Chapter 182-538B WAC
BEHAVIORAL HEALTH WRAPAROUND SERVICES

WAC

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 and appeal system and agency administrative hearing. (1) **Introduction.** This section contains information about the managed care organization (MCO) grievance and appeal system and the agency's administrative hearing process 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 and appeal system and access to an agency administrative hearing to allow enrollees to file grievances and seek review of an MCO action as defined in this chapter.

(b) The agency's administrative hearing rules in chapter 182-526 WAC apply to agency 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.

(2) **MCO grievance and appeal system.** The MCO grievance and appeal system includes:

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

(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 the enrollee's 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 agency administrative hearing in regards to the resolution 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 resolution 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 in writing receipt of each appeal to both the enrollee and the requesting provider within five calendar days of receiving the appeal request. The

appeal acknowledgment letter sent by the MCO serves as written confirmation of an appeal filed orally by an enrollee.

(d) The enrollee must file an appeal of an MCO action within sixty calendar days of the date on the MCO's notice of action.

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

(f) The MCO appeal 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 representative the enrollee's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the MCO, PIHP or PAHP (or at the direction of the MCO, PIHP or PAHP) in connection with the action. This information must be provided free of charge and sufficiently in advance of the resolution time frame for appeals as specified in this section; 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 people 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 seventy-two hours 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.

(j) **Deemed completion of the appeals process**. If the MCO fails to adhere to the notice and timing requirements for appeals, the enrollee is deemed to have completed the MCO's appeals process and may request an agency administrative hearing under WAC 182-526-0200.

(5) **Agency administrative hearing.**

(a) Only an enrollee or enrollee's authorized representative may request an agency 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 and has completed the MCO appeal process, 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. The enrollee must request an agency administrative hearing within ninety calendar days of the notice of resolution of appeal.

(c) An MCO is an independent party and responsible for its own representation in any agency administrative hearing, independent review, appeal to the board of appeals, and any subsequent judicial proceedings.

(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) **Available resources exhausted.** When available resources are exhausted, any appeals process, independent review, or agency 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 and 42 C.F.R. Parts 431, 433, 438, 440, 457, and 495. WSR 17-23-199, § 182-538B-110, filed 11/22/17, effective 12/23/17. 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.]