

Chapter 10

# Grievances and Appeals

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The grievance procedure is set forth 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 re-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.

Beacon Health Options, Inc. (Beacon) provides for an internal level of a grievance following an initial medical necessity review that resulted in non-authorization of a service request. Medicaid may have the state of Maryland’s Office of Administrative Hearings (OAH) review the decision for Medicaid services, at any stage, as the final authority. The Maryland Behavioral Health Administration (BHA) is the final authority for participants who are uninsured eligible. The timeframes for making the initial determination by Beacon is one hour for an urgent request and 24 hours for a non-urgent request. The timeframes for making reconsideration, grievance, and appeal determinations are listed in the applicable sections below.

## 10.1. Definitions

TERM	DEFINITION
<b>Administrative or Technical Denial</b>	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.
<b>Appeal</b>	A formal process available to Medicaid recipients to request the OAH to review the decision.
<b>Care Manager</b>	A mental health professional responsible for reviewing, coordination, and approving the mental health treatment of individuals served by the Maryland PBHS.
<b>Clinical Service Non-Authorization</b>	A determination by a Beacon Maryland Physician Advisor that the mental health services requested are not medically necessary.
<b>Complaint</b>	An expression of dissatisfaction with some aspect of the Maryland PBHS.
<b>Grievance</b>	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.
<b>Non-Urgent Request</b>	A request for continued acute inpatient services or any other service level other than a request for pre-authorization of an acute inpatient admission.
<b>Participant</b>	A Maryland Medicaid recipient, uninsured eligible individual, or the participant’s legal guardian who requests mental health services. For this chapter of the provider manual, a parent of the child is considered the participant.

TERM	DEFINITION
<b>Physician Advisor</b>	A board-certified psychiatrist who reviews authorization requests and performs medical necessity determinations.
<b>Reconsideration</b>	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. The reconsideration must be requested within 24 hours from the notification of the initial non-authorization.
<b>Urgent Request</b>	A request for pre-authorization for admission to an acute inpatient facility or a service level in which the participant or provider of service believes that waiting 24 hours for a decision would potentially be harmful to the participant.

## 10.2. Grievances

### GRIEVANCE REVIEW I – BEACON MARYLAND GRIEVANCE

The initial review of an authorization request submitted by a provider on behalf of a participant is completed by a Beacon Care Manager. A Care Manager may only authorize service requests. When a Care Manager cannot authorize services based on the information submitted via ProviderConnect or submitted telephonically, the Care Manager may ask the provider for additional information. When the additional information is received, the Care Manager will authorize the services requested or suggest an alternative level of care. If the Care Manager is not able to authorize the requested services or negotiate an alternative level of care, the Care Manager will refer the case to the Beacon Maryland Medical Director or Physician Advisor.

A non-authorization of services results when the Beacon Medical Director or Physician Advisor reviews a service request and cannot approve the request because it does not meet the medical necessity criteria established for that level of service.

Following the initial non-authorization of service, a participant, provider, or advocate (with the participant’s consent) may request a reconsideration. A reconsideration is available to the provider when the initial non-authorization of service was done without the benefit of a peer-to-peer review.

The reconsideration is a request for a peer-to-peer review between the provider and Beacon. The reconsideration must be requested within 24 hours from the notification of initial denial. Beacon will make the reconsideration decision within 24 hours or by close of next business day from when the reconsideration request was received. If the decision to non-authorize the service is affirmed, then Beacon forwards a non-authorization letter to the participant and provider. If the participant or provider continues to disagree with the continued non-authorization decision, then a request can be made to have the service request reviewed by another Beacon Physician Advisor as a Grievance Review I. If the decision to non-authorize the service request is upheld, Beacon forwards a non-authorization letter to the participant and provider.

If the participant continues to disagree with the continued non-authorization decision, then a request can be made to have the service request reviewed by the BHA as a Grievance Review II. A participant with Medicaid has a final appeal, which is to the OAH.

### **Grievance Review I Timeframes**

A Grievance Review I must be filed within 10 business days of the initial non-authorization of service or completion of the reconsideration process. The Grievance Review I is completed telephonically between a Beacon Physician Advisor and the provider. The timeframes for making the Grievance Review I determination by Beacon is 24 hours or by the close of the next business day for an urgent request and five calendar days for a non-urgent request.

- Direct contact with the provider is required in order to make timely decisions.
- If the provider is not available within the timeframe allotted, the provider or participant may request that Beacon place the request on hold for up to 72 hours.
- The Beacon Physician Advisor will make reasonable attempts to reach the provider.
- Beacon may request documentation from the treatment record when the telephonic information is unclear or incomplete.
- If the Beacon Physician Advisor concludes that services are medically necessary, Beacon authorizes the requested service and forwards a Grievance Review I authorization letter to the participant and the provider within two business days. The authorization is also entered into ProviderConnect and is available to the provider via download.
- If the Beacon Physician Advisor concludes that the non-authorization or partial non-authorization is appropriate, Beacon informs the provider of the decision and his or her grievance rights during the telephonic review. A Grievance Review I non-authorization letter that includes information about the next level of grievance available to the participant is sent to the provider and participant within two business days.

### **GRIEVANCE REVIEW II – BHA**

A Grievance Review II must be requested in writing to BHA within 10 business days after the receipt of a Grievance I non-authorization decision. To file a Grievance Review II with BHA via mail, use the following address:

Behavioral Health Administration  
Attn: Grievances and Appeals  
Spring Grove Hospital Center – Dix Building  
55 Wade Avenue  
Catonsville, MD 21228

The Grievance Review II will be completed within five business days for an urgent request or within 10 business days for a non-urgent request.

- BHA may refer the grievance to Beacon for re-review when grievance levels have not been utilized.
- BHA's review process may include input from the Core Service Agency (CSA) and/or Local Addictions Authority (LAA), as needed.

- BHA will notify the participant and provider, in writing, of the outcome to all grievances.
- BHA is the final authority for participants or are uninsured eligible. However, Medicaid recipients will be informed by BHA of their rights to appeal to the OAH.

## 10.3. Appeals

### APPEAL TO THE OFFICE OF HEALTH SERVICES

If a Medicaid participant wishes to appeal the BHA's decision, he or she must file a notice in writing to the Office of Health Services within 90 business days of BHA's decision to not authorize services. Request for appeal hearings should be submitted via mail to:

- Mail to: Maryland Department of Health  
Office of Health Services  
Attention: Appeals Coordinator  
201 West Preston Street, Room 127  
Baltimore, Maryland 21201

The appeals coordinator will receive the materials and transmit the request to the Office of Administrative Hearings, an independent State agency.

## 10.4. Administrative Denials

An administrative denial means the claim is denied due to one of the reasons listed 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 participant in the primary coverage carrier's network.
- The participant is not a Medicaid beneficiary.

You have 90 days from the date of the notice of the administrative denial to contact Beacon Maryland for a reconsideration of the denial based on documentation from the provider that the denial was made in error. To contact the Beacon Grievances and Appeals Department, call 410.691.4049. To submit the required documentation showing the administrative denial was due to an error on the part of Beacon, you can:

- Fax to: 877.381.5571
- Email to: [grievances@beaconhealthoptions.com](mailto:grievances@beaconhealthoptions.com)
- Mail to: Beacon Health Options, Inc.  
Attn: Grievances and Appeals Department  
1099 Winterson Road, Suite 200  
Linthicum, MD 21090

## 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](mailto:grievances@beaconhealthoptions.com)
- Mail to: Beacon Health Options, Inc.  
Attn: Complaints Department  
1099 Winterson Road, Suite 200  
Linthicum, MD 21090

If you give Beacon your name, address, and permission, we will send you at least two letters.

1. A letter confirming receipt of your complaint will be sent within five days.
2. A letter informing you of the resolution status of your complaint will be send within 30 days.

If you are not satisfied with the resolution, you may request a resolution review. Instructions for this will be included in the resolution letter.