Section 5 - Billing Reimbursement Procedures

Senior Health Partners is committed to provide the highest level of service in claims processing, including rapid reimbursement. Senior Health Partners also adheres to the New York State Insurance Department's prompt payment requirement.

5.1 a Claims Submission Procedures

Submitting Claims Electronically

Senior Health Partners utilizes the Emdeon (WebMD) clearinghouse for all electronic claims. Claims submitted electronically on the CMS 1500 and UB 04 receive a status report indicating which claims were accepted, rejected and/or pending, and the amount paid on the claim once it has been finalized. Claims submitted electronically must include:

1. Senior Health Partners Payer ID Number 80141
2. Complete Senior Health Partner Member's CIN ID number
3. A National Provider Identifier (NPI) should reside in:

- 837 Professional (CMS)-Loop 2310B Rendering Provider Secondary ID, Segment/Element NM109. NM 108 must qualify with an XX (NPI)
- 837 Institutional (UB04)-Loop 201 AA Billing Provider, Segment/Element NM 109. NM 108 must qualify with an XX (NPI)

To sign up for electronic billing providers must contact their software vendor and request that their Senior Health Partners claims be submitted through Emdeon. Providers can also direct their current clearinghouse to forward claims to Emdeon. Please contact Emdeon at (800) 845-6592 for information on how to set up electronic billing.

If you have any questions regarding claims issues, please call (877) 737-2693. Representatives are available Monday-Friday, 9am-5pm.

Submitting Paper Claims

All paper claims should be submitted to:

Senior Health Partners Claim Department
P. O. Box 958439
Lake Mary, FL 32795-8439

All Paper claims should include the National Provider Identifier (NPI) and well as the Senior Health Partners-assigned Provider ID Number, (the latter is not required for electronic claims). The Senior Health Provider ID is a unique provider number for each practice site.

Timely Claim Submission

In-network providers must file claims within 180 days of the date of service. Out-of-network providers must file claims according to Medicare fee-for-service rules.

Authorizations: All Senior Health Partners network providers and Out of Network Providers will receive an authorization for covered services EXCEPT FOR Dentistry, Optometry, Audiology and Podiatry. Except for

emergency services and treatment of urgent medical conditions, providers are required to receive authorization prior to providing services to Senior Health Partner members, whether or not Senior Health Partners providers referred the members. Contact Senior Health Partner's Care Management Team at (212) 324-2600 for questions related to care management and service authorizations.

Billing Senior Health Partners

All payments for services provided to Senior Health Partners members constitute payment in full. **Providers may not balance bill members for the difference between their actual charges and the reimbursed amounts; any such billing is violation of the provider's contract with Senior Health Partners and applicable New York State Law.** Where appropriate, Senior Health Partners will refer providers who willfully or repeatedly bill members to the relevant regulatory agency for further action.

Reference: Tab 3 – Sample Blank HCFA Form 1500

SAMPLE LHCSA-BILLING FORM-SHP
Senior Health Partners Claims Department
PO Box 958439
Lake Mary, Florida 32795-8439

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID) [X]

1a. INSURED'S I.D. NUMBER (For Program in Item 1): MEDICAID#

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SAME AS INSURED

3. PATIENT'S BIRTH DATE MM DD YY | SEX M [ ] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): JOHN DOE

5. PATIENT'S ADDRESS (No., Street):

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 100 PATATE STREET

CITY: | STATE:

8. PATIENT STATUS: Single [ ] Married [ ] Other [X]

CITY: BROOKLYN | STATE: NY

ZIP CODE: | TELEPHONE (Include Area Code): ( )

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: 11232 | TELEPHONE (Include Area Code): (718) 555-5555

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: 10 12 1946 | SEX M [X] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, return to and complete items 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ON FILE DATE 10/17/11

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ON FILE

14. DATE OF CURRENT: MM DD YY | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP): 10 17 11

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1, 2, 3 or 4 to Item 24E by Line)

1. 250.00

2.

3.

4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: R000000

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1	11 01 12	11 01 12	12		T1019		1	3 50	4		NPI	TAX ID#-001 / NPI
2	11 02 12	11 02 12	12		T1020		1	200 00	1		NPI	111111111111
3	11 03 12	11 03 12	12		S5125		1	3 50	4		NPI	11111111111111
4	11 04 12	11 04 12	12		S5135		1	3 56	4		NPI	1111111111111
5	10 14 11	10 14 11	12		S5136		1	112 50	1		NPI	11111111111111
6	10 14 11	10 14 11	12		99082		1	14 00	1		NPI	1111111111111

25. FEDERAL TAX I.D. NUMBER: 777777777 | SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: TP5245

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 00 00

29. AMOUNT PAID: $

30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Must sign SIGNED 10/15/11 DATE

32. SERVICE FACILITY LOCATION INFORMATION

MYHOME CARE SERVICE, INC.
15 PAUL STREET
BROOKLYN NY 11220

a. 1236987563 b.

33. BILLING PROVIDER INFO & PH # ( )

15 PAUL STREET
BROOKLYN NY 11220
718-533-3333

a. 1236987563 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

5.1b Requests for Review and Reconsideration of a Claim

At times, a provider may be dissatisfied with a decision made by Senior Health Partners regarding a claim determination. Some of the common reasons include, but are not limited to, incorrectly processed or denied claim, the untimely submission of claims or failure to obtain prior authorization.

Providers who are dissatisfied with a claim determination made by Senior Health Partners must submit a **written** request for review and reconsideration with all supporting documentation to Senior Health Partners within **ninety (90) calendar days** from paid date on the provider's Explanation of Payment (EOP). Written requests, including attachments, must be mailed to the following location:

Senior Health Partners Claims Department

PO Box 958439

Lake Mary, FL 32795-8439

All written requests for Review and Reconsideration should include the following information: a copy of the EOP, the claim, supporting documentation, and a written statement explaining why you disagree with Senior Health Partners' determination as to the amount or denial of payment.

Examples of information and supporting documentation that should be submitted with written request for review and reconsideration include:

- A written statement explaining why you disagree with Senior Health Partners claim determination
- Providers name, address and telephone number
- Providers identification number
- Member's name and Senior Health Partners identification number
- Date(s) of service
- Senior Health Partners claim number
- A copy of the original claim or corrected claim if applicable
- A copy of the Senior Health Partners EOP
- A copy of the EOP from another insurer or carrier (e.g. Medicare) along with supporting medical records to demonstrate medical necessity
- Contract rate sheet to support payment rate or fee schedule
- Evidence of eligibility verification (e.g. copy of Senior Health Partners member ID card)
- Evidence of timely filing
  - R059 Report (insurance Carrier Rejection report) or Emdeon Vision "Claim for Review" / "Claim Summary Report
  - Please note: Senior Health Partners **does not** accept copies of certified mail or overnight mail receipts, or documentation from internal billing practice software as proof of timely filing.
- Copy of the approval number issued by the Care Management Team

Senior Health Partners will investigate all written requests for Review and Reconsideration and issue a written explanation stating that the claim has been either reprocessed or the initial denial has been upheld, within thirty (30) calendar days from the date of receipt of the provider's request for Review and Reconsideration.

Senior Health Partners will not review or reconsider claims determinations which are not appealed according to the procedures set forth above. If a provider submits a request for review and

reconsideration after the ninety (90) calendar day time frame, the request is deemed ineligible and will be dismissed. Providers will not be paid for any services irrespective of the merits of the underlying dispute if the request for review and reconsideration is not timely filed. In such cases providers may not bill members for services rendered.

All questions concerning requests for review and reconsideration should be directed to the Provider services unit at **1-877-737-2693.**

5.2 Provider Information

Providers are responsible for contacting Senior Health Partners to report any changes in their agency. It is essential that Senior Health Partners maintains an accurate provider database in order to ensure proper payment of claims, to comply with provider reporting requirements mandated by governmental and regulatory authorities, and to provide the most up-to-date information on provider choices to our members. Provider must notify Senior Health Partners with any of the following changes:

- Provider's name and Tax ID number (s)
- Providers address, zip code, telephone or fax number
- Provider's billing address
- Languages spoken in the provider's office
- National Provider Identification Number (if applicable)
- Office hours
- Provider closes their agency to new business

Providers should call the Senior Health Partners' Provider Services number at (877)737-2693 with any questions or fax all updates to the Provider Services Department at

(646) 313-4634.

5.3 Fraud Waste and Abuse

It is the policy of Senior Health Partners to comply with all Federal and State laws regarding fraud, waste and abuse, to implement and enforce procedures to detect and prevent fraud, waste and abuse regarding claims submitted to Federal and State healthcare programs, and to provide protection for those who report, in good faith, actual or suspected wrongdoing.

Potential fraud or misconduct related to the Medicare program is reported to HHS-OIG and the Medicare Drug Integrity Contractor (MEDIC) for fraud or misconduct related to the Medicare Prescription Drug Program. Potential fraud, waste, and abuse related to the NY state funded programs, are reported to the State Department of Health (SDOH) and/or the Office of the Medicaid Inspector General (OMIG).

The Compliance Policy

Senior Health Partners maintains a strict policy of *zero tolerance* toward fraud and abuse and other

inappropriate activities. Individuals who engage in any inappropriate activity alone or in collaboration with another employee, member, or provider are subject to immediate disciplinary action up to and including, termination.

As part of our commitment to this zero-tolerance policy, Senior Health Partners provides this information to vendors to achieve the following goals:

- Demonstrate to vendors its commitment to responsible corporate conduct
- Maintain an environment that encourages employees and vendors to report potential problems
- Ensure appropriate investigation of possible misconduct by the company and its vendors

Senior Health Partners has adopted various fraud prevention and detection programs whose purpose is to protect the member, the government, and/or Senior Health Partners from paying more for a service than it is obligated to pay. In addition, Healthfirst established a Special Investigations Unit (SIU), who ensures that Healthfirst is in compliance with all applicable state and federal regulations. Senior Health Partners may utilize the services of the Healthfirst Special Investigation Unit (SIU) for assistance in investigating alleged fraud events.

Definitions

Abuse - Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost, or in reimbursement for services that are not medically necessary, or that fail to meet professionally recognized standards of care. It also includes enrollee practices that result in unnecessary cost.

Fraud - An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or other person. It includes any act that constitutes fraud under applicable federal or State law.

Waste - The extravagant, careless, or needless expenditure of funds resulting from deficient practices, systems, controls, or decisions.

Relevant Statutes and Regulations

False Claims Act

The federal government amended the False Claims Act (FCA) to make it a more effective tool. Using the False Claims Act, private citizens (i.e., whistleblowers) can help reduce fraud against the government. The act allows everyday people to bring suits against groups or other individuals that are defrauding the government through programs, agencies, or contracts (the act does not cover tax fraud).

For the purposes of this policy, “knowing and/or knowingly” means that a person, has actual knowledge of the information; acts in a deliberate ignorance of the truth or falsity of the information; or acts in reckless disregard of the truth or falsity of the information; no proof of specific intent to defraud is required.

Both federal and state False Claims Acts (FCA) apply when a company or person:

a) Knowingly presents (or causes to be presented) to the Federal Government a false or fraudulent claim for payment,

b) Knowingly uses (or causes to be used) a false record or statement to get a claim paid by the Federal Government,

c) Conspires with others to get a false or fraudulent claim paid by the Federal Government,

d) Knowingly uses (or causes to be used) a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Federal Government.

Examples of the type of conduct that may violate the FCA include the following:

- Knowingly submitting premium claims to the Medicaid program for members not actually served by Senior Health Partners;

■ Knowingly failing to provide members with access to services for which Senior Health Partners has received premium payments; and
■ Knowingly submitting inaccurate, misleading or incomplete Medicaid cost reports.

What Money Can Be Recovered?

Those that defraud the government can end up paying triple the damages done to the government, a fine (between $5,000 and $10,000) for every false claim, and the claimant's costs and attorneys' fees.

If the government takes on the case, the individual who brings the claim is usually entitled to receive 15% to 25% of the recovered funds. If the government decides not to intervene, the individual is entitled to 25% to 30% of the funds.

Protections for Whistle Blowers

Whistle blower protection is provided by Federal acts and related State and Federal laws that shield employees from retaliation for reporting illegal acts of employers. An employer cannot rightfully retaliate in any way, such as discharging, demoting, suspending or harassing the whistle blower. If an employer retaliates in any way, whistle blower protection might entitle the employee to file a charge with a government agency, sue the employer, or both.

If you suspect that fraud, waste or abuse is taking place against New York's Medicaid program, call the fraud hotline toll free at **1-877-87 FRAUD (1-877-873-7283)** to make an anonymous report.

To report information about fraud, waste or abuse involving Medicare or any other health care program involving only federal funds you can call the toll-free hotline established by the federal Office of Inspector General in the U.S. Department of Health and Human Services. The hotline number is **1-800-HHS-TIPS (1-800-447-8477).** For more information about this hotline and about other ways to contact the Office of Inspector General, you can go to https://oig.hhs.gov/

The following are the applicable false claim act regulations for further reference:

Federal Program Fraud Civil Remedies Act

31 U.S.C. 3801-3812

For a copy of this citation, please visit

https://www.federalregister.gov/articles/2009/06/04/E9-12170/program-fraud-civil-remedies-act

Provides federal administrative remedies for false claims and statements, including those made to federally funded health care programs. Current civil penalties are $5,500 for each false claim or statement, and an assessment in lieu of damages sustained by the federal government of up to double damages for each false claim for which the Government makes a payment. The amount of the false claims penalty is to be adjusted periodically for inflation in accordance with a federal formula.

For a copy of the New York citation listed below, you may find them on the Law of New York website at

http://public.leginfo.state.ny.us/menugetf.CGI?COMMONQUERY=laws.

NY False Claims Act (State Finance Law, §§187-194)

The NY False Claims Act closely tracts the federal False Claims Act. It imposes penalties and fines on individuals and entities that file false or fraudulent claims for payment from any state or local government, including health care programs such as Medicaid. The penalty for filing a false claim is $6,000 -$12,000 per claim and the recoverable damages are between two and three times the value of the amount falsely received. In addition, the false claim filer may have to pay the government's legal fees.

The Act allows private individuals to file lawsuits in state court, just as if they were state or local government parties. If the suit eventually concludes with payments back to the government, the person who started the case can recover 25-30% of the proceeds if the government does not participate in the suit and 15-25% if the

government participates in the suit.

Social Services Law §145-b False Statements

It is a violation to knowingly obtain or attempt to obtain payment for items or services furnished under any Social Services program, including Medicaid, by use of a false statement, deliberate concealment or other fraudulent scheme or device. The State or the local Social Services district may recover three times the amount incorrectly paid. In addition, the Department of Health may impose a civil penalty of up to $2,000 per violation. If repeat violations occur within 5 years, a penalty up to $7,500 per violation may be imposed if they involve more serious violations of Medicaid rules, billing for services not rendered or providing excessive services.

Social Services Law §145-c Sanctions

If any person applies for or receives public assistance, including Medicaid, by intentionally making a false or misleading statement, or intending to do so, the person's family's needs are not taken into account for 6 months if a first offense, 12 months if a second (or once if benefits received are over $3,900) and five (5) years for 4 or more offenses.

Social Services Law §145 Penalties

Any person who submits false statements or deliberately conceals material information in order to receive public assistance, including Medicaid, is guilty of a misdemeanor.

Social Services Law § 366-b, Penalties for Fraudulent Practices

- Any person who obtains or attempts to obtain, for himself or others, medical assistance by means of a false statement, concealment of material facts, impersonation or other fraudulent means is guilty of a Class A misdemeanor.
- Any person who, with intent to defraud, presents for payment and false or fraudulent claim for furnishing services, knowingly submits false information to obtain greater Medicaid compensation or knowingly submits false information in order to obtain authorization to provide items or services is guilty of a Class A misdemeanor.

Responsible Parties – Health Care Fraud

Senior Health Partners conducts annual focused, audits on high volume, high risk service vendors. Results of audits are shared with vendors. Plans of corrections or quality improvement activities are developed to enhance operational practice and support member satisfaction.

If, after a review of all documentation provided, it is believed that the services billed are unsupported, they will be considered overpayments and Senior Health Partners will determine the total overpayment and ask the selected provider to refund the monies paid. In addition, education will be provided to ensure further billings are submitted according to established guidelines. The results of these audits are presented to the Senior Health Partners Audit, Fraud, Abuse and Compliance Committee (AFAC). Failure to cooperate may result in the non-renewal of your contract with Senior Health Partners and/or additional reporting to state and/or federal authorities.

Senior Health Partners Audit, Fraud, Abuse and Compliance Committee (AFAC)

The AFAC Committee is responsible for reviewing all allegations of improper billing and potential fraudulent and/or abusive activity committed by providers; and has the authority to make recommendations to the Senior Health Partners Board of Directors regarding the allegation including, but not limited to, termination of the provider agreement according to the guidelines described in the provider contract and any other applicable regulatory or law enforcement agencies; and recovery of overpayments.

In addition, the AFAC committee reviews and updates its annual compliance plan. The Plan describes the responsibilities of the Compliance Officer, employees and contractors to act in a lawful and ethical manner.

Each is expected to fully comply with applicable standards, recognize and avoid actions and relationships that might violate those standards and seek counsel in situations raising legal and ethical concerns.

Senior Health Partners AFAC Committee meets at least three times a year and is comprised of the following Senior Health Partners and Healthfirst staff members:

- Senior Health Partners, Executive Director
- Senior Health Partners, Vice President of Clinical Excellence, Compliance Officer
- Senior Health Partners, Medical Director
- Senior Health Partners Community Board Representative
- Healthfirst , Senior Vice President and General Counsel
- Healthfirst, Vice President Compliance and Audit

Common Methods of Fraud and Abuse

In order to assist you with understanding and/or identifying what may constituent fraud, waste and/or abuse, we have provided some typical examples for your reference.

Fabrication of Claims: In the outright fabrication of claims or portions of claims, a fraud perpetrator uses legitimate patient names and insurance information either to concoct entirely fictitious claims or to add to otherwise legitimate claims fictitious charges for treatments or services that were never provided or performed. Examples are as follows:

- Submitting claims for services not rendered.
- A provider who, in the course of billing for actual authorized services submits additional charges for services that were never performed
- A Durable Medical Equipment provider submitting claims for equipment and supplies never delivered, or continuing to submit claims for rented equipment after it has been picked up.

Falsification of Claims: In the falsification of claims, the perpetrator makes a material and intentional misrepresentation of one or more elements of information in the claim, for the purpose of obtaining a payment to which he or she is not entitled. Examples are as follows:

- A provider performs medically unnecessary services solely in order to bill and be paid for doing so.
- A provider falsifies the dates on which services were provided, so that they fall within a given eligibility period of the member.
- A provider falsifies the identity of the provider of services, so as to obtain payment for services rendered by a non-covered and/or non-licensed provider
  - For example, submitting claims for clinical social worker services as psychiatric treatment provided by a licensed psychiatrist, or billing fitness center massages as a licensed physical therapy.
- A provider upcodes the services rendered to obtain greater reimbursement.
- Upcoding of Evaluation and Management services to indicate a greater complexity of medical decision making than was actually rendered; encounters that required straightforward decision making are reported as having required highly complex decision making.

Unbundling: Provider submits a claim reporting comprehensive procedure code or with multiple incidental procedure codes that are an inherent part of performing the comprehensive procedure. Some providers may submit the unbundled procedures on multiple claims in an attempt to bypass bundling edits in the claims processing system.

Fragmentation: Provider submits a claim with all the incidental codes or itemizes the components of the procedures/services. Some providers may submit the unbundled procedures on multiple claims in an attempt to bypass fragmentation edits in the claims processing system.

Duplicate claim submissions: Submitting claims under two Tax Identification Numbers to bypass duplicate claim edits in the claims processing system.

Fictitious Providers: Perpetrators obtain current membership information from operatives working in the billing offices of legitimate providers (usually hospitals) and submit claims, usually on the CMS 1500 claim

form.

Reporting of fraudulent, wasteful and abusive activities

Senior Health Partners maintains a strict policy of ***zero tolerance*** toward fraud and abuse and other inappropriate activities. As part of our commitment to this "**zero-tolerance**" policy, Senior Health Partners wants to ensure that our providers understand that we expect vendors to bring any alleged inappropriate activity which involves Senior Health Partners to our attention. Providers may confidentially report a potential violation of our compliance policies or any applicable regulation by contacting the following departments:

Corporate Compliance Officer at Healthfirst

100 Church Street

New York, NY 10007

By Phone: (212) 453-4495

E-Mail: **compliance@healthfirst.org**

Anonymously - to the Confidential Compliance Hotline at **1-877-879-9137**

5.4 Claims Appeals/Review and Reconciliation Process

Providers who are dissatisfied with the outcome of the Review and Reconsideration may submit a **written** request for a formal appeal within **sixty** (60) calendar days from the date listed on the reconsideration determination letter.

Providers should submit all written requests for an appeal of a claim determination to the following location:

Provider Claim Appeals
PO Box 958432
Lake Mary, FL 32795-8432

Providers should provide a written statement explaining why they disagree with Senior Health Partners decision regarding the review and reconsideration, and submit a copy of that determination. Providers should also specify the name, address and telephone number of the individual who may be contacted regarding the appeal, and include any additional relevant documentation to support the providers position. Senior Health Partners will not accept appeals from providers that are not made in writing and fail to address the reason for the appeal.

For appeals on payments rates, providers should specify in writing the basis for the dispute and enclose all relevant documentation including, but not limited to, contract rate sheets or fee schedules.

Senior Health Partners will send a letter to the provider acknowledging the request for an appeal with the fifteen (15) business days of receipt. This acknowledgment letter will request any additional information that may be necessary in order for Senior Health Partners to render a decision. If additional information is requested, the provider must submit the information with (30) calendar days. If a provider fails to submit the additional requested information, the file will be closed and the denial letter will be issued to the provider.

Upon the receipt of all the necessary information, Senior Health Partners will issue a decision, in writing, within thirty (30) calendar days of receipt of the additional requested information. If medical records are necessary to resolve a claim determination, excluding those claims which are denied for failure to obtain prior authorization, the supporting clinical documentation will be retrospectively reviewed by staff in the Quality Management Department and or Senior Health Partners' Medical Director.

Senior Health Partners will not consider appeals that are not filed according to the procedures set forth above.

If a provider files an appeal after the (60) calendar day time frame, the request is deemed ineligible and will be dismissed. Providers will not be paid for any services irrespective of the merits of the underlying dispute if an appeal is not filed within timely filing requirements.

5.5 Overpayment Recovery Appeals Process

Senior Health Partners periodically reviews payments made to providers to ensure the accuracy of claim payments pursuant to the terms of the provider contracts, or as part of its continuing utilization review and fraud control programs. In doing so, Senior Health Partners may identify instances when we have overpaid a provider for certain services. When this happens, Senior Health Partners provides notice to the provider and recoups the overpayment consistent with Section 3224-b of the New York State insurance Law.

Senior Health Partners will not pursue overpayment recovery efforts for claims older than twenty-four (24) months after the date of the original payment to a provider unless the overpayment is (1) based upon a reasonable belief of fraud, intentional misconduct or abusive billing; (2) required or initiated by the request of a self-insured plan or (3) required by state or federal government program. The above restrictions shall not apply to any overpayment recovery efforts made by Senior Health Partners prior to January 1, 2007 when notice has been provided to the provider of such recovery efforts.

In addition, we may at times apply the procedures described in this section in order to recoup duplication claims payments but reserve the right to use other procedures to do so. In addition, if a provider asserts that Senior Health Partners has underpaid any claim(s) to a provider, Senior Health Partners may offset any underpayments that may be owed against past overpayments made by Senior Health Partners dating as far back as the claimed underpayment.

We will Provide Notice of Overpayments before We Seek Recovery

If Senior Health Partners has determined that an overpayment has occurred, Senior Health Partners will provide sixty (60) days written notice to the provider of the overpayment and request repayment. This notice will include the member's name, service dates, payment amounts, proposed adjustments and a reasonably specific explanation of the reason for the overpayment and the proposed adjustment. In response to this notice, the provider may dispute the finding or remit payment as outline below.

If You Agree That We Have Overpaid You

Upon the receipt of a request for repayment, providers may voluntarily submit a refund check made payable to the corporate entity named on the demand letter (e.g. Senior Health Partners) within sixty (60) days from the date the overpayment notice was mailed by Senior Health Partners. Providers should further include a statement in writing regarding the purpose of the refund check to ensure the proper recording and timely processing of the refund.

If You Disagree That We Overpaid You

If a provider disagrees with Senior Health Partners determination concerning **the overpayment, the provider must submit in written request for an appeal within sixty (60) days from the date the overpayment notice was mailed by Senior Health Partners** and include all supporting documentation in accordance with the provider appeal procedure described in Section 5.4. If, upon reviewing all supporting submitted by a provider, Senior Health Partners determines that the overpayment determination should be upheld, providers may initiate arbitration pursuant to their provider agreement. Senior Health Partners **will proceed to offset the amount of the overpayment prior to the final determination made pursuant to binding arbitration**.

If You Fail to Respond to Our Notice of Overpayments

If a provider fails to dispute a request for repayment concerning an overpayment determination made by

Senior Health Partners with sixty (60) days form the date the overpayment notice was mailed by Senior Health Partners, the provider will have acknowledge and accepted the amount demanded by Senior Health Partners and, subject to the provider's right to arbitration pursuant to the provider agreement, Senior Health Partners will offset the amount outstanding against current and future claim remittance(s) until the full amount is recovered by Senior Health Partners.

If an Offset Result in a Negative Balance

If an overpayment offset result in a vendor negative balance the provider will not receive an explanation of payment until the entire offset amount had been recovered. The provider will receive a weekly negative balance letter that states the current negative amount and any claim activity that has taken place since the check cycle period. Once the entire negative amount has been recovered, the provider will resume receiving EOPs.

5.6 Adverse Reimbursement Change

Effective January 1, 2010, Public Health Law 4406-c was amended to indicate the requirement for giving written notice of adverse reimbursement changes to the provider's contract and allowing the provider to terminate the contract, as follows:

- Senior Health Partners will provide written notice at least 90 days prior to an adverse reimbursement change to the provider contract.
- If the provider objects to the change, he/she may, within thirty days of the date of the notice give written notice to Senior Health Partners to terminate the contract effective upon the implementation of the reimbursement change.
- Under the law, an adverse reimbursement change is defined as one that "could reasonably be expected to have an adverse impact on the aggregate level of payment to a health care professional."

The following statutory exceptions to the notice requirement:

The change is otherwise required by law, regulation or applicable regulatory authority, or is required due to changes in fee schedules, reimbursement methodology or payment policies by the State or Federal government or by the American Medical Association's Current Procedural Terminology (CPT) Codes, Reporting Guidelines and Conventions; and

The change is provided for in the contract between Managed Care Organization (MCO) and the provider or the IPA and the provider through inclusion of or reference to a specific fee or fee schedule, reimbursement methodology or payment policy indexing mechanism.

There is no private right of action for a health care professional relative to this provision.

5.7 Provider External Appeals – Effective January 1, 2010

Provider External Appeal Rights

Public Health Law 4914 was amended to extend external appeal rights to providers in connection with concurrent adverse determinations. Payment for an external appeal at PHL 4914 was amended to include a health care provider filing an external appeal of a concurrent adverse determination. A provider will be

responsible for the full cost of an appeal for a concurrent adverse determination upheld in favor of Senior Health Partners; Senior Health Partners is responsible for the full cost of an appeal that is overturned; and the provider and Senior Health Partners must evenly divide the cost of a concurrent adverse determination that is overturned in part.

The fee requirements do not apply to providers who are acting as the member's designee, in which case the cost of the external appeal is the responsibility of the MCO. For the provider to claim that the appeal of the final adverse determination is made on behalf of the member will require completion of the external appeal application (see Attached External Appeals Application and Instructions) and the designation. The Superintendent has the authority to confirm the designation or to request additional information from the member. Where the member has not responded, the Superintendent will inform the provider to file an appeal. A provider responding within the timeframe will be subject to the external appeal payment provision described above. If the provider is unresponsive, the appeal will be rejected.

Hold Harmless

Public Health Law was amended to add a new section 4917. A provider requesting an external appeal of a concurrent adverse determination, including a provider requesting the external appeal as the member's designee, is prohibited from seeking payment, except applicable copays, from a member for services determined to be not medically necessary by the external appeal agent. Thus, members are held harmless in such cases.

NEW YORK STATE EXTERNAL APPEAL APPLICATION

New York State Insurance Department, PO Box 7209, Albany NY, 12224-0209

If an HMO or insurer (health plan) denies health care services as not medically necessary, experimental / investigational, a clinical trial, a rare disease treatment, or out-of-network, complete and send this application to the above address within 45 days of the plan's final adverse determination. For help call 1-800-400-8882.

1. **Applicant Name:**

_____

(Please check one) [ ]Insured/Patient [ ]Patient's Designee [ ]Provider

2. **Patient Name:**

_____

3. Patient Address:

_____
_____

4. **Patient Phone Number:**

Home(_____)_____**Work(_____)**_____

5. **Patient E-mail (if you want contact by e-mail):** _____

6. **Health Plan Name:**

_____

7. If the patient is covered under a Medicaid Managed Care Plan, has the patient requested a fair hearing through Medicaid or received a fair hearing determination?

Yes _____ No_____

8. **Reason for Health Plan Denial: (Please check one.)**

[ ] Not medically necessary. [ ] Experimental / investigational.

[ ] Clinical trial. [ ] The treatment is for a rare disease.

[ ] Out-of-network and the health plan proposed an alternate in-network service.

9. Describe the service and the date(s) of service. **Attach the final adverse determination from the first level of appeal with the health plan, or the health plan's letter waiving the appeal,** along with any other information you would like considered.

_____
_____

_____
_____

_____
_____

_____
_____

_____
_____

10. If the patient has not received the service, the appeal may be expedited if the patient's physician fills out the attached form stating a delay will seriously threaten the patient's health. An expedited decision will be made in 3 days instead of 30 days, even if the patient or the patient's physician do not provide needed medical information to the external appeal agent.

Is this a request for an expedited appeal? [ ] Yes No [ ]

11. If this is a request for an **expedited appeal,** an appeal of **experimental / investigational services**, a **clinical trial denial**, an **out-of-network denial**, or a **rare disease treatment,** the patient must give the attached Physician Attestation (pages 3-5) to the physician who prescribed the treatment. (See special rules for rare diseases on page 3.) The physician must complete the form and send it to the Insurance Department. (Please check one.)

[ ] I gave the form to my physician [ ] I did not give the form to my physician.

12. **External Appeal Fee:** You must enclose a check or money order made out to the health plan if required by the health plan. If the appeal is decided in your favor, the fee will be returned to you. (Please check one.)

[ ] I enclosed a check or money order made out to the health plan.

[ ] I faxed my application and will mail the fee to the Insurance Department within 3 days.

[ ] The patient is covered under Medicaid, Child Health Plus or Family Health Plus and no fee is charged.

[ ] The patient requests a fee waiver for hardship and the patient will provide documentation to the health plan.

[ ] The health plan does not charge a fee for an external appeal / the fee is not required.

13. **I am sending this application to the Insurance Department by:** (Please check one.)

[ ] Certified or registered mail to New York State Insurance Department, PO Box 7209, Albany, NY 12224-0209.

[ ] Fax to **1-800-332-2729.** If your appeal is expedited, you must also call toll free 1-888-990-3991 to tell us.

14. **Name of the Patient's Physician / Provider:** _____

Address: _____
_____

Phone Number: (_____)_____

Fax Number: (_____)_____

15. **Complete this only if a designee submits this external appeal on the patient's behalf.** The patient is under no obligation to request an appeal and may be asked to confirm that a designee was authorized.

Name of Designee: _____

Relationship to Patient: _____

Address: _____

Phone Number: (_____)_____

Fax Number: (_____)_____

Designee E-mail (if you want contact by e-mail): _____

16. The patient must sign and date this external appeal request and consent to the release of medical records. An external appeal agent assigned by the New York State Insurance Department will use this consent to obtain medical information from the patient's health plan and health care providers. The name and address of the external appeal agent will be provided with the request for medical information.

I, _____ hereby request an external appeal. I attest that the information provided in this application is true and accurate to the best of my knowledge. I authorize my health plan and providers to release all relevant medical or treatment records related to the external appeal, including any HIV-related, mental health, or alcohol / substance abuse treatment information, to the external appeal agent. I understand the external appeal agent will use this information solely to make a decision on my appeal and the information will be kept confidential and not released to anyone else. This release is valid for one year. I may revoke my consent at any time, except to the extent that action has been taken in reliance on it, by contacting the New York State Insurance Department in writing. I understand that my health plan cannot condition treatment, enrollment, eligibility, or payment on whether I sign this form. I acknowledge that the decision of the external appeal agent is binding. I agree not to commence a legal proceeding against the external appeal agent to review the agent's decision; provided, however, this shall not limit my right to bring an action against the external appeal agent for damages for bad faith or gross negligence, or to bring an action against my health plan.

_____

Signature of Patient

_____

(Date)

(Or the patient's representative who can consent to the release of the patient's medical records. If a parent signs for a minor child, indicate the age of the child. If a guardian or executor signs, include proof of the appointment.)

Patient's Health Plan ID#:_____

17. Health care providers have a right to an external appeal of a concurrent or retrospective final adverse determination. **This item should only be completed by providers appealing on their own behalf, or as the patient's designee.** The health plan's initial denial and final adverse determination from the first level of appeal must be attached. I attest that the information provided in this application is true and accurate to the best of my knowledge. I agree not to pursue reimbursement for the service from the patient if a concurrent denial is upheld by the external appeal agent, except to collect a copayment or deductible. If I appeal a concurrent denial on my own behalf, and not as the patient's designee, the $50.00 fee is not required; however, I agree to pay the external appeal agent's fee in full if the health plan's concurrent denial is upheld, or to pay half of the agent's fee if the health plan's concurrent denial is upheld in part. I agree not to commence a legal proceeding against the external appeal agent to review the agent's decision; provided, however, this shall not limit my right to bring an action against the external appeal agent for damages for bad faith or gross negligence, or to bring an action against the health plan.

Provider Name: _____

Provider Contact Person: _____

Phone Number:(_____)_____

Provider E-mail (if you want contact by e-mail): _____

Provider Signature:_____

PHYSICIAN ATTESTATION FOR AN EXTERNAL APPEAL

New York State Insurance Department, PO Box 7209, Albany NY, 12224-0209

The patient's physician must complete this attestation for any external appeal of a health plan's denial of services as experimental / investigational; a clinical trial; a rare disease; out-of-network; or for any expedited appeal.

- For an **experimental / investigational** denial, the patient's physician must complete items **1-12 and 16**.
- For a **clinical trial** denial, the patient's physician must complete items **1-10, 13 and 16**.
- For an **out-of-network** denial, the patient's physician must complete items **1-9, 12 and 16**.
- For a **rare disease** denial, a physician, other than the treating physician, must complete items **1-9, 14 and 16**.
- For an **expedited appeal**, the patient's physician must complete items **1-9, 15 and 16**.

You must mail this attestation to the above address or fax it to 1-800-332-2729. The Insurance Department or the external appeal agent may need to request additional information from you, including the patient's medical records. This information should be provided immediately. If you have any questions call 1-800-400-8882.

1. **Name of Physician completing this form:**

_____

To appeal an experimental / investigational, clinical trial, or out-of-network denial, the physician must be a licensed, board-certified or board-eligible physician qualified to practice in the area of practice appropriate to treat the patient, who recommended the patient's treatment. For a rare disease appeal, a physician must meet the above requirements but may not be the patient's treating physician.

2**. Physician Address:**

_____

3. **Contact Person:** _____

4. **Phone Number: (_____)**_____

Fax Number: (_____)_____

5. **Physician E-mail (if you want contact by e-mail):** _____

6. **Name of Patient:** _____

7. **Patient Address:** _____

8. **Patient Phone Number:**

_____

9. **Patient Health Plan Name and ID Number:**

_____

10. **Complete this item for an external appeal of an experimental / investigational denial or a clinical trial denial. DO NOT complete this item for an appeal of an out-of-network denial or a rare disease denial**. As the patient's physician, I attest: (Select a or b without altering.)

a. ___ The patient has a life-threatening condition or disease with a high probability of causing the patient's death.

OR

b. ___ The patient has a disabling condition or disease which renders the patient unable to engage in any substantial gainful activities by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has or can be expected to last for a continuous period of not less than 12 months; or who, in the case of a child under the age of 18, suffers from any medically determinable physical or mental impairment of comparable severity.

11. **Complete this item for an external appeal of an experimental / investigational denial. DO NOT complete this item for an appeal of a patient's clinical trial participation, an out-of-network denial, or a rare disease denial.** As the patient's physician, I attest: (Select a or b without altering.)

a. ___ Standard health services or procedures have been ineffective or would be medically inappropriate.

OR

b. ___ There does not exist a more beneficial standard health service or procedure covered by the health plan.

12. **Complete this item for an external appeal of an experimental / investigational denial or an out-of-network denial. DO NOT complete this item for an appeal of a patient's clinical trial participation or rare disease.**

For an experimental / investigational denial: As the patient's physician I attest that I recommended a health service or pharmaceutical product that, based on the following **two** documents of medical and scientific evidence, is likely to be more beneficial to the patient than any covered standard health service. (Complete a and b below.)

For an out-of-network denial: As the patient's physician I attest that the out-of-network health service (identify service)

_____

_____

_____

is materially different from the alternate in-network health service recommended by the health plan, and based on the following two documents of medical and scientific evidence, is likely to be more clinically beneficial than the alternate in-network health service and the adverse risk of the requested health service would likely not be substantially increased over the alternate in-network health service. **(Complete a and b below.)**

a. List the documents relied upon in the space below and **attach a copy of the documents.**

Document #1 Title:_____

Publication Name: _____

Issue Number : _____ Date: _____

Document #2 Title: _____

Publication Name: _____

Issue Number :_____ Date: _____

b. The medical and scientific evidence listed above meets one of the following criteria *(note peer-reviewed literature does not include publications or supplements sponsored to a significant extent by a pharmaceutical manufacturing company or medical device manufacturer):* (**Check the applicable items below for each of the documents**.)

[ ] Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus, Medline and MEDLARS database Health Services Technology Assessment Research;

Document #1 [ ] Document #2 [ ]

[ ] Peer-reviewed scientific studies published in, or accepted for publication by, medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;

Document #1 [ ] Document #2 [ ]

[ ] Peer-reviewed abstracts accepted for presentation at major medical association meetings;

Document #1 [ ] Document #2 [ ]

[ ] Medical journals recognized by the Secretary of Health and Human Services, under section 1861(t)(2) of the Federal Social Security Act;

Document #1 [ ] Document #2 [ ]

[ ] The following standard reference compendia: (i) the American Hospital Formulary Service Drug Information; (ii) the American Medical Association Drug Evaluation; (iii) the American Dental Association Accepted Dental Therapeutics; and (iv) the United States Pharmacopeia-Drug Information;

Document #1 [ ] Document #2 [ ]

[ ] Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes including the federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Centers for Medicare and Medicaid Services, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services.

Document #1 [ ] Document #2 [ ]

13. **Complete this item only for a denial of a patient's participation in a clinical trial.**

a. ___ There exists a clinical trial which is open, the patient is eligible to participate, and the patient has or will likely be accepted. (**Although not required, it is recommended you enclose the clinical trial protocols and related information.**)

The clinical trial must be a peer-reviewed study plan which has been: (1) reviewed and approved by a

qualified institutional review board, and (2) approved by one of the National Institutes of Health (NIH), or an NIH cooperative group or center, or the Food and Drug Administration in the form of an investigational new drug exemption, or the federal Department of Veteran Affairs, or a qualified nongovernmental research entity as identified in guidelines issued by individual NIH Institutes for center support grants, or an institutional review board of a facility which has a multiple project assurance approved by the Office of Protection from Research Risks of the National Institutes of Health.

14. **Complete this item only for a rare disease denial.**

As a physician other than the patient's treating physician, I attest the patient has a rare life-threatening or disabling condition or disease. There is no standard treatment that is likely to be more clinically beneficial to the patient than the requested service, the requested service is likely to benefit the patient in the treatment of the patient's rare disease, and such benefit outweighs the risk of the service. I **do**____ **do not**____ (**check one**) have a material financial or professional relationship with the provider of the service **AND**: (Select a or b without altering.)

a. ___ The patient's rare disease currently or previously was subject to a research study by the National Institutes of Health Rare Diseases Clinical Research Network.

OR

b.___ The patient's rare disease affects fewer than 200,000 U.S. residents per year.

* If provision of the service requires approval of an Institutional Review Board include the approval with this attestation.

15. **Complete this item only for an expedited appeal.**

If the patient has **not yet received the treatment**, and a **delay would pose an imminent or serious threat to the patient's health**, the patient's physician may request the appeal to be expedited. The external appeal agent must make an expedited decision in 3 days, instead of 30 days, regardless of whether you provide all necessary medical information or records to the agent. **You must send any information to the agent immediately in order for it to be considered. (Please check one.)**

___**YES**, this appeal must be expedited. I am aware that the external appeal agent may need to contact me during non-business days for medical information, including medical records, and that a decision will be made by the external appeal agent within 3 days of receiving this expedited appeal request, regardless of whether or not I provide medical information or medical records to the external appeal agent.

During non-business days I can be reached at: _____

___**NO,** this appeal does not need to be expedited.

16. **Complete this item for an external appeal of a health plan's denial of services as experimental / investigational; a clinical trial; a rare disease; out-of-network; or for any expedited appeal.**

I attest that the above information is true and correct. I understand that I may be subject to professional disciplinary action for making false statements.

Physician Name (Please Print Clearly):

_____

Signature of Physician **(Date)**

EXTERNAL APPEAL INSTRUCTIONS & APPLICATION

Consumers have the right to an external appeal when health care services are denied by an HMO or insurer (health plan) as not medically necessary, experimental/ investigational, a clinical trial, a rare disease

treatment, or out-of-network. Providers have their own right to an external appeal when these health care services are denied concurrently or retrospectively. To request an external appeal, complete the attached application and send it to the New York State Insurance Department within 45 days of the date of the health plan's final adverse determination.

What Is An External Appeal? It is a request you make to the New York State Insurance Department when a health plan denies health care services. Your appeal will be reviewed by an independent external appeal agent with medical experts that will either overturn (in whole or part), or uphold the health plan's denial.

When Do I Request An External Appeal? You must send an external appeal application to the Insurance Department within 45 days from the date of the final adverse determination from the first level of appeal with the health plan OR the health plan's letter waiving the internal appeal process. If your application is not sent to the Insurance Department within 45 days (with an additional 8 days allowed for mailing), you will not be eligible for an external appeal.

What If A Health Plan Offers A Second Level Of Internal Appeal? You do not have to request a second level of internal appeal. However, if you request a second-level internal appeal, you must still request an external appeal within 45 days of the health plan's first level appeal determination.

What If Services Are Denied As Experimental / Investigational, A Clinical Trial, Or A Rare Disease? The patient must have a life-threatening or disabling condition or disease and the patient's physician (who for rare diseases may not be the treating physician) must complete and send pages 3-5 of the application to the Insurance Department.

What If Services Are Denied As Out-Of-Network? The patient must be covered under an HMO or managed care insurance contract and a pre-authorization request must be denied because the requested service is not available in-network and the health plan recommends an alternate in-network service that it believes is not materially different from the out-of-network service. The patient's physician must complete and send pages 3-5 of the application to the Insurance Department.

When Will An External Appeal Agent Make A Decision? In 3 days for expedited appeals or 30 days for standard appeals. The external appeal agent's decision is binding on the patient and the patient's health plan.

How Do I Request An Expedited (fast-tracked) External Appeal? The patient's physician must complete pages 3-5 of the application and attest that the patient has not received the treatment and a delay would pose a serious threat to the patient's health. Once an appeal is expedited, a decision will be made in 3 days, even if all of the patient's medical information has not been submitted.

When Can I Send Information To The External Appeal Agent? The patient, the patient's designee, and where appropriate the patient's provider, will be notified when an external appeal agent is assigned to the appeal.You must send any information to the agent immediately. Once the agent makes a decision, additional information will not be considered.

Do I Pay A Fee For An External Appeal? Some health plans charge $50.00, which is waived for patients who appeal and are covered under Medicaid, Child Health Plus, Family Health Plus, or if the fee will pose a hardship to the patient. The fee will be returned to you if the external appeal agent overturns the health plan's denial.

What If A Patient Has Medicare Or Medicaid Coverage? Patients covered under Medicare are not eligible for an external appeal and should call 1-800-MEDICARE or visit www.medicare.gov. Patients covered under regular Medicaid are not eligible for an external appeal; however, patients covered under a Medicaid Managed Care Plan are eligible. All Medicaid patients may also request a fair hearing, and the fair hearing decision will be the one that applies. Call 1-800-342-3334 or visit www.otda.state.ny.us/oah for fair hearing information.

What Are My External Appeal Rights If I Am A Health Care Provider? You have your own right to an external appeal of a concurrent or retrospective final adverse determination. Regardless of whether you appeal on your own behalf, or as the patient's designee, you may not pursue reimbursement from the patient

for the health care service if a concurrent denial is upheld by the external appeal agent, except to collect a copayment, coinsurance, or deductible.

FOR QUESTIONS OR HELP WITH AN APPLICATION CALL THE NEW YORK STATE INSURANCE DEPARTMENT AT 1-800-400-8882 OR VISIT http://www.dfs.ny.gov/insurance/extapp/extappl.pdf