Getting Ready for the End of the Shift Care Freeze:

A Guide to Prior Authorizations & Appeals

PENNSYLVANIA Health Law PROJECT

Introduction

During the COVID-19 Public Health Emergency (PHE), the Pennsylvania Department of Human Services (DHS) temporarily suspended the need for a Medicaid health insurer or plan to determine medical necessity (also called prior authorization) for children receiving shift care services like skilled nursing and home health aide. As a result, anyone who was getting shift care services when the pandemic began, or who was approved for services during the pandemic, could not have those services reduced or terminated while the PHE continued.

However, DHS has announced that the freeze on pediatric shift care services will lift on November 1, 2022. This guide explains what families need to do to get ready for the end of the shift nursing freeze, including submission of prior authorization requests and, if necessary, appealing the denial of reduced or denied services.

Prior Authorization Packets

In preparation for the end of the freeze, it is critical to begin preparing a prior authorization packet for the number of skilled nursing or home health aide hours needed, even if your child's Medicaid Managed Care Organization (MCO) has not asked for this packet yet. A

strong prior authorization packet increases the chances that the Medicaid MCO approves the requested shift care services, thus avoiding the need for an appeal. Below is a prior authorization checklist to assist in obtaining the necessary documentation for a shift care service request:

Submitted (Y/N)	Documentation Needed
	Letter of Medical Necessity – required with all requests, even if the MCO only requires a "LOMN form". See Guide to Writing a Letter of Medical Necessity.
	Home Health Certification and Plan of Care (Form CMS 485)
	Social History (Letter from clinical nurse manager)
	Nursing Notes
	Medication/PRN (as needed) charts
	Seizure/Glucose Logs
	Nursing Assessment/Monthly Progress Notes/Reports
	Letter from school, if applicable – Be sure to include days and hours of attendance, transportation issues, school nurse availability, and classroom aides' availability
	Verification Letters for Parent(s) – Include work, school, vocational verification letters
	Parents' health/medical letters; SSDI Award Letters
	Sibling information – Include health/special needs, extracurricular activities which parents must attend
	Family schedule – See template/sample here.

Once the prior authorization packet is submitted, the Medicaid MCO has two (2) business days to notify you of the decision (i.e., whether the services are approved or denied), unless additional information is needed. If no additional information is needed, the Medicaid MCO

must mail a written decision to you, your child's PCP, and the prescribing provider. If services your child is currently getting are at issue, that notice must be sent at least ten (10) days in advance of the decision's effective date. A phone call telling you or your home health agency about the decision does not suffice – written notice of a decision impacting services is always required!

If, based on the prior authorization packet that has been submitted, the Medicaid MCO feels additional information is needed to make the decision, the Medicaid MCO must request this information within forty-eight (48) hours of receiving the prior authorization request. They must then allow fourteen (14) days for submission of the additional information. If the requested additional information is not provided within 14 days, the Medicaid MCO must contact the prescribing provider at least once to confirm that all available documentation related to the requested nursing services has been submitted. Failure to provide the additional information requested will likely result in a denial.

What if Services are Denied?

Even with a strong prior authorization packet, participants may still be denied for the continuation of current services or denied new or additional services. If services are denied, individuals have the right to challenge that decision by filing an appeal. The next sections of this guide outline the steps families must take to file an appeal if shift care services are denied or reduced when the freeze lifts.

Step 1: Ask for a Grievance

The first step in challenging a denial of services is to ask for a grievance with your Medicaid MCO. If your child is in Fee for Service Medicaid (they have no health plan and use their ACESS card for care), skip to Step 3 to learn how to ask for a fair hearing.

A grievance is a review of the Medicaid MCO's decision. The decision is reviewed by a panel of at least three (3) people, including a doctor, usually a medical director, from the Medicaid MCO. To ask for a grievance, call your health plan's member services line or complete the grievance request form that came with your denial letter. If you complete the form, send it by certified mail or fax and keep a receipt.

> **TIP:** If your child's Medicaid MCO tries to reduce any services your child is currently getting, request a grievance within **ten (10) days** of the date on the written notice to keep those services in place while the appeal is being decided. You have 60 days from the date on the denial letter to file a grievance.

You have the right to participate in the grievance either in person, by videoconference, or by phone. You also can bring a representative with you such as a lawyer, and you can have your doctor or others participate to support why your child needs the services in question.

You also have the right to submit new and/or additional documentation that supports a finding that the services are medical necessity. Ask your child's doctor to participate by attending the review by phone or in person and/or by writing a letter that explains why the service is medically necessary. See PHLP's Guide to Writing a Letter of Medical Necessity. The grievance panel must hold the review meeting and give you a decision in writing within thirty (30) days from when you asked for the grievance.

TIP: If waiting 30 days for a grievance decision would harm your child's health, you can request an "expedited" grievance. An expedited grievance is requested by having your doctor submit a letter that says waiting 30 days will harm your child's health and they are requesting the grievance be expedited. Along with any other relevant information. For an "expedited" grievance, the panel must hold your meeting and provide you with a decision within 72 hours of your request.

The grievance can result in one of three decisions by the Medicaid MCO:

1) **Overturned** – The shift care service hours are approved by your child's Medicaid MCO as originally requested by the prescribing doctor;

2) **Approved Other than as Requested** – Approved some services or hours, but not fully as requested by the prescribing doctor. For example, your child's doctor requested 40 hours per week, and the Medicaid MCO instead approved just 20 hours per week. You will need to continue appealing to get the remainder of the hours in question; or

3) **Upheld** – The Medicaid MCO is upholding their original decision to deny the services. You will need to continue appealing to get the services your child needs.

If the grievance decision is anything other than overturned, you will need to move forward with the next phases of appeal in order to obtain the services your child needs. Importantly, if this is a new service request (i.e. your child has not already been getting shift care services) and the decision is "approved other than as requested", your child can begin using the approved hours while you await the external review and/or fair hearing decisions, i.e. the next appeal decisions.

Step 2: Ask for a Fair Hearing

If you do not agree with the plan's grievance decision, you have the right to a fair hearing. A fair hearing is a meeting where the plan must explain its decision to an administrative law judge. You must take part in the hearing either in person or by phone. At the hearing, you have the right to submit evidence and to explain your position to the judge. Your doctor or others can also take part.

To ask for a fair hearing, complete the Fair Hearing Request form that came with your grievance decision. Include the grievance decision with your form. Send it by certified mail or fax and keep a receipt.

TIP: If your child's Medicaid MCO tries to reduce any services your child is currently getting, request a grievance within **ten (10) days** of the date on the written notice to keep those services in place while the appeal is being decided. If current services are not at issue, you have 120 days from the date on the grievance decision to ask for a fair hearing.

Once you request the fair hearing, the hearing will be scheduled either in-person or via telephone (whichever you selected). You should get at least ten (10) days' notice of the date and time of the hearing and again, you must participate in the proceeding. You will receive a written decision from your fair hearing in approximately 60 days from your request.

TIP: If your child's life or health could be harmed by waiting months for a hearing decision, give the judge a letter from your doctor that says you need a faster review. In an "expedited" fair hearing, the judge will hold the hearing and give you a decision within three business days of your request.

If the fair hearing decision results in the services being approved, you can stop appealing. If the Medicaid MCO's denial is upheld in the fair hearing decision, you can ask for another appeal known as Reconsideration. For more information about asking for Reconsideration, call PHLP's Helpline at 1-800-274-3258.

Step 3: Also Ask for an External Review

If you do not agree with the grievance decision, in addition to requesting a fair hearing, you have the right to ask for an external review. An external review is a review of the appeal record by an independent doctor chosen by the Pennsylvania Department of Insurance. The external reviewer must give you a decision within sixty (60) days of your request.

TIP: If waiting 60 days for a decision would harm your child's health, you can request an "expedited" external review. An expedited external review can be requested by having your doctor submit a letter that says waiting 60 days will harm your child's health and they are requesting that the external review process be expedited, along with any other relevant information. For an "expedited" external review, the external reviewer must give you a decision within 72 hours of your request.

Call your health plan's member services phone number to ask for an external review. You have 15 days from the date on the grievance decision to ask for an external review. Ask within 10 days of the grievance decision if you want benefits to continue during the external review process.

TIP: If your child's Medicaid MCO tries to reduce any services your child is currently getting, request an external review within **ten (10) days** of the date on the grievance decision notice to keep those services in place while the external review is being decided, which takes up to 60 days.

The external review is an entirely paper review; there is no meeting. You can submit new and updated information for review at the external review level. You want to submit the documentation to the external reviewer itself but be sure to also send a copy to your child's Medicaid MCO. You can send the information to the appeals department at the MCO.

For More Information

If you need additional help with your child's prior authorization request or appeal, call PHLP's Helpline at 1-800-274-3258 or e-mail staff@phlp.org.

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This publication is intended to provide general legal information, not legal advice. Each person's situation is different. If you have questions about how the law applies to your particular situation, please consult a lawyer or call the Helpline at 1-800-274-3258.