Maryland
DEPARTMENT OF HEALTH

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

Maryland Medicaid Managed Care Program
MCO Transmittal No. 137
March 16, 2020

To: Managed Care Organizations

From: Jill Spector, Director
Medical Benefits Management

Re: Processing Appeals Filed by Providers Representing HealthChoice Enrollees

Note: Please ensure that appropriate staff members in your organization are informed of the contents of this memorandum.

This transmittal clarifies HealthChoice managed care organizations' (MCOs) responsibility to process appeals timely that providers file on behalf of enrollees. Specifically, the Centers for Medicare and Medicaid Services (CMS) Medicaid and CHIP Managed Care Final Rule (Final Rule) requires providers to obtain written consent from enrollees when filing appeals of MCO preauthorization denials. While CMS included the provision to protect enrollees from incurring unnecessary costs for denied services or benefits pending the appeal, this protection does not delay the timeframe under which the MCO must process the appeal.

Since implementing the Final Rule in 2018, MDH has identified two scenarios which may create barriers for enrollees to access care:

- MCOs are requiring providers to present written enrollee consent before initiating review of expedited appeal requests (which must be resolved with notification to the enrollee and provider within 72 hours of the request); and
- MCOs are delaying the start date of the standard appeal timeframe pending receipt of the enrollee's written consent for the provider to file the appeal.

In response to these scenarios, MDH is clarifying the appeals process:

- **MCOs may not delay review of expedited appeals while waiting for the enrollee's written consent for the provider to file.**
  COMAR 10.67.09.05A(4) and 42 CFR § 438.406(b)(3) provide that oral requests for appeal start the appeal timeframe. Further, if the enrollee, their representative, or the

provider requests an expedited appeal, the MCO must waive the requirement for written confirmation of a request for an appeal. Accordingly, a request for an expedited appeal must be resolved no later than 72 hours after the MCO receives the appeal, whether or not the enrollee provides written confirmation of the appeal.

- **The 30-day clock for the MCO to resolve a provider's request for a standard appeal on behalf of an enrollee begins on the day the appeal request is presented to the MCO.**

  Oral requests for an appeal establish the earliest possible filing date for the appeal. MCOs must treat the provider's request as the initiation of the appeal, pending written consent from the enrollee. During standard appeal timeframes, enrollees may provide written consent for the provider to file an appeal at any time during review of the appeal.

MDH encourages MCOs to work with providers, representatives, and enrollees to obtain written consent for appeals when required. Please share this information with your provider networks.

If you have questions about the contents of this transmittal, please contact Bernadette Benta, Division Chief of HealthChoice Complaint Resolution, at (410) 767-5703 or bernadette.benta@maryland.gov.