CCM Select
Approved 1/19/06

SUBJECT: Appeals Policy

Purpose:
To ensure that CCM Select members have the opportunity to challenge actions taken by CCM Select such as, denial of coverage or payment for services. *[NOTE: Dissatisfaction with quality* of *services is addressed in the Grievance Policy]*

Policy:
Upon enrolment each Member will be presented with a Member Handbook that explains the appeals process in detail. Members will be informed of how to directly access Member Services to obtain clarification with regard to the appeals process. The Member Services Department is responsible for the oversight of the appeal process and for referring an appeal to the Appeals Panel, which will decide on appeals. CCM Select assures Members that appeals will be kept confidential and that assistance with the appeal will be provided whenever necessary. In the case of a termination, reduction, or suspension of service CCM Select will continue to provide the services under appeal if requested by the Member, with the understanding that the Member may be liable for the cost of the disputed service if the appeal is denied,

All CCM Select members have the opportunity to appeal whenever CCM Select takes certain actions. When CCM Select does any of the following, it is defined as an action:

- Denies or limits authorization of a service requested by a member or their health care provider; this includes the type and level of service
- Reduces, suspends or terminates previously authorized services
- Denies payment for services in whole or in part;
- Does not provide service in a timely manner;
- Denies a request for a covered service provided by an out-of-network provider
- Determines that a requested service is not a covered benefit. (e.g., the member requests a level of service/product that is beyond the scope of the CCM Select covered benefit. This does not include a service for which reimbursement is available from another payer
- Does not make grievance or grievance appeal determinations within the required timeframes.

All actions are subject to appeal by the Member or a provider acting on the Member's behalf.

If a member appeals:

- There will be no change in services or the way members are treated by CCM Select staff or a health care provider because an appeal has been filed
- The member's privacy will be maintained.
- The member will be given any help they may need to file an appeal. This includes

providing interpreter services or help if they have vision and/or hearing problems.

- A member may choose someone (relative or friend or a health care
- provider) to act on his or her behalf.

Timing of Notice of Action

- If CCM Select denies or limits requested services or decides not to pay for all or part of a covered service, the Care Manager will send the member or provider acting on member's behalf a Notice of Action. A copy will be sent as notification to Member Services and the Clinical Director. (See Service Authorizations policy for timeframes for issuing the Notice of Action.)
- If CCM Select reduces, suspends or terminates a service that was previously authorized, the Notice of Action will be sent at least 10 days before date of planned change in service.

Content of Notice of Action and of the Right to Appeal

- Notice of Action forms approved by the Department of Health will be used.
- The following information will be included in the notice:
    - Explanation of the action taken - including date and summary of request, if applicable
    - Procedures to request aid to continue will be included for circumstances that involve the reduction, suspension, or termination of a previously authorized service
    - Reasons for the action, including the clinical rationale, if any;
    - Description of how to file an internal appeal and the circumstances under which an expedited appeal can be requested
    - Description of the availability of the clinical review criteria relied upon in making the decision, if the action involved issues of medical necessity or whether the treatment or service in question was experimental or investigational; and the member opportunity to review his/her record
    - Description of the information, if any, that must be obtained by CCM Select in order for us to render a decision on appeal (if applicable), and request that the member submit any evidence that he/she wishes to support the appeal
    - Description of multiple ways to contact the health plan to file an appeal, i.e., toll free phone line, fax, via mail or in case of hearing impairment, and offers assistance in filing the appeal for members who are unable to do so without help.

Filing an Appeal

- A member or their designated family member may file an appeal at any time, up to 45 days from the postmark date of the notice of action.
- A health care provider may file an appeal on behalf of the member with the written consent of the member.
- Appeals may be filed verbally, but we will request that they be confirmed in writing by the member or their representative. If the member is unable to or refuses to file the appeal in writing, CCM Select will summarize the verbal appeal in the written acknowledgement to the member that the appeal was received.
- Requests for expedited appeals can be filed verbally; written confirmation is not

required in this instance. In these instances, CCM Select will summarize the verbal appeal in the program's written acknowledgement to the member.

Appeal Process

- CCM Select Member Services receives all requests for appeals and manages the appeals review process and responses.
- All appeals are logged in and tracked through resolution.
- All requests for appeals are acknowledged in writing within 15 days of receipt.
- The acknowledgement letter may also include the following:
    - If a decision is reached before the acknowledgement is sent, a combined acknowledgement and notice of decision will be sent to the member.
    - If the appeal is made later than the deadline for filing it, the information that the appeal will not be considered because it is late will be included in the acknowledgement.
- Special Requirements for Appeals
    - The member will be given reasonable opportunity to present additional information in support of their appeal in person as well as in writing. The plan will encourage the member to provide this information as quickly as possible in order to expedite the resolution. If necessary, the member will be encouraged to request an extension, so that he/she can gather the pertinent information that will assist in the decision.
    - The member and/or his or her representative will be provided with an opportunity (before and during the appeal process) to examine the member's case file and any documents considered during the appeals process.

Review Personnel

- Appeals decisions will be made by individuals who were not involved in any previous level of review of decision-making.
- Appeals decisions will be made by individuals who have appropriate clinical expertise in the specific service or treatment under review. Member Services staff who coordinates the appeal process will determine the appropriate individual to conduct the clinical review.

Timing of Standard Appeal Decisions

- Unless the appeal is related to a situation in which a delay could jeopardize the member's health, CCM Select will handle the appeal as a standard appeal. (See below for detailed procedures related to expedited appeals; the need for an expedited review of the appeal can be determined by CCM Select or requested by the member/provider.) .
- For standard appeals, the decision will be made as fast as the member's condition requires but no later than 30 calendar days from the day the appeal is received.
- Within 2 business days of making its decision, CCM Select will send the member a written notice of the decision.
- The appeal review period can be increased up to 14 days if the member (or provider on member's behalf) requests an extension or the Plan needs more information and the delay is in the member's interest. In all cases, the reason for the extension will be well documented. If the extension is initiated by CCM Select, CCM Select

will notify the member, in writing, of (1) the reason for the extension, (2) how the delay is in the best interest of the member, and (3) the additional information that is needed to make the determination.

Notice of Appeal Determination (for both expedited and standard appeals)

- A written notice about the appeal decision and the date that the decision was reached will be sent to the member and the requestor of the appeal by CCM Select Member Services. Depending on the outcome of the appeal, this notice will include the following:
    - If the appeal is granted, a Notice of Decision on Appeal –In Favor is sent to the member outlining the service, the favorable outcome, and the date that services will commence.
    - If the appeal is denied, the CCM Select a Notice of Decision is sent to the member, indicating that the appeal has been denied. In addition, this mailing to the member will include:
        - √ The State of New York's "Managed Long Term Care Plan Action Taken" form, which includes the state's Fair Hearing Notice.
        - √ If the denial was due to issues of medical necessity or because the service was experimental or investigational, the notice will include detailed instructions for filing an External Appeal. (The external appeal information and application that is provided to members is identical to the information that is available in the New York State Department of Insurance website).
- If the appeal decision was related to the plan's initial determination to reduce, suspend or terminate services, the member will be sent the version of the State of New York's "Managed Long Term Care Plan Action Taken" form, which also includes the form to request that services continue while the fair hearing is pending .
- If the CCM Select initial decision is reversed upon appeal, and services were not furnished while the appeal was pending, the disputed services will be provided to the member as quickly as their health condition requires. At the time the decision is made, Member Services will notify the Care Manager by telephone to provide the service.
- Members may file both a State Fair Hearing and External Appeal.

Procedures for Continuing Service During the Appeal Process

- If CCM Select reduces, suspends or terminates an authorized service within the authorization period, the notice of action that is sent to the member by CCM Select Member Services will also provide information about the member's right to have services continue while awaiting the appeal decision; including how to request that services be continued and the circumstances under which the member might have to reimburse CCM Select for those services, if they are continued while the appeal is under review.

- CCM Select will continue the service under the following circumstances:
    - The member makes a request no later than 10 days from the postmark date of the notice of action sent to the member or by the intended effective date of the action; and
    - The original period covered by the service authorization has not

expired.

- Services will continue during the appeal process or fair hearing process, or until the member has withdrawn the appeal, or until the original authorization period for the services has expired. If the result of the appeal is not in the member's favor, the services would continue until 10 days after the date the plan mailed the notice about the appeal decision, unless a State Fair Hearing is requested.
- Although the member may request and receive a continuation of services while the appeal or fair hearing is under review, CCM Select will require the member to reimburse CCM Select for these services if the appeal is not decided in the member's favor. (No payment is to be made if the appeal is granted.) Members will be sent an invoice for these services by mail, and will be expected to make payment within thirty days. Failure to pay the amount that is owed to CCM Select can result in disenrollment from the program.

Expedited Appeals Process

- Expedited appeals will be triggered in three ways:
  - CCM Select will address the appeal using an expedited process if it is determined that a delay would seriously jeopardize the member's life or health. This determination will be made by CCM Select whenever program staff believe that a delay could potentially have this effect.
  - Appeals of a concurrent review decision will be handled as an expedited review.
  - A member/provider may ask for an expedited review of their appeal, if he/she or the provider believes that taking the time for a standard appeal could result in a serious problem to their health or life or function. CCM Select staff will then make a determination as to whether an appeal should be handled as expedited.
- If the appeal is to be handled in an expedited manner, CCM Select will respond with a decision as fast as the member's condition requires but within 2 business days after receiving all of the necessary information.
  In no event will the time for making the decision be more than 3 business days after receiving the request for appeal. Members will be informed by phone by Member Services of the decision on their expedited appeal, and in writing (via first class mail), sent within two working days of the decision.
- The review period can be increased up to 14 days, if the member or the provider on the member's behalf requests an extension or if CCM Select needs more information and the delay is in the member's interest. In all cases the extension reason will be documented. If the extension is initiated by CCM Select, CCM Select will notify the member, in writing, of the reason for the extension and how the delay is in the best interest of the member.
- If CCM Select does not agree with the request to expedite the appeal, best and reasonable efforts will be made to notify the member verbally of the decision to deny the request for an expedited appeal and that the appeal will be handled within standard appeal timeframes.
- A written notice of the decision to deny the request for an expedited appeal will be sent by Member Services within 2 calendar days of receiving the request.
- If member does not agree with plan's decision to handle as a Standard Appeal, member may file a grievance.

State Fair Hearings

- If CCM Select does not decide an appeal totally in the member's favor, the member may request a Medicaid Fair Hearing from New York State within 60 days of the date of the notice about the decision on the appeal.
- If the appeal involved the reduction, suspension or termination of authorized services the member is currently receiving, and they requested a Fair Hearing, the member may also request to continue to receive these services while awaiting the Fair Hearing decision by checking the box on the form to request a Fair Hearing indicating that they want the services at issue to continue.
    - The member's request to continue the services must be made within 10 days of the date the appeal decision was sent by the Plan or by the intended effective date of the action to reduce, suspend or terminate the services, whichever occurs later.
    - CCM Select will continue to provide the service as long as the appeal is pending or until the member withdraws the appeal; or until the original authorization period for the services ends; or the State Fair Hearing Officer issues a hearing decision that is not in the member's favor, whichever occurs first.
- If the State Fair Hearing Officer reverses CCM Select's decision, we will provide the disputed services to the member promptly, and as soon as their health condition requires. If the member received the disputed services while their appeal was pending, CCM Select will be responsible for payment for the covered services ordered by the Fair Hearing Officer.
- If the member asked to continue services while awaiting the Fair Hearing decision, and the Fair Hearing was not decided in their favor, the member will be responsible for reimbursing CCM Select for the services that were the subject of the Fair Hearing. Members will be sent an invoice for these services by mail, and will be expected to make payment within thirty days. Failure to pay the amount that is owed to CCM Select can result in disenrollment from the program.

State External Appeals

- If CCM Select denies a member's appeal because a determination is made that the service is not medically necessary or is experimental or investigational, the member may ask for an external appeal from New York State. Reviewers who do not work for CCM Select or New York State decide the external appeal. (The reviewers are qualified people approved by New York State.) The member does not have to pay for an external appeal.
- When CCM Select makes a decision to deny an appeal for lack of medical necessity or on the basis that the service is experimental or investigational, information will be provided to the member about how to file an external appeal, including a form on which to file the external appeal along with the decision to deny an appeal.
- If the member wants an external appeal, he/she must file the form with the New York State Department of Insurance within 45 days from the date the appeal was denied by CCM Select.
- The external appeal will be decided within 30 days. More time (up to 5 business

days) may be needed if the external appeal reviewer asks for more information. The reviewer will notify the member and CCM Select of the final decision within two business days after the decision is made.

- A member can receive an expedited external appeal if their doctor can say that a delay will cause serious harm to their health. (This information is also provided to the member in the instructions regarding filing of external appeals).
- In an expedited external appeal, the reviewer will make a determination in 3 days or less, and will immediately notify the member and CCM Select of the decision by phone or fax. (A letter will then be sent that tells the member the decision).
- A member may ask for both a Fair Hearing and an External Appeal. If a both a Fair Hearing and an external appeal is requested by the member, the decision of the Fair Hearing officer will prevail.

Forms
Notice of Action
Appeal Acknowledgement
Notice of Extension
Refusal to Make a Determination on Appeal (late filing)
Notice of Decision – In Favor
Notice of Decision on Appeal