DISPUTE RESOLUTION FOR MEDICARE PLANS

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DISPUTE RESOLUTION FOR MEDICARE 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 EmblemHealth Medicare HMO and EmblemHealth Medicare PPO plans, as well as Medicare Part D.

View the processes for **HIP Medicaid and HIP Family Health Plus plans**.

View the processes for **Commercial and HIP Child Health Plus 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 descriptions below provide a general overview of the dispute resolution terminology used with Medicare Advantage plans.

- **Appeal**
  A request to review any aspect of a *claim determination or adverse benefit determination or a clinical adverse determination* denied with regards to medical necessity.
- **Coverage Determination**
  A notification sent when a Part D drug is denied.
- **Grievance**
  A request to review an *administrative process, service or quality of care issue* NOT pertaining to a medical necessity determination, a benefit determination or a claims determination.
- **Organization Determination**
  A notification sent when a health care service, procedure or treatment is denied.

Medicaid Advantage plans include coverage components from both Medicare Advantage and Medicaid managed care. These dual-eligible members have the right to select which dispute process to use. In the written notice of initial adverse determination to all dual-eligible members, EmblemHealth will provide notice that:

- A Medicare appeal must be filed within 60 days from the date of the denial.
- Filing a Medicare appeal means that the member **cannot** file for a state fair hearing.
- The member may still file for Medicare appeal **after** filing for Medicaid appeal, if it is within the 30-day period.

Certain disputes may be filed as **Expedited** or **Standard** depending on the urgency of the patient's condition.

Certain disputes may also be filed as **Pre-Service** or **Post-Service** depending on the timing of the determination in question.

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.

Appointing a Designee

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

Extensions

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

INITIAL ADVERSE DETERMINATIONS

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

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

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

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

For retrospective review requests, EmblemHealth must make a decision and notify the member by mail on the date of the payment denial, in whole or in part. The decision must be made within 60 calendar days of receipt of the request.

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

- Relevant medical information presented to EmblemHealth or the utilization review agent upon retrospective review is materially different from the information that was presented during the prior approval.
- The information existed at the time of the prior approval review but was withheld or not made available.
- EmblemHealth or the utilization review agent was not aware of the existence of the information at the time of the prior approval review.
- Had they been aware of the information, the treatment, service or procedure being requested would not have been authorized.

FINAL ADVERSE DETERMINATIONS

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

The FAD contains the following information:

- The date the review request was received.
- A summary of the review.
- The results and the reasons for the determination, including the clinical rationale.
- The words "final adverse determination."
- A clear statement that the notice constitutes the final adverse determination.

- The terms "medical necessity" or "experimental/investigational."
- The member's coverage type.
- The service in question and, if available and applicable, the name of the provider and developer/manufacturer of the health care service.
- Information on available alternative and/or external dispute resolution options. To determine if further resolution options are applicable, please refer to your contract agreement.

Notice of Final Appeal Determination

We will notify the contracted facility in writing of the final appeal determination within three calendar days of when we make the decision.

PROVIDER DISPUTE RESOLUTION PROCEDURES: COMPLAINTS AND GRIEVANCES

Practitioner Complaint Procedures

If a practitioner is dissatisfied with an administrative process, quality of care issue and/or any aspect of service rendered by EmblemHealth that does not pertain to a benefit or claim determination, the practitioner may file a complaint on 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.

Contracted Provider Grievance Process for Medicare HMO and PPO Plans

If a provider is not satisfied with any aspect of a claim determination rendered by the plan (or any entity designated to perform administrative functions on its behalf) which does not pertain to a medical necessity determination, that provider may file a 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 provider may also file a grievance regarding how a claim was processed, including issues such as computational errors, interpretation of contract reimbursement terms, or timeliness of payment. 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 date. If a claim was submitted more than one year from date of service, EmblemHealth may deny the claim in full or in the alternative may reduce payments by up to 25 percent of the amount that would have been paid had the claim been submitted in a timely manner.

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

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

The provider has the option to question a claim's payment by submitting an inquiry along with supporting documentation within the Claim's Inquiry tool in the secure provider website: **www.emblemhealth.com/Providers**. For multiple claims, use the Message Center tool 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.

Procedures for initiating a Contracted Provider Grievance with respect to an EmblemHealth Medicare member are outlined in the table below.

Notice of Determinations of Grievance Decision

The written Notice of Determination will include the following:

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

TABLE 23-1, PROVIDER COMPLAINT/GRIEVANCE PROCEDURES					
EMBLEMHEALTH MEDICARE HMO AND PPO PLANS					
BENEFIT PLAN(S)	**WHAT/HOW /WHERE TO FILE HARD COPY **: INSTRUCTIONS**	**TIME FRAMES***			**ADDITIONAL RIGHTS**
		Initial Practitioner Filing	**EmblemHealth Acknowledges Receipt**	**EmblemHealth Determination Notification**	
EmblemHealth Medicare HMO Plans	Sign in to: **www.emblemhealth.com**. Write to: EmblemHealth Medicare HMO P.O. Box 2807 New York, NY 10116-2807	45 calendar days from event. **Exceptions:** SUNY Downstate - 90 calendar days from event; Stony Brook Affiliations - 120 calendar days from event.	15 calendar days from receipt of request.	Complaint: 30 calendar days from receipt of request. Grievance: 45 calendar days from receipt of request.	Decision is final.
EmblemHealth Medicare PPO Plans	Sign in to: **www.emblemhealth.com**. Write to: EmblemHealth Medicare PPO PO Box 2807 New York, NY 10116-2807	45 calendar days from event.	15 calendar days from receipt of request.	Complaint: 30 calendar days from receipt of request. Grievance: 45 calendar days from receipt of request.	Decision is final.

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

FACILITY RETROSPECTIVE UTILIZATION REVIEWS REQUESTS FOR MEDICARE HMO

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

For Denials Based on No Prior Approval Medicare HMO Only

If the facility fails to obtain prior approval, payment will be denied for "no prior approval." The remittance statement will include information regarding the facility's right to request a retrospective utilization review for medical necessity. See the "Care Management" chapter.

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

If EmblemHealth or the managing entity fails to render and communicate a 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" - Medicare HMO Only

If the facility admits a patient through the emergency room without notifying EmblemHealth or the managing entity and submits a claim for services rendered, EmblemHealth will request medical records to initiate a retrospective utilization review for medical necessity.

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

For facility retrospective utilization review requests for outpatient physical and occupational therapy services managed by Palladian, please follow the process outlined in the **Physical and Occupational Therapy Program** chapter.

TABLE 23-2, 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**	
EmblemHealth Medicare HMO plans	Write to: EmblemHealth Medicare HMO PO Box 2807	45 calendar days from receipt of remittance statement. **Exceptions:** North Shore -	15 calendar days from receipt of necessary information.	30 days from receipt of all information.	May file a facility clinical appeal.

	New York, NY 10116-2807 Telephone: **1-800-447-8255**	180 calendar days; SUNY Downstate - 90 calendar days; NY Presbyterian - 365 calendar days from discharge date or 60 calendar days from denial date (whichever is later).			

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

FACILITY CLINICAL APPEALS

Contracted Facility Clinical Appeals - Medicare HMO Plans

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

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

- If the managing entity has a direct contract with the facility.
- The managing entity has denied the case based on medical information.
- The managing entity has denied the case for "no information."

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

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

Procedures for initiating a contracted facility clinical appeal are outlined in the table below:

TABLE 23-3, APPEAL - CONTRACTED FACILITY CLINICAL APPEAL					
EMBLEMHEALTH MEDICARE HMO PLANS					
BENEFIT PLAN(S)	**WHAT/HOW /WHERE TO FILE:** **INSTRUCTIONS**	**TIME FRAMES**			**ADDITIONAL RIGHTS**
		Initial Provider* Filing	**EmblemHealth Acknowledges Receipt**	**EmblemHealth Determination Notification**	
EmblemHealth Medicare HMO Plans	Write to EmblemHealth Medicare HMO PO Box 2807 New York, NY 10116-2844 Telephone: **1-888-447-8255**	45 calendar days from receipt of written adverse determination. **Exceptions:** NY Presbyterian - 365 calendar days from discharge date or 60 calendar days from denial date (whichever is later); Long Island Health Network - 60 calendar days; SUNY Downstate - 120 calendar days.	15 calendar days from receipt of request.	60 calendar days from receipt of request. The provider notified within 2 days of determination.	N/A

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

For Medicare PPO facility disputes, please refer to the **Contracted Provider Grievances - Medicare PPO Plans** section in this chapter.

MEMBER DISPUTE RESOLUTION PROCEDURES: GRIEVANCES AND APPEALS

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

EMBLEMHEALTH MEDICARE HMO/PPO/PDP

Member Grievance Procedures

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

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

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

Grievances can be filed as follows:

EmblemHealth Medicare HMO

- In writing: EmblemHealth Grievance and Appeal Department
  PO Box 2807
  New York, NY 10116
- By phone: **1-877-344-7364**

EmblemHealth Medicare PPO

- In writing: EmblemHealth Grievance and Appeal Department
  PO Box 2807
  New York, NY 10116
- By phone: **1-866-557-7300**

EmblemHealth Medicare PDP (non-City of New York)

- In writing: EmblemHealth Grievance and Appeal Department

PO Box 2807
New York, NY 10116

- By phone: **1-877-444-7241**

EmblemHealth Medicare PDP (City of New York employees)

- In writing: Express Scripts
  Attn: Pharmacy Appeals GH3
  6625 West 78th Street
  Mail Route B20390
  Bloomington, MN 55439

- By phone: **1-800-585-5786**

EmblemHealth members who use a TTY/TDD can dial **711** for Telecommunications Relay Services.

Standard Reconsiderations (Appeals) - Part C

An enrollee who has received an adverse organization determination may request that it be reconsidered.

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

EmblemHealth will notify the enrollee of its decision no later than 60 calendar days from the date the request was received. If a standard reconsideration request is granted in whole or in part, EmblemHealth will effectuate the decision no later than 60 calendar days from the date the reconsideration request was received.

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

EmblemHealth Medicare HMO

- In writing: EmblemHealth Grievance and Appeal Department
  PO Box 2807
  New York, NY 10116
- By phone: **1-877-344-7364**

EmblemHealth Medicare PPO

- In writing: EmblemHealth Grievance and Appeal Department
  PO Box 2807
  New York, NY 10116
- By phone: **1-866-557-7300**

EmblemHealth members who use a TTY/TDD can dial **711** for Telecommunications Relay Services.

Reopening Medicare Part C

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

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

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

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

Good cause is established when:

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

Note: A general statement of dissatisfaction is not grounds for a Reopening. When possible, please use the **Medicare Organization Determination Reopening Request Form** when submitting Reopening requests.

The Reopening Request Form, along with any additional relevant information, can be mailed or faxed to:

EmblemHealth
ATTN: Predetermination Department, 4th Floor
441 9th Avenue
New York, NY 10001

Fax: 212-510-3006

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

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

Standard Redeterminations (Appeals) - Part D

An enrollee who has received an adverse coverage determination for a drug may request that it be redetermined.

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

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

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

EmblemHealth Medicare HMO

- In writing: EmblemHealth Grievance and Appeal Department
  PO Box 2807
  New York, NY 10116
- By phone: 1-877-344-7364

EmblemHealth Medicare PPO

- In writing: EmblemHealth Grievance and Appeal Department
  PO Box 2807
  New York, NY 10116
- By phone: 1-866-557-7300

EmblemHealth Medicare PDP (non-City of New York)

- In writing: EmblemHealth Grievance and Appeal Department
  PO Box 2807
  New York, NY 10116
- By phone: 1-877-444-7241

EmblemHealth Medicare PDP (City of New York employees)

- In writing: EmblemHealth Grievance and Appeal Department
  PO Box 2807
  New York, NY 10116
- By phone: **1-877-444-7241**

EmblemHealth members who use a TTY/TDD can dial **711** for Telecommunications Relay Services.

2016 RECONSIDERATION RIGHTS FOR NETWORK NON-RENEWAL: FOR MEDICARE HMO LINE OF BUSINESS ONLY

A reconsideration request may be initiated if the non-renewed provider believes that there is information about his/her practice which might be unknown to EmblemHealth and should be reviewed in reconsideration of this decision. Please note, however, that reconsideration applies only to the Medicare HMO line of business; no other plans/lines of business are subject to reconsideration. All decisions are final. The non-renewed Medicare HMO provider has thirty days from receipt of the provider contract non-renewal notification letter to request reconsideration for the Medicare HMO line of business. Upon receipt of a completed reconsideration request, EmblemHealth will schedule an in-person meeting to be held during normal business hours at an EmblemHealth location.

To request a reconsideration of your non-renewal from the Medicare Essential and/or Medicare Advantage HMO networks, please follow these instructions:

- Submit requests for reconsideration in writing to:

  EmblemHealth
  55 Water Street, North Tower
  Dept. 30301 – Non Renewal Coordinator
  New York, NY 10041-8190

- Requests must include the following:
  - A letter describing what special circumstances of which EmblemHealth may be unaware.
  - A checklist of the following, along with supporting documentation, as specified.

Applicability	Present in Practice (Yes/No)	Criteria	Documentation Required
PCPs		Patient Center Medical Home (PCMH)	Evidence of participation in a Level 2 or Level 3 PCMH.

Specialists		Patient Centered Medical Practice (PCSP)	Evidence of participation as a PCSP.
All Physicians		Electronic Health Record (EHR)	A copy of the CMS attestation proving EHR stage 1 or stage 2 meaningful use.
All Physicians		E-Prescribing	Identification of the E-prescribing vendor used and the date implemented.
All Physicians		Hierarchical Condition Categories (HCC)	Any evidence of adoption of ePASS® for reporting HCC gap closure to EmblemHealth.
All Physicians		Wellness Programs	Example(s) of any wellness programs administered by the practice to EmblemHealth members. Please include any improved outcomes demonstrated by these wellness programs.
All Physicians		Electronic Lab Results	Any evidence of the practice's adoption of Care360®, a free tool used to order lab tests and obtain results from Quest Diagnostics, EmblemHealth's preferred diagnostic testing laboratory.
All Physicians		Other info	Any documentation supporting specified criteria.

- After receipt of this information, reconsideration meetings will be scheduled and conducted at an EmblemHealth location during normal business hours.
- An Adhoc Reconsideration Board, consisting of three physicians will conduct the reconsideration hearing.
- The Adhoc Reconsideration Board makes the final decision.
- The provider will be notified in writing within seven business days of the decision.
- Providers whose non-renewal status is upheld will be notified, citing the original date of non-renewal. Participation in the Medicare HMO line of business will continue uninterrupted for providers whose non-renewal status is overturned.

2017 RECONSIDERATION RIGHTS FOR NETWORK TERMINATIONS AND NON-RENEWAL: EMBLEMHEALTH MEDICARE HMO

A reconsideration request may be initiated if the terminated or non-renewed provider believes that there is significant and relevant information about his/her practice which might be unknown to EmblemHealth. EmblemHealth will review this additional information in reconsideration of this decision. All decisions are final. The terminated or non-renewed provider has thirty days from receipt of the termination letter or provider contract non-renewal notification letter to request reconsideration for the applicable Medicare networks. Upon receipt of a completed reconsideration request, EmblemHealth will schedule an in-person meeting to be held during normal business hours at an EmblemHealth location. For terminations and non-renewals from the Enhanced Care Prime Network (Medicaid, HARP and Essential Plan) see **Dispute Resolution for Medicaid Managed Care Plans**.

To request a reconsideration of your non-renewal or termination, please follow these instructions:

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

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

- Requests submitted must include a letter describing special circumstances of which EmblemHealth may be unaware.
- Reconsideration meetings will be scheduled and conducted via phone at an EmblemHealth

location during normal business hours.

- An Ad hoc Reconsideration Board, consisting of three physicians will conduct the reconsideration hearing.
- The Ad hoc Reconsideration Board makes the final decision.
- The provider will be notified in writing within seven business days of the decision.
- Providers whose termination or non-renewal status is upheld will be notified, citing the original date of the change. Participation in the impacted networks will continue uninterrupted for providers whose termination or non-renewal status is overturned.
- Prior to August 1, 2017, a checklist of the following, along with supporting documentation, as specified, was required. Reconsideration requests filed after this date do not require this additional information.

Applicability	Present in Practice (Yes/No)	Criteria	Documentation Required
PCPs		Patient Center Medical Home (PCMH)	Evidence of participation in a Level 2 or Level 3 PCMH.
Specialists		Patient Centered Medical Practice (PCSP)	Evidence of participation as a PCSP.
All Physicians		Electronic Health Record (EHR)	A copy of the CMS attestation proving EHR stage 1 or stage 2 meaningful use.
All Physicians		E-Prescribing	Identification of the E-prescribing vendor used and the date implemented.
All Physicians		Hierarchical Condition Categories (HCC)	Any evidence of adoption of ePASS® for reporting HCC gap closure to EmblemHealth.
All Physicians		Wellness Programs	Example(s) of any wellness programs administered by the practice to EmblemHealth members. Please include any improved outcomes demonstrated

			by these wellness programs.
All Physicians		Electronic Lab Results	Any evidence of the practice's adoption of Care360®, a free tool used to order lab tests and obtain results from Quest Diagnostics, EmblemHealth's preferred diagnostic testing laboratory.
All Physicians		Other info	Any documentation supporting specified criteria.