EmblemHealth

Chapter 33: Dispute Resolution for Medicaid Managed Care Plans

Download the Chapter
Return to Provider Manual
Search the Provider Manual

Chapter Summary

This chapter contains the processes, time frames, and contact information for our Medicaid and HARP managed care plan members and their providers to dispute a determination that results in a denial of payment and/or covered service.

Members have the right to have a designee to file a dispute on their behalf. Our Customer Service department is available to assist. We have interpreter services available to help those with language and hearing/vision impairments.

EmblemHealth contracts with various utilization review agents to manage care for certain groups of members or certain types of medical conditions. In these cases, the designated Managing Entity or the utilization review agent will determine the applicable workflow for filing a dispute. For details, visit the following chapters:

- Behavioral Health Services
- Chiropractic Program
- Outpatient Diagnostic Imaging Privileging, Cardiology Imaging, Radiology, and Radiation Therapy Programs
- Physical and Occupational Therapy Program
- Specialty Pharmacy Program
- Spine Surgery and Pain Management Therapies Program

Utilization review agents are required to follow the regulatory time frames set out in this chapter. Thus, references to EmblemHealth include its Managing Entities and utilization review agents.

We do not discriminate against providers, members or their representatives, or attempt to terminate a provider's agreement or attempt to disenroll a member for filing a request for dispute resolution.

Who Conducts EmblemHealth's Reviews

In general, denials, grievances, and appeals must be peer-to-peer — that is, the credential of the licensed clinician denying the care must be at least equal to the recommending clinician. The reviewer should have clinical experience relevant to the denial. Our reviews are conducted by a qualified medical director who was neither involved in prior determinations nor the subordinate of any person involved in the initial action determination.

For reviews related to children:

1. A physician board-certified in child psychiatry should review all inpatient denials for psychiatric treatment for children under the age of 21.
2. A physician certified in addiction treatment must review all inpatient level of care/continuing stay denials for substance use disorder treatment.
3. Any appeal of a denied behavioral health medication for a child should be reviewed by a board-certified child psychiatrist.
4. A physician must review all denials for services for a Medically Fragile Child and such determinations must take into consideration the needs of the family/caregiver.

We apply the above reviewer criteria to initial (preauthorization), concurrent, retrospective, expedited, and standard reviews.

EmblemHealth will separately track, trend, and report appeals, denials, and complaints (grievances) concerning the Children membership under 21 years of age, including those in the following subpopulations: medically fragile with physical, emotional or developmental disabilities diagnosis, children across multiple Home and Community Based Services (HCBS) categories, and children in voluntary foster care agencies. Additionally, EmblemHealth will also separately track and

Preauthorization and Concurrent Review Requests Notification and Time Frames

Preauthorization and concurrent review requests may be filed as expedited or standard depending on the urgency of the patient's condition.

Expedited Reviews

Expedited review of a Service Authorization Request must be conducted when EmblemHealth determines or the provider indicates that a delay would seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. The member may request expedited review of a Preauthorization Request or Concurrent Review Request.

If EmblemHealth denies the member’s request for expedited review, EmblemHealth must handle the request under standard review time frames.

Preauthorization Decisions

EmblemHealth must make a decision on:

- An expedited preauthorization request (this includes Certified Court Mental Health/Substance Use Disorder (SUD) Services): within 72 hours of receipt of the request
- A standard preauthorization request: within 3 business days of receipt of necessary information but no more than 14 calendar days after the request
- A pharmacy preauthorization request: within 24 hours; immediate authorization for 72-hour emergency supply; immediate access to 5-day supply for SUD treatment medication (from INSL 3216, 3221, and 4303); immediate authorization of 7-day supply for opioid withdrawal/ stabilization.

We will make a decision and notify the member and provider, by phone and in writing, as fast as the member's condition requires.

Concurrent Review Decisions

EmblemHealth must make a decision on:

- An expedited concurrent review request: within 1 business day of receipt of necessary information, but no more than 72 hours of the request
- A standard concurrent review request: within 1 business day of receipt of necessary information but no more than 14 days after the request

We will make a decision and notify the member and provider, by phone and in writing, as fast as the member's condition requires.

Retrospective Review Decisions

EmblemHealth must make a decision within 30 days of receipt of necessary information. We will notify the member by mail on the date of whole or partial payment denial.

EmblemHealth may reverse a preauthorized treatment, service, or procedure on retrospective review pursuant to section 4905(5) of the Public Health Law only when:

1. the relevant medical information presented to EmblemHealth or the utilization review agent upon retrospective review is materially different from the information that was presented during the preauthorization review; and
2. the relevant medical information presented to EmblemHealth or the utilization review agent upon retrospective review existed at the time of the preauthorization but was withheld from or not made available to EmblemHealth or the utilization review agent; and
3. EmblemHealth or the utilization review agent was not aware of the existence of the information at the time of the preauthorization review; and
4. had EmblemHealth or the utilization review agent been aware of the information, the treatment, service, or procedure being requested would not have been authorized. This determination is to be made using the same specific standards, criteria, or procedures as used during the preauthorization review.

Extensions for Expedited and Standard Review Time Frames

Expedited and standard preauthorization and concurrent reviews may be extended by an additional 14 days if:

1. The member, designee, or provider requests an extension; or
2. We demonstrate there is a need for more information and the extension is in the member's interest.
3. We will send the member a notice of the extension which includes:
    - The reason for the extension.
    - An explanation of how the delay is in the best interest of the member.
    - A description of any additional information that EmblemHealth requires to make its determination.
    - Information regarding the member's right to file a complaint regarding the extension.
    - The process for filing a complaint and the time frames within which a complaint determination must be made.
    - The member's right to designate a representative to file a complaint on his/her behalf.
    - Information regarding the member's right to contact the New York State Department of Health, including a toll-free number.

Initial Adverse Determination

Reasons for Adverse Determinations – Also Called Actions

We send a written notice of action on the date of denial when a service authorization request for a health care service, procedure, or treatment is given an adverse determination (denial) based on the following grounds:

- service is not medically necessary
- request did not have enough information to determine if the service is medically necessary
- service is experimental/investigational
- service is not covered by benefits
- the benefit coverage limit has been reached
- service can be provided by a participating provider
- service is not very different from a service that is available from a participating provider

Failure to make a utilization review (UR) determination within the specified regulatory time periods is deemed an adverse determination subject to appeal. EmblemHealth must send notice of denial on the date the utilization review's time frames expire.

Notices of Action

All notices of action shall be in writing, in easily understood language, and accessible to non-English-speaking and visually impaired members. Oral interpretation and alternate formats of written material for members with special needs are available. We make reasonable effort to provide oral notice to the member and provider at the time the initial adverse determination is made.

Notice of Action Content

A notice of action provides an explanation of our decision. The required content for notices of action are summarized in Table 22-9: Notice of Action Content.

Reconsideration

When we make an adverse determination without provider input, the provider has the right to a reconsideration. The member's health care provider and the clinical peer reviewer making the initial determination shall conduct the reconsideration within 1 business day of receipt of the request (except for retrospective, which is within 30 days of the request).

Note: When we deny a claim exclusively due to untimely filing, the provider acting on their own behalf may file a request for reconsideration. In order to qualify, the provider must demonstrate that the late submission was an unusual occurrence and that they have a pattern of submitting claims in a timely manner.

Appeal Options for Medicare Members Who Also Have Medicaid Benefits (Dual-Eligible Members)

The dual-eligible member has the choice of selecting a Medicaid or Medicare appeal process. In the written notice of the initial adverse determination, we provide notice that:

- A Medicare appeal must be filed within 60 days from the date of the denial.
- Filing a Medicare appeal means that the member cannot file for a State Fair Hearing.
- The member may still file for Medicare appeal after filing for a Medicaid Action Appeal, if it is within the 60-day period.

Who May File an Action Appeal (Standard Appeal)

A member may dispute an action themselves or designate a person to act on their behalf. To appoint a designee who is not the member's practitioner, the member must fax or mail to EmblemHealth a signed HIPAA-compliant Appointment of Representative form or a Power of Attorney form specifying the authorized designee.

A provider may file a utilization review (UR) Action Appeal for concurrent and retrospective denials. A provider does not need an Appointment of Representative form or Power of Attorney form to file a dispute on behalf of a member.

How to File an Action Appeal (Standard Appeal)

Procedures for initiating a standard Action Appeal are provided in Table 22-1: Standard Action Appeals Procedures for Members and Practitioners.

The member may file a written Action Appeal or an oral Action Appeal. Oral Action Appeals must be followed by a written and signed Action Appeal. EmblemHealth may provide a written summary of an oral Action Appeal to the member (with the acknowledgement or separately) for the member to review, modify if needed, and sign and return to EmblemHealth. If the member or provider requests expedited resolution of the Action Appeal, the oral Action Appeal does not need to be confirmed in writing. The date of the oral filing of the Action Appeal will be the date of the Action Appeal for the purposes of the time frames for resolution of Action Appeals. Action Appeals resulting from a Concurrent Review must be handled as an expedited Action Appeal.

The standard Action Appeal may be filed in writing or by telephone along with:

- a copy of the Action Appeal,
- an explanation detailing the review request, and
- all documentation to support a reversal of the decision.

A clinical peer reviewer is available within 1 business day.

Before and during the appeal review period, the member or designee may see their case file. The member may present evidence to support their Action Appeal in person or in writing.

Acknowledgement of Standard Action Appeal

We send acknowledgement within 15 days of receipt of the Action Appeal and may request any necessary information in writing. Oral Action Appeals are followed up by written and signed Action Appeals.

Oral Action Appeal acknowledgement letters include a statement summarizing the substance of the Action Appeal. If the substance of this summary is not accurate or is not understood by the member/representative, he/she is instructed in the letter to correct the attached confirmation statement and return it to EmblemHealth.

Expedited Action Appeals

If a member, designee, practitioner acting on a member's behalf, or practitioner acting on their own behalf is not satisfied with an Action, including a medical necessity determination, experimental/investigational determination, rare disease determination or (in certain instances) out-of-network determination, and a delay would seriously jeopardize the member's life, health or ability to attain, maintain or regain maximum function, the member may request an expedited Action Appeal.

An expedited Action Appeal may be filed:

- For continued or extended health care services, procedures or treatments
- For additional services for member undergoing a course of continued treatment
- When the health care provider believes an immediate appeal is warranted
- When EmblemHealth honors the member's request for an expedited review

Process for Filing an Expedited Action Appeal

The utilization review (UR) Action Appeal may be filed in writing or by telephone. Expedited Action Appeals should be accompanied by:

- a copy of the Action,
- an explanation detailing the review request, and
- all documentation to support a reversal of the decision.

Time Frame for Expedited Action Appeal Decisions

The review time frame begins upon EmblemHealth’s receipt of the Action Appeal, whether filed orally or in writing. If EmblemHealth requires information necessary to conduct an expedited Action Appeal, EmblemHealth shall immediately contact the member and provider by telephone or fax to identify and request information necessary to conduct the expedited Action Appeal.

An expedited Action Appeal is decided as fast as the member's condition requires and within 2 business days of receipt of the necessary information, but no more than 72 hours from receipt of the Action Appeal. This time may be extended for up to 14 days upon:

- member’s request,
- provider request or
- EmblemHealth demonstrates more information is needed, delay is in member’s best interest, and EmblemHealth notifies member.

Denial of an Expedited Action Appeal Request

If EmblemHealth denies the member's request for an expedited Action Appeal, the Action Appeal will proceed under Standard Action Appeal time frames and EmblemHealth will immediately notify the member by phone, followed by written notice within 2 days of the denial.

Expedited Action Appeals not resolved to the satisfaction of the appealing party may be re-appealed via the Standard Action Appeal process or through the external appeal process.

Review of Expedited Action Appeal Requests

A qualified EmblemHealth medical director who was neither involved in prior determinations nor the subordinate of any person involved in the Initial Adverse Determination will conduct the Expedited Action Appeal review. A clinical peer reviewer is available to discuss the Action Appeal within 1 business day.

Before and during the Action Appeal review period, the member or designee may see their case file. The member may present

evidence to support their Action Appeal in person or in writing.

Expedited utilization review Action Appeals are reviewed and if request is denied, a written notice of final adverse determination is transmitted to the member within 24 hours of rendering the determination. EmblemHealth makes reasonable efforts to provide oral notice to the member and provider at the time the determination is made.

Failure to make a determination with the applicable time periods is deemed a reversal of the utilization review agent's adverse determination. Procedures for initiating an Expedited Action Appeal are outlined in Table 22-2: Expedited Action Appeals Procedures for Members.

Final Adverse Determinations

Waiving the Internal Appeal Process

The member and EmblemHealth may jointly agree to waive the internal appeal process. If this occurs, EmblemHealth must provide a written letter with instructions for filing an external appeal to the member. We will send this letter within 24 hours of the agreement to waive EmblemHealth's internal appeal process. For more information, please see the section on New York State External Appeals later in this chapter.

Missing Information

We will notify the member and their provider, in writing, within 15 days of receipt of the Action Appeal, of missing information necessary to conduct the Action Appeal. The notice will identify and request submission of same. If only a portion of such necessary information is received, we shall request the missing information, in writing, within 5 business days of receipt of the partial information.

Notice of Final Action Appeal Determination

We will notify the member, the member's designee, and provider in writing of the Action Appeal determination within 2 business days of when we make the decision.

We will make an Action Appeal determination as fast as the member's condition requires, and no later than 30 days from receipt of the Action Appeal .This time may be extended for up to 14 days upon the member or provider's request, or if we demonstrate that more information is needed, and a delay is in the member’s best interest and we provide the member with notice.

Action Appeals are reviewed and EmblemHealth notifies the member, the member's designee, and provider in writing of the appeal determination within 2 business days of when EmblemHealth makes the decision.

Failure to make a determination within the applicable time periods is deemed a reversal of the utilization review agent's adverse determination.

Payments for Services in Dispute

Our network practitioners may not seek payment from members for either covered services or services determined by our Care Management program not to be medically necessary unless the member is told the cost of the service and agrees, in writing and in advance of the service, to such payment as a private patient and the written agreement is placed in the member's medical record. Any practitioner attempting to collect such payment from the member in the absence of such a written agreement does so in breach of the EmblemHealth Participation Agreement. Such breach may be grounds for termination of the practitioner's contract.

Final Adverse Determination Notification

When a decision regarding an Action Appeal is upheld in whole or in part, we issue a final adverse determination (FAD).

We make reasonable efforts to provide oral notice to the member and provider at the time the determination is made. We send written notice of final adverse determination concerning an expedited utilization review (UR) appeal to the member within 24 hours of making the determination.

Notices to members of final action appeal adverse determinations are in writing, dated and summarized in the Table 22-9:Notice of Action Content.

Practitioner Complaint and Grievance Procedures

Practitioner Complaint Process

If a practitioner is dissatisfied with an administrative process, quality-of-care issue, and/or any aspect of service rendered by EmblemHealth that does not pertain to a benefit or claim determination, the practitioner may file a complaint on his/her own behalf. Examples of such dissatisfaction include:

- Long wait times on EmblemHealth's authorization phone lines
- Difficulty accessing EmblemHealth's systems
- Quality-of-care issues

Once a decision is made on a practitioner's complaint, it is considered final and there are no additional internal review rights.

Complaints must be submitted in writing to the EmblemHealth Grievance and Appeals (GAD) department. A complaint should include a detailed explanation of the clinician's request and any documentation to support the practitioner's position.

EmblemHealth acknowledges receipt of the practitioner's complaint in writing no later than 15 days after its receipt. Practitioner complaints are reviewed and a written response is issued directly to the practitioner no later than 30 days after receipt. See Table 22-3: Complaint Procedures for Practitioners.

Practitioner Grievance Process

If a practitioner is not satisfied with any aspect of a claim determination rendered by EmblemHealth (or any entity designated to perform administrative functions on its behalf) which does not pertain to a medical necessity determination, that practitioner may file a grievance with EmblemHealth.

Examples of reasons for filing grievances include: dissatisfaction with a decision resulting from a failure to follow EmblemHealth policy or procedure, or failure to obtain preauthorization for an inpatient admission. A practitioner may also file a grievance regarding how a claim is processed, including issues such as computational errors, interpretation of contract reimbursement terms, or timeliness of payment. The Grievance and Appeals Department is not involved in determining claim payment or authorizing services, but independently investigates all grievances.

In addition, providers who wish to challenge the recovery of an overpayment or request a reconsideration for claims denied exclusively for untimely filing may follow the grievance procedures in this sub-section.

Note: The right to reconsideration shall not apply to a GHI claim submitted 365 days after the service, or a HIP claim submitted 120 days after the service, unless the participation agreement states an alternative time frame to be applied. If a claim was submitted more than one year from date of service, EmblemHealth may deny the claim in full or in the alternative may reduce payments by up to 25% of the amount that would have been paid had the claim been submitted in a timely manner.

For grievances related to untimely filing, the provider must demonstrate that the late submission was an unusual occurrence and that they have a pattern of submitting claims in a timely manner. Examples of an unusual occurrence include:

- Medicaid reclamation
- Member submitted the wrong insurance information to the provider
- Coordination of Benefits-related issues
- Member retroactively reinstated

The practitioner has the option to question a claim's payment by submitting an inquiry along with supporting documentation in the secure provider portal at emblemhealth.com/providers using My Messages under username drop-down. For multiple claims, utilize the messenger center function to send grievances and attach files.

The grievance should be accompanied by a copy of the notice of the standard denial or other documentation of the denial, an explanation outlining the details of the request for a review, and all documentation to support a reversal of the decision.

EmblemHealth acknowledges, in writing, receipt of a grievance that is submitted in writing no later than 15 days after its receipt. The grievance is reviewed, and a written response is issued for grievances with a final disposition of partial overturn or upheld, no later than 45 days after receipt. The determination included in the response is final. See Table 22-8: Grievance Procedures for Practitioners.

Grievances with a favorable disposition receive a claims remittance advice in lieu of a written response no later than 45 days after receipt.

Member Complaint Process

A member, member's designee, or practitioner acting on a member's behalf may file a complaint when the member is dissatisfied with any aspect of service rendered by EmblemHealth that *does not* pertain to an action. Examples of such dissatisfaction include:

- Treatment received from EmblemHealth, its practitioners, or benefit administrators
- Quality of care
- EmblemHealth's privacy practices in using or disclosing protected health information
- Alleged violation of EmblemHealth's privacy practices and/or state and federal law regarding the privacy of protected health information
- Fraud and abuse

Complaints should include a detailed description of the circumstances surrounding the occurrence. EmblemHealth acknowledges receipt of the complaint and requests any necessary information in writing. Complaints are reviewed, and a response is issued in writing within the time frames applicable to the member's benefit plan as detailed in Table 22-4: Expedited Complaint Procedures for Members and Table 22-5: Standard Complaint Procedures for Members.

Member Complaint Appeal Process

If a member, member's designee, or practitioner acting on behalf of a member is not satisfied with the resolution of a complaint, EmblemHealth provides a complaint appeal process.

To initiate a complaint appeal, a member, designee, or practitioner must make the request in writing. EmblemHealth responds within the time frames noted in Table 22-6: Expedited Complaint Appeals Process for Members and Table 22-7: Standard Complaint Appeals Process for Members. Once we reach a decision, that decision is final and there are no further internal appeals.

Complaint appeals should include a detailed explanation of the request and any documentation to support the member's position.

Complaint appeals filed verbally must be followed up with a written, signed appeal.

New York State External Appeals

A member has a right to an external appeal of a final adverse determination. New York State's External Appeal Law provides the opportunity for the external review of adverse determinations for members and providers based on lack of medical necessity, experimental/investigational treatment, clinical trial, or in certain instances, out-of-network services. Further, a member, the member's designee and, in conjunction with retrospective adverse determinations, a member's health care provider has the right to request an external appeal.

This law also applies to rare diseases, which are defined as any life-threatening or disabling condition that is or was subject to review by the National Institutes of Health's Rare Disease Council or affects fewer than 200,000 U.S. residents per year, and there is no standard health service or treatment more beneficial than the requested health service or treatment. To qualify as a rare disease, the condition must be certified by an outside physician specialized in an area appropriate to treat the disease in question. The patient should likely benefit from the proposed treatment and the benefits must outweigh the risks.

The provider may only file an external review on their own behalf for concurrent and retrospective adverse determinations.

Right to Request an External Appeal

Members have the right to request an external appeal when:

1. The member has had coverage of a health care service, which would otherwise be a covered benefit under a subscriber contract or governmental health benefit program, denied on appeal, in whole or in part, on the grounds that such health care service is not medically necessary ,and
2. EmblemHealth has rendered a final adverse determination with respect to such health care service or both EmblemHealth and the member have jointly agreed to waive any internal appeal.

Filing an External Appeal

An external appeal may also be filed when:

1. The member has had coverage of a health care service denied on the basis that such service is experimental or investigational and the denial has been upheld on appeal or both EmblemHealth and the member have jointly agreed to waive any internal appeal, and
2. the member's attending physician has certified that the member has a life-threatening or disabling condition or disease (a) for which standard health services or procedures have been ineffective or would be medically inappropriate or (b) for which there does not exist a more beneficial standard health service or procedure covered by the health care plan or (c) for which there exists a clinical trial or rare disease treatment, and

3. the member's attending physician, who must be a licensed, board-certified or board-eligible physician qualified to practice in the area of practice appropriate to treat the member's life-threatening or disabling condition or disease, must have recommended either (a) a health service or procedure including a pharmaceutical product within the meaning of PHL4900(5)(b)(B) that, based on two documents from the available medical and scientific evidence, is likely to be more beneficial to the member than any covered standard health service or procedure, or in the case of a rare disease, based on the physician's certification required by Section 4900 (7)(g) of the PHL and such other evidence as the member, the designee or the attending doctor may present, that the requested health service or procedure is likely to benefit the member in the treatment of the enrollee's rare disease and that the benefit outweighs the risks of such health service or procedure; or (b) a clinical trial for which the member is eligible. Any physician certification provided under this section shall include a statement of the evidence relied upon by the physician in certifying his or her recommendation, and
4. the specific health service or procedure recommended by the attending physician would otherwise be covered under the policy except for EmblemHealth's determination that the health service or procedure is experimental or investigational.

External Appeal for Denial of Out-of-Network Service

1. The member has had coverage of the health service, which would otherwise be a covered benefit under the member's benefit plan which is denied on appeal, in whole or in part, on the grounds that such health service is out-of-network and an alternate recommended health service is available in-network, and EmblemHealth has rendered a final adverse determination with respect to an out-of-network denial or both EmblemHealth and the member have jointly agreed to waive any internal appeal; and
2. the member's attending doctor, who shall be a licensed, board-certified or board-eligible physician qualified to practice in the specialty area of practice appropriate to treat the member for the health service sought, certifies that the out-of-network health service is materially different from the alternate recommended in-network service, and recommends a health care service that, based on two documents from the available medical and scientific evidence, is likely to be more clinically beneficial than the alternate recommended in-network treatment and the adverse risk of the requested health service would likely not be substantially increased over the alternate recommended in-network health service.

EmblemHealth has only one level of internal appeal; it does not require the member to exhaust any second level of internal appeal to be eligible for an external appeal.

How to File an External Clinical Appeal

To file an external clinical appeal, the practitioner appealing on his/her own behalf must complete a New York State External Appeal Application with the New York State Department of Financial Services (DFS) within 60 days of the date of the final adverse determination.

The member and member's designee (including the provider in the capacity of the member's designee) may submit the same form within 4 months of the final adverse determination. If the member files on their own behalf, signed applications authorizing the release of medical records must also be sent to DFS along with the application. (Note: Application fees are waived for Medicaid members.)

An external appeal must be submitted within the applicable time frame upon receipt of the final adverse determination of the first level appeal, regardless of whether or not a second level appeal is requested. If a member chooses to request a second level internal appeal, the time may expire for the member to request an external appeal.

DFS screens applications and assigns eligible appeals to state-certified external appeals agents. DFS then notifies both the filer and EmblemHealth whether the request is eligible for appeal, provides explanation thereof, and sends a copy of the signed release form.

EmblemHealth provides medical and treatment records and an itemization of the clinical standards used to determine medical necessity within 3 business days of receiving the agent's information and completed release forms. For an expedited appeal, this information is provided within 24 hours of receipt.

For urgent medical circumstances, an expedited review may be requested which renders a decision within 3 days. For standard

cases, a determination is made within 30 days from receipt of the member's request, in accordance with the commissioner's instructions. The external appeal agent shall have the opportunity to request additional information from the member, practitioner, and EmblemHealth within the 30-day period, in which case the agent shall have up to 5 additional business days to make a determination.

The decision of the external appeal agent is final and binding on both the member and EmblemHealth.

For questions or help with an application, contact DFS at 800-400-8882 or email externalappealquestions@dfs.ny.gov.

Note: Practitioners appealing concurrent review determinations cannot pursue reimbursement from members other than copayments from a member for services deemed not medically necessary by the external appeal agent.

New York State Fair Hearings

Medicaid Members' Rights to a State Fair Hearing

In accordance with applicable federal and state laws and regulations, Medicaid members may request a fair hearing after receiving an appeal resolution that an adverse benefit determination has been upheld. An enrollee may be deemed to have exhausted the plan's appeal process and may request a state fair hearing where notice and time frame requirements have not been met. EmblemHealth must abide by and participate in New York State's Fair Hearing Process and comply with determinations made by a fair hearing officer.

Along with the right to a fair hearing for the reasons stated above, the member has a right to information on how to request a fair hearing, the rules of a fair hearing, the right to Aid Continuing, and information on their liability for services if EmblemHealth's denial is upheld in a fair hearing.

EmblemHealth members may request a fair hearing for adverse local department of social service (LDSS) determinations concerning enrollment, disenrollment and eligibility, and the denial, termination, suspension or reduction of a clinical treatment or other benefit package services by EmblemHealth or the delegate entity responsible for managing the member's medical care. For issues related to disputed services, members must have received a final adverse determination either overriding a recommendation to provide services by a participating provider or confirming the decision of a participating provider to deny those services. Members who choose to request a fair hearing must do so within 120 days from the date of our final adverse determination notice.

Members may also seek a fair hearing for a failure by EmblemHealth to comply with required notification time frames.

Members may request a fair hearing by:

- Telephone: 800-342-3334
- Fax: 518-473-6735
- Internet: www.otda.ny.gov
- Mail:

  New York State Office of Temporary and Disability Assistance
  Office of Administrative Hearings
  Managed Care Hearing Unit
  PO Box 22023
  Albany, NY 12201

Members have a right to:

- Designate an individual to represent them in fair hearing proceedings. Members may also be able to get legal help by contacting their local Legal Aid Society or advocate group.
- Free copies of the Evidence Package that EmblemHealth gives to the fair hearing officer. We send a copy of the Evidence Package to members at the same time we send it to the fair hearing officer.
- Free copies of other documents from the member's file that the member may want for the fair hearing.

To ask for copies of documents, the member may call 800-447-8255 or write to EmblemHealth at PO Box 2844, New York, NY 10116. Members should ask for these documents before the date of the fair hearing. Usually, they are sent within 3 working days of when the request was received.

If the services a member is receiving are scheduled to end, the member can choose to ask to continue the services ordered by his/her doctor pending the fair hearing decision. If the fair hearing officer grants Aid Continuing, the member will continue to receive services until the fair hearing determination is made. However, if the fair hearing is decided against the member, the member may have to pay the cost for the services received while waiting for the decision.

Fair hearing officer determinations are final and supersede New York State External Review determinations.

Aid Continuing

EmblemHealth must provide Aid Continuing immediately upon receipt of a Plan Appeal disputing the termination, suspension, or reduction of a previously authorized service, the partial approval, termination, suspension, or reduction in quantity or level of services authorized for long-term services and supports or nursing home stay for a subsequent authorization period, filed verbally or in writing within 10 days of the date of the notice of adverse benefit determination (Initial Adverse Determination), or the effective date of the action, whichever is later, unless the enrollee indicates they do not wish their services to continue unchanged.

EmblemHealth and its contractors will be required to continue or restore the provision of services that are the subject of appeal under the following circumstances:

- When EmblemHealth has or is seeking to reduce, suspend, or terminate a treatment or benefit package service currently being provided.
- When the enrollee is in receipt of LTSS or nursing home services (short-term or long-term) and the plan determines to partially approve, suspend, terminate, or reduce level or quantity of LTSS or nursing home stay (short-term or long-term) for a subsequent authorization period.
- While a Plan Appeal or Fair Hearing is pending, if the enrollee timely requests the Plan Appeal and/or Fair Hearing.
  - Timely filing means:
    - The enrollee must ask for a Plan Appeal within 10 days of the initial adverse determination notice or by the effective date of the decision, whichever is later.
    - The enrollee must ask for a Fair Hearing within 10 days of the final adverse determination, or by the effective date of the appeal decision, whichever is later.

EmblemHealth will provide Aid Continuing until one of the following occurs (whichever comes first):

- The enrollee withdraws the request for Aid Continuing, the plan appeal, or the fair hearing;
- The enrollee fails to request a fair hearing within 10 days of the plan´s final adverse determination or the effective date of the decision, whichever is later;
- The provider order has expired, except in the case of a home bound enrollee.

Reconsideration Rights for Network Terminations and Non-renewal

A reconsideration request may be initiated if the terminated or non-renewed provider believes that there is significant and relevant information about his/her practice which might be unknown to EmblemHealth. EmblemHealth will review this additional information in reconsideration of this decision. Please note, however, that reconsideration may only apply to the Enhanced Care Prime Network. All decisions are final. The terminated or non-renewed provider has 30 days from receipt of the termination letter or provider contract non-renewal notification letter to request reconsideration. Upon receipt of a completed reconsideration request, EmblemHealth will schedule a telephonic hearing to be held during normal business hours. For terminations and non-renewals from the VIP Prime Network, see Dispute Resolution for Medicare Plans.

To request a reconsideration of your termination or non-renewal from the Enhanced Care Prime Network, please follow these instructions:

- Should you exercise your right to an appeal/hearing of this decision, your response should be sent to Tonya Volcy, Director of Credentialing, by certified mail, return receipt requested, to the following address:

  Tonya Volcy
  Director of Credentialing
  EmblemHealth
  55 Water Street, 2nd floor
  New York, NY 10041

- Requests submitted must include a letter describing special circumstances of which EmblemHealth may be unaware.
- Reconsideration meetings will be scheduled and conducted via phone during normal business hours.
- An Ad hoc Reconsideration Board, consisting of 3 physicians, will conduct the reconsideration hearing.
- The Ad hoc Reconsideration Board makes the final decision.
- The provider will be notified in writing within 7 business days of the decision.
- Providers whose termination or non-renewal status is upheld will be notified, citing the original date of the change. Participation in the impacted networks will continue uninterrupted for providers whose termination or non-renewal status is overturned.