Approved

Service Authorization/Actions/Appeals Policy and Procedures

(Revised 4.11.05)

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POLICY

CO-OP Care Plan will ensure all Enrollee's have equitable access to all covered services of the program to which they are entitled and which are medically necessary, or necessary for them to remain safely in the community. CO-OP Care Plan has also established a procedure under which each Member or provider/s acting on Member's behalf may challenge the denial of coverage, or payment for medical assistance and/or the services provided by CO-OP Care Plan and the Network Providers. (98.14, 4408A-1-3, 5, CMS Part 438-Managed Care, New York State Article 4900)

OBJECTIVE:

Enrollees, Staff and Network Providers will understand the Service Authorization/Utilization review process and the Enrollee's right to file an Appeal on Actions, for covered services or benefits and the process and time frames for filing an Appeal, External Appeal and Request for State Fair Hearings.

Members, Staff and Network Providers will understand the Enrollee's right to designate a representative to file an Appeal, External Appeal or Request a State Fair Hearing and how to access the External Appeal system and State Fair Hearing system when CO-OP Care Plan denies an appeal in whole or in part.

Members, Staff and Network Providers will understand the circumstances for which benefits may continue for the Member when the Enrollee files an Appeal, External Appeal or Requests a State Fair Hearing.

Members, Staff and Network Providers will understand the circumstances and process for filing an Expedited Appeal.

DEFINITIONS

1. **ADVERSE DETERMINATION:**

   A determination, by a utilization review agent, that an admission, extension of stay or other health care service has been reviewed and based on the information provided is not medically necessary. (New York State Public Health Law, Article 49, Section 4900)

2. **APPEAL:**

   A request for review of an action, as "action" is defined below;

3. **ACTION:**

   - The denial, or limited authorization of a requested service, including the type or level of service; (See Utilization Review/Service Authorization section for information about procedures and timeframes for making decisions.)
   - The reduction, suspension, or termination of a previously authorized service;
   - The denial, in whole or in part, of payment for a service;
   - *The failure to provide services in a timely manner, as defined by the State;
   - Determination that a requested services is not a covered benefit (does not include requests for services that are paid for as fee-for-service outside the plan)
   - *The failure to make a grievance or grievance appeal determination within required time frames.

NOTICE OF ACTION:

A Notice of Action is sent when an Action described above occurs.

The **Notice of Action** will explain the action CO-OP Care Plan has taken or intends to take including the date of the action; the reasons for the action, and in cases where the determination has a clinical basis, the clinical rationale for the determination; the right of the Member or provider on the Member's behalf to file an Appeal with CO-OP Care Plan; how to file an Appeal and the circumstances

under which the Member can request an Expedited review of the Appeal; a description of what additional information, if any, must be obtained in order to make an appeal decision if an appeal is requested; a reference to the option of filing a State Fair Hearing request after the internal appeals process is exhausted, as well as an External Appeal if the service denial is related to issues of medical necessity or experimental or investigational nature of service process. If CO-OP Care Plan is reducing, suspending or terminating an authorized service, the notice will also inform the Member of their right to have the covered services continued while the Appeal is decided; how to request the covered services be continued; and the circumstances under which the Member may have to reimburse The Plan for the service if they are continued while the Appeal is being reviewed.

4. **ACCESS TO THE STATE FAIR HEARING SYSTEM:**

   All Members have a right to request a State Fair Hearing once the internal Appeal process has been exhausted when the Appeal involves an Action as defined above.

5. **AUTHORIZATION PERIOD:**

   The time frame for which CO-OP Care Plan is giving permission for the Member to receive delineated services from a network health care provider.

6. **EXTERNAL APPEAL:**

   An appeal conducted by an external agent in accordance with the provisions of 49:14. (New York State Public Health Law, Article 49, Section 4900)

7. **EXTERNAL APPEAL AGENT:**

   An entity certified by the commissioner pursuant to 4911. (New York State Public Law, Article 49, Section 4900)

8. **CLINICAL PEER REVIEWER:**

   A. For purposes of **Title one** of this Article (New York State Public Law,

Article 49, Section 4900):

(i) A physician who possesses a current and valid non-restricted license to practice medicine; or

(ii) A health care professional other than a licensed physician who:

(a) Where applicable, possesses a current and valid non-restricted license, certificate or registration or, where no provision for a license, certificate or registration exists, is credentialed by the national accrediting body appropriate to the profession; and

(b) Is in the same profession and same or similar specialty as the health care provider who typically manages the medical condition or disease or provides the health care service or treatment under review; and

B. For purposes of **Title two** of this Article (New York State Public Law 49, Section 4900):

(i) A physician who:

(a) Possesses a current and valid non-restricted license to practice medicine;

(b) Where applicable, is board certified or board eligible in the same or similar specialty as the health care provider who typically manages the medical condition or disease or provides the health care service or treatment under appeal;

(c) Has been practicing in such area of specialty for a period of at least five years; and

(d) Is knowledgeable about the health care service or treatment under appeal; or

(ii) A health care provider other than a licensed physician who:

(a) Where applicable, possesses a current and valid non-restricted license, certificate or registration;

(b)Where applicable, is credentialed by the national accrediting body appropriate to the profession in the same profession and same specialty as the health care provider who typically manages the medical condition or disease or provides the health care service or treatment under appeal;

(c) Has been practicing in such area of specialty for a period of at least five years;

(d) Is knowledgeable about the health care service or treatment under appeal; and

(e)Where applicable to such health care professional's scope of practice, is clinically supported by a physician who possesses a current and valid non-restricted license to practice medicine.

(f) Nothing herein shall be construed to change any statutorily defined scope of practice. (New York State Public Health Law, Article 49, Section 4900)

9. **CLINICAL STANDARDS:**

Those guidelines and standards set forth in the utilization review plan by the Utilization Review Agent whose adverse determination is under appeal. (New York State Public Health Law, Article 49, Section 4900)

10. **CLINICAL TRIAL:**

A peer-reviewed study plan as described in New York State Public Health Law, Article 49, Section 4900 2-b (a) (b).

11. **DISABLING CONDITION OR DISEASE:**

A condition or disease as described in New York State Public Health Law, Article 49,

Section 4900 2-c

12. **EMERGENCY CONDITION:**

A medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain that a prudent layperson, possessing average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in

a. Placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy;

b. Serious impairment to such person's bodily functions;

c. Serious dysfunction of any bodily organ or part of such person; or

d. Serious disfigurement of such person. (New York State Public Health Law, Article 49, Section 4900)

13. **ENROLLEE/MEMBER:**

A person subject to service authorization/utilization review.

14. **EXPERIMENTAL AND INVESTIGATIONAL TREATMENT REVIEW PLAN:**

A written clinical review criterion used in rendering an experimental and investigational treatment review determination as described in New York State Public Health Law, Article 49, Section 4900.4-a (a) (b).

15. **FINAL ADVERSE DETERMINATION:**

An adverse determination, which has been upheld by a utilization review agent with respect to a proposed health care service following a standard appeal, or an expedited appeal where applicable, pursuant to 4914. (New York State Health Law, Article 49, Section 4900)

16. **HEALTH CARE PLAN:**

Any organization certified under New York State Public Health Law, Article 49,

Section 4400, 4910.

17. **HEALTH CARE PROFESSIONAL:**

An appropriately licensed, registered or certified health care professional.

18. **HEALTH CARE PROVIDER:**

A health care professional or a facility licensed pursuant to New York State Public Health Law, Articles 28, 36, 44, or 47 or a facility licensed pursuant to Article 19, 23, 31 or 32 of the Mental Hygiene Law

19. **LIFE THREATENING CONDITION OR DISEASE:**

A condition or disease, which according to the current diagnosis of the Enrollee's attending physician, has a high probability of causing the Enrollee's death.

20. **MEDICAL NECESSITY:**

Necessary to prevent, diagnose, correct or cure conditions in the Enrollee that cause acute suffering, endanger life, result in illness or infirmity, interfere with such Enrollee's capacity for normal activity, or threaten some significant handicap.

21. **PREVENTIVE CARE:**

Care, which should be provided in order to prevent/arrest the development of health related problems.

22. **SERVICE AUTHORIZATION/UTILIZATION REVIEW:**

The review to determine whether health care services that have been, are being, or proposed to be provided, to a patient prior to, concurrent with or subsequent to the delivery of such services are medically necessary. For the purpose of this article none of the following shall be considered utilization review:

a. Denials based on failure to obtain health care services from a designated or approved health care provider as required under a subscriber's contract.
b. Where any determination is rendered pursuant to the dispute resolution provision of Public Health

Law 2807 (C) (3-a)

c. The review of the appropriateness of the application of a particular coding to a patient, including the assignment of diagnosis and procedure.
d. Any issues relating to the determination of the amount or extent of payment other than determinations to deny payment based on an adverse determination and
e. Any determination of any coverage issues other than whether health care services were medically necessary. (New York State Public Health Law, Article 49, Section 4900)

23. **UTILIZATION REVIEW AGENT:**

Any company, organization or other entity performing utilization review except:

- An agency of the federal government
- An agency acting on behalf of the federal government, but only to the extent that the agent is providing services to the federal government
- An agent acting on behalf of the state or local government for services provided pursuant to the Title XIX of the federal social security act
- A hospital's internal quality assurance program except if associated with a health care financing mechanism or
- Any insurer subject to Article 32 or 43 of the Insurance Law and any independent utilization review agent performing utilization under a contact with such insurer, which shall be subject to Article 49 of the Insurance Law." (New York State Public Health Law, Article 49, Section 4900)

24. **SERVICE AUTHORIZATION/UTILIZATION REVIEW PLAN:**

- A description of the process for developing the written clinical review criteria:
- A description of the types of written clinical information which the plan might consider in its clinical review, including but not limited to, a set of specific written clinical review criteria;
- A description of practice guidelines and standards used by a utilization review agent in carrying out a determination of medical necessity;
- The procedures for scheduled review and evaluation of the written clinical review criteria; and
- A description of the qualifications and experience of the health care professionals who developed the criteria, who are responsible for periodic evaluation of the criteria and of the health care professionals or others who use the written clinical review criteria in the process of utilization review.

25. **CO-OP CARE PLAN SERVICE AUTHORIZATION/UTILIZATION REVIEW PROCESS:**

A.) Clinical Review Criteria/Clinical Standards:

The Clinical Review Criteria/Clinical Standards are developed by the Executive Team* through review of current medical literature and review of current standards of practice related to home care. Once the Clinical Standards have been finalized they will be adopted into practice for Utilization Review. The Standards will be reviewed every two (2) years and more often if necessary.

CO-OP Care Plan has developed Clinical Standard Policies (See Standards of Care Policy) for all covered services and they are to be utilized during the Utilization Review Process.

* The Executive Team consists of:

• Administrator for Community Programs: Will have a minimum of 5 years of Home Care experience. Masters in a health related field preferably Health Care

Administration. Preferably Managed Care experience

• Director of Managed Care: Will be a Registered Professional Nurse with a minimum of 5years experience in Home Care and/or Managed Care with Bachelors in Nursing. Preferably Master prepared.

• Quality Improvement Supervisor/Grievance and Appeal Officer: A minimum or 5 years Quality Improvement experience, Bachelors in Nursing preferred. Certified by the American Board of Quality Improvement/Utilization. Managed Care experience preferred.

• Medical Director: Licensed Physician with minimum of 5 years experience specializing in Gerontology. Private practice and nursing home experience preferred.

(B) Utilization Review Agent:

The Utilization Review Agent may be the Nurse Care Manager, Nurse Care Management Supervisor, Quality Improvement Supervisor, Quality Improvement Coordinator or the Medical Director depending upon the type of review being conducted. Descriptions of each review with responsible parties can be found in section D of this plan. The Medical Director is responsible for the supervision and oversight of the Utilization Review Process.

(C) Clinical Peer Reviewer:

The Clinical Peer Reviewer may be the Quality Improvement Supervisor, Quality Improvement Coordinator, Nurse Care Manager, Nurse Care Management Supervisor or Medical Director. In addition, CO-OP Care Plan may contract with independent professionals credentialed by the plan to act as Clinical Peer Reviewers.

(D) Service Authorization/Utilization Review:

Prior Service Authorization Review Procedure:

The Nurse Care Manager, acting as Utilization Review Agent, will develop a Plan of Care/Service Plan for each Member based on the following:

- OASIS (Comprehensive Nursing Assessment)
- DMS-1
- Task Based Assessment
- Mini-Mental Exam
- Collaboration with Primary Care Practitioner
- Standards of Care
- Member input

The Service Plan will delineate the type and amount of services the Member will receive in a given authorization period. An authorization will be transmitted to the network providers who are delivering the authorized services to the Member. The authorization will delineate the amount, frequency and type of service the Member is to receive (See Authorization Policy)

•If a Member or provider on the Member's behalf requests a new service (whether for a new authorization period or within an existing authorization period) or to change a services as determined in the plan of care for a new authorization period, the Nurse Care Manager will review the Member's need for the new service. (See **Standard Review, Expedited Review and Review Extension of up to 14 days for procedure and timeframes**:)

•If the Nurse Care Manager determines the requested service is medically necessary, she/he will approve the request and notify the Member by phone and in writing within the required timeframes. The Nurse Care Manager will provide an authorization to the appropriate provider, adjust and implement the Member's plan of care accordingly.

•If the Nurse Care Manager determines the service is **not medically necessary** based on the information gathered during the review process, he/she will immediately discuss the request and the Member's plan of care with the Nurse Care Management Supervisor for advice regarding the need for the requested

service.

•If the request is to be **denied**, the Nurse Care Management Supervisor sends the Member or provider a **Notice of Action (See template, "Request for Service decision letter" Notice of Action)** denying the requested service within the following required timeframes.

Standard Review: As fast as the Member's condition requires but no more than: three (3) business days of receipt of necessary information, but no more than 14 days of receipt of the request for services.

Expedited Review: **As fast as the Member's condition requires but no more than: three (3) business days of the request for the service;** An Expedited review is conducted when the Nurse Care Manager and Nurse Care Management Supervisor in collaboration with the Medical Director and Director of Plan 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. The Member may request an Expedited Review of a Prior Authorization. If the Nurse Care Manager and Nurse Care Management Supervisor, in collaboration with the Medical Director and Director of Plan denies the Member's request for an Expedited Review, the person that requested the Expedited Review will be notified by phone and in writing (See template: denial to expedite request for services letter) and the request for service will be handled as a Standard Review.

• A **Review Extension of up to 14 days** An extension may be requested verbally or in writing by the Member or provider on the Member's behalf. The Nurse Care Manager and Nurse Care Management Supervisor in collaboration with the Medical Director/Director of Plan CO-OP Care Plan may also initiate an

extension if the need for additional information is justified and the extension is in the Member's interest. In all cases the reason for the extension will be well documented and the **Member/provider will immediately be notified of the reason for the Extension by phone and in writing**. (See template: "Service Request Extension Letter")

Appeal of Adverse Determination:

•If the Member or provider wishes to Appeal the Adverse Determination, the Member or provider must notify CO-OP Care Plan verbally or in writing of the request for an Appeal within 45 days of postmark date of the Notice of Action. The Member will **not** have appeal rights if the request for an **appeal is not within 45 days of the postmark date of the Notice of Action**. The Member will be notified in writing of such. (See template "denial to make a determination on an appeal to a Notice of Action")

• The Grievance and Appeal Officer/designee will send a written acknowledgement (See templates "Verbal Appeal Acknowledgement Letter" and "Written Appeal Acknowledgement Letter") of the Appeal request within 15 days of receipt of the request. If the Appeal was received verbally, the written acknowledgment letter will have a summary of the Appeal as part of the letter or the summary will be provided separately along with the acknowledgement letter. The date of the verbal appeal request will be the date of the appeal. If a decision is reached before the written acknowledgement is sent, the acknowledgement letter may include the notice of the decision.

• The decision on the Appeal will be made as fast as the Member's condition requires, and within the following timeframes

Expedited Appeal: As fast as the Member's condition requires, **but no more than 2 business days of receipt of necessary information and no later than 3**

business days of receipt of appeal request.

Standard Appeal: As fast as the Member's condition requires, but no more than 30 calendar days of receipt of the appeal request.

Appeal Extension up to 14 Calendar Days: The Member or provider on the Member's behalf may request verbally or in writing for an Extension of the Appeal decision **of up to 14 calendar days**. The Grievance & Appeal Officer/designee in collaboration with the Medical Director/Director of Plan may also initiate an extension, if the need for additional information can be justified and the extension is in the Member's interest. In all cases the reason for the extension will be well documented and the Member/provider **will immediately be notified by phone and in writing**. (See template, "Action Appeal Decision Extension Letter")

• If the Member requested an Expedited Appeal and the Grievance & Appeal Officer/designee in collaboration with the Medical Director/Director of Plan **do not agree** the Expedited Appeal is warranted the request will be denied and reasonable efforts to give oral notice of denial of an expedited review and **send written notice within 2 calendar days of the oral request** and notify the Member or provider that the appeal will be handled as a Standard Appeal. (See template: "denial to expedite Appeal request letter") If the Member or provider does not agree with the decision to handle the Appeal as a Standard Appeal, the disagreement is considered a grievance. See Grievance Procedure.

•The Grievance & Appeal Officer/designee in collaboration with the Medical Director/Director of Plan will **either uphold or reverse** the Plan's decision to deny the service.

•The Grievance & Appeal Officer/designee will make reasonable efforts to give **oral notice for Expedited Appeals** and will **send written notice within 2 business days of the decision for all Appeals**. (See template: "Appeal decision")

The written notice of the Appeal decision will include the following information:

a.) Date and summary of the appeal;

b.) Date appeal process was completed by CO-OP Care Plan;

c.) The reason for the determination, and in cases where the determination has a clinical basis, the clinical rationale for the determination.

d.) If the decision is not in favor of the Member, a State Fair Hearing notice and description of the process for filing a Fair Hearing request and how the Member may obtain assistance from CO-OP Care Plan with filing for a State Fair Hearing request.

e. If the denial of the appeal was due to issues of medical necessity or because the service was experimental or investigational, the notice will clearly state that the notice constitutes the final adverse determination and procedures for filing an External Appeal and how the Member may obtain assistance from CO-OP Care Plan in filing an External Appeal.

f. The availability and how to access assistance for language, hearing or speech issues if the Member wants to file Fair Hearing request and/or an External Appeal.

• If the Member or provider is not satisfied with the Appeal decision, he/she may file for both State Fair Hearing and External Appeal. If both are filed, the State Fair Hearing decision is the one that counts.

2) Concurrent Authorization of Services Review Procedure: The Nurse Care Manager, will develop a Plan of Care/Service Plan for each Member based on the following:

• OASIS (Comprehensive Nursing Assessment)
• DMS-1
• Task Based Assessment
• Mini-Mental Exam

- Collaboration with Primary Care Practitioner
- Standards of Care
- Member Input

The Service Plan will delineate the type and amount of services the Member will receive in a given authorization period. An authorization will be transmitted to the network providers who are delivering the authorized services to the Member. The authorization will delineate the amount, frequency and type of service the Member is to receive (See Authorization Policy)

- If a Member or provider on the Member's behalf requests additional services (i.e., more of the same) that are currently authorized in the plan of care, the Nurse Care Manager will review the Member's need for the additional services, **(See Standard Review, Expedited Review and Review Extension of up to 14 days for procedures and timeframes:)**
- If the Nurse Care Manager determines the requested service **is medically necessary**, she/he will **approve the request and notify** the Member by **phone and in writing within the required timeframes**. The Nurse Care Manager will provide an authorization to the appropriate provider, adjust and implement the Member's plan of care accordingly.
- If the Nurse Care Manager determines the additional services is **not medically necessary** based on the information gathered during the review process, he/she will **immediately** discuss the request and the Member's plan of care with the Nurse Care Management Supervisor for advice regarding the need for additional services.
- If the request for additional services is to be **denied**, the Nurse Care Management Supervisor will **notify the Member or provider by phone of the decision and send** the Member or provider a **Notice of Action (See template, Request for Service decision letter Notice of Action)** denying the requested additional services within the following required timeframes:

- **Standard-as fast as the Member's condition requires and within 1 business day of receipt of necessary information, but no more than 14 days of receipt of request for services.**
- **Expedited- as fast as the Member's condition requires and within 1 business day of receipt of necessary information, but no more than 3 business days of receipt of the request for more services** An Expedited review is conducted when the Nurse Care Manager and Nurse Care Management Supervisor in collaboration with the Medical Director/Director of Plan 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. The Member or provider may request an Expedited Review of a Concurrent Authorization. If Nurse Care Manager and Nurse Care Management Supervisor in collaboration with the Medical Director/Director of Plan denies the Member's or provider's request for an Expedited Review, the request for the additional services will be handled as a Standard Review and the **Member will be notified by phone and in writing** (see template; "denial to expedite request for services letter") that their request for an expedited review has been denied.
- A **Review Extension of up to 14 days** An extension may be requested verbally or in writing by the Member or provider on the Member's behalf. The Nurse Care Manager and/or Nurse Care Management Supervisor may also initiate an extension if the need for additional information is justified and the extension is in the Member's interest. In all cases the reason for the Extension will be well documented and the Nurse Care Manager or Nurse Care Management Supervisor will **immediately notify the Member by phone and in writing.** (See template: "Service Request Extension Letter")

Appeal of Adverse Determination:

• If the Member or provider wishes to Appeal the decision, the Member or provider must notify CO-OP Care Plan verbally or in writing of the request for an Appeal:

• **within 45 days of postmark date of the Notice of Action;** Member will **not** have appeal rights if appeal request is not received within 45 days of postmark date of the Notice of Action (see template, "denial to make a determination on an appeal to Notice of Action")

• **Appeals of a Concurrent Review will be handled as an Expedited Appeal**.

• The Grievance and Appeal Officer/designee will send a written acknowledgement, (See template of "Appeal Verbal Acknowledgement Letter" and "Written Appeal Acknowledgment Letter") of the Appeal **request within 15 days of receipt of the request**. If the Appeal was received verbally, the written acknowledgment letter will have a summary of the Appeal as part of the letter or will be provided separately along with the acknowledgement letter. The date of the verbal appeal request will be the date of the appeal. If a decision is reached before the written acknowledgement is sent, the acknowledgement letter may include the notice of the decision.

• The **decision on the Appeal will be made as fast as the Member's condition requires, and within 2 business days of receipt of necessary information and no later than 3 business days of receipt of appeal request**.

Appeal Extension of up to 14 Calendar Days: The Member or provider on the Member's behalf may request verbally or in writing for an Extension of the Appeal decision **of up to 14 calendar days**. The Grievance and Appeal Officer/designee may also initiate an extension, if the need for additional information can be justified and the extension is in the Member's interest. In all cases, the reason for the extension will be well documented and the **Member will immediately be notified by phone and in writing** of the reason for the

extension. (See template, "Action Appeal Decision Extension Letter")

- The Grievance and Appeal Officer/designee will either **uphold or reverse the Plan's decision to deny the service** and will notify all involved parties of the decision immediately.
- If the decision to deny the requested service is **reversed** all involved parties will be immediately notified of the appeal decision **by phone and in writing** and the Member will immediately receive the requested service. The Nurse Care Manager will adjust and implement the plan of care accordingly.
- If the Appeal decision **upholds The Plan's decision to deny** the requested service, the Grievance and Appeal Officer/designee will make **reasonable efforts to give oral notice and will send a written notice within 2 business days of the decision on the appeal.** The written notice of the Appeal decision (See template: "Appeal decision") will include the following information:

  a.) Date and summary of the appeal;

  b.) Date appeal process was completed by CO-OP Care Plan;

  c.) The reason for the determination, and in cases where the determination has a clinical basis, the clinical rationale for the determination.

  d.) If the decision is not in favor of the Member, State Fair Hearing notice and description of the process for filing Fair Hearing request and how the Member may obtain assistance from CO-OP Care Plan with filing for a State Fair Hearing request.

  e.) If the denial of the appeal was due to issues of medical necessity or because the service was experimental or investigational, the notice will clearly state that the notice constitutes the final adverse determination and procedures for filing an External Appeal and how the Member may obtain assistance from CO-OP Care Plan in filing an External Appeal.

  f.) The availability and how to access assistance for language, hearing or

speech issues if the Member wants to file Fair Hearing request and/or an External Appeal.

• If the Member or provider is not satisfied with the Appeal decision, he/she may file for both State Fair Hearing and External Appeal. If both are filed, the State Fair Hearing decision is the one that counts.

3) Reduction, Suspension or Termination of Services Authorization Review Procedure:

This review would be applicable only if services will be **Reduced, Suspended or Terminated** within a designated authorization period.

•The decision to **Reduce, Suspend, or Terminate** services may be made by the Nurse Care Manager, on the advice of the Nurse Care Management Supervisor and based on information obtained either through nursing assessments, conversations with physician, Member/family/provider and the standards of care.

•For any Reduction, Suspension or Termination of services, the Nurse Care Management Supervisor will provide a **Notice of Action (See "Notice of Action for Reduction, Termination, and Suspension for services")** informing the Member of the **Reduction/Suspension/Termination** of the service at least **ten (10) days prior to the date of the intended reduction/suspension or termination of services.**

•If the Member or the provider on behalf of the Member, wishes to **Appeal** the Adverse Determination and to have services continued, the Member or provider must notify CO-OP Care Plan **within 10 days of the Notice of Action's postmark date or by the intended effective date of the action**. If the Member does **not request services continued**, the appeal request must be made within **45 days of the postmark date of the Notice of Action.**

• If the Member or provider **requests the service be continued** during the Appeal process, CO-OP Care Plan will continue to provide the service throughout the Appeal decision process until the sooner of:

a. Appeal is withdrawn;
b. The original authorization period has expired, or
c. Until 10 days after the appeal decision is mailed, if the decision is not in the Member's favor, unless a NYS Fair Hearing has been requested.

• The Grievance & Appeal Officer/designee will send a written acknowledgement (See template: "Verbal Appeal Acknowledgement Letter" and "Written Appeal Acknowledgement Letter") of the Appeal request **within 15 days of receipt of the request**. If the Appeal was received verbally, the written acknowledgment letter will have a summary of the Appeal as part of the letter or will be provided separately along with the acknowledgement letter. The date of the verbal appeal request will be the date of the appeal. If a decision is reached before the written acknowledgement is sent, the acknowledgement letter may include the notice of the decision.

• **Standard Appeal review decision:** The decision on the Appeal will be made **as fast as the Member's condition requires, but no later than 30 calendar days of receipt of appeal request.**

• **Expedited Appeal review decision:** The decision on the Appeal will be made **as fast as the Member's condition requires, and within 2 business days of receipt** of necessary information and **no later than 3 business days of receipt of appeal request.**

• Appeal Extension up to 14 Calendar Days: The Member or provider on the Member's behalf may request, verbally or in writing, an **Extension of up to 14**

calendar days for a decision on the Appeal. The Grievance and Appeal Officer/designee may also initiate an extension, if the need for additional information can be justified and the extension is in the Member's interest. In all cases, the reason for the extension will be well documented and the Member/provider will be **immediately notified by phone and in writing the reason for the extension**. (See template: "Action Appeal Decision Extension Letter")

The Grievance and Appeal Officer/designee will **either uphold or reverse the Plan's decision** to reduce, suspend or terminate the service and will notify all involved parties of the decision immediately. (See template: Appeal decision")

- If through the Appeal process, the decision to reduce, suspend or terminate the services is **reversed,** the Grievance and Appeal Officer/designee will make reasonable efforts to **give oral notice for expedited appeals** and will send written notice **within 2 business days of the decision for all appeals**. The Nurse Care Manager will adjust and implement the plan of care accordingly.
- If the Appeal decision **upholds The Plan's decision** to reduce, suspend or terminate the service, the Grievance and Appeal Officer/designee will make **reasonable efforts to give oral notice for expedited appeals** and will send **written notice within 2 business days of the decision for all appeals**.

The written notice of the Appeal decision will include the following information

a.) Date and summary of the appeal;

b.) Date appeal process was completed by CO-OP Care Plan;

c.) The reason for the determination, and in cases where the determination has a clinical basis, the clinical rationale for the determination.

d.) If the decision is not in favor of the Member, State Fair Hearing notice and description of the process for filing Fair Hearing request and how the Member

may obtain assistance from CO-OP Care Plan with filing for a State Fair Hearing request.

e.) If the denial of the appeal was due to issues of medical necessity or because the service was experimental or investigational, the notice will clearly state that the notice constitutes the final adverse determination and procedures for filing an External Appeal and how the Member may obtain assistance from CO-OP Care Plan in filing an External Appeal.

f.) The availability and how to access assistance for language, hearing or speech issues if the Member wants to file Fair Hearing request and/or an External Appeal.

• If the Member or provider is not satisfied with the Appeal decision, he/she may file for both State Fair Hearing and External Appeal. If both are filed, the State Fair Hearing decision is the one that counts.

4) Retrospective Authorization of Services Review Procedure: Will be handled as a claims payment issue.

•To enable CO-OP Care Plan to handle all Appeals in an expeditious manner and eliminate any delay that could significantly increase risk to the Member's health, The CO-OP Care Plan Director/designee will be available, via pager, on a 24 hour (twenty-four), seven (7) days a week basis. The Medical Director is also available to make significant health care decisions. If the request for an Appeal is received verbally during off business hours, On Call Staff will contact CO-OP Care Plan's Director, who will contact the Medical Director via pager 24 hours, seven days a week, when there is a significant health care decision to be made.

GENERAL INFORMATION

1. The process for Service Authorization/Actions/Appeals is described to the Member in the Member Handbook (available in Spanish and English, written in a manner easily understood,) which is reviewed with the Member by the Nurse

Care Manager during the Initial Nursing Visit (INV), the Start of Care Visit (SOC) and again when the Appeal process is initiated.

2. CO-OP Care Plan Quality Improvement Supervisor/designee will assist the Member file an Appeal, External Appeal or Request a State Fair Hearing. When it is in the Member's best interest or by their request, refer the Member to an advocacy group to assist the Member in filing the Appeal, External Appeal or Request a State Fair Hearing.
3. Interpreters are available free of charge when needed or requested by the Member.
4. The CO-OP Care Plan Quality Improvement Supervisor coordinates the Appeal Process and serves as the Grievance and Appeals Officer. The Quality Improvement Supervisor works closely with the Medical Director and Plan Director in all activities related to the Appeals process.
5. The CO-OP Care Plan Quality Improvement Supervisor ensures that all staff is oriented to the Service Authorization/Actions/Appeals Policy and Procedures. This orientation will occur during the regularly scheduled orientation program for new employees and as needed on an on-going basis.
6. The Quality Improvement Supervisor will ensure Network Providers are oriented to the Service Authorization/Actions/Appeals Policy and Procedures. This orientation will occur at the time of the onset of their contract and will be reinforced on an ongoing basis as needed.
7. The Grievance and Appeal Officer/designee will ensure the correct forms and timeframes are adhered to for all Appeals, Request for External Appeals and requests for State Fair Hearings.
8. The Grievance and Appeal Officer/designee maintains confidential files and logs of all Appeals/Requests for External Appeals and Requests for State Fair Hearings and their resolutions.

9. The Grievance and Appeal Officer/designee is responsible for providing a report of the status of all Appeals/Request for External Appeals and requests for State Fair Hearings to the Medical Director, and Quality Improvement Committee on an ongoing basis, but no less than quarterly and to the NY DOH at least quarterly.

See attachments: Templates letters/forms

Approved

CO-OP CARE PLAN
3677 East Tremont Avenue
Bronx, NY 10465
Toll free: (888) 830-5620

(Template: Service Request Extension Letter)

(Date)

(Name of Member/provider requesting the service and/or extension)
(Address of Member/provider requesting the service and/or extension)

Re: (Name and MA# of Member)

Dear _____:

This letter is to notify you that CO-OP Care Plan is extending the review period of your Request for Services dated (Date of Request) by up to 14 days to review additional information regarding your request.

The reason for the extension is as follows:
(If reason for the extension is due to Member/provider request, it will be stated here, otherwise the reason the NCM/NCMS is extending review will be stated here)

_____
_____
_____

The delay is in your interest due to the following reasons:

_____
_____
_____
_____

The additional information required to make our determination is as follows:

_____
_____
_____

If you have any questions while we are handling your request for services, please call me at anytime. Telephone: (Number)

Sincerely,

(Name)_____, (Title)

approved

CO-OP CARE PLAN
3677 East Tremont Avenue
Bronx, NY 10465
Toll free: (888) 830-5620

(Template denial to make a determination on an appeal to a Notice of Action)

(Date)

(Name of person requesting appeal to a Notice of Action)
(Address of person requesting the above)

Re: (Name and MA# of Member)

Dear _____:

We have received your request for an appeal to the Notice of Action decision dated _____, however we regret to inform you that the request is denied because the request or an appeal was not submitted within 45 days of the postmark of the Notice of Action.

If you have any questions regarding your request, please contact me at the above address and phone number.

Sincerely,

(Name)_____, (Title)

CO-OP CARE PLAN
3677 East Tremont Avenue
Bronx, NY 10465
Toll free: (888) 830-5620

(Template **Verbal Appeal Acknowledgement** Letter)

(Date)

(Name of person filing appeal)
(Address of person filing appeal)

Re: (Name and MA# of Member)

Dear _____:

We have received your verbal Appeal on (date) regarding the Notice of Action dated _____.

The Nature of your appeal is as follows:

_____
_____

The name, title, address and phone number of the staff person designated to investigate your appeal is:

_____
_____
_____
(888) 830-5620 extension: _____
Quality Improvement Department

Your Appeal will be investigated and a decision will be made by (Date) To facilitate the investigation process, the following additional information is required to make a decision on your Appeal:

_____
_____

If you have any questions while we are handling your appeal, please call the designated staff above at anytime.

Sincerely,
(Name)_____, (Title)

Enclosure

CO-OP CARE PLAN
3677 East Tremont Avenue
Bronx, NY 10465
Toll free: (888) 830-5620

(Template **Written Appeal Acknowledgement** Letter)

(Date)

(Name of person filing written appeal)
(Address of person filing written appeal)

Re: (Name and MA# of Member)

Dear _____:

We have received your written Appeal on (date) regarding the Notice of Action dated _____.

The Nature of your appeal is as follows:

_____
_____

The name, title, address and phone number of the staff person designated to investigate your appeal is:

_____
_____
_____
(888) 830-5620 extension: _____
Quality Improvement Department

Your Appeal will be investigated and a decision will be made by (Date) To facilitate the investigation process, the following additional information is required to make a decision on your Appeal:

_____
_____

If you have any questions while we are handling your appeal, please call the designated staff above at anytime.

Sincerely,
(Name)_____, (Title)

Enclosure

approved

CO-OP CARE PLAN
3677 East Tremont Avenue
Bronx, NY 10465
Toll free: (888) 830-5620

(Template: **Action Appeal Decision Extension** Letter)

(Date)

(Name of person filing action appeal and/or extension)
(Address of person filing action appeal and/or extension)

Re: (Name and MA# of Member)

Dear _____:

This letter is to notify you that CO-OP Care Plan is extending the review period of your action appeal dated (Date of action appeal) by 14 days to complete the investigation process.

The reason for the extension is as follows:
(If the reason for the extension is due to Member/provider request, it will be stated here)
_____
_____
_____
The delay is in your interest due to the following reasons:
_____
_____
_____
_____

The additional information required to make our determination is as follows:
_____
_____
_____

If you have any questions while we are handling your action appeal, please call me at anytime. Telephone: (Number)

Sincerely,

(Name)_____, (Title)

approved

CO-OP CARE PLAN
3677 East Tremont Avenue
Bronx, NY 10465
Toll free: (888) 830-5620

(Template **denial to expedite Appeal request** letter)

(Date)

(Name of person requesting the expedited Appeal review)
(Address of person requesting the above)

Re: (Name and MA# of Member)

Dear _____:

We have received your request dated (date of request) to expedite the review process for your Appeal.
Brief description of the Appeal:
_____
_____
Your request for the expedited Appeal review has been denied based on the following information, which indicates your Appeal, does not involve a significant health risk for (Name of Member): Your Appeal will be handled has a standard appeal.
Reason:
_____
_____

The name and address of the staff making the decision on your request for an Expedited Appeal is:
_____
_____
_____
_____
(888) 830-5620 ext.: _____

Your Appeal will be reviewed and a decision will be made by (Date)

If you have any questions while we are handling your Appeal, you may contact the person above at anytime.

If you do not agree with the decision to handle your appeal as a standard appeal, you may file a grievance and initiate the grievance process by contacting 1-888) 830-5620 x 1610.

Sincerely,
(Name)_____, (Title)

Approved

CO-OP CARE PLAN
3677 East Tremont Avenue
Bronx, NY 10465
Toll free: (888) 830-5620

(Template denial to expedite request for services letter)

(Date)

(Name of person requesting the expedited request review)
(Address of person requesting the above)

Re: (Name and MA# of Member)

Dear _____:

We have received your request dated (date of request) to expedite the review process for your request for services.
Brief description of the requested service:
_____
_____
Your request for the expedited review has been denied based on the following information, which indicates your request for services, does not involve a significant health risk for (Name of Member): Your request will be handled has a standard request.
Reason:
_____
_____

The name and address of your Nurse Care Manager making the decision on your request is:

_____
_____
_____
_____
(888) 830-5620 ext.: _____
Your request for services will be reviewed and a decision will be made by (Date)

If you have any questions while we are handling your request for services, please call your Nurse Care Manager at anytime.

If you do not agree with the decision to handle your request as a standard request, you may initiate the grievance process by contacting 1-888) 830-5620 x 1610 to file a grievance.

Sincerely,

(Name)_____, (Title)

CO-OP CARE PLAN
3677 East Tremont Avenue
Bronx, NY 10465
Toll free: (888) 830-5620

(Template: **Reduction, Terminations, and Suspension for services** decision letter)

NOTICE OF ACTION

(Date)

(Name of person receiving the services)
(Address of above person)

Re: (Name and MA# of Member)

Dear _____:

We are taking the following **Action effective (date of action):**

☐ **Reduction**

☐ **Termination**

☐ **Suspension**

Of the following Services:

_____
_____

The following describes the reason for our Action and in cases where the Action has a clinical basis, the clinical rationale:

_____
_____
_____
_____
_____
_____

(Name)_____, (Title)

See reverse side for Appeal procedure

Appeal procedure:

If you are not satisfied with the decision, **you may file an appeal within 45 days of the postmark date of this notice if there is no request for the service to continue, or within 10 days of this notice's postmark date, or by the intended date of the action if service to continue is requested and the notice involves the termination, suspension or reduction of a previously authorized service.** The Appeal may be filed in writing to the CO-OP Care Plan Quality Improvement Department at 3677 East Tremont Avenue, Bronx, NY 10465 or verbally at (888) 830-5620 extension 1610. You may also present evidence and examine your case file during the appeal by contacting the Quality Improvement Department. You have an option to file for a Fair Hearing request after the internal appeal process is exhausted, as well as an External Appeal if the service denial is related to issue of medical necessity or experimental or investigational nature of service. A request can be made for an expedited review of the appeal if a longer time frame would be injurious to your health. The clinical review criteria that were relied upon in making this decision is available for your review if this Notice of Action involved medical necessity or if treatment or service was experimental or investigational.

The following additional information is needed for CO-OP Care Plan to make an appeal decision:

_____
_____
_____
_____
_____
_____

If you have a language, hearing or speech problem, we will provide you with assistance, free of charge by contacting me at the above phone number, extension: (_____)

APPROVED

CO-OP CARE PLAN
3677 East Tremont Avenue
Bronx, NY 10465
Toll free: (888) 830-5620

(Template: Request for Service decision letter)

NOTICE OF ACTION

(Date)

(Name of person requesting the services)
(Address of above person)

Re: (Name and MA# of Member)

Dear _____:

We have made a decision to deny your request dated: _____ for services, as described below:

_____
_____
_____
_____

The following describes the reason for our Action and in cases where the Action has a clinical basis, the clinical rationale:

_____
_____
_____
_____
_____
_____

(Name)_____, (Title)

See reverse side for Appeal procedure

Appeal procedure:

If you are not satisfied with the decision, **you may file an Appeal within 45 days of the postmark date of this notice.** The appeal may be filed in writing to the CO-OP Care Plan Quality Improvement Department at 3677 East Tremont Avenue, Bronx, NY 10465 or verbally at (888) 830-5620 extension 1610. You may also present evidence and examine your case file during the appeal by contacting the Quality Improvement Department. You have an option to file for a Fair Hearing request after the internal appeal process is exhausted, as well as an External Appeal if the service denial is related to issue of medical necessity or experimental or investigational nature of service.
A request can be made for an expedited review of the appeal if a longer time frame would be injurious to your health. The clinical review criteria that were relied upon in making this decision is available for your review if this Notice of Action involved medical necessity or if treatment or service was experimental or investigational.

The following additional information is needed for CO-OP Care Plan to make an appeal decision:

_____
_____
_____
_____
_____
_____

If you have a language, hearing or speech problem, we will provide you with assistance, free of charge by contacting me at the above phone number, extension: (_____)

NOTE: This letter was replace by 1/30/06 version

CO-OP Care Plan
3677 East Tremont Avenue
Bronx, NY 10465
(888) 830-5620
(Template for Appeal decision)

Date of Notice: _____

Case #: _____

Enrollee Name and Address:
_____
_____
_____

This is to inform you that CO-OP Care Plan reviewed your Appeal regarding the Notice of Action decision letter dated: _____.

Date and Summary of appeal:
(Date) (Summary)
_____
Through the appeal process, which was completed on _____, the decision is (to reverse or uphold Notice of Action decision deny a requested service or terminate, suspend, reduce a service):
_____
This is because:
_____
The clinical rationale (if applicable) for the decision is as follows:
_____
The name, address and phone number of person that investigated the appeal:
_____
_____
_____
_____
If you think this Appeal decision is wrong, you may ask for a State Fair Hearing by phone or in writing by following the instructions under the RIGHT TO FAIR HEARING section below.

If the appeal decision was due to issues of medical necessity or because the service was experimental or investigational, you also have the **RIGHT TO AN EXTERNAL APPEAL**.
(If both are filed, the State Fair Hearing decision is the one that counts.) See following pages for procedure for filing State Fair Hearings and External Appeals:

☐ This decision is due to an issue of Medical Necessity see further information regarding External Appeal.
☐ This decision is due to the service was experimental or investigational see further information regarding External Appeal.

RIGHT TO A FAIR HEARING

For Fair Hearings regarding:
TERMINATION, REDUCTION, SUSPENSION, OR DENIAL OF BENEFITS UNDER MLTCP

IF YOU WISH TO RECEIVE A FAIR HEARING, YOU MUST ASK FOR THE FAIR HEARING WITHIN 60 DAYS FROM THE DATE OF THIS NOTICE. For detailed instructions on how to file for a Fair Hearing, please see pages 2 and 3 of the attached "Managed Long Term Plan Action Taken" form.

HOW TO REQUEST THAT SERVICES CONTINUE UNCHANGED: If our decision was to terminate, reduce or suspend your services and you request a Fair Hearing, you may request that the services continue unchanged. If you want your benefits to continue unchanged, check the box on page 3 of the attached "Managed Long Term Care Plan Action Taken" form. Your request to continue services must be made within 10 days of the postmark date of this notice or by the effective date of the action. Your benefits will continue until the hearing request is withdrawn, the original authorization period for the service ends, or the fair hearing decision is made and the decision is not in your favor, whichever occurs first. But if you ask for your benefits to continue unchanged and the Fair Hearing decision is not in your favor, CO-OP Care Plan can make you pay back the cost of any of the services that were continued while you were waiting for the ruling.

PROCEDURE FOR REQUESTING AN EXTERNAL APPEAL:

To file for an External Appeal, review the attached NEW YORK STATE EXTERNAL APPEAL APPLICATION, which also includes instructions and a phone number for help with requesting the External Appeal. You may also receive information regarding the External Appeal process via the Internet: www.ins.state.ny.us. Or call the New York State Insurance Department at 1-800-400-88882. You may also contact the person above that investigated the appeal for assistance for language, hearing or speech issue if you want to file a Fair Hearing request and/or External Appeal.To request an External Appeal, you must complete the attached NEW YORK EXTERNAL APPEAL APPLICATION and mail it to New York State Insurance Department at PO Box 7209,

Albany, NY 12224-0209 **within 45 days of this appeal decision letter. If you do not send an External Appeal application to the Insurance Department within 45 days of the date on this appeal decision letter, you will not be eligible for an External Appeal.**

The External Appeal agent will make a decision within 30 days. More time (up to 5 business days) may be needed if the External Appeal agent asks for more information.

You can get faster decision if you doctor feels that a delay in providing the treatment would pose a serious threat to your health. This is called an Expedited External Appeal. To request an Expedited External Appeal, your doctor must complete the Attending Physician Attestation in the attached NEW YORK STATE EXTERNAL APPEAL APPLICATION. Once an appeal is expedited, the External Appeal agent must make a decision in 3 days, even if all your medical information has not been provided to the agent. When an appeal is expedited, you and your doctor should immediately send any information to the agent so that it may be reviewed.

The External Appeal agent will notify you and Co-Op of the decision right away and will send you a letter later.

Attachments