SECTION 10- Grievances & Appeals

10.1- Provider Notice Requirements – ALL Plans

The objective of VNSNY CHOICE's Grievance and Appeals department is to provide practitioners with processes for resolving concerns that relate to service or claims payment. VNSNY CHOICE manages reconsiderations (Appeals) in accordance with its policies and procedures, which are based on CMS and NYSDOH regulatory requirements. VNSNY CHOICE informs each provider of the process and their right to file an appeal according to the plan-type regulatory requirements.

All participating providers must cooperate with VNSNY CHOICE in the administration of the Grievance and Appeals process.

All VNSNY CHOICE plans adhere to the following:

- Determinations of all clinical appeals involving clinical decisions are made by qualified clinical personnel.
- All appeals are handled confidentially. If requested, member anonymity is also ensured.
- VNSNY CHOICE will not retaliate nor take any discriminatory action against a provider because he/she has filed an appeal.
- There will be no change in a member's services because an appeal has been filed.
- The provider is informed of the toll-free number to call in order to file an appeal and of their right to appeal to the appropriate regulatory agency.

VNSNY CHOICE will give our providers any help that is needed to file an appeal. This includes interpreter services or help for those with a vision and/or hearing impairment.

Providers may call Member Services and speak to a Member Services Representative to file an expedited appeal. Standard appeals must be submitted in writing. After hours, the provider may leave a message that will be responded to no later than the next business day. Member Services Representatives are available to assist in filing appeals as necessary.

10.2- Standard Appeals – All Plans

Actions
When VNSNY CHOICE does one of the following, these decisions are considered plan "actions:"

- Denies or limits services requested by a member or his/her provider
- Denies a request for a referral
- Decides that a requested service is not a covered benefit
- Reduces, suspends or terminates services that we already authorized
- Denies payment for services
- Doesn't make grievance or appeal determinations within the required timeframes
- Doesn't provide timely service

An action is subject to appeal.

Timing of Notice of Action
If we decide to deny or limit services that a provider requested or decide not to pay for all or part of a covered service, we will send the member and provider a notice when we make our decision. If we are proposing to reduce, suspend or terminate a service that is authorized, our letter will be sent at least 10 days before we intend to change the service.

Contents of the Notice of Action
Any notice we send to a member and provider about an action will:

- Explain the action we have taken or intend to take; cite the reasons for the action, including the clinical rationale, if any does apply.
- Describe the member's and provider's right to file an appeal with us (including whether the member may also have a right to the State's external appeal process).
- Describe how to file an internal appeal and the circumstances under which you can request that we speed up (expedite) our review of your internal appeal.

- Describe the availability of the clinical review criteria relied upon in making the decision, if the action involved issues of medical necessity or whether the treatment or service in question was experimental or investigational.

- Describe the information, if any that must be provided by the member or provider in order for us to render a decision on appeal.

If we are reducing, suspending or terminating an authorized service, the notice will also inform the member/provider about his/her rights to have services continue while we decide on the appeal and how to request that services be continued. The notice also informs members/providers that if the initial action is not overturned on appeal, the member could be responsible for payment for these services if they are continued while we were reviewing the appeal**.**

Once we receive the appeal, we will send a written acknowledgement telling you the name, address and telephone number of the individual we have designated to respond to the appeal. All appeals will be conducted by appropriate professionals, including health care professionals for involving clinical matters. Also, all appeals will be conducted by individuals who were not involved in the initial decision.

Filing an Appeal
If the provider is not satisfied with the decision we make concerning an action, a second review of the issue can be requested by filing an appeal. As with the original request, a provider may request an appeal on behalf of the VNSNY CHOICE member, with his/her consent. All claim appeals must be filed in writing and must be filed within 60 calendar days of our initial decision about the request or as otherwise specified in the provider contract. Service appeals may be filed orally or in writing.

- Within 15 calendar days of receipt of the appeal, VNSNY CHOICE provides written acknowledgement of the appeal including the name, address and telephone number of the individual designated to respond to the appeal. CHOICE indicates what additional information, if any, must be provided for CHOICE to render a decision.

- Appeals of a clinical matter are decided by personnel qualified to review the appeal including licensed, certified or registered health care professionals who did not make the initial determination, at least one of whom will be a clinical peer reviewer. The clinical peer reviewer is a physician or other healthcare provider who typically manages the medical condition, procedure or treatment under review.

- Appeals of non-clinical matters are determined by qualified personnel at a higher level than the personnel who made the original appeal determination.

- Appeals are decided and notification is provided to the provider.

A Plan Appeal can be filed by phone call or in writing to:

Phone: 1-866-867-6555

Fax: 1-866-791-2213

Mail: P.O. Box 445
Elmsford, NY 10523
Attn: VNSNY CHOICE Grievance & Appeals

A provider can call or write us to ask for a Plan Appeal. A provider can ask for the Plan Appeal to be fast tracked if they think a delay will cause harm to the member's health. A claim appeal cannot be fast tracked and must be submitted in writing. If you need help, or need a Plan Appeal right away, call us at 1-888-867-6555. Our timeframe to respond begins when the plan receives the appeal whether orally or in writing.

Plan Determinations

The notice of the Plan Appeal decision to deny the member's/member reps request or to approve it for an amount that is less than requested is called a Final Adverse Determination. This notice will provide the member or their representative with the following information:

- Member's plan coverage type
- A summary of the appeal and date it was filed
- The date the appeal process was completed
- The service/benefit that was denied, including the provider/facility name or developer/manufacturer of the service/benefit as available
- Name and contact information of the person who reviewed the appeal
- Description of the member's fair hearing rights and timeframes
- Description of the member's external appeal rights and timeframes when applicable
- The member's right to complain to the Department of Health at any time by calling 1-866-712-7197.
- A statement that our notices are available in other languages and formats

and how to access these formats

When VNSNY CHOICE affirms (upholds) or partially affirms an appeal, a member, a member's designee and, in the case of concurrent or retrospective adverse determinations, the member's healthcare provider, have the right to request an external appeal when the plan said the service was:

- not medically necessary; or
- experimental or investigational; or
- not different from care you can get in the plan's network; or
- available from a participating provider who has the correct training and experience to meet your needs.

Appealing a Final Adverse Determination

If a provider, member or designee thinks our Final Adverse Determination is wrong:

- The provider, member or designee can ask for a Fair Hearing. See the Fair Hearing section of this manual.
- For some decisions, the provider, member or designee may be able to ask for an External Appeal. See the External Appeal section of this manual.

The provider, member or designee may file a complaint with the New York State Department of Health at 1-800-206-8125.

External Appeals

For these types of decisions, the member or provider may be eligible for an External Appeal. An External Appeal is a review of the case by health professionals that do not work for your plan or the State. A member may need their doctor's help to fill out the External Appeal application.

Before a member can ask for an External Appeal:

- They must file a Plan Appeal and get the plan's Final Adverse Determination or
- If the member asks for a Fast Track Plan Appeal, they may also ask for a Fast Track External Appeal at the same time or
- The member and the plan may jointly agree to skip the Plan Appeal

process and go directly to the External Appeal. If this occurs, VNSNY CHOICE sends a letter with information regarding filing an external appeal to member within 24 hours of the agreement to waive the internal appeal process.

The timeframe to file an External Appeals is 4 months from when the member receives the plan's Final Adverse Determination, or from when the member and the plan agreed to skip the internal Plan Appeal process.

One business day after the receipt of the request all necessary information when a delay would significantly increase the risk to a member's health (expedited appeal), member is eligibile for 14-day extension if additional information is required. Thirty calendar business days after the receipt of the request all necessary information in all other instances (standard service appeal). Eligible for 14-day extension. Sixty calendar days after receipt of the request (claim appeals).

The notice of appeal determination includes:

- The detailed reasons for the determination
- The clinical rationale for the determination in cases where the determination has a clinical basis
- Information notifying the member of his/her option to also contact the New York State Department of Health at 1 (800) 206-8125 with his/her complaint. In New York City, members may call New York Medicaid Choice at 1 (800) 505-5678.

Aid to Continue for Service Appeals

If we decided to reduce, suspend or stop services the member is getting now, they may be able to continue the services while they wait for the Plan Appeal to be decided. The provider, member or designee must ask for a Plan Appeal:

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

If the Plan Appeal results in another denial the member may have to pay for the cost of any continued benefits they received.

For **Member Services,** call 1-866-469-7774. TTY users, call 711.
For **Behavioral Health Services Crisis Line**, call 1-855-735-6098. TTY users call 1-866-727-9441.

Timeframes for Plan Appeals

- **Standard Service Plan Appeals:** If we have all the information we need we will tell the provider, member or designee our decision within 30 calendar days from when they asked for a Plan Appeal.
- **Fast Track Plan Service Appeals:** If we have all the information we need, fast track Plan Service Appeal decisions will be made in 72 hours from the Plan Appeal from when they asked for a Plan Appeal. We will tell the provider, member or designee within in 72 hours if we need more information.
  Standard Claim Plan Appeals: We will tell the provider of our decision with 60 calendar days from when we received the appeal. If the request was denied when the member or designee asked for more inpatient substance use disorder treatment at least 24 hours before the member was to leave the hospital, we will make a decision about the appeal within 24 hours.

- For **Fast Track Plan Service Appeals,** we will tell the provider and the member or designee our decision by phone and send a written notice later.

- For **Standard Service and Claim Plan appeals** we will notify the provider in writing.

  The member can also write to the NYS Department of Health, Bureau of Managed Care Certification and Surveillance, ESP Corning Tower Room 1911, Albany, NY 12237.

10.3- Expedited Appeals – All Plans

Submission

VNSNY CHOICE has established and maintains procedures for expediting reconsiderations. These include establishing an efficient and convenient method for individuals to call or submit written requests for expedited appeals, documenting verbal requests, and maintaining the documentation in the case file.

VNSNY CHOICE has designated the Grievance and Appeal department to receive both verbal or written requests and a telephone number (866) 783-1444, 24 hours a day, seven (7) days a week (including holidays), TTY 711 for verbal requests, and includes a secure facsimile number (866) 791- 2213 to facilitate receipt of requests for expedited appeals. VNSNY CHOICE promptly decides whether to expedite or follow the time frame for standard reconsiderations.

When the request is made or supported by a physician, VNSNY CHOICE grants the expedited reconsideration request if the physician indicates (the physician does not have

to use this exact language in his or her verbal or written request or support of the request) that the life or health of the member, or the member's ability to regain maximum function could be seriously jeopardized by applying the standard time frame in the processing of the reconsideration request.

- For a member request not supported by a physician, VNSNY CHOICE's Medical Director or other licensed clinician determines whether the life or health of the member, or the member's ability to regain maximum function, could be seriously jeopardized by applying the standard time frame in the processing of the reconsideration request.

- The 72-hour time frame may be extended by up to 14 calendar days if the extension is in the interest of the member, e.g., the receipt of additional medical evidence from a non-contracted provider may change the VNSNY CHOICE decision to deny.

Process

When VNSNY CHOICE extends the time frame, VNSNY CHOICE notifies the member/provider in writing of the reasons for the extension and informs the member of the right to file an expedited grievance if he or she disagrees with the VNSNY CHOICE decision to grant an extension.

The Grievance and Appeal Specialist notifies the member/provider of its determination as expeditiously as the member's health condition requires, but no later than the last day of the extension.

If medical information is required from non-contracted providers, the Grievance and Appeals Specialist requests the necessary information from the non-contracted provider within twenty-four (24) hours of the initial request for an expedited reconsideration.

Non-contracted providers must make reasonable and diligent efforts to expeditiously gather and forward all necessary information to assist VNSNY CHOICE in meeting the required time frame.

Regardless of whether VNSNY CHOICE must request information from non-contracted providers, VNSNY CHOICE is responsible for meeting the same time frame and notice required as it does with contracting providers.

Timeframes

Appeals must be decided as fast as member's condition requires, but no more than:

A. **Expedited: 72 hours from receipt of the request. (Can be extended 14 days)**

B. **Standard**: 30 calendars days from receipt of the request. (Can be extended 14 days)

Appeals are tracked and investigated by the Grievance & Appeals Department.

1. VNSNY CHOICE must provide written notice of their decision. The notice must include the reason for the determination and in cases where the determination has a clinical basis, the clinical rationale for the determination. Plan must provide oral notification for expedited appeals and must send written notice with 2 business days for all appeals.

2. If an expedited appeal is requested, the Medical Director and/or Grievance & Appeals Department will determine if the appeal meets the criteria for an expedited appeal. If not, a letter will be sent to the member/provider and the appeal will be handled as a standard complaint.

10.4 - External Review – All Plans

VNSNY CHOICE Total
Information in this section applies to **all** of your Medicare and most of your Medicaid benefits. This
information does not apply to your Medicare Part D prescription drug benefits.

If we say **No** to your Level 1 Appeal, your case will **automatically** be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Hearing Office** reviews our decision for your Level 1 appeal. This organization decides whether the decision we made should be changed.

- **The Hearing Office is an independent New York State agency**. It is not connected with us. Medicare and Medicaid oversee its work.

- We will send the information about your appeal to this organization. This information is called your "case file." **You have the right to ask us for a free copy of your case file**.

- You have a right to give the Hearing Office additional information to support your appeal.

- Reviewers at the Hearing Office will take a careful look at all of the information related to your appeal. The Hearing Office will contact you to schedule a hearing.

- If you had a fast appeal to our plan at Level 1 because your health could be

seriously harmed by waiting for a decision under a standard timeframe, you will automatically get a fast appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal **within 72 hours** of when it gets your appeal.

- If the Hearing Office needs to gather more information that may benefit you, **it can take up to 14 more calendar days**.

If you had a "standard" appeal at Level 1, you will also have a "standard" appeal at Level 2

- If you had a standard appeal to our plan at Level 1, you will automatically get a standard appeal at Level 2.

- The review organization must give you an answer to your Level 2 Appeal **within 90 calendar days** of when it gets your appeal.

- If the Hearing Office needs to gather more information that may benefit you, it can take up to 14 more calendar days.

If you qualified for continuation of benefits when you filed your Level 1 Appeal, your benefits for the service, item, or drug under appeal will also continue during Level 2. Go to page 7 for information about continuing your benefits during Level 1 Appeals.

The Hearing Office will tell you its decision in writing and explain the reasons for it.

- If the Hearing Office says **yes** to part or all your request, we must authorize the service or give you the item **within one business day of when we get the Hearing Office's decision**.

- If the Hearing Office says **no** to part or all of your appeal, it means they agree with our plan that your request (or part of your request) for coverage for medical care should not be approved. (This is called "upholding the decision" or "turning down your appeal.")

If the Hearing Office says no to part or all of your appeal, you can choose whether you want to take your appeal further.

- There are two additional levels in the appeals process after Level 2 (for a total of four levels of appeal).

- If your Level 2 Appeal is turned down, you must decide whether you want to go on to Level 3 and make a third appeal. The written notice you got after your Level 2 Appeal has the details on how to do this.

- The Medicare Appeals Council handles the Level 3 Appeal. After that, you may have the right to ask a federal court to look at your appeal.

- The decision you get from the Medicare Appeals Council related to **Medicaid** benefits will be **final**.

At any time in the process you or someone you trust can also file a complaint about the review time with the New York State Department of Health by calling 1-866-712-7197.

External Appeals for MLTC & Select Health
You or your doctor can ask for an External Appeal for **Medicaid covered benefits only**. You can ask New York State for an independent **external appeal** if our plan decides to deny coverage for a medical service you and your doctor asked for because it is:

- Not medically necessary or

- Experimental or investigational or

- Not different from care you can get in the plan's network or

- Available from a participating provider who has correct training and experience to meet your needs.

- Or if the enrollee's attending physician has certified that the enrollee has a life threatening or disabling condition or disease (a) for which standard health services or procedures have been ineffective or would be medically inappropriate or (b) for which there does not exist a more beneficial standard health service or procedure covered by the health care provider or(c) for which there exists a clinical trial.

- Or the enrollee's attending physician, who must be licensed, board-certified or board eligible physician qualified to practice in the area of practice appropriate to treat the enrollee's life-threatening or disabling condition nor disease, must have recommended either (a) health service or procedure (including pharmaceutical product within the meaning of PHI. 4900(5)(b)(B) that based on two documents from the available medical and scientific evidence, it is likely to be more beneficial to the enrollee than any covered health service or procedure, or (b) a clinical trial for which the enrollee 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.

- Or 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 is experimental or investigational.

Note that if the MCO offers two levels of internal appeals, the MCO may not require the enrollee to exhaust the second level of internal appeal to be eligible for an external appeal.

- This is called an External Appeal because reviewers who do not work for the health plan or the state make the decision. 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. You do not have to pay for an external appeal.

Before you appeal to the state:

- You must file a Level 1 appeal with the plan and get the plan's Final Adverse Determination; **or**

- You may ask for an expedited External Appeal at the same time if you have not gotten the service and you ask for a fast appeal. (Your doctor will have to say an expedited 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 Level 1 appeal.

You have **4 months** after you get 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 4 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 1-866-783-1444 (TTY users call 711) 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, 1-800-400-8882

- Go to the Department of Financial Services' website at www.dfs.ny.gov .

- Contact the health plan at 1-866-783-1444 (TTY users call 711)

The reviewer will decide your External Appeal in 30 days. If the External Appeal reviewer asks for more information, more time (up to five work days) may be needed. The reviewer will tell you and the plan the final decision within two days after making the decision.

You can get a faster decision if your doctor says that a delay will cause serious harm to your health. This is called an **expedited External Appeal**. The External Appeal reviewer will decide an expedited appeal in 72 hours or less. The reviewer will tell you and the plan the decision right away by phone or fax. Later, the reviewer will send a letter that tells you the decision.

At any time in the process, you or someone you trust can also file a complaint about the review time with the New York State Department of Health by calling 1-866-712-7197.

MLTC and Select Health

If we did not decide the appeal totally in your favor, you may request a Medicaid Fair Hearing from New York State within 120 days of the date we sent you the notice about our decision on your appeal.

If your appeal involved the restriction, reduction, suspension or termination of authorized services you are currently receiving, and you have requested a Fair Hearing, you will continue to receive these services while you are waiting for the Fair Hearing decision. Your request for a Fair Hearing must be made within 10 days of the date the appeal decision was sent by us or by the intended effective date of our action to restrict, reduce, suspend or terminate your services, whichever occurs later.

Your benefits will continue until you withdraw the Fair Hearing; or the State Fair Hearing Officer issues a hearing decision that is not in your favor, whichever occurs first.

If the State Fair Hearing Officer reverses our decision, we must make sure that you receive the disputed services promptly, and as soon as your health condition requires but no later than 72 hours from the date the plan receives the Fair Hearing decision. If you received the disputed services while your appeal was pending, we will be responsible for payment for the covered services ordered by the Fair Hearing Officer.

Although you may request to continue services while you are waiting for your Fair Hearing decision, if your Fair Hearing is not decided in your favor, you may be responsible for paying for the services that were the subject of the Fair Hearing.

You can file a State Fair Hearing by contacting the Office of Temporary and Disability Assistance:

- Online Request Form: http://otda.ny.gov/oah/FHReq.asp
- Mail a Printable Request Form:

  NYS Office of Temporary and Disability Assistance
  Office of Administrative Hearings
  Managed Care Hearing Unit
  P.O. Box 22023
  Albany, New York 12201-2023

- Fax a Printable Request Form: (518) 473-6735
- Request by Telephone:

Standard Fair Hearing line – 1 (800) 342-3334
Emergency Fair Hearing line – 1 (800) 205-0110
TTY line – 711 (request that the operator call 1 (877) 502-6155)

Request in Person:

New York City
14 Boerum Place, 1st Floor
Brooklyn, New York 11201

Albany
40 North Pearl Street, 15th Floor
Albany, New York 12243

For more information on how to request a Fair Hearing, please visit:
http://otda.ny.gov/hearings/request/

If we deny your appeal because we determine the service is not medically necessary or is experimental or investigational, or the service is not different from care you can get in the plan's network, you may ask for an external appeal from New York State. The external appeal is decided by reviewers who do not work for us or New York State. These reviewers are qualified people approved by New York State. You do not have to pay for an external appeal.

When we make a decision to deny an appeal for lack of medical necessity or on the basis that the service is experimental or investigational, we will provide you with information about how to file an external appeal, including a form on which to file the external appeal along with our decision to deny an appeal. If you want an external appeal, you must file the form with the New York State Department of Financial Services within four months from the date we denied your appeal.

Your external appeal will be decided within 30 days. More time (up to 5 work days) may be needed if the external appeal reviewer asks for more information. The reviewer will tell you and us of the final decision within two work days after the decision is made.

You can get a faster decision if your doctor can say that a delay will cause serious harm to your health. This is called an expedited external appeal. The external appeal reviewer will decide an expedited appeal in 3 days or less. The reviewer will tell you and us the decision right away by phone or fax. Later, a letter will be sent that tells you the decision.

You may ask for both a Fair Hearing and an external appeal. If you ask for a Fair Hearing and an external appeal, the decision of the Fair Hearing officer will be the "one that counts."

Line(s) of Business	External Entity	Timeframe to Submit	Timeframe for Decision
Total	IAHO – Integrated Administrative Hearing Office	Partial Denials & Upholds automatically forwarded to IAHO when final determination is issued	Expedited: 72 hours (Plus a 14 day extension) Standard: 90 Calendar Days
MLTC / SelectHealth	DFS – Department of Financial Services	4 Months from Final Adverse Determination	Expedited: 72 hours Standard: 30 Calendar Days
MLTC / SelectHealth	Office of Temporary and disability assistance (OTDA – Fair Hearing Office)	120 days from the date of the decision	Determined by hearing office

10.5- Notification to Members of Non-Coverage of Inpatient Care—Total and MLTC

Medicare
If VNSNY CHOICE does not authorize coverage of the inpatient admission of a Medicare member, either directly or by delegation (or the admission constitutes an emergency or urgently needed care), VNSNY CHOICE is required to issue the member a written notice of non-coverage: Integrated Denial Notice.

The Integrated Denial Notice will include:

- The services that have been requested
- The services that have been denied
- The reason for denial
- The right for the member, the AOR, or the provider acting on behalf of the member to appeal the adverse determination.

VNSNY CHOICE will issue a Notice of Medicare Non-Coverage (NONMC) to members receiving covered skilled nursing, home health, or comprehensive outpatient facility services. The NOMNC will be delivered at least two calendar days before the Medicare covered services end.

- The provider will be notified of the termination of services two days prior to the termination.
- The provider will deliver the NOMNC to the member explaining the member's rights regarding an expedited appeal through the BFCC/QIO Agency.
- The provider will return a copy of the signed NOMNC to VNSNY CHOICE

The following rules apply to the immediate QIO review process:

- On the date that the QIO receives the member's request, the QIO must notify VNSNY CHOICE that the member has filed a request for immediate review.
- VNSNY CHOICE and/or the hospital must supply any information that the QIO requires to conduct its review. This must be made available by phone, fax or in writing by the close of business of the first full working day immediately following the

day the member submits the request for review.

- In response to a request from VNSNY CHOICE, the hospital must submit medical records and other pertinent information to the QIO by close of business of the first full working day immediately following the day VNSNY CHOICE makes its request.

- The QIO must solicit the views of the member who requested the immediate QIO review.

- The QIO must make an official determination of whether continued hospitalization is medically necessary, and notify the member, the hospital, and VNSNY CHOICE by close of business of the first working day after it receives all necessary information from the hospital, VNSNY CHOICE, or both.

A member who fails to request an immediate QIO review in accordance with these requirements may file a request for an expedited reconsideration with VNSNY CHOICE. VNSNY CHOICE is encouraged to expedite the request for an expedited reconsideration. Likewise, if the QIO receives a request for immediate QIO review beyond the noon (12 p.m.) filing deadline and forwards that request to VNSNY CHOICE. Thus, VNSNY CHOICE would generally make an expedited decision about the services within 72 hours. However, the financial liability rules governing immediate QIO review do not apply in an expedited review situation.

Liability for Hospital Costs

The presence of a timely appeal for an immediate QIO review as filed by the member in accordance with this section entitles the member to automatic financial protection by VNSNY CHOICE. This means that if VNSNY CHOICE authorizes coverage of the inpatient hospital admission directly or by delegation, or this admission constitutes emergency or urgently needed care, VNSNY CHOICE continues to be financially responsible for the costs of the hospital stay until noon of the calendar day following the day the QIO notifies the member of its review determination.

Medicaid, MLTC and Dual Eligibles

Members enrolled in the VNSNY CHOICE Total or MLTC plans have different options when filing an appeal for services covered under the benefit package. For VNSNY CHOICE services funded by the State contract, members must follow Medicaid appeal rules. For services funded through the Medicare program, members must follow Medicare appeal rules. For services covered by both Medicaid and Medicare funding, members can follow either Medicaid or Medicare rules.

If a member chooses to pursue Medicaid appeal rules to challenge an organization determination or action, he/she has sixty (60) calendar days from the date on the

"Notice of Denial of Coverage" issued by VNSNY CHOICE to pursue Medicare appeal, regardless of the status of the Medicaid appeal. However, if a member chooses to pursue Medicare rules, they may not file an appeal under Medicaid rules. VNSNY CHOICE determines whether Medicaid, Medicare, or both cover a particular service.

Hospitals must notify Medicare enrollees who are hospital inpatients about their in-patient hospital discharge appeal rights. Hospitals use 'An Important Message from Medicare About

Your Rights' (IM) a statutorily required notice, to explain the enrollee's rights as a hospital in-patient, including discharge appeal rights. Hospitals must issue the IM (See Appendix) up to seven days before admission, or within two calendar days of admission, must obtain the signature on the form and provide the member with a copy of the signed notice. Hospitals may also need to deliver a copy of the signed notice as far in advance of discharge as possible, but not more than two calendar days before discharge.

Hospitals must follow the procedures listed below in delivering the IM. Valid notice consists of the "Use of Standardized Notice". Hospitals must use the standardized form (CMS-R- 193), dated 05/07. The notices are also available on www.cms.hhs.gov/bni at the Link for Hospital Discharge Appeal Notices. Hospitals may not deviate from the content of the form except where indicated. The OMB control number must be displayed on the notice.

Delivery Timeframe: If the IM is not given prior to admission, hospitals must deliver it to the enrollee at or near admission, but no later than two calendar days following the date of the enrollee's admission to the hospital as an in-patient (The hospital may deliver the Important Message within seven days of admission but only in those cases where an enrollee has a scheduled inpatient visit, such as elective surgery). Hospitals may not deliver the Important Message to an enrollee who is in an outpatient or observation setting on the chance that the patient may end up receiving inpatient care.

In-Person Delivery: The IM must be delivered to the enrollee in person. However, if the enrollee is not able to comprehend the notice, it must be delivered to and signed by the enrollee's representative.

Notice Delivery to Representatives: CMS requires that notification of an enrollee who is not competent be made to a representative of the enrollee. A representative is an individual who, under State or other applicable law, may make health care decisions on a beneficiary's behalf, (e.g., the enrollee's legal guardian, or someone appointed in accordance with a properly executed "durable medical power of attorney").

Otherwise, a person (typically, a family member or close friend) whom the enrollee has indicated may act for him or her, but who has not been named in any legally binding

document may be a representative for the purpose of receiving the notices described in this section. Such representatives should have the enrollee's best interests at heart and must act in a manner that is protective of the enrollee and the enrollee's rights. Therefore, a representative should have norelevant conflict of interest.

Regardless of the competency of an enrollee, if the hospital is unable to personally deliver a notice to a representative, then the hospital should telephone the representative to advise him or her of the enrollee's rights as a hospital in-patient, including the right to appeal a discharge decision.

When direct phone contact cannot be made, the hospital should send the notice to the representative by certified mail, return receipt requested or any method in which delivery may be tracked and verified (e.g., UPS, FedEx, etc). The date that someone at the representative's address signs (or refuses to sign) the receipt is the date received. The hospital should place a copy of the notice in the enrollee's medical file, and document the attempted telephone contact with the member's representative. The documentation should include: the name of the staff person initiating the contact, the name of the representative you attempted to contact, the date and time of the attempted call, and the telephone number called. If both the hospital and the representative agree, hospitals may send the notice by fax or e-mail. However, hospitals must meet the HIPAA privacy and security requirements when transmitting the IM by e-mail or fax.

Ensuring Enrollee Comprehension: Notices should not be delivered during an emergency. Hospitals must make every effort to ensure the enrollee comprehends the contents of the notice before obtaining the enrollee's signature. This includes explaining the notice to the enrollee if necessary and providing an opportunity for the enrollee to ask questions. The hospital should answer all the enrollee's questions orally to the best of its ability. The enrollee should be able to understand that he or she may appeal a discharge decision without financial risk but may have to pay for any services received after the discharge date if he or she stays in the hospital and does not appeal.

These instructions do not preclude the use of assistive devices, witnesses, or interpreters for notice delivery. Thus, if an enrollee is able to comprehend the notice, but either is physically unable to sign it or needs the assistance of an interpreter to translate it or an assistive device to read or sign it, valid delivery may be achieved by documenting use of such assistance.

Enrollee Signature and Date: (Unless an appropriate reason for the lack of signature is recorded on the IM.) The IM must be signed and dated by the enrollee to indicate that he or she received the notice and understands its contents.

If a member disputes (appeals) the discharge and contacts the Quality Improvement Organization (QIO) for an immediate review, VNSNY CHOICE will complete and fax the

"Detailed Notice of Discharge" (DND) to the hospital administrator or nursing director on duty (the member's medical record must be faxed to VNSNY CHOICE by 4 p.m. that day). The hospital must deliver a copy of the DND to the member. The hospital may not create its own DND and deliver it to the member without VNSNY CHOICE's approval. VNSNY CHOICE will also fax a copy of the DND to the QIO for review and/or an expedited reconsideration. The QIO and/or VNSNY CHOICE will work with the hospital and attending physician to determine if discharge is appropriate.

If an appeal occurs during a weekend, a VNSNY CHOICE Manager or Director will contact the nursing office or hospital administrator on duty to facilitate the delivery of the *"Detailed Notice of Discharge."*

Template documents to be used for this new process are available on the CMS web site at www.cms.hhs.gov/BNI/12_HospitalDischargeAppealNotices.asp#TopOfPage.

Requesting Immediate Quality Improvement Organization (QIO) Review of Inpatient Hospital Care

A member remaining in the hospital who wishes to appeal the VNSNY CHOICE discharge decision that inpatient care is no longer necessary must request an immediate QIO review of the determination in accordance with CMS requirements. A member will not incur any additional financial liability if he/she:

- Remains in the hospital as an inpatient
- Submits the request for immediate review to the QIO that has an agreement with the hospital
- Makes the request either in writing, by telephone or fax
- Makes the request before the end of the day of discharge.

Medicare

When VNSNY CHOICE receives a request for payment or to provide services to a member, it must make an organizational determination to decide whether or not payment and or coverage is necessary and appropriate. If the determination is not made in a timely manner or is not favorable, the member has the right to request a reconsideration or appeal.

A member who disagrees with a practitioner's decision about a request for a service or a course of treatment has a right to request an organizational determination from VNSNY CHOICE. This member should be referred to Member Services for additional information.

VNSNY CHOICE is required to make organizational determinations and process appeals as expeditiously as the member's health status requires.

Prospective Coverage Decisions Standard Decisions
VNSNY CHOICE will make decisions regarding authorization for items and services that a member has not yet received within 14 days of a request and 72 hours following the receipt of a request for Medicare Part B drugs.

Expedited Decisions
In the event that the standard 14-day time frame would seriously jeopardize the life or health of the member or the ability of the member to regain maximum function, VNSNY CHOICE will issue an expedited decision within 72 hours of a request for an expedited decision for items and services. Twenty-four hours for Medicare Part B drugs.

The member or a participating physician can request an expedited decision if the member or the member's physician believes that waiting for a standard decision could seriously harm the member's health or ability to function.

If a participating physician asserts in writing that this standard is met, VNSNY CHOICE will issue an expedited decision within 72 hours of the request. If the member makes a request for an expedited decision without the support of his or her treating physician, VNSNY CHOICE will, in its sole discretion, determine whether the standard has been met for an expedited decision.

Reconsiderations
VNSNY CHOICE will make decisions regarding payment for care that members have already received within 60 days.

If VNSNY CHOICE does not make a decision within the timeframe and does not notify the member regarding why the timeframe must be extended, the member can treat the failure to respond as a denial and may appeal.

10.6- Organization Determinations and Reconsiderations –CHOICE TotaL

Medicare
When VNSNY CHOICE receives a request for payment or to provide services to a member, it must make an organizational determination to decide whether or not payment and or coverage is necessary and appropriate. If the determination is not made in a timely manner or is not favorable, the member has the right to request a reconsideration or appeal.

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10.7- SNF/HHA Provider Service Terminations—CHOICE Total

As part of a settlement agreement between CMS and Medicare beneficiaries, the federal rules governing Medicare appeals were revised for Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF) providers. Pursuant to 42 CFR Section 422.624, the provider of services is responsible for delivering the Notice of Medicare Non-Coverage to Medicare managed care members prior to the cessation of services, regardless of the

reason for cessation. The delivery must be made to the managed care member two days prior to the termination of the covered services and will not be considered valid until the patient signs and dates the notice. If the member is incompetent or otherwise incapable of receiving the notice, the notice must be delivered to the member's legal authorized representative. If no authorized representative has been appointed, then the facility should seek the requested signature from the caregiver on record (i.e. the family member involved in the plan of treatment). Although the caregiver is not a legal authorized representative, he/she has assumed responsibility for the member's medical treatment. If the member has no legal authorized representative or caregiver on record, then the facility should annotate the notice and sign on behalf of the member.

Request of Immediate Quality Improvement Organization (QIO) Review (QIO Appeal) of SNF/HHA/CORF Provider Service Terminations

A member receiving provider services in a SNF, HHA or CORF who wishes to appeal a VNSNY CHOICE decision to terminate such services because care is no longer necessary must request an immediate QIO review of the determination in accordance with CMS requirements.

When to Issue Detailed Explanation of Non-Coverage (DENC)

Once the QIO receives an appeal, it must issue a notice to VNSNY CHOICE that a member appealed the termination of services in SNF/HHA/CORF settings. Upon receipt of this notice, CHOICE is responsible for issuing the DENC, a written notice that is designed to provide specific information to Medicare members regarding the end of their SNF, HHA or CORF care is ending.

VNSNY CHOICE must issue a DENC to both the QIO and the member no later than the close of business when the QIO notifies CHOICE that a member has requested an appeal.
CHOICE is also responsible for providing any pertinent medical records used to make the termination decision to the QIO, although the QIO will seek pertinent records from both the provider and CHOICE.

Immediate QIO Review Process of SNF/HHA/CORF Provider Service Terminations

On the date that the QIO receives the member's request, the QIO must notify CHOICE and the provider that the member has filed a request for immediate review. The SNF/HHA/CORF must supply a copy of the Notice of Medicare Non-Coverage and any other information that the QIO requires to conduct its review. The information must be made available by phone, fax or in writing by the close of the business day of the appeal request date.

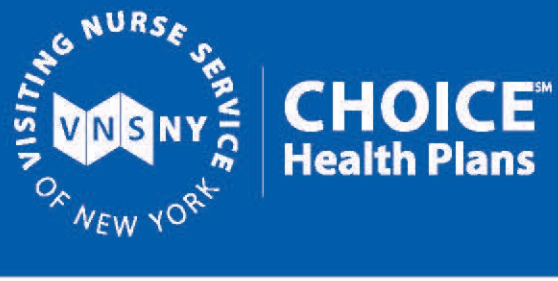
VNSNY CHOICE must supply a copy of the "Notice of Medicare Non-Coverage", DENC and any medical information that the QIO requires to conduct its review. The information must be made available by phone, fax or in writing by the close of the business day that the QIO notifies CHOICE of an appeal. If a member requests an appeal on the same day the member receives the "Notice of Medicare Non-Coverage", then CHOICE has until close of business the following day to submit the case file.

The QIO must solicit the views of the member who requested the immediate QIO review. The QIO must make an official determination of whether continued provider services are medically necessary, and notify the member, the provider, and CHOICE by the close of the business day after it receives all necessary information from the SNF/HHA/CORF, CHOICE or both. If the QIO does not receive the information it needs to sustain the CHOICE decision to terminate services, then the QIO may make a decision based on the information at hand, or it may defer its decision until it receives additional required information. If the QIO defers its decision, then coverage of the services by CHOICE will continue and the QIO will refer violations of notice delivery to the CMS regional office.

A member should not incur financial liability if, upon receipt of the *"Notice of Medicare Non-Coverage":*

- The member submits a timely request for immediate review to the QIO that has an agreement with the provider
- The request is made either in writing, by telephone or by fax, by noon (12 p.m.) of the next day after receiving the notice
- The QIO either reverses the VNSNY CHOICE termination decision or the member stops receiving care no later than the date that the member receives the QIO's decision. The member will incur one day of financial liability if the QIO upholds the CHOICE termination decision and the member continues to receive services until the day after the QIO's decision. This should be the same date as the CHOICE initial decision to terminate services.

A member who fails to request an immediate QIO review in accordance with these requirements may file a request for an expedited reconsideration/appeal with VNSNY CHOICE. VNSNY CHOICE will expedite the request for an expedited reconsideration/ appeal if the QIO receives a request for an immediate QIO review beyond the noon filing deadline and forwards that request to VNSNY CHOICE. VNSNY CHOICE would generally make an expedited decision about the services within 72 hours. Financial liability applies in both the immediate QIO review and VNSNY CHOICE expedited review situations.



Any questions? Call toll-free

1-866-783-0222 (TTY: 711)
9 am – 5 pm, Monday – Friday

www.vnsnychoice.org