DISPUTE RESOLUTION FOR COMMERCIAL AND CHP PLANS

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DISPUTE RESOLUTION FOR COMMERCIAL AND CHP PLANS

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

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 Commercial/CHP plans.

View the processes for **Medicaid plans**.

View the processes for **Medicare plans**.

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 following descriptions provide a general overview of the terminology used with Commercial plans (including Child Health Plus).

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

Appeal
A request to review any aspect of an adverse clinical determination based on medical necessity.

Complaint
A request to review an administrative process, service or quality-of-care issue that does not pertain to a determination based on claims, benefits or medical necessity.

Grievance
A request to review any aspect of an adverse benefit or claim determination that is not based

on medical necessity.

Certain disputes - whether they are appeals, complaints or grievances - 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.

Managing Entities' Role in Dispute Resolution

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. Any aspect of service rendered by EmblemHealth or any entity designated to perform administrative functions on our behalf is hereafter jointly referred to as "EmblemHealth."

INITIAL ADVERSE DETERMINATIONS

EmblemHealth will send a written notice on the date when a 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, clinical trial and out-of-network services).
- 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 reasons for the determination, including the clinical rationale, if any.
- Instructions on how to initiate internal appeals (standard and expedited appeals) and eligibility for external appeals.
- 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.
- A description of what additional information, if any, must be provided to, or obtained by, EmblemHealth in order for EmblemHealth to make an appeal determination.
- The description of the Action to be taken.
- A statement that EmblemHealth will not retaliate or take any discriminatory action against the member if an appeal is filed.
- The process and time frame for filing/reviewing an appeal with EmblemHealth, including the member's right to file an expedited review.
- The member's right to contact the DOH, with 1-800 number regarding their complaint.

The failure of EmblemHealth to make a utilization review (UR) determination within the time periods prescribed in the **Care Management** chapter is deemed to be an adverse determination

subject to appeal. EmblemHealth must send notice of denial on the date that the utilization review's time frames expire.

Reconsideration

When an adverse determination is rendered without provider input, the provider has the right to reconsideration. The reconsideration shall occur within one business day of receipt of the request (except for retrospective, which is within 5 days) and shall be conducted by the member's health care provider and the clinical peer reviewer making the initial determination. See the **Care Management** chapter for more information.

Retrospective Review Requests

For retrospective review requests, EmblemHealth must make a decision and notify member by mail on the date of the payment denial, in whole or in part. The decision must be made within 30 days of receipt of the necessary information.

EmblemHealth may reverse a prior approval decision for a treatment, service or procedure on retrospective review pursuant to section 4905(5) of PHL 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; and
- The information existed at the time of the prior approval review but was withheld or not made available; and
- EmblemHealth or the utilization review agent was not aware of the existence of the information at the time of the prior approval review; and
- Had they been aware of the information, the treatment, service or procedure being requested would not have been authorized.

Home Health Care Determinations Following an Inpatient Hospital Admission

EmblemHealth will provide notice of our determination within one business day of receipt of the necessary information, or if the day after the request for services falls on a weekend or holiday, within 72 hours of receipt of necessary information. If a request for home health care services and all necessary information is provided to us prior to a member's inpatient hospital discharge, we will not deny the home care coverage request on the basis of a lack of medical necessity or a lack of prior authorization while the review determination is pending. There may, however, be other reasons for denying the service such as the exhaustion of a benefit. Denials for home health services following a discharge from a hospital admission will be treated as expedited appeals.

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, EmblemHealth will issue a final adverse determination (FAD) in writing to the member and provider.

The FAD contains the following information:

- The basis and clinical rationale for the determination.
- The words "final adverse determination."
- EmblemHealth contact person and phone number.
- The member's coverage type.
- EmblemHealth's contact person or UR agent, address and phone number.
- A summary of the appeal.
- The date the appeal was filed.
- The date the appeal process was completed.
- The health service that was denied, including the name of the facility/provider and developer/manufacturer of the health care service as available.
- A statement that the member may be eligible for external appeal and time frames for appeal.
- A standard description of external appeals process, including a clear statement in bold that the member/designee has 4 months and the provider has 60 days (45 days before July 1, 2014) from the final adverse determination to request an external appeal and choosing a second level of internal appeal may cause the time to file external appeal to expire. This applies to GHI PPO FEHB plan members only.
- Standard description of external appeals process attached.
- The terms "medical necessity", "experimental/investigational", "out-of-network", "clinical trial" or "rare disease treatment".
- Information on available alternative and/or external dispute resolution options.

Notice of Final Appeal Determination

EmblemHealth will notify the member or member's designee in writing of the final appeal determination within two business days of when we make the decision. However, written notice of final adverse determination concerning an expedited utilization review appeal shall be transmitted to the member within 24 hours of rendering the determination.

PRACTITIONER DISPUTE RESOLUTION PROCEDURES: COMPLAINTS AND GRIEVANCES

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's 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.

The Plan 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.

Practitioner Grievance Process

If a practitioner is not satisfied with any aspect of a claim determination rendered by the Plan (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 a Plan policy or procedure, or failure to obtain prior approval for an inpatient admission. A practitioner 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. The Grievance and Appeal 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 commercial 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 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 agree to reduce payments by up to twenty five 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 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 within the Claim's Inquiry function in the secure site at **www.emblemhealth.com**. For multiple claims, utilize the messenger center function to send grievance 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 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 45 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 45 days after receipt.

TABLE 21-1, PRACTITIONER COMPLAINT/GRIEVANCE PROCEDURES					
COMMERCIAL AND CHILD HEALTH PLUS PLANS					
BENEFIT PLAN(S)	**WHAT/HOW /WHERE TO FILE HARD COPY****	**TIME FRAMES***			**ADDITIONAL RIGHTS**
		Initial Practitioner Filing	**EmblemHealth Acknowledges Receipt**	**EmblemHealth Determination Notification**	
HIP Commercial, HIP Child Health Plus and EmblemHealth CompreHealth EPO (Retired August 1, 2018)	Unless otherwise directed in the denial letter or Explanation of Payment (EOP), write to: EmblemHealth Grievance and Appeal Dept PO Box 2844 New York, NY 10116-2844 Telephone: **1-800-447-8255**	60 calendar days from event.	15 calendar days from receipt of the request.	Complaint: 30 calendar days from receipt of request. Grievance: 45 calendar days from receipt of request.	Decision is final.
GHI HMO	Unless otherwise directed in the denial letter or Explanation of Payment	90 calendar days from event.	15 calendar days from receipt of the request.	Complaint: 30 calendar days from receipt of request. Grievance: 45	Decision is final.

	(EOP), write to: GHI HMO Appeals and Complaints Dept PO Box 2807 New York, NY 10117-2807 Telephone: **1-877-244-4466** TDD: **1-877-208-7920** Fax to: **1-845-340-3435**			calendar days from receipt of request.	
GHI EPO/PPO and EmblemHealth EPO/PPO	Unless otherwise directed in the denial letter or Explanation of Payment (EOP), write to: EmblemHealth/GHI PO Box 2857 New York, NY 10116-2857 Telephone: **1-212-501-4444**	90 calendar days from event.	15 calendar days from receipt of the request.	Complaint: 30 calendar days from receipt of request. Grievance: 45 calendar days from receipt of request.	Decision is final.

*Privacy complaints are not subject to the above timeframes.

** Emblemhealth.com is the preferred method for filing.

MEMBER DISPUTE RESOLUTION PROCEDURES: COMPLAINTS AND GRIEVANCES

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 HIPAA Compliant Authorization 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.

Member Complaint - First Level Process

A member or designee may file a first level complaint when the member is dissatisfied with any aspect of an EmblemHealth-rendered service that does not pertain to a benefit or claim determination. Examples of such dissatisfaction include:

- Dissatisfaction with treatment received from EmblemHealth, its practitioners or benefit administrators
- Quality-of-care complaints
- Privacy complaints regarding EmblemHealth's 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 will acknowledge receipt of the complaint and request any necessary information in writing. Complaints will be reviewed and a response will be issued in writing according to the time frames applicable to the member's benefit plan and detailed in the table on the following pages.

TABLE 21-2, FIRST MEMBER LEVEL COMPLAINT - EXPEDITED					
COMMERCIAL AND CHILD HEALTH PLUS PLANS					
BENEFIT PLAN(S)	**WHAT/HOW /WHERE TO FILE**	**TIME FRAMES**			**ADDITIONAL RIGHTS**
		Initial Member Filing	**EmblemHealth Acknowledges Receipt**	**EmblemHealth Determination Notification**	
HIP Commercial,	Write to:	60 business days from	N/A	Verbal response	May file a second level

HIP Child Health Plus and EmblemHealth CompreHealth EPO (Retired August 1, 2018)	EmblemHealth Grievance and Appeal Dept PO Box 2844 New York, NY 10116-2844 Telephone: **1-800-447-8255**	event.		within 48 hours of receipt of necessary information. Written notice sent within 3 business days of determination	complaint, expedited or standard. Additional complaint may be filed with the NYS DOH at any time by calling **1-800-206-8125.**
GHI HMO	Write to: GHI HMO Appeals and Complaints Dept PO Box 2807 New York, NY 10117-2807 Telephone: **1-877-244-4466** TTY/TDD: **711** Fax to: **1-845-340-3435**	90 calendar days from event.	N/A	Verbal response within 48 hours of receipt of necessary information. Written notice sent within 3 business days of determination.	May file a second level complaint, expedited or standard Additional complaint may be filed with the NYS DOH at any time by calling **1-800-206-8125.**
GHI and EmblemHealth EPO/PPO	Write to: EmblemHealth/GHI PO Box 2857 New York, NY 10116 Telephone: **1-212-501-4444**	90 calendar days from event.	N/A	Verbal response within 48 hours of receipt of necessary information Written notice sent within 3 business days	May file a second level complaint, expedited or standard.

				of determinatio n.	

TABLE 21-3, FIRST LEVEL MEMBER COMPLAINT - STANDARD					
COMMERCIAL AND CHILD HEALTH PLUS PLANS					
BENEFIT PLAN(S)	**WHAT/HOW /WHERE TO FILE**	**TIME FRAMES**			**ADDITIONAL RIGHTS**
		Initial Member Filing	**EmblemHealth Acknowledges Receipt**	**EmblemHealth Determination Notification**	
HIP Commercial, HIP Child Health Plus and EmblemHealth CompreHealth EPO (Retired August 1, 2018)	Write to: EmblemHealth Grievance and Appeal Dept PO Box 2844 New York, NY 10116-2844 Telephone: **1-800-447-8255**	60 business days from event.	15 business days from the receipt of the request	45 calendar days from receipt of all necessary information.	May file a second level complaint. Additional complaint may be filed with the NYS DOH at any time by calling **1-800-206-8125.**
GHI HMO	Write to: GHI HMO Appeals and Complaints Dept PO Box 2807 New York, NY 10117-2807 Telephone: **1-877-244-4466** TTY/TDD: **711** Fax to:	90 calendar days from event.	15 business days from the receipt of the request	45 calendar days from receipt of all necessary information.	May file a second level complaint. Additional complaint may be filed with the NYS DOH at any time by calling **1-800-206-8125.**

	1-845-340-3435				
GHI and EmblemHealth EPO/PPO	Write to: EmblemHealth/GHI PO Box 2857 New York, NY 10116 Telephone: **1-212-501-4444**	90 calendar days from event.	15 business days from the receipt of the request	45 calendar days from receipt of all necessary information.	May file a second level complaint.

Member Complaint - Second Level Process

If a member or designee is not satisfied with the resolution of a first level complaint, EmblemHealth provides a second level complaint review.

To initiate a second level complaint, a member or designee must submit the second level complaint for review. We will respond within the timeframes noted in the tables on the following pages. Once we reach a decision, that decision is final and there are no further formal appeals or external mediation opportunities. Please refer to the grids, as in some instances, a member may have the right to complain to the NYS Department of Health.

Second level complaints should include a detailed explanation of the request and any documentation to support the member's position.

TABLE 21-4, SECOND LEVEL MEMBER COMPLAINT - EXPEDITED					
COMMERCIAL AND CHILD HEALTH PLUS PLANS					
BENEFIT PLAN(S)	**WHAT/HOW /WHERE TO FILE**	**TIME FRAMES**			**ADDITIONAL RIGHTS**
		Initial Member Filing	**EmblemHealth Acknowledges Receipt**	**EmblemHealth Determination Notification**	
HIP Commercial, HIP Child Health Plus and EmblemHealth CompreHealth EPO	Write to: EmblemHealth Grievance and Appeal Dept PO Box 2844 New York, NY	60 business days from receipt of first level determination.	N/A	2 business days from receipt of necessary information.	Additional complaints may be filed with the NYS DOH at any time by calling **1-800-206-8125.**

(Retired August 1, 2018)	10116-2844 Telephone: **1-800-447-8255**				
GHI HMO	Write to: GHI HMO Appeals and Complaints Dept PO Box 2807 New York, NY 10117-2807 Telephone: **1-877-244-4466** TTY/TDD: **711** Fax to: **1-845-340-3435**	60 business days from receipt of first level determination.	N/A	2 business days from receipt of necessary information.	Additional complaints may be filed with the NYS DOH at any time by calling **1-800-206-8125.**
GHI and EmblemHealth EPO/PPO	Write to: EmblemHealth/GHI PO Box 2857 New York, NY 10116 Telephone: **1-212-501-4444**	60 business days from receipt of first level determination.	N/A	2 business days from receipt of necessary information.	Decision is final.

TABLE 21-5, SECOND LEVEL MEMBER COMPLAINT - STANDARD					
COMMERCIAL AND CHILD HEALTH PLUS PLANS					
BENEFIT PLAN(S)	**WHAT/HOW /WHERE TO FILE**	**TIME FRAMES**			**ADDITIONAL RIGHTS**
		Initial Member Filing	**EmblemHealth Acknowledges Receipt**	**EmblemHealth Determination Notification**	

HIP Commercial, HIP Child Health Plus and EmblemHealth CompreHealth EPO (Retired August 1, 2018)	Write to: EmblemHealth Grievance and Appeal Dept PO Box 2844 New York, NY 10116-2844 Telephone: **1-800-447-8255**	60 business days from receipt of first level determination.	15 business days from receipt of the request.	30 business days from receipt of all necessary information.	Additional complaints may be filed with the NYS DOH at any time by calling **1-800-206-8125.**
GHI HMO	Write to: GHI HMO Appeals and Complaints Dept PO Box 2807 New York, NY 10117-2807 Telephone: **1-877-244-4466** TTY/TDD: **711** Fax to: **1-845-340-3435**	60 business days from receipt of first level determination.	15 business days from receipt of the request.	30 business days from receipt of all necessary information.	Additional complaints may be filed with the NYS DOH at any time by calling **1-800-206-8125.**
GHI and EmblemHealth EPO/PPO	Write to: EmblemHealth/GHI PO Box 2857 New York, NY 10116 Telephone: **1-212-501-4444**	60 business days from receipt of first level determination.	15 business days from receipt of the request.	30 business days from receipt of all necessary information.	Decision is final.

Member Grievance - First Level Process

If a member or designee is not satisfied with any aspect of a benefit or claim determination rendered by EmblemHealth that does not pertain to a medical necessity, experimental determination or investigational determination, he/she may file a first level grievance.

Grievances should be accompanied by a copy of the adverse determination, an explanation outlining the details of the request for a review and all documentation to support a reversal of the decision. We will acknowledge receipt of the grievance and request any necessary information in writing. Grievances will be reviewed and a response will be issued according to the time frames detailed in the tables on the following pages.

TABLE 21-6, FIRST LEVEL MEMBER GRIEVANCE - EXPEDITED					
COMMERCIAL AND CHILD HEALTH PLUS PLANS					
BENEFIT PLAN(S)	**WHAT/HOW /WHERE TO FILE**	**TIME FRAMES**			**ADDITIONAL RIGHTS**
		Initial Member Filing	**EmblemHealth Acknowledges Receipt**	**EmblemHealth Determination Notification**	
HIP Commercial, HIP Child Health Plus and EmblemHealth CompreHealth EPO (Retired August 1, 2018)	Unless otherwise directed in the denial letter, write to: EmblemHealth Grievance and Appeal Dept PO Box 2844 New York, NY 10116-2844 Telephone: **1-800-447-8255**	180 calendar days from receipt of written adverse determination.	N/A	No later than 48 hours from receipt of all necessary information but not to exceed 72 hours from receipt of the grievance. Verbally at time of determination. Written notice provided no later than 48 hours from receipt of all necessary information or 72 hours	May file a second level grievance. Additional complaints may be filed with the NYS DOH at any time by calling **1-800-206-8125.**

				from receipt of the grievance.	
GHI HMO	Unless otherwise directed in the denial letter, write to: GHI HMO Appeals and Complaints Dept PO Box 2807 New York, NY 10117-2807 Telephone: **1-877-244-4466** TTY/TDD: **711** Fax to: **1-845-340-3435**	180 calendar days from receipt of written adverse determination.	N/A	No later than 48 hours from receipt of all necessary information but not to exceed 72 hours from receipt of the grievance. Verbally at time of determination. Written notice provided no later than 48 hours from receipt of all necessary information or 72 hours from receipt of the grievance.	May file a second level grievance. Additional complaints may be filed with the NYS DOH at any time by calling **1-800-206-8125.**
GHI and EmblemHealth EPO/PPO	Unless otherwise directed in the denial letter, write to: EmblemHealth/GHI PO Box 2857 New York, NY 10116	180 calendar days from receipt of written adverse determination.	N/A	No later than 48 hours from receipt of all necessary information but not to exceed 72 hours from receipt of the grievance.	May file a second level grievance.

	Telephone: **1-212-501-4444**			Verbally at time of determination. Written notice provided no later than 48 hours from receipt of all necessary information or 72 hours from receipt of the grievance.	

TABLE 21-7, FIRST LEVEL MEMBER GRIEVANCE - STANDARD					
FOR COMMERCIAL AND CHILD HEALTH PLUS PLANS					
BENEFIT PLAN(S)	**WHAT/HOW /WHERE TO FILE:** **INSTRUCTIONS**	**TIME FRAMES**			**ADDITIONAL RIGHTS**
		Initial Member Filing	**EmblemHealth Acknowledges Receipt**	**EmblemHealth Determination Notification**	
HIP Commercial, HIP Child Health Plus and EmblemHealth CompreHealth EPO (Retired August 1, 2018)	Unless otherwise directed in the denial letter, write to: EmblemHealth Grievance and Appeal Dept PO Box 2844 New York, NY 10116-2844 Telephone: **1-800-447-82**	180 calendar days from receipt of written adverse determination.	Pre-Service: Acknowledgement is not required if the response is sent by the 15th calendar day of receipt. Post-Service: 15 calendar days from receipt of the grievance.	Pre-Service: 15 calendar days from receipt of the grievance. Post-Service: 30 calendar days from receipt of grievance.	May file a second level grievance. Additional complaints may be filed with the NYS DOH at any time by calling **1-800-206-8125.**

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GHI HMO	Unless otherwise directed in the denial letter, write to: GHI HMO Appeals and Complaints Dept PO Box 2807 New York, NY 10117-2807 Telephone: **1-877-244-4466** TTY/TDD: **711** Fax to: **1-845-340-3435**	180 calendar days from receipt of written adverse determination.	*15 business days from receipt of the grievance (post-service) *acknowledgement is not required if responded to within 15 calendar days	Pre-Service: 15 calendar days from receipt of the grievance. Post-Service: 30 calendar days from receipt of grievance.	May file a second level grievance Additional complaints may be filed with the NYS DOH at any time by calling **1-800-206-8125.**
GHI and EmblemHealth EPO/PPO	Unless otherwise directed in the denial letter, write to: EmblemHealth/GHI PO Box 2857 New York, NY 10116 Telephone: **1-212-501-4444**	180 calendar days from receipt of written adverse determination.	*15 business days from receipt of the grievance (post-service) *acknowledgement is not required if responded to within 15 calendar days	Pre-Service: 15 calendar days from receipt of the grievance. Post-Service: 30 calendar days from receipt of grievance.	May file a second level grievance.

Member Grievance - Second Level Process

If a member or designee is not satisfied with the resolution of a first level grievance, we provide

a second level grievance review.

To initiate a second level member grievance, the member or designee must submit the second level grievance with all supporting documentation. We will review the grievance and respond within the time frames noted in the tables on the following pages.

TABLE 21-8, SECOND LEVEL MEMBER GRIEVANCE - EXPEDITED					
COMMERCIAL AND CHILD HEALTH PLUS PLANS					
BENEFIT PLAN(S)	**WHAT/HOW /WHERE TO FILE:** **INSTRUCTIONS**	**TIME FRAMES**			**ADDITIONAL RIGHTS**
		Initial Member Filing	**EmblemHealth Acknowledges Receipt**	**EmblemHealth Determination Notification**	
HIP Commercial, HIP Child Health Plus and EmblemHealth CompreHealth EPO (Retired August 1, 2018)	Unless otherwise directed in the denial letter, write to: EmblemHealth Grievance and Appeal Dept PO Box 2844 New York, NY 10116-2844 Telephone: **1-800-447-8255**	60 business days from receipt of written grievance determination.	N/A	Within 2 business days of receipt of necessary information but not to exceed 72 hours. Verbally at time of determination. Written notice is provided no later than 2 business days from receipt of all necessary information, or 72 hours from receipt of the grievance.	Additional complaints may be filed with the NYS DOH at any time by calling **1-800-206-8125.**
GHI HMO	Unless otherwise directed in the denial	60 business days from receipt of written	N/A	Within 2 business days of receipt of necessary	Additional complaints may be filed with the NYS

	letter, write to: GHI HMO Appeals and Complaints Dept PO Box 2844 New York, NY 10116-2844 Telephone: **1-877-244-4466**	grievance determination.		information but not to exceed 72 hours. Verbally at time of determination. Written notice is provided no later than 2 business days from receipt of all necessary information, or 72 hours from receipt of the grievance.	DOH at any time by calling **1-800-206-8125.**
GHI and EmblemHealth EPO/PPO	Unless otherwise directed in the denial letter, write to: EmblemHealth/GHI PO Box 2844 New York, NY 10116 Telephone: **1-212-501-4444**	60 business days from receipt of written grievance determination.	-- N/A	Within 2 business days of receipt of necessary information but not to exceed 72 hours. Verbally at time of determination. Written notice is provided no later than 2 business days from receipt of all necessary information, or 72 hours from receipt	Decision is final

				of the grievance.	

TABLE 21-9, SECOND LEVEL MEMBER GRIEVANCE - STANDARD					
COMMERCIAL AND CHILD HEALTH PLUS PLANS					
BENEFIT PLAN(S)	**WHAT/HOW /WHERE TO FILE INSTRUCTIONS**	**TIME FRAMES**			**ADDITIONAL RIGHTS**
		Initial Practitioner Filing	**EmblemHealth Acknowledges Receipt**	**EmblemHealth Determination Notification**	
HIP Commercial, HIP Child Health Plus and EmblemHealth CompreHealth EPO (Retired August 1, 2018)	Unless otherwise directed in the denial letter, write to: EmblemHealth Grievance and Appeal Dept PO Box 2844 New York, NY 10116-2844 Telephone: **1-800-447-8255**	60 business days from receipt of written grievance determination.	Pre-Service: Acknowledgement is not required if responded to within 15 calendar days. Post-Service: 15 calendar days from receipt of the grievance-appeal.	Pre-Service: 15 calendar days from receipt of grievance-appeal. Post-Service: 30 calendar days from receipt of grievance-appeal.	Additional complaints may be filed with the NYS DOH at any time by calling **1-800-206-8125.**
GHI HMO	Unless otherwise directed in the denial letter, write to: GHI HMO Appeals and Complaints Dept PO Box 2844 New York, NY	60 business days from receipt of written grievance determination.	Pre-Service: Acknowledgement is not required if responded to within 15 calendar days. Post-Service: 15 calendar days from receipt of the grievance-	Pre-Service: 15 calendar days from receipt of grievance-appeal. Post-Service: 30 calendar days from receipt of grievance-appeal.	Additional complaints may be filed with the NYS DOH at any time by calling **1-800-206-8125.**

	10116-2844 Telephone: **1-877-244-4466**		appeal.		
GHI and EmblemHealth EPO/PPO	Unless otherwise directed in the denial letter, write to: EmblemHealth/GHI PO Box 2844 New York, NY 10116-2844 Telephone: **1-877-842-3625**	60 business days from receipt of written grievance determination.	Pre-Service: Acknowledgement is not required if responded to within 15 calendar days. Post-Service: 15 calendar days from receipt of the grievance-appeal.	Pre-Service: 15 calendar days from receipt of grievance-appeal. Post-Service: 30 calendar days from receipt of grievance --	Decision is final.

PROVIDER AND MEMBER CLINICAL APPEAL PROCESSES

Waiving the Internal Appeal Process

The member or designee and EmblemHealth may jointly agree to waive the internal expedited and standard appeal processes. If this occurs, EmblemHealth must provide a written letter with information regarding filing an **External Appeal** to the member and the member's health care provider 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.

CLINICAL APPEAL - EXPEDITED PROCESS

If a member or designee is not satisfied with a service or a determination that was rendered based on issues of medical necessity, an experimental or investigational use, a rare disease or (in certain instances) out-of-network services, an expedited appeal may be filed if we determine or the provider indicates that a delay would seriously jeopardize the member's life, health or ability to attain, maintain or regain maximum function. The member or designee may request expedited review of a prior approval request or concurrent review request.

An expedited appeal may be filed:

- For continued or extended health care services, procedures or treatments
- For additional services for members 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

Expedited appeals should be accompanied by a copy of the denial letter, an explanation outlining the details of the request for a review and all documentation to support a reversal of the decision. The expedited utilization review appeal may be filed in writing or by telephone.

Missing Information

If EmblemHealth required information necessary to conduct an expedited appeal, EmblemHealth shall immediately notify the member and the member's health care provider by phone or fax and to identify and request the necessary information followed by written notification.

Reviewer of Expedited Appeal Requests

The review will be conducted by a qualified EmblemHealth medical director who was neither involved in prior determinations nor the subordinate of any person involved in the initial adverse determination. A clinical peer reviewer will be available to discuss the appeal within one business day.

Denial of Expedited Appeal Process

If we deny the request for expedited review because it does not meet the criteria for an expedited appeal, we will process the request through the standard appeal review time frames and will notify the appellant of this verbally and in writing.

Failure to Render a Decision

If we do not render a decision on the appeal within the applicable timelines, the adverse determination will be reversed automatically and the requested services or benefits will be approved.

Expedited Appeal Not Resolved to Member's Satisfaction

Expedited appeals not resolved to the satisfaction of the member or designee may be re-appealed through EmblemHealth's process for standard appeals described below. In the alternative, the member or designee may request an **external appeal process**.

We will review the request and respond within the time frames noted in the following table:

TABLE 21-10, CLINICAL APPEAL - EXPEDITED					
COMMERCIAL AND CHILD HEALTH PLUS PLANS					
BENEFIT PLAN(S)	**WHAT/HOW/ WHERE TO FILE: INSTRUCTIONS**	**TIME FRAMES**			**ADDITIONAL RIGHTS**
		Initial Member/Provider* Filing	**EmblemHealth Acknowledges Receipt**	**EmblemHealth Determination Notification**	
HIP Commercial, HIP Child Health Plus and EmblemHealth	Unless otherwise directed in the denial letter, write to:	Member: 180 calendar days from receipt of written adverse determination.	Expedited determinations are made in less than 15 days.	2 business days from receipt of all necessary information, but not to exceed 72	May appeal using our standard appeal process. External appeal

CompreHealth EPO (Retired August 1, 2018)	EmblemHealth Grievance and Appeal Dept PO Box 2844 New York, NY 10116-2844 Telephone: **1-888-447-6855** Fax to: **1-866-350-2168**	Provider: Pre-Service on behalf of the member: 180 calendar days from receipt of written adverse determination.		hours from receipt of appeal.	process. Additional complaints may be filed with the NYS DOH at any time by calling **1-800-206-8125.**
GHI HMO	Unless otherwise directed in the denial letter, write to: GHI HMO Appeals and Complaints Dept PO Box 2807 New York, NY 10117-2807 Telephone: **1-877-244-4466** TDD: **1-877-208-7920** Fax to: **1-845-340-3435**	Member: 180 calendar days from receipt of written adverse determination. Provider: Pre-Service on behalf of the member 180 calendar days from receipt of written adverse determination.	Expedited determinations are made in less than 15 days.	2 business days from receipt of all necessary information, but not to exceed 72 hours from receipt of appeal.	May appeal using our standard appeal process. External appeal process. Additional complaints may be filed with the NYS DOH at any time by calling **1-800-206-8125.**
GHI PPO and EmblemHealth PPO/EPO	Unless otherwise directed in the denial letter, write to: GHI or EmblemHealth Supervisor of Appeals PO Box 2809 New York, NY 10116 Telephone: **1-888-906-7668** Fax to: **1-212-287-2754**	Member: 180 calendar days from receipt of written adverse determination. Provider: Pre-Service on behalf of the member: 180 calendar days from receipt of written adverse determination.	Expedited determinations are made in less than 15 days.	2 business days from receipt of all necessary information, but not to exceed 72 hours from receipt of appeal.	May appeal using our standard appeal process. External appeal process

*Contracted provider time frames in provider agreements will supersede time frames in this manual except in the case of regulatory requirements.

CLINICAL APPEAL - STANDARD PROCESS

If a member or designee or provider is not satisfied with a service or a determination that was rendered based on issues of medical necessity, an experimental or investigational use, a clinical trial, a rare disease or (in certain instances) out-of-network services, an appeal may be filed. The standard Clinical Appeal may be filed in writing or by telephone.

Missing Information

If we require information necessary to conduct a standard internal appeal, we will notify the member and the member's health care provider, in writing, within 15 calendar days of receipt

of the appeal (as noted in the tables below), to identify and request the necessary information. In the event that only a portion of such necessary information is received, we shall request the missing information, in writing, within five business days of receipt of the partial information.

Reviewer of Standard Appeal Requests

The review will be conducted by a qualified EmblemHealth medical director who was neither involved in prior determinations nor the subordinate of any person involved in the initial adverse determination. A clinical peer reviewer will be available to discuss the appeal within one business day.

Failure to Render A Decision

If we do not render a decision on the appeal within the applicable timelines, the adverse determination will be reversed automatically and the requested services or benefits will be approved.

Standard Appeal Not Resolved to Members Satisfaction

Member or designee may request an **External Appeal** as described in this chapter.

Procedures for initiating a standard appeal are outlined in the tables on the following pages:

TABLE 21-11, APPEAL - STANDARD

COMMERCIAL AND CHILD HEALTH PLUS PLANS

BENEFIT PLAN(S)	WHAT/HOW /WHERE TO FILE: INSTRUCTIONS	TIME FRAMES			ADDITIONAL RIGHTS
		Initial Member/ Provider* Filing	EmblemHealth Acknowledges Receipt	EmblemHealth Determination Notification	
HIP Commercial, HIP Child Health Plus and EmblemHealth CompreHealth EPO (Retired August 1, 2018)	Unless otherwise directed in the denial letter, write to: EmblemHealth Grievance and Appeal Dept PO Box 2844 New York, NY 10116-2844 Telephone: **1-888-447-6855**	Member: 180 calendar days from receipt of written adverse determination. Provider: Pre-Service on behalf of member: 180 calendar days from receipt of written adverse determination. For Payment: 45 calendar days from receipt of written adverse determination.	15 calendar days from receipt of the appeal	HMO: 30 calendar days from receipt for pre-service requests 60 calendar days from receipt of request for post service requests PPO/EPO: 30 calendar days for all requests Both member and provider notified within 2 business days of determination but not to exceed determination timeframe.	External Appeal Additional complaints may be filed with the NYS DOH at any time by calling **1-800-206-8125**
GHI HMO	EmblemHealth Grievance and Appeal Dept	Member: 180 calendar days from receipt of written adverse	15 calendar days from receipt of the appeal	30 calendar days from receipt for pre-service requests	External Appeal Additional complaints may be

	PO Box 2844 New York, NY 10116-2844 Telephone: **1-877-244-4466** TDD: **1-877-208-7920** Fax to: **1-845-340-3435**	determination. Provider: Pre-Service on behalf of member: 180 calendar days from receipt of written adverse determination. For Payment: 45 calendar days from receipt of written adverse determination.		60 calendar days from receipt of request for post service requests Both member and provider notified within 2 business days of determination but not to exceed determination timeframe.	filed with the NYS DOH at any time by calling **1-800-206-8125**
GHI PPO and EmblemHealth PPO/EPO	Unless otherwise directed in the denial letter, write to: GHI or EmblemHealth Supervisor of Appeals PO Box 2809 New York, NY 10116 Telephone: **1-888-906-7668** Fax to: **1-212-287-2754**	Member: 180 calendar days from receipt of written adverse determination. Provider: Pre-Service on behalf of member: 180 calendar days from receipt of written adverse determination. For Payment: 45 calendar days from receipt of written adverse determination.	15 calendar days from receipt of appeal	30 calendar days Both member and provider notified within 2 business days of determination but not to exceed determination timeframe.	External appeal

*Contracted provider time frames in provider agreements will supersede time frames in this manual.

NEW YORK STATE EXTERNAL APPEALS

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 or investigational treatment, a clinical trial or (in certain instances) out-of-network services. Further, a member, the member's designee and, in conjunction with concurrent and retrospective adverse determinations, a member's health care provider has the right to request an external appeal.

As of January, 1, 2010, 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 less than 200,000 US 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 be likely to 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.

The Circumstances When an External Appeal May Be Filed

1. When 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**
3. both EmblemHealth and the member have jointly agreed to waive any internal appeal.

An External Appeal May Also Be Filed

1. When the member has had coverage of a health care service denied on the basis that such service is experimental or investigational **and**
2. the denial has been upheld on appeal **or** both EmblemHealth and the member have jointly agreed to waive any internal appeal
3. **and** the member's attending physician has certified that the member has a life-threatening or disabling condition or disease
   - for which standard health services or procedures have been ineffective or would be medically inappropriate or
   - for which there does not exist a more beneficial standard health service or procedure covered by the health care plan or
   - for which there exists a clinical trial or rare disease treatment
4. **and** 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 health service or procedure (including a pharmaceutical product within the meaning of PHL 4900(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
   - 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,
5. **and** the specific health service or procedure recommended by the attending physician would otherwise be covered under the policy except for the health care plan's determination that the health service or procedure is experimental or investigational.

External Appeal for Denial of Out-of-Network Service

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

the member's attending doctor, who shall be a licensed, board-certified or 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, accessible at **www.dfs.ny.gov/insurance/extapp/extappl.pdf** and send it to the New York State Department of Financial Services within 60 days (45 days before July 1, 2014) from the date of the final adverse determination of the first level appeal.

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 the New York State Department of Financial Services along with the application. (**Note:** Application fees are waived for Child Health Plus 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. Second level internal appeals are for GHI PPO FEHB plan participating providers only.

The New York State Department of Financial Services screens applications and assigns eligible appeals to state-certified external appeals agents. The Department of Financial Services 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 will provide medical and treatment records and an itemization of the clinical standards used to determine medical necessity within three business days of receiving the agent's information and completed release forms. For an expedited appeal, this information

will be provided within 24 hours of receipt.

For urgent medical circumstances, an expedited review may be requested which will render a decision within three days.

For standard cases, a determination will be 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 five additional business days to make a determination.

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

To obtain an application or to inquire about external appeals, please contact the New York State Department of Financial Services at **1-800-400-8882** or e-mail **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.

FACILITY DISPUTE RESOLUTION PROCEDURES

Alternative Dispute Resolution

An Article 28 facility may agree to an alternative dispute resolution in lieu of an external appeal. The alternative dispute process does not affect a member's external appeal rights or the member's right to establish the provider as their designee.

Retrospective Utilization Review Requests

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"**
  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 decision to the facility within 30 days of receipt of all information, the case will be deemed automatically

denied and the facility will have the right to appeal the decision.

- **For Denials Based on "No E.R. Notification"**
  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.

  For Facility Retrospective Utilization Review requests for outpatient PT/OT Services managed by Palladian, please follow the process in the **PT/OT** section.

TABLE 21-12, FACILITY RETROSPECTIVE REVIEW REQUEST					
FOR DENIALS BASED ON "NO PRIOR APPROVAL"					
FOR DENIALS BASED ON "NO E.R. NOTIFICATION"					
BENEFIT PLAN(S)	**WHAT/HOW /WHERE TO FILE INSTRUCTIONS**	**TIME FRAMES**			**ADDITIONAL RIGHTS**
		Initial Facility Filing	**EmblemHealth Acknowledges Receipt**	**EmblemHealth Determination Notification**	
All HIP** and EmblemHealth CompreHealth EPO	Unless otherwise directed in the denial letter, write to: EmblemHealth Grievance and Appeal Dept PO Box 2844 New York, NY 10116-2844 Telephone: 1-800-447-8255	45 days from the claim denial, unless specified otherwise by your contract with HIP.	15 calendar days from receipt of necessary information.	Determination is made within 30 days from receipt of request for retrospective utilization review.	May file a facility clinical appeal.
GHI HMO**	See Member Appeal.				

GHI PPO** and EmblemHealth PPO/EPO	Unless otherwise directed in the denial letter, write to: GHI or EmblemHealth Supervisor of Appeals PO Box 2809 New York, NY 10116 Telephone: **1-866-447-9717** Fax to: **1-212-287-2754**	Member: 180 calendar days from receipt of written adverse determination. Provider: 45 calendar days from receipt of written adverse determination.	15 calendar days from receipt of necessary information.	60 calendar days from receipt. (30 days for PPO accounts) Both member and provider notified within 2 business days of determination.	External appeal

* EmblemHealth does not send acknowledgement letters for "No E.R. Notification" retrospective review requests.

** HIP, GHI HMO and GHI PPO request medical records within 30 days of receipt of the claim and wait 45 to 60 days from the date of the request before sending out a denial for lack of information.

Facility Clinical Appeals

If an EmblemHealth-contracted facility is not satisfied with a claim determination regarding denial of payment for inpatient services based on medical necessity, the facility may file a facility clinical appeal.

EmblemHealth provides one internal level of appeal for facilities. Federal Accounts do not have external appeal rights. Effective 1/1/2010, in cases where the initial adverse determination was made retrospectively or concurrently, the facility has the additional right to file a New York State External Appeal.

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."

EmblemHealth or the managing entity will render a decision within 30 days of receipt of the appeal request (for PPO accounts) or 60 days of receipt of the appeal request for all others.

- For Members Already Discharged
  If the facility provides additional information after the denial is issued and after the member is already discharged, no reconsideration review will be performed. However, the facility may exercise its right to a clinical appeal.
- The appeal request must be filed within 45 days of the initial adverse determination or as stated in the facility contract. If the appeal request is received outside of this time frame, the original denial will be upheld and there will be no further appeal rights. Facilities are not permitted to balance bill members for such denials.
- For Denials Based on "No Information"
  If the facility fails to provide any clinical information to establish medical necessity for an admission or procedure, the claim will be denied based on "no information" and the facility may file a clinical appeal.

TABLE 21-13, FACILITY CLINICAL APPEAL					
FOR DENIALS BASED ON "NO INFORMATION"					
WHEN MEMBERS ARE ALREADY DISCHARGED					
BENEFIT PLAN(S)	**WHAT/HOW /WHERE TO FILE INSTRUCTIONS**	**TIME FRAMES**			**ADDITIONAL RIGHTS**
		Initial Facility Filing	**EmblemHealth Acknowledges Receipt**	**EmblemHealth Determination Notification**	
All HIP and EmblemHealth CompreHealth EPO	Unless otherwise directed in the denial letter, write to: EmblemHealth Grievance and Appeal Dept. PO Box 2844 New York, NY 10116-2844 Telephone: **1-800-447-8255**	45 calendar days from receipt of written adverse determination.	15 calendar days from receipt of necessary information	For members already discharged or "no information" denial: 5 business days from determination. For no E.R. notification: Within 2 business days of determination. 60 calendar days.	

				(30 days for PPO accounts) Both member and provider notified within 2 business days of determinatio n.	
GHI HMO	For members already discharged: This process does not exist for these plans. Please file a member appeal. For "no information" denial or no E.R. notification: This process does not exist for these plans. Please file a dispute of this type as a practitioner grievance.				
GHI PPO and EmblemHealt h PPO/EPO	Unless otherwise directed in the denial letter, write to: GHI or EmblemHealt	Member: 180 calendar days from receipt of written adverse determinatio n. Provider: 45	15 calendar days from receipt of necessary information.	60 calendar days from receipt . (30 days for PPO accounts) Both member	External appeal

	h Supervisor of Appeals PO Box 2809 New York, NY 10116 Telephone: **1-866-447-9717** Fax to: **1-212-287-2754**	calendar days from the claim denial, unless specified otherwise by your contract with HIP.		and provider notified within 2 business days of determination.	