Part 6A. Appeals Process for Certain Medicaid and NC Health Choice Determinations.

§ 108A-70.9A. Definitions; Medicaid recipient appeals.

(a) Definitions. – The following definitions apply in this Part:

(1) Adverse determination. – A determination by the Department to deny, terminate, suspend, or reduce a Medicaid service or an authorization for a Medicaid service through the fee-for-service program. An adverse benefit determination as defined in G.S. 108D-1 is not an adverse determination for purposes of this Part.

(1a) Adverse disenrollment decision. – As defined in G.S. 108D-1.

(1b) Contested Medicaid case. – A case commenced by (i) a Medicaid recipient appealing an adverse determination under this Part or (ii) a Medicaid recipient appealing an adverse disenrollment determination under G.S. 108D-5.9.

(2) OAH. – The Office of Administrative Hearings.

(3) Recipient. – A recipient and the recipient's parent, guardian, or legal representative, unless otherwise specified.

(b) Medicaid Recipient Appeals. – Notwithstanding any provision of State law or rules to the contrary, this section shall govern the process used by a Medicaid recipient to appeal an adverse determination made by the Department and the process used by a Medicaid recipient to appeal an adverse disenrollment determination by the Department.

(c) Notice. – Except as otherwise provided by federal law or regulation, at least 10 days before the effective date of an adverse determination, the Department shall notify the recipient, and the provider, if applicable, in writing of the adverse determination and of the recipient's right to appeal the adverse determination. The Department shall not be required to notify a recipient's parent, guardian, or legal representative unless the recipient's parent, guardian, or legal representative has requested in writing to receive the notice. The notice shall be mailed on the date indicated on the notice as the date of the determination. The notice shall include:

(1) An identification of the recipient whose services are being affected by the adverse determination, including the recipient's full name and Medicaid identification number.

(2) An explanation of what service is being denied, terminated, suspended, or reduced and the reason for the determination.

(3) The specific regulation, statute, or medical policy that supports or requires the adverse determination.

(4) The effective date of the adverse determination.

(5) An explanation of the recipient's right to appeal the Department's adverse determination in an evidentiary hearing before an administrative law judge.

(6) An explanation of how the recipient can request a hearing and a statement that the recipient may represent himself or herself or use legal counsel, a relative, or other spokesperson.

(7) A statement that the recipient will continue to receive Medicaid services at the level provided on the day immediately preceding the Department's adverse determination or the amount requested by the recipient, whichever is less, if the recipient requests a hearing before the effective date of the adverse determination. The services shall continue until the hearing is completed and a final decision is rendered.

(8) The name and telephone number of a contact person at the Department to respond in a timely fashion to the recipient's questions.

(9) The telephone number by which the recipient may contact a Legal Aid/Legal Services office.

(10) The appeal request form described in subsection (e) of this section that the recipient may use to request a hearing.

(c1) Notice Availability. – The Department shall make available to OAH a copy of the notice of adverse determination required under subsection (c) of this section. The information contained in the notice is confidential unless the recipient appeals the adverse determination under subsection (d) of this section. OAH may dispose of these records after one year.

(d) Appeals. – Except as provided by this section and G.S. 108A-70.9B, a request for a hearing to appeal an adverse determination of the Department under this section is a contested case subject to the provisions of Article 3 of Chapter 150B of the General Statutes. The recipient shall request a hearing within 30 days of the mailing of the notice required by subsection (c) of this section by filing an appeal request with OAH. Where a request for hearing concerns the reduction, modification, or termination of Medicaid services, including the failure to act upon a timely request for reauthorization with reasonable promptness, upon the receipt of a timely appeal, the Department shall reinstate the services to the level or manner prior to action by the Department as permitted by federal law or regulation. The Department may not influence, limit, or interfere with the recipient's decision to request a hearing.

(e) Appeal Request Form. – Along with the notice required by subsection (c) of this section, the Department shall also provide the recipient with an appeal request form which shall be no more than one side of one page. The form shall include the following:

(1) A statement that, in order to request an appeal, the recipient must file the form with OAH within 30 days of mailing of the notice, and the form may be filed by either (i) sending the form by mail or fax to the address or fax number listed on the form or (ii) calling the telephone number on the form and providing the information requested on the form.

(2) The recipient's name, address, telephone number, and Medicaid identification number.

(3) A preprinted statement that indicates that the recipient would like to appeal the specific adverse determination of which the recipient was notified in the notice.

(3a) The option for the recipient to request an expedited appeal.

(4) A statement informing the recipient that he or she may choose to be represented by a lawyer, a relative, a friend, or other spokesperson.

(5) A space for the recipient's signature and date.

(e1) Expedited Appeal Request. – In accordance with 42 C.F.R. § 431.224, a recipient may request that an appeal under subsection (d) of this section be expedited if the time otherwise permitted for a hearing could jeopardize the recipient's life, health, or ability to attain, maintain, or regain maximum function. With regard to a request for an expedited appeal, all of the following apply:

(1) The recipient shall submit any additional documentation from a licensed health care professional with relevant excerpts from the recipient's medical record that was not already provided with regard to the adverse determination to demonstrate the need for an expedited appeal.

(2) The Department shall determine if the recipient's request meets the criteria for an expedited appeal.

(3) If the Department determines that the recipient's request does not meet the criteria for an expedited appeal, then (i) the Department shall make reasonable efforts to give the recipient, or the recipient's parent, guardian, or legal representative, oral notice of the denial as expeditiously as possible and shall follow up with a written notice of denial and (ii) the recipient's appeal shall not

be subject to the expedited time frame in subdivision (4) of this subsection. The denial is not appealable.

(4) If the Department determines that the recipient's request meets the criteria for an expedited appeal, then (i) the mediation procedure under G.S. 108A-70.9B(c) shall not apply to the appeal request and (ii) the decision required under G.S. 108A-70.9B(g) shall be made as expeditiously as possible.

(f) Final Decision. – After a hearing before an administrative law judge, the judge shall return the decision to the Department in accordance with G.S. 150B-37. The Department shall notify the recipient of the final decision and of the right to judicial review of the decision pursuant to Article 4 of Chapter 150B of the General Statutes. (2010-31, s. 10.30(a); 2011-398, s. 32; 2019-81, s. 6; 2021-62, ss. 2.1(a)-(c), 2.2(a), (b); 2022-74, s. 9D.15(z).)