

# DISPUTE RESOLUTION FOR MEDICAID MANAGED CARE AND FAMILY HEALTH PLUS PLANS

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# DISPUTE RESOLUTION FOR MEDICAID MANAGED CARE AND

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.

Members have the right to file complaints, complaint appeals and action appeals. This chapter covers the processes and time frames and provides toll-free numbers for filing orally. Members have the right to a designee to file on their behalf. Our Customer Service department is available to provide assistance to members to file complaints, complaint appeals and action appeals.

We do not discriminate against practitioners or members, attempt to terminate a practitioner's agreement or attempt to disenroll a member for filing a request for dispute resolution.

We have interpreter services available to assist members with language and hearing/vision impairments.

## KEY TERMINOLOGY

The descriptions below provide a general overview of the terminology used with Medicaid Managed Care and Family Health Plus plans.

### **Service Authorization Request**

A request submitted to EmblemHealth for the provision of a service (including requests for referral or noncovered services). The request can be classified in one of two categories:

- **Prior Approval Request**

A type of service authorization request applicable to coverage of a new service, whether for a new authorization period or within an existing authorization period, before such service is provided.

- **Concurrent Review Request**

A type of service authorization request applicable to continued, extended or additional service beyond what is currently authorized.

### **Service Authorization Determination**

The decision regarding a service authorization request, whether approved or denied.

### **Adverse Determination**

The denial of a service authorization request, or approval in an amount, duration or scope that is less than requested. The *initial adverse determination* may be appealed by the member or the provider. If the decision is upheld it is considered a final adverse determination.

# DISPUTE RESOLUTION FOR MEDICAID MANAGED CARE AND

## Action

An activity performed by EmblemHealth or its subcontractor that results in the:

- Denial or limited authorization of a service authorization request, including the type or level of service.
- Reduction, suspension or termination of a previously authorized service.
- Denial, in whole or in part, of payment for a service.
- In rural areas, as defined by 42 CFR §412.62(f)(a), where enrollment in the MMC program is mandatory and there is only one managed care organization (MCO), the denial of a member's request to obtain services outside the plan's network pursuant to 42 CFR §438.52(b)(2)(ii).

Also, an "action" is an activity performed by EmblemHealth or its subcontractor that is caused by the:

- Failure to act in a timely manner as defined by applicable state law and regulation.
- Failure to act within the time frames for resolution and notification of determinations regarding Complaints, Action Appeals and Complaint Appeals.

## Notice of Action

A notification sent when an action is taken.

## Action Appeal

A request to review an action.

## Complaint

A request to review an administrative process, service or quality-of-care issue, or any aspect of care *not* pertaining to an action.

## Complaint Appeal

A request to review a complaint determination.

## Dispute

Either an action appeal or complaint appeal.

Certain disputes and requests for prior approval and concurrent review may be filed as **expedited** or **standard** depending on the urgency of the patient's condition.

## SERVICE AUTHORIZATION REQUESTS

Please refer to the **Care Management** chapter for information on prior approvals and concurrent reviews.

## INITIAL ADVERSE DETERMINATION

EmblemHealth will 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) on the following grounds:

# DISPUTE RESOLUTION FOR MEDICAID MANAGED CARE AND

- 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 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.

All notices of action shall be in writing, in easily-understood language, and be 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 will make reasonable effort to provide oral notice to the member and provider at the time the initial adverse determination is made. The member will have assistance available and provided to file complaints, complaint appeals and action appeals.

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.
- A Fair Hearing notice including aid to continue rights.
- A statement that notice is available in other languages and formats for special needs and how to access these formats.
- The member's right to file an action appeal, including:
  - The member's right to designate a representative to file action appeals on his/her behalf.
  - Notice that an expedited review of the action appeal can be requested if a delay would significantly increase the risk to a member's health, a toll-free number for filing an oral action appeal and a form, if used by EmblemHealth, for filing a written action appeal.
  - The time frames within which the action appeal determination must be made.
  - The notice entitled "Managed Care Action Taken" for denial of benefits or for termination or reduction in benefits, as applicable, containing the member's fair hearing and aid continuing rights.

For actions based on issues of medical necessity or an experimental or investigational treatment, the written notice of action shall also include:

# DISPUTE RESOLUTION FOR MEDICAID MANAGED CARE AND

- A clear statement that the notice constitutes the initial adverse determination and specific use of the terms "medical necessity" or "experimental/investigational", "rare disease", "clinical trial" or in certain instances, "out of network."
- A statement that the specific clinical review criteria relied upon in making the determination is available upon request.
- A statement that the member may be eligible for an external appeal.

For actions based on a determination that a requested out of network service is not materially different from an alternate service available from a Participating Provider, the notice of Action shall also include:

- Notice of the required information for submission when filing an Action Appeal as provided for in PHL 4904(1-a).
- A statement that the Enrollee may be eligible for an External Appeal.
- A statement that if the denial is upheld on Action Appeal, the Enrollee will have 4 months from the receipt of the final adverse determination to request an External Appeal.
- A statement that if the denial is upheld on an expedited Action Appeal, the Enrollee may request an External Appeal or request a standard Action Appeal.
- A statement that the Enrollee and the contractor may agree to waive the internal appeal process and the Enrollee will have 4 months to request an External Appeal from receipt of written notice of that agreement.

Notices of action regarding denial of an expedited review request shall specify that the request will be reviewed under standard time frames and shall include a description of the standard time frames.

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 30 days) and shall be conducted by the member's health care provider and the clinical peer reviewer making the initial determination.

## NOTIFICATION METHODS AND TIME FRAMES

The failure of EmblemHealth to make a utilization review (UR) determination within the time periods prescribed in this section 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.

### **For Prior Approval and Concurrent Review Requests**

EmblemHealth must make a decision and notify member *and* provider, by phone *and* in writing as fast as the member's condition requires for both prior approval and concurrent review requests. In addition, for prior approval requests the decision must be made: (1) within three business days of our receipt of an expedited authorization request or (2) in all other cases, within 3 business days of receipt of necessary information but no more than 14 days of the request. For concurrent review requests, the time frame for a decision is (1) within 1 business day of receipt of necessary information but no more than 3 business days of an expedited authorization request or (2) in all other cases, within 1 business day of receipt of necessary

# DISPUTE RESOLUTION FOR MEDICAID MANAGED CARE AND

information but no more than 14 days of the request.

## **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 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 review; 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.

## **Expedited Review Requests**

Expedited review requests must be conducted when EmblemHealth or the provider indicates delay would seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum functions. Members have the right to request expedited review, but EmblemHealth may deny and notice will process under standard time frames.

## **Extensions for Expedited and Standard Review Time Frames**

Reviews of expedited and standard reviews of prior approval and concurrent review requests may be extended by an additional 14 days if:

- (1) The member, designee or provider requests an extension; or
- (2) EmblemHealth demonstrates there is a need for more information and the extension is in the member's interest. Notice of extension will be provided to the member.

Notice to members regarding an extension initiated by EmblemHealth shall include:

- 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.

# DISPUTE RESOLUTION FOR MEDICAID MANAGED CARE AND ACTION APPEALS (STANDARD APPEAL)

The dual-eligible member has the choice of selecting a Medicaid or Medicare appeal process. In the written notice of the initial adverse determination, 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 60-day period.

## How to File an Action Appeal

Members wishing to dispute an action may do so themselves or designate a person to act on their behalf by filing an action appeal. To appoint a designee, members must submit by fax or by mail a signed HIPAA-compliant Appointment of Representative form or a Power of Attorney form that specifies the individual as an authorized party. An Appointment of Representative form is not necessary for members who choose to have their practitioner file a dispute on their behalf. A provider may file a UR appeal for concurrent and retrospective denials.

Action appeals should be accompanied by a copy of the action, an explanation outlining the details of the request for a review and all documentation to support a reversal of the decision. The appeal may be filed in writing or by telephone. We will send acknowledgement within 15 days of receipt of the appeal and request any necessary information in writing. Oral appeals are followed up by written signed appeal. Oral appeal acknowledgement letters include a statement summarizing the substance of the 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 the attention of EmblemHealth.

## Action Appeal Reviews

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 action determination. A clinical peer reviewer must be available within one 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 appeal in person or in writing.

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

## NOTIFICATION METHODS AND TIME FRAMES FOR NOTIFYING 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 information regarding filing an



# DISPUTE RESOLUTION FOR MEDICAID MANAGED CARE AND

external appeal to the member 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

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 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.

## Notice of Final Appeal Determination

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

We will make an appeal determination as fast as the member's condition requires, and no later than 30 days from receipt of the 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 best interest of the member, and we provide the member with notice stating this.

Action appeals will be reviewed and EmblemHealth will notify 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 by EmblemHealth to make a determination within the applicable time periods as stated in this section shall be deemed to be a reversal of the utilization review agent's adverse determination.

Procedures for initiating a standard action appeal are provided on the following page.

**Table 22-1: Standard Action Appeals Procedures for Members and Practitioners**

TABLE 22-1, ACTION APPEAL - STANDARD MEMBER, MEMBER DESIGNEE OR PRACTITIONER FILING ON MEMBER'S BEHALF AND PRACTITIONER FILING ON HIS/HER OWN BEHALF					
MEDICAID MANAGED CARE AND FAMILY 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 Medicaid/ Family Health Plus	Write to: EmblemHealth Grievance and Appeal Dept. PO Box 2844 New York, NY 10116-2844 Submit in	Within 90 calendar days from receipt of written adverse determination	Within 15 calendar days	Within 30 calendar days from receipt of request May be extended for up to 14 days for reasons noted in Extensions	<b>External appeal</b> (if applicable) <b>Fair hearing</b> (if applicable) Additionally, a complaint may be filed with the NYSDOH at

# DISPUTE RESOLUTION FOR MEDICAID MANAGED CARE AND

	person at: EmblemHealth Customer Access Unit 55 Water Street New York, NY 10041 Telephone: <b>1-800-447-8255</b> EmblemHealth members who use a TTY/TDD can dial <b>711</b> for Telecommunications Relay Services.			above	any time by calling <b>1-800-206-8125</b>
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## 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 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 contractual provisions with EmblemHealth. Such breach may be grounds for termination of the practitioner's contract.

## EXPEDITED ACTION APPEALS

If a member, designee, practitioner acting on 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.

The member or designee may request expedited review of a prior authorization request or concurrent review request. EmblemHealth's time frame to file the appeal is at least 90 calendar days after notification to the member of the UR decision.

An expedited 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.

# DISPUTE RESOLUTION FOR MEDICAID MANAGED CARE AND

- When EmblemHealth honors the member's request for an expedited review.

## Process for Filing an Expedited Action Appeal

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

## Time Frame for Expedited Action Appeal Decisions

The review time frame begins upon receipt of the appeal, whether filed orally or in writing. If EmblemHealth requires information necessary to conduct an expedited appeal, EmblemHealth shall immediately notify the member and the member's health care provider by telephone or by fax to identify and request the necessary information followed by written notification.

An expedited appeal will be decided as fast as the member's condition requires and within two business days of receipt of the necessary information, but no more than three business days of receipt of the appeal. This time may be extended for up to 14 days upon the member or provider's request, or if EmblemHealth demonstrates more information is needed and a delay is in best interest of member and so notifies member.

## Denial of an Expedited Action Appeal Request

EmblemHealth may deny the member's request for expedited review and the notice of action will be processed under **standard action appeal** time frames. If EmblemHealth denies the member's request for an expedited review, EmblemHealth must immediately provide notice by phone, followed by written notice within two days of the denial.

Expedited appeals not resolved to the satisfaction of the appealing party may be re-appealed via the **standard appeal process** or through the **external appeal process**.

## Review of Expedited Action 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 action appeal within one 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 appeal in person or in writing.

Expedited action appeals will be reviewed and a 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. EmblemHealth will make reasonable efforts to provide oral notice to the member and provider at the time the determination is made. Failure by EmblemHealth to make a determination with the applicable time periods in this section shall be deemed to be a reversal of the utilization review agent's adverse determination. Procedures for initiating an expedited action appeal are as follows:

## Table 22-2: Expedited Action Appeals Procedures for Members

TABLE 22-2, EXPEDITED ACTION APPEAL

# DISPUTE RESOLUTION FOR MEDICAID MANAGED CARE AND

MEMBER, MEMBER DESIGNEE OR PRACTITIONER FILING ON MEMBER'S BEHALF					
MEDICAID MANAGED CARE AND FAMILY 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 Medicaid/ Family Health Plus	<p>Telephone: Expedited Appeal Line <b>1-888-447-6855.</b></p> <p>Fax to: Expedited Appeal Line <b>1-866-350-2168.</b></p> <p>EmblemHealth members who use a TTY/TDD can dial <b>711</b> for Telecommunications Relay Services.</p> <p>For actions issued by CareCore National, file appeals with CareCore National.</p> <p>For actions issued by Palladian Health, file appeals with Palladian Health.</p>	Within 90 calendar days from receipt of written adverse determination	Expedited determinations are made more quickly than the time frame to send the acknowledgment letter.	<p>Within 2 business days from receipt of all necessary information or 3 business days from receipt of action appeal request</p> <p>May be extended for up to 14 days for reasons noted in Extensions above</p>	<p><b>May appeal using our standard action appeal process</b></p> <p><b>External appeal</b> (if applicable)</p> <p><b>Fair hearing</b> (if applicable)</p> <p>Additional complaints may be filed with the NYSDOH at any time by calling <b>1-800-206-8125.</b></p>

## FINAL ADVERSE DETERMINATIONS

When a decision regarding an action appeal is upheld in whole or in part, EmblemHealth will issue a final adverse determination (FAD). 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.

EmblemHealth will make reasonable effort to provide oral notice to the member and provider at the time the determination is made. Written notice of final adverse determination

# DISPUTE RESOLUTION FOR MEDICAID MANAGED CARE AND

concerning an expedited UR appeal shall be transmitted to the member within 24 hours of rendering the determination.

Notices to members of final action appeal adverse determinations will be in writing, dated and include:

- 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 action appeal.
- The date the action 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.
- Standard description of external appeals process attached.
- Summary of appeal and date filed.
- Date appeal process was completed.
- Description of enrollee's fair hearing rights if not included with initial denial.
- Right of member to complain to the Department of Health at any time with 1-800 number.
- A statement that notice available in other languages and formats for special needs and how to access these formats.

For action appeals involving medical necessity or an experimental or investigational treatment, a clinical trial, rare disease or in certain instances out-of-network services, the final adverse determination notice shall also include:

- A clear statement that the notice constitutes the final adverse determination, and specifically use the terms "final adverse determination", "medical necessity" or "experimental/investigational", "clinical trial", "rare disease", or in certain instances, "out of network."
- A list of titles and qualifications of the individuals participating in the review, including the title and specialty of the clinical peer reviewer.
- A copy of the "Standard Description and Instructions for Health Care Consumers to Request an External Appeal" and the External Appeal application form.

## **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.

## PRACTITIONER DISPUTE RESOLUTION PROCEDURES: COMPLAINTS AND GRIEVANCES

# DISPUTE RESOLUTION FOR MEDICAID MANAGED CARE AND

## **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 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 365 days after the service. 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 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

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- 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 no later than 45 days after its receipt. The determination included in the response will be final.

**Table 22-3: Complaint Procedures for Practitioners**

TABLE 22-3, PRACTITIONER COMPLAINT PROCEDURES PRACTITIONER FILING ON HIS/HER OWN BEHALF					
MEDICAID MANAGED CARE AND FAMILY 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 Medicaid/Family Health Plus	Write to: EmblemHealth Grievance and Appeal Dept. P.O. Box 2844 New York, NY 10116-2844 Telephone: <b>1-800-447-8255</b> EmblemHealth members who use a TTY/TDD can dial <b>711</b> for Telecommunications Relay	Within 60 calendar days from event	Within 15 calendar days from receipt	Within 30 calendar days from receipt	N/A

# DISPUTE RESOLUTION FOR MEDICAID MANAGED CARE AND

	Services.				
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\* Privacy complaints are not subject to these time frames.

## 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:

- 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 within the time frames applicable to the member's benefit plan as detailed in the table below.

**Table 22-4: Expedited Complaint Procedures for Members**

TABLE 22-4, COMPLAINT - EXPEDITED MEMBER, MEMBER DESIGNEE OR PRACTITIONER FILING ON MEMBER'S BEHALF					
MEDICAID MANAGED CARE AND FAMILY 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 Medicaid/Family Health Plus	Write to: EmblemHealth Grievance and Appeal Dept. P.O. Box 2844 New York, NY 10116-2844 Telephone: <b>1-800-447-8255</b> EmblemHealth members	Within 90 calendar days from event	Within 15 business days from receipt	Within 48 hours from receipt of all necessary information and no later than 7 days after receipt of the complaint	May file a complaint appeal, <b>expedited</b> or <b>standard</b> Additional complaints may be filed with the NYSDOH at any time by calling <b>1-800-206-8125</b> .



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	who use a TTY/TDD can dial <b>711</b> for Telecommunications Relay Services.				
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**Table 22-5: Standard Complaint Procedures for Members**

TABLE 22-5, COMPLAINT - STANDARD MEMBER, MEMBER DESIGNEE OR PRACTITIONER FILING ON MEMBER'S BEHALF					
MEDICAID MANAGED CARE AND FAMILY 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 Medicaid/Family Health Plus	Write to: EmblemHealth Grievance and Appeal Dept. P.O. Box 2844 New York, NY 10116-2844 Telephone: <b>1-800-447-8255</b>  EmblemHealth members who use TTY/TDD can dial <b>711</b> for Telecommunications Relay Services.	90 calendar days	Within 15 business days from receipt	Within 45 calendar days from receipt of all necessary info, but not to exceed 60 calendar days from receipt of the complaint	May file a complaint appeal, <b>expedited or standard</b>  Additional complaints may be filed with the NYSDOH at any time by calling <b>1-800-206-8125</b> .

### 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 will respond within the time frames noted in the tables below. 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.

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**Table 22-6: Expedited Complaint Appeals Process for Members**

TABLE 22-6, COMPLAINT APPEAL - EXPEDITED MEMBER, MEMBER DESIGNEE OR PRACTITIONER FILING ON MEMBER'S BEHALF					
MEDICAID MANAGED CARE AND FAMILY 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 Medicaid/Family Health Plus	Write to: EmblemHealth Grievance and Appeal Dept. P.O. Box 2844 New York, NY 10116-2844 Telephone: <b>1-800-447-8255</b> EmblemHealth members who use a TTY/TDD can dial <b>711</b> for Telecommunications Relay Services.	Within 60 business days from receipt of complaint determination	Within 15 business days from receipt	Within 2 business days from receipt of necessary information	Additional complaints may be filed with the NYSDOH at any time by calling <b>1-800-206-8125</b> .

**Table 22-7: Standard Complaint Appeals Process for Members**

TABLE 22-7, COMPLAINT APPEAL - STANDARD MEMBER, MEMBER DESIGNEE OR PRACTITIONER FILING ON MEMBER'S BEHALF					
MEDICAID MANAGED CARE AND FAMILY 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 Medicaid/Family Health Plus	Write to: EmblemHealth Grievance and Appeal Dept. P.O. Box 2844 New York, NY 10116-2844	Within 60 business days from receipt of complaint determination	Within 15 business days from receipt	Within 30 business days from receipt of all necessary information	Additional complaints may be filed with the NYSDOH at any time by calling <b>1-800-206-8125</b> .

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	Telephone: <b>1-800-447-8255</b> EmblemHealth members who use a TTY/TDD can dial <b>711</b> for Telecommunications Relay Services.				
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## 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.

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 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 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.

### Medicaid FHPlus Members Right to a State Fair Hearing

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

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3. **and** the member's attending physician has certified that the member has a life-threatening or disabling condition or disease
  1. for which standard health services or procedures have been ineffective or would be medically inappropriate or
  2. for which there does not exist a more beneficial standard health service or procedure covered by the health care plan or
  3. 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
  1. 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
  2. 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.

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## 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 <http://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 prior to July 1, 2014) of 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 Medicaid and Family 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.

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](mailto: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.

# DISPUTE RESOLUTION FOR MEDICAID MANAGED CARE AND NEW YORK STATE FAIR HEARINGS

## Medicaid/FHPlus Members' Rights to a State Fair Hearing

In accordance with applicable federal and state laws and regulations, Medicaid and Family Health Plus members may request a fair hearing for adverse determinations made by EmblemHealth regarding the denial, termination, suspension or reduction of a clinical treatment or other benefit package services. A member may also seek a fair hearing for a failure by EmblemHealth to act with reasonable promptness with respect to such services. 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 fair hearing.

HIP 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 HIP or the delegate entity responsible for managing the member's medical care. For issues related to disputed services, members must have received an 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 60 days from the date of our initial action notice that the member previously received. The time frame to request a fair hearing is not delayed or suspended if the member pursues other appeal options.

Members may also seek a fair hearing for a failure of the Plan to comply with required notification timeframes.

Members may request a fair hearing by:

- Telephone: **1-800-342-3334**
- Fax: **1-518-473-6735**
- Internet: **[www.otda.ny.gov](http://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 HIP will give to the fair hearing officer. We will send members a copy of the Evidence Package at the same time we send it to the fair hearing

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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 **1-800-447-8255** or write to HIP at the address on the top of the front page of the Fair Hearing Request form. Members should ask for these documents before the date of the fair hearing. Usually, they will be sent within three 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 and its contractors will be required to continue or restore the provision of services that are the subject of the fair hearing if so ordered by the New York State Office of Administrative Hearings (OAH) 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 a member has filed a timely request for a fair hearing with OAH.
- When there is a valid order for the treatment or service from a participating practitioner.

EmblemHealth will provide aid continuing until one of the following occurs (whichever comes first):

- The matter has been resolved to the member's satisfaction.
- The administrative process is complete and there is a determination from OAH that the member is not entitled to receive the service.
- The member withdraws the request for aid continuing and/or the fair hearing in writing.
- The treatment or service originally ordered by the practitioner has been completed.