ELDERSERVE POLICY AND PROCEDURE
ACTION AND APPEAL

POLICY:

ElderServe ensures that members have the opportunity to appeal actions taken by ElderServe.

ElderServe ensures that members understand the appeals process, have access to and can fully participate in the appeals system by providing assistance whenever necessary, including interpreter services and help with vision and hearing problems. Upon enrollment, each member will receive a Member Handbook that describes the appeals process in detail. Members will be informed how to directly access Member Services for any clarification regarding the appeals process and the assistance available to them.

ElderServe will not discriminate against any member because the member filed an appeal. Appeals are kept confidential, and will not in any way affect the services offered to a member or the way a member is treated.

Action:

The following are defined as actions:

- Denial of coverage (does not include denial of benefit for which reimbursement is available from another payer);
- Denial or limitation of requested services, including the type and level of service;
- Denial of a request for referral;
- Reduction, suspension or termination of a previously authorized service;
- Denial, in whole or in part, of payment for a service;
- Failure to provide services in a timely manner;
- Failure to make a grievance/grievance appeal determination within the required time frames.

Notice of Action: Member Services notifies a member in writing upon ElderServe's decision in taking an action. If ElderServe intends to reduce, suspend or terminate an authorized service, Member Services will send the member a written Notice of Action at least 10 days prior to the intended action. The Notice of Action will include the following:

- Date and summary of service request;
- Reason for action and clinical rationale, if any;
- Member's right to appeal, and right to file a Fair Hearing request after exhaustion of the internal appeal process;

- Information on how to file an internal appeal and circumstances under which an expedited review can be requested;
- Information required by ElderServe to render its appeal decision;
- Information regarding the availability to members of clinical review criteria that ElderServe can rely upon in making the appeal decision if the action involves issues of medical necessity, or if the treatment or service in question is considered experimental or investigational;
- Member's right to have services continue while the appeal is pending if the action involves reduction, suspension or termination of an authorized service, and circumstances under which the Member may have to pay for such continued services;
- Opportunity for a Member to present evidence and examine the case file during appeal;
- Availability of assistance with language, hearing and speech issues.

Appeal:

All actions are subject to appeal by a member or a provider acting on behalf of the member.

Appeals Panel**:** The Appeals Panel decides appeals, and includes the COO or designee, and the Medical Director, who oversee the review of appeals. The COO assures that each appeal is handled by individuals who were not involved in any previous level of review or decision-making. The Medical Director assures that appeals with a clinical basis are reviewed by qualified personnel, including licensed, certified or registered health care professionals who were not involved in the initial decision.

PROCEDURE:

Appeals Process:

Member Services receives all appeal requests and manages the appeals process. Member Services logs, tracks and maintains appeals information.

A member, the member's representative, or a provider on behalf of the member, may file an appeal. An appeal may be filed by calling 1-XXX-XXX-XXXX, or by writing to ElderServe, Member Services Department, attn: Grievance and Appeal, (address).

An appeal request must be filed with ElderServe within 45 days from the postmark date of the Notice of Action. An appeal received past this time frame will not be processed, and Member Services will send a letter to that effect to the member.

A verbal appeal request must be confirmed in writing unless the member requests an expedited review. If a member is unable or refuses to file the appeal in writing, Member Services will summarize the verbal appeal, which will be included in the written acknowledgment to the member.

During the review period, a Member will be given reasonable opportunity to submit additional information, present his or her case in person and in writing, and to examine the records that are part of the review.

Appeals will be expedited if the COO or designee determines or the provider indicates that a delay would seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function. A member may also request an expedited review, and if denied, Member Services will send a written notice of denial to the member within 2 business days of receipt of the request. The notice will inform the member that the appeal will be handled on a standard basis, and describe the member's right to file a grievance, and the grievance procedure.

Time frames for response: Member Services sends written acknowledgment of an appeal within 15 days of receipt. If a decision is reached before the acknowledgment is sent, the acknowledgment may be included with the notice of decision (one notice).

All appeals will be decided as fast as a member's condition requires, and in accordance with the following:

(a) Expedited: within 2 business days of receipt of necessary information, but no later than 3 business days of receipt of appeal request;

(b) Standard: within 30 days of receipt of appeal request.

Extension of time frame: An extension of up to 14 days may be requested, verbally or in writing, by a member or provider on the member's behalf. Member Services may initiate an extension if it can justify the need for additional information and if an extension is in a member's interest. Member Services an extension letter to the member and document all extensions.

Procedure for continuation of service during appeal process: If a member is appealing a reduction, suspension or termination of currently authorized services, the member may request a continuation of these services while the appeal is under review. The member must submit a request either within 10 days of the postmark date of the Notice of Action, or by the intended effective date of such action, if the original period covered by the service authorization has not expired. ElderServe will continue these services until the sooner of: (i) the appeal is withdrawn; or (ii) the original authorization period has expired; or (iii) 10 days after ElderServe mails the appeals decision to the member, unless the member requests a NYS Medicaid Fair Hearing with continuation of services. ElderServe

will require the member to reimburse ElderServe for these services if the appeal is not decided in the member's favor.

Notice of decision: Member Services provides the member with a written notice of decision setting forth:

- Date and summary of appeal;
- Date appeal process was completed by ElderServe;
- Reasons, and the clinical rationale for determinations with a clinical basis;
- If the decision is not in favor of the member, the member will be given a State Fair Hearing notice, description of process for filing the Fair Hearing request, process and time frames for requesting a continuation of service if the member is entitled to make such a request as a result of termination, reduction or suspension of services; and the assistance available in filing the Fair Hearing request;
- If the denial was due to issues of medical necessity or because the service was experimental or investigational, the notice will include a clear statement that it constitutes the final adverse determination, a description of the procedures for filing an External Appeal and the assistance available in filing the External Appeal.

Record Keeping and Documentation:

Member Services maintains a file on each action and associated appeals, which will include:

- Copy of Notice of Action, and appeal;
- Date of filing of appeal;
- Date of receipt;
- Acknowledgment letter;
- Requests for expedited review, and ElderServe's decisions;
- Extensions, and supporting documentation;
- Determinations, including dates, titles (and for clinical determinations, credentials) of ElderServe personnel who reviewed the appeal.

State Fair Hearing:

If the appeal decision is not totally in favor of the member, the member may request a Medicaid Fair Hearing from NYS within 60 days of the date of the Notice of Decision on the appeal.

If the appeal involved the reduction, suspension or termination of currently authorized services, the member may request a continuation of these services while the Fair Hearing decision is pending. The request must be filed either within 10 days of the date that ElderServe sent the Notice of Decision, or by the intended effective date of the action, whichever occurs later. ElderServe will

continue services until: (i) the appeal is withdrawn; or (ii) the expiration of the original authorization period; or (iii) the State Fair Hearing Officer issues a decision not in the Member's favor, whichever occurs first. The member may be required to reimburse ElderServe for services that were the subject of the Fair Hearing.

If the State Fair Hearing Officer reverses ElderServe's decision, ElderServe will provide the disputed services to the member promptly, and as soon as the member's health condition requires. ElderServe will be responsible for payment of covered services ordered by the Fair Hearing Officer.

State External Appeal:

If the member's appeal is denied because ElderServe determines that the service is not medically necessary or is experimental or investigational, the member may ask for an external appeal from NYS. The external appeal is decided by reviewers who are approved by NYS, but do not work for ElderServe or NYS. The member must file the external appeal with the NYS Department of Insurance within 45 days from the date the appeal is denied.

Time frames for response:

(a) Standard: within 30 days, with additional time of up to 5 days if the reviewer asks for more information. The reviewer will notify the member and ElderServe of its decision within 2 business days after the decision is made.
(b) Expedited: If the member's doctor states that a delay will cause serious harm to the member's health, an expedited review will be decided in no more than 3 days. The reviewer will notify the member and ElderServe of the decision immediately by phone, followed up by a letter.

The Member may request both a Fair Hearing and an external appeal, however, the decision of the Fair Hearing Officer will control.