EmblemHealth

Chapter 34: Dispute Resolution for Medicare Plans

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Chapter Summary

This chapter contains processes for our Medicare members and practitioners to dispute a determination that results in a denial of payment or covered service.

To see the dispute resolution process for our other members, view:

HIP Medicaid plans.

Commercial and HIP Child Health Plus plans.

Overview

EmblemHealth provides processes for members and practitioners to dispute a determination that results in a denial of payment and/or covered services. Process, terminology, filing instructions, applicable time frames, and additional and/or external review rights vary based on the type of plan in which the member is enrolled.

The processes in this section apply to EmblemHealth Medicare HMO and EmblemHealth Medicare PPO plans, as well as Medicare Part D plans. Integrated Benefits Dual plans include coverage components from both Medicare Advantage and Medicaid managed care. These dual-eligible members have the right to select which dispute process to use.

We do not discriminate against practitioners or members or attempt to terminate a practitioner's agreement or disenroll a member for filing a request for dispute resolution. We have interpreter services available to assist members with language and hearing/vision impairments.

Payments for Services in Dispute
EmblemHealth network practitioners may not seek payment from members for either covered services or services determined by EmblemHealth's Care Management program not to be medically necessary unless the member 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 contractual provisions with EmblemHealth. Such breach may be grounds for termination of the practitioner's contract.

Key Terminology

The descriptions below provide a general overview of the dispute resolution terminology used with Medicare Advantage plans.

Appeal
A request to review any aspect of a claim determination, adverse benefit determination, or an adverse clinical determination denied with regards to medical necessity.

Complaint
A request to review an administrative process, service, or quality of care issue NOT pertaining to a medical necessity determination, a benefit determination, or a claims determination.

Coverage Determination
A notification sent when a Part D drug is denied.

Grievance
A request to review a claim determination NOT pertaining to a medical necessity determination. Certain disputes may be filed as Expedited or Standard depending on the urgency of the patient's condition. Certain disputes may also be filed as Pre-Service or Post-Service depending on the timing of the determination in question.

Organization Determination
A notification sent when a health care service, procedure or treatment is denied.

Managing Entities
EmblemHealth contracts with separate managing entities to provide care for certain types of medical conditions. In these cases, the designated managing entity will determine the applicable process for filing a dispute.

Appointing a Designee
Members wishing to dispute a determination or claim denial may do so themselves or designate a person or practitioner to act on their behalf. To appoint a designee, members must submit by fax or by mail a signed Appointment of Representative (AOR) form or a Power of Attorney form that specifies the individual as an authorized party.

Extensions
In certain circumstances, dispute resolution time frames may be extended if permitted by law and requested by the complainant, or if EmblemHealth believes an extension is in the best interest of the member.

Initial Adverse Determinations

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

- Service does not meet or no longer meets the criteria for medical necessity, based on the information provided to us.
- Service is considered to be experimental or investigational (rare disease).
- Elective non-urgent service requested by an out-of-network provider can be provided by a participating provider, and there is no medical necessity to access an out-of-network provider.
- Service is approved, but the amount, scope or duration is less than requested.

- Service is not a covered benefit under the member's benefit plan.
- Service is a covered benefit under the member's benefit plan, but the member has exhausted the benefit for that service.

The written notice will be sent to the member and provider and will include:

- The description of the action EmblemHealth has taken or intends to take.
- The reasons for the initial adverse determination, including the clinical rationale, if any.
- The member's right to file an appeal, including the member's right to designate a representative to file an appeal on his or her behalf.
- The process and time frame for filing/reviewing an appeal with EmblemHealth, including
  - An explanation that an expedited review of the appeal can be requested if a delay would significantly increase the risk to a member's health.
  - A toll-free number for filing an appeal.
- Instructions on how to initiate an appeal and time frames for submitting the appeal.
- Notice of the availability, upon request of the member or the member's designee, of the clinical review criteria relied upon to make such determination.
- EmblemHealth's time frame for making a decision on an appeal.

In the written notice of initial adverse determination to all dual-eligible members, EmblemHealth will 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 Medicaid appeal, if it is within the appeal review period.

Retrospective Review Requests
For retrospective review requests, EmblemHealth must make a decision and provide written notification of the determination. The decision must be made within 30 days of receipt of the necessary information.

Final Adverse Determinations

For decisions that uphold or partially uphold a determination made regarding a clinical issue for which no additional internal appeal options are available to the contracted provider, EmblemHealth will issue a final adverse determination (FAD) in writing to the contracted facility.

The FAD contains the following information:

- The date the review request was received.
- A summary of the review.
- The results and the reasons for the determination, including the clinical rationale.
- The words "final adverse determination."
- A clear statement that the notice constitutes the final adverse determination.
- The terms "medical necessity" or "experimental/investigational."
- The member's coverage type.
- The service in question and, if available and applicable, the name of the provider and developer/manufacturer of the health care service.
- Information on available alternative and/or external dispute resolution options. To determine if further resolution options are applicable, please refer to your contract agreement.

Notice of Final Appeal Determination
We will notify the contracted facility in writing of the final appeal determination.

Provider Dispute Resolution Procedures: Complaints and Grievances

Procedures for initiating a contracted provider complaint/grievance with respect to an EmblemHealth Medicare member are outlined in the table below.

Table 23-1, Provider Complaint/Grievance Procedures

Practitioner Complaint Procedures
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 their own behalf. Examples of such dissatisfaction include:

- Long wait times on EmblemHealth's authorization phone lines.
- Difficulty using 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's Grievance and Appeals Department. A complaint should include a detailed explanation of the clinician's request and any documentation to support the practitioner's position.

EmblemHealth will acknowledge receipt of the practitioner's complaint in writing no later than 15 days after its receipt. Practitioner complaints will be reviewed, and a written response will be issued directly to the practitioner no later than 30 days after receipt.

Contracted Provider Grievance Process for Medicare HMO and PPO Plans
If a provider 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 provider may file a claim inquiry with EmblemHealth. If the inquiry does not resolve the issue, the provider may then file a grievance.

The provider should use the secure provider portal to submit a claim inquiry along with **supporting documentation**. To initiate an inquiry, sign in to **emblemhealth.com/providers** and follow these steps:

1. Select the Claims tab and click Search Claims to **locate** your claim.
2. On the Claims Detail page, click Ask a Question.
3. On the Message Details page, select Claims and Payments category (and a subcategory) to file a claim inquiry.
4. Enter Message Content and upload Attachments (if necessary) and click Submit.

If the provider is not satisfied with the outcome of the inquiry, they have the option of filing a grievance via the secure provider portal. To submit a grievance, sign in to **emblemhealth.com/providers** and follow these steps:

1. Click the User Profile icon and select My Messages.
2. On the My Messages page, search and **locate** the message you submitted for the initial claim inquiry.
3. Click Follow-up to create a linked message.
4. On the Message Details page, select Grievances & Appeals category (and a subcategory) to file a grievance.
5. Enter Message Content and upload Attachments (if necessary) and click Submit.

See the provider portal **training guides and videos** for step-by-step instructions on using the Message Center and Claims –

Search, View, and Export.

The Grievance and Appeals Department is not involved in determining claim payment or authorizing services, but independently investigates all grievances.

Examples of reasons for filing grievances include dissatisfaction with a decision resulting from a failure to follow a plan policy or procedure, or failure to obtain prior approval for an inpatient admission. A provider may also file a grievance regarding how a claim was processed, including issues such as computational errors, interpretation of contract reimbursement terms, or timeliness of payment.

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 claim submitted after the time frame outlined in the Timely Submission section of the **Claims chapter**. If a claim was submitted more than the specified time frame, EmblemHealth may deny the claim in full or may reduce payments by up to 25 percent 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 provider the wrong insurance information.
- Coordination of Benefits related issues.
- Member retroactively reinstated.

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 will acknowledge, in writing, receipt of a grievance that is submitted in writing no later than 15 days after its receipt. The grievance will be reviewed, and a written response will be issued for grievances with a final disposition of partial overturn or upheld, no later than 30 days after receipt. The determination included in the response will be final.

Grievances with a favorable disposition will receive a claims remittance advice in lieu of a written response no later than 30 days after receipt.

Notice of Determinations of Grievance Decision
The written Notice of Determination will include the following:

- The date the request was received.
- Detailed reasons for the determination, including the clinical rational if applicable.
- A statement that the notice is a final determination.
- Notice that the member and EmblemHealth will be held harmless.

Facility Retrospective Utilization Reviews Requests For Medicare HMO

View **Table 23-2, Facility Retrospective Review Request**

If an EmblemHealth-contracted facility fails to follow prior approval and/or emergency admittance procedures, payments for such services may be denied and the facility, EmblemHealth or its managing entity may initiate a retrospective utilization review (RUR).

For Denials Based on No Prior Approval Medicare HMO Only
If the facility fails to obtain prior approval, payment will be denied for "no prior approval." The remittance statement will include information regarding the facility's right to request a retrospective utilization review for medical necessity. See the "Care Management" chapter.

If the facility fails to request a retrospective utilization review and submit the medical record within 45 days of receipt of the remittance statement, the claim denial will be upheld, and the facility will have no further appeal rights.

If EmblemHealth or the managing entity fails to render and communicate a timely decision to the facility, the case will be deemed automatically denied and the facility will have the right to a clinical appeal of the decision.

For Denials Based on "No E.R. Notification" - Medicare HMO Only
If the facility admits a patient through the emergency room without notifying EmblemHealth or the managing entity and submits a claim for services rendered, EmblemHealth will request medical records to initiate a retrospective utilization review for medical necessity.

If the facility fails to submit the medical record within the time frame, the facility will receive an adverse determination stating inability to establish medical necessity based on no information received. The facility will then have the opportunity to file a facility clinical appeal.

Facility Clinical Appeals

Procedures for initiating a contracted facility clinical appeal are outlined in **Table 23-3, Appeal - Contracted Facility Clinical Appeal**.

EmblemHealth may reverse a prior approval decision for a treatment, service, or procedure on retrospective review when:

- 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 prior approval.
- The information existed at the time of the prior approval review but was withheld or not made available.
- EmblemHealth or the utilization review agent was not aware of the existence of the information at the time of the prior approval review.
- Had they been aware of the information, the treatment, service, or procedure being requested would not have been authorized.

Contracted Facility Clinical Appeals - Medicare HMO Plans
If an EmblemHealth-contracted facility is not satisfied with an initial adverse determination related to an EmblemHealth Medicare HMO member for a retrospective review that was rendered based on issues of medical necessity, experimental or investigational use, or services cannot be approved because the facility has not submitted information to establish medical necessity, an appeal may be filed. EmblemHealth provides one internal level of appeal for facilities. EmblemHealth will acknowledge receipt of the appeal request in writing within 15 calendar days.

EmblemHealth handles all facility clinical appeals, except in the following situations, where the managing entity handles the appeal:

- If the managing entity has a direct contract with the facility.

- The managing entity has denied the case based on medical information.
- The managing entity has denied the case for "no information."

An EmblemHealth medical director reviews appeals. Personnel who have previously rendered decisions in the case or subordinate(s) of that person are not permitted to render a decision on the appeal.

EmblemHealth or the managing entity will render a decision within 60 days of receipt of the appeal request.

For Medicare PPO facility disputes, please refer to the Provider Dispute Resolution Procedures: Complaints and Grievances section in this chapter.

Member Grievance and Appeal Procedures

The processes members need to follow if they want to report a problem, file a grievance, or submit an appeal are documented in the members' Evidence of Coverage. This is the same process a provider would follow when acting on behalf of a member. Copies of each Medicare plan's Evidence of Coverage can be found on our Web site at **emblemhealth.com/plans/medicare-advantage** by searching under the applicable plan.

Member Grievance Procedures
An EmblemHealth Medicare enrollee may file a grievance if he or she has a problem with us or one of our network providers or pharmacies related to office or prescription fill waiting times, the behavior of a network provider or pharmacist, or the inability to reach someone by phone. Complaints regarding coverage for a service or prescription drug are not considered a grievance under these terms.

An EmblemHealth Medicare enrollee or his or her representative may file a grievance by phone or in writing no later than 60 days after the incident that precipitated the grievance. Grievances submitted in writing will be responded to in writing. Grievances submitted by phone may be responded to either by phone or in writing unless the enrollee requests a written response. All grievances related to quality of care, regardless of how the grievance is filed, will be responded to in writing.

EmblemHealth will notify the enrollee of its decision as soon as possible, but no later than 30 days after the date EmblemHealth receives the grievance. This time period may be extended by up to 14 days if the enrollee requests such an extension or EmblemHealth can justify the need. If EmblemHealth extends the timeframe, the enrollee will be immediately notified.

Grievances can be filed as follows:

EmblemHealth Medicare HMO

- Sign in to **emblemhealth.com** and use My Messages under username drop-down.
- In writing: EmblemHealth Grievance and Appeal Department
  P.O. Box 2807
  New York, NY 10116
- By phone: **877-344-7364** (TTY: **711**).

EmblemHealth Medicare PPO

- Sign in to **emblemhealth.com** and use My Messages under username drop-down.
- In writing: EmblemHealth Grievance and Appeal Department
  P.O. Box 2807
  New York, NY 10116
- By phone: **866-557-7300** (TTY: **711**).

EmblemHealth Medicare PDP (City of New York employees)

- In writing: Express Scripts
  Attn: Pharmacy Appeals GH3
  6625 West 78th Street
  Mail Route B20390
  Bloomington, MN 55439
- By phone: **800-585-5786** (TTY: **711**).

Standard Reconsiderations (Appeals) - Part C
An enrollee who has received an adverse organization determination may request that it be reconsidered.

For standard reconsiderations, an enrollee or his or her representative must make a request within 60 calendar days of the notice of the organization determination. This may be extended if the enrollee shows good cause (in writing). For expedited reconsiderations, an enrollee or his or her prescribing physician may make a request by phone or in writing. EmblemHealth will promptly decide whether to expedite the request.

EmblemHealth will notify the enrollee of its decision no later than 30 calendar days for pre-service requests and no later than 60 calendar days for post service requests from the date the request was received. If a standard reconsideration request is granted in whole or in part, EmblemHealth will effectuate the decision no later than 30/60 calendar days from the date the reconsideration request was received. For pre-service appeals, EmblemHealth may take an extension of up to 14 calendar days if requested by the member or in the member's best interest.

Standard reconsiderations (appeals) for Medicare Part C can be filed as follows:

EmblemHealth Medicare HMO
- Sign in to: **emblemhealth.com** and use My Messages under username drop-down.
- In writing: EmblemHealth Grievance and Appeal Department
  PO Box 2807
  New York, NY 10116
- By phone: **877-344-7364** (TTY: **711**).

EmblemHealth Medicare PPO
- Sign in to: **emblemhealth.com** and use My Messages under username drop-down.
- In writing: EmblemHealth Grievance and Appeal Department
  P.O. Box 2807
  New York, NY 10116
- By phone: **866-557-7300** (TTY: **711**).

Reopening Medicare Part C
EmblemHealth, as a National Committee for Quality Assurance (NCQA)-certified Medicare Managed Care Organization, does not recognize Peer-to-Peer Conversations as a mechanism to change adverse determination decisions. Therefore, the only mechanisms available for physicians to challenge an initial adverse organization determination are to either:

1. Submit Reconsideration per Section 70.2 in the Medicare Managed Care Manual (MMCM) as described in the Appeal Rights page attached to the Medicare Denial Notice. Reopening requests must be clearly stated in writing and include the specific reason for requesting the Reopening such as good cause and new and additional material evidence or;
2. Submit a written Reopening Request per Section 130.1 in the MMCM.

In the event the subject of an appeal is to address a clerical error, (minor errors or omission) EmblemHealth will process the request as a Reopening, instead of a Reconsideration. A Reopening is defined as a remedial action taken to change a final determination or decision even though the determination or decision was correct based on the evidence of record. The process of Reopening applies only to Medicare Part C products and does not apply to Medicare Part D services.

Reopening requests must be submitted within one (1) year of the initial determination however the timeframe may be extended if good cause is established. EmblemHealth will not reopen an issue that is under appeal until all appeal rights, at the particular appeal level, have been exhausted. The decision to grant the Reopening request is solely EmblemHealth's discretion.

Good cause is established when:

- The evidence that was considered in making the organization determination decision clearly shows on its face that an obvious error was made at the time of the organization determination decision. For example, a piece of evidence could have been contained in the file but misinterpreted or overlooked by the person making the determination.
- There is new and additional material evidence that was not available or known at the time of the initial organization determination decision. New and material evidence is evidence that may result in a conclusion different from that reached in the initial organization determination.

If the request is found not to qualify under the Reopening Process, EmblemHealth will advise the enrollee or his or her representative of any appeal rights they may have and provide the time frame to request an appeal assuming the original denial has not expired.

For additional information, please go to the Medicare Managed Care Appeals & Grievances section of the CMS website: **cms.gov/Medicare/Appeals-and-Grievances/MMCAG/index.html**.

Standard Redeterminations (Appeals) - Part D
An enrollee who has received an adverse coverage determination for a drug may request that it be redetermined.

For standard redeterminations, an enrollee, or their representative, must make a redetermination request within 60 calendar days of the notice of the coverage determination. This may be extended if the enrollee shows good cause (in writing). For expedited redeterminations, an enrollee or their prescribing physician may make a request by phone or in writing. EmblemHealth will promptly decide whether to expedite the request.

EmblemHealth will notify an enrollee of the decision no later than 7 calendar days from receipt of the request. If a standard redetermination request is granted in whole or in part, EmblemHealth will authorize the drug in question no later than 7 calendar days from receipt. If a standard redetermination request for payment is granted in whole or in part, EmblemHealth will effectuate the decision no later than 7 calendar days from receipt of the request and make payment no more than 30 days from receipt.

Standard redeterminations (appeals) for Medicare Part D can be filed as follows:

EmblemHealth Medicare HMO

- Sign in to: **emblemhealth.com** and use My Messages under username drop-down.
- In writing: EmblemHealth Grievance and Appeal Department
  P.O. Box 2807
  New York, NY 10116
- By phone: **877-344-7364** (TTY: **711**).

EmblemHealth Medicare PPO

- Sign in to: **emblemhealth.com** and use My Messages under username drop-down.
- In writing: EmblemHealth Grievance and Appeal Department
  P.O. Box 2807
  New York, NY 10116
- By phone: **866-557-7300** (TTY: **711**).

EmblemHealth Medicare PDP (City of New York employees)

- Sign in to: **emblemhealth.com** and use My Messages under username drop-down
- In writing: EmblemHealth Grievance and Appeal Department
  P.O. Box 2807
  New York, NY 10116
- By phone: **877-444-7241** (TTY: **711**).