

## DMAP questions for appeals and hearings

1. There have been changes made in the hearings process with nothing in writing from MAP or OHA, no consistency in the application, and confusion and anxiety/stress for both plan staff and more importantly, our members. CCOs understand that the hearing process is fluid and constantly changing. Could we please be informed in a uniform manner (in writing) when there is a change, what is involved or required, and a date to implement?
2. Who is allowed to be a plan representative/witness at the hearing?
3. What is the hearing process with regards to expert witnesses and the inability for witnesses (physicians, dentists, and mental health providers) to question the member after they give testimony? Some judges have allowed this, (there has been a change) and some have not. Where it was not allowed, and was felt to be pertinent to the case, the CCO had to recess to allow them to call the expert physician witness and get their questions and then ask them when the hearing reconvened. This seems to be a barrier to a fair hearing; the only information at the hearing that the experts do not have prior to the hearing is the testimony of the member and their representatives. If the CCOs are allowed to recess and call the expert in question, then the questions are asked second hand, which is not optimal, and the hearing takes considerably longer, disrupting schedules.
4. There was a recent change noted in the OAR for denial of Below the Line diagnosis. It appears to have been implemented 1/2015, but it did not appear in the on-line Oregon Administrative rules until the 6/2015 release. CCOs have received some requests for amended NOARs, but there had been no written notification of the change in process regarding the new rule or how it should be applied. This has not been applied 100% in current hearing files where BTL diagnosis is part of the denial, which adds to the confusion for the plans.
5. CCOs have been told that the date of the letter from MAP notifying us that a hearing has been requested starts the clock for the 2/16 day deadline. Recently, one hearing representative stated that the date is the date the appeal was initiated by the plan. This is not consistent. Please clarify the process in writing for all CCOs and distribute it.
6. Many CCOs have expressed concern regarding the amount of administrative hearings requests that are processed all the way to a scheduled hearing and then cancelled. There is an enormous amount of work and paperwork that has to be sent back and forth to complete the process as it currently exists. No benefit to the member.
7. What is the script for the pre-hearing conference for the member, and when does it take place?
8. What is the cause of all these hearings not completed?
9. What is the plan to reduce the amount of hearings not completed?
10. For mental health denials, are the AMH OARs allowed to be used in the denial letters or only the CCO OARs?
11. There have been many questions about what makes the patient waiver valid or in-valid, specifically around the need for a specific CPT or CDT code. Our question is if the CPT or CDT code is missing from the waiver but a description of the service is present is the waiver valid? A CPT/CDT code is not layperson and it seems more appropriate to have the description of the service that the member is agreeing to pay for. I couldn't locate in OAR 410-120-1280 the

specific need for a CPT/CDT code but we have received some push back from the hearing unit recently. For example, a crown on tooth ## is more descriptive than D2750.



## OHP Client Agreement to Pay for Health Services



This is an agreement between a 'client' and a 'provider,' as defined in OAR 410-120-0000. The client agrees to pay the provider for health service(s) not covered by the Oregon Health Plan (OHP), coordinated care organizations (CCOs) or managed care plans. For the purposes of this Agreement "services" include but are not limited to health treatment, equipment, supplies and medications.

### Provider Section

① Health care services requested: \_\_\_\_\_  
 Procedure codes (CPT/HCPCS): \_\_\_\_\_

② Expected date(s) of service: \_\_\_\_\_

③ Condition being treated: \_\_\_\_\_

④ Estimated fees \$ \_\_\_\_\_ to \$ \_\_\_\_\_

Check one:  There are no other costs that are part of this service.  
 There may be other costs that are part of this service and you may have to pay for them, too. Other procedures that usually are part of this service may include:  
 Lab  X-ray  Hospital  Anesthesia  Other

12. A dental plan that has a closed panel does not prior authorize services but creates a treatment plan at the time of the visit. On several occasions the member needs dentures but there is no benefit for dentures as it has been greater than 6 months since edentulous. The dentures are denied at the time of the appointment since there is no benefit but a CDT is not entered on the NOA/NOAR because the dentist is not the specialist and can't assign a clinical code. Recently, one hearing representative has made several requests for call logs or information on how the member requested the service. We are wondering why these logs are necessary as everything is in the clinical record.
13. "Does the state require that CCOs (or other downstream providers) include a time element i.e. received at 11:48 a.m., when the organization date stamps receipt of a members' written request for an appeal of a denial?" We believe this is only required for expedited but wanted confirmation. Including the OAR would help.