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External Medical Review (EMR) Provider Training

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Purpose

The purpose of this training is to provide an overview to providers on the role/responsibilities for participants involved in an external medical review (EMR) following receipt of an Adverse Benefit Determination from an MCO or Dental Contractor.

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Talking Tip (1 of 2)

MCO means managed care organization and dental contractor throughout this presentation.

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Talking Tip (2 of 2)

"Emergency" and "expedited" appeal mean the same thing.

Acronyms

Acronym	Full Name
AR	Authorized Representative
DMO	Dental Maintenance Organization
EMR	External Medical Review
HHS	Health and Human Services
HHSC	Health and Human Services Commission
IRO	Independent Review Organization
MCO	Managed Care Organization
SFH	State Fair Hearing
TMPPM	Texas Medicaid Provider Procedures Manual

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Key Terms (1 of 14)

Adverse Benefit Determination means:

- The denial or limited authorization of a Member or Provider requested services, including the type or level of service, requirements for **medical necessity**, appropriateness, setting, or effectiveness of a covered benefit
- The reduction, suspension, or termination of a previously authorized service

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Key Terms (2 of 14)

Authorized Representative (AR)

- Any person or entity acting on behalf of the member and with the member's written consent in the complaint and appeals process.

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Key Terms (3 of 14)

Authorized Representative (AR)

Your Authorized Representative's or Parent's Information*

Name:
Address:
Phone number:

*This only gives the authorized representative or parent information if you are choosing someone else to represent you. You can represent yourself. If you would like someone to represent you, such as, parent, relative or friend, complete the following information. By completing this section, you are authorizing your designated representative to appeal on your behalf.

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Key Terms (4 of 14)

Authorized Representative (AR)

Reason for the Appeal

This section is optional. You can fill it out to tell us about your services under appeal and why you think they're needed.

Services under appeal:
Why you need them:

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Key Terms (5 of 14)

Authorized Representative (AR)

Sign this form:
By signing this form, you or your authorized representative are requesting an appeal and giving your health plan, <MCO>, authorization to get your medical records and to contact your appeal representative if you listed one.

Member/Authorized representative signature

Printed name

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Key Terms (6 of 14)

Complaint

- An expression of dissatisfaction expressed by a Complainant, orally or in writing to the MCO, about any matter related to the MCO other than an Adverse Benefit Determination.
- Complainant's oral or written dissatisfaction with an Adverse Benefit Determination is considered a request for an MCO appeal.

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Key Terms (7 of 14)

Dental Contractor

- A company or organization contracted with HHSC to provide Medicaid dental benefits to Medicaid Members.

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Key Terms (8 of 14)

Emergency Health Plan Appeal

- When a member feels their health will be seriously harmed by waiting for a decision on their health plan appeal, they can ask for an emergency health plan appeal.
- Providers should submit supporting documentation for this request in writing to the MCO.

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Key Terms (9 of 14)

Expedited External Medical Review (EMR)

- Same as Emergency External Medical Review
- When a member feels their health will be seriously harmed by waiting for a decision on their health plan appeal, they can ask for an emergency health plan appeal.

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Key Terms (10 of 14)

External Medical Review (EMR)

- An independent review of the relevant information the MCO used related to an Adverse Benefit Determination based on functional necessity or medical necessity.

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Key Terms (11 of 14)

Independent Review Organization (IRO)

- A third-party organization contracted by HHSC that conducts an External Medical Review (EMR) during Member appeal processes related to Adverse Benefit Determinations based on functional necessity or medical necessity

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Key Terms (12 of 14)

Managed Care Organization (MCO)

- The company or organization contracted with HHSC to provide Medicaid benefits for Medicaid Members

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Key Terms (13 of 14)

Provider or Network Provider

- An appropriately credentialed and licensed individual, facility, agency, institution, organization or other entity, and its employees and subcontractors that has a Provider Contract for the delivery of Health Care Services to the MCO's Members.

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Key Terms (14 of 14)

State Fair Hearing

- A State Fair Hearing is when the Texas Health and Human Services Commission (HHSC) directly reviews MCO decisions about member medical care

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Legislation

Senate Bill 1096

Senate Bill 1207

Legislation in Action (1 of 10)

Senate Bill 1096

- Requires HHSC to provide guidance and additional education to Medicaid managed care organizations (MCOs) which the commission enters into contracts regarding requirements under federal law to continue to provide services if requested based on an Adverse Benefit Determination

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Legislation in Action (2 of 10)

Senate Bill 1207

- Directs HHSC to contract with a third-party medical reviewer or Independent Review Organization (IRO) that provides objective, unbiased medical necessity determinations conducted by clinical staff

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Legislation in Action (3 of 10)

Senate Bill 1207

- Clinical staff reviewing determinations must have the same or similar practice area for which an independent medical necessity is sought and may only be determined by an appropriate physician, doctor, or other health care provider with appropriate credentials under §19.1706 of this title (relating to Requirements and Prohibitions Relating to Personnel) to determine medical necessity or appropriateness, or the experimental or investigational nature, of health care services.

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Legislation in Action (4 of 10)

Senate Bill 1207

- Independent medical reviewers employed by the Independent Review Organization (IRO) will conduct EMRs and review:
  - The resolution of a Medicaid Member appeal related to a reduction in or denial of services on the basis of medical necessity for a managed care program.

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Legislation in Action (5 of 10)

Senate Bill 1207

- The MCO may not have a financial interest in the medical reviewer with which HHSC contracts.
- The IRO must:
  - Be overseen by a medical director who is a physician licensed in Texas
  - Employ or be able to consult with staff with experience in providing private duty nursing and long-term services and supports

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Legislation in Action (6 of 10)

Senate Bill 1207

- Medical necessity must be based on publicly available, up-to-date, evidence-based, and peer reviewed clinical criteria.
- This criteria must be consistent with state and federal law and HHSC medical policy as set forth in the TMPPM and other guidance.
- The review must be conducted within a timeframe defined by HHSC, including a timeframe for expedited reviews.

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Legislation in Action (7 of 10)

*MEMBER EMR AND STATE FAIR HEARING REQUEST		
Requirement	**Standard Request Entry and Document Upload Time Frame**	**Expedited Request Entry and Document Upload Time Frame**
MCO/ Dental Contractor to enter member EMR/State Fair Hearing request and upload determination information into TIERs	Within 3 calendar days of the receipt of member's request for EMR and State Fair Hearing	As soon as possible and no later than one calendar day of the receipt of member's request for EMR and State Fair Hearing.
HHSC EMR Intake Team to assign EMR request and provide MCO Internal Appeal documentation	No later than the next business day from receipt in TIERS of MCO Internal Appeal documentation	Same day from receipt in TIERS of MCO Internal Appeal documentation, if possible and no later than the next business day
IRO to mail the decision letter to the member and copy the MCO and email HHSC Intake Team	Within 10 calendar days from receipt of MCO Internal Appeal documentation from the HHSC Intake Team	No later than the next business day from receipt of MCO Internal Appeal documentation from the HHSC Intake Team
*Note: EMR and SFH must be requested at same time, if member wants an EMR. Due dates is for **TIERS entry of the EMR request and documentation**. This allows for the 72-hour timeline for the State Fair Hearing expedited process		

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Legislation in Action (8 of 10)

Senate Bill 1207

- Reviews for service reductions or denials
  - The review occurs after the internal MCO appeal and before the State Fair Hearing.
- Reviews for eligibility denials
  - The review occurs after the eligibility denial and before the State Fair Hearing

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Legislation in Action (9 of 10)

Senate Bill 1207

- The IRO's determination of medical necessity establishes the minimum level of services a Medicaid Member must receive, except that the level of services may not exceed the level identified as medically necessary by the ordering health care provider.

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Legislation in Action (10 of 10)

Senate Bill 1207

- The IRO must require the MCO/Dental Contractor to submit a detailed reason for the service reduction and include supporting documents.

Member Responsibilities (1 of 22)

- Once a member has received an adverse benefit determination notice from their MCO, the member must contact their MCO and request
  - MCO Internal Appeal verbally or in writing
  - Benefit continuation

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Member Responsibilities (2 of 22)

Member Notice of MCO Internal Appeal Decision

- Members will receive a notice from the MCO. Within 120 days of the date the MCO mailed the MCO notice Members can request
  - An EMR and State Fair Hearing or a State Fair Hearing only verbally, or in writing, by email, or a phone call, to the MCO or by going in person to a local HHSC office.

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Member Responsibilities (3 of 22)

MCO Internal Appeal Notice of Adverse Benefit Determination

- Letter
- Flyer
- Form

  MMC Notices of Actions Required

Member Responsibilities (4 of 22)

Member Notice of MCO Internal Appeal flyer includes the following:

- What to expect when requesting an External Medical Review and State Fair Hearing
- What to expect after requesting an External Medical Review and State Fair Hearing
- When to expect the notice of State Fair Hearing

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Member Responsibilities (5 of 22)

Member Notice of MCO Internal Appeal flyer includes the following:

- State Fair Hearing Logistics
  - Hearings are held by phone (in person when needed)
  - Members can see all information that will be used unless it is expedited
  - Members can share new details with HHSC
  - The SFH decision will not reduce benefits below EMR decision
  - SFH decision can take up to 90 days
  - Members have a right to have case reviewed by an HHSC attorney if they disagree

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Member Responsibilities (6 of 22)

Member Notice of MCO Internal Appeal flyer includes the following:

- Emergency State Fair Hearings and External Medical Reviews.
- Offers places to get help
  - MCO
  - MCO Member advocate

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Member Responsibilities (7 of 22)

Member Notice of MCO Internal Appeal Decision Form

- Members can contact their MCO verbally or in writing (Email, Mail, or Fax)
- Members can go in person to a local HHSC office.

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Member Responsibilities (8 of 22)

Member Notice of MCO Internal Appeal Decision FORM

Do you want your services to continue? ____ Yes ____ No

Your services can only be continued if they were also continued during your health plan appeal. If you want your services to continue, you must request a state fair hearing and ask to keep your services by **<date must be the later of the following: date 10 Days from the date this notice is mailed or the date services will change>**.

You can make this request by phone. Call us at <MCO telephone number> if you believe this form will not reach us by mail before the deadline.

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Member Responsibilities (9 of 22)

Member Notice of MCO Internal Appeal Decision

- If members kept receiving services during their health plan appeal, they may be able to continue receiving the denied services during the EMR and State Fair Hearing
- The member must request the service be continued within 10 days from the date on the MCO notice

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Member Responsibilities (10 of 22)

Member Notice of MCO Internal Appeal Decision Form

Members can select the State Fair Hearing option of their choice

Mark the state fair hearing option you want:

Only select one.

____ State fair hearing

____ State fair hearing and external medical review

____ Emergency state fair hearing*

____ Emergency state fair hearing and emergency external medical review*

Member Responsibilities (11 of 22)

Member Notice of MCO Internal Appeal Decision Form

Members will need to provide all the requested information such as

<Denial Reference Number: Number>

Member Responsibilities (12 of 22)

Member Notice of MCO Internal Appeal Decision Form

Member Details

Member last name:	Member first name:
Parent or guardian last name:	Parent or guardian first name:
Member Medicaid ID and subscriber number:	Preferred phone number:

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Member Responsibilities (13 of 22)

Member Notice of MCO Internal Appeal Decision Form

Member or Representative who is requesting, will signs the form

Your Hearing Representative's or Parent's Information

You can represent yourself. If you would like someone to represent you, such as, parent, relative or friend, complete the following information. By completing this section, you are authorizing your designated representative to appeal and obtain information on your behalf.

Name:
Address:
Phone number:

Member Responsibilities (14 of 22)

Member Notice of MCO Internal Appeal Decision Form

Reason

Services under appeal:
Why you need them:

Member Responsibilities (15 of 22)

Member Notice of MCO Internal Appeal Decision Form

Sign the form.

Sign this form

By signing this form, you or your representative are requesting a state fair hearing and giving the Texas Health and Human Services Commission authorization to get your medical records and to contact a representative if you listed one.

Member/Authorized representative signature

_____

Printed Name

_____

Date

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Member Responsibilities (16 of 22)

Member Change of Address

- If a member ever mentions their contact information has changed, please have them call the enrollment broker, MAXIMUS, at 800-964-2777 and their MCO to provide the update.

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Member Responsibilities (17 of 22)

Post MCO Internal Appeal

- Member must contact their MCO and request
  - EMR and State Fair Hearing;
  - State Fair Hearing only; or
  - No appeal and accept MCO decision.

***REMINDER**: EMR and State Fair Hearing must be requested by the member, member's parent, authorized representative or legally authorized representative.*

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Member Responsibilities (18 of 22)

Post IRO Decision

- Member or authorized representative must decide
  - Continue to State Fair Hearing
  - Withdraw from the State Fair Hearing
  - Request that the IRO attend the State Fair Hearing

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Member Responsibilities (19 of 22)

Member Repayment to MCO for Services Received if the Decision is Upheld:

- Members may have to pay MCOs for services provided during the fair hearing process
- MCOs cannot ask members to pay them back for services received without permission from HHSC

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Member Responsibilities (20 of 22)

Post IRO Decision Questions and Concerns:

- **Email HHSC Intake Team at: (recommended)**
  EMR_Intake_Team@hhsc.state.tx.us

- **Mail HHSC Intake Team at:**
  HHSC EMR Intake Team
  Managed Care Contracts and Oversight
  P.O. Box 149030 H-320
  Austin, Texas 78714-9030

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Member Responsibilities (21 of 22)

Post IRO Decision Questions and Concerns:

Office of Ombudsman Contact

Phone: (877) 787-8999

Online: HHS.Texas.Gov/Ombudsman

Fax: (888) 780-8099

Mail:

HHS Office of the Ombudsman
P.O. Box 13247
Austin, Texas 78711-3247

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Member Responsibilities (22 of 22)

Post IRO Decision Questions and Concerns:

- **STAR KIDS Escalation Helpline**
  Escalation Help Line: 844-999-9543
- Members in the following programs may utilize this number for EMR questions and concerns:
  - Medically Dependent Children Program (MDCP)
  - Deaf Blind with Multiple Disabilities (DBMD) waiver program
  - STAR Health Members receiving benefits under the MDCP or DBMD waiver program

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MCO Responsibilities (1 of 2)

- Inform members of their right to continued services during an appeal, EMR, State Fair Hearing or any other review
- Continue to provide services during an internal appeal, an EMR, a Medicaid State Fair Hearing, or any other review when requested and certain criteria is met
- Enter EMR/State Fair Hearing request in TIERS
- Upload supporting documentation.

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MCO Responsibilities (2 of 2)

Post IRO Decision

- **The MCO must:**
  - **Implement any partial or full decisions overturned by the IRO:**
  - As expeditiously as the Member's health condition requires
  - No later than 72 hours from the date it receives notice reversing the determination
- Request IRO attendance if member is continuing to a State Fair Hearing.

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Provider Responsibilities (1 of 3)

Examples of MCO Internal Appeal Documentation

- Providers are responsible for submitting to the MCO all supporting documentation to substantiate the member's needs, at the time that the services are requested.
- Examples include:
  - Service request (including prior authorizations)
  - Supporting clinical documentations
  - Documentation of any phone calls with MCO

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Provider Responsibilities (2 of 3)

Note to Providers:

- MCOs will be able to provide education on what their processes are for you to provide information when a member appeals an adverse benefit determination
- If you are unsure, reach out to your MCO's provider relations staff

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Provider Responsibilities (3 of 3)

Provider complaint contact:

- **Email:**
  Research and Resolution Team at
  HPM_Complaints@hhsc.state.tx.us
- **On-line form at:**
  Provider Complaint or Inquiry Form

  If the link does not work here is the long address:
  https://hhsportal.hhs.state.tx.us/heartwebextr/public/assignment_hhsc_txmed?methodToCall=loadExternalAssignmentHome

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HHSC Responsibility (1 of 2)

The EMR Intake team:

- Receives the request and reviews IRO assignee for conflict of interest using a round robin process
  - If conflict, next IRO in rotation is assigned
  - If no conflict, IRO assignment email occurs
- Should the IRO assigned identify that a conflict of interest exist, the EMR Intake team will be notified via email
  - The assignment process starts over
- Track and trend IRO decision notifications, decisions, timeliness

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HHSC Responsibility (2 of 2)

The HHSC EMR Intake Team will share the following with the IRO:

- Date of EMR Request
- Due date
- Member information
- MCO name, address, phone number
- MCO documentation used to determine adverse benefit determination

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IRO Responsibility (1 of 3)

IRO responsibilities

- After the MCO records are uploaded to HHSC the IRO will review:
  - The same information that was reviewed by the MCO
  - Make a decision based on what was received
  - Send Member, MCOs, and HHSC the decision in the manner specified by HHSC.

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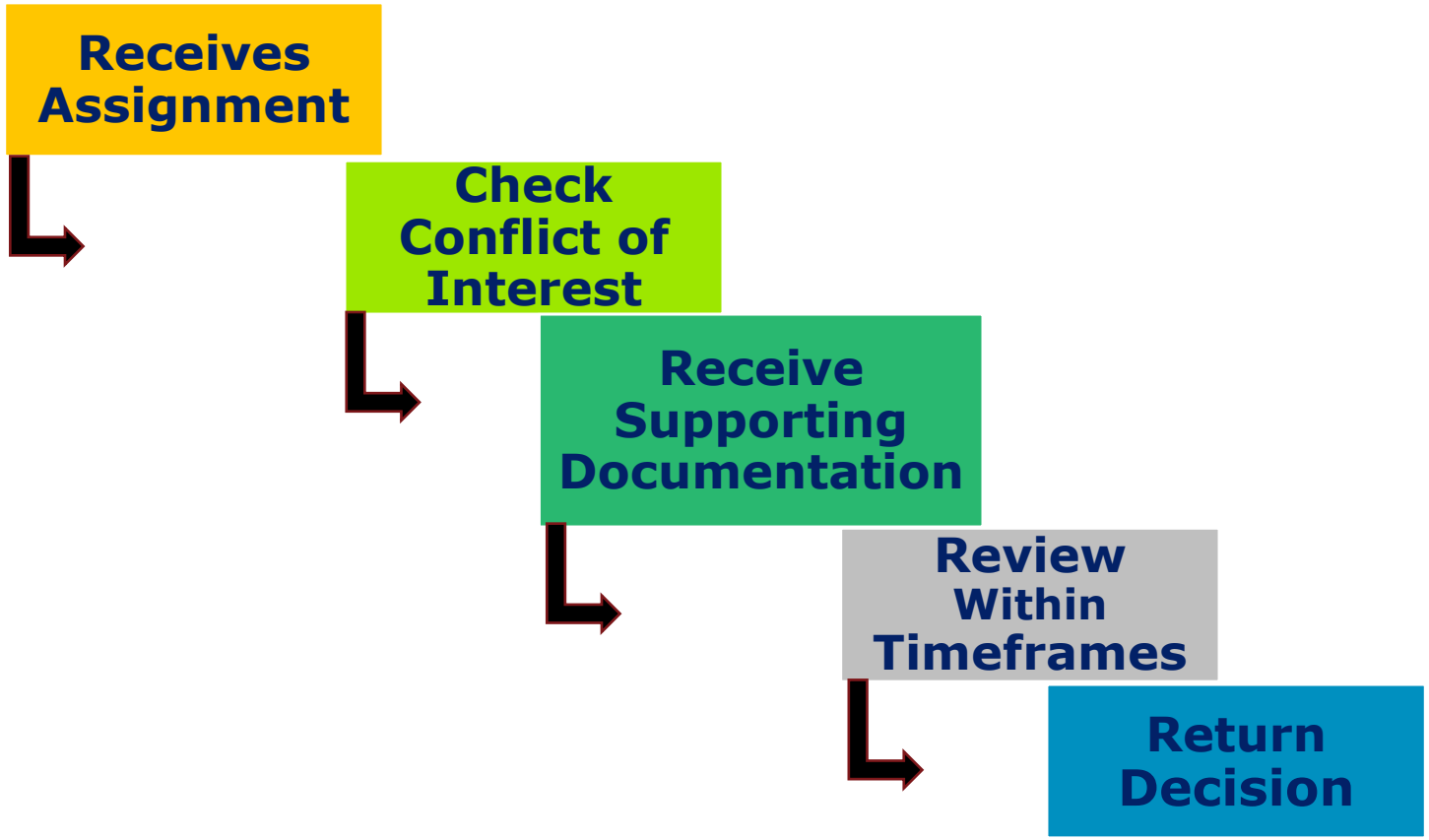
IRO Actions Flow



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IRO Responsibility (2 of 3)

IRO Decisions

- IRO decisions of "overturned" are considered final
- IRO decisions of "partially overturned" are considered final for MCO 72-hour action requirements.
- IRO decision of "upheld" member can withdraw or continue to State Fair Hearing

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IRO Responsibility (3 of 3)

Provider decision request

- 2.3.6 Upon written request from the provider associated with the denied services of the Member requesting the EMR, the IRO must provide written notice of the EMR decision to the requesting provider, following HIPAA standards outlined in Exhibit C of this Open Enrollment.
  - Include preferred receipt method
  - IRO must respond by mail or email 3 days from receipt of provider request

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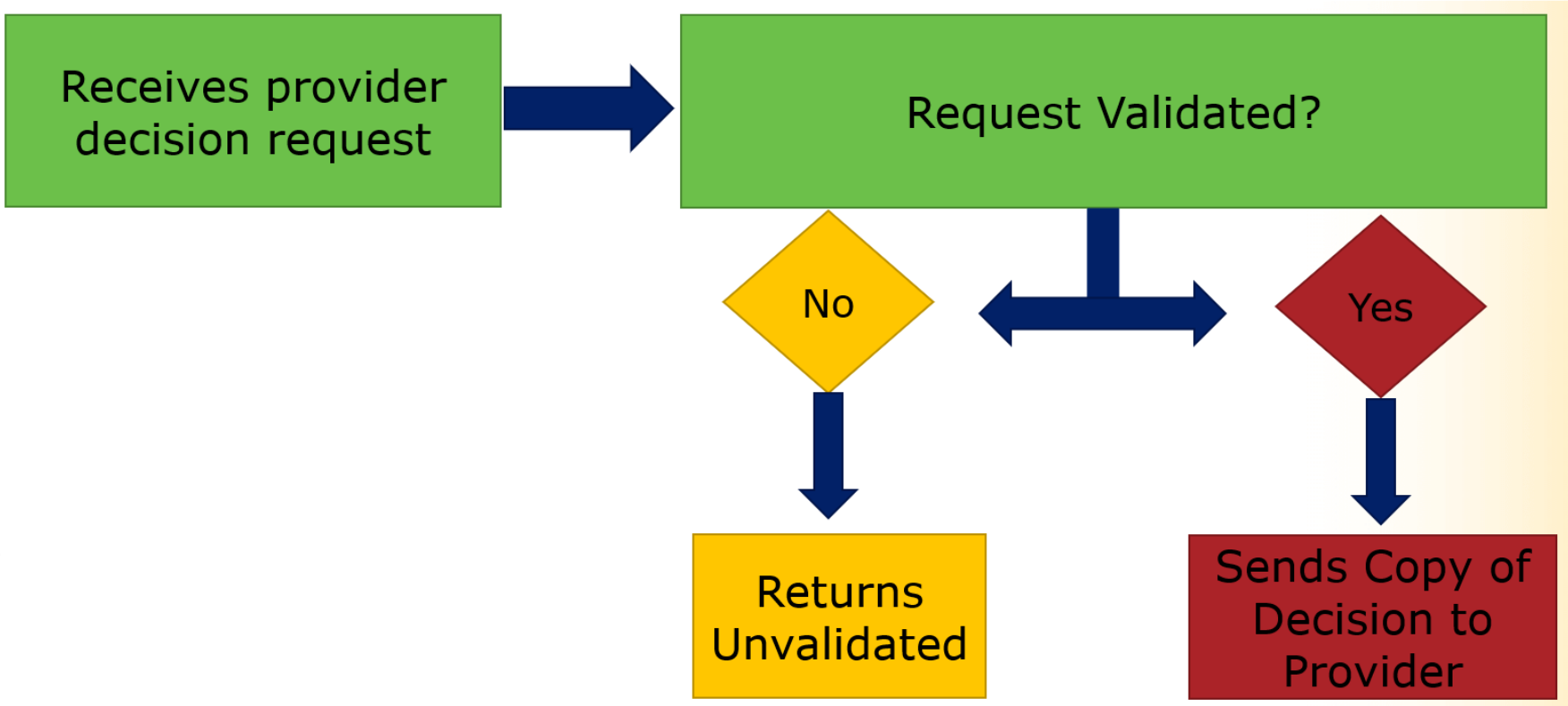
IRO Provider Request Flow



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Questions and Answers

Q & A (1 of 4)

Q: Can new information be shared in an EMR?

A: No, only in a State Fair Hearing, that is why it is very important to get all of the relevant supporting documentation to the MCO in the member's internal appeal.

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Q & A (2 of 4)

Q: Can a provider get a copy of the IRO decision?

A: Yes, if you are the provider of record for the services in question.

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Q & A (3 of 4)

Q: What "date" should be used to calculate the deadline a member has to request continued benefits after receipt of the MCO Notice of Adverse Benefit Determination?

A: Date the notice is mailed is date the notice is postmarked

- No postmark?
  - The metered date is the date
- If there is no postmark or meter mark?
  - The date on the notice must be the date the notice was mailed.

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Q & A (4 of 4)

Q: How long does the member have to ask for an EMR and State Fair Hearing?

A: 120 days to request

- EMR and State Fair Hearing, or
- State Fair Hearing only

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Resources (1 of 2)

Managed Care Contracts, Manuals, Handbooks

- Managed Care Contracts, Manuals, Handbooks

Uniformed Managed Care Manual (Section 3.21)

- MMC Notices of Actions Required

Texas Administrative Code Chapter 357 Hearings

- Texas Administrative Code

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Resources (2 of 2)

Fair and Fraud Hearings Handbook

- Fraud and Fair Hearings Handbook

Electronic Code of Fair Regulations See Subpart F (Grievance and Appeal System)

- Electronic Code of Federal Regulations

SB 1207 Legislation (see Sec 531.024164):

- SB 1207 Sec 531.024164 External Medical Review

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More Questions?

HHSC EMR Intake Team

EMR_Intake_Team@hhsc.state.tx.us

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Thank you