10A NCAC 27G .7004 APPEALS REGARDING UTILIZATION REVIEW DECISIONS FOR NON-MEDICAID SERVICES

(a) This Rule governs appeals by a client, or the client's legally responsible person, to the Local Management Entity-Managed Care Organization (LME-MCO), area authority or county program Director of Utilization Review (UR) decisions made by the agency to deny, reduce, suspend or terminate a client's non-Medicaid funded services.

(b) The LME-MCO, area authority or county program shall:

(1) send to the client, or the client's legally responsible person, notification letters regarding utilization review decisions for non-Medicaid funded services.

(2) date and mail the notification letter no later than the next business day following the UR decision to deny, reduce, suspend, or terminate a non-Medicaid state funded service.

(3) separately notify the provider regarding the service authorization.

(c) The letter shall include information regarding the reason for the UR decision and any available service options while the appeal is under review.

(d) Only the client, or the client's legally responsible person, may file an appeal of the non-Medicaid UR decision. The appeal must be in writing and received by the LME-MCO, area authority or county program within 15 business days of the date of the notification letter. The LME-MCO, area authority or county program shall provide help to a client who requests assistance in filing the appeal.

(e) The LME-MCO, area authority or county program shall acknowledge receipt of the appeal in writing in a letter to the client, or the client's legally responsible person, dated the next business day after receipt of the appeal.

(f) The LME-MCO, area authority or county program may authorize interim services until the final review decision, as set forth in 10A NCAC 27I .0609, is reached. The decision to authorize interim services shall be based upon medical necessity criteria as set forth in State-funded Service Definitions. State-funded service definitions are available via this link: https://www.ncdhhs.gov/providers/provider-information/mental-health-development-disabilities-and-substance-use-services/service-definitions. The decision shall also be in compliance with G.S. 122C-2.

(g) The LME-MCO, area authority or county program Director shall assign staff to conduct a clinical review of the UR decision.

(h) The clinical review shall be conducted by an employee(s) or contractor(s) of the LME-MCO, area authority or county program not involved in the UR decision that is the subject of the appeal. The clinical reviewer(s) clinical credentials shall be at least comparable to those of the person who rendered the initial UR decision.

(i) The clinical reviewer(s) shall issue a written decision to uphold or overturn the original UR decision.

(j) The LME-MCO, area authority or county program shall notify the client, or the client's legally responsible person, of the clinical review decision in a letter dated and mailed within seven business days from receipt of the appeal request and shall separately notify the provider regarding the service authorization.

(k) If the clinical review overturns the initial UR decision, the decision letter shall state the date on which the denied service shall be authorized or the date on which the suspended, reduced or terminated service shall be reinstated.

(l) In cases in which the clinical review decision upholds the original UR decision, the LME-MCO, area authority or county program shall inform the client, or the client's legally responsible person, in writing of the opportunity to appeal the clinical review decision to the Division of Mental Health, Developmental Disabilities and Substance Use Services pursuant to Rules 10A NCAC 27I .0601-.0609.

History Note: *Authority G.S. 122C-112.1(a)(29); 143B-147;*
Eff. July 1, 2008;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 20, 2019;
Amended Eff. May 1, 2024.