15.6 Expedited Organizational Determinations and Appeals

If a Healthfirst member, appointed representative, or member's provider believes an expedited organizational determination is required because a delay would significantly increase risk to the member's health, the Healthfirst member, their appointed representative, or the provider may request an **expedited organizational determination** by calling Healthfirst at 1-888-394-4327. If Healthfirst denies the request for an expedited organizational determination, Healthfirst will notify the member or the member's representative and the provider in writing within three (3) calendar days (Medicare and Leaf Plans) or 3 business days (Medicaid) and include the member's right to an expedited grievance. Healthfirst will then process the organizational determination using the standard determination time frames.

If a provider requests or supports the member's request for an expedited organizational determination, Healthfirst must automatically expedite the organizational determination. We will make a determination and provide the member, the member's designee, and the provider by telephone within seventy-two (72) hours (Medicare and Leaf Plans) or 3 business days (Medicaid) of receipt of the request. Written notice will follow within one (1) calendar day of the determination. If the member requests an extension or Healthfirst needs additional information, we will extend the timeframe up to fourteen (14) calendar days. The member, the member's designee, and provider will be notified in writing of the extension and will be provided with the right to file an expedited grievance if he or she disagrees with Healthfirst's decision to grant an extension.

If a Healthfirst member or that member's provider believes an **expedited appeal** is required because a delay would significantly increase risk to the member's health, the member or the member's appointed representative may request an expedited appeal by calling Healthfirst at **1-877-779-2959**. If Healthfirst denies the request for an expedited appeal, Healthfirst will notify the member and/or the member's representative and review the appeal using the standard appeal process. If a provider requests or supports the member's request for an expedited determination or appeal, Healthfirst must automatically expedite the review.

The member's provider can also request an expedited appeal if the denial was made during concurrent review (request for extension of services beyond the time period or quantity currently authorized).

In addition, the member or the member's designee may provide additional information to Healthfirst, either in person or in writing, including evidence and allegations of fact or law related to the issue in dispute. If further information regarding the member's appeal is required to render the reconsideration decision, providers must submit the additional information in a timely manner. For an expedited appeal, the additional information must be provided within three (3) business days from the date of Healthfirst receipt of the appeal.

The time frame for appeal resolution may be extended up to fourteen (14) days if the member, the member's designee, or the member's provider requests an extension orally or in writing. The expedited appeal may be extended by Healthfirst for up to fourteen (14) days if Healthfirst justifies the need for more information and believes the extension is in the best interest of the member.

Oral appeals may be requested by calling 1-888-260-1010. Any oral appeal can be followed up with a written submission for the request. Please send such requests to our Appeals and Grievances department at:

Healthfirst
Appeals and Grievances Department
P.O. Box 5166
New York, NY 10274

Appeal Determinations

Healthfirst will make a determination with regard to a STANDARD appeal within **thirty (30) calendar days from the date we received the appeal.**

Healthfirst will make a determination with regard to an EXPEDITED (fast-track) appeal within the lesser of 72 hours of receipt of the request (Healthfirst Leaf Plan and Medicare Plan members)/3 business days from receipt of request (Medicaid members) or two (2) business days of receipt of the necessary information to conduct the appeal for all members.

If Healthfirst reverses an initial adverse organizational determination, then services will be authorized or provided as expeditiously as the member's health condition requires, but no later than thirty (30) calendar days from the date the request for standard appeal was received or no later than upon expiration of an extension; and within 72 hours from the date the request for expedited appeal was received or no later than upon expiration of an extension. For payment-related requests, payment will be made no later than sixty (60) calendar days after the appeal request was received.

If Healthfirst upholds an initial adverse organizational determination upon appeal, the case will be referred to the Independent Review Entity (IRE) contracted by CMS for an independent review.

If CMS's contractor upholds the Healthfirst adverse organizational determination, the contractor will notify the member in writing and explain further appeal options that may be available to the member.

If CMS's contractor reverses Healthfirst appeal determination for standard service requests, Healthfirst will effectuate the services appealed within fourteen (14) calendar days of receipt of the IRE's notice, and if the member's condition does not allow for this, then services will be authorized within 72 hours from the date of the IRE notice. IRE reversals of expedited service request appeals will be authorized or provided within 72 hours of receipt of the IRE notice. Payment requests that are reversed by the IRE will be effectuated within 30 calendar days of receipt of the IRE's notice.

If Healthfirst does not complete an expedited appeal process within seventy-two (72) hours or a standard appeals process within thirty (30) calendar days, the case will be automatically referred to CMS's contractor for an independent review.

A member who wishes to submit a verbal request for an expedited appeal should be directed to **1-877-779-2959.**

Please Note: Dual-eligible members only

CompleteCare members have both Medicaid and Medicare benefits and have different options when filing an appeal for services covered under the benefit package. For Healthfirst services funded by the state contract, members must follow Medicaid appeal rules. For services funded through the Medicare program, members must follow Medicare appeal rules. For services covered by both Medicaid and Medicare funding, members can follow either Medicaid or Medicare rules. If a member chooses to pursue Medicaid appeal rules to challenge an organizational determination or action, he/she has sixty (60) calendar days from the date on the Notice of Denial of Coverage issued by Healthfirst to also pursue a Medicare appeal, regardless of the status of the Medicaid appeal. However, if a member chooses to pursue a Medicare appeal, he or she may not file an appeal under Medicaid. Healthfirst determines whether Medicaid, Medicare, or both cover a particular service.