Healthfirst

OPERATING POLICY – MM-CC 135v1

CompleteCare
Notice of Action and Appeals

Date of Initial Issue: **Date Last Reviewed:**

Classification

- ☐ NY Medicare
- ☐ NJ Medicare
- ☐ Corporate
- ☐ Family Health Plus
- ☐ NJ FamilyCare/Medicaid
- ☐ Child Health Plus
- ☐ PHSP Medicaid
- ☐ Commercial

I. Policy Overview

Healthfirst will provide a notice of action whenever a service authorization determination or other activity results in denial, limitation, reduction, or suspension of a service to the member. All notices of action are subject to appeal. Healthfirst will assist members with the request for an appeal, and make every effort to ensure understanding of the appeals policy and member rights. When Healthfirst determines that a requested service is not a covered benefit, Healthfirst will offer to coordinate and assist enrollees in obtaining the non-covered services. This coordination of a Healthfirst non-covered service does not require a Notice of Action.

II. Responsible Parties and Related Departments

The Care Management Team in conjunction with the Appeals and Grievances within the Medical Management Department is responsible for implementation of this policy.

III. Definitions

See "Medical Management and Appeals and Grievances Definitions for Policies and Procedures" Refer to Service Authorization Policy.

IV. Policy

A. Timeframes for Prior Authorization and Concurrent Reviews – The member may request an expedited review of a Prior Authorization or Concurrent Review. If the Medical Director feels that a delay would not jeopardize the member's life or health or ability to attain, maintain, or regain maximum function the request for an expedited review will be denied in writing and the request will be handled using standard timeframes. Appeals of actions resulting from the concurrent review must be handled as expedited.

B. Expedited and Standard:

1. The Healthfirst care team will make a determination and notify member of decision by telephone and in writing as fast as the member's condition requires but no more than:
    a. **Prior authorization**
        i. Expedited – 3 business days from request for service
        ii. Standard – within 3 business days of receipt of necessary information, but no more than 14 days of receipt of request for services
    b. **Concurrent review**
        i. Expedited – within 1 business day of receipt of necessary information but no more than 3 business days of receipt of request for services
        ii. Standard – within 1 business day of receipt of necessary information, but no more than 14 days of receipt of request for services.
2. Extensions: Extensions up to 14 days may be requested by member or provider on behalf of the member (written or verbal to the care management team). The Healthfirst care management team may also initiate an extension if we can justify the need for additional information and if the extension is in the member's interest. If Healthfirst requests an extension, the care management team will notify the member in. In all cases, the extension must be documented in the member's medical record.
3. Retrospective Review
    a. Healthfirst shall make a utilization review determination involving health care services which have been delivered within thirty days of receipt of the necessary information

C. Authorizations

1. Healthfirst service authorization time period is 180 days, unless otherwise indicated based on changes in the Member's condition or a sentinel event. Every 180 days, another service authorization is implemented according to the care plan.
2. Service authorizations will be reviewed by a Healthfirst Manager prior to any notice of action letter.
3. Requests for health care services that require pre-authorization will be reviewed by qualified trained personnel who will provide notice of a determination to the enrollee by telephone and in writing.
4. Determinations involving continued or extended health care services or additional services will be made by telephone and in writing

D. Notice of Action

1. Member initiated requests for reductions do not require a Notice of Action
2. Care Management Team initiated Reduction, Suspension, or Termination of service requires a Notice of Action (NOA) that must be issued ten (10) days in advance of proposed action. The Care Management Team members determine the need for a change in the service plan. The professional staff of the CMT has primary responsibility for completing the NOA and for providing documentation in the member record (MIS). The member and provider are notified by the CMT by telephone and in writing.
3. If Reduction, Suspension or Termination of service occurs at the time of 180 day reassessment, a Notice of Action is **not** required.
4. The member always has the option to request an increase or continuation in services including the services that were authorized at a new level or amount at the time of the new authorization. If they request the services, it will be treated as any other request for service. If the decision is to deny the request, a Notice of Action must be sent.
5. When the request for services results in a denial or a reduction, limitation or suspension of services, there is a denial to not pay for all or part of a covered service:
    a. The CMT communicates the change and new authorization by phone and in writing to the provider and member.
    b. Documentation of the above and the notices reside in the member's record in MIS.
6. If the notice is to propose a reduction, suspension, or termination of a service that is authorized, or to deny, in whole or in part any requested service, the notice of action letter will be initiated by the CMT at least 10 days before the intended service change.

This advance notice is required even when the member agrees to the proposed action. The underlying premise is, even if the member agrees, it ensures that the member has time to reconsider the action before it actually occurs. This also verifies what was mutually agreed to in the event there is a misunderstanding – the member has an opportunity to appeal.

a. All notices of action letters will contain the following:
- **i.** The date and summary of service request;
- **ii.** The action taken or intended action;
- **iii.** The reason for the action, including the clinical rationale or criteria if any;
- **iv.** Explanation of member's right to file an internal appeal with the procedure;
- **v.** Explanation of option for filing a Fair Hearing request after exhausting the internal appeal process and any information that must be provided and/or requesting a New York State External Appeal, where appropriate
- **vi.** Notification of the availability of clinical criteria relied upon to make decisions related to actions involving medical necessity or treatments/services that were experimental or investigational.
- **vii.** The circumstances under which the member can request an expedited review of the appeal;
- **viii.** If Healthfirst is reducing, suspending or terminating an authorized service, the notice will also tell the member about the right to have services continue (but only for the period the services were initially authorized) while decides on the appeal; how to request that services be continued; and the circumstances under which the member might have to pay for services if they are continued while is reviewing the appeal;
- **ix.** Notification of opportunity to present evidence and examine his/her record during the appeal;
- **x.** will provide information and assistance for any member with language, hearing, speech or visual impairments;

E. APPEALS – Expedited and Standard

1. Filing an appeal:

a. A member can file an appeal with the plan orally or in writing.

b. The member will be assisted in filing a written request for appeal. If member makes oral request, Healthfirst will provide the member with a written summary of the appeal as part of the acknowledgement or as a separate document.

c. The CMT professional staff will assist the member in filing the appeal.

d. The member or designee will have no less than **forty-five (45) days** from the date of the notice of Action to file an Action Appeal. A Member filing an Action Appeal within ten (10) days of the notice of Action or by the intended date of an Action, whichever is later, that involves the reduction, suspension, or termination of previously approved services may request "aid continuing".

e. If continuation of services is requested, services will continue until the sooner of: a) appeal is withdrawn, b) the original authorization period has expired, or c) until 10 days after appeal decision is mailed, if the decision is not in the member's favor,.

f. CMT professional staff will send written acknowledgment of the appeal within 15 business days of receipt. If a decision is reached before the written acknowledgement is sent, the plan may include the written acknowledgement with the notice of decision (one notice).

g. Determining whether an appeal is standard or expedited is made by the Medical Director in conjunction with the CMT professional staff.

h. Decision must be reached as soon as member's condition requires, but:

2. ***Expedited Appeal:*** within 2 business days of receipt of necessary information and no later than 3 business days of receipt of appeal request. Members or providers on a member's behalf may request an expedited review of an appeal. The Medical Director in conjunction with the CMT professional staff in conjunction with the Appeals and Grievances staff will make the determination to deny or approve the member's request for an expedited review. The member is notified in writing within 2 calendar days of the request.. Healthfirst will also make reasonable efforts to give oral notice of the denial by contacting member or caregiver that their or their provider's request for an expedited review has been denied and the request will be handled using standard timeframes. If they do not agree with the decision, the member may file a grievance. Healthfirst Appeals and Grievances staff will respond to the grievance
3. ***Standard Appeal:*** no later than 30 calendar days from receipt of appeal request.
    a. Up to a 14 calendar day extension may be requested by the member or provider on behalf of the member (written or verbal). The CMT professional staff in conjunction with the Appeals and Grievances staff may also initiate an extension if we can justify the need for additional information and if the extension is in the member's interest. In all cases, extension reason must be well documented. The need for additional information will be documented on the grievance tracking log. Healthfirst will document efforts to obtain additional information. The Appeals and Grievances staff will send the member written notification of the need for an extension which will include a request for the additional information needed and will also include the reason for the extension, and how the delay is in the best interest of the member.

    The CMT will make a reasonable effort to give oral notice and must send written notice within 2 business days of decision for all appeals.
4. **Determinations of Clinical Appeals** 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 must be a clinical peer reviewer.
5. **Appeals of non-clinical matters** shall be determined by qualified personnel at a **higher level** than the personnel who made the original determination and who were not involved in the original determination
    a. During Healthfirst's review the member can present their case in person and in writing.
    b. The member can also look at any of their records that are part of the appeal review
    c. When the Appeals and Grievances staff sends the member a notice about the decision that was made about the appeal, the notice will identify the decision made and the date the decision was reached.
    d. If Healthfirst reverses the decision to deny or limit requested services, or reduce, suspend or terminate services, and services were not furnished while the member's appeal was pending, Healthfirst will provide the disputed services as quickly as the member's health condition requires.
6. **Appeals Determination** Healthfirst's decision about the member's appeal will be in writing and include:
    a. Date and summary of the appeal
    b. Date Healthfirst completed the appeal process
    c. **The results and the reasons for the determination, including the clinical**
    d. Rationale, if any.
    e. The reason for the determination, in cases where the determination has a clinical basis, the clinical rationale for the determination
    f. If decision was not in favor of the member, their right to request a State Fair Hearing.
    g. The State Fair Hearing Notice.
    h. How to file a Fair Hearing request and how Healthfirst will assist the member.
    i. Who can appear at the Fair Hearing on their behalf,

j. And for appeals which involves reduction, suspension or termination or authorized services, the member's right to request to receive these services, aid continuing, while the Hearing is pending and how to make the request.

k. If the denial of appeal was based on medical necessity or because the service in question was:

- **i.** experimental or investigational,
- **ii.** Not medically necessary

The notice will also explain the procedure for filing an External Appeal and how the member may receive assistance from Healthfirst in filing the External Appeal.

l. Healthfirst will provide information and assistance for any member with language, hearing, speech or visual impairments.

m. If dissatisfied, members may file both State Fair Hearing and External Appeal. If both are filed, the State Fair Hearing decision is the one that counts.

7. Required Documentation for Appeals:

a. Healthfirst maintains an Appeals and Grievances MIS that tracks and stores all Actions and Appeals information

- **i.** A copy of the notice of action
- **ii.** The date the appeal was filed
- **iii.** A copy of the appeal
- **iv.** Member/provider requests for expedited appeals and Healthfirst's decision
- **v.** The date of receipt and a copy of the member's acknowledgement letter of the appeal (if any)
- **vi.** Necessary documentation to support any extensions and
- **vii.** The determination made by Healthfirst including the date of the determination, the titles and in the case of clinical determinations, the clinical credentials of Healthfirst personnel who reviewed the appeal.

V. Sanctions

Violation of this policy will be considered in accordance with the corporate sanction policy.

VI. Approval Date/Signatures

Print Name	Signature/Title	Date
Print Name	Signature/Title	Date

P&P Committee Approval - Print Name Signature/Title Date

VII. Procedures/Job Aids/Documents/Forms

VIII. Revision History: