15. Appeals and Grievances

Please note:

Medicare-related information can be found in Sections 15.1 through 15.7.

Medicaid/CHPlus/Commercial-related information can be found in Sections 15.8 through 15.18.

15.1 Provider Notice Requirements – Medicare

Because Healthfirst serves various types of members who are covered under a variety of commercial and governmental contracts, the requirements for appeals and grievances may differ among the different products offered. The title bar above each section indicates the program(s) for which the information applies. The sections within Appendix XIII contain copies of all forms, notifications, and documents referenced in this section.

Member Dissatisfaction with Specialist Providers

Members who are not satisfied with the care provided by a particular specialist provider have the option of switching to an alternative in-network provider of the same specialty if a suitable alternative exists. The member's PCP must be involved in the transition of the member to an appropriate specialist and should discuss the issue with the member. The PCP may also suggest that the member obtain a second opinion prior to changing a specialist altogether.

If the PCP feels strongly that the specialist with whom the member is dissatisfied is uniquely qualified to deal with the member's medical needs, the PCP should discuss this with the member, in an attempt to continue the existing relationship. If the member still wants to change specialists, the PCP should refer the member to a new specialist and inform him/her to contact Member Services to file a grievance against the initial specialist.

Noncovered Benefits

If the provider recommends a course of treatment or service that is a noncovered benefit, the provider must:

- Inform the member, in writing, that the service or item may not be covered by Healthfirst and that the member will be responsible for payment of those services.

OR

- If the provider is willing to waive payment, inform the member that he or she will be held harmless for payment if Healthfirst determines that the treatment or service is not covered. Where a provider has not been given a list of covered services by Healthfirst or the provider is uncertain as to whether a service is covered, the provider should make reasonable efforts to contact Healthfirst to obtain a coverage determination prior to advising a member about coverage and liability for payment and prior to providing the service.

15.2 SNF/HHA/CORF Provider Service Terminations – Medicare

Grijalva Decision

For Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF) providers, Healthfirst would like to advise you of some important changes that have taken place with respect to the appeals process and delivery of the notification of termination of covered services.

As part of a settlement agreement between CMS and Medicare beneficiaries, the federal rules governing Medicare appeals were recently revised. Specifically, pursuant to 42 CFR Section 422.624, the provider of services is responsible for delivering the Notice of Medicare Non-Coverage (NOMNC) to Medicare managed

care members prior to the cessation of services for medical necessity determinations. For denials of SNF 100 day Benefit Exhaustion, admission to SNF, Home Care or CORF that is Not Covered, or when single service ends but skilled stay continues, the Notice of Denial of Medical Coverage (NDMC) will be issued. The delivery must be made to the managed care member two (2) days prior to the termination of the covered services and will not be considered valid until the member signs and dates the notice. If the member is incompetent or otherwise incapable of receiving the notice, the notice must be delivered to the member's legally authorized representative. If no authorized representative has been appointed, then the facility should seek the requested signature from the caregiver on record (i.e., the family member involved in the plan of treatment). If the member has no legally authorized representative or caregiver on record, then the facility should annotate the notice and sign on behalf of the member.

The Notice of Medicare Non-Coverage will be faxed to you, along with every preauthorization and concurrent authorization approval letter issued on behalf of Healthfirst members. It is imperative that you keep this form on file until it is time to present it two (2) days prior to discharge or within the last two sessions of home health services or therapy/rehabilitation. In addition, it is important that you understand that Healthfirst will not be responsible for any charges that extend past the authorized amount due to the failure of a provider/facility to deliver the notice and secure a member's signature.

Request of Immediate Quality Improvement Organization (QIO) Review (QIO Appeal) of SNF/HHA/CORF

Provider Service Terminations

A member receiving skilled provider services in a SNF, HHA, or CORF who wishes to appeal a Healthfirst decision to terminate such services because care is no longer medically necessary must request an immediate QIO review of the determination, in accordance with CMS requirements.

When to Issue Detailed Explanation of Non-Coverage

Once the QIO receives an appeal, it must issue a notice to Healthfirst that a member appealed the termination of services in SNF/HHA/CORF settings. Upon receipt of this notice, Healthfirst is responsible for issuing the Detailed Explanation of Non-Coverage – a written notice that is designed to provide specific information to Medicare members regarding the end of their SNF, HHA, or CORF care. (See Appendix XIII).

Healthfirst must issue a Detailed Explanation of Non-Coverage (DENC) to both the QIO and the member no later than the close of business when the QIO notifies Healthfirst that a member has requested an appeal.

Healthfirst is also responsible for providing any pertinent medical records used to make the termination decision to the QIO, although the QIO will seek pertinent records from both the provider and Healthfirst.

Immediate QIO Review Process of SNF/HHA/CORF Provider Service Terminations

On the date that the QIO receives the member's request, the QIO must notify Healthfirst and the provider that the member has filed a request for immediate review. The SNF/HHA/CORF must supply a copy of the Notice of Medicare Non-Coverage and any other information that the QIO requires to conduct its review. The information must be made available by phone, by fax, or in writing by the close of the business day of the appeal request date.

Healthfirst must supply a copy of the Notice of Medicare Non-Coverage, Detailed Explanation of Non-Coverage, and any medical information that the QIO requires to conduct its review. The information must be made available by phone, by fax, or in writing by the close of the business day that the QIO notifies Healthfirst of an appeal. If a member requests an appeal on the same day the member receives the Notice of Medicare Non-Coverage, then Healthfirst has until close of business the following day to submit the case file.

The QIO must solicit the views of the member who requested the immediate QIO review. The QIO must make an official determination of whether continued provider services are medically necessary and notify the member, the provider, and Healthfirst by the close of the business day after it receives all necessary

information from the SNF/HHA/CORF, Healthfirst, or both. If the QIO does not receive the information it needs to sustain the Healthfirst decision to terminate services, then the QIO may make a decision based on the information at hand or it may defer its decision until it receives additional required information. If the QIO defers its decision, then coverage of the services by Healthfirst will continue and the QIO will refer violations of notice delivery to the CMS regional office.

A member should not incur financial liability if, upon receipt of the Notice of Medicare Non-Coverage:

the member submits a timely request for immediate review to the QIO that has an agreement with the provider;

the request is made either in writing, by telephone, or by fax by noon (12pm) of the next day after receiving the notice;

Healthfirst meets its time-frame obligations to deliver medical information and a Detailed Explanation of Non-Coverage to the QIO; and

the QIO either reverses the Healthfirst termination decision or the member stops receiving care no later than the date that the member receives the QIO's decision.

The member will incur **one (1) day** of financial liability if the QIO upholds the Healthfirst termination decision and the member continues to receive services until the day after the QIO's decision. This should be the same date as the Healthfirst initial decision to terminate services.

A member who fails to request an immediate QIO review in accordance with these requirements may file a request for an expedited appeal with Healthfirst. Healthfirst will expedite the request for an expedited appeal if the QIO receives a request for an immediate QIO review beyond the noon (12pm) filing deadline and forwards that request to Healthfirst. Healthfirst would generally make an expedited decision about the services within seventy-two (72) hours. Financial liability applies in both the immediate QIO review and Healthfirst expedited review situations.

If an appeal occurs during a weekend, a Healthfirst Care Manager will contact the nursing office or SNF/HHA/CORF administrator on duty to facilitate the delivery of the Detailed Explanation of Non-Coverage.

15.3 Notification to Members of Non-Coverage of Inpatient Hospital Care – Medicare

Where Healthfirst has authorized coverage of the inpatient hospital admission of a Medicare member, either directly or by delegation (or the admission constitutes emergency or urgently needed care), Healthfirst is required to issue the member a written notice of non-coverage only under the circumstances described below.

Hospital Discharge Notification Process

In late 2006, the Centers for Medicare and Medicaid Services (CMS) issued a final rule regarding the hospital discharge notification process for Medicare Advantage beneficiaries, effective July 1, 2007.

The prior Medicare Advantage process required hospitals to issue a Notice of Discharge and Medicare Appeals Rights (NODMAR). Under the final rule, the NODMAR has been replaced by a two-step notification process where Medicare beneficiaries are notified that services will be discontinued and/or their original Medicare or Medicare Advantage Plan will no longer pay for their benefits. Healthfirst delegates the issuance of discharge notices to all of its contracted hospitals.

Effective July 1, 2007, hospitals must:

- Issue a revised version of the Important Message from Medicare About Your Rights (IM) (see Appendix XIII) and explain discharge rights to beneficiaries within two (2) calendar days of admission. They must also obtain the signature of the beneficiary or his/her representative's. If a member refuses to sign the notice, the hospital must annotate the refusal.

- Deliver a copy of the signed notice not more than two (2) calendar days prior to discharge. In short-stay situations, when inpatient stays are five (5) days or less, hospitals are not required to deliver a follow-up notice as long as the initial notice was delivered within two (2) calendar days of discharge.
- If a member disputes (appeals) the discharge and contacts the Quality Improvement Organization (QIO) for an immediate review, Healthfirst will complete and fax the Detailed Notice of Discharge (DNOD) to the hospital administrator or nursing director on duty (the member's medical record must be faxed to Healthfirst by 4pm that day). The hospital **must** deliver a copy of the DNOD to the member. **The hospital may not create its own DNOD and deliver it to the member without Healthfirst's approval.** Healthfirst will also fax a copy of the DNOD to the QIO for review and/or an expedited reconsideration. The QIO and/or Healthfirst will work with the hospital and attending physician to determine if discharge is appropriate.

If an appeal occurs during a weekend, a Healthfirst Care Manager will contact the nursing office or hospital administrator on duty to facilitate the delivery of the Detailed Notice of Discharge.

Template documents to be used for this new process are available on the CMS website at www.cms.hhs.gov/BNI/12_HospitalDischargeAppealNotices.asp#TopOfPage.

For additional information, please visit our website at www.healthfirst.org/providerservices.

Requesting Immediate Quality Improvement Organization (QIO) Review of Inpatient Hospital Care

A member remaining in the hospital who wishes to appeal the Healthfirst discharge decision that inpatient care is no longer medically necessary must request an immediate QIO review of the determination in accordance with CMS requirements. A member will not incur any additional financial liability if he/she:

- Remains in the hospital as an inpatient;
- Submits the request for immediate review to the QIO that has an agreement with the hospital;
- Makes the request either in writing, by telephone, or by fax; and
- Makes the request before the end of the day of discharge.

The following rules apply to the immediate QIO review process:

- On the date that the QIO receives the member's request, the QIO must notify Healthfirst that the member has filed a request for immediate review.
- Healthfirst and/or the hospital must supply any information that the QIO requires to conduct its review. This must be made available by phone, by fax, or in writing by the close of business of the first full working day immediately following the day the member submits the request for review.
- In response to a request from Healthfirst, the hospital must submit medical records and other pertinent information to the QIO by close of business of the first full working day immediately following the day Healthfirst makes its request.
- The QIO must solicit the views of the member who requested the immediate QIO review.
- The QIO must make an official determination of whether continued hospitalization is medically necessary and notify the member, the hospital, and Healthfirst by close of business of the first working day after it receives all necessary information from the hospital, Healthfirst, or both.

A member who fails to request an immediate QIO review in accordance with these requirements may file a request for an expedited appeal with Healthfirst. Healthfirst is encouraged to expedite the request for an expedited appeal. Likewise, the QIO is encouraged to expedite a request for immediate QIO review if received beyond the noon (12pm) filing deadline and to forward that request to Healthfirst. Thus, Healthfirst would generally make an expedited decision about the services within seventy-two (72) hours; however, the

financial liability rules governing immediate QIO review do not apply in an expedited review situation.

Liability for Hospital Costs

The presence of a timely appeal for an immediate QIO review as filed by the member or member representative in accordance with this section entitles the member to automatic financial protection by Healthfirst. This means that if Healthfirst authorizes coverage of the inpatient hospital admission directly or by delegation, or this admission constitutes emergency or urgently needed care, Healthfirst continues to be financially responsible for the costs of the hospital stay (less any member copayments, coinsurance, or deductibles) until noon (12pm) of the calendar day following the day the QIO notifies the member of its review determination.

15.5 Organizational Determinations and Reconsiderations – Medicare

When Healthfirst receives a request for payment or to provide services to a member, it must make an organizational determination to decide whether or not payment and or coverage is necessary and appropriate. If the determination is not made in a timely manner or is not favorable, the member has the right to request a reconsideration or appeal. A member who disagrees with a practitioner's decision about a request for a service or a course of treatment has a right to request an organizational determination from Healthfirst. This member should be referred to their EOC or contact Healthfirst Member Services for additional information.

Healthfirst is required to make organizational determinations and process appeals as expeditiously as the member's health status requires, but no later than indicated in the following chart:

Time Frames for Organizational Determinations & Reconsiderations (Appeals)

Organizational Determinations	Reconsiderations (Appeals)
Standard – Not to exceed 14 calendar days. (The 14-day deadline may be extended by an additional 14 calendar days if the member requires the extension or Healthfirst justifies the need for additional information that will benefit the member.)	**Standard (Service-Related)** – Not to exceed 30 calendar days. (The 30-day deadline may be extended by an additional 14 calendar days if the member requires the extension or Healthfirst justifies the need for additional information that will benefit the member.)
Expedited – Not to exceed 72 hours. (The 72-hour deadline may be extended by an additional 14 calendar days if the member requires the extension or Healthfirst justifies the need for additional information that will benefit the member.)	**Expedited** – Not to exceed 72 hours. (The 72-hour deadline may be extended by an additional 14 calendar days if the member requires the extension or Healthfirst justifies the need for additional information that will benefit the member.)
	Standard Only – Payment/Claims-Related Not to exceed 60 calendar days.

A member has a right to appeal if the member believes that:

- Healthfirst has not paid for emergency, post-stabilization, or urgently needed services
- Healthfirst has not paid a bill in full
- Health services have been furnished by a noncontracting medical provider or facility or supplier that the member believes should have been provided by, arranged for, or reimbursed by Healthfirst
- Services that the member feels are the responsibility of Healthfirst to provide or pay for have not been

received or paid

- Previously authorized ongoing course of treatment that has been reduced or prematurely discontinued and member believes the services are still medically necessary
- An organizational determination has not been made within the appropriate time frames
- Noncovered services that the member believes should be provided, arranged, or reimbursed have not been provided, arranged, or reimbursed

Time Frames and Methods for Submitting Standard Appeals

All appeal requests must be made in writing within sixty (60) calendar days from the date of the notice of organizational determination. Healthfirst may extend the time frame for filing a request for reconsideration for good cause.

A member or a member's representative may request a standard appeal request of an organizational determination in writing or orally. A member can name a relative, friend, advocate, attorney, doctor, or someone else to act on his/her behalf; in some cases, others authorized under state law may act on behalf of the member. Providers acting on behalf of a member must complete an Appointment of Representative Statement (Appendix XIII-E) for the services in question.

Requests for Additional Medical Documentation

If further information about the member's appeal is required to render a reconsideration decision, providers must submit the additional information in a timely manner to allow for resolution within regulatory time frames.

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.

15.7 Coverage Determinations for Part D Prescription Drugs – Medicare

Most Healthfirst Medicare plans offer Medicare prescription drug coverage (Part D). Generally, the members must share costs for their prescription drugs. Drugs on the formulary are grouped into four (4) tiers *with the lowest cost share being Tier 1 and the highest being Tier 4*:

- **Tier 1**: Generic
- **Tier 2**: Preferred Brand
- **Tier 3**: Non-Preferred Brand
- **Tier 4**: Specialty

Healthfirst 65 Plus Plan however is designed to be the preferred plan for Medicare beneficiaries who do not qualify for "Extra Help," either in the form of Low Income Subsidy (LIS) for Part D or Medicare Savings Programs (MSP) for Medical benefits. As such, this plan offers a comprehensive benefit package, including additional benefits not covered by Original Medicare, but at a $0 monthly premium, making it a high-value yet affordable choice. Healthfirst 65 Plus Plan has a 5 tier prescription drug formulary.

Tier 1: Generic
Tier 1: Non-Preferred Generic Drugs
Tier 3: Preferred Brand Drugs
Tier 4: Non-Preferred Brand Drugs
Tier 5: Specialty Tier Drugs

Coverage determinations include exception requests. An exception request is the way a member can exercise his or her right to ask for an "exception" to the formulary. In other words, to request lower cost-sharing. An exception request must be accompanied by a supporting statement from the prescribing provider.

Healthfirst strongly encourages and recommends that a prescribing provider review the current Medicare Part D formulary to identify the drugs that are covered for Healthfirst members. The formulary can help a provider identify the therapy or therapies that will be least expensive for the member. In general, the lower the drug tier, the lower the cost of the drug. The formulary can also help a provider identify the drugs and therapies that are preferred by Healthfirst. The formulary was developed by a Pharmaceutical and Therapeutics (P&T) Committee comprising a national panel of clinicians. The formulary can help providers understand the Healthfirst strategy for managing the pharmacy benefit. Healthfirst recognizes that sometimes this strategy may not align with a provider's treatment criteria.

Prior Authorization (PA)

Healthfirst Medicare Plan requires a member or his or her provider to request prior authorization for certain drugs. This means the member must obtain prior approval for a prescription from Healthfirst Medicare Plan before the prescription is filled. If you do not obtain approval, Healthfirst Medicare Plan may not cover the drug.

- **Quantity Limit (QL):** For certain drugs, Healthfirst Medicare Plan limits the amount of the drug that

Healthfirst Medicare Plan will cover.

- **Step Therapy (ST):** In some cases, Healthfirst Medicare Plan requires the member first try certain drugs to treat their medical condition before we will cover another drug for that condition.

Healthfirst's Medicare formulary, as well as Prior Authorization (PA), Step Therapy (ST), and Quantity Limit (QL) criteria listings, can be found on Healthfirst's public website:www.healthfirst.org/formulary.html.

To initiate a coverage determination request, including a request for a Part D drug that is not on the formulary (formulary exception), please contact the CVS Caremark Prior Authorization department, 7:00am to 5:30pm MST, Monday–Friday, in one of the following ways:

- **CALL** CVS Caremark at 1-855-344-0930, 7:00am to 5:30pm MST, Monday–Friday
- **FAX** CVS Caremark at 1-855-633-7673, 7:00am to 5:30pm MST, Monday–Friday
- **WRITE** CVS Caremark

CVS Caremark Part D Services

Attention: Prior Authorization – Part D

MC109

PO Box 52000

Phoenix, AZ 85072-2000

Medicare Part D Appeals

A member's appointed representative or his or her prescribing provider may request that a coverage determination be expedited. Time frames begin after receipt of the request. A member may appeal an adverse coverage determination; however, if an exception request for a non-formulary drug is approved, the member cannot request an exception to the copayment they are required to pay for the drug.

A member has a right to appeal if he or she believes that Healthfirst/CVS Caremark, Inc. did any of the following:

- Decided not to cover a drug, vaccine, or other Part D benefit,
- Decided not to reimburse a member for a part D drug that he/she paid for,
- Asked for payment or provided reimbursement with which a member disagrees,
- Denied the member's exception request,
- Made a coverage determination with which the member disagrees.

Appeals for Part D Prescription Drugs

- **CALL** CVS Caremark at 1-855-344-0930, 7:00am to 5:30pm MST, Monday–Friday
- **FAX** CVS Caremark at 1-855-633-7673, 7:00am to 5:30pm MST, Monday–Friday
- **TTY** Number: 1-866-236-1069
- **WRITE** CVS Caremark

CVS Caremark Part D Services

Attention: Prior Authorization – Part D

MC109

PO Box 52000

Phoenix, AZ 85072-2000

Complaints About Part D Prescription Drugs

WRITE TO:

CVS Caremark
Attn: Grievance Department
MC 121
P.O. Box 53991
Phoenix, AZ 85072-3991

If CVS Caremark fails to meet coverage determination or redetermination time frames, it must automatically forward the member's request(s) to the Independent Review Entity (IRE) contracted by CMS.

If the IRE upholds the Healthfirst adverse coverage determination, the IRE will notify the member in writing and explain further appeal options that may be available to the member.

Time Frames for Coverage Determinations and Appeals

CVS Caremark is required to make coverage determinations and to process appeals as expeditiously as the member's health status requires but no later than is indicated in the following chart:

Medicare Prescription Drug (Part D) Time Frames for Appeals

	STANDARD*	EXPEDITED*
Pharmacy Coverage Determinations (Initial Decision)	72-hour time limit†	24-hour time limit†
APPEAL PROCESSES		
FIRST LEVEL OF APPEAL (Internal)	**MAPD/PDP** **Standard Redetermination** 7-day time limit	**MAPD/PDP** **Expedited Redetermination** 72-hour time limit
SECOND LEVEL OF APPEAL (Independent Review Entity – IRE)	**Independent Review Entity** **Standard Redetermination** 7-day time limit	**Independent Review Entity** **Expedited Redetermination** 72-hour time limit
THIRD LEVEL OF APPEAL (Office of Medicaid Hearings and Appeals) For amounts in controversy ≥ $150.00‡	**Administrative Law Judge** **Standard Decision** 90-day time limit	**Administrative Law Judge** **Expedited Decision** 10-day time limit
FOURTH LEVEL OF APPEAL (Medicare Appeals Council – MAC)	**Standard Decision** 90-day time limit	**Standard Decision** 10-day time limit
FINAL LEVEL OF APPEAL – JUDICIAL REVIEW (Federal District Court)	**Federal District Court**	

Note: Each appeal level requires member or member's representative to file the appeal within 60 days of previous determination.

* A request for a coverage determination includes a request for a tiering exception or a formulary exception. A request for a coverage determination may be filed by the member, by the member's appointed representative, or by the member's provider or other prescriber.

† The adjudication time frames generally begin when the request is received by CVS Caremark/Healthfirst.

However, if the request involves an exception request, the adjudication time frame begins when CVS Caremark/Healthfirst receives the provider's supporting statement.

‡ The amount in controversy requirement for an Administrative Law Judge hearing and Federal District Court is adjusted annually in accordance with the medical care component of the consumer price index. The chart reflects the amounts for calendar year 2015.

15.8 Coverage Determinations for Prescription Drugs – Medicaid, CHPlus and Leaf Plans

The formulary outlining the Medicaid, Child Health Plus, and Leaf Plans pharmacy benefits can be found on the Healthfirst website www.healthfirst.org/formulary.html.

Coverage determinations include requests for prior authorization or formulary exceptions.

Healthfirst strongly encourages/recommends that a prescribing provider review the current Medicaid, CHPlus, and Leaf Plan formularies to identify the drugs that are covered for Healthfirst members. The formulary can help a provider identify the therapy or therapies that will be least expensive for the member. In general, the lower the drug tier, the lower the cost of the drug. In addition, the formulary can help a provider identify the drugs and therapies that are preferred by Healthfirst. The formulary was developed by a Pharmaceutical and Therapeutics Committee (P&T) comprising a national panel of clinicians. The formulary can help providers understand the Healthfirst strategy for managing the pharmacy benefit. Healthfirst recognizes that sometimes this strategy may not align with a provider's treatment criteria.

Some covered drugs may have additional requirements or limits on coverage. These requirements or limits may include:

- **Prior Authorization:** Healthfirst requires prior authorization for certain drugs. This means that approval from Healthfirst must be obtained before the prescription is filled. If approval is not obtained, Healthfirst may not cover the drug

  In order to obtain prior authorization, prescribers should contact CVS Caremark at **1-877-433-7643** and be prepared to provide relevant clinical information that supports the medical necessity of the required medication. A comprehensive formulary is also available on the Healthfirst website www.healthfirst.org or by contacting the Member Services department at **1-866-463-6743.**

- **Quantity Limits:** For certain drugs, Healthfirst limits the amount of the drug that is covered.

- **Step Therapy:** In some cases, Healthfirst requires a member to first try certain drugs to treat their medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat the medical condition, Healthfirst may not cover Drug B unless the member tries Drug A first. If Drug A does not work for the member, Healthfirst will then cover Drug B. However, if it is a new member who has already tried Drug A before taking Drug B, Healthfirst will not require the member to try Drug A again. You should notify us if this is the case.

You can ask Healthfirst to make an exception to these restrictions or limits. Please contact CVS Caremark at 1-877-433-7643 for information about how to request an exception.

To initiate a coverage determination request, including a request for a drug that is not on the formulary (formulary exception), please contact the CVS Caremark Prior Authorization department in any of the following ways:

Coverage determinations for Medicaid and CHPlus

- **CALL** CVS Caremark at 1-877-433-7643

  Calls to this number are free, 8:00am–6:00pm CST

- **FAX** 1-866-848-5088

While no specific form is required, the NY State Medicaid Standard Global Prior Authorization form can be found at the website: www.healthfirst.org/providerforms.

WRITE:: CVS Caremark

Attn: Healthfirst NY Medicaid Prior Authorization

1300 E. Campbell Road

Richardson, TX 75081

Healthfirst's Medicaid and CHPlus formulary, as well as Prior Authorization (PA), Step Therapy (ST), and Quantity Limit (QLL) criteria listings, can be found on Healthfirst's public website: www.healthfirst.org/formulary.html.

Coverage determinations for Leaf Plans

- **CALL** CVS Caremark at 1-800-294-5979
- **FAX** 1-888-836-0730

  Calls to these numbers are free, 8:00am–6:00pm CST.

- **WRITE**

  CVS Caremark
  Attn: Healthfirst NY Exchange Prior Authorization
  1300 E. Campbell Road
  Richardson, TX 75081

Healthfirst's Exchange formulary, as well as Prior Authorization (PA), Step Therapy (ST) and Quantity Limit (QLL) criteria listings, can be found on Healthfirst's public website www.healthfirst.org/formulary.html.

15.9 Action Denial Notice – Medicaid/CHPlus

An action can be considered any of the following activities of the Plan or its delegated entities that results in:

- The denial or limited authorization of a Service Authorization Request, including the type or level of service.
- The reduction, suspension, or termination of a previously authorized service.
- The denial, in whole or in part, of payment for a service.
- Failure to provide services in a timely manner, as defined by applicable state law and regulation.
- Failure of Healthfirst to act within the time frames for resolution and notification of determinations regarding Complaints, Action Appeals, and Complaint Appeals provided in Section 15.6 of this manual.
- The restriction of an enrollee to certain network providers under the Contractor's Recipient Restriction Program.

15.10 Action Appeals – Medicaid, and Medicaid Advantage Plus

An Action Appeal is a request for a review of an Action (see Glossary of Terms, Section 18 of Manual). A member or a member's designee shall have no more than ninety (90) calendar days after receipt of the notice of the Action determination for MMC and forty-five (45) calendar days for Medicaid Advantage Plus, to file an appeal, which may be submitted orally by calling Member Services or by submitting a written request.

An oral Action Appeal can be filed by calling the Healthfirst Member Services toll-free telephone (open no less than forty [40] hours per week during normal business hours), as well as via a telephone system available to

take calls during other hours.

Within fifteen (15) calendar days of receipt of the appeal, Healthfirst shall provide written acknowledgment of the Action Appeal including the name, address, and telephone number of the individual designated by Healthfirst to respond to the appeal and what additional information, if any, must be provided in order for the organization to render a decision.

Healthfirst shall designate one (1) or more qualified personnel to review the Action Appeal, provided that when the Action Appeal pertains to clinical matters, the personnel shall include licensed, certified, or registered healthcare professionals.

Healthfirst must allow the member or his/her designee, both before and during the Action Appeals process, the opportunity/ability to examine the member's case file, including medical records and any other documents and records considered during the Action Appeals process. The member or his/her designee is subject to the Release of Information process.

Clinical Matters

The determination of an appeal on a clinical matter is made by personnel qualified to review the appeal, including licensed, certified, or registered healthcare professionals who did not make the initial determination, at least one of whom must be a clinical peer reviewer as defined in Article 49 of the NYS Public Health Law.

Nonclinical Matters

The determination of an appeal on a matter which is not clinical shall be made by qualified personnel at a higher level than the personnel who made the Action determination.

Timeliness of Action Appeals Determination

Healthfirst shall seek to resolve all appeals in the most expeditious manner.

Healthfirst must resolve an Action Appeal as fast as the member's condition requires and no later than thirty (30) calendar days from the date of receipt of the Action Appeal.

Healthfirst must resolve Expedited Action Appeals as fast as the member's condition requires but within two (2) business days of receipt of necessary information and not later than within three (3) business days of the date of the receipt of the Action Appeal.

Time frames for Action Appeal resolution may be extended for up to fourteen (14) calendar days if requested by Healthfirst, the member, his or her designee, or the provider if it is in the best interest of the member.

In the event Healthfirst requires additional information to process the appeal, Healthfirst shall request the additional information in writing.

If Healthfirst does not make a determination within the time frames specified, as applicable, this shall be deemed to be a reversal of the UR agent's adverse determination.

15.11 Expedited Appeals – Medicaid, and Medicaid Advantage Plus, Absolute Care

A Healthfirst member, his or her representative, or a participating provider may request expedited consideration of an appeal if the standard time frame would seriously jeopardize the life or health of the member or the member's ability to regain maximum function. Expedited appeals are processed within two (2) business days of receipt of necessary information and not later **than three (3) business days of the date of the receipt of the appeal.**

Notice of an Action Appeal Determination

The **notice of a determination on an appeal shall include the detailed reasons for the determination**

and, in cases where the determination has a clinical basis, the clinical rationale for the determination.

Healthfirst must send written notice to the member, his or her designee, and the provider (where appropriate) within two (2) business days of the Action Appeal determination.

Healthfirst shall not retaliate or take any discriminatory action against a member because a member or a member's representative has filed an Action Appeal.

15.12 Member Rights to a Fair Hearing – Medicaid, Medicaid Advantage Plus

Medicaid and Medicaid Advantage Plus members may request a Fair Hearing regarding adverse determinations concerning:

- Enrollment, disenrollment, eligibility
- Denial, termination, suspension, or reduction of a clinical treatment or other benefit package services by Healthfirst that is covered under the Medicaid benefit
- Healthfirst's lack of reasonable promptness to act regarding these services

The Medical Management department will issue the Managed Care Action Taken Form, which contains the member's Fair Hearing Rights with instructions on how to request a Fair Hearing, along with its initial adverse determination when Healthfirst has denied a request to approve a benefit package service ordered by a participating provider. For Medicaid Advantage Plus members, the Appeals and Grievances department will issue the Managed Care Action Taken Form with the final adverse determination on an Action Appeal of the denial of Medicaid-only services. If you have questions about the Fair Hearing process or would like additional information, please call **1-888-801-1660.**

15.13 External Review – Medicaid, Medicaid Advantage Plus, Healthfirst Leaf Plans, and Commercial Plans

External Appeal

In connection with a concurrent or retrospective review, members and a member's healthcare provider are able to request an external appeal for the three (3) types of adverse determinations – **not medically necessary services, experimental or investigational, or clinical trial or treatment of rare disease or when out-of-network services are denied as not materially different from services available in-network or when services are denied because they are considered treatment for a rare disease.**

If both the member and Healthfirst agree to waive the Healthfirst appeals process, then the member must ask for the external appeal within four (4) months of when the member made the agreement from the date of the denial determination. If this occurs, Healthfirst will provide a written letter with information regarding filing an external appeal to the member within twenty-four (24) hours of agreement to waive the internal appeal process.

Providers may elect an external appeal on behalf of the member within 60 days of the final adverse determination.

Members are also instructed about the external appeal process at the time of the internal appeal determination if any part of the denial determination is upheld. Healthfirst provides a copy of the External Appeal Process developed jointly by the State Department of Health (SDOH) and the State Department of Financial Services (DFS), including an application and instructions to members or providers regarding how to request an external appeal.

For Providers

Healthfirst will forward an external appeal application for providers to appeal a concurrent or retrospective

final adverse determination within three (3) calendar days of the provider's request.

The external appeal determination decision will be made in thirty (30) days; however, more time may be needed if the external appeal reviewer needs to obtain more information (up to five [5] additional days).

The member and Healthfirst will be notified of the final determination within two (2) days after the external appeal decision is made. The external appeal agent may also notify providers of the outcome of the member's external appeal, where appropriate.

Providers must not seek reimbursement (except for copayments, coinsurance, or deductibles, where applicable) from members when a provider-initiated external review of a concurrent adverse determination determines that the healthcare services are not medically necessary.

The member's healthcare provider can request an expedited external appeal if the delay could cause the member serious harm. These expedited external appeal determinations will be made within three (3) days, and notification by phone or fax to the member and Healthfirst will occur. The external appeal agent may also notify providers of the outcome of the member's external appeal, where appropriate.

In most cases, Healthfirst will retain financial responsibility for external appeals that have been assigned to a certified external appeal agent. Providers are responsible for the costs of an unsuccessful appeal of a concurrent adverse determination. Providers and Healthfirst will share the cost of the external review when a concurrent adverse determination is upheld in part. If Healthfirst reverses a denial which is the subject of an external appeal after assignment to a certified external appeal agent but prior to assignment of a clinical peer reviewer, Healthfirst shall be responsible for the administrative fee as assessed.

15.14 Member Complaints – Medicaid

If a member has a problem, he/she can speak with his/her PCP or call or write to Member Services. Most problems can be solved right away. If a member has a problem or dispute with the care he/she is receiving, he/she can file a complaint with Healthfirst. Problems that are not solved right away over the phone and any complaint received via mail will be handled according to our complaint procedure described below.

Members can ask someone they trust (such as a legal representative, a family member, or friend) to file the complaint for them. If a member needs help because of a hearing or vision impairment or if he/she needs translation services or help filing the forms, we can help. Healthfirst will not take any action against the member for filing a complaint.

A member also has the right to file a complaint with the local area office of the New York State Department of Health or local Department of Social Services. To file with the New York State Department of Health, members may call **1-800-206-8125** or write to NYSDOH Division of Managed Care, Bureau of Managed Care Certification and Surveillance, Corning Tower ESP Room 1911, Albany, NY 12237.

To file with the City of New York, members may call the Human Resources Administration, Medicaid Assistance Program Helpline at **1-800-505-5678.**

A member may also contact their local Department of Social Services with their complaint at any time. A member may call the State Department of Financial Services at **1-800-342-3736** if their complaint involves a billing problem.

How to File a Complaint with the Plan

To file by phone, a member can call Member Services at **1-866-463-6743**. If a member calls Healthfirst after hours, they can leave a message and Healthfirst will return the call the next working day. If we need more information to make a decision, we will inform the member.

A member can write to us with a complaint or call the Member Services number and request a complaint form, which should be mailed to Healthfirst Appeals & Grievances Department, P.O. Box 5166, New York, NY 10274-5166 or faxed to **1-646-313-4618**.

What Happens Next?

If we don't solve the member's problem right away over the phone, we will send him/her a letter within fifteen (15) business days. The letter will tell the member who is working on the complaint, how to contact this individual, and whether more information is needed.

A member's complaint will be reviewed by one (1) or more qualified people. If the complaint involves clinical matters, the case will be reviewed by one or more qualified healthcare professionals.

After We Review the Complaint

We will let the member know our decision within forty-five (45) calendar days of when we have all the information we need to answer the complaint, but the member will hear from us within no more than sixty (60) calendar days from the day we get the original complaint. We will write the member and will tell him/her the reasons for our decision.

When a delay would risk the member's health, we will let the member know of our decision within forty-eight (48) hours of when we have all the information we need to answer the complaint, but the member will hear from us within no more than seven (7) days from the day we get the original complaint. We will call the member with our decision or try to reach the member to tell him/her. The member will get a letter to follow up on our communication within three (3) business days.

The member will be told how to appeal our decision if he/she is not satisfied, and we will include any forms needed. If we are unable to make a decision about a member's complaint because we don't have enough information, we will send a letter to let the member know.

Appeal of Complaints

If a member disagrees with a decision we made about his/her complaint, he/she can make a complaint appeal personally or ask someone they trust to file the appeal for them. If a member is not satisfied with what we decide, he/she has sixty (60) business days after hearing from us to file an appeal, which must be in writing. After a member calls, we will send a form which is a summary of their phone appeal.

What Happens After We Receive the Member's Complaint Appeal?

After we get a member's complaint appeal, we will send him/her a letter within fifteen (15) business days. The letter will tell him/her who is working on the complaint, how to contact this individual, and whether more information is needed.

The complaint appeal will be reviewed by one (1) or more qualified people at a higher level than those who made the first decision about the complaint. If the complaint appeal involves clinical matters, the case will be reviewed by one (1) or more qualified health professionals, with at least one (1) clinical peer reviewer who was not involved in making the first decision about the complaint.

If we have all the information we need, the member will know our decision in thirty (30) business days. If a delay would risk his/her health, he/she will get our decision within two (2) working days of when we have all the information we need to decide the appeal. The member will be given the reasons for our decision and our clinical rationale, if it applies. If the member is still not satisfied, he/she or someone on their behalf can file a complaint at any time with the New York State Department of Health at **1-800-206-8125.**

15.15 Standard Appeals – Commercial, CHPlus

A CHPlus member or a member's designee shall have no more than forty-five (45) days from the date the adverse determination notice is received to file a standard appeal. Healthfirst will accept an oral or written standard appeal. An oral appeal can be filed by calling our toll-free telephone Member Services number, Monday through Friday, between 8am and 8pm.

We will send a notice that the appeal has been received for review within fifteen (15) business days of our receiving the request. The appeal will then be investigated and a decision made within thirty (30) calendar days.

Once we make a decision, the member or member's designee, as appropriate, will be notified within two (2) business days of our reaching a decision. This notice will include the reasons (and any related medical information) for our decision and further appeal rights.

Healthfirst commercial members have 180 calendar days from the date the adverse determination notice is received to file a standard appeal.

Healthfirst will provide written acknowledgment of the member's appeal within fifteen (15) calendar days of receipt of the appeal request.

Written notice of the appeal determination will be provided to the member or member's designee, as appropriate, and the provider within two (2) business days of our reaching a decision.

15.16 Appealing the Grievance – CHPlus, Commercial (Small Group)

A member or a member's designee shall have no more than sixty (60) business days after receipt of notice of the grievance determination to file an appeal.

Within fifteen (15) business days of receipt of the appeal, Healthfirst shall provide written acknowledgment of the appeal, including the name, address, and telephone number of the individual designated by Healthfirst to respond to the appeal and what additional information, if any, must be provided in order for the organization to render a decision.

Clinical Matters: The determination of an appeal on a clinical matter is made by personnel qualified to review the appeal, including licensed, certified, or registered healthcare professionals who did not make the initial determination, at least one (1) of whom must be a clinical peer reviewer as defined in Article 49 of the NYS Public Health Law.

Nonclinical Matters: The determination of an appeal on a matter which is not clinical shall be made by qualified personnel at a higher level than the personnel who made the grievance determination.

Healthfirst individual market commercial members do not have grievance appeal rights. If a Healthfirst Leaf Plan member is dissatisfied with the grievance determination, they may call the New York State Department of Health at
1-800-206-8125 or write to them at New York State Department of Health, Corning Tower, Empire State Plaza, Albany, NY 12237.

Timeliness of Appeals Determination

Healthfirst shall seek to resolve all appeals of grievances in the most expeditious manner and shall make a determination and provide notice no more than two (2) business days after the receipt of all necessary information when a delay would significantly increase the risk to a member's health, and no more than thirty (30) business days after the receipt of all necessary information in all other instances.

Notice of Appeals Determination

The notice of a determination on an appeal shall include the detailed reasons for the determination, and in cases where the determination has a clinical basis, the clinical rationale for the determination.

Healthfirst shall not retaliate or take any discriminatory action against a member because a member has filed an appeal or grievance.

15.17 Expedited Appeals – Commercial, CHPlus

A Healthfirst member, the member's representative, or a participating provider may request expedited consideration of an appeal if the standard time frame would seriously jeopardize the life or health of the member or the member's ability to regain maximum function. Expedited appeals are processed within two (2) business days of receipt of requested information and within no more than 72 hours of receipt of the request.

The notice of determination regarding the appeal will include the reason(s) for a Healthfirst decision, including any clinical factors. Appeals for services previously provided are not eligible for an expedited appeal. Appeal of claims determinations are also not eligible for an expedited appeal.

15.18 External Review – Commercial, CHPlus

External Appeal

In connection with a concurrent or retrospective review, members and a members' healthcare providers are able to request an external appeal for four (4) types of adverse determinations: **1) services deemed not medically necessary, 2) services deemed experimental or investigational (include clinical trials and treatments for rare diseases), 3) services denied because they are not materially different from services available in-network, 4) or in the instance of a denied referral to an out-of-network non-participating provider.**

A member may elect to file an external appeal at the time of the initial adverse determination if s/he and Healthfirst both agree to waive Healthfirst's internal appeals process. If both the member and Healthfirst agree to waive the Healthfirst appeals process, then the member must ask for the external appeal within four (4) months of the date of the denial determination. Providers may elect an external appeal on behalf of the member within sixty (60) days of the final adverse determination.

Members are also instructed about the external appeal process at the time of the internal appeal determination if any part of the denial determination is upheld. Healthfirst provides a copy of the External Appeal Process developed jointly by the State Department of Health (SDOH) and the State Department of Financial Services (DFS) including an application and instructions to members or providers to request an external appeal.

Members must file their external appeal with the DFS within four (4) months of the time that Healthfirst gave the notice of final adverse determination from the appeals process.

For Providers

Healthfirst will forward an external appeal application for providers to appeal a concurrent or retrospective final adverse determination within three (3) calendar days of the provider's request.

The external appeal determination decision will be made in thirty (30) days; however, more time may be needed if the external appeal reviewer needs to obtain more information (up to five [5] additional days).

The member and Healthfirst will be notified of the final determination within two (2) days after the external appeal decision is made. The external appeal agent may also notify providers of the outcome of the member's external appeal, where appropriate.

Providers must not seek reimbursement (except for copayments, coinsurance, or deductibles, where applicable) from members when a provider-initiated external review of a concurrent adverse determination determines that the healthcare services are not medically necessary.

The member's healthcare provider can request an expedited appeal if the delay could cause the member serious harm. These expedited external appeal determinations will be made within three (3) days, and notification by phone or fax to the member and Healthfirst will occur. The external appeal agent may also notify providers of the outcome of the member's external appeal, where appropriate.

In most cases, Healthfirst will retain financial responsibility for external appeals that have been assigned to a certified external appeal agent. Providers are responsible for the costs of an unsuccessful appeal of a concurrent adverse determination. Providers and Healthfirst will share the cost of the external review when a concurrent adverse determination is upheld in part. If Healthfirst reverses a denial which is the subject of an external appeal after assignment to a certified external appeal agent but prior to assignment of a clinical peer reviewer, Healthfirst shall be responsible for the administrative fee as assessed.