AMERIGROUP CORPORATION	DEPARTMENT PROCEDURE

Subject: MAP Appeals of Adverse Determinations		
Primary Department:	**Secondary Department(s):**	**Prior Procedure Reference(s):** 4.001
Effective Date of Procedure: February 1, 2010	**Date Procedure Last Reviewed:**	**Date Procedure Last Revised:**
Plan CEO or COO Approval/Signature:	**Corporate Dept Sr Mgmt Approval/Signature:**	**Check Only One:** ☐ Procedure is Corporate Owned ☑ Procedure is Health Plan Owned

Check All That Apply:
Procedure is applicable to:

☐ Corporate

☐ All Health Plans

Only the following Health Plans (please list): New York
(Note: If there are multiple Health Plans within a state, please list each specific Health Plan directly above, as appropriate)

Purpose

To establish a procedure for a member to appeal a decision to deny a service due to failure to meet the standards for medical necessity (Action/adverse determination).

Definitions

Action/Adverse determination – for the purpose of this policy, and Action or adverse determination is the denial or limited authorization of a requested service including the type or level of service. Actions also include a reduction, suspension or termination of a previously authorized service; denial of payment in part or in full for a service when the enrollee may be liable for payment of a claim; failure to provide services in a timely manner; denial of a request for a referral.
An Action is subject to appeal.

Appeal – An Appeal is a request for a review of an Action taken by the plan.

Expedited Appeal – the plan determines or the provider indicates that a delay would seriously jeopardize the enrollee's life or health or ability to attain, maintain or regain maximum function or the action was the result of a concurrent review of a service authorization request. A member may also request an expedited review of an appeal. If an expedited review is not requested, the appeal is treated as a standard appeal.

Standard Appeal – the plan determines that utilization of the standard timeframes for appeal determination will not negatively impact the health or well being of the member.

Procedures

1) **<u>Methods and Ownership of Action Appeals Processing</u>:**
   a) If an Action Appeal is filed for a service that is deemed by AMERIGROUP to be a Medicare Only Benefit, AMERIGROUP must follow the Medicare Advantage process for appeals. Processing of these determinations will be performed by the Senior Services Organization (SSO) Designated Service Unit (DSU) in

accordance with procedures and requirements of 42 CFR Subpart M of Part 422 and the Medicare Managed Care Manual.

b) If an Action Appeal is filed for a service that is deemed by AMERIGROUP to be a Medicaid Only Benefit, AMERIGROUP must follow the Medicaid Advantage Plus Grievance System for appeals. Processing of these determinations will be performed by the NYHP in accordance with Appendix F.3 of the Medicaid Advantage Plus contract, Articles 44 and 49 of the Public Health Law as well as Title 10 NYCRR, Part 98.

c) If an Action Appeal is filed for a service that is deemed by AMERIGROUP to be a benefit under both Medicare and Medicaid, AMERIGROUP must follow the choice of the member to follow either the Medicare or Medicaid appeals process. If the member fails to choose a process the Action Appeal will be defaulted to processing under the Medicaid appeals process. If the member files an Action Appeal under the Medicaid process the member still has the right to file an Action Appeal under the Medicare process for up to sixty (60) days from the date of the Notice of Action. If the member chooses to file an Action Appeal under the Medicare process first then he/she loses their right to file an Action Appeal under the Medicaid appeal process and also loses the right to obtain a Fair Hearing.

2) **<u>Action Appeal general requirements for Medicaid Only Benefits</u>:**

a) An appeal may be filed orally or in writing. If oral, the Plan will provide the member with a summary of the appeal in writing as part of the acknowledgement or as a separate document within fifteen (15) days of receipt. The date of the oral appeal request for both standard and expedited appeal is treated as the date of the appeal. The member, provider or member's representative must request an appeal within the following timeframes:
   i) Within forty-five (45) days of postmark date of Notice of Action if there is no request for aid to continue:
   ii) If the member fails to make the request for appeal within the forty-five (45) calendar days, AMERIGROUP will send a letter indicating that the appeal will not be considered.
   iii) Within ten (10) days of the Notice of Action postmark date, or by the intended date of the Action, if aid to continue is requested and appeal involves termination, suspension or reduction of a previously authorized service.

b) If a member or provider requests are to continue while the plan is making a determination on the appeal, services will continue until the sooner or:
   i) Appeal is withdrawn
   ii) The original authorization period has expired until ten (10) days after the appeal decision is mailed, if the decision is not in the member's favor, unless a New York State Fair Hearing has been requested (see Fair Hearing Rights – NY)

c) Written appeals are received directly by the Quality Department. The Appeals Coordinator will send written acknowledgement of appeal within fifteen (15) days of receipt. If a decision is reached

before the written acknowledgement is sent, the written acknowledgement may be included in the notice of decision

d) The member, member's designee or member's provider can submit written clinical justification to support their appeal request.
e) An appeal must be decided as fast as a member's condition requires.
f) A decision will be made on a standard appeal no later than thirty (30) calendar days from the receipt date of the appeal request.
g) A decision will be made on an expedited appeal within two (2) business days of receipt of necessary information, but no later than three (3) business days from receipt of appeal request.
h) A member or the provider may request an expedited appeal when it is believed that a delay would seriously jeopardize the enrollee's life or health or ability to attain, maintain or regain maximum function
i) If the plan denies a request for expedited appeal. The appeal is then handled within standard appeal timeframes.
j) The plan will make all reasonable efforts to give oral notice of denial of an expedited review and will send written notice within two (2) calendar days of the request.
k) A member's disagreement with the plan's decision to handle the appeal within standard timeframes is considered a grievance and is handled according to the procedures described in the MA and MAP Complaints/Grievance Procedure
l) Appeals related to a concurrent review decision are always expedited.
m) If an expedited appeal is not requested, the appeal is treated as a standard appeal.
n) AMERIGROUP will make all reasonable efforts to give oral notice for expedited appeals and will send written notice within two (2) business days of decision for all appeals
o) An extension of up to fourteen (14) days may be requested by a member or provider on member's behalf (written or verbal). The request for an extension may be oral or in writing. AMERIGROUP may also initiate an extension if it can justify need for additional information and if an extension is in the member's interest.
p) Requests for extension, whether member, provider or plan initiated, are well documented describing rationale for the extension. All extensions are documented in Facets.
q) If the plan initiates an extension, a written explanation is sent to the member including:
    i) the reason for extension,
    ii) how the delay is in the best interest of the member and
    iii) any additional information that the plan requires from any source to make an appeal determination is sent to the member. This may be sent at the same time as the acknowledgement letter.
r) Members are required to exhaust the Internal Appeal process before they may request an External Appeal or Fair Hearing.
s) Notice of Decision – the written notice of decision will include:
    i) Date and summary of appeal
    ii) Date appeal process was completed by the plan
    iii) Reason for determination, and in cases where the determination

has a clinical basis, the clinical rationale for the determination
   iv) If a decision is not in favor of the member, State Fair Hearing Notice and description of the process for filing a Fair Hearing request
   v) Process and timeframes for requesting aid to continue
   vi) How a member may obtain assistance in filing a request for Fair Hearing
   vii) If denial of appeal was due to issues of medical necessity or because the service was experimental or investigational, will include a clear statement that the notice constitutes the final adverse determination and procedures for filing an External Appeal and how member may obtain assistance is filing said request.

t) If the appeal decision to deny or limit requested services or reduce, suspend or terminate services is reversed and services were not furnished while the appeal was pending, the Care Manager will ensure that member is provided with the disputed services as quickly as the member's health condition requires.
u) If the decision is not in the member's favor, the services will be discontinued in accordance with the original authorization terms, unless they have requested a Fair Hearing with continuation of services.
v) AMERIGROUP may require the member to pay for services if they were provided only because the member requested that they be continued while the appeal was being reviewed and the decision of the appeal is adverse.

3) <u>Appeal tracking and documentation</u>:

a) If the appeal is received orally, the MAP Care Manager accepts the appeal and enters it into Facets and forwards it to the Appeals Coordinator in the Quality Department for processing tracking and trending.
b) If a written appeal is received, the Quality Department enters it into Facets and processes the appeal.
c) The Appeals Coordinator reviews the appeal and all supporting documentation from prior authorization or concurrent review process, and forwards the file to the Chief Medical Officer/designee for review or to the Vice President (VP) of MAP for appeals that do not require clinical expertise.
d) The Chief Medical Officer/designee or VP of MAP will identify one or more qualified personnel who were not involved in any previous level of review or decision-making to review the appeal and, if the appeal pertains to clinical matters, will ensure that qualified personnel are licensed, certified or registered health care professionals.
e) Chief Medical Officer/designee, Medical Director, or VP of MAP will advise the Appeals Coordinator of the appeal decision.
f) The Appeals Coordinator will enter the decision into FACETS and send a written notice to the member within two (2) business days of the decision.
g) If the decision is in the member's favor, the "Notice of Favorable

Appeals of Decision" will be sent; if the decision is adverse, the "Notice of Unfavorable Appeals Decision" will be sent.

h) If the decision is not in the member's favor, a State Fair Hearing Notice and procedures for filing a State External Appeal will be included in the adverse determination notice sent to the member. (see Fair Hearing Rights-NY; External Appeals - NY)

i) The Appeals Coordinator ensures that the following information is logged into Facets for quality purposes:
   i) Date of appeal
   ii) Member name and CIN number
   iii) Type of appeal (reason)
   iv) Date of acknowledgement and resolution letters
   v) Summary of appeal and appeal decision
   vi) Date resolved
   vii) Status of appeal – upheld or overturned
   viii) Primary investigator of appeal

j) The Appeals Coordinator prepares a quarterly summary of appeals. The report indicates numbers of appeals received by reason and status of resolution.

k) The Appeals Coordinator maintains records on all appeals, including file with a printout of the original appeal, all correspondence and an explanation of the decision. Records relating to the receipt and disposition of appeals will be retained for at least three years. The file will contain, at a minimum:
   i) A copy of the original Notice of Action
   ii) The date the appeal was filed
   iii) A copy of the appeal
   iv) Member/provider requests for expedited appeals, the plans' decision and any notices sent to member related to request
   v) A copy of the acknowledgement letter of appeal
   vi) Necessary documentation to support any extensions
   vii) The determination by the plan, including the names and credentials of plan personnel involved in the review and resolution of the appeal

l) On a monthly basis, the Appeals Report is reviewed by Vice President of Quality Management (QM), and the Chief Medical Officer to identify opportunities for improvement

m) On a quarterly basis, the Appeals Report is presented to the Quality Management Committee (QMC), The QMC will:
   i) Review the appeals documentation for trend, compare it to previous quarters and make recommendations for improvements and any necessary follow-up actions.

n) On a quarterly basis the Quarterly Grievance/Appeal/Fraud and Abuse Report is due to NYS Department of Health, no later than fifteen (15) days after the close of the quarter.

Exceptions None

References 42 CFR Subpart M of Part 422

Related Policies and Procedures	Policy #4.003 – Service Authorization – Requests for Services Policy #4.011 - MAP Service Authorization – Adverse Determination Policy #5.002 - External Appeals – NY Policy #5.003 - Fair Hearing Rights-NY
Related Materials	MAP Acknowledgement of Action Appeal MAP Acknowledgement of Expedited Appeal – approved MAP Acknowledgement of Expedited Appeal – Not Approved MAP Notice of Favorable Appeal Decision MAP Notice of Unfavorable Appeal Decision MAP Denial of Appeal Request MAP Notice of Plan Initiated Extension of Appeal Request for Fair Hearing Forms New York State External Appeal Request Forms