filed an appeal (i.e., request for fair hearing, internal MCO appeal, or request for rehearing), but a decision has not been issued by the end of the quarter being reported. The pending status should be removed, and updated information should be entered in subsequent quarterly reports. If there is a resolution within the 45 day period for the submission of the report, update the Appeal Log to reflect this.

**23. Summary of Resolution/Reason for withdrawal (column W):**

Briefly describe the resolution of the member's appeal. This should be brief but provide sufficient information to be meaningful.

- **When a written formal resolution** is made by the MCO Grievance and Appeal Committee or the Administrative Law Judge renders a written decision, please include a brief synopsis of the decision maker's ruling and reasoning.
- **When the member withdraws the appeal request** and the MCO knows the reason why, indicate whether the MCO:
    - Changed its initial decision
    - Maintained its initial decision
- **If the appeal is resolved by informal mediation or negotiation**, describe the terms of that compromise or solution. Be specific in describing how the MCO responded or compromised

with the member rather than making a general statement like, "Member agreed with second assessment and withdrew." See examples below, which are brief but provide enough specificity to be meaningful.

**Examples of possible resolution summaries**:

- Member disenrolled from program and decided to join IRIS.
- IDT reversed its initial decision to reduce SHC hours from 20 to 10.
- IDT maintained its initial decision to reduce SHC hours from 20 to 10 but arranged for member to go to senior center two days/week to achieve an alternative that member was satisfied with.
- IDT conducted second in-home assessment and partially reversed its initial decision; initial assessment reduced member's SHC hours from 20 to 10 hours per week; second assessment reduced member's hours from 20 to 15 hours per week, and member thought her neighbor and adult daughter could make up the difference.

**Note:** Select **"Pending/In Process"** from the drop-down menu if a member filed an appeal (i.e., request for fair hearing, internal MCO appeal, or request for rehearing), but a decision has not been issued by the end of the quarter being reported. The pending status should be removed, and updated information should be entered in subsequent quarterly reports. If there is a resolution within the 45 day period for the submission of the report, update the Appeal Log to reflect this.

### 24. Did Member Disenroll? (column X)

Select an entry from the drop-down menu:

- Select **"yes"** if the member disenrolled during the course of the appeal or within fourteen calendar days of receipt of a decision from the MCO Grievance and Appeal Committee or DHA.
- Select **"no"** if the member did not disenroll during the course of the appeal or within fourteen calendar days of receipt of a decision from the MCO Grievance and Appeal Committee or DHA.

### 25. Reason for Disenrollment, if applicable (column Y):

If the answer to the previous column was "yes," briefly state, to the best of your knowledge, the reason the member disenrolled.

### 26. Comments (column Z):

Comments are only mandatory when applicable to the situation, requested in the instruction form, or when requested after the MCO selects “other.” Examples of information to include in the *Comments* column:

- Additional target groups if a person is in more than one target group.
- Relevant notes for a pending/in process appeal.
- Relevant notes on formal or informal reviews or meetings.
- Explanation of why a member's appeal was not acknowledged within 5 business days of receipt.
- Explanation of why a member's standard or expedited appeal was not timely resolved.
- Explanation of why the MCO did not provide a summary to DHA within 10 days.
- The reason for a member not following through with the appeal process.
- Explanation of why benefits were not continued for appeals of adverse benefit determinations involving the reduction, suspension, or termination of a service.
- Explanation of why, for benefits for that were continued, for appeals of adverse benefit determinations involving the reduction, suspension or termination of a service, continued services were ended.
- Any other information the MCO would like to report to BQO or would like to track.