FIDA Integrated Appeal and Grievance Process FAQ – Updated 3/1/18

Q1. Do we use the integrated appeal and grievance process that was created for FIDA for appeals and grievances related to Part D benefits?

A1. No, appeals and grievances for Part D benefits should follow the standard Medicare Part D rules and procedures for appeals and grievances.

Q2. Do we use the integrated appeal and grievance process that was created for FIDA for appeals and grievances related to Medicaid prescription drug benefits?

A2. Yes. Medicaid prescription drug determinations follow the integrated process. They are considered standard appeals, however notice of decision must be given within seven (7) days of receipt of the appeal, orally or in writing.

Q3. The Acknowledgment of Appeal notice includes an insert stating that participants will continue to get the disputed service while their appeal is processing. Are plans supposed to automatically continue the benefits or does the participant need to request continuation?

A3. Plans should automatically continue the participant's benefits (and include the referenced text on the Acknowledgement of Appeal notice) if:

1) The action involves a stoppage, reduction, or restriction of a previously authorized benefit, and
2) The appeal was received within ten (10) days of the Integrated Care Denial Notice (ICDN) postmark date or the date the action was intended to take effect, whichever is later.

Q4. If a 14-day decision extension was initiated by the Plan or Participant, can the FIDA Plan make an appeal decision before the new deadline?

A4. A Plan may only issue a decision before the new deadline if doing so is in the participant's best interest. For example, if a Plan extends the deadline and then decides to issue a fully favorable decision, the Plan may issue its decision before the date of the new deadline.

Q5. May Plans extend the Level 1 appeal decision timeframe by more than 14 days if the request to do so comes from the Participant (and not the Plan)?

A5. No. Plans may only extend the decision timeframe by up-to 14 additional days, even when the Participant requests the extension (or wants to schedule an in-person review) after this date.

Q6. When should the FIDA Plan send the Appeal Decision Notice to the participant (and their representative, as applicable)?

A6. For Expedited Appeals, barring an extension, FIDA plans must decide the appeal as fast as the Participant's condition requires, but never later than seventy-two (72) hours of receipt of the Appeal (orally or in writing). The FIDA plan must make reasonable efforts to provide prompt oral notice in-person or by phone, no later than seventy two (72) hours after receipt of the Appeal. After attempting oral notice, whether successful or not, the FIDA Plan has two (2) calendar days to send the Appeal Decision Notice.

For most Standard Appeals, barring an extension, FIDA Plans must send the Appeal Decision Notice as fast as the Participant's condition requires, but never later than thirty (30) calendar days from the date of receipt of the Appeal (orally or in writing).

For Medicaid prescription drug appeals, barring an extension, FIDA Plans must send the Appeal Decision Notice as fast as the Participant's condition requires, but never later than seven (7) calendar days from the date of receipt of the Appeal (orally or in writing).

For appeals on retroactive claims or payment denials, barring an extension, FIDA Plans must send the Appeal Decision Notice as fast as the Participant's condition requires, but never later than sixty (60) calendar days from the date of receipt of the Appeal (orally or in writing).

Q7. Are participants required to follow an oral filing of an appeal with a written filing?

A7. No. Participants are not required, and cannot be required, to follow an oral filing of an appeal with a written filing. The participant may choose to submit supplemental written information for the plan to consider during its review, but he/she may not be required to follow an oral appeal with a written filing.

Q8. Can plans delegate all or part of the Medicaid drug appeal process to their Pharmacy Benefits Manager (PBM)?

A8. Yes, plans can delegate all or part of the Medicaid drug appeal process to their PBM as long as the process is seamless to FIDA participants (e.g. Participants are not burdened with extra steps or multiple phone numbers, address, etc.) and the Plan monitors the PBM to ensure compliance with requirements.

Q9. Can a delegated vendor send out an Integrated Care Denial Notice (ICDN) (e.g., PBM, behavioral health vendor, etc.)?

A9. Yes. Similar to plans delegating Part B drug functions to PBMs, plans may delegate such functions to vendors as long as the regulatory requirements under 42 CFR 422.504(i) are met. ICDNs sent by delegated vendors must prominently display the FIDA Plan name.

Plans should also note Section IV.F of the Interdisciplinary Team (IDT) Policy: "When decisions are made by the FIDA Plan outside of the IDT meetings, such decisions must be communicated to the Care Manager and recorded in the shared, accessible Participant record (i.e. Comprehensive Participant Health Record) and then must be communicated to all IDT members within one business day of the decision."

Q10. What is the standard for getting an expedited appeal review?

A10. Plans must grant an expedited determination if applying the standard timeframe could

seriously jeopardize the life or health of the participant or the participant's ability to attain, maintain, or regain maximum function.

Q11. Are plans required to send the Acknowledgement of Appeal notice for expedited appeals? If so, and if the appeal is resolved on the same day as the request, can it be mailed in the same envelope as the Appeal Decision Notice?

A11. No. Plans are not required to send the Acknowledgement of Appeal notice for expedited appeals, assuming the FIDA Plan resolves the expedited appeal within seventy-two (72) hours of receipt and properly notifies the Participant of the decision. However, if the plan chooses to send the Acknowledgment of Appeal notice, it can be sent in the same envelope as the Appeal Decision Notice.

Q12. The appeal form that is attached to the ICDN calls for an email address for the participant to submit appeals to the FIDA Plan. Is this a requirement for FIDA, or is submission via fax and mail sufficient? Also, can FIDA Plans include a secure portal web address?

A12. Allowing for email submissions of the appeals form is an option, not a requirement. If the secure portal meets HIPAA/HITECH security requirements, then the FIDA Plan may include the address. FIDA Plans using a portal must submit a description of the system capabilities and certify that it meets requisite privacy and security standards. These should be sent to the plan's Monitoring and Oversight Coordinator (MOC).

Q13. Will participating providers be allowed to use the FIDA integrated appeals process? More specifically, can they use the integrated appeals process for retrospective medical necessity reviews?

A13. Participating providers may only use the integrated appeals process on behalf of the participant, essentially serving as a representative. They cannot appeal organization determinations through the integrated appeals process on their own behalf. Disputes between a participating provider and a FIDA Plan are generally governed by the contract between them.

Q14. Will non-participating provider appeals regarding claim denials continue to follow the existing CMS process? If yes, will adverse determinations be automatically forwarded to MAXIMUS Federal or the Office of Temporary and Disability Assistance (OTDA)?

A14. No. Effective November 29, 2016, Non-Participating Provider appeals are adjudicated through the FIDA Integrated Appeals Process. For more information, see https://www.health.ny.gov/health_care/medicaid/redesign/fida/mrt101/faq/2017-04_ppa_faq.htm. .

Q15. Can a single notice be used to describe multiple reductions/denials if they are all determined within the IDT meeting and accompany a Person-Centered Service Plan (PCSP)?

A15. Yes, as stated in the Instructions for the ICDN Models, ICDN Model 2 should be used when the participant had a certain level of care recorded in his or her prior PCSP and then the IDT denies, reduces, or stops at least one of the services in the new PCSP.

Q16. Do Plans have to send an ICDN to participants for administrative claims denials (*e.g.*, denials for exceeding authorization, wrong code, missing information, etc.)? If so, what does the Plan send to the requesting provider (*e.g.*, the ICDN or an Explanation of Payment (EOP) notice)?

A16. Plans should send an ICDN to a Participant whenever a claim is denied, with the following exceptions. Plans do not need to send an ICDN to a Participant in the following circumstances:

- When there is a prepaid capitation arrangement with a participating provider and the participating provider submits a fee-for-service claim to the Plan for a service that falls within the capitation payment;
- If a participating provider of the Plan itemizes or "unbundles" a claim for services encompassed by a previously negotiated global fee arrangement;
- If a duplicate claim is submitted by the enrollee or a participating provider, no notice is required, provided an initial notice has been issued;
- If the claim is for a service that is carved-out of the Managed Long-Term Care (MLTC) benefit package and is provided to MLTC enrollees through Medicaid fee-for-service, however, the Plan should notify the provider to submit the claim to Medicaid;
- If the Plan makes a coding adjustment to a claim (up-coding or downcoding) and its provider agreement with the participating provider includes a provision allowing the Plan to make such adjustments; or
- If the Plan has paid the negotiated amount reflected in the provider agreement with a participating provider for the services provided to the enrollee and denies the participating provider's request for additional payment.

Q17. May the Plan's administrative staff who are involved in administrative tasks surrounding the initial coverage determination also be involved in administrative tasks supporting an appeal of the same case?

A17. FIDA Plans must ensure that those staff who are making decisions on 1st Level appeals and grievances are not involved in any previous level of review or decision-making of that case, whether by making the initial coverage determination themselves or by reviewing and approving an initial coverage determination made by staff or delegated entities. In addition to having no involvement in the making of the initial coverage determination, 1st Level Appeal Decision-makers must be health care professionals with clinical expertise in treating the Participant's condition or disease if:

1) the initial determination was based on medical necessity;
2) the grievance or appeal is regarding the denial of expedited resolution of an appeal; or
3) the grievance or appeal involves clinical issues.

Staff that are only involved in administrative tasks related to the initial coverage determination (like entering information into a database or drafting notices of decisions made by others) are not decision-makers and may be involved in administrative tasks related to the 1st Level Appeal.

Q18. Do Sections 2.13.1.1.2.3.1 and 2.13.1.1.2.3.2 of the Three-way Contract (Sections 2.13.1.1.4.2.1, and 2.13.1.1.4.2.3 in the amended Three-way Contract) require FIDA Plans to allow the Participant to be involved in the review process in person?

A18. These Sections require FIDA Plans to give Participants a reasonable opportunity to present evidence and allegations of fact or law about the issue in dispute. At the Participant's request, this opportunity should be in-person. The FIDA Plan must have a way to schedule these proceedings and to administer the in-person review at a particular time and location.

Q19. What if the participant requests an expedited in-person review? Does the FIDA Plan have to provide the in-person review, decide within 72 hours, or both?

A19. Participants have a right to an in-person review, even in expedited cases. However, in accordance with 42 CFR § 422.586, the Plan should explain to the Participant (or his/her representatives) that if the shortened timeframe will limit the ability to present evidence, the Participant may request a 14-day extension. .

Q20. Who is required to be present at an in-person Level 1 appeal review?

A20. The Participant, and/or his or her representative should be present at the in-person review, in addition to the Plan reviewer. Others persons, such as witnesses, caretakers, or providers are permitted to be present.

Q21. What happens if the Participant, and/or his or her representative, does not appear at the in-person review? Has the Participant abandoned the appeal?

A21. No, the Plan is still required to render a decision within the applicable timeframe. The Plan should document its efforts to contact the Participant, and/or his or her representative, and reschedule the in-person review if reasonably possible within the applicable timeframe.

Q22. Does a plan have to pay for transportation to the Level 1 appeal in-person review?

A22. Yes, upon request Plans must provide transportation for participants, transportation attendants, representatives, and witnesses as may be medically or financially necessary.

Q23. Are FIDA Plans required to schedule in-person reviews at the Participant's home? If so, then what is the standard for providing a <u>home-based</u> in-person review?

A23. If a participant requests an in-person review and transportation to the Plan's normal review location could seriously jeopardize the life or health of the participant or the participant's ability to attain, maintain, or regain maximum function, then the Plan should conduct the review at the participant's home or current residence.

Q24. If a participant qualifies for a home-based in-person review can the plan send an agent to the home and conference in the reviewer, or have the agent gather information to take back to the reviewer?

A24. No. If a person requests and qualifies for a home-based in-person review, the reviewer must travel to the location of the participant.

Q25. Do plans have to provide transportation to in-person hearings with the Integrated Administrative Hearing Office (IAHO)?

A25. Yes. As with in-person reviews at Level 1, Plans are required to provide transportation for participants and transportation attendants to attend IAHO hearings.

Q26. What is the process for Plan participation in the integrated administrative hearings? Are Plans required to attend in person or by phone? Who from the Plan must participate?

A26. As is noted in section 2.13.1.1.2.9 of the Three-way Contract, "the staff person participating must be knowledgeable in the appeal decision reached by the FIDA plan and the basis for the decision." At the discretion of the Integrated Administrative Hearing Officer, the FIDA plan may waive its right to appear in person, in accordance with and subject to the process outlined in § 358-4.3(c). Plans should contact the IAHO for more information on requirements related to waiving appearance at the hearing.

Q27. What is the timeframe for sending notice to a participant and/or provider of an organization's initial coverage determination?

A27. The timeframes for sending written notice of any decision by the FIDA Plan to deny a Service Authorization Request, or to authorize a service in an amount, duration, or scope that is less than requested, (*i.e.*, ICDN Model 3) are prescribed in section 2.9.4.5 of the original FIDA Three-way Contract, section 2.9.3.5 of the amended Three-way Contract.

The timeframes for sending notice of any authorization decisions by the IDT (*i.e.*, ICDN Models 1 and 2) are prescribed in section 2.9.4.6 of the original Three-way Contract, Section 2.9.3.6 of the amended Three-way Contract.

Q28. Can a participant file an appeal if the FIDA Plan or IDT fails to make a coverage decision within the timeframes under sections 2.9.4.5 or 2.9.4.6 of the Three-way Contract (sections 2.9.3.5 and 2.9.3.6 in the amended Three-way contract)? Does the FIDA Plan have to notify the participant if this happens?

A28. Yes and yes. The failure to provide a coverage decision in a timely matter is an action than may be appealed to the FIDA Plan using the integrated appeal process. If FIDA Plan or IDT fails to make a timely determination, the FIDA Plan must send the appropriate model ICDN for the action.

Q29. If a FIDA plan fails to make a Level 1 appeal decision within the required timeframe, do they need to forward the case to the Integrated Administrative Hearing Office (IAHO)? For example, if an expedited/fast appeal is requested and granted, but the plan doesn't make the decision within the required 72-hour window.

A29. Yes. Failure of the FIDA plan to make a Level 1 appeal decision within the required timeframes is deemed an adverse decision which must be auto-forwarded to IAHO. Plans should use the code "F0U – FAILURE TO DECIDE TIMELY" on the Cover Note when auto- forwarding these cases to the IAHO. Please refer to the Cover Note and the FHIS Code Instructions for further details.

Q30. All of the model notices request the "Participant Number." Which number should be used (*e.g.*, HICN)?

A30. Plans should use the Participant Identification Number that the plan has assigned to the Participant upon enrollment.

Q31. What is the review and submission process for the model notices?

A31. The Appeals and Grievances notices and ICDNs are marketing materials but are file and use. If FIDA Plan wish to make changes to the models, they must request prior approval from the NYDOH and CMS.

Please see the marketing codes at the following link: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/NYMMPModelsCodesMemo051514.pdf

Q32. In order to satisfy the need to notify participants that an appeal has been auto-forwarded, can plans send the Appeal Decision Notice (Adverse) and the Acknowledgement of Auto-Forward of Appeal notice together?

A32. Yes, the notices may be sent together.

Q33. The Request for Additional Information notice advises the Participant that they may get more information from his or her provider. Should the FIDA Plan contact the provider instead of putting the onus on the Participant? Also, can a copy of the notice be sent to the provider?

A33. The FIDA Plan is responsible for procuring relevant information and material from network providers, and should make all reasonable attempts to discover and procure such information and material from out-of-network providers as well. The Request for Additional Information notice should not be used unless the FIDA Plan is unable to procure potentially significant, information or material after reasonable attempts to do so.

If the FIDA Plan sends a Request for Additional Information notice to a Participant, a copy should go to any provider that the FIDA Plan is specifically aware of that has or may have the relevant information or material.

Q34. Does a person or entity have to be the Participant's representative in order to file an appeal or grievance on their behalf?

A34. No, the Plan must accept and process appeal and grievance requests from the Participant, the participant's representative, attorney, family member, provider, or members of the Participant's IDT. These individuals do not need to have a written letter or Form 1696 just to file the appeal or grievance on the Participant's behalf. The FIDA Plan may not dismiss an appeal or grievance or delay processing of the Level 1f appeal or grievance if the appeal or grievance is filed by someone who is not the Participant's representative. In these circumstances, the plan should send the written confirmation of the receipt of the appeal or grievance to the Participant and Participant's representative (if an authorized representative is on file with the Plan). Any questions or scheduling communications after the appeal or grievance is filed, including the notice of the Level 1 decision, should be sent to the Participant and the Participant's representative (if any). The Plan must also inform the Participant or Participant's representative that written authorization will be required if they wish to have the person who filed the appeal or grievance be contacted or to act further as the representative on the appeal or grievance matter. If necessary, the Plan should assist the Participant in completing a written authorization of representation.

Q35. Does a person or entity have to be the Participant's representative in order to represent the Participant in hearing proceedings?

A35. Yes. In order to represent a Participant in a hearing, the representative must be designated in writing, either through a letter from the Participant designated the person he/she wants to have serve as representative or through completion of an Appointment of Representative

(form 1696) (http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf).

Q36. Can plans adjust ICDN Model 3 to add a letterhead/plan mailing address field at the top?

A36. Yes.

Q37. According to the FAQ released on 2/13/15, disclaimers must be included on utilization management service approval notices. As such, should the ICDN also have disclaimers?

A37. The disclaimers that are required for the ICDN are already included on the model. The plans do not need to add any additional disclaimers.

Q38. Who is the "specialist" mentioned in ICDN Model 3 under the "Who denied your services" section? Is this a specialist on the IDT?

A38. These are the specialists listed identified in Section 2.9.3.1 of the Three-way Contract.

Q39. When Auto-Forwarding an adverse Level 1 Appeal to IAHO, must the plan use the Cover Note provided by DOH?

A39. Yes. A fully completed Cover Note must be sent to IAHO by the FIDA Plan.

Q40. Section 2.13.1.1.2.7.2.3 of the original FIDA Three-way contract (section 2.13.1.2.2.2 of the amended contract) requires FIDA Plans to list the name of a contact person for use by IAHO. Whose contact information should be used on the Cover Note? Will a contact "group" be accepted?

A40. The Cover Note must indicate the name of an appropriate contact person at the FIDA plan or its delegated entity who has knowledge of the case and basis for decision.

Q41. Will IAHO contact the person listed on the Cover Note during normal business hours or do they have to be available 24 hours a day, 7 days a week?

A41. For expedited appeals forwarded to IAHO, the Plan must make sure that someone with knowledge of the case and basis for decision is available 24 hours per day, 7 days per week.

Q42. Do OTDA procedural rules apply to FIDA Integrated Hearings?

A42. Yes. All preexisting procedural rules apply unless expressly made inapplicable by conflicting language in the Three-way Contract.

Q43. Can a Non-Participating Provider appeal using the Integrated Appeals Process?

A43. Both a Non-Participating Provider and a Participating Provider can appeal using the Integrated Appeals Process when appealing on behalf of a Participant. In November 2016, the Department issued a policy permitting Non-Participating Providers to use the Integrated Appeals Process when appealing on their own behalf (not on behalf of a Participant).

Q44. Can a FIDA Plan dismiss a non-participating provider appeal if the non-participating provider

does not submit the waiver of liability?

A44. In the event that a non-participating provider files a request for appeal but the non-participating provider does not submit a waiver of liability, the FIDA plan must make, and document, its reasonable efforts to secure the waiver of liability form. If after 60 days for a reimbursement request, or 30 days for all other appeals, from the date of the appeal being filed by the non-participating provider, the non-participating provider does not provide the waiver, the FIDA plan can dismiss the appeal. Again, the FIDA plan need not review the appeal until a signed waiver of liability form has been received. The 60-day or 30-day clock to review the appeal starts when the waiver is received.

Q45. If the FIDA Plan dismisses the appeal for failure to submit a waiver of liability after waiting 30 days, can the non-participating provider appeal again?

A45. The non-participating provider may appeal a second time and, if the deadline for appealing the plan's decision has not yet lapsed, the FIDA Plan must accept the second appeal. If the deadline has passed, the FIDA Plan must apply the good cause policy to decide whether to accept the second appeal.

Q46. When FIDA Plans auto-forward a Non-Participating Provider appeal to the IAHO, does the plan also send it to the IRE simultaneously based on the Fair Hearing Information System (FHIS) code list?

A46. Yes for appeals decided prior toJanuary 2, 2018. On February 12, 2016, we issued "Guidance to FIDA Plans for Submitting Appeals Files to the Medicare IRE for Quality Assurance". This policy is rescinded, effective January 2, 2018. As of January 2, 2018, FIDA Plans will no longer have to send a hard copy of their adverse Level 1 Appeal decisions involving Medicare covered items to the Medicare IRE. Plans must continue to auto-forward all of their adverse Level 1 Appeal decisions to the IAHO, and follow all other appeal process requirements outlined in the Three-way Contract.

Q47. Can the FIDA Plan just send the Non-Participating Provider Appeal Rights Summary with an Explanation of Payment?

A47. FIDA Plans must send an ICDN to providers when denying a requested service or request for payment. As per the Non-Participating Provider Appeals policy issued 11/29/16, FIDA Plans must send the Non-Participating Provider Appeal Rights Summary with the required ICDN. . The FIDA Plan may also send the Summary with the Explanation of Payment (EOP). The Plan may send the Summary, ICDN, and EOP all together.

Q48. Can a Non-Participating Provider request an expedited appeal?

A.48 No.

Q49. The Appeals Rights and Process Summary indicates "When a Non-Participating Provider receives a denial or <u>partial denial of a claim</u>, the Non-Participating Provider may file a 1st Level Appeal (with the FIDA Plan)." Partially denied claims typically fall into one of three buckets: corrected claim required; payment amount dispute; or an appeal. Please confirm that this is applicable to only appeals, and not the other 2 categories.

A49. Yes. This is only applicable to appeals and not to payment amount disputes or corrections of claims.

Q50. In reference to the model Waiver of Liability (WOL) template, is the "Claim ID Number" required; can plans remove this from their template? Providers typically reference the most recently denied claim to meet the appeal filing deadline although there are instances where the same claim was previously submitted and denied. Is the Claim ID Number mandatory?

A50. Including the Claim ID Number on the WOL is optional and Plans may remove it.

Q51. DOH issued letters with the Non-Par Provider Appeals guidance in November 2016. Will model letters be issued for Par (Participating) Provider Appeals as well, or should the plan continue to use the member notices when a Par Provider requests an appeal?

A51. The model notices issued with the November 2016 guidance are for use only by Non-Participating Providers when they are filing on their own behalf. When Non-Participating Providers or Participating Providers file on behalf of a Participant, Plans should continue to use the Participant notices. Participating Providers are not permitted to use the integrated appeals process on their own behalf. Participating Providers' appeal rights and procedures are governed by the contract between the Plan and the Participating Provider.

Q52. What is the correct mailing address for OTDA?

A52. In the fall we corrected the contact info for OTDA:

MAILING ADRESS: FIDA Integrated Administrative Hearings Office P.O. Box 1930 Albany, New York 12201
PHYSICAL ADDRESS: 14 Boerum Place, Brooklyn, New York 11201
EMAIL ADDRESS: otda.sm.FIDA.Integrated.Appeals.Office@otda.ny.gov
FAX: 518-473-8783

Q53. May the FIDA Plan post a link to the Waiver of Liability form on its website and direct providers to the link, instead of enclosing a hard copy?

A.53 Yes, the notices have been revised and reissused allowing the use of a link instead of enclosure.