HERITAGE PROVIDER NETWORK
&
AFFILIATED MEDICAL GROUPS

APPEAL PROGRAM
2022

Approval Signature:

Dr. Michael Wettstein, Committee Chair

Date: **03/01/2022**

2019 - Heritage Provider Network, Inc.
All rights reserved. No part of this document may be reproduced or transmitted in any form or by any means, electronic, mechanical, photocopying, recording, or otherwise, without prior written permission of Heritage Provider Network, Inc.

Table of Contents

PURPOSE 3
OUR ROLE 3
POLICY 3
DEFINITIONS 4
STAFF RESPONSIBILITY 6
- Designated Physician 6
- Designated Behavioral Health Care Practitioner 7
- Quality Director and/or Quality Manager 7
- Utilization Management, Case Management, and Claims 7
- Customer Service Director and/or Customer Service Manager 7
- After Hour Coverage 7

QI AND UM COMMITTEE FUNCTIONS 7
TYPES OF APPEALS 8
DMHC APPEALS PROCESS 9
MEDI-CAL MANAGED CARE APPEAL PROCESS 12
MEDICARE ADVANTAGE (PART C) APPEALS PROCESS 13
QUALITY IMPROVEMENT ORGANIZATION (QIO) 16
HPN APPEALS PROCESS 16
- Routing Appeals to the Health Plan 16
- Support for Filing Appeals for Hearing and Speech Impaired Members 17
- Support for Filing Appeals for Members with Linguistic and Cultural Needs 17
- Receipt of Appeals from the Health Plan 18
- Record Maintenance 18
- Internal Review 18
- Physician Review of Appeals 18
- Documentation of Appeal Outcome 19
- Documents Sent to Health Plan 19
- Notification to Member and/or Provider 19
- Authorization/Effectuation (As Necessary) 19

UNLAWFUL ACTIVITY 19
PENALTIES 20
FEEDBACK WITH THE MEMBERS 20
REPORTING TO THE HEALTH PLAN 20
REPORTING TO REGULATORY AGENCIES 20
COORDINATION WITH RISK MANAGEMENT 21
TRACKING AND TRENDING 21
PROGRAM EVALUATION 21
APPENDIX A: APPEAL TIMEFRAMES 23

PURPOSE

Heritage Provider Network (HPN) and its affiliated Medical Groups shall ensure that it supports the full-service Health Plans in processing appeals pursuant to NCQA, State, and Federal requirements and that it performs the appropriate tracking, consideration and rectification (when appropriate) of appeals given its non-delegated status.

OUR ROLE

HPN and its Medical Groups are not delegated by any full-service Health Plan to process or resolve appeals. However, we shall submit all appeals we receive to the Health Plan for review, per our agreements and non-delegated status with each Health Plan. We will also perform our own internal review and monitoring of appeals for quality and process improvement purposes.

The Medical Groups must also provide written information to the member or their representative regarding appeal procedures available to them through their respective Health Plan, at the following times:

1. Upon involuntary disenrollment initiated by the Health Plan, upon denial of a member's request for routine or expedited review of an organization determination/authorization or appeal, and upon member's request;
2. Upon notification of an adverse organization determination/authorization, and upon notification of a service or coverage termination (e.g., hospital, CORF, HHA or SNF settings including the right to an expedited review; and
3. Quality of care complaint process available under QIO process as described in §1154(a)(14) of the Social Security Act (the Act).

HPN and its Medical Groups will also complete authorization/effectuation of appeals when necessary based on the appeal determination made by the full-service Health Plan or other responsible entity.

POLICY

Each Medical Group shall adopt the HPN Appeals Program. Staff training shall be conducted upon hire, and annually thereafter to ensure the Group complies with the program and the established regulatory guidelines.

1. HPN and the Medical Groups will not discriminate against any member solely on the grounds that the member filed an appeal (including disenrollment or cancellation of contract).
2. HPN and the Medical Groups shall ensure that the linguistic and cultural needs of its member population and of those with disabilities are met. Our process will ensure that all members have access to and can fully participate in the appeal process by providing assistance for those with limited English proficiency, or with a visual or other communicative impairment.
3. HPN and the Medical Groups will ensure that records maintained will be available and accessible to the full-service Health Plan, State, Federal and other regulatory agencies upon request, and be in compliance with Federal and State confidentiality laws, including, but not limited to, Health Insurance Portability and Accountability Act (HIPAA) and 42 C.F.R. 431.300 et seq.
4. Copies of appeals files shall be maintained for no less than five years[1], and shall include a copy

[1] 28 CCR 1300.68(d)(6)

of all medical records, documents, evidence of coverage and other relevant information upon which the Medical Groups reached its decision. All information shall be made available to the member, provider, Health Plan, State, and/or Federal authorized representative upon request.

DEFINITIONS

Appeal

Under California regulations, an "Appeal" is defined as a review by the Health Plan of an Adverse Benefit Determination.[2] While state regulations[3] do not explicitly define the term "Appeal", they do delineate specific requirements for types of Grievances that would fall under the definition of an Appeal. These types of Grievances involve the delay, modification, or denial of services based on medical necessity, or a determination that the requested service was not a covered benefit. The Health Plan shall treat these Grievances as Appeals under California regulations.

Adverse Benefit Determination

An Adverse Benefit Determination[4] is defined to mean any of the following actions taken by a Health Plan:

The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit.

1. The reduction, suspension, or termination of a previously authorized service.
2. The denial, in whole or in part, of payment for a service.
3. The failure to provide services in a timely manner.
4. The failure to act within the required timeframes for standard resolution of Grievances and Appeals.
5. For a resident of a rural area with only one Health Plan, the denial of the beneficiary's request to obtain services outside the network.
6. The denial of a beneficiary's request to dispute financial liability.
7. A denial for a service, solely because the claim does not meet the definition of a ''clean claim'' is not an adverse benefit determination.
    a. A clean claim is one that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a State's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

Notice of Action

A formal letter informing a beneficiary of an Adverse Benefit Determination.
DHCS will retain use of "NOA" for ease of understanding.

Notice of Adverse Benefit Determination[5]

A formal letter informing a beneficiary of an Adverse Benefit Determination. Under Medi-Cal regulations the term "Notice of Action" (NOA) has been replaced with "*Notice of Adverse Benefit Determination.*"

[2] Title 42, CFR, Section 438.400(b)
[3] Title 28, CCR, Sections 1300.68(d)(4) and (5
[4] Title 42, CFR, Section 438.400(b)
[5] Title 42, CFR, Section 438.404

Notice of Appeal Resolution
A "Notice of Appeal Resolution" (NAR) is a formal letter from a Managed Care Plan (MCP) informing a member of the outcome of the appeal of an adverse benefit determination. The NAR informs the member whether the MCP has overturned or upheld its decision on the adverse benefit determination.

Grievance[6]
A Grievance is an expression of dissatisfaction about any matter other than an *Adverse Benefit Determination*. Grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, and the beneficiary's right to dispute an extension of time proposed by the Health Plan to make an authorization decision.

W*hile the state definition does not specifically distinguish "Grievances" from "Appeals," federal regulations define "Grievance" and "Appeal" separately.*[7] *Due to distinct processes delineated for the handling of each, Health Plans shall adopt the federal definition but also incorporate applicable sections of the existing state definition that do not pose conflicts.*

Complaint
A complaint is the same as a Grievance. Where unable to distinguish between a Grievance and an inquiry, it shall be considered a Grievance.

Inquiry
An inquiry is a request for information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other Health Plan processes.

Reconsideration
Under Part C, the first level in the appeals process which involves a review of an adverse organization determination by an MA Plan, the evidence and findings upon which it was based, and any other evidence submitted by a party to the organization determination, the MA plan or CMS. The term may also refer to the second level of appeal in the Part C appeals process in which an independent review entity reviews an adverse plan decision.

Reopening
A remedial action taken to change a binding determination or decision even though the determination or decision may have been correct at the time it was made based on the evidence of record.

Withdrawal
A verbal or written request to rescind or cancel a grievance, initial determination, or appeal.

Independent Review Entity (IRE)
An independent entity contracted by CMS to review adverse level 1 appeal decisions made by the plan. Under Part C, an IRE can review plan dismissals.

Resolved
Means that the appeal has reached a final conclusion with respect to the member's submitted appeal, and

---
[6] Title 42, CFR, Section 438.400(b)
[7] Title 42, CFR, Section 438.400(b)

there are no pending member appeals within Medical Group's grievance system, including entities with delegated authority.

1. If the Health Plan has multiple internal levels of appeal resolution, all levels must be completed within 30 calendar days of the Health Plan's receipt of the grievance. Appeals that are not resolved within 30 calendar days, or appeals referred to the Department's complaint or independent medical review system, shall be reported as "pending" grievances.
2. Appeals referred to external review processes, such as reviews of Medicare Managed Care determinations pursuant to 42 C.F.R. Part 422, or the Medicaid/Medi-Cal Fair Hearing process, shall also be reported until the review and any required action by the Health Plan resulting from the review is complete.

Same Specialty
Refers to a practitioner with similar credentials and licensure as those who typically treat the condition or health problem in question in the appeal.

Similar Specialty
Refers to a practitioner who has experience treating the same problems as those in question in the appeal, in addition to experience treating similar complications of those problems.

STAFF RESPONSIBILITY

Designated Physician

The Quality Medical Director is the designated physician who is involved in the Appeal Program and will review each medical necessity appeal received on a retrospective basis to potential opportunities for Quality Improvement. The Physician will make recommendations based on various analyzed clinical care and administrative data. He/she may also refer cases to the Quality Improvement Committee (QIC) and/or Utilization Management Committee (UMC) for more intensive review. Documented evidence of the Medical Director's review shall be maintained in each case file, including withdrawn/dismissed cases.

1. He/she must be a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the appeal, and/or health care services requested by the provider or member.
2. The designated physician must determine that he/she is competent to evaluate the specific clinical issues presented. If the designated physician determines that he/she is not competent to evaluate the specific clinical issues of the appeal, he/she shall consult with an appropriately licensed health care provider who is competent to evaluate the specific clinical issues presented. The reviewer must have the education, training, and relevant expertise that are pertinent for evaluating the specific clinical issues that serve as the basis of the appeal.
3. The Medical Director or designee cannot review a request twice. The appeal review must be completed by a physician not involved in the initial determination.
4. If there is a conflict of interest, the Medical Director or their designee involved in the review process must remove themselves from the case. No persons shall be involved in the review process of Quality Improvement issues in which they were directly involved. Another qualified reviewer must be assigned.
5. The Medical Director or their designee's review must state their rationale, and refer back to the specific guideline, provision in the contract, Evidence of Coverage (EOC), criteria, or member

handbook that for which their determination was based. It must be in clear and concise language that explains how it applied to the specific health care service, or quality of care issue presented.

Designated Behavioral Health Care Practitioner

The Medical Director of the Medical Group's contracted Behavioral Health Care provider shall be available for assistance with behavioral health appeals.

Quality Director and/or Quality Manager

The Quality Director and/or Quality Manager are designated as having the primary responsibility for the Appeals Program and shall continuously review the operation of the appeal processes to identify any emergent patterns to improve service/care and to improve our policies and procedures.

The Quality Director and/or Quality Manager will identify and report patterns of appeals to the QM Medical Director, UM Medical Director, UM Director/Manager, and the QIC/UMC to formulate policy changes and procedural improvements.

Utilization Management, Case Management, and Claims

Other Management shall be responsible for the operational area that is subject to the appeal received. They shall promptly review the appeal, conduct an internal review, and provide a written detailed report to the Quality Director and/or Manager for review.

Customer Service Director and/or Customer Service Manager

The Customer Service Director and/or Customer Service Manager shall oversee and monitor all appeals received by telephone. The member shall be directed to and/or assisted in the filing their appeal with the Health Plan. The Customer Service Director/Manager or their designee will identify and report patterns of member appeals to formulate policy changes and procedural improvements.

After Hour Coverage

The appeals system shall allow for the Health Plan, State Agency, and/or QIO Organization to contact us regarding urgent appeals twenty-four hours a day, seven days a week. The Medical Group is required to provide medical records, and other documents, to the Health Plan per request and per Heath Plan stated timelines.

1. During normal work hours, the Medical Group shall respond to the Health Plan, State Agency, and/or QIO Organization within 30 minutes, or specified time period if less than thirty minutes, after initial contact.
2. During non-work hours, the Medical Group shall respond to the Health Plan, State Agency, and/or QIO Organization within one hour after initial contact, unless other time frame is specified.
3. The Medical Group will ensure the appeals system has provisions for scheduling qualified representatives, including back-up plan representatives as necessary, to be available twenty-four hours a day, seven days a week to respond to the Health Plan, State Agency, and/or QIO Organization contacts regarding urgent appeals.

QI AND UM COMMITTEE FUNCTIONS

The Quality Improvement Committee and the Utilization Management Committee oversee the appeals functions and activities provided by the Designated Physician, assigned Quality Management staff, and assigned Utilization Management staff. These Committees are composed of participating practitioners who represent primary care and commonly used specialties and shall be responsible to:

1. Develop, implement and oversee the Appeal Program.
2. Direct the investigation of identified and suspected problems and direct the responsible parties to implement action.
3. Recommend corrective action for resolution of appeals.
4. Institute corrective action for cases where serious harm and injury have occurred to the member.
5. Recommend education/training programs.
6. Recommend new policies and/or procedures, or policy, procedure, and/or program changes based on their findings.
7. Recommend follow-up with the member and assistance as needed to ensure that the immediate health care needs are met.
8. Conduct periodic review, including tracking and trending of appeals received no less than quarterly.

The QI and UM Committees will ensure follow-up as appropriate on potential problems or poor performance until resolution is achieved and interventions are implemented to prevent future recurrences.

TYPES OF APPEALS

Pre-Service Appeal

A pre-service appeal is a request to change an adverse determination for care or services that the organization must approve, in whole or in part, in advance of the member obtaining care or services.

Post Service Appeal

A post service appeal is a request to change an adverse determination for care or services that have already been received by the member. These are generally claims appeals, and different standards may apply.

External Appeal

An external appeal is a request for an independent, external review of the final adverse determination made by the Health Plan through its internal appeal process.

Expedited Appeal

An expedited appeal is a request to change an adverse determination for care or services which are "Urgent". Expedited appeals are only applicable for pre-service appeals.

Urgent

Any request for medical care or treatment with respect to which the application of the period for making non-urgent determinations could result in the following circumstances.

1. Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment, ***or***
2. In the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that

is the subject of the request.

All Health Plan members have the right to request an expedited initial determination and/or an expedited appeal for situations that are considered "Urgent."

DMHC APPEALS PROCESS

If the member or provider/practitioner on behalf of a member is dissatisfied with a Utilization Management decision to deny or modify a requested service, he or she may initiate an appeal by telephone, fax, in writing, or on the Health Plan's website. Groups' Customer Service staff and our providers/practitioners may refer members to the website for additional information on how to file a member appeal.

Standard Appeal: If the Health Plan decides not to cover or continue the requested service or item, the plan then has 30 days from the receipt of the ***service request*** for appeal to notify the member of its decision. For a ***payment requests***, the plan has 60 days from the receipt of the request for appeal to notify the member of its decision.

Expedited Appeal - The plan must notify the member of its decision within 72 hours if it determines that the member's health or life could be seriously harmed by waiting for a decision in the standard period.

Voluntary Second Level Review to the Health Plan

1. If the member or provider still disagrees with the first level decision, they may send the Health Plan a request for a second-level review. The second level review is voluntary.
    - If the Group receives a request for a second level review, it will route the request to the Health Plan.
2. The member or provider must file the request for second level review within sixty (60) days of receiving the Health Plan's first level decision. The member or provider must explain the reason for their dissatisfaction with the first level decision, and provide any additional information they may think should be considered.
3. Generally, another physician will review the appeal. A physician reviewer who did not make the initial decision shall be appointed.

Level 2 Appeal – Application for Independent Medical Review (IMR)

We are not delegated for IMR by the Health Plans. We will assist the Health Plan as necessary to meet regulatory requirements and timelines. The member may designate an agent to act on his or her behalf. The physician may join with or otherwise assist the member in seeking an independent external review and may advocate on their behalf.

Criteria for IMR

The member may request an IMR if:

1. The member's provider has recommended a health care service as medically necessary.
2. The member has received urgent care or emergency services that a provider determined was medically necessary.
3. The member, in the absence of a provider recommendation or the receipt of urgent care or emergency services by a provider has been seen by an in-network provider for the diagnosis or treatment of the medical condition for which the member seeks independent review.
4. The Health Plan did not meet routine and expedited determination time frames.

5. He/she has filed an appeal with the Health Plan and the disputed decision is upheld.
6. He/she has filed a grievance with the Health Plan for expedited review, and it remains unresolved after three days.
7. He/she has filed a grievance with the Health Plan and the grievance remains unresolved after 30 days.

Note: *The member's provider may be an out-of-network provider, however the Medical Group will have no liability for payment of services provided by an out-of-network provider, except as specified by State law.*

Documents for Submission

Upon notice that the member has applied for an independent external review, the Health plan will notify the Medical Group. The Medical Group shall provide the Health Plan with a copy of all requested documents the same business day upon receipt of their notice, or other timeline as specified by the Health Plan.

Timeframes for Submission

All attempts must be made to assist the Health Plan in processing the case. Timelines for the Health Plan submission of all documents to the State department are: three (3) business days for a regular review and within one (1) calendar day in the case of an expedited review.

Additional Records Requested

Any medical records or other relevant matters not available at the time of the initial notification, or that result from the member's on-going medical care or treatment for the medical condition or disease under review, must be submitted to the Health Plan when requested. Such matters shall be forwarded as soon as possible upon receipt by the Medical Group. The Health Plan must process the request within five (5) business days in routine cases or one (1) calendar day in expedited cases.

Expedited Review / Imminent Harm and Serious Threat to the Member

1. In cases of imminent and serious threat to the health of the member, which include, but are not limited to, serious pain, the potential loss of life, limb or major bodily function, or the immediate, and serious deterioration of the health of the member, all necessary information and documents must be delivered to the independent medical review organization within 24 hours of approval of the request for review.
2. In cases involving a claim for out of plan emergency or urgent services that a provider determined were medically necessary, the independent medical review shall determine whether the services were emergency or urgent services necessary to screen and stabilize the member's condition.
3. In reviewing a request for review, the State or Federal agency may waive the requirement that the member follow the grievance provides in extraordinary and compelling cases, where it is determined that the member has acted reasonably. The request will be reviewed expediently, and the member notified of the determination.

Investigational Therapy

Members may request an independent medical review when the Health Plan has denied a therapy or medical service that would otherwise be covered based on the plan's determination that the therapy or medical service is experimental or investigational. The Groups are not delegated to perform experimental

or investigational reviews.

Level 3 Appeal: State Fair Hearing

Either at the conclusion of the first level review, or if the member or provider choose not to pursue a voluntary second level review, or at the end of the second level review, if they are still dissatisfied with the Health Plan's decision, they may pursue for judicial remedies by bringing a civil action under section 502(a) of ERISA (the Employee Retirement Income Security Act of 1974). A state fair hearing occurs where the appeal is presented before an administrative law judge.

The written request for a state fair hearing are filed with the Health Plan, who will forward the written request to State to schedule a hearing. State fair hearings are only available when a Health Plan issues a decision on an appeal or "action". The Health Plan's decision on a grievance is final.

Requests for a State Fair Hearing are noted on the Notice of Action form. Requests can be made by calling the division directly, using their toll-free telephone number, facsimile, or by mail. The Medical Group will assist the Health Plan and provide medical records and documents needed in the adjudication of the appeal. The voluntary review will not affect the member's rights to any other Health Plan benefits.

The member or the member's representative may choose to be represented by a friend, an attorney, or another person at the State Fair Hearing. The member or the member's representative may also call the State Ombudsman for further assistance.

Level 4 Requests for Rehearing

The member has a right to request a rehearing. The request for rehearing must be done within 30 days of release of initial hearing decision or 180 days with good cause. The Judge has 75 days to submit his/her decision and DHCS has 30 days to adopt or reject the decision.

Level 5 State Court

The member has the right to skip a request for rehearing and file a claim in state court. Filing a claim in state court must be filed within one (1) year of final decision.

MEDI-CAL MANAGED CARE APPEAL PROCESS

Level 1 Health Plan Appeal

A member, a provider or an authorized representative either orally or in writing may file an appeal within 60[8] calendar days of the date services or benefits were denied, or 180 days with good cause. Appeals filed by the provider on behalf of the member requires written consent from the member.[9] The Medi-Cal Health Plan will review the member's appeal and respond within 30 calendar days, or sooner, if expedited.

If a **physician determines the member has an urgent health condition** and they file an appeal within 10 days of receiving the notice of action, then the plan must give a response within three (3) calendar days. While the plan is making the decision the benefits continue.

Level 2 Appeal: Independent Medical Review

The member may ask for an Independent Medical Review through the Department of Managed Health Care if the NOA indicates that the member's treatment is "not medically necessary, experimental or investigational". The member may ask for an IMR after 30 days from the date the grievance is filed or as soon as it's denied, whichever comes sooner.

Level 3 Appeal: State Fair Hearing Process

A request for a State Fair Hearing must be filed through the Department of Social Services. A member may request a State Fair Hearing only after filing an internal appeal with the full-service Health Plan and receiving notice that the Adverse Benefit Determination was upheld.[10] The request for hearing must be filed within 120 calendar days from the date of the NAR, which informs the beneficiary that the Adverse Benefit Decision has been upheld[11] , or180 days with good cause. An expedited hearing must be resolved within 10 calendar days. Benefits continue pending review (Aid Paid Pending) if the hearing is filed within 10 days of action. This allows the member to continue receiving the services while the case is being reviewed.

Standard Hearings

The Health Plan shall notify beneficiaries that the State must reach its decision within 90 calendar days of the date of the request.[12]

Expedited Hearings

The Health Plan shall notify beneficiaries that the State must reach its decision within three (3) working days of the date of the request.[13]

Overturned Decisions

The Health Plan shall authorize or provide the disputed services promptly and as expeditiously as the beneficiary's health condition requires, but no later than 72 hours from the date it receives notice reversing the determination.[14]

---

[8] Title 42, CFR, Section 438.402(c)(2)(ii)
[9] Title 42, CFR, Sections 438.402(c)(1)(ii)
[10] Title 42, CFR, Section 438.404(b)(3)
[11] Title 42, CFR, Sections 438.408(f)(1) and (2)
[12] Title 42, CFR, Section 431.244(f)(1
[13] Title 42, CFR, Section 431.244(f)(2
[14] Title 42, CFR, Section 438.424(a)

Level 4 Requests for Rehearing
DHCS determines if a rehearing is allowed. The request for rehearing must be filed within 30 days of release of initial hearing decision or 180 days with good cause. The Judge has 75 days to submit his/her decision and DHCS has 30 days to adopt or reject the decision.

Level 5 State Court
Filing a claim in state court must be filed within one (1) year of final decision.

MEDICARE ADVANTAGE (PART C) APPEALS PROCESS

Level 1 Appeals (Reconsiderations)
A party to the enrollee to an adverse initial determination has a right to a reconsideration by the plan. A reconsideration consists of a review of an adverse initial determination, the evidence and finding upon which it was based, and any other evidence that the parties submit or that is obtained by the plan.

The parties to an organization determination for purposes of an appeal include:

- The enrollee (including his or her representative);
- An assignee of the enrollee (i.e., a physician or other provider who has furnished a service to the enrollee and formally agrees to waive any right to payment from the enrollee for that service);
- The legal representative of a deceased enrollee's estate; or
- Any other provider or entity (other than the MA plan) determined to have an appealable interest in the proceeding.

Who May Request a Level 1 Appeal

Type of Requests	Who May Request An Appeal
Standard Pre-Service Reconsideration	• An enrollee; • An enrollee's representative; • The enrollee's treating physician acting on behalf of the enrollee*or staff of physician's office acting on said physician's behalf (e.g., request is on said physician's letterhead).; or • Any other provider or entity (other than the MA plan) determined to have an appealable interest in the proceeding.
Standard Payment Reconsideration	• An enrollee; • An enrollee's representative; • Non-contract provider or • The legal representative of a deceased enrollee's estate.
Expedited Reconsideration	• An enrollee; • An enrollee's representative; • Any physician or staff of physician's office acting on said physician's behalf (e.g., request is on said physician's letterhead) acting on behalf of the enrollee.

Withdrawal of Request for Level 1 Appeal
The party who files a request for a level 1 appeal may withdraw the request in writing at any time before an appeal decision is mailed by the plan. A plan may also accept withdrawal requests verbally, provided that the plan mails a written confirmation of the withdrawal to the party within 3 calendar days from the

date of the verbal request. The written confirmation should clearly indicate which request is being withdrawn (i.e. name of drug or type of service or item requested). If the withdrawal request is received after the plan has forwarded the case file to the IRE, then the plan must forward the withdrawal request to the IRE for processing.

Automatic Forward to Level 2 Appeals - If during a Level 1 Appeal reconsideration the plan fails to meet established deadlines or does not decide in favor of the member, the plan is required to forward the appeal to an independent outside entity.

Table 1.

Level 1 Appeal Time Frames		
Type	**Part C**	**Part C with Extension**
Standard Pre-Service or Benefit	**30 days**	**44 days**
Expedited Pre-Service or Benefit or Part B Drug	**72 hours**	**17 days***
Standard Part B Drug	**7 Days**	**NA***
Payment	**60 days**	**N/A**

** *Part B Drug timeframes cannot be extended.*

Level 2 Appeals

Level 2 Appeals: Part A & B

A Qualified Independent Contractor (QIC), retained by CMS, will conduct the Level 2 appeal, called a *reconsideration* in Medicare Parts A & B. QICs have their own physicians and other health professionals to independently review and assess the medical necessity of the items and services pertaining to the case. The QIC will notify members of a decision within 60 days. If the request for reconsideration is expedited, the QIC will notify members of its decision on the reconsideration within 72 hours of receiving the request.

Level 2 Appeals: Part C

An Independent Review Entity (IRE) retained by CMS, will conduct the Level 2 appeal, called a *reconsidered determination* in Medicare Part C. IREs have their own doctors and other health professionals to independently review and assess the medical necessity of the items and services pertaining to the case.

If the IRE disagrees with the MA plan, they will send a letter to the member and the plan about its decision and tell the plan to provide or pay for the service or item.

If the IRE agrees with the MA plan, they will send the member a letter about its decision and information about the next level of appeal.

Table 2.

Level 2 Appeal Time Frames	
Type	**Part C**
Standard	**Pre-service: 30 days** **Payment: 60 days**

Expedited	72 hours

Level 3 Appeals: Administrative Law Judge (ALJ)
If the member disagrees with the outcome of the Level 2 appeal (called a *reconsideration* or *reconsidered determination*), the member or their representative can request the dismissal or decision be reviewed by an OMHA adjudicator. At Level 3 of the appeals process, the appeal will be reviewed by an OMHA adjudicator, and the member may have a hearing before an Administrative Law Judge (ALJ).

Review by an OMHA adjudicator gives the member the opportunity to present the appeal to a new person who will independently review the facts of the appeal before making a new and impartial decision in accordance with the applicable law.

In some instances, an OMHA adjudicator may decide a case on the record (for example, if all the parties who would be sent a notice of hearing indicate in writing that they do not wish to appear at a hearing, or if the documentary evidence supports a finding fully favorable to the appellant(s) on every issue and no other party to the appeal is financially responsible for any of the claims at issue). Decisions, dismissals, and remands that do not require a hearing may be issued by an adjudicator.

Timeframes to Request a Review
At the *third, fourth, and fifth* levels of review, the request must be filed within 60 calendar days of receipt of a decision or dismissal from the IRE, ALJ/attorney adjudicator, or the Council, respectively.

Timeframes to Complete Review
There are no statutory or regulatory decision-making timeframes for Part C appeals at the third level of review and beyond. [15]

Level 4 Appeals: Medicare Appeals Council
The Medicare Appeals Council does not review every case it receives. If the Council decides not to review the member's case, the member, or the plan may ask for a review by a Federal court (No amount in controversy).

Level 5: Federal Court
To appeal the Medicare Appeals Council's decision, the member must file a lawsuit in Federal district court if the amount in controversy is $1,630 or more (in 2019). This is the last level of appeal.[16]

Timeframes to Request a Review by Federal Court
The member has 60 days from the date of the Medicare Appeals Council's written decision to request a review by a Federal court if the amount in controversy is $1,630 or more. This is the fifth and last level of appeal.[17]

Hospital Discharge Appeals
Important Message from Medicare
Hospitals are required to deliver the *Important Message from Medicare* (IM), CMS-R-193, to all Medicare beneficiaries (Original Medicare beneficiaries and Medicare Advantage plan enrollees) who are hospital

[15] 42 CFR §422.562(d)
[16] https://www.cms.gov/medicare/appeals-and-grievances/mmcag/fed.html
[17] https://www.cms.gov/medicare/appeals-and-grievances/mmcag/fed.html

inpatients. [18] The IM informs hospitalized inpatient beneficiaries of their hospital discharge appeal rights.

- The hospital must provide the notice at or near admission, but no later than two (2) calendar days following the member's admission to the hospital.

- The IM notice must be signed and dated by the beneficiary (patient or appointed representative) to acknowledge receipt. The IM notice must contain essential information:
    - The name(s) of the patient's physician(s) and the patient's ID number.
    - A statement of the right to file an appeal or raise questions with a QIO about quality of care, including hospital discharge.
    - The name and telephone number of the QIO that serves the area in which the hospital in question is located.
    - A space for the beneficiary or representative to sign and date the document

QUALITY IMPROVEMENT ORGANIZATION (QIO)

QIOs monitor the appropriateness, effectiveness, and quality of care provided to Medicare beneficiaries. They are private contractor extensions of the federal government that work under the auspices of the U.S. Centers for Medicare and Medicaid Services (CMS).

When a Medicare health plan, either directly or by delegation, terminates pre-authorized coverage of an inpatient hospital admission or Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF) services, a special expedited review procedure applies. Expedited review requests filed timely bypass the health plan's reconsideration process, and an independent review entity known as a Quality Improvement Organization (QIO) performs the review.

Appeals received under Medicare may be acted upon by the Health Plan under their appeals process, and by an independent organization called the QIO, or by both. For example, if an enrollee believes he/she is being discharged from the hospital too soon, the enrollee may file an appeal with the QIO in addition to or in lieu of a complaint/appeal filed with the Health Plan.

The member has the right to request information from Medicare by calling: 1-800-MEDICARE (1-800-633-4227; TTY 1-877- 486-2048), 24 hours a day, 7 days a week.

For any appeal filed with the QIO, the Health Plan and the Medical Group will cooperate fully with the QIO in resolving the dispute. The Medical Group will assist the QIO and Health Plan to obtain documents relevant to the member's appeal and as requested. The link below identifies the QIO associated by region: QIO by Region

HPN APPEALS PROCESS

Routing Appeals to the Health Plan

HPN, the Medical Groups, each contracted facility and practitioner shall direct its members or the member's representative to their respective Health Plan, and instruct him/her how to file an appeal with the plan. Appeal forms and a brief description of the appeal procedure shall be provided with the Health Plan's mailing address, URL address, and toll free telephone number or local telephone number readily

[18] 42 CFR 422.62 (b) 1 & 2

available to the member upon request.

All appeals received by mail, email, and telephone must be forwarded to the Health Plan for handling.

Member Representation

The member may be represented by anyone he/she chooses. The representative can be a family member, friend, advocate, attorney, doctor or someone else to act on their behalf. The member has the right to have a representative act on their behalf at all levels of appeal.

By Mail or Email

For member appeals received by U.S. mail, the envelope and letter shall be date stamped. The letter shall be forwarded to the Health Plan for processing. HPN does not advise receiving or sending PII and PHI information via e-mail. The member will be referred to contact the Health Plan's Customer Service representative for filing.

By Telephone

The Group's Customer Service representative will assist the member in filing an appeal to the Health Plan using one of the following methods:

1. Providing the member with the Health Plan's Customer Service telephone number which is located at the back of the membership card and/or referencing to the "HPN Health Plan Contact List."
2. Directing the member to the Health Plan's website to their on-line form. The member shall be assisted to complete the on-line form, as needed.
3. Providing the member with the Health Plan's mailing address. A form can be mailed to the member upon request and based on their language preference.
4. Warm transfer of the member to the Health Plan's Member Services representative.

Support for Filing Appeals for Hearing and Speech Impaired Members

All members with hearing and speech impairment shall be provided with assistance. Such assistance shall include, but is not limited to, TDD telephone number, translations of appeal procedures, forms, and plan responses to appeals, as well as access to interpreters, telephone relay systems and other devices that aid disabled individuals to communicate.

Support for Filing Appeals for Members with Linguistic and Cultural Needs

We recognize that the hearing and speech impaired have special needs, and need to recognize their individuality and attend to their requests quickly and promptly. Our goal is to address problems experienced by children and adults who are deaf or hard of hearing and ensure their needs are met.

1. All members with disabilities and who have linguistic and cultural needs shall have access to and fully participate in the appeal process by providing assistance for those with limited English proficiency or with a visual or other communicative impairment.
2. Such assistance shall include, but is not limited to, translations of appeal procedures, forms, and plan responses to appeals, as well as access to interpreters, telephone relay systems and other devices that aid disabled individuals to communicate.
3. Forms shall be available in Spanish and English, and/or the member's language of choice. They shall be made easily accessible to the member on-line and in print and be readily available at the

member's request.

Receipt of Appeals from the Health Plan

HPN is not delegated to process appeals, but will assist the Health Plan in resolution of the appeals received. Appeals are sent to the Group's Quality Management (QM) Department from the full-service Health Plan via facsimile or secured email. A worksheet/form will be prepared by the assigned QM staff upon receipt of the appeal from the Health Plan to document the details of the appeal.

Record Maintenance

A written case record shall be made for each appeal received by the Medical Group, including the date received, the staff person recording the appeal, a summary of other documents describing the appeal, all aspects of clinical care involved, and its disposition. Any communication to the member and provider regarding the appeal will be completed by the full-service Health Plan.

The written record shall be reviewed by the Medical Director, his/her designee, and/or the Quality Improvement Committee. The findings and their review shall be thoroughly documented in the appropriate system.

Internal Review

Each Medical Group conducts an internal review of appeals received by the Health Plan to assist in process improvement. This process is as follows:

1. Appeal is received by secure email or facsimile from the Health Plan.
2. Medical Group representative fills out the worksheet, noting the appeal as stated by the appellant in quotation marks.
3. A case "incident" file is opened in the customer service module, indicating the date received.
4. Prioritization of action(s) needed to resolve immediate care needs, when appropriate.
5. Obtain denial packet, and request medical records/supporting documents from the provider(s) relevant to the case.
6. Document any/all conversations relevant to the case in the data base system.
7. Attach UM criterion used in making the determination.
8. Examination of completed case file, and communication with involved individuals / providers if additional information is required.
9. The case file is forwarded to the assigned physician reviewer.

Physician Review of Appeals

After receiving the appeal, the Medical Director will review the issue, including any new information brought to our attention, including withdrawn/dismissed cases.The reviewer shall:

1. Review the appeal received.
2. Review the case file and all supporting documents.
3. Review trend reports and evaluate overturned initial determinations
4. Make a determination – Does the Physician Reviewer agree or disagree with the Health Plan determination with supporting rationale.

5. Record his/her expert opinion; and criteria used to make determination. A written response from or summary of the documents received.
6. Recommend interventions to resolve, and prevent similar incidences from recurring.
7. Determine if the appeal shall be forwarded to the department management for the deficient operational area that is the subject of the appeal review.
8. Determine if the appeal shall be forwarded to the Quality and/or Utilization Management committee(s) for additional peer review.
9. Report his/her findings to the Quality and/or Utilization committees.
10. Report to the Health Plan, if indicated.
11. Report to the appropriate County, State or Federal regulatory authority and/or agency, if indicated.

Documentation of Appeal Outcome

The Medical Director or assigned physician reviewer will assign an appeal resolution status for each appeal received based on the appeal determination rendered by and provided to the Group by the Health Plan and/or Regulatory Agency. The status codes are:

1. **Overturn Health Plan** – The Health Plan does not agree with the Medical Group's initial determination and authorizes services.
2. **Overturn Regulatory Agency** – A State or Federal agency does not agree with the Medical Group's initial determination and authorizes services.
3. **Uphold Health Plan** – The Health Plan agrees with the Medical Group's determination to deny requested services.
4. **Uphold Regulatory Agency** – A State or Federal agency agrees with the Medical Group's or initial determination to deny requested services.
5. **Unable to determine** – The appeal was sent to the Health Plan, IRE, and/or IRO and the determination is still pending.

Documents Sent to Health Plan

The Medical Group's rationale for which the initial determination was based, medical records, and any other supporting documents relevant to the appeal will be forwarded to the Health Plan for review at the time the appeal is routed to the Health Plan or upon request from the Health Plan. If an authorization is issued as a result of the appeal determination rendered by the Health Plan and/or Regulatory Agency, documented evidence shall be faxed to the Health Plan for closure of the case file.

Notification to Member and/or Provider

Any written and/or oral notification of an appeal decision to the provider or member is completed by the full-service Health Plan and/or Regulatory Agency (or Independent Review Entity acting on its behalf).

Authorization/Effectuation (As Necessary)

Upon receiving the decision that a disputed health care service is medically necessary, the Medical Group shall promptly effectuate the decision. Authorization of services must occur upon receipt of the written decision from the Health Plan and shall inform the member and provider of the authorization. Timeframes for effectuation are subject to State and federal regulation as well as contractual agreements.

UNLAWFUL ACTIVITY

The Medical Group will not engage in any conduct that prolongs the appeal and/or independent review

process. Failure to promptly implement the decision shall subject the Medical Group representatives to fines, penalties, and other remedies. The member will be reimbursed for any reasonable costs associated with those services if found that the services were a covered benefit, and the member's decision to secure the services outside of the network was reasonable under the emergency or urgent medical circumstances. The Medical Group will be required to promptly reimburse the member for any reasonable costs associated with IMR/IRE actions found in the member's favor.

PENALTIES

Where substantial harm to a member has already occurred because of the decision of the Medical Group, or one of its contracting providers, to delay, deny, or modify covered health care services that an independent medical review determines to be medically necessary penalties may be imposed.

FEEDBACK WITH THE MEMBERS

The Medical Group is not delegated for member communication for appeals. Member communication regarding the disposition of each appeal received is maintained by the full-service Health Plan. At the conclusion of each appeal received the Medical Group may follow-up with the member to ensure their needs were adequately met and to coordinate their care. This may include, but is not limited to:

1. Immediate authorization of services, if previously denied. To include a telephone call the same business day, notifying the member of the reversal of the initial determination.
2. Advocating for the member and providing assistance to ensure that their immediate healthcare needs are met.

REPORTING TO THE HEALTH PLAN

If an adverse event occurred due to a delay in treatment / denial of services, the Medical Group will report the adverse event to the Health Plan.

1. The Medical Group will report to the Health Plan any deviation or suspected deviation from State or Federal program requirements or regulations that impact one or more beneficiaries.
2. The Medical Group will fully disclose to the Health Plan all circumstances surrounding the event to assist them in the completion of their investigation.
3. The Health Plan will be notified upon discovery for all events that place the member in immediate jeopardy.
4. The Health Plan will be notified verbally and in writing within 24 hours of all other incidents. All documents relevant to the case shall be obtained by the Quality Department in collaboration with the Risk Department.
5. The case documents shall be submitted to the Health Plan within seven (7) days of incident.
6. The Medical Group will cooperate with Federal and State designated agencies and the Health Plan in the resolution and closure of all events resulting in harm to the member.

REPORTING TO REGULATORY AGENCIES

The Medical Group may notify and report to the appropriate regulatory agency and/or State and Federal agency for further research/review or action on appeals received which resulted in an adverse negative outcome to the member.

Initial reporting may be made verbally, but must be followed by a written report within one (1) business day. The Medical Group must ensure that member health records are available and accessible to authorized staff of their organization and to appropriate State and Federal authorities, or their delegates. Member record availability and accessibility must in in compliance with Federal and State confidentiality laws. Information must be available to regulatory agencies upon request.

COORDINATION WITH RISK MANAGEMENT

For cases identified as potential risk management issues, the QM Department advises the Corporate Compliance / Legal Department of the issue and forwards the case file for review. Corporate Compliance and Quality Management coordinate their efforts where they overlap to ensure better alignment of patient safety initiatives and use of resources.

TRACKING AND TRENDING

HPN and the Medical Groups also track quality of care investigations to identify trends or patterns of issues that may be either provider specific or system-wide. If significant negative trends are noted, the issue may be considered as the topic for a performance improvement activity to improve the issue resolution process itself, and to make improvements that address other system issues raised in the resolution process.

On a quarterly basis, category reports are prepared for a rolling 12-month period. These reports are analyzed prior to the committee meetings by the QM/UM Director/Manager and the Medical Director to determine potential system-wide problems that may need a change in policy and procedure.

1. The appeal system shall track and monitor appeals received by each respective Health Plan. The report shall be presented to the QIC and UMC quarterly for review.
2. The QIC and UMC shall conduct an aggregate analysis of appeals to track and trend potential issues and barriers to care.
3. Evidence of review will be documented in the committee meeting minutes. Meeting minutes will be signed by the respective committee chairperson and the Medical Director and/or Quality Director/Manager.

Reports submitted to the QIC and UMC shall include and not be limited to:

1. Category and volume of appeals as a percentage of membership;
2. Appeals by category and sub-type;
3. Appeals by provider type, including organizational providers such as but not limited to nursing facilities and hospitals;
4. Appeals by line of business and by Health Plan;
5. Appeals by type and exigency (e.g., routine, urgent, expedited, post service); and
6. Appeals by outcome (e.g., resolved in favor, not in favor, dismissed, withdrawn) (uphold and overturn rates).

PROGRAM EVALUATION

There is an annual written evaluation of the appeals received and the overall effectiveness of the program that is reviewed and approved by the QIC / UMC. Benchmark goals are established by HPN and each Medical Group notes this in their evaluation. The program evaluation includes:

1. A summary of aggregate scores and ongoing activities that address the quality and safety of clinical care and quality of service.
2. A trending of measures to assess performance in the quality and safety of clinical care and quality of service.
3. An analysis of the results, including barrier analysis.
4. An evaluation of the overall effectiveness of the Appeals Program, including progress toward influencing network wide safe clinical practices.
5. The impact the process has had on the need for Appeal Program revisions and modifications.
6. Findings that will be used to develop and improve member satisfaction for the upcoming year.

If significant negative trends are noted, HPN and the Medical Group will consider making it the topic for one of its performance improvement activities to improve the issue resolution process, and to make improvements that address other system issues found.

APPENDIX A: APPEAL TIMEFRAMES

Element	National Committee for Quality Assurance	Department of Managed Health Care	Medicaid Managed Care	Medicare Part C
Member filing of appeal to Health Plan from date of NOA *Level 1 Appeal*	180 days	180 days	60 days	60 days
Health Plan acknowledge of receipt	5 days	5 days	5 days	5 days
Routine Appeal **Member Notification/ Resolution**	30 days	30 days	30 days	30 days
Health Plan Determination *Routine/Standard Appeals*	Service 30 days Payment 60 days	Service 30 days Payment 60 days	Service 30 days Payment 60 days	Service 30 days Payment 30 days ** Payment 60 days
Expedited Appeal Member Notification	72 hours	3 calendar days	72 hours	72 hours
Member Filing Second Level Voluntary Appeal	Per State and Federal guidelines	60 days	30 days	N/A
Member Filing Independent Medical Review IMR/IRE *Level 2 Appeal*	Per State and Federal guidelines	30 days from when the appeal is filed with HP or as soon as its denied, and within 6 months	30 days from when the appeal is filed with HP or as soon as its denied, and within 6 months	Automatic Forwarding from the Health Plan
Member Notification IMR/IRE Decision	30 days Routine 72 hours Urgent (with 5 calendar days extension good cause)	30 days Routine 72 hours Urgent	30 days Routine 72 hours Urgent	30 days Routine 72 hours Urgent
Extensions	Per Federal and State Guidelines	None IMR 1 business day urgent IMR 5 business days routine	None IMR 1 business day urgent IMR 5 business days routine	14 Calendar days
Member Filing *Level 3 Appeal*	Per State and Federal Guidelines	State Hearing At the conclusion of the Level 1 review or voluntary second level internal review.	State Hearing 120 Days from NAR	Administrative Law Judge 60 days

Element	National Committee for Quality Assurance	Department of Managed Health Care	Medicaid Managed Care	Medicare Part C
Member Filing Level 4 Appeal	Per State and Federal Guidelines	Re-Hearing 90 day NOA 180 days Good Cause 10 days urgent	Re-Hearing 90 day NOA 180 days Good Cause 10 days urgent	Medicare Appeals Council 60 days
Member Filing Level 5 Appeal	Per State and Federal Guidelines	State Court (1) year of final decision	State Court (1) year of final decision	Federal Court 60 days

**Regulations vary by State and Territory, in the Commonwealth of the United States (that is, Puerto Rico), or the District of Columbia, therefore please refer to your state regulations for your State specific time frames.*