

Chapter 182-538B WAC

BEHAVIORAL HEALTH WRAPAROUND SERVICES

WAC

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WAC 182-538B-040 Behavioral health wraparound services. (1) This chapter governs nonmedicaid funded behavioral health services provided under the medicaid agency's behavioral health services wraparound contract.

(2) Washington apple health fully integrated managed care (FIMC) behavioral health wraparound services are available only through a managed care organization (MCO) contracted to provide FIMC services or behavioral health services only (BHSO).

(3) The MCO provides contracted nonmedicaid funded behavioral health wraparound services to medicaid enrollees in an FIMC regional service area:

- (a) Within available resources;
- (b) Based on medical necessity; and
- (c) In order of priority to populations as identified by state and federal authorities.

(4) When nonmedicaid funding is exhausted, behavioral health wraparound services are no longer paid for and cannot be authorized regardless of medical necessity.

[Statutory Authority: RCW 41.05.021, 41.05.160. WSR 16-05-051, § 182-538B-040, filed 2/11/16, effective 4/1/16.]

WAC 182-538B-050 Definitions. The following definitions and those found in chapters 182-500, 182-538, and 182-538A WAC apply to this chapter, unless otherwise stated.

"Action" means the denial or limited authorization of a service covered under the behavioral health services wraparound contract based on medical necessity.

"Available resources" means funds appropriated for the purpose of providing behavioral health wraparound services.

- (a) This includes:
 - (i) Federal funds, except those provided according to Title XIX of the Social Security Act; and
 - (ii) State funds appropriated by the legislature for the purpose of providing services under the behavioral health administrative services organization contract.

(b) This does not include funds appropriated for the purpose of operating and administering the state psychiatric hospitals.

[Statutory Authority: RCW 41.05.021, 41.05.160. WSR 16-05-051, § 182-538B-050, filed 2/11/16, effective 4/1/16.]

WAC 182-538B-110 Grievance system. (1) This section contains information about the managed care organization (MCO) grievance system for enrollees under the behavioral health services wraparound contract in fully integrated managed care (FIMC) regional service areas.

(a) The MCO must have a grievance system to allow enrollees to file grievances and seek review of an MCO action as defined in this chapter.

(b) The agency's hearing rules in chapter 182-526 WAC apply to administrative hearings requested by an enrollee to review the resolution of an enrollee's appeal of an MCO action.

(c) If a conflict exists between the requirements of this chapter and other rules, the requirements of this chapter take precedence.

(d) The MCO's policies and procedures regarding the grievance system must be approved by the agency.

(e) The MCO must maintain records of grievances and appeals.

(2) MCO grievance system. The MCO grievance system includes:

(a) A grievance process for addressing complaints about any matter that is not an action, which is called a grievance;

(b) An appeals process to address an enrollee's request for review of an MCO action;

(c) Access to an independent review by an independent review organization (IRO) under RCW 48.43.535 and WAC 182-526-0200;

(d) Access to the agency's administrative hearing process for review of an MCO's resolution of an appeal; and

(e) Allowing enrollees and their authorized representatives to file grievances and appeals orally or in writing. An MCO cannot require enrollees to provide written follow up for a grievance or an appeal the MCO received orally.

(3) The MCO grievance process.

(a) An enrollee or enrollee's authorized representative may file a grievance with an MCO. A provider may not file a grievance on behalf of an enrollee without the enrollee's written consent.

(b) An enrollee does not have a right to an administrative hearing in regards to the disposition of a grievance.

(c) The MCO must acknowledge receipt of each grievance either orally or in writing within two business days.

(d) The MCO must notify enrollees of the disposition of grievances within five business days of determination.

(4) The MCO appeals process.

(a) An enrollee, the enrollee's authorized representative, or a provider acting on behalf of the enrollee with the enrollee's written consent may appeal an MCO action.

(b) An MCO treats oral inquiries about appealing an action as an appeal to establish the earliest possible filing date for the appeal. The MCO confirms the oral appeal in writing.

(c) An MCO must acknowledge receipt of each appeal to both the enrollee and the requesting provider within three calendar days. The appeal acknowledgment letter sent by the MCO serves as written confirmation of an appeal filed orally by an enrollee.

(d) An appeal of an MCO action must be filed within ninety calendar days of the date on the MCO's notice of action.

(e) The MCO will not be obligated to continue services pending the results of an appeal or subsequent administrative hearing.

(f) The MCO appeals process:

(i) Provides the enrollee a reasonable opportunity to present evidence and allegations of fact or law, both in person and in writing;

(ii) Provides the enrollee and the enrollee's authorized representative opportunity before and during the appeals process to examine the enrollee's case file, including medical records and any other documents and records considered during the appeals process; and

(iii) Includes as parties to the appeal:

(A) The enrollee and the enrollee's authorized representative; and

(B) The legal representative of the deceased enrollee's estate.

(g) The MCO ensures that the individuals making decisions on appeals:

(i) Were not involved in any previous level of review or decision making; and

(ii) Are health care professionals who have appropriate clinical expertise in treating the enrollee's condition or disease if deciding either of the following:

(A) An appeal of an action involving medical necessity; or

(B) An appeal that involves any clinical issues.

(h) Time frames for resolution of appeals.

(i) An MCO resolves each appeal and provides notice as expeditiously as the enrollee's health condition requires and no longer than three calendar days after the day the MCO receives the appeal.

(ii) The MCO may extend the time frame by an additional fourteen calendar days if:

(A) The enrollee requests the extension; or

(B) The MCO determines additional information is needed and delay is in the interests of the enrollee.

(i) Notice of resolution of appeal. The notice of the resolution of the appeal must:

(i) Be in writing and be sent to the enrollee and the requesting provider;

(ii) Include the results of the resolution of the appeal process and the date it was completed; and

(iii) Include information on the enrollee's right to request an agency administrative hearing and how to do so as provided in the agency hearing rules in WAC 182-526-0200, if the appeal is not resolved wholly in favor of the enrollee.

(5) Administrative hearing.

(a) Only an enrollee or enrollee's authorized representative may request an administrative hearing. A provider may not request a hearing on behalf of an enrollee.

(b) If an enrollee does not agree with the MCO's resolution of an appeal, the enrollee may file a request for an agency administrative hearing based on the rules in this section and the agency hearing rules in WAC 182-526-0200.

(c) An MCO is an independent party and responsible for its own representation in any administrative hearing, inde-

pendent review, appeal to the board of appeals, and any subsequent judicial proceedings.

(d) An enrollee must exhaust the appeals process within the MCO's grievance system before requesting an administrative hearing with the agency.

(6) Effect of reversed resolutions of appeals. If an MCO, a final order as defined in chapter 182-526 WAC, or an independent review organization (IRO) reverses a decision to deny or limit services, the MCO must authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires.

(7) Grievance system termination. When available resources are exhausted, any appeals process, independent review, or administrative hearing process related to a request to authorize a service will be terminated, since services cannot be authorized without funding regardless of medical necessity.

[Statutory Authority: RCW 41.05.021, 41.05.160. WSR 16-05-051, § 182-538B-110, filed 2/11/16, effective 4/1/16.]

WAC 182-538B-170 Notice requirements. Chapter 182-518 WAC applies to notice requirements in fully integrated managed care (FIMC) regional service areas.

[Statutory Authority: RCW 41.05.021, 41.05.160. WSR 16-05-051, § 182-538B-170, filed 2/11/16, effective 4/1/16.]