EmblemHealth

HARP Appeal Information

PLAN APPEALS

There are some treatments and services that you need to get approval for before you receive them or in order to be able to continue receiving them. This is called **prior authorization**. Asking for approval of a treatment or service is called a **service authorization** request. This process is described earlier in this handbook. The notice of our decision to deny a service authorization request or to approve it for an amount that is less than requested is called an **Initial Adverse Determination**.

If you are not satisfied with our decision about your care, there are steps you can take.

Your provider can ask for reconsideration:

If we made a decision that your service authorization request was not medically necessary or was experimental or investigational, and we did not talk to your doctor about it, your doctor may ask to speak with the plan's Medical Director. The Medical Director will talk to your doctor within one work day.

You can file a Plan Appeal:

If you think our decision about your service authorization request is wrong, you can ask us to look at your case again. This is called a Plan Appeal.

- You have 60 calendar days from the date of the Initial Adverse Determination notice to ask for a Plan Appeal.
- You can call Member Services at **855-283-2146** if you need help asking for a Plan Appeal or following the steps of the appeal process. We can help if you have any special needs like a hearing or vision impairment, or if you need translation services.
- You can ask for a Plan Appeal, or you can have someone else, like a family member, friend, doctor or lawyer, ask for you. You and that person will need to sign and date a statement saying you want that person to represent you.
- We will not treat you any differently or act badly toward you because you ask for a Plan Appeal.

Aid to continue while appealing a decision about your care:

If we decided to reduce, suspend, or stop services you are getting now, you may be able to continue the services while you wait for your Plan Appeal to be decided. You must ask for your Plan Appeal:

- Within 10 days from being told that your care is changing; or
- By the date the change in services is scheduled to occur, whichever is later.

If your Plan Appeal results in another denial, you may have to pay for the cost of any continued benefits that you received.

You can call, write, or visit us to ask for a Plan Appeal. When you ask for a Plan Appeal, or soon after, you will need to give us:

- Your name and address.
- Enrollee number.
- Service you asked for and reason(s) for appealing.
- Any information that you want us to review, such as medical records, doctors' letters, or other information that explains why you need the service.
- Any specific information we said we needed in the Initial Adverse Determination notice.
- To help you prepare for your Plan Appeal, you can ask to see the guidelines, medical records, and other documents we used to make the Initial Adverse Determination. If your Plan Appeal is fast tracked, there may be a short time to give us information you want us to review. You can ask to see these documents or ask for a free copy by calling **855-283-2146**.

Give us your information and materials by phone, fax, mail, or in person:

Phone: **855-283-2146**

Fax: **212-510-5320**

Mail: **Grievance and Appeals Department**
EmblemHealth
55 Water Street, New York, NY 10041

In Person: By visiting any of our Neighborhood Care locations.

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If you ask for a Plan Appeal by phone, unless it is fast tracked, you must also send your Plan Appeal to us in writing. After your call, we will send you a form, which is a summary of your phone Plan Appeal. If you agree with our summary, you should sign and return the form to us. You can make any needed changes before sending the form back to us.

If you are asking for an out-of-network service or a provider:

- If we said that the service you asked for is not very different from a service available from a participating provider, you can ask us to check if this service is medically necessary for you. You will need to ask your doctor to send this information with your Plan Appeal:

  1. A statement in writing from your doctor that the out-of-network service is very different from the service the plan can provide from a participating provider. Your doctor must be a board certified or board eligible specialist who treats people who need the service you are asking for.

  2. Two medical or scientific documents that prove the service you are asking for is more helpful to you and will not cause you more harm than the service the plan can provide from a participating provider.

- If you think our participating provider does not have the correct training or experience to provide a service, you can ask us to check if it is medically necessary for you to be referred to an out-of-network provider. You will need to ask your doctor to send this information with your Plan Appeal:

  1. A statement in writing that says our participating provider does not have the correct training and experience to meet your needs, and

  2. That recommends an out-of-network provider with the correct training and experience who is able to provide the service.

Your doctor must be a board certified or board eligible specialist who treats people who need the service you are asking for. If your doctor does not send this information, we will still review your Plan Appeal. However, you may not be eligible for an External Appeal. See the External Appeals section later in this handbook.

What happens after we get your Plan Appeal:

- Within 15 days, we will send you a letter to let you know we are working on your Plan Appeal.
- We will send you a free copy of the medical records and any other information we will use to make the appeal decision. If your Plan Appeal is fast tracked, there may be a short time to review this information.
- You can also provide information to be used in making the decision in person or in writing. Call EmblemHealth at **855-283-2146** if you are not sure what information to give us.
- Plan Appeals of clinical matters will be decided by qualified health care professionals who did not make the first decision, at least one of whom will be a clinical peer reviewer.
- Non-clinical decisions will be handled by persons who work at a higher level than the people who worked on your first decision.
- You will be given the reasons for our decision and our clinical rationale, if it applies. The notice of the Plan Appeal decision to deny your request or to approve it for an amount that is less than requested is called a Final Adverse Determination.
- If you think our Final Adverse Determination is wrong:
  - You can ask for a Fair Hearing. See the Fair Hearings section of this handbook.
  - For some decisions, you may be able to ask for an External Appeal. See the External Appeals section of this handbook.
  - You may file a complaint with the New York State Department of Health at **800-206-8125**.

Time frames for Plan Appeals:

- Standard Plan Appeals: If we have all the information we need, we will tell you our decision within 30 calendar days from when you asked for your Plan Appeal.
- Fast track Plan Appeals: If we have all the information we need, fast track Plan Appeal decisions will be made in two working days from your Plan Appeal but not more than 72 hours from when you asked for your Plan Appeal.
  - We will tell you within 72 hours if we need more information.
  - If your request was denied when you asked for more inpatient substance use disorder treatment at least 24 hours before you were to leave the hospital, we will make a decision about your appeal within 24 hours.
  - We will tell you our decision by phone and send a written notice later.

Your Plan Appeal will be reviewed under the fast track process if:

- If you or your doctor asks to have your Plan Appeal reviewed under the fast track process. Your doctor would have to explain how a delay will cause harm to your health. If your request for fast track is denied, we will tell you, and your Plan Appeal will be reviewed under the standard process; or
- If your request was denied when you asked to continue receiving care that you are now getting or need to extend a service that has been provided; or
- If your request was denied when you asked for home health care after you were in the hospital; or
- If your request was denied when you asked for more inpatient substance use disorder treatment at least 24 hours before you were to leave the hospital.

If we need more information to make either a standard or fast track decision about your Plan Appeal, we will:

- Write you and tell you what information is needed. If your request is in a fast track review, we will call you right away and send a written notice later.
- Tell you why the delay is in your best interest.
- Make a decision no later than 14 days from the day we asked for more information.

You or your representative may also ask us to take more time to make a decision. This may be because you have more information to give the plan to help decide your case. This can be done by calling **855-283-2146** or writing to:

Grievance and Appeals Department
EmblemHealth
55 Water Street, New York, NY 10041

You or your representative can file a complaint with the plan if you don't agree with our decision to take more time to review your Plan Appeal. You or someone you trust can also file a complaint about the review time with the New York State Department of Health by calling **800-206-8125**.

If you do not receive a response to your Plan Appeal or we do not decide in time, including extensions, you can ask for a Fair Hearing. See the Fair Hearings section of this handbook.

If we do not decide your Plan Appeal on time, and we said the service you are asking for is:

1. Not medically necessary;
2. Experimental or investigational;
3. Not different from care you can get in the plan's network; or
4. Available from a participating provider who has the correct training and experience to meet your needs, the original denial will be reversed. This means your service authorization request will be approved.

External Appeals

You have other appeal rights if we said the service you are asking for was:

1. Not medically necessary;
2. Experimental or investigational;
3. Not different from care you can get in the plan's network; or
4. Available from a participating provider who has the correct training and experience to meet your needs.

For these types of decisions, you can ask New York State for an independent External Appeal. This is called an External Appeal because it is decided by reviewers who do not work for the health plan or the state. These reviewers are qualified people approved by New York State. The service must be in the plan's benefit package or be an experimental treatment, clinical trial, or treatment for a rare disease. You do not have to pay for an External Appeal.

Before you ask for an External Appeal:

- You must file a Plan Appeal and get the plan's Final Adverse Determination; or
- If you have not gotten the service, and you ask for a fast track Plan Appeal, you may ask for an expedited External Appeal at the same time. Your doctor will have to say an expedited External Appeal is necessary; or
- You and the plan may agree to skip the plan's appeals process and go directly to External Appeal; or
- You can prove the plan did not follow the rules correctly when processing your Plan Appeal.

You have four months after you receive the plan's Final Adverse Determination to ask for an External Appeal. If you and the plan agreed to skip the plan's appeals process, then you must ask for the External Appeal within four months of when you made that agreement.

To ask for an External Appeal, fill out an application and send it to the Department of Financial Services. You can call Member Services at **855-283-2146** if you need help filing an appeal. You and your doctors will have to give information about your medical problem. The External Appeal application says what information will be needed.

Here are some ways to get an application:

- Call the Department of Financial Services: **800-400-8882**
- Go to the Department of Financial Services' website: **dfs.ny.gov**
- Contact the health plan: **855-283-2146**

Your External Appeal will be decided in 30 days. More time (up to five work days) may be needed if the External Appeal reviewer asks for more information. You and the plan will be told the final decision within two days after the decision is made.

You can get a faster decision if:

- Your doctor says that a delay will cause serious harm to your health; or
- You are in the hospital after an emergency room visit and the hospital care is denied by the plan.

This is called an expedited External Appeal. The External Appeal reviewer will decide an expedited appeal in 72 hours or less.

If you asked for inpatient substance use disorder treatment at least 24 hours before you were to leave the hospital, we will continue to pay for your stay if:

- You ask for a fast track Plan Appeal within 24 hours, and
- You ask for a fast track External Appeal at the same time.

We will continue to pay for your stay until there is a decision made on your appeals. We will make a decision about your fast track Plan Appeal in 24 hours. The fast track External Appeal will be decided in 72 hours.

The External Appeal reviewer will tell you and the plan the decision right away by phone or fax. Later, a letter will be sent that tells you the decision.

If you ask for a Plan Appeal, and you receive a Final Adverse Determination that denies, reduces, suspends, or stops your service, you can ask for a Fair Hearing. You may ask for a Fair Hearing or ask for an External Appeal, or both. If you ask for both a Fair Hearing and an External Appeal, the decision of the Fair Hearing officer will be the one that counts.

Fair Hearings

You may ask for a Fair Hearing from New York State if:

- You are not happy with a decision your local Department of Social Services or the State Department of Health made about your staying with or leaving EmblemHealth.
- You are not happy with a decision we made to restrict your services. You feel the decision limits your Medicaid benefits. You have 60 calendar days from the date of the Notice of Intent to Restrict to ask for a Fair Hearing. If you ask for a Fair Hearing within 10 days of the Notice of Intent to Restrict, or by the effective date of the restriction, whichever is later, you can continue to get your services until the Fair Hearing decision. However, if you lose your Fair Hearing, you may have to pay the cost for the services you received while waiting for the decision.
- You are not happy with a decision that your doctor would not order services you wanted. You feel the doctor's decision stops or limits your Medicaid benefits. You must file a complaint with EmblemHealth. If EmblemHealth agrees with your doctor, you may ask for a Plan Appeal. If you receive a Final Adverse Determination, you will have 120 calendar days from the date of the Final Adverse Determination to ask for a state Fair Hearing.
- You are not happy with a decision that we made about your care. You feel the decision limits your Medicaid benefits. You are not happy we decided to:
  - Reduce, suspend, or stop care you were getting.
  - Deny care you wanted.
  - Deny payment for care you received.
  - Not let you dispute a copay amount, other amount you owe, or payment you made for your health care.

You must first ask for a Plan Appeal and receive a Final Adverse Determination. You will have 120 calendar days from the date of the Final Adverse Determination to ask for a Fair Hearing.

If you asked for a Plan Appeal, and receive a Final Adverse Determination that reduces, suspends, or stops care you are getting now, you can continue to get the services your doctor ordered while you wait for your Fair Hearing to be decided. You must ask for a Fair Hearing within 10 days from the date of the Final Adverse Determination or by the time the action takes effect, whichever is later.

However, if you choose to ask for services to be continued, and you lose your Fair Hearing, you may have to pay the cost for the services you received while waiting for a decision.

- You asked for a Plan Appeal, and the time for us to decide your Plan Appeal has expired, including any extensions. If you do not receive a response to your Plan Appeal or we do not decide in time, you can ask for a Fair Hearing.

The decision you receive from the Fair Hearing officer will be final.

You can use one of the following ways to request a Fair Hearing:

1. By phone: **800-342-3334**
2. By fax: **518-473-6735**
3. By web: **otda.state.ny.us/oah/forms.asp**
4. By mail: **NYS Office of Temporary and Disability Assistance**
   Office of Administrative Hearings
   Managed Care Hearing Unit
   P.O. Box 22023
   Albany, NY 12201-2023

When you ask for a Fair Hearing about a decision EmblemHealth made, we must send you a copy of the evidence packet. This is information we used to make our decision about your care. The plan will give this information to the Fair Hearing officer to explain our action.

If there is not time enough to mail it to you, we will bring a copy of the evidence packet to the hearing for you. If you do not get your evidence packet by the week before your hearing, you can call **855-283-2146** to ask for it.

Remember, you may complain anytime to the New York State Department of Health by calling **800-206-8125**.

You can also call the Independent Consumer Advocacy Network (ICAN) to get free, independent advice about your coverage, complaints, and appeals' options. They can help you manage the appeal process.

Contact ICAN to learn more about their services:

Phone: **844-614-8800 (TTY: 711)**

Web: **icannys.org**

Email: **ican@cssny.org**

Complaint Process

Complaints:

We hope our health plan serves you well. If you have a problem, talk with your primary care provider (PCP), or call or write Member Services. Most problems can be solved right away. If you have a problem or dispute with your care or services, you can file a complaint with the plan. Problems that are not solved right away over the phone and any complaint that comes in the mail will be handled according to our complaint procedure described below.

You can call Member Services at **855-283-2146**. Their hours are 8 am to 6 pm, Monday through Friday if you need help filing a complaint or following the steps of the complaint process. We can help if you have any special needs like a hearing or vision impairment, or if you need translation services.

We will not make things hard for you or take any action against you for filing a complaint.

You also have the right to contact the New York State Department of Health about your complaint at **800-206-8125** or write to: Complaint Unit, Bureau of Consumer Services, OHIP DHPCO 1CP-1609, New York State Department of Health, Albany, NY 12237.

You may also contact your local Department of Social Services with your complaint at any time. You may call the New York State Department of Financial Services at **800-342-3736** if your complaint involves a billing problem.

How to file a complaint with our plan:

You can file a complaint, or you can have someone else, like a family member, friend, doctor or lawyer, file the complaint for you. You and that person will need to sign and date a statement saying you want that person to represent you.

To file by phone, call Member Services at **855-283-2146**, Monday through Friday, from 8 am to 6 pm. If you call us after hours, leave a message. We will call you back the next work day. If we need more information to make a decision, we will tell you.

You can write us with your complaint or call the Member Services number and request a complaint form. It should be mailed to:

Grievance and Appeals Department
EmblemHealth
55 Water Street, New York, NY 10041

What happens next?

If we don't solve the problem right away over the phone or after we get your written complaint, we will send you a letter within 15 work days. The letter will tell you:

- Who is working on your complaint
- How to contact this person
- If we need more information

You can also provide information to be used reviewing your complaint in person or in writing. Call EmblemHealth at **855-283-2146** if you are not sure what information to give us.

Your complaint will be reviewed by one or more qualified people. If your complaint involves clinical matters, your case will be reviewed by one or more qualified health care professionals.

After we review your complaint:

- We will let you know our decision in 45 days of when we have all the information we need to answer your complaint, but you will hear from us in no more than 60 days from the day we get your complaint. We will write you and will tell you the reasons for our decision.
- When a delay would risk your health, we will let you know our decision in 48 hours of when we have all the information we need to answer your complaint, but you will hear from us in no more than seven days from the day we get your complaint. We will call you with our decision or try to reach you to tell you. You will get a letter to follow up our communication in three work days.
- You will be told how to appeal our decision if you are not satisfied and we will include any forms you may need.
- If we are unable to make a decision about your complaint because we don't have enough information, we will send a letter and let you know.

Complaint Appeals

If you disagree with a decision we made about your complaint, you can file a complaint appeal with the plan.

How to make a complaint appeal:

- If you are not satisfied with what we decide, you have at least 60 work days after hearing from us to file a complaint appeal; you can do this yourself or ask someone you trust to file the complaint appeal for you.
- The complaint appeal must be made in writing. If you make a complaint appeal by phone, it must be followed up in writing. After your call, we will send you a form, which is a summary of your phone appeal. If you agree with our summary, you must sign and return the form to us. You can make any needed changes before sending the form back to us.

What happens after we get your complaint appeal?

After we get your complaint appeal, we will send you a letter within 15 work days. The letter will tell you:

- Who is working on your complaint appeal
- How to contact this person
- If we need more information

Your complaint appeal will be reviewed by one or more qualified people at a higher level than those who made the first decision about your complaint. If your complaint appeal involves clinical matters, your case will be reviewed by one or more qualified health professionals, with at least one clinical peer reviewer, that were not involved in making the first decision about your complaint.

If we have all the information we need, you will know our decision in 30 work days. If a delay would risk your health, you will get our decision in two work days of when we have all the information we need to decide the appeal. You will be given the reasons for our decision and our clinical rationale, if it applies. If you are still not satisfied, you or someone on your behalf can file a complaint at any time with the New York State Department of Health at **800-206-8125**.

You can also call the Independent Consumer Advocacy Network (ICAN) to get free, independent advice about your coverage, complaints, and appeals' options. They can help you manage the appeal process. Contact ICAN to learn more about their services:

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