

ARTICLE XIV. APPEAL PROCESS

Section 14.01 Re-rating

To re-rate a client, you must complete a new CICIP application.

Sometimes even though clients' financial situations may not have changed, they feel their initial ratings do not accurately reflect their current financial situations. The CICIP has several methods for changing a CICIP client's initial rating. The methods are listed in order below:

1. Provider Management Appeal
2. Provider Management Exception

Section 14.02 Instructions for Filing an Appeal

You must inform the client that they have the right to appeal if they are not satisfied with the rating. All appeals must be handled at the provider level. For example, the client must receive a written denial for a Provider Management Appeal and Provider Management Exception. A client can request a Provider Management Appeal and/or exception in the same letter. Each of these methods requires the client to submit a written request and provide documentation supporting the reasons for the request.

Section 14.03 Provider Management Appeals

A Provider Management Appeal means that an eligibility technician at your facility has found that the client's initial rating was inaccurate. Provider Management Appeals can result in higher or lower ratings depending on the documentation. A client has 15 days from the date of completing the application to request a Provider Management Appeal. If this time frame is not met and there was not a death in the client's immediate family, you do not have to review a Provider Management Appeal. However, please notify the client that the Provider Management Appeal was denied because the client did not submit the request by the deadline.

A client can request a Provider Management Appeal for the following reasons:

1. The initial rating contains inaccurate information or miscalculations because the family member or representative was uninformed, OR
2. Miscommunication between the client and the rating technician caused incomplete or inaccurate data to be recorded on the application.

Each provider must designate a manager to review client appeals and grant management exceptions. A Provider Management Appeal involves receiving a written request from the client and reviewing the application completed by the rating technician, including all back-up documentation, to determine if the CICIP application is accurate. Your facility must notify clients in writing of the results of Provider Management Appeals within 15 working days of receipt of the appeal request from the client.

If the designated manager finds that the initial application is not accurate, the designated manager must correct the application and assign the correct rating to the client. The correct rating is effective retroactive to the initial date of application. This means that

charges incurred 90 days prior to the initial date of application must be discounted. If the initial application is accurate, the designated manager may grant a management exception to the client.

Section 14.04 Provider Management Exception

A Provider Management Exception means that the client has an unusual circumstance, which may justify the lowering of the CICP rating. **Provider Management Exceptions should not be used for applicants who do not qualify for the CICP because their resources exceed the limit (as an example, applicants earning \$100 over income limit).** Clients can either request Provider Management Exceptions when requesting a Provider Management Appeal or within 15 days from receipt of a Provider Management Appeal notice. If this time frame is not met, the provider does not have to review the Provider Management Exception request. However, please notify the client in writing that the Provider Management Exception was denied because the client did not submit the request by the deadline.

Your facility must notify clients in writing of the results of Provider Management Exceptions within 15 working days of receipt of the exception request from the client.

Designated managers can authorize a three-month exception to a client's rating based on unusual circumstances. After the 90-day period ends, the client must be re-rated. You must note Provider Management Exceptions on the application and the designated manager must initial the application. The number of Provider Management Exceptions granted by a provider cannot exceed 5% of all ratings performed. Providers must treat clients equitably in the Provider Management Exception process.

Ratings from a Provider Management Exception are effective retroactive to the initial date of application. This means that charges incurred 90 days prior to the initial date of application must be discounted. CICP providers do not need to honor exceptions made by other CICP providers.

Section 14.05 Department Appeals

The Department has determined that the CICP is NOT a "covered entity" under the Health Insurance Portability and Accountability Act of 1996 privacy regulations (45 C.F.R. Parts 160 and 164). Because the CICP is not a part of Health First Colorado, and its principal activity is the making of grants to providers who serve eligible persons who are medically indigent, CICP is not considered a covered entity under HIPAA. The state personnel administering the CICP will provide oversight in the form of procedures and conditions, to ensure funds provided are being used to serve the target population, but **will not be significantly involved in any health care decisions involving a qualified health care provider or client.**

HIPAA prevents the Department from being involved in client issues due to the Personal Health Information (PHI) clause. Each provider should establish procedures at their facility that sets forth the manner for handling appeals. The applicant should also be notified of these procedures.