

12 CARE COORDINATION & APPEALS

12.1 OVERVIEW

The Plan has outsourced and delegated Utilization Management to Royal HealthCare LLC, a Management Service Organization. The Care Coordination Department encompasses Utilization Management and all associated processes as well as Case Management Programs. All policies and processes contained herein have been mutually agreed to by both the Plan and Royal.

12.2 UTILIZATION MONITORING AND EVALUATION

The utilization management process is comprised of monitoring activities conducted to meet internal and external review requirements and to ensure services are medically necessary. **Medically necessary means health care and services that are necessary to prevent, diagnose, manage or treat conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interference with such person's capacity for normal activity, or threaten some significant handicap.** The circumstances under which utilization review occurs are pre-authorization of services, concurrent review of services or retrospective review of services.

12.2.1 PRE-AUTHORIZATION OF ELECTIVE HOSPITAL ADMISSIONS AND SELECTED AMBULATORY SERVICES

The following services require pre-authorization by the Plan. You may request a pre-authorization electronically by going online to the Plan's website or by calling the Plan Care Coordination line. **You may also fax the request for pre-authorization of services.** Authorization should be submitted within seven (7) days prior to the service. Payment will not be made unless Plan approval is given prior to the date of service.

- ✧ Admissions - Elective
- ✧ Cardiac Rehabilitation
- ✧ Continuity of care
- ✧ Cosmetic Surgery (See Cosmetic list)
- ✧ Diagnostic Testing Includes only MRI, PET Scans and all CT scans- (please see the Plan website for the detailed list of diagnostic procedures that require authorization)
- ✧ Selected Durable Medical Equipment (DME)-See Plan website for detailed list of procedure codes
- ✧ Experimental/Investigational treatment

- ✧ Erectile Dysfunction- Medicaid and Family Health Plus has excluded coverage for drugs, procedures and supplies for the treatment of erectile dysfunction for any registered sex offenders. As part of the prior authorization process, when the Plan receives a request for any services related to erectile dysfunction, the Plan confirms the eligibility of member through the NYS Department of Health. Therefore, all services related to the treatment of erectile dysfunction require prior authorization to facilitate the screening and approval process. Contact the Plan's Care Coordination Department to inquire or make a request.
- ✧ Hearing aids
- ✧ Home Health Care-includes skilled nursing, post-partum, private duty and home infusion.
- ✧ Home Care Home Telehealth services are a covered Medicaid Managed Care benefit when provided by agencies approved by the NYSDOH. **Not covered for Family Health Plus**
- ✧ Obesity surgery-All bariatric surgery
- ✧ Prosthetics
- ✧ Orthopedic shoes and shoe inserts: Shoes are only covered for diabetics, and children under the age of 21. Also covered if the shoe is part of a brace -See Plan website for specific procedure code list
- ✧ Orthotics-see DME PreAuth List
- ✧ Out of network services-non emergent: All services are required to be performed by a participating provider. Medical necessity and the reason why a non-par provider should provide a service over a participating provider is required with all requests.
- ✧ Speech therapy after first visit
- ✧ Personal Care Services
- ✧ Rare Disease treatment
- ✧ Referral to a Specialty Care Center
- ✧ Transportation-non emergent
- ✧ Treatment of Erectile Dysfunction

12.2.2 2011 BENEFIT CHANGES

1. Physical Therapy, Occupational Therapy, Speech Therapy

Physical Therapy, Occupational Therapy and Speech Therapy benefits will be limited to twenty (20) visits per therapy in a twelve (12) month period from the date the member start receiving services. This benefit limitation will not apply to enrollees under the age of 21 or to the developmentally disabled population and to therapy provided via home health care services

2. Pharmacy

The pharmacy benefit is now covered by the Plan instead of Medicaid FFS. This applies to Medicaid, Child Health Plus, and Family Health Plus recipients. More details are available on our websites: www.getnhp.com or www.suffolkhealthplan.com. Express Scripts (“ESI”) completes all prior authorization requests as per the NHP formulary and specialty drugs-See our website for a full copy of the formulary and the related authorization rules.

- For Prior authorization-Formulary-Call ESI at 1-800-417-81640
- For Prior authorization-Specialty Drugs-Call Curascript Phone: 888.773.7376- must also complete a request form
http://www.curascript.com/content/Referral_Forms.htm
- Enteral formulas coverage is limited to the following met:
 - tube-fed individual who cannot chew or swallow food and must obtain nutrition through formula via tube;
 - individual with rare inborn metabolic disorders requiring specific medical formulas to provide essential nutrients not available through any other means; or,
 - children who require medical formulas due to mitigating factors in growth and development; if patient meets condition

3. Prescription Footwear and Compression Stockings

Medicaid benefit limitations were put in place for Prescription Footwear & Compression Stockings is only covered in the certain circumstances. To see a list of specific codes related to these benefit limitations please go to the Provider section of our websites at www.getnhp.com or www.suffolkhealthplan.com

4. Personal Care

Effective August 1, 2011, NHP became responsible for reviewing and making determinations for Personal Care. All members receiving personal care are managed by the Care Coordination Department.

Personal care services means some or total assistance with personal hygiene, dressing and feeding, and nutritional and environmental support functions. Such services must be essential to the maintenance of the patient's health and safety in his or her own home, as determined by the social services district, or its designee, in accordance with the regulations of the DOH.

Personal care services may include but are not limited to:

- assistance with nutrition and diet activities such as shopping and meal preparation;

- performance of household services such as changing bed linens, making beds, washing dishes, cleaning the kitchen, dusting and vacuuming rooms, shopping for essential supplies;
- assistance with basic personal care such as bathing, grooming, bathroom and/or bedpan routines, walking, transferring from bed to chair or wheelchair; and assistance with self-administration of medications.

a. Criteria for Consideration

The member's ability to be Self-Directing:

- Ability to demonstrate unimpaired judgment,
- Able to manage own affairs and finances
- understands situations that are emergent and life threatening to their health and safety,
- Knows how to obtain assistance when personal care services are not present in the home-verbally or with the aid of a device
- Capable of making activity of daily living decisions
- Accepts responsibility for decisions
- If member is not self-directing, there is a person or agency that provides supervision and direction which may include, but are not limited, to the following functions:
 - i. Managing the Member's financial affairs.
 - ii. Deciding the order of, or manner in which, specific functions or tasks identified in the Member's plan of care are to be performed, if such decisions are ordinarily left to the Member's discretion.
- Supervision and direction of non-self-directing members is not an appropriate role for individuals providing personal care services.
- Needs cannot be for supervision only
- Functional deficits that support the need for the provision of home care services.
- Diagnosis alone does not qualify the member for personal care services- e.g., the diagnosis must impact the member ability to function in the home
- Medical condition is stable. A stable medical condition is defined as follows:
 - i. Condition is not expected to exhibit sudden deterioration or improvement; and

- ii. Condition does not require frequent medical or nursing judgment to determine changes in the Member's plan of care; and
- Condition is such that a physically disabled individual is in need of routine supportive assistance to maintain his or her level of functioning and does not need skilled professional care in the home; or
- Condition is such that a physically disabled or frail elderly individual does not need professional care but does require assistance in the home to prevent a health or safety crisis from developing. If the Member's medical condition is not stable, the provision of personal care services is inappropriate unless a determination is made that the provision of personal care services in combination with the intervention of appropriate skilled nursing services, home health aide and/or therapy can adequately meet the Member's needs.

b. Level 1-Services considered housekeeping in nature

Performance of household tasks must be related to medical need and essential to the patient's health and comfort in the home. Such functions may include, but need not be limited to:

- assistance with preparing and serving meals,
- making and changing beds,
- washing dishes,
- cleaning the kitchen,
- dusting and vacuuming rooms the patient uses,
- caring for the patient's laundry,
- shopping for essential supplies, and
- performing other pertinent functions in accordance with the patient's approved plan of care.

c. Level 2- Personal Care Services – includes both housekeeping and personal care Level 2 services include assistance with basic personal care, such as:

- bathing,
- grooming,

- bathroom and/or bedpan routines,
- walking,
- transferring from bed to chair or wheelchair, and
- assistance with medications ordinarily self-administered on physician's orders

In Summary the following criteria must be met to consider the member for personal care services:

1. Member can take care of their personal affairs or
2. Has a friend, family or agency who manages the member's affairs and
3. Member has a stable condition that will not exhibit deterioration or improvement and has a
4. Disability requires non-medical support to maintain their safety and/or level of functioning to allow the member to live in their home.
5. Care Coordination reviews all requests for personal care services.
6. The following must be completed to consider personal care services:
 - ✓ Completed physician order- M11Q (form can be found on provider link at www.getnhp.com)
 - ✓ Home nursing assessment-(M27r)
 - ✓ Social assessment-completed by Care Coordination

5. Restricted Recipients

As of August 1, 2011, Medicaid beneficiaries in the Restricted Recipient Program became eligible to join managed care plans. These restrictions may be for members who have inappropriately used pharmacy benefits, misused medical services, equipment or supplies, abused coordination of care, or when requested by the member or provider. In these situations the member may be restricted to the use of a single or limited number of pharmacies or providers. Restrictions may be based on a single situation or any combination as detailed below.

a. Types of Restrictions

- Primary Medical Provider; this can be a physician, physician group or clinic.
- Primary Pharmacy; an additional pharmacy may be added if there is a need for a specialty item that only that pharmacy can provide.

- Primary Hospital Provider
- Primary Dental Provider (may be a dental clinic or dentist)
- Primary DME Provider
- Primary Podiatrist (rarely used)

b. Criteria for Review and Examination of a Member’s Utilization Patterns

- Excessive drugs, supplies or appliances: The member has received more of a drug, medical supply or appliance in a specified time period than is necessary, according to acceptable medical practice.
- Duplicative drugs, supplies or appliances: The member has received two or more similarly acting drugs in an overlapping time frame or has received duplicative supplies or appliances. The drugs, if taken together, may result in harmful drug interaction(s) or adverse reaction(s). Duplicative supplies and appliances, while not harmful, have no medical indication and are therefore unwarranted.
- Duplicative health care services: The member has received health care services from two or more providers for the same or similar conditions in an overlapping time frame. Health care services include, but are not limited to, physician, clinic, pharmacy, dental, podiatry and DME services.
- Contraindicated care or conflicting care: The member has received drugs, supplies or appliances and/or health care services which may be inadvisable in the presence of certain medical conditions or which conflict with care being provided or ordered by another provider.
- Unnecessary hospital emergency room services. The member has received services in a hospital emergency room for a condition which does not require emergency care or treatment.
- Excessive inpatient hospital services: The member has received multiple inpatient hospital discharges for the same or similar conditions which are more than necessary, according to acceptable medical practice, including but not limited to multiple inpatient hospital discharges against medical advice. For purposes of this paragraph, discharge against medical advice means discontinuance by a member of inpatient hospital services contrary to the advice of the attending physician.
- Abusive practices by members.

The following are abusive practices warranting an investigation to consider the application of restrictions.

- ✧ A member uses or permits a Medicaid identification card to be used to obtain services for an unauthorized person;
- ✧ A member presents a forged or altered prescription or fiscal order to an enrolled Medicaid provider to obtain supplies, drugs or services under the Medicaid Program;
- ✧ A member is in possession of two or more Medicaid identification cards which represent two or more Medicaid cases; or
- ✧ A member sells or trades, or attempts to sell or trade, drugs or supplies acquired with a Medicaid identification card.

The Plan monitors utilization data and patterns to identify any of the above practices as well as any reports obtained through external sources indicating potential abusive practices. The data is validated and confirmed before ever placing a restriction on a member.

When the Plan newly restricts members based on the above practices, the specific provider is notified by the Care Coordination Department of the restriction. An assigned Care Coordinator will reach out to the provider and confirm acceptance of the member and assure they are able to manage the member's restrictions.

12.2.3 SERVICE EXTENSIONS

The following services require authorization for extensions by the Plan. You may request a service extension by calling the Plan Care Coordination line. **You may also fax the request for services.**

- ✧ Home health care
- ✧ DME rentals
- ✧ Services provided a non- participating provider previously approved by the Plan
- ✧ Other services that require ongoing authorization
- ✧ Telehealth services

12.2.4 HOSPITAL CONCURRENT REVIEW

The Plan performs concurrent review of **selected** inpatient admissions. Cooperation is expected from Plan participating hospitals, the attending provider and the PCP. The patient status is monitored by the Plan during the admission primarily for discharge planning purposes.

Denial of the hospital continued stay is the responsibility of the Plan Chief Medical Officer. The provider(s), hospital and member or member's designees are notified of this determination by the Plan. Hospital services are not denied when there is a demonstrated and documented need for acute care services and the hospital cooperates in the continued stay review process. If for any reason the provider and/or hospital feel that continued stay is justified, the provider/hospital may invoke the Plan's appeal process. **If clinical information is not received upon request by the Plan's Care Coordination Department, the admission could be potentially denied if no clinical information is received for post stabilization or continued stays.**

12.2.5 TIMEFRAMES AND GUIDELINES FOR SERVICE DETERMINATION

Standard Review

Prospective or "pre-certification" UM decisions are made regarding the requested services. The member or member's designee and provider(s) are notified of determinations in writing and by telephone within three (3) business days of receiving all necessary information or as fast as the enrollee's condition requires him/her to make the decision but Care Coordination will complete the request within fourteen (14) days after we receive the request. If additional information is needed Care Coordination will inform the provider's office before the fourteenth day. A written "Notice of Action-Adverse Determination" is sent to the member, requesting provider, and facility (see # 12.2.6 of this provider manual). The provider is notified by telephone and in writing. **The Plan delegates member notification to the Provider for all determinations made by the Care Coordination Department.**

Expedited Requests

A provider/member or designee may request an expedited review of a service authorization request if they indicate that a delay would seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.

The expedited review is conducted within 3 business days after receipt of the service authorization request.

If the Plan denies the request for expedited review, the Plan will notify the provider/member or designee that the request for an expedited review has been denied and that the request will be handled under standard review timeframes of up to (14) fourteen calendar days after receipt of the request.

The Plan delegates member telephonic notification to the Provider for all determinations made by the Care Coordination Department.

The following information is necessary to obtain an authorization:

- ✧ Patient's name
- ✧ Patient's CIN number (Medicaid & Family Health Plus)

- ✧ Patient's ID number (Child Health Plus)
- ✧ PCP's name
- ✧ Attending MD's name (if different)
- ✧ Facility name
- ✧ Expected date of admission
- ✧ Diagnosis(es)
- ✧ Planned surgical procedure(s)
- ✧ Treatment plan and medical history
- ✧ Other insurance information for Coordination of Benefits (COB)

The Plan's Care Coordination staff applies review criteria to determine medical appropriateness. If, based on the information given, the Plan is unable to authorize the care; the case is referred to the Plan Chief Medical Officer. A notice of approval/denial of a request for hospital services is sent to the provider(s) and member or member's designee. Elective admissions that are not pre-certified will result in a "notice of action" denial of the professional and hospital claims. Members, member designee, physicians and hospitals can appeal the Plan's decision and submit the medical record within forty-five (45) days after the initial decision.

Extensions for Making Service Determinations

Timeframes for prior authorization review determinations may be extended by the Plan the member, member designee or provider for up to fourteen (14) calendar days if:

- ✧ The member, member's designee, or member's provider requests an extension orally or in writing
- ✧ The Plan can demonstrate or substantiate that there is a need for additional information and how the extension is in the member's interest.

The Plan must notify the member/provider of the extension in writing. The written notice must include:

- ✧ The reason for the extension;
- ✧ An explanation of how the delay is in the best interest of the enrollee;
- ✧ Any additional information that may be needed to make the determination;
- ✧ The right of the enrollee to file a complaint regarding the extension;
- ✧ The process for filing a complaint with the Plan and the timeframes within which a complaint determination must be made;
- ✧ The right of the enrollee to designate a representative to file a complaint on behalf of the enrollee;
- ✧ The right of the enrollee to contact the NYSDOH regarding his or her complaint, including the NYSDOH's toll-free number for complaints;

- ✧ Statement that oral interpretation and alternate formats of written material for enrollees with special needs are available and how to access the alternate formats.

If the Plan extends its review, the member/provider is notified of the service authorization determination by phone and in writing as fast as the member's condition requires and within (3) three business days after receipt of necessary information for prior authorization requests, but no later than the date the extension expires.

Concurrent Review and Extended Services Request

For concurrent review, the member's provider is notified of the determination by telephone and in writing within one (1) business day or as the enrollee's condition requires of receiving all the material the Plan needs to make the decision but no more than fourteen (14) days of receipt of the request.

For expedited requests, the Plan will complete the determination within one business day but no more than three (3) days of receipt of the request.

The Plan delegates member telephonic notification to the provider for all determinations made by the Care Coordination Department.

Extensions

Timeframes for concurrent review determinations may be extended by the Plan, the member, member designee or provider for up to fourteen (14) calendar days if:

- ✧ The member, member's designee, or member's provider requests an extension orally or in writing
- ✧ The Plan can demonstrate or substantiate that there is a need for additional information and how the extension is in the member's interest.

The Plan must notify the member/provider of the extension in writing. The written notice must include:

- ✧ The reason for the extension;
- ✧ An explanation of how the delay is in the best interest of the enrollee;
- ✧ Any additional information that may be needed to make the determination;
- ✧ The right of the enrollee to file a complaint regarding the extension;
- ✧ The process for filing a complaint with the Plan and the timeframes within which a complaint determination must be made;
- ✧ The right of the enrollee to designate a representative to file a complaint on behalf of the enrollee;
- ✧ The right of the enrollee to contact the NYSDOH regarding his or her complaint, including the NYSDOH's toll-free number for complaints;

- ✧ Statement that oral interpretation and alternate formats of written material for enrollees with special needs are available and how to access the alternate formats.

If the Plan extends its review, the member/provider is notified of the service authorization determination by phone and in writing as fast as the member's condition requires and within (3) three business days after receipt of necessary information for prior authorization requests, but no later than the date the extension expires.

12.2.6 RETROSPECTIVE REVIEW

The Plan may reverse a pre-authorized treatment, service or procedure on retrospective review pursuant to section 4905(5) of the Public Health Law only when:

- ✧ Relevant medical information presented to the Plan during retrospective review is materially different from the information that was presented during the pre-authorization review; and
- ✧ Relevant medical information presented to the Plan on retrospective review existed at the time of the pre-authorization but was withheld from or not made available to the Plan; and
- ✧ The Plan was not aware of the existence of the information at the time of the pre-authorization review; and
- ✧ Had the Plan been aware of the information, the treatment, service or procedure being requested would not have been authorized. This determination is to be made using the same specific standards, criteria or procedures as used during the pre-authorization review.

In addition, inpatient and ambulatory claims may be screened against selection criteria, on a retrospective basis. Criteria used to conduct such retrospective review can include:

- ✧ DRGs with complications/comorbidities
- ✧ Readmissions
- ✧ Out of network admissions/services
- ✧ Emergency admissions/visits
- ✧ Encounter patterns for service over- or under-utilization

Medically unnecessary services may result in full or partial professional and/or hospital claims denial. Claims, which are not properly coded, may result in payment adjustment.

For retrospective review, the Plan will make a decision within thirty (30) days of the receipt of all necessary information. The member and provider are notified in writing of the determination on the date of the determination.

12.2.7 NOTICE OF ACTION – ADVERSE DETERMINATIONS

A notice of action-adverse determination is a decision made by the Plan that states that an admission, extension of stay or other health care service has been reviewed and, based on the information provided, is not medically necessary. This includes:

- ✧ Experimental treatment
- ✧ Rare disease treatment
- ✧ Treatment provided by a non participating provider that is not available in the Plan's network but it not considered medically necessary

A clinical peer reviewer must make adverse determinations.

The Notice of Action-Initial Adverse Determination will be sent in writing to both the member and the provider and includes:

- ✧ Description of the Action NHP has taken
- ✧ Reasons for the action including the clinical rationale, if any;
- ✧ Member's rights to file an Action Appeal orally or in writing
- ✧ A statement that oral action appeals must be followed by a written signed action appeal
- ✧ The fact that there will be no retaliation by NHP if the member files an Action Appeal
- ✧ The right of the Member to designate a representative to file an Action Appeal
- ✧ Explanation that the Action Appeal must be filed within ninety (90) calendar days from the date of the Notice of Action.
- ✧ The process for filing an Action Appeal
- ✧ Instructions on how to initiate an expedited appeal if care were delayed that could significantly increase the risk to a Member's health
- ✧ Toll free number (and/or TTY number) on how to initiate an oral Action Appeal including assistance with filling out the Appeal form for filing a written Action Appeal
- ✧ The additional information needed from any source in order for NHP to make an Action Appeal determination
- ✧ Explanation that the Action Appeal will be completed within thirty (30) days of receipt of the Action Appeal request
- ✧ Notice of the right of the member to contact the New York State Department of Health (800-206-8125) with their complaint

- ✧ Fair hearing statement and notice entitled “Managed Care Action Taken” containing the member’s fair hearing and aid continuing rights (Medicaid and Family Health Plus members)
- ✧ A statement that oral interpretation and alternate formats of written material for members with special needs are available and how to access the alternate formats
- ✧ For Actions based on a determination that a requested out-of network service is not materially different from an alternate service available from a Participating Provider, the notice of Action shall also include:
 - the required information for submission when filing an Action Appeal from NHP’s determination
 - a statement that the Member may be eligible for an External Appeal
 - if the denial is upheld on an expedited Action Appeal, the Member will have 45 days from the receipt of the final adverse determination to request an External Appeal
 - if the denial is upheld on an expedited Action Appeal, the Member may request an External Appeal or request a standard Action Appeal; and
 - the Member and NHP may agree to waive the internal appeal process and the Member will have 45 days to request an External Appeal form receipt of written notice of that agreement.
- ✧ For Actions based on issued of Medical necessity or an experimental or investigational treatment, the notice of Action shall also include:
 - the notice constitutes the initial adverse determination and is in regards to “medical necessity or experimental/investigational”;
 - the specific clinical review criteria relied upon in making the determination is available upon request
 - the Member may be eligible for an External Appeal
 - if the denial is upheld on Action Appeal, the Member will have 45 days from receipt of the final adverse determination to request an External Appeal
 - if the denial is upheld on an expedited Action Appeal, the Member may request an External Appeal or request a standard Action Appeal; and
 - the Member and NHP may agree to waive the internal appeal process, and the Member will have 45 days to request an External Appeal form receipt of written notice of that agreement

- ✧ Reasons and clinical rationale are the individualized medical basis for an adverse determination.
- ✧ Statement of reasons and clinical rationale must, at a minimum, identify:
 - The member and the nature of his/her condition(s);
 - The medical service, treatment or procedure in question; and
 - The bases or basis on which denied for lack of medical necessity:
 - _ Request did not meet clinical criteria for medically necessary
 - _ Is considered experimental/investigational,
 - _ Out of network referral for an alternative treatment can be provided by conventional treatment in plan
 - _ A rare disease treatment program without proof of the program's effectiveness
- ✧ For Actions involving personal care services, the determination notice, whether adverse or not, shall include the number of hours per day, number of hours per week, and the personal care services function (Level 1/Level 2):
 - That were previously authorized, if any;
 - That were requested by the member or their designee, if so specified in the request;
 - That are authorized for the new authorization period;
 - The original authorization period and the new authorization period, as applicable.

Failure of the Plan to complete the utilization review determination within the required timeframes constitutes an adverse determination and is subject to appeal. Notice of denial as will be sent in writing as described above on the date that the review timeframes expire.

Reconsiderations

In the event that an adverse determination is made without attempting to discuss the matter with the member's health care provider who specifically recommended the service, procedure or treatment under review, that health care provider will have the opportunity to ask for a reconsideration of the adverse determination. This review occurs within one (1) business day of the request. The member's health care provider and the physician reviewer who made the initial determination conduct the review. If the case is overturned, the denial is reversed.

12.2.8 NOTICE OF ACTION-DENIAL OF SERVICE

A notice of action-denial of service is a decision by the Plan based on the provider's failure to provide appropriate notification to the Plan, failure to cooperate in the concurrent review process or failure to obtain preauthorization (for non-emergent services). Providers who do not comply with Plan notification and precertification requirements (e.g., do not call admissions in to the Plan within specified time frames or pre-certify required services) will have claim payment denied in full. Appeals will be considered if there are extraordinary circumstances. In addition, reasons for Notice of Action denials also include other non-clinical reasons such as non-covered services, member eligibility, other insurance coverage or no fault coverage. The written notification will include the address and telephone number to be used for filing an appeal.

The Notice of Action-Denial of Service (non- UR) will be sent in writing to both the member and the provider and includes:

- Description of the Action NHP has taken
- Reasons for the action including the clinical rationale, if any;
- Member's rights to file an Action Appeal orally or in writing
- A statement that oral action appeals must be followed by a written signed action appeal
- The fact that there will be no retaliation by NHP if the member files an Action Appeal
- The right of the Member to designate a representative to file an Action Appeal
- Explanation that the Action Appeal must be filed within ninety (90) calendar days from the date of the Notice of Action.
- The process for filing an Action Appeal
- Instructions on how to initiate an expedited appeal if care were delayed that could significantly increase the risk to a Member's health
- Toll free number (and/or TTY number) on how to initiate an oral Action Appeal including assistance with filling out the Appeal form for filing a written Action Appeal
- The additional information needed from any source in order for NHP to make an Action Appeal determination
- Explanation that the Action Appeal will be completed within thirty (30) days of receipt of the Action Appeal request

- Notice of the right of the member to contact the New York State Department of Health (800-206-8125) with their complaint
- Fair hearing statement and notice entitled “Managed Care Action Taken” containing the member’s fair hearing and aid continuing rights (Medicaid and Family Health Plus members)
- Statement that if the enrollee requests a fair hearing within ten (10) days of the notice of action, they
- A statement that oral interpretation and alternate formats of written material for members with special needs are available and how to access the alternate formats
- For Actions based on a determination that a requested out-of network service is not materially different from an alternate service available from a Participating Provider, the notice of Action shall also include:
 - the required information for submission when filing an Action Appeal from NHP’s determination
 - a statement that the Member may be eligible for an External Appeal
 - if the denial is upheld on an expedited Action Appeal, the Member will have 45 days from the receipt of the final adverse determination to request an External Appeal
 - if the denial is upheld on an expedited Action Appeal, the Member may request an External Appeal or request a standard Action Appeal; and
 - the Member and NHP may agree to waive the internal appeal process and the Member will have 45 days to request an External Appeal from receipt of written notice of that agreement.

For Actions involving personal care services, the determination notice, whether adverse or not, shall include the number of hours per day, number of hours per week, and the personal care services function (Level I/Level 2):

- ✧ That were previously authorized, if any;
- ✧ That were requested by the member or their designee, if so specified in the request;
- ✧ That are authorized for the new authorization period;
- ✧ The original authorization period and the new authorization period, as applicable.

12.3 ACTION APPEAL OF SERVICE AUTHORIZATION DENIALS

Actions appeals are completed by clinical staff who were not involved in the initial decision or action. If any of the following applies, determinations must be made by qualified clinical personnel as specified in Appendix F of the Managed Medicaid Model Contract; The following are examples of denials where an Action Appeal applies:

- ✧ A denial of action appeal based on medical necessity, experimental, or investigational treatment, rare disease treatment or treatment provided by a non par provider that is not available in network..
- ✧ A denial based on non coverage or eligibility, failure to follow administrative process such as lack of prior authorization.
- ✧ Complaint regarding denial of expedited resolution of an Action Appeal.

The member or his or her designee will have up to ninety (90) days from the date of the notice of Action to file an Action Appeal. The appeal process provides an objective, impartial mechanism for adverse determination disagreement resolution. At anytime during the appeal process, the member has the right to obtain a copy of their medical record and may also provide information to support their appeal in writing or in person. All action appeals are completed within thirty (30) calendar days from receipt of the request of the appeal. The timeframe may be extended an additional fourteen (14) days upon request of the Plan, the member or provider but the condition of the member is considered to determine if a delay in the decision could jeopardize the members' health condition.

The members/providers are provided reasonable opportunity to present evidence, and allegation of fact or law, in person as well as in writing. The member is informed of the limited time to present such evidence in the case of an expedited Action appeal. The member or his or her designee may request both before and during the Action appeal process, to examine the member's case file, including medical records and any other documents and records considered during the Action appeals process. The member, his or her designee, or legal estate representative of a deceased member, a party to the Action appeal.

Whenever possible the Plan will use a physician who is in the same profession/specialty as the healthcare provider who typically manages the medical condition.

Both types of denials are subject to the "Action Appeal" process. All member rights to appeals and complaints including timeframes are included in the "Notice of Action" letter that is sent to the member and copied to the provider.

For Action Appeals of clinical matters, the Plan ensures that all decisions are provided by a clinical peer reviewer who is qualified to review the appeal, including licensed, certified, registered health care professionals who were not involved in making the initial determination.

If the registered healthcare professional determines that the original determination should be upheld, the case is referred to a Peer Reviewer.

At the level of appeal, a clinical peer reviewer is a physician who possesses a current and valid non-restricted license to practice medicine and must be available within one (1) business day of receipt of the information.

Retrospective denial of service or adverse determinations are also subject to the “Action Appeal” process.

Plan members, members’ designees and, in connection with retrospective adverse determinations, a member’s health care provider, have a right to request an action appeal up to ninety (90) days after the Plan informed the member/provider of the “notice of action”. The types of action appeals that are available are an “expedited” appeal and a “standard” appeal.

12.3.1 EXPEDITED ACTION APPEAL

Plan members, members’ designees and, in connection with retrospective adverse determinations, a member’s health care provider can call Care Coordination for expedited (urgent) appeals. An expedited appeal is used for adverse utilization review decisions involving:

- ✧ Concurrent or extended health care services, procedures or treatments or additional services for a member undergoing a course of continued treatment prescribed by a health care provider; or
- ✧ Home health care services following discharge from an inpatient hospital admission; or
- ✧ An adverse determination in which the health care provider believes an immediate appeal is warranted except any retrospective determination.

If Plan requires additional or necessary information to conduct an expedited appeal, Plan shall immediately notify the provider and/or member or the member’s representative by telephone or fax informing them of the information required followed by written notification.

The Plan will make a decision with regard to the expedited appeal within two (2) days of receipt of all necessary information. For Medicaid/FHP members, the Plan will make a decision as fast as the enrollee’s condition requires and within two (2) business days of receipt of necessary information but no more than 3 (three) business days of receipt of appeal. This time may be extended for up to 14 days upon enrollee or provider request; or if the Plan demonstrates more information is needed and that the delay is in the best interest of the enrollee in which case the Plan will notify the enrollee.

Notice to the member/provider of the Expedited action appeal determination shall include:

- The member’s coverage type; all Plan members belong to a Health Maintenance Organization (HMO)
- Plan’s contact person and telephone number

- Date the Expedited Action Appeal was filed and a summary of the Expedited Action Appeal
- Date the Expedited Action Appeal process was completed
- Rights to request a standard appeal within ninety (90) business days.
- Statement indicating the action that the Plan is taking
- Reason for the action
- A description of the member's fair hearing rights, if applicable, including a copy of the "Managed Care Action Taken" form
- The right of the member to contact the New York State Department of Health regarding his or her Complaint, at (800-206-8125)

For Expedited Action Appeals involving Medical Necessity or an experimental or investigational treatment, rare disease treatment or out of network treatment not provided by the Plan, the notice must also include:

- A clear statement that the notice constitutes the final adverse determination and specifically use the terms "medical necessity" or "experimental/investigational"
- The member's coverage type; all Plan members belong to a Health Maintenance Organization (HMO)
- The procedure in question, and if available and applicable the name of the provider and developer/manufacturer of the health care service

The clinical rationale in the Expedited Action Appeal adverse determination letter must meet the following definition:

Reasons and clinical rationale means the individualized medical basis for an adverse determination. A statement of reasons and clinical rationale must, at a minimum, identify:

- The member and the nature of his/her condition(s);
- The medical service, treatment or procedure in question; and
- The bases or basis on which the Plan determined that the service, treatment or procedure is or was not medically necessary or experimental / investigational, which demonstrates that the Plan considered member specific information in its determination.

If the Plan denies the request for an Expedited Action Appeal, the Plan will send written notice of the denial within twenty-four (24) hours of the appeal determination. For Medicaid/FHP members the Plan makes reasonable efforts to provide prompt oral notice of the denial to the member/provider within twenty-four (24) hours.

If the member's request for an expedited review is denied, the request will be handled under standard Action appeals resolution timeframes. A notice is sent to the member informing him/her that the request was denied and that the request will be reviewed under standard timeframes.

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

12.3.2 STANDARD ACTION APPEAL

Plan members, members' designees and, in connection with retrospective adverse determinations, a member's health care provider can file a standard appeal of a "Notice of Action – up to ninety (90) days from the date the Plan informed the member/provider of the service authorization denial decision. **Standard action appeals should be submitted to the Plan's Care Coordination Department.**

The Plan member, member's designee and, in connection with retrospective denials of service, a member's health care provider can either write to or call Plan to request a standard appeal. Members may designate their provider to appeal on their behalf in writing. The Plan will acknowledge receipt of an action appeal request within fifteen (15) days. Oral appeals are followed up by a confirmation letter sent to the member or member's designee for their signature.

If Plan requires more information to conduct a standard internal action appeal, the member, member's designee and the member's health care provider shall be notified, in writing, within fifteen (15) days of receipt of the appeal, to identify and request the necessary information. In the event that only a portion of such necessary information is received, The Plan shall request the missing information, in writing, within five (5) business days of receipt of the partial information. The provider may call the Care Coordination Department and ask for the Appeals Coordinator to request additional time to provide the information to the Plan. Once we receive the additional information we will provide an action appeal notice within fourteen (14) days from the day we requested additional information.

Timeframes for completion of an Action Appeal may be extended for up to fourteen (14) days if:

- ✧ The enrollee, his or her designee or the provider requests an extension orally or in writing; or
- ✧ The Plan can demonstrate or substantiate that there is a need for additional information and the extension is in the best interest of the member and so notifies the member or the member's designee. Plan maintains documentation of the extension determination within the Action Appeal case.

A Notice of the Enrollee extension must include:

- The reason for the extension
- An explanation of how the delay is in the best interest of the Enrollee
- Any additional information the Plan requires to make the determination
- The Right of the Enrollee to file a Complaint regarding the extension.
- Explanation of how to file a complaint
- The right of the Enrollee to designate a representative to file a Complaint on behalf of the Enrollee and
- The right of the Enrollee to contact the New York State Department of Health, regarding his or her Complaint, including the SDOH's toll free number for complaints.

The notice, which may be combined with the acknowledgement, includes a statement that the request will be reviewed under standard Action Appeal timeframes, including a description of the timeframes. For Medicaid and FHP members, before and during the appeal review period, the enrollee or their designee may see their case file. The enrollee may present evidence to support their appeal in person or in writing.

The Plan will make the standard appeal decisions within thirty (30) days of receipt of the appropriate information the Plan needs to conduct the action appeal. **For Medicaid/FHP members**, the Plan will make an appeal decision as fast as the member's condition requires, and no later than 30 days from the receipt of the appeal. The Plan will notify the member or member's designee and provider, in writing, within two (2) business days of making the decision.

Failure by the Plan to make a determination within the applicable time periods in this section shall result in a reversal of the utilization review agent's adverse determination. In addition, the enrollee and the Plan may jointly agree to waive the internal appeal process; if this occurs, the Plan will provide written notification with information regarding filing an external appeal to the member within 24 hours of the agreement to waive Plan's internal appeal process.

12.3.3 WRITTEN NOTIFICATION

If the original decision is overturned during the Action Appeal process, the member or member's designee and requesting provider are sent written notification that the determination has been overturned and is approved and includes the following:

- The member's coverage type; all Plan members belong to a Health Maintenance Organization (HMO)
- Plan's contact person and telephone number

- Date the Action Appeal was filed and a summary of the Action Appeal
- Date the Action Appeal process was completed
- Statement indicating the action that the Plan is taking
- Presented in an understandable language which may include oral interpretation if necessary.

If the original determination is upheld, the written Action Appeal determination notice includes:

- The basis and clinical rationale for the determination
- The words “final adverse determination”
- The member’s coverage type; all Plan members belong to a Health Maintenance Organization (HMO)
- Plan’s contact person and telephone number, full name and address and the phone number
- Name and address of the UR agent, contact person and phone number
- Date the Action Appeal was filed and a summary of the Action Appeal
- Date the Action Appeal process was completed
- Statement indicating the action that the Plan is taking
- Reason for the action
- A description of the member’s fair hearing rights including a copy of the “Managed Care Action Taken” form, if applicable; how to request a fair hearing and the rules; the right to aid continuing; and the liability of the member for services if Plan’s denial is upheld in the fair hearing.
- The right of the member or member’s designee to contact the New York State Department of Health regarding his or her Complaint, at (800-206-8125)
- Presented in an understandable language which may include an oral interpretation and notice if necessary.
- Statement that enrollee may be eligible for external appeal and timeframes for appeal

For Final Adverse Determination (FAD’s) Action Appeals involving Medical Necessity or an experimental or investigational treatment, the notice must also include:

- A clear statement that the notice constitutes the final adverse determination and specifically use the terms “medical necessity” or “experimental/investigational”

- The procedure in question, and if available and applicable the name of the provider and developer/manufacturer of the health care service
- A clear statement written in bolded text that the (45) forty-five day time frame for requesting an external appeal begins upon receipt of the final adverse determination of the first level Action Appeal
- A copy of the “Standard Description and Instructions for Health Care Consumers to Request an External Appeal” and the External Appeal application form

The clinical rationale in the Action Appeal adverse determination letter must meet the following definition:

Reasons and clinical rationale means the individualized medical basis for an adverse determination. A statement of reasons and clinical rationale must, at a minimum, identify:

- ✧ The member and the nature of his/her condition(s);
- ✧ The medical service, treatment or procedure in question; and
- ✧ The bases or basis on which the Plan determined that the service, treatment or procedure is or was not medically necessary or experimental / investigational, which demonstrates that the Plan considered member specific information in its determination.

The Plan does not have a second level appeal therefore a member or the member’s designee may immediately request an External Action Appeal upon their receipt of the notification of the Final Adverse Determination.

12.3.4 EXTERNAL APPEAL

In accordance with 11 NYCRR 410, Plan members and providers have the right for an external appeal of a final adverse determination. **External appeals must be submitted within forty-five (45) days upon receipt of the final adverse determination.** An enrollee, the enrollee’s designee and, in connection with retrospective adverse determinations, an enrollee’s health care provider has the right to request an external appeal. External appeals may be filed when:

- a. The enrollee has had coverage of a health care service, which would otherwise be a covered benefit under a subscriber contract or governmental health benefit program, denied on appeal, in whole or in part, on the grounds that such health care service is not medically necessary and
- b. The Plan has rendered a final adverse determination with respect to such health care service or
- c. Both the Plan and the enrollee have jointly agreed to waive any internal appeal.

An external appeal may also be filed when:

- d. enrollee has had coverage of a health care service denied on the basis that such service is not considered medically necessary or is experimental or investigational, and
- e. such denial has been upheld on appeal or both the Plan and the member have jointly agreed to waive the internal appeal process
- f. and the member's attending physician has certified that the member has a life-threatening or disabling condition or disease
 - i) for which standard health services or procedures have been ineffective or would be medically inappropriate or
 - ii) for which there does not exist a more beneficial standard health service or procedure covered by the health plan or
 - iii) for which there exists a clinical trial
- g. and the member'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 or disease, must have recommended either
 - i) a health service or procedure (including a pharmaceutical product meeting Public Health Law guidelines (PHL4900(5)(b)(B)) that based on two documents from the available medical and scientific evidence, is likely to be more beneficiary to the member than any covered standard health service or procedure; or
 - ii) a clinical trial for which the member is eligible. Any physician certification provided under this section must include a statement of the evidence relied upon by the physician in certifying their recommendation,
- h. and the specific health service or procedure recommended by the attending physician would otherwise be covered under the policy except for the Plan's determination that the health procedure is experimental or investigational.
- i. Rare Disease treatment-must provide two forms of documentation that provides evidence that the for which there does not exist a standard health service or procedure covered by the health care plan that is more clinically beneficial than the requested health service or treatment
- j. Medical treatment provided by a non participating provider that is materially different then conventional treatment that can be provided by a participating provider.

Providers may request an external appeal in connection with a retrospective adverse utilization review determination when the decision is made on the grounds that a health care service is not medically necessary or is experimental or investigational. The New York State Departments of Health and Insurance have developed a separate form and

instructions for providers. The form includes notification that the member or a person authorized pursuant to law to consent to health care for the member must sign the request and consent to the release of medical and treatment records for the health care provider to be eligible for an external appeal.

If a provider would like the “New York State External Appeal Application For Health Care Providers To Request An External Appeal of A Retrospective Final Adverse Determination,”

- ✧ Call Provider Services and request a copy; OR
- ✧ Download a copy from the New York State Department of Insurance website at www.ins.state.ny.us

12.3.5 FAIR HEARING

Plan Medicaid, and Family Health Plus members may be eligible to access the State Fair Hearing Process in accordance with Federal and State statutory requirements. Fair Hearing does not apply to Child Health Plus members. When the Plan denies services or benefits that have been requested by a physician, the Plan must send the member a notice of action and a notice containing fair hearing rights, how to request a fair hearing, fair hearing rules, right to aid continuing and liability of enrollee for services if the Plan denial is upheld in the fair hearing.

The Plan will also notify the member of their rights to file complaints, complaint appeals and action appeals, with process and timeframes and the toll-free number for filing orally. The Plan will always assist members to file complaints, complaint appeals and action appeals.

Enrollees also have the right to designate someone to act on their behalf, however, this request must be sent to the Plan in writing. The member may elect to pursue the matter by requesting a state fair hearing, filing a grievance through the Plan’s internal process, filing a complaint with the New York State Department of Health (SDOH), seeking a utilization review appeal and/or any combination of these procedures.

For denials without a physician's order, the member must complete the internal grievance and appeals process or utilization review process prior to obtaining a notice containing fair hearing rights. The Plan would be required to issue a notice of adverse determination. At the conclusion of the internal process, the Plan must provide the member a notice containing fair hearing rights. The member may then request an external review from the state, file a complaint with the SDOH, request a fair hearing, or any combination of these procedures.

When the Plan renders an adverse determination with respect to a termination, suspension or reduction of clinical treatment and/or service, Plan must notify the member of this adverse determination at least ten days prior to the effective date of the intended action and must send the member a notice of adverse determination and a

notice containing fair hearing rights. The notice will contain information regarding the availability of aid continuing and the process by which the member may receive such assistance. The member may elect to pursue the matter by requesting a State fair hearing, filing a grievance through the Plan's internal process, filing a complaint with the SDOH, seeking a utilization review appeal and/or any combination of these procedures.

12.4 CASE MANAGEMENT PROGRAMS

12.4.1 DEFINITION

Case management is a proactive process with an emphasis on early identification of high-risk members and comprehensive management to prevent unwarranted utilization, poor service coordination, functional decline, and patient dissatisfaction.

12.4.2 GENERAL PROGRAM OVERVIEW

Case management is a collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs across the healthcare continuum through communication and available resources to promote quality, cost effective outcomes. Policies and procedures are defined and designed by the Plan that reflects the detailed process of the program overview. Case Management is initiated at any entry point into the health care delivery system and is managed along all entry points.

The Plan provides case management for members who are:

1. Adults and children with chronic health conditions and physical or developmental disabilities, and children with special needs
2. Member with HIV, Diabetes, Asthma, Cardiac conditions
3. High risk maternity cases
4. Members who have one or more of the following:
 - ✧ Poorly controlled chronic condition,
 - ✧ Lack of understanding about their chronic illness
 - ✧ Two or more emergency room visits in three months
 - ✧ Re-admissions within thirty (30) days
 - ✧ Non compliance with their treatment plan
 - ✧ Require complex care coordination of health care services after an acute event/hospitalization or
 - ✧ Are new to the Plan and require coordination of transitional and continuity of care coordination
 - ✧ Provider or member requests case management services

5. Members with medically complex or catastrophic conditions who have multiple resource needs and require intensive care coordination
6. Members or providers that request case management services.

The Plan strives to address the health care needs of new and existing members and identify those members who are at risk for a health care crisis that may require additional support and care coordination.

The Plan's Case Managers key responsibilities include:

- ✧ Performing health assessment of those members identified in the five focus groups
- ✧ Reaching out to any member who requires assistance in managing their health care needs and services.
- ✧ Arranging physician visits-especially those who have never seen their PCP or has not seen them in the last six months.
- ✧ Coordinate referrals to specialists.
- ✧ Providing education and educational literature.
- ✧ Monitoring health care status and compliance.
- ✧ Identifying socio-economic issues and coordinate assistance.
- ✧ Arranging transportation and provision of medical equipment when medically necessary.
- ✧ Coordinating referrals to educational programs within the community.
- ✧ Utilize community services and social supports to supplement the member's care provided by the physician.
- ✧ Coordinating care with the PCP and/or Specialist.

The Plan's Case Manager assists the member to articulate their health care needs to their PCP or Specialist. The PCP/Specialist may receive a checklist of needs and or questions that will need to be addressed during their member's next appointment.

The Case Manager also sends the PCP/Specialist a care plan that includes identifies issues and goals established for the member. See sample that follows:

Physicians may receive a copy of this letter from a Plan Case Manager

Sample Check List of Questions

**Neighborhood Health Providers
4944 Parkway Plaza Blvd, Suite 110
Charlotte, NC 28217**

Re: Member Name

Member ID: Member ID

PCP: PCP Name

Member: Please remember to discuss the following checked items with the Physician.

Please be advised that the member would like to discuss the following checked items at their next appointment.

- Blood pressure check
- Laboratory studies: _____
- Thyroid assessment
- Medication review - dosages and side effects
- Cardiac Evaluation
- Mammogram
- Gyn Exam and Pap Smear
- Colorectal Screen
- Prostate Exam
- Depression Screening
- Vision / Hearing Evaluation
- Neurological Evaluation
- Flu vaccine and Pneumovax
- Diet management - nutritional plan
- Smoking Cessation - Education and Medications
- Educational materials and/or action plan for self management
- Exercise Plan
- Referrals to: _____
- Other: _____

12.5 REPORTS

The Plan generates reports of primary care, specialty care and ancillary service utilization through the Plan's Management Information System.

12.6 ENCOUNTER DATA

Providers are required to submit claims to the Plan for services rendered to Plan members regardless of providers' payment arrangements. Claims (or encounter forms) are required for both capitated and fee-for-service encounters so that the Plan can monitor service utilization and fulfill regulatory reporting requirements.

12.7 CARE COORDINATION

DEFINITION

Care Coordination (Case management) is a proactive process with an emphasis on early identification of high-risk members and comprehensive management to prevent unwarranted utilization, poor service coordination, functional decline, and patient dissatisfaction.

GENERAL PROGRAM OVERVIEW

Neighborhood Health Providers (NHP) provides case management for members who are:

- Adults and children with chronic health conditions and physical or developmental disabilities, and children with special needs
- Member with HIV,
- High risk maternity cases
- Members who have one or more of the following:
 - Poorly controlled chronic condition,
 - Lack of understanding about their chronic illness
 - Two or more emergency room visits in three months
 - Re-admissions within thirty (30) days
 - Non compliance with their treatment plan
- Require complex care coordination of health care services after an acute event/hospitalization or

- Members with medically complex or catastrophic conditions who have multiple resource needs and require intensive care coordination
- Members or providers that request case management services.

NHP strives to address the health care needs of new and existing members and identify those members who are at risk for a health care crisis that may require additional support and care coordination.

NHP Care Coordinators key responsibilities include:

- Performing health assessment of those members identified in the five focus groups
- Reaching out to any member who requires assistance in managing their health care needs and services.
- Arranging physician visits-especially those who have never seen their PCP or has not seen them in the last six months.
- Coordinate referrals to specialists.
- Providing education and educational literature.
- Monitoring health care status and compliance.
- Identifying socio-economic issues and coordinate assistance.
- Arranging transportation and provision of medical equipment when medically necessary.
- Coordinating referrals to educational programs within the community.
- Utilize community services and social supports to supplement the member's care provided by the physician.
- Coordinating care with the PCP and/or Specialist.

The NHP Care Coordinator assists the member to articulate their health care needs to their PCP or Specialist. The PCP/Specialist may receive a checklist of needs and or questions that will need to be addressed during their member's next appointment. The Care Coordinator also sends the PCP/Specialist a care plan that includes identifies issues and goals established for the member. See samples below.

To make a referral for Care Coordination, complete the Care Coordination referral form found on www.getnhp.com or www.suffolkhealthplan.org and fax to 1-800-338-4139 or call 1-800-765-3805

