Introduction

MVP Health Care takes great pride in providing our members with the highest quality health care and customer service. However, on occasion, misunderstandings and differences of opinion may occur. The MVP appeal and complaint procedures provide members with a dignified and confidential process to resolve these differences. MVP's subscriber contract, certificate of coverage or summary plan description will prevail in cases of any dispute or question concerning coverage or rules of eligibility, enrollment, or participation in an MVP health plan. MVP is committed to resolving all appeals and complaints fairly and amicably, and to assure a high level of quality care and service for members. MVP encourages members to utilize the appeal and complaint procedures when necessary. MVP will not retaliate or take any discriminatory action against a member who files an appeal or complaint.

Appeal

An appeal is a request for MVP to change a decision that has been made. It may concern whether or not a requested service is a benefit covered by MVP, or the way a complaint has been resolved.

Appeal Reviewers

For all levels of internal appeal, appeals are reviewed by persons who are not subordinate to those who made prior adverse benefit determinations. Appeals of clinical matters will be decided by personnel qualified to review the appeal, including licensed, certified, or registered healthcare professionals who were not involved in the initial determination, at least one of whom will be a clinical peer reviewer.

Provider Submitting Appeals on a Member's Behalf

A provider may appeal a request for a service or claim denial as the designated representative of an MVP member. MVP shall only accept appeals submitted by providers on a member's behalf after the member or appropriately appointed member representative has designated the provider to act on their behalf. Such designation must be in accordance with MVP's policies and procedures. (A provider filing an appeal on their own behalf for a retrospective UM denial follows the provider appeals process.)

Expedited Appeals Provider/Hospital on Member's Behalf

An expedited appeal is used whenever a member or member's designee appeals a denial of services that:

- Could seriously jeopardize the member's life or health or the member's ability to regain function, as determined by MVP applying the prudent layperson standard.
- In the opinion of the provider/hospital with knowledge of the member's medical condition would subject the member to severe pain that cannot adequately be managed without the care or treatment that is the claim's subject.
- Involves MVP's review of continued or extended health care services or additional services when the member is undergoing a course of continued treatment prescribed by the health care provider.

Providers/hospitals can initiate an expedited appeal on a member's behalf prior to the provider/hospital being appointed the member's designated representative, if the provider/hospital does the following:

- Calls the MVP Customer Care Center and indicates that he/she would like to submit an expedited member appeal on the member's behalf.

- Confirms to MVP's Customer Care Center that it is his/her reasonable belief that an expedited member appeal is appropriate in this case.
- Advises MVP's Customer Care Center that it is his/her reasonable belief that any further delay in submitting an appeal could have a detrimental effect on the member's health.

For **first level expedited appeals**, [An expedited External Appeal for medical necessity or experimental/investigational services can be made simultaneously with an expedited first level of internal appeal. Members requesting an expedited external appeal must still pursue all internal appeal options.] The Member Appeals Coordinator responsible for the disposition of the appeal investigates the situation thoroughly, including contacting the member, provider, MVP medical director or clinical peer, who are available 24/7, for clarification of issues or additional information when necessary.

MVP will make the expedited appeal determination and notify the member and practitioner(s) by telephone as expeditiously as the medical condition requires, but no later than 24 hours after the request is received (for NY State of Health members, as expeditiously as the medical condition requires, but no later than 72 hours after the receipt of the appeal or two business days of receipt of the information necessary to conduct the Appeal). **For Medicaid and FHPS members, this time may be extended for up to 14 days upon the member's or the provider's request; or if MVP demonstrates that more information is needed and the delay is in the best interest of the member. The member and/or provider will be notified of this verbally and in writing.** Any medical necessity related appeal not conducted within the required timeframes shall be deemed a reversal of the determination. The member is also sent written confirmation of the decision within two working days of rendering the decision. A written notice of final adverse determination concerning an expedited utilization review appeal will be transmitted to the member within 24 hours of the decision being rendered.

To submit an expedited appeal on the member's behalf, the provider/hospital must contact the Customer Care Center at **1-888-687-6277**, between 8 am and 6 pm Monday through Friday or FAX the appeal to MVP Member Appeals Department at 518-386-7600. Appeals should be filed within 180 days (90 calendar days for Medicaid and FHPS members) of the member's receipt of a denial notice.

Member Appeals (Excludes Medicare Members)

MVP has two levels of internal appeal. The first level of appeal must be initiated within 180 days of the initial denial. Second level of appeals must be initiated within 180 days of the date of denial of the first level of appeal as applicable (Vermont members have 90 days to request a second level appeal, NY State of Health members under a group policy only have 45 days,). Medicaid,and FHPS members have 90 calendar days to file a first or second level of appeal. (NY State of Health Individual and Vermont Non-Group Indemnity policies have only one level of internal appeal per Federal Health Care Reform.)

A full investigation of each appeal, including any aspects of clinical care involved, is conducted and completed within 15 calendar days of receipt of the appeal or as expeditiously as the member's condition requires (NY State of Health appeals are completed within the following timeframes, small group, pre-service/pre-authorization 15 calendar days, individual policy, 30 calendar days, small group, post-service/retrospective 30 calendar days, individual policy, 60 calendar days). Any medical necessity related appeal not conducted within the required timeframes shall be deemed a reversal of the determination. A written acknowledgement is sent to the member within five calendar days of the appeal receipt. Within two days of rendering the decision, MVP sends the member written confirmation of the appeal decision, including an

explanation of the member's right to appeal further or to proceed directly to external review, if applicable. For expedited appeals, MVP will make a determination and notify the member and practitioner by telephone as expeditiously as the medical condition requires, but no later than 24 hours after the request is received. **For Medicaid and Family Health Plus (FHPS) members, this time may be extended for up to 14 days upon the member's or the provider's request; or if MVP demonstrates that more information is needed and the delay is in the best interest of the member. The member and/or provider will be notified of this verbally and in writing.**

A member or his/her representative, or a provider acting on behalf of a member, may file an appeal verbally or in writing. (See policies for acceptance of verbal and written appeals filed by a member representative or provider acting on behalf of a member). An appeal may be filed verbally by contacting the Customer Care Center at **1-888-687-6277**, Monday through Friday from 8 am to 6 pm (Refer to Member Services Policy and Procedure: Accepting Verbal Appeals). If the member calls after hours, the MVP Answering Service will accept the member's name and telephone number, and a Customer Care Center representative will return the call during the next working day. If the member does not speak English, either a bilingual MVP employee will speak with the member or MVP will use the services of the AT&T language line, which provides interpreters in 150 different languages. Appeals should be filed within 180 days (90 calendar days for Medicaid and FHPS members) after receipt of the denial notice. An appeal may be filed in writing to the following address:

MVP Health Care
Attn: Member Appeals Department
PO Box 2207, 625 State Street
Schenectady, New York 12301

Written requests for appeal submitted by a member will be accepted into the member appeals process. For written requests for appeal submitted by a designated representative acting on behalf of the member, the appeals coordinator will first send a Third Party Authorization form to the member to verify that the member authorizes this representative to act on the member's behalf. The appeal will initiate once this authorization is obtained.

For appeals submitted by a provider acting on the member's behalf, refer to the Member Appeals section.

Department policies and procedures: Providers Submitting Appeal Requests
If a Medicaid or FHPS member files a verbal appeal, the Customer Care Center will accept the appeal, and also request that the member submit a written summary of the verbal appeal. (For verbally requested expedited appeals, the appeal does not need to be confirmed in writing.)

If additional information is needed in order to complete the appeal, MVP will also notify the provider and member in writing, as soon as possible but within 15 days of receipt of the appeal, of such request for information. In the event that only a portion of the information is received, MVP will request the missing information, in writing, within five business days of receipt of the partial information. If the appeal is expedited, this request for information will be made by telephone, followed by written notification to the member and provider.

MVP will provide the member with reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. If the appeal is expedited, MVP will inform the member of the limited time to present such evidence. MVP will allow the member or member's

designee, both before and during the appeal process, to examine the member's case file, including medical records and any other documents and records considered during the appeal process. MVP will consider the member, member's designee, or legal representative of a deceased member a party to the appeal.

A written response is sent to a member on MVP letterhead within two business days of the appeal determination. The letter includes the date the appeal was filed, a summary of the appeal, the appeal coordinator's name and telephone number; the member's coverage type; the name of the provider or facility, as applicable, the date the appeal process was completed, the disposition of the appeal, in clear terms, with contractual (benefits) and/or clinical (medical necessity) rationale if appropriate and the member's right to appeal further (MVP's Second Level Appeals Committee or to external review if appropriate, including relevant written procedures to do so). If an adverse determination is rendered; a list of titles and qualifications of the individuals participating in the review of the appeal; a statement of the reviewer's understanding of the pertinent facts of the appeal; reference to the evidence or documentation used as the basis for the decision (such as the Medical Policy Criteria, Subscriber Contract, Member Handbook, Summary Plan Description, Certificate of Coverage, or clinical criteria, including either a copy of the specific rule, guideline, protocol, or criterion, or a statement that such rule, guideline, protocol, or criterion is available upon request, free of charge); a statement that the member is entitled to receive upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the member's claim for benefits by contacting a Customer Care Center Representative at the number on the back of their ID card, between 8:00AM and 6:00PM Monday through Friday. Members may also write to us at: MVP Health Care, Attn: Member Appeals Department, 625 State Street, Schenectady, New York 12305; and a statement of the member's right to bring civil action under section 502 (a) of ERISA (excluding Federal Government members, Medicaid, FHPS, CHP and New York State members).

For Medicaid and FHPS members, this written response will include a statement regarding fair hearing rights if applicable; the right of the member to contact the New York State Department of Health (including the Department's toll-free number), New York State allows members the right to request a review by a State approved external appeal agent if MVP has denied coverage on the basis of medical necessity or because the service is experimental and/or investigational.

For New York members (this does not apply to MVP's self-insured policies or federal government policies), denials for medical necessity and experimental/investigational natures of appeal will include a statement of Final Adverse Determination (FAD). The member must first request a level one of internal appeal through MVP or the member and MVP must have jointly agreed to waive the internal appeal process. The letter agreeing to a waiver must contain all the applicable elements issued in a final adverse determination letter and must be provided to the member within 24 hours of the agreement to waive MVP's internal appeal process. The member has four months from the date of MVP's FAD to request an external appeal.

If the requested health care service has already been provided and the member appealed, the physician may file an external appeal application on the members behalf, but only if the member consents to this in writing. The FAD also will include a statement written in bolded text stating that the four-month timeframe for requesting an external appeal begins upon receipt of the final adverse determination of the first level appeal, regardless of whether or not a second level appeal is requested, and that by choosing to request a second level internal appeal, the time may expire for the member to request an external appeal. For Vermont members, the external

appeal request can be requested either after a standard level one or voluntary level two appeal, unless the request is for an expedited appeal; please refer to the Expedited Appeals section. New Hampshire members must complete both levels of internal appeal before requesting an external appeal. [New Hampshire allows members the right to request a review by a State approved independent review organization (IRO) if all internal appeals have been exhausted (unless the standards for an expedited review have been met) (an adverse determination has been rendered by the Second Level Appeals Committee), and MVP has denied services that are a covered benefit under the members plan or at least something that could be a covered benefit in some circumstances (excluding eligibility and the request for an external appeal cannot be for the purpose of pursuing a claim or allegation of provider malpractice, professional negligence or other professional fault).]

The Member's Right to Appeal a Determination that a Health Care Service is Not Medically Necessary. If MVP denies benefits on the basis that the health care service is not Medically Necessary, the member may appeal to an External Appeal Agent if they can satisfy the following three criteria:

a) The service, procedure or treatment must otherwise be a Covered Service under this Contract;
b) They must have received a Final Adverse Determination through MVP's internal appeal process and MVP must have upheld the denial or the member and MVP must agree in writing to waive any internal appeal; and
c) The appeal is an expedited appeal in which case the member can choose to file an internal expedited appeal at the same time as the external expedited appeal.

An "Out-of-Network Denial" means a denial of a request for prior authorization to receive a particular health service from an out-of-network provider, which is based on the determination that the requested service is not materially different from a service available in-network. (A denial of a referral to an in-network provider is available to provide the requested service is not an Out-of-Network Denial.) To appeal an Out-of-Network Denial, you must submit the following items with your appeal:

a) A written statement from the member's attending physician certifying that the requested out-of-network service is materially different from that which is available in-network; and
b) Two documents citing medical and scientific evidence that the requested out-of-network service is likely to be more clinically beneficial to the member than the in-network service and that the requested out-of-network service is not likely to increase the adverse risk to the member substantially.

The Member's Right to Appeal a Determination that a Health Care Service is Experimental or Investigational. If the member has been denied benefits on the basis that the health care service is an experimental or investigational treatment, they must satisfy the following three criteria:

a) The service must otherwise be a Covered Service under this Contract;
b) They must have received a Final Adverse Determination through MVP's internal appeal process and MVP must have upheld the denial or the member and MVP must agree in writing to waive any internal appeal; and
c) The appeal is an expedited appeal in which case the member can choose to file an internal expedited appeal at the same time as the external expedited appeal.

In addition, the attending physician must certify that the member has a life-threatening or disabling condition or disease. A “life-threatening condition or disease” is one in which, according to the current diagnosis of the attending physician, has a high probability of death. A “disabling condition or disease” is any medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months, which renders the member unable to engage in any substantial gainful activities. In the case of a child under the age of 18, a “disabling condition or disease” is any medically determinable physical or mental impairment of comparable severity.

The attending physician must also certify that the members life threatening or disabling condition or disease is one for which standard health services are ineffective or medically inappropriate or one for which there does not exist a more beneficial standard service or procedure covered by MVP or one for which there exists a clinical trial (as defined by law). In addition, the attending physician must have recommended one of the following:

a) A service, procedure or treatment that two documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard Covered Service (only certain documents will be considered in support of this recommendation – the attending physician should contact the State in order to obtain current information as to what documents will be considered acceptable); or
b) A clinical trial for which the members are eligible (only certain clinical trials can be considered).

For the purposes of this Section, the physician must be a licensed, board-certified or board-eligible physician qualified to practice in the area appropriate to treat the member’s life-threatening or disabling condition or disease.

The external review agent will render a decision within 30 days of receiving the member’s application for a standard appeal, or within three days for an expedited appeal. The agent’s decision is final and binding for both the member and MVP. In cases where the external review agent overturns MVP’s decision, MVP will provide written notification to the member.

The Member’s Right to Appeal a Determination to Allow an Out-of-Network Referral. If MVP denies an Out-of-Network Referral (OON referral), these denials are eligible for further appeal through the New York State external appeal process. The member or his/her designee can appeal an out-of-network referral denial by submitting a written statement from the member’s attending physician, who must be a licensed, board certified or board eligible physician qualified to practice in the specialty area of practice appropriate to treat the member for the health care service sought. The written statement must:

1) **specify that the in-network health care provider(s) recommended by MVP does not have the appropriate training and experience to meet the particular health care needs of the member, and**

2) **identify an out-of-network provider with the appropriate training and experience to meet the particular health care needs of the member, who is able to provide the requested service.**

The external appeal agent will consider the training and experience of the in-network health care provider, the training and experience of the OON provider, the clinical standards of the plan, the information provided concerning the member, the attending physicians' recommendation, the member's medical record and any other pertinent information. The external appeal agent will overturn MVP's denial if they determine that MVP does not have a provider with the appropriate training and experience to meet the particular health care needs of the member who is able to provide the requested service, and that the OON provider has the appropriate training and experience to meet the health care needs of the member who is able to provide the requested service and is likely to produce a more clinically beneficial outcome.

The change is effective for HMO and EPO policies that require a referral from their Primary Care Physician for denials issued on or after March 31, 2015.

When the Department of Financial Services receives an external appeal application for an OON referral denial MVP will be contacted to determine the eligibility of the application. MVP will be required to provide the type of policy providing the coverage and the renewal date of the policy. Similar to other requests for information on an external appeal, MVP will be required to provide this information within 24 hours for a standard appeal or 1 hour for an expedited appeal.

ASO External Appeals

EXTERNAL APPEALS

External appeals of certain adverse benefit determinations are only available to members of non-grandfathered self-funded plans. Members who have questions about their plan's status may contact their employer's human resources personnel or MVP's Customer Care Center at **1-800-229-5851**.

STANDARD EXTERNAL APPEALS

Under the following circumstances, members may request a standard External Appeal:

a) If they have completed all levels of internal appeal of an adverse benefit determination (for reasons other than eligibility) and the adverse benefit determination was upheld, and/or;
b) If, at any point during the internal claim or appeal process, the plan fails to adhere to the requirements outlined in this attachment.

EXPEDITED EXTERNAL APPEALS

Under the following circumstances, members may be eligible to file an expedited external appeal:

a) If they receive an adverse benefit determination (claim denial) that: involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize their life or health, or that would jeopardize their ability to regain maximum function, and they have filed a request for an expedited internal appeal.
b) If a member receives a final adverse benefit determination (claim denial upheld on internal appeal) and:
    - they have a medical condition for which the timeframe for completion of a standard external appeal would seriously jeopardize their life or health, or that would jeopardize their ability to regain maximum function, or;

- if the final adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which they have received emergency services but have not been discharged from a facility.

HOW TO FILE AN EXTERNAL APPEAL

An external appeal request must be received by MVP within 120 days or four (4) months after the receipt of a notice of a final adverse benefit determination (the denial of the internal appeal). A member (or their authorized representative) may file an appeal either verbally or in writing as follows:

To file an appeal, members can call MVP's Customer Care Center at **1-800-229-5851**. They should have their claim denial notice, ID card and any other information they would like to have considered in connection with the appeal with them when they make the call.

To file a written appeal, members can write a letter to MVP's Appeal Department stating their position. The letter must be sent to:

MVP Health Care
Attn: Member Appeals Department
PO Box 2207, 625 State Street
Schenectady, NY 12301

Whether filing a verbal request for an external appeal or filing a written request, the external appeal application form must be submitted. A filing fee of $25 must accompany the application form. There is an annual limit for any member of $75 per year. (A filing fee needs to have been imposed.) If the external agent overturns MVP's denial the $25 filing fee is returned to the member. If the external review agent agrees with MVP's denial then MVP will retain the check which will be credited back to the employer group. For an expedited external appeal, a filing fee of $25 must be submitted within 30 days. For more information on how to file an appeal, including how to designate an authorized representative, members can contact MVP's Customer Care Center at **1-800-229-5851**.

THE DECISION MAKERS

Within five business days from the receipt of the standard external appeal, MVP will complete a preliminary review of the request in order to determine a member's eligibility for an external appeal. Within one business day after completion of the preliminary review, MVP will issue the member and/or the authorized representative (and the IRO) a written notification of the member's eligibility for an external appeal. If the request is complete but not eligible for external appeal, the notice will include the reasons for ineligibility. If the request is incomplete, the notice will describe the information or materials needed to make the request complete and the member will have an opportunity to complete the request. MVP will assign an eligible and complete external appeal request to an independent review organization (IRO) to conduct the appeal. Please note that the IROs are independent from MVP and MVP does not make external appeal determinations. MVP will maintain contracts with no fewer than three (3) IROs for assignments, and the assignments will be made in a random and unbiased fashion.

THE EXTERNAL APPEAL PROCESS

Standard External Appeals*:* within five business days after the external appeal request has been assigned to an IRO, MVP must provide to the IRO the documents and any information considered in making the adverse benefit determination. If MVP fails to provide the information in a timely manner, the IRO may terminate the external appeal and reverse the adverse benefit

determination in the member's favor. The IRO will review all of the information and documents received in a timely manner and it will not be bound by any decisions or conclusions reached during the claims and internal appeal processes. The IRO also will, to the extent the information and documents are available and the IRO considers them appropriate, consider other sources of information including, but not limited to, the member's medical records, the health care professional's recommendations, the terms of the plan, appropriate practice guidelines and clinical review criteria. The IRO will provide, to members and the plan, written notice of its decision within 45 days after it receives the request for the external appeal. Upon receipt of a notice of a final external appeal decision reversing the adverse benefit determination, the plan immediately will provide coverage or payment for the claim.

Expedited External Appeals

Immediately upon receipt of the request for an expedited external appeal, MVP will complete a preliminary review of the request in order to determine the member's eligibility for an external appeal. Immediately after completion of the preliminary review, MVP will issue the member and/or the authorized representative a written notification of the member's eligibility for an external appeal. If the request is complete but not eligible for external appeal, the notice will include the reasons for ineligibility. If the request is incomplete, the notice will describe the information or materials needed to make the request complete and the member will have an opportunity to complete the request. Upon the determination that a request is eligible for an expedited external review, MVP will assign an IRO for review and transmit all necessary documents and information to the IRO. The IRO will provide notice, to the member and the plan of the final external appeal decision as expeditiously as possible, but in no event no later than 72 hours after the IRO receives the request for the expedited external appeal. Upon receipt of a notice of a final external appeal decision reversing the final adverse benefit determination, the plan immediately will provide coverage or payment for the claim.

For both standard and expedited external appeals, please note that the determination of the assigned IRO is final and binding on the plan, the member and MVP.

RIGHT TO SUE

When an initial claim denial is upheld after the appeals process and a member has complied in full with the plan's claim and appeal procedures as well as any time limits for taking legal action, they may bring a civil action under Section 502(a) of the federal law commonly known as "ERISA" regarding the denied claim. Any questions relative to this right should be addressed to a member's own legal advisor.

FOR ASSISTANCE

For further questions about a member's appeal rights or for assistance, New York members can contact the Employee Benefits Security Administration at **1-866-444-3272**; Vermont members can contact Vermont Legal Aid at **1-800-917-7787**; and New Hampshire members can contact the New Hampshire Department of Insurance at **1-800-852-3416**.

Member Complaints

A complaint is a written or verbal expression of dissatisfaction with MVP. If the member submits a complaint, it will be investigated thoroughly, and the member will be sent a response within 30 calendar days (15 calendar days for Vermont members). A full investigation of each complaint is conducted and completed within 30 calendar days of receipt of the complaint. A written acknowledgement is sent to the member within five calendar days of the complaint receipt and written confirmation of the complaint decision within two business days of rendering the

decision. All quality of care issues are fully investigated and responded to by MVP's QI department.

A member or his/her representative, or a provider acting on behalf of a member as the designated representative, may file a complaint verbally or in writing.

A complaint may be filed verbally by contacting the Customer Care Center at **the number on the back of their ID card, between 8:00 am and 6:00 pm Monday through Friday**
A complaint may also be filed in writing to:

MVP Health Care
Attn: Member Appeals Department
PO Box 2207, 625 State Street
Schenectady, NY 12301

For Medicaid and FHPS members:

- If the member is not satisfied with an action we took or what we decide about their service authorization request, they have 60 business days after hearing from us to file an appeal.
- They can do these themselves or ask someone they trust to file the appeal for them. They can call the Customer Care Center at **1-800-**339- 4557 if they need help filing an appeal.
- We will not treat them differently or badly because they file an appeal.
- The appeal can be made by phone or in writing.

If they make an appeal by phone it must be followed up in writing. The member also may ask for a fair hearing if MVP decided to deny, reduce or end coverage for a medical service. They may request a fair hearing and ask for an external appeal. If they ask for a fair hearing and an external appeal, the decision of the fair hearing officer will be the one that counts.

Fair Hearings
The member may ask for a fair hearing from New York State if:

- They are not happy with a decision their local Department of Social Services or the State Department of Health made about them staying or leaving MVP Health Care;
- They are not happy with a decision that MVP made about medical care they were receiving and they feel the decision limits their benefits or that we did not make the decision in a reasonable amount of time;
- They are not happy about a decision MVP made that denied medical care they wanted and they feel the decision limits their benefits;
- They are not happy that their doctor would not order services they wanted and feel the doctor's decision stops or limits their benefits. They must file a complaint and an appeal with MVP Health Care. If MVP Health Care agrees with their doctor, they may ask for a state fair hearing.

The decision they receive from the fair hearing officer will be final.

If the services they are now getting are scheduled to end, they can choose to ask to continue the services their doctor ordered while they wait for their case to be decided. However, if they choose to ask for services to be continued, and the fair hearing is decided against them, they may have to pay the cost for the services they received while waiting for a decision.

They can use one of the following ways to request a Fair Hearing:

- Phone: call **1-800-342-3334**
- Fax: **518-473-6735**
- Online: **www.otda.state.ny.us/oah/forms.asp**
- Mail:
  NYS Office of Temporary and Disability Assistance
  Fair Hearings
  PO Box 22023
  Albany, NY 12201-2023

A member also may make a complaint to the New York State Department of Health at any time by calling **1-800-206-8125**.

Inpatient Hospital Appeal Process

For the reconsideration process, please refer to Section 5, Utilization Management (UM).

DEFINITIONS

1. **Hospital**
   For the purpose of MVP's Reconsideration and Appeal Process, a hospital shall mean a facility that has an agreement with MVP to provide services to MVP's members, and is licensed pursuant to Articles 28, 36, 44 or 47 of the New York State Public Health Law or licensed pursuant to Articles 19, 23, 31 or 32 of the Mental Hygiene Law or applicable Vermont or New Hampshire law. If a facility is licensed outside of New York State, then comparable legislation of the state where licensure has been obtained will be reviewed to determine if the facility meets the definition of a hospital.
2. **New York, Vermont, and New Hampshire Fully-Insured Products**
   For the purpose of MVP's Reconsideration and Appeal Process, the reference to "New York, Vermont, and New Hampshire Fully-Insured Products" refers to health insurance or HMO products issued by MVP Health Plan, Inc., MVP Health Insurance Company, MVP Health Services Corp., MVP Health Plan of New Hampshire, Inc., or MVP Health Insurance of New Hampshire, Inc., which are subject to Article 49 of the New York State Public Health Law, Article 49 of the New York State Insurance Law, or applicable Vermont Law.
3. **Provider**
   For the purpose of MVP's Hospital Reconsideration and Appeal Process, provider shall mean a hospital (as defined above) or other appropriately licensed health care professional.

Services Deemed Not Medically Necessary or Experimental or Investigational

A hospital appeal is a request submitted by a hospital to MVP requesting review of a denial of a properly-submitted claim on the basis that such services are or were:

a. not medically necessary; or
b. experimental or investigational.

MVP provides two levels of hospital appeals (described below). Eligibility requires that the hospitals are appealing on their own behalf (NOT the member); therefore, the hospitals are not the member's representative designee for this appeal process.

1. **Level One Hospital Appeals**
   The first step in the hospital appeal process is to initiate a Level One Hospital Appeal, which will be reviewed by MVP's Appeals Department.

2. A hospital may request to initiate a Level One Hospital Appeal by writing within 180 days, (or per the specific contracted payment dispute time frame) from the hospital's receipt of MVP's initial denial notice (either the UM denial letter or the EOB, or MVP's Remittance Advice – whichever comes first) to:

   MVP Health Care
   Attn: Member Appeals Department
   PO Box 2207, 625 State Street
   Schenectady, NY 12301

For New York fully insured products, MVP will render a decision on an appeal of a post-service (retrospective) claim denial within 60 days of MVP's receipt of all necessary information to conduct the appeal and will provide written notice of the decision within two business days upon rendering its decision.

3. **Level Two Hospital Appeals**
   Unless otherwise contracted, if the hospital is not satisfied with the result of the Level One Hospital Appeal, it may commence a Level Two Hospital Appeal, which a third-party arbitrator shall conduct. A hospital may initiate a Level Two Appeal by submitting a written request to the designated third-party arbitrator within 30 days of the hospital's receipt of MVP's Level One Appeals determination notice.

Under Chapter 237 of the PHL's Alternative Dispute Resolution (ADR): A facility licensed under Article 28 of the Public Health Law and the MCO may agree to alternative dispute resolution in lieu of an external appeal under PHL 4906(2). This Level II Hospital Appeal conducted by MVP's designated third-party arbitrator is binding on both parties and serves as the final level of appeal. A hospital requesting a Level II Appeal is prohibited from seeking payment from a member for services determined not medically necessary by the designated third-party arbitrator.

The party submitting the appeal to a third-party arbitrator is responsible for payment of the processing fee. MVP will reimburse a hospital for the entire processing fee if MVP's denial is reversed in total; and reimburse 50 percent of the processing fee if MVP's denial is reversed in part. In such cases, to obtain reimbursement from MVP for the third-party arbitrator processing fee, the hospital must submit a written request with a copy of the third-party arbitrator decision to MVP at:

MVP Health Care
Attn: Member Appeals Department
PO Box 2207, 625 State Street
Schenectady, NY 12301

Facilities not subject to the third-party arbitrator may have External appeal rights with the New York State Department of Financial Services (DFS) (for New York fully insured products). If the facility is subject to this option, they will be sent the External appeal application packet with the letter of final adverse determination. The completed application along with the filing fee of $50 (make checks payable to MVP Health Care) should be sent to the address listed in the packet within 45-days of the date of the letter.

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 co-pays, from a member for services determined not medically necessary by the external appeal agent.

Practitioner Claims Appeals

A practitioner claims appeal is a request submitted by the provider, on his/her own behalf, to have MVP review a denial of a properly submitted ("clean") claim. Practitioners have only one level of internal appeal. An appeal must be submitted within 180 days of the date on MVP's remittance advice. Appeals can be submitted in writing by letter with supporting documentation.

Provider appeals denied for "not medically necessary" should be mailed to:

MVP Health Care
Attn: Member Appeals Department
PO Box 2207, 625 State Street
Schenectady NY 12301

All other appeals should be mailed to:

MVP Health Care
Operations Adjustment Team
PO Box 2207
Schenectady, NY 12301

Providers may appeal verbally by calling the Customer Care Center for Provider Services at **1-800-684-9286**. They may also call this number for more information about initiating an appeal.

MVP will make a determination on appeals within 60 days of receipt of all necessary information. MVP will mail a written notice of the determination within two business days of the determination. If the services being appealed are approved, the claim(s) in question will be adjusted.

For New York fully insured products, if you are appealing a post-service claim denial based upon medical necessity or because the service was determined to be experimental or investigational in nature, then the written notice will include instructions on how to submit an External Appeal with the state of New York.

MVP staff who were not involved in the initial claims denial process will review the appeal. Likewise, appropriate clinical peer reviewers who also were not involved in the initial claim denial process will review claims based on clinical criteria.

Medicare Member Appeals and Complaints (grievance)

A "**general issue**" is a type of expressed dissatisfaction that does not involve attitude, access, or quality of services received. It does not involve an initial determination (e.g. denied claim or referral) and there is no further financial liability from the member or the member's representative. MVP will document and investigate all general issues brought to our attention either by phone or mail. All findings and actions taken will be reported to the member as expeditiously as necessary but no later than 30 days by either phone or mail.

A "**grievance**" is the type of complaint a member makes **if they have any other type (except for an appeal) of problem with MVP or one of their plan providers**. For example, they would file a grievance if they have a problem with things such as:

- The quality of their care,
- Waiting times for appointments or in the waiting room,
- The way their doctors or others behave,
- Being able to reach someone by phone or get the information they need, or
- The cleanliness or condition of the doctor's office.

An "**appeal**" is the type of complaint made **when the member wants MVP to reconsider and change a decision made about what services are covered or what will be paid for a service**. Specifically, the member has the right to appeal if:

- MVP refuses to cover or pay for services they think should be covered,
- MVP or one of their plan providers refuses to give them a service they think should be covered,
- MVP or one of their plan providers reduces or cuts back on services they have been receiving, or
- The member thinks MVP is stopping coverage of a service too soon.

Medicare Grievance Process

If the member has a complaint regarding attitude, access, or quality of service received, MVP encourages them to call the MVP Medicare Customer Care Center, 1-800-665-7924. MVP will try to resolve their complaint over the phone. If the complaint cannot be resolved over the phone, a formal procedure called the "Grievance Procedure" is used to review the complaint. The member may also submit a grievance in writing to the Member Service - Grievances Department, 220 Alexander Street, 5th floor, Rochester, NY 14617. The grievance must be filed within 60 calendar days of the incident and include a description of the incident or events that led to the grievance. The grievance will be investigated by MVP's Quality Improvement Department.

A member may file his or her own grievance or the member may appoint a representative. To appoint a representative:

- In writing, the member must provide their name, Medicare number, and a statement that appoints an individual as their representative. For example, "I [*member name*] appoint [*name of representative*] to act as my representative in requesting a grievance from MVP regarding (service/claim)"
- The member and the representative must sign and date the statement
- The authorization statement must be submitted with the grievance

Non-Contracted Providers

A non-contracted provider may file a post-service appeal only if the provider completes a waiver of liability statement, which says they will not bill the member regardless of the outcome of the appeal. A court appointed guardian or an agent under a health care proxy to the extent provided under state law. If the member is unable to appoint a representative due to their mental status, the appeal must be signed by a legal representative as determined by state law. If the member

is deceased, the appeal must be filed by a legal representative as determined by state law. The member's treating physician may also file an expedited or pre-service appeal on behalf of the member without appointment of representation.

Medicare Standard Grievances
MVP will acknowledge the complaint within 3 days of receipt. MVP will respond to the member's concern within 30 days from receipt of the grievance, by letter. In some instances, MVP may need more than 30 days to properly address the member's concern. If more than 30 days is necessary, MVP will notify the member and explain why additional time is required.

Expedited "Fast" Grievances
A member may file an expedited grievance if they disagree with MVP's decision not to expedite an appeal, not to expedite a request for approval made by a provider or if they disagree with MVP's request for more time to complete an appeal or request for more time to approve a service requested by a provider. MVP will respond to these requests within 24 hours.

Quality Improvement Organization (QIO) Complaint Process
If members are concerned about the quality of care they receive, including care during a hospital stay, they may file a grievance through MVP, or a complaint with Livanta BFCC-QIO. Livantais a Quality Improvement Organization (QIO) for the States of New York and Vermont that is paid to handle this type of complaint from Medicare patients. The QIO review process is designed to allow an external review organization to investigate health care issues. To contact Livanta, members may call **866-815-54405**. TTY users may call **1-866-868-2289**. USA Care members must contact the QIO within the state in which he/she resides.

Five Possible Steps for Requesting Care or Payment from MVP
If the member has problems getting care, or payment for care, there are five possible steps they can take. At each step, their request is considered and a decision is made. If they are unhappy with the decision there may be an additional step they can take.

- In Step one the member makes their request directly to MVP. It is reviewed and the decision is communicated.
- In Steps two through five, people in organizations that are not connected to MVP make the decisions. To keep the review independent and impartial, those who review the request and make the decision in Steps two through five are part of (or in some way connected to) the Medicare program, the Social Security Administration, or the federal court system.

The five possible steps are summarized below:

Step One: Appealing the Initial Decision by MVP
If the member disagrees with the initial decision one, they may ask MVP to reconsider the decision. This is called an "**appeal**" or a "request for reconsideration". The member can ask for a "fast or expedited appeal" if their request is for medical care and it needs to be decided more quickly than the standard time frame. After reviewing the appeal, MVP will decide whether to stay with the original decision, or change this decision and give the member some or all of the care or payment they want.

Step Two: Review of the Request by an Independent Review Organization (IRO)
If MVP turns down part of the request or the entire request (step one), MVP is then **required** to send the request to an independent review organization that has a contract with the federal government and is not part of MVP. This organization will review the request and make a decision about whether the member is granted the care or payment they requested. MVP staff who were not involved in the initial claims denial process will review the appeal. Likewise, appropriate clinical peer reviewers who also were not involved in the initial claim denial process will review claims based on clinical criteria.

Step Three: Review by an Administrative Law Judge (ALJ)
If the member is unhappy with the decision made by the organization that reviews their case in step two, they may ask an Administrative Law Judge to consider their case and make a decision. The Administrative Law Judge works for the federal government. To qualify for review by an ALJ, the amount in controversy must meet a minimum amount to be determined by the ALJ. The amount in controversy must be at least $150.00 and this minimum amount is incrementally increased annually by CMS, based on increases in the consumer-pricing index.

Step Four: Review by a Departmental Appeals Board
If the member or MVP are unhappy with the decision made in step three, either party may be able to ask the **Medicare Appeals Council (MAC)** to review the case**.** This Board is part of the federal department that runs the Medicare program.

Step Five: Federal Court
If the member or MVP are unhappy with the decision made by the Medicare Appeals Council in step four, either party may be able to take the case to a Federal Court. The dollar value of the contested medical care must be at least $1460.00.

Pre-Service and Post-Service Appeals Process
All appeals must be completed as expeditiously as the member's health requires, but no later than the times indicated. If the member wants to file a pre-service or post-service appeal, the following steps must be taken:

- File the request verbally by contacting MVP's Medicare Customer Care Center. If the member calls after hours, the MVP Answering Service will accept the member's name and telephone number, and a Customer Care Representative will return the call during the next working day. If the member does not speak English, either a bilingual MVP employee will speak with the member or MVP will use the services of the AT&T language line, which provides interpreters in 150 different languages. Members may also submit the request in writing to MVP at the following address: MVP Health Care, Attn: Member Appeals Department, 625 State Street, Schenectady, NY, 12305. Alternatively, the request may be filed with an office of the Social Security Administration or the Railroad Retirement Board (if the member is a railroad retiree). Even though the member may file a request with the Social Security Administration or Railroad Retirement Board office, that office will transfer the request to MVP for processing.

- Mail, FAX, or deliver the request in person. Use the address above or FAX the appeal to MVP Member Appeals Department at **585-327-5724** or **1-800-398-2560**.

- The request must be filed within 60 calendar days from receipt of the initial denial notice.

MVP will gather all necessary information, including referral notes, medical records, and all information used in the initial determination and any new information that may be relevant to the

appeal. Appeal decisions that do not involve medical necessity are made by a reviewer(s) trained and experienced in interpreting contracts, policies, benefits, member eligibility, and health care regulations. Decisions that involve medical necessity will be made by a licensed provider in the same or similar specialty as the health care provider who typically manages the medical condition or disease, or provides the service or treatment under review. In addition, the appeal decision is made by a reviewer who was not involved in the initial determination, and is not a subordinate of any person involved in the initial determination.

To protect the member's privacy and ensure an unbiased review of the appeal, all personally identifiable health and financial information will be removed from the record unless a business associate's agreement is in effect between MVP and the health care provider reviewing the appeal.

A member may request free of charge, a copy of all documents relevant to the appeal, including the clinical criteria; internal policy, guidelines, protocol or rule relied upon to make the appeal decision by contacting a Medicare Customer Care Center Representative at the number on the back of their ID card, Monday – Friday, 8am – 8pm, Saturday 8am – 4pm Eastern Time. From October 1 – February 14, call seven days a week, 8am – 8pm. Members may also write to us at: MVP Health Care, Attn: Member Appeals Department, 625 State Street, Schenectady, New York 12305. A member is given the opportunity to submit written comments, documents or other information related to the appeal.

A decision must be provided to the member within 30 calendar days from receipt of a pre-service appeal and within 60 calendar days of a post-service appeal. However, if the member requests it, or if MVP finds that some information is missing which can help them, MVP can take up to an additional14 calendar days to make the decision for a pre-service appeal. No extension is allowed for post service appeals. The substance of the appeal and any actions taken are documented in the member's file. If MVP does not notify the member of the decision within 30 calendar days or by the end of the extended time period for a pre-service appeal, or within 60 calendar days for a post-service appeal, the request will *automatically* go to Medicare's External Review Organization, currently Maximus Federal Services for review of the case. The member is notified in writing within three (3) calendar days of the decision. If the decision is unfavorable, the notice will also include information advising them that the case has been forwarded to Maximus Federal Services who will render an appeal decision.

Expedited Appeals Process

An expedited appeal may be initiated verbally or in writing by the member, the members appropriately appointed representative or a provider acting on behalf of the member. If any party requests an expedited decision, he or she must do the following:

- File a verbal or written request for an expedited (fast) appeal, specifically stating that they want an expedited appeal, fast appeal, or 72-hour appeal, or that they believe that their health could be seriously harmed by waiting 30 days for a standard appeal.
- To file a verbal request, the member or the members appropriately appointed representative can call MVP's Medicare Customer Care Center at. **1-800-665-7924**. TTY users may call **1-800-662-1220**.
- A hand delivered request can be received at the following addresses, 220 Alexander Street, Rochester, New York, 14607 or 625 State Street, Schenectady, NY 12305. Members can also mail their request to 625 State Street, Schenectady, NY 12305. The 72-hour review time will begin when the request for appeal is received by MVP.
- To FAX a request, our FAX number is **585-327-5724**, or **1-800-398-2560**. If the member is in

a hospital or a nursing facility, he or she may request assistance in having the written appeal transmitted to MVP by use of a FAX machine.

- The member must file the request within 60 calendar days of the date of the initial denial.
- The Expedited Appeal process applies only to **pre-service** appeals.

If a member requests a 72 hour expedited (fast) appeal, MVP's Medical Director will decide if an expedited appeal is appropriate. If it is not appropriate, the appeal will be processed within 30 days. MVP will notify the member verbally and in writing of the decision not to expedite the appeal within 72 hours. If any physician supports the need for a fast appeal, it must be granted. For this process, Medicare defines a physician as any Medical Doctor, Doctor of Osteopathic Medicine, or a Doctor of Podiatry.

MVP will make a decision and notify the member and practitioner within 72 hours or sooner if the member's health condition requires, from receipt of the expedited request. A written confirmation of the decision will be sent to the member and practitioner within 24 hours from the date of the appeal decision. However, if the member requests it, or if MVP finds that some information is missing which can help them, MVP can take up to an additional 14 calendar days to make the decision. If MVP does not inform the member or the provider of the decision within 72 hours (or by the end of the extended time period), their request will *automatically* go to Medicare's External Review Organization, currently Maximus Federal Services for review of the case. The member is notified in writing within 24 hours that the decision was unfavorable and the case has been forwarded to Maximus Federal Services who will render an appeal decision.

If the decision is not fully in favor of the member's request, MVP will automatically forward the appeal to Maximus Federal Services for an independent review decision. Maximus will notify the member and MVP of their decision within 72 hours from receipt of the appeal. If necessary, Maximus may require an extension up to 14 additional days.

Inpatient Hospital Appeals

When a member is hospitalized, they have the right to get all the hospital care covered by MVP that is necessary to diagnose and treat their illness or injury. The day they leave the hospital (discharge date) is based on when their stay in the hospital is no longer medically necessary.

If a member is inpatient at a hospital the facility on behalf of MVP will provide them with the *Notice of Discharge & Medicare Appeal Rights* notice, they have the right by law to ask for a review of their discharge date. As explained in the *Notice of Discharge & Medicare Appeal Rights*, if they act quickly, they can ask an outside agency called the Livanta BFCC-QIO to review whether their discharge is medically appropriate. The *Notice of Discharge & Medicare Appeal Rights* gives the name and telephone number of Livanta and tells them what they must do.

Livanta is a group of doctors and other health care experts paid by the federal government to check on and help improve the care given to Medicare patients. They are not part of MVP or the hospital. The doctors and other health experts in Livanta review certain types of complaints made by Medicare patients. These include complaints about quality of care and complaints from Medicare patients who think the coverage for their hospital stay is ending too soon.

The member must be sure that they have made their request to Livanta **no later than noon** on the first working day after they are given written notice that they are being discharged from the

hospital. This deadline is very important. If they meet this deadline, they are allowed to stay in the hospital past their discharge date without paying for it themselves, while they wait to get the decision from Livanta.

Livanta will make this decision within one full working day after it has received their request and all of the medical information it needs to make a decision.

- If Livanta decides that the member's discharge date was medically appropriate, the member will not be responsible for paying the hospital charges until noon of the calendar day after Livanta gives them its decision.
- If Livanta agrees with the member, then MVP will continue to cover their hospital stay for as long as medically necessary.

If the member requests an Livanta appeal, he/she cannot subsequently request an appeal for the same denial through MVP.

Skilled Nursing Home (SNF), Home Health Care, and CORF Appeals

When the member is a patient in a SNF, home health agency, or Comprehensive Outpatient Rehabilitation Facility (CORF), they have the right to get all SNF, home health or CORF care covered by MVP that is necessary to diagnose and treat their illness or injury. The day MVP ends their SNF, home health agency or CORF coverage is based on when their stay is no longer medically necessary.

If MVP decides to end coverage for a member's SNF, home health agency, or CORF services, they will receive a written notice from their provider at least two (2) calendar days in advance of MVP ending the coverage. The member (or someone they authorize) may be asked to sign and date this document to show that they received the notice. Signing the notice does not mean that they agree that coverage should end – it only means that they received the notice.

Review of the termination of your coverage by Livanta BFCC

The member has the right, by law to ask for an appeal of MVP's termination of their coverage. They can ask Livanta to review whether MVP terminating their coverage is medically appropriate and this is explained in the notice they get from their provider.

Getting the Livanta review

If the member wants to have the termination of their coverage appealed, they must act quickly to contact Livanta. The written notice they get from their provider gives the name and telephone number of Livanta and tells them what they must do.

- If they get the notice two days before coverage ends, they must be sure to make their request **no later than noon** of the day after they get the notice from their provider.
- If they get the notice and they have more than two days before coverage ends, then they must make their request **no later than noon** the day before the date that their Medicare coverage ends.
- Livanta will make this decision within one full day after it receives the information it needs to make a decision.
- If Livanta decides that the decision to terminate coverage was medically appropriate, the member will be responsible for paying the SNF, home health or CORF charges after the termination date on the advance notice they got from their provider.

- If Livanta agrees with the member, then MVP will continue to cover the SNF, home health, or CORF services for as long as medically necessary.

If the member does not ask Livanta for a "fast appeal" of their discharge by the deadline, they can ask MVP for a "fast appeal" of their discharge.

If the member asks for a fast appeal of their termination and they continue getting services from the SNF, home health agency, or CORF, they run the risk of having to pay for the care they received past their termination date. Whether they have to pay or not depends on the decision MVP makes.

- If MVP decides, based on the fast appeal, that the member needs to continue to get services covered, then MVP will continue to cover their care for as long as medically necessary.
- If MVP decides that they should not have continued getting coverage of their care, then MVP will **not** cover any care they received if they stayed after the termination date.

If the member does not ask Livanta by noon after the day they are given written notice that MVP will be terminating coverage for their SNF, home health or CORF services, and if they continue to receive services from the SNF, home health agency or CORF after this date, they run the risk of having to pay for the SNF, home health or CORF care received on and after this date. However, the member can appeal any bills for the SNF, home health or CORF care received using the appeals process.

The following information applies to all Medicare Appeals:

Support for an Appeal

The member is not required to submit additional information to support their appeal. MVP is responsible for gathering all necessary medical information, however, it may be helpful for the member to include additional information to clarify or support their position. For example, the member may want to include information such as medical records or physician opinions in support of their appeal. MVP will provide an opportunity for the member to submit additional information in person or in writing.

Providers are required to abide by CMS guidelines. If a member requests an Expedited Appeal, MVP will request that the provider fax (or expedite mailing) all pertinent medical records to the Appeals Department. This will allow MVP to meet the required 72-hour time frame.

Who May File an Appeal

1. The member may file their own appeal.

2. The member may appoint a representative. To appoint a representative:

   a. In writing, the member must provide their name, Medicare number, and a statement that appoints an individual as their representative. For example, "I [*name*] appoint [*name of representative*] to act as my representative in requesting an appeal from MVP regarding (service/claim)."
   b. The member and the representative must sign and date the statement.
   c. The authorization statement must be submitted with the appeal.

3. A non-plan provider may file a post-service appeal only if the provider completes a waiver of liability statement which says they will not bill the member regardless of the outcome of the appeal.

4. A court appointed guardian or an agent under a health care proxy to the extent provided under state law.

5. If the member is unable to appoint a representative due to their mental status, the appeal must be signed by a legal representative as determined by state law.

6. If the member is deceased, the appeal must be filed by a legal representative as determined by state law.

7. The member's treating physician may also file an expedited or pre-service appeal on behalf of the member without appointment of representation.

Part D Appeals Only
MVP must provide a decision to the member within seven calendar days from receipt of a pre-service or post-service request. If MVP does not notify the member of the decision within seven calendar days, the request will automatically go to Medicare's External Review Organization, currently MAXIMUS Federal Services, for review of the case. For Part D denials, members must request a review by MAXIMUS Federal Services except as noted above, MVP does not automatically send these appeals.