GUILDNET

Policies and Procedures | **Appeals of Actions [Denials of Member's Request for New or Additional Services or Plan Action to Deny Payment or to Terminate, Reduce or Suspend a Covered Service]**

POLICY:

An internal appeal of a Plan Action may be initiated when a member or provider[1] disagrees with GuildNet's decision to deny a request for additional service or payment or to terminate, reduce or suspend a service. The member or provider may make the request for an appeal verbally or in writing within 45 days of receipt of the notice of GuildNet's action. If the request is made after the 45-day requirement the appeal will not be processed. If the member is requesting aid continuing as a result of a GuildNet decision to terminate, reduce or suspend services, the member must file the appeal within 10 days of notice or by the intended date of the action, if aid continuing is provided, services will continue until:

a) an appeal is withdrawn, or

b) the original authorization period has expired, or

c) until 10 days after an appeal decision is mailed if the decision is not in the member's favor, unless a New York State Fair Hearing is requested.

All requests for concurrent authorization (additional services) that GuildNet denied are reviewed as expedited appeals, the decision rendered within three business days and a maximum 14 days extension if additional information is needed or it is in the member's best interests. The member will be notified in writing that an extension is necessary and in his/her best interest.

GuildNet may identify a need for or the member/provider may request an expedited appeal. Expedited appeals are approved if the member's life or health is jeopardized or physical function is compromised. A request for expedited review if denied, should be communicated verbally as soon as possible, but at least within 2 days in writing. The appeal, if not expedited as requested is then handled as a standard appeal. If the member disagrees with standard processing, then the member may file a Grievance. (see Grievance section)

GuildNet staff will resolve all appeals without disruption of the member's plan of care and without coercion, discrimination or reprisal by the program. Members are instructed

[1] Note: use of the word provider should be understood to be the "provider on the member's behalf".

during enrollment of their right to appeal a plan action. Information on plans actions and appeal rights are included in the enrollee handbook.

Members are advised in writing of his or her right to appeal a denial of a request for additional benefits and a GuildNet termination, reduction or suspension of services.

Members may choose a friend or family member to represent them in the appeals process; the member or his or her designee can present their case for appeal verbally or in writing. The member may review his or her records used in the appeals process and will be advised of the specific reasons and rationale used to make appeal decisions.

If the appeal relates to a termination, reduction or suspension of services by GuildNet, and the member requests in writing to continue services during the appeals process, the member will be financially responsible for the costs, if the appeal decision is not in the member's favor. Further continuance of services can occur if the member requests a Fair Hearing because of an adverse determination on the appeal. Responsibility for the costs will fall to the member in this instance, as well, if the Fair Hearing is not in the member's favor.

<u>Procedures</u>**:**

[The following procedures pertain to all services with the exception of Dental, which is administered by HealthPlex and is described immediately following the internal procedures.]

1. The member must file an appeal verbally or in writing to the Director of QAPI within 45 days of the postmark date of the notice of action. The member can make a verbal or written request for assistance to file an appeal, which will be referred to the Quality Assurance Performance Improvement staff (QAPI). Requested assistance may respond to hearing, vision, language, or other special needs. In addition, assistance with letter or form preparation may be given by the appropriately skilled Care Management or GuildNet administrative support staff.

   The Case Manager (CM) will send an acknowledgement of receipt of the appeal within 15 days of its receipt. If the appeal request is made after 45 days, the CM will send a letter stating, "the appeal will not be processed."

2. If a decision is reached before the written acknowledgement is sent, the CM may include the written acknowledgement with the notice of decision (one notice). If the appeal is expedited, the acknowledgement and decision may be combined in the same letter.

3. The Director of QAPI will be responsible for coordination of the appeals process and maintaining files on all member appeals. QAPI staff will maintain a file on each action and associated appeal (both expedited and standard), if any, that includes (at a minimum):

- A copy of the notice of action;
- The date the appeal was filed;
- A copy of the appeal;
- Member/provider requests for expedited appeals and the plan's decision;
- The date of the receipt of and a copy of the enrollee's acknowledgement letter of the appeal (if any);
- Necessary documentation to support any extensions; and,
- The determination made by the plan, including the date of the determination, the titles and, in the case of clinical determinations, the credentials of the plan's personnel who reviewed the appeal.

All documentation is re-reviewed during the appeals process, including the members record and any other relevant information. The GuildNet staff responsible for the appeal determination is not the same GuildNet staff that initiated the decision to deny services.

4. The staff responsible for appeal decisions will be clinically knowledgeable and may include the Medical Director, other clinical professionals, senior supervisory or administrative staff (including all levels from Care Management supervisor to the Executive Vice President). The staff designated by the Director of Care Management to review the member's appeal will not be the staff involved in GuildNet's initial decision or action being appealed.

5. The CM will advise the member in writing of their right to an expedited appeal. The member will receive a written notice acknowledging the date the appeal was received and it is "standard" or "expedited." In addition, the letter will identify the GuildNet contact person and request any additional information needed to make an appeal decision. The member will be informed that he/she may present an appeal in person or in writing and may look at their records that are a part of the appeal. The Case Manger will be guided as follows:

   Standard appeals will be decided as quickly as the member's condition requires, but no later than 30 days after GuildNet's receipt of the appeal request. (The review period may be extended for up to 14 days if the members request an extension and if GuildNet determines an extension is in the member's best interest).

   An **expedited appeal** process is initiated when the member/provider or Care Management staff feels that a standard appeals time frame would pose a serious health or life risk to the member. Care Management staff will make the determination regarding the need for an expedited appeal. An expedited appeal is decided as quickly as the member's condition requires; that is within 2 business days after receiving all the necessary

information and no more than 3 days past the receipt of the member's request. In addition, all requests for a concurrent authorization (additional services) that GuildNet denied must be treated as expedited appeals.

If the waiting time for an appeal involves a significant health risk, the plan will render an expedited decision within 2 business days of receiving information on the appeal issue, but no more than 3 days past the receipt of the member's request. If Care Management staff do not agree to expedite the appeal process the member will be notified as soon as possible verbally or at least in writing within 2 business days of the date of GuildNet's decision that GuildNet will not expedite the appeal and, that Care Management staff will make the appeal decision within the standard time frame. The CM will notify the member that a grievance can be filed regarding a GuildNet decision to not expedite an appeal.

GuildNet may add up to a 14-day extension. If an extension is needed, GuildNet will notify the member in writing indicating the duration and reason for the extension and how the extension is in the best interest of the member.

6) **Reversed decisions on appeal**- if after the GuildNet appeal review group makes a determination that the requested services meet the "Service Utilization Criteria," or for other reasons the services are appropriate, the CM directs the member services representative to authorize the services. CM notifies the member verbally and in writing (using the "reversal on appeal" letter).

7) **Appeal Denial** – if the GuildNet appeal review group determines that the initial decision to deny a request for additional services is upheld, the CM will advise the member in writing. The reason for the appeal denial will be stated. If a decision is not totally in member's favor, the notice to the member will include:

- the date and summary of the appeal, and the date the appeal process was completed by GuildNet,
- the reason for determination, and in cases where the determination has a clinical basis, the clinical rationale for the determination
- must explain member's right to request a Medicaid fair hearing from New York State and how to obtain a fair hearing, who can appear at the fair hearing on member's behalf
- if appeal denied because of issues of medical necessity or because the service in question was experimental or investigational
- how member may obtain assistance from the plan with filing of Fair Hearing request and the notice will also explain the member's right and how to request an external appeal of the decision.
- GuildNet must notify members of the availability of assistance (for language, hearing, speech issues) if a member wants to file Fair Hearing request and/or an External Appeal and how to access that assistance.

Dental

Dental services are managed under contract with HealthPlex. HealthPlex shall participate in and comply with GuildNet's action and appeal procedures and timeframes described above. HealthPlex shall maintain a written record, not limited to but including type of action and numbers of same, of any action and provide such record monthly. At such time, HealthPlex will also provide all GuildNet specified relevant documentation regarding the action and shall provide any other applicable documentation in a timely manner as reasonably requested.

GuildNet will review periodically HealthPlex's compliance with GuildNet Policies and Procedures including such particulars as use of GuildNet letterhead for pertinent member correspondence and adherence to required timeframes.