Chapter 7

Appeal Process

This chapter covers the appeal process and the responsibilities of the patient, the hospital, the county, the Agency, and any other organizations or offices involved in the administration of the Health Care Responsibility Act (HCRA). An appeal may be requested when there is a denial of a claim or an application. It is suggested that before an appeal is made, every effort be made by the parties involved to resolve the issue. The Agency will provide technical assistance as needed.

7-1 Appeals: The following persons/entities may request an appeal:

A. The hospital, if eligibility or county of residence is denied;

B. The hospital, if reimbursement is not received from the county of residence;

C. The county, if it believes the services provided by the hospital were not medically necessary or appropriate.

D. The county, if the hospital delays in refunding any amounts received by the county and a third party payer.

7-2 Time Standards: All appeals must be requested within 90 days from the date of the Notification which denies eligibility or reimbursement.

A. The Notification of Eligibility instructs the hospital to contact the certifying agency to appeal a decision. It is, therefore, the responsibility of the certifying agency to forward such requests to the appropriate source within five calendar days of the receipt of the request.

B. Informal county hearings must be held within 30 days of the date of request, unless both parties agree to a later date.

C. Written decisions on all appeals must be provided by the hearing officer to both parties within 45 days of the hearing date.

7-3 Ways That Appeals May Be Conducted: Appeals may be conducted through an informal county procedure, the informal Agency process, the Quality Improvement Organization (QIO) or through the Division of Administrative Hearings (DOAH).

A. Appeals by the hospital when eligibility is denied may be made through the Administrative Appeals process or, informally, through an Agency hearing or a county-level hearings process.

B. If the Agency is acting as the certifying agency for the county, the county may not appeal the eligibility decision made by the Agency. However, if the county believes that the Agency is not determining eligibility correctly, the county must report this information to the Agency at the address specified in Chapter 1, Section 1-11.

C. Appeals by the hospital regarding the determination of the county residence may also be sent to the Agency address.

D. Appeals by the county regarding medical necessity and appropriateness of the services provided may be made to the QIO with which Medicaid has a contract for its outside utilization review or may be made through the formal administrative appeals process.

E. Appeals by the hospital regarding non-receipt of reimbursement from a county may be made through the administrative appeals process, an Agency informal hearing, or the informal county-level process.

7-4 Agency and DOAH Administrative Appeals: To request an informal Agency hearing or a formal DOAH hearing, the patient or the certifying agency must submit a request to:

Agency for Health Care Administration
Bureau of Central Services
Attn: HCRA Program
2727 Mahan Drive, Mail Stop Code 26
Tallahassee, Florida 32308

7-5 Request Format for an Informal Agency Hearing: The request should clearly identify who is appealing the action, what action is being appealed, the name and address of the agency that took the action, and the reason the requester believes the action is in error.

A. Appeal requests by a hospital or county regarding appropriateness of an admissions, length of stay, and medical necessity of the services do not go through the certifying agency. Instead, such requests are made directly to the PRO with which Medicaid has a contract for its outside utilization review. See Sections 7-8 and 7-9 for further information.

B. In appeal requests for other than reimbursement, the request may consist of a copy of the Notification of Eligibility and a memo stating when the request was received by the certifying agency.

C. Legal representation is not mandatory. It is not required that a lawyer represent either party at a hearing on an appeal.

D. The hearing officer's decision is binding on all parties.

7-6 Request Format for a Formal DOAH Hearing: The request for a formal DOAH hearing must meet the requirements of Florida Administrative Code, Section 28-5.201. For information regarding the formal DOAH hearing request, contact the agency office at the address specified in Section 7-4 of this Chapter.

7-7 Informal County-Level Appeals: Appeals regarding eligibility and/or reimbursement may be handled informally at the county level if the following conditions are met:

A. The hearing on the appeal is conducted at a reasonable time, date and place;

B. The party appealing the action is given an opportunity to examine the following at a reasonable time before and/or during the hearing:

   1. The contents of the case and/or fiscal records; and

   2. All documents and records to be used at the hearing by the agency that took the action.

C. The party appealing the action is given the opportunity to do the following:

   1. Bring witnesses,

   2. Establish all pertinent facts and circumstances,

   3. Present an argument without undue interference, and

   4. Question or refute any testimony or evidence, including the opportunity to confront and cross-examine adverse witnesses.

D. Both parties must be informed that the decision by the county hearing officer may be challenged through the administrative appeal process if either party does not agree with the county hearing officer's decision.

E. The hearing officer must be impartial.

F. A person involved in making the decision being appealed must not be the hearing officer on that particular case.

G. The decision of the hearing officer must be based on an independent review of the facts and on the administrative rules governing this program. This decision must be in writing and must include the following:

   1. A summary of the facts;

2. Identification of the administrative rules supporting the decision; and

3. A statement that if either party does not agree with the decision, a request for an administrative appeal may be made and the address to which such a request should be sent.

7-8 QIO Appeals: An appeal regarding the appropriateness of an admission, length of stay, and medical necessity of the services provided may be submitted to the QIO with which Medicaid has a contract for its outside utilization review. Please contact the Agency's Bureau of Central Services for the contact information.

7-9 Request Format for QIO Appeals: The format of the request must include the name and address of the county official requesting the appeal, the name and address of the hospital providing the service, the patient's name, admission date, discharge date or date emergency outpatient services were provided, medical record number, and a statement of why the county believes the services were inappropriate or unnecessary.

7-10 Appeal Reports: The county must complete Part III of the Monthly Caseload and Appeals Report informing the Agency of the status of such appeals. Instructions on how to complete this report are specified in Chapter 2, Section 2-7. A copy of the report is provided as Appendix B.