

Please keep this with your Member Handbook

Montefiore Diamond Care will try its best to deal with your concerns or issues as quickly as possible and to your satisfaction. You may use either our complaint process or our appeal process, depending on what kind of problem you have.

There will be no change in your services or the way you are treated by Montefiore Diamond Care staff or a health care provider because you file a complaint or an appeal. We will maintain your privacy. We will give you any help you may need to file a complaint or appeal. This includes providing you with interpreter services or help if you have vision and/or hearing problems. You may choose someone (like a relative or friend or a provider) to act for you.

To file a complaint or to appeal a plan action, please call: **1-855-556-6683 Monday-Friday 8:30am-5:00pm. (TTY/TDD 711)** or write to:

**Montefiore Diamond Care
Grievances and Appeals Department
Box 500
200 Corporate Blvd. South, Suite 200
Yonkers, NY 10701**

When you contact us, you will need to give us your name, address, telephone number and the details of the problem.

What is a Complaint?

A complaint is any communication by you to us of dissatisfaction about the care and treatment you receive from our staff or providers of covered services. For example, if someone was rude to you or you do not like the quality of care or services you have received from us, you can file a complaint with us.

The Complaint Process

You may file a complaint orally or in writing with us. The person who receives your complaint will record it, and appropriate plan staff will oversee the review of the complaint. We will send you a letter telling you that we received your complaint and a description of our review process. We will review your complaint and give you a written answer within one of two timeframes.

1. If a delay would significantly increase the risk to your health, we will decide within 48 hours after receipt of necessary information but the process will be completed within 7 days of receipt of the complaint.
2. For all other types of complaints, we will notify you of our decision within 45 days of receipt of necessary information, but the process must be completed within 60 days of the receipt of the complaint.

Our answer will describe what we found when we reviewed your complaint and our decision about your complaint.

How do I Appeal a Complaint Decision?

If you are not satisfied with the decision we make concerning your complaint, you may request a second review of your issue by filing a complaint appeal. You must file a complaint appeal in writing. It must be filed within 60 business days of receipt of our initial decision about your complaint. Once we receive your appeal, we will send you a written acknowledgement telling you the name, address and telephone number of the individual we have designated to respond to your appeal. All complaint appeals will be conducted by appropriate professionals, including health care professionals for complaints involving clinical matters, who were not involved in the initial decision.

For standard appeals, we will make the appeal decision within 30 business days after we receive all necessary information to make our decision. If a delay in making our decision would significantly increase the risk to your health, we will use the expedited complaint appeal process. For expedited complaint appeals, we will make our appeal decision within 2 business days of receipt of necessary information. For both standard and expedited complaint appeals, we will provide you with written notice of our decision. The notice will include the detailed reasons for our decision and, in cases involving clinical matters, the clinical rationale for our decision.

What is an Action?

When (insert plan name) denies or limits services requested by you or your provider; denies a request for a referral; decides that a requested service is not a covered benefit; restricts, reduces, suspends or terminates services that we already authorized; denies payment for services; doesn't provide timely services; or doesn't make complaint or appeal determinations within the required timeframes, those are considered plan "actions". An action is subject to appeal. (See How do I File an Appeal of an Action? below for more information.)

Timing of Notice of Action

If we decide to deny or limit services you requested or decide not to pay for all or part of a covered service, we will send you a notice when we make our decision. If we are proposing to restrict, reduce, suspend or terminate a service that is authorized, our letter will be sent at least 10 days before we intend to change the service.

Contents of the Notice of Action

Any notice we send to you about an action will:

- Explain the action we have taken or intend to take;
- Cite the reasons for the action, including the clinical rationale, if any;
- Describe your right to file an appeal with us (including whether you may also have a right to the State's external appeal process);
- Describe how to file an internal appeal and the circumstances under which you can request that we speed up (expedite) our review of your internal appeal;
- Describe the availability of the clinical review criteria relied upon in making the decision, if the action involved issues of medical necessity or whether the treatment or service in question was experimental or investigational;
- Describe the information, if any, that must be provided by you and/or your provider in order for us to render a decision on appeal.

If we are restricting, reducing, suspending or terminating an authorized service, the notice will also tell you about your right to have services continue while we decide on your appeal; how to request that services be continued; and the circumstances under which you might have to pay for services if they are continued while we were reviewing your appeal.

How do I File an Appeal of an Action?

If you do not agree with an action that we have taken, you may appeal. When you file an appeal, it means that we must look again at the reason for our action to decide if we were correct. You can file an appeal of an action with the plan orally or in writing. When the plan sends you a letter about an action it is taking (like denying or limiting services, or not paying for services), you must file your appeal request within 60 days of the date on our letter notifying you of the action.

How do I Contact my Plan to file an Appeal?

We can be reached by calling **1-855-556-6683 Monday-Friday 8:30am-5:00pm. (TTY/TDD 711)** or writing to:

**Montefiore Diamond Care
Grievances and Appeals Department
Box 500
200 Corporate Blvd. South, Suite 200
Yonkers, NY 10701**

The person who receives your appeal will record it, and appropriate staff will oversee the review of the appeal. We will send a letter telling you that we received your appeal, and include a copy of your case file which includes medical records and other documents used to make the original decision. Your appeal will be reviewed by knowledgeable clinical staff who were not involved in the plan's initial decision or action that you are appealing.

For Some Actions You May Request to Continue Service During the Appeal Process

If you are appealing a restriction, reduction, suspension or termination of services you are currently authorized to receive, you may request to continue to receive these services while your appeal is being decided. We must continue your service if you make your request no later than 10 days from the date on the notice about the restriction, reduction, suspension or termination of services or the intended effective date of the proposed action, whichever is later.

Your services will continue until you withdraw the appeal, or until 10 days after we mail your notice about our appeal decision, if our decision is not in your favor, unless you have requested a New York State Medicaid Fair Hearing with continuation of services. (See Fair Hearing Section below.)

Although you may request a continuation of services while your appeal is under review, if the appeal is not decided in your favor, we may require you to pay for these services if they were provided only because you asked to continue to receive them while your case was being reviewed.

How Long Will it Take the Plan to Decide My Appeal of an Action?

Unless you ask for an expedited review, we will review your appeal of the action taken by us as a standard appeal and send you a written decision as quickly as your health condition requires, but no later than 30 days from the day we receive an appeal. (The review period can be increased up to 14 days if you request an extension or we need more information and the delay is in your interest.) During our review you will have a chance to present your case in person and in writing. You will also have the chance to look at any of your records that are part of the appeal review.

We will send you a notice about the decision we made about your appeal that will identify the decision we made and the date we reached that decision.

If we reverse our decision to deny or limit requested services, or restrict, reduce, suspend or terminate services, and services were not furnished while your appeal was pending, we will provide you with the disputed services as quickly as your health condition requires. In some cases you may request an “expedited” appeal. (See Expedited Appeal Process Section below.)

Expedited Appeal Process

If you or your provider feels that taking the time for a standard appeal could result in a serious problem to your health or life, you may ask for an expedited review of your appeal of the action. We will respond to you with our decision within 72 hours. In no event will the time for issuing our decision be more than 72 hours after we receive your appeal. (The review period can be increased up to 14 days if you request an extension or we need more information and the delay is in your interest.)

If we do not agree with your request to expedite your appeal, we will make our best efforts to contact you in person to let you know that we have denied your request for an expedited appeal and will handle it as a standard appeal. Also, we will send you a written notice of our decision to deny your request for an expedited appeal within 2 days of receiving your request.

If the Plan Denies My Appeal, What Can I Do?

If our decision about your appeal is not totally in your favor, the notice you receive will explain your right to request a Medicaid Fair Hearing from New York State and how to obtain a Fair Hearing, who can appear at the Fair Hearing on your behalf, and for some appeals, your right to request to receive services while the Hearing is pending and how to make the request.

Note: You must request a Fair Hearing within 120 calendar days after the date on the Final Adverse Determination Notice.

If we deny your appeal because of issues of medical necessity or because the service in question was experimental or investigational, the notice will also explain how to ask New York State for an “external appeal” of our decision.

State Fair Hearings

If we did not decide the appeal totally in your favor, you may request a Medicaid Fair Hearing from New York State within 120 days of the date we sent you the notice about our decision on your appeal.

If your appeal involved the restriction, reduction, suspension or termination of authorized services you are currently receiving, and you have requested a Fair Hearing, you will continue to receive these services while you are waiting for the Fair Hearing decision. Your request for a Fair Hearing must be made within 10 days of the date the appeal decision was sent by us or by the intended effective date of our action to restrict, reduce, suspend or terminate your services, whichever occurs later.

Your benefits will continue until you withdraw the Fair Hearing; or the State Fair Hearing Officer issues a hearing decision that is not in your favor, whichever occurs first

If the State Fair Hearing Officer reverses our decision, we must make sure that you receive the disputed services promptly, and as soon as your health condition requires but no later than 72 hours from the date the plan receives the Fair Hearing decision. If you received the disputed services while your appeal was pending, we will be responsible for payment for the covered services ordered by the Fair Hearing Officer.

Although you may request to continue services while you are waiting for your Fair Hearing decision, if your Fair Hearing is not decided in your favor, you may be responsible for paying for the services that were the subject of the Fair Hearing.

You can file a State Fair Hearing by contacting the Office of Temporary and Disability Assistance:

- Online Request Form: <http://otda.ny.gov/oah/FHReq.asp>

- Mail a Printable Request Form:

NYS Office of Temporary and Disability Assistance
Office of Administrative Hearings
Managed Care Hearing Unit
P.O. Box 22023
Albany, New York 12201-2023

- Fax a Printable Request Form: (518) 473-6735

- Request by Telephone:

Standard Fair Hearing line – 1 (800) 342-3334
Emergency Fair Hearing line – 1 (800) 205-0110
TTY line – 711 (request that the operator call 1 (877) 502-6155)

- Request in Person:

New York City
14 Boerum Place, 1st Floor
Brooklyn, New York 11201

For more information on how to request a Fair Hearing, please visit: <http://otda.ny.gov/hearings/request/>

State External Appeals

If we deny your appeal because we determine the service is not medically necessary or is experimental or investigational, you may ask for an external appeal

from New York State. The external appeal is decided by reviewers who do not work for us or New York State. These reviewers are qualified people approved by New York State. You do not have to pay for an external appeal.

When we make a decision to deny an appeal for lack of medical necessity or on the basis that the service is experimental or investigational, we will provide you with information about how to file an external appeal, including a form on which to file the external appeal along with our decision to deny an appeal. If you want an external appeal, you must file the form with the New York State Department of Financial Services within four months from the date we denied your appeal.

Your external appeal will be decided within 30 days. More time (up to 5 business days) may be needed if the external appeal reviewer asks for more information. The reviewer will tell you and us of the final decision within two business days after the decision is made.

You can get a faster decision if your doctor can say that a delay will cause serious harm to your health. This is called an expedited external appeal. The external appeal reviewer will decide an expedited appeal in 3 days or less. The reviewer will tell you and us the decision right away by phone or fax. Later, a letter will be sent that tells you the decision.

You may ask for both a Fair Hearing and an external appeal. If you ask for a Fair Hearing and an external appeal, the decision of the Fair Hearing officer will be the “one that counts.”

3. SERVICE AUTHORIZATIONS & ACTION REQUIREMENTS

Definitions

Prior Authorization Review: review of a request by the Enrollee, or provider on Enrollee’s behalf, for coverage of a new service (whether for a new authorization period or within an existing authorization period) or a request to change a service as determined in the plan of care for a new authorization period, before such service is provided to the Enrollee.

Concurrent Review: review of a request by an Enrollee, or provider on Enrollee’s behalf, for additional services (i.e., more of the same) that are currently authorized in the plan of care or for Medicaid covered home health care services following an inpatient admission.

Expedited Review: An Enrollee must receive an expedited review of his or her Service Authorization Request when the plan determines or a provider indicates that a delay would seriously jeopardize the Enrollee’s life, health, or ability to attain, maintain, or regain maximum function. The Enrollee may request an expedited

review of a Prior Authorization or Concurrent Review. Appeals of actions resulting from a Concurrent Review must be handled as expedited.

General Provisions

Any Action taken by the Contractor regarding medical necessity or experimental or investigational services must be made by a clinical peer reviewer as defined by PHL §4900(2)(a).

Adverse Determinations, other than those regarding medical necessity or experimental or investigational services, must be made by a licensed, certified, or registered health care professional when such determination is based on an assessment of the Enrollee's health status or of the appropriateness of the level, quantity or delivery method of care. This requirement applies to determinations denying claims because the services in question are not a covered benefit when coverage is dependent on an assessment of the Enrollee's health status, and to Service Authorization Requests including but not limited to: services included in the Benefit Package, referrals, and out-of-network services.

The plan must notify members of the availability of assistance (for language, hearing, speech issues) if member wants to file appeal and how to access that assistance.

The Contractor shall utilize the Department's model MLTC Initial Adverse Determination and 4687 MLTC Action Taken notices.

Timeframes for Service Authorization Determination and Notification

1. For Prior Authorization requests, the Contractor must make a Service Authorization Determination and notice the Enrollee of the determination by phone and in writing as fast as the Enrollee's condition requires and no more than:
 - a. Expedited: Seventy-two (72) hours after receipt of the Service Authorization Request
 - b. Standard: Fourteen (14) days after receipt of request for Service Authorization Request.
2. For Concurrent Review Requests, the Contractor must make a Service Authorization Determination and notice the Enrollee of the determination by phone and in writing as fast as the Enrollee's condition requires and no more than:
 - a. Expedited: Seventy-two (72) hours of receipt of the Service Authorization Request
 - b. Standard: Fourteen (14) days of receipt of the Service Authorization Request
 - c. In the case of a request for Medicaid covered home health care services following an inpatient admission, one (1) business day after receipt of necessary information; except when the day subsequent to the Service Authorization

Request falls on a weekend or holiday, then seventy-two (72) hours after receipt of necessary information; but in any event, no more than three (3) business days after receipt of the Service Authorization Request.

3. Up to 14 calendar day extension. Extension may be requested by Enrollee or provider on Enrollee's behalf (written or verbal). The plan also may initiate an extension if it can justify need for additional information and if the extension is in the Enrollee's interest. In all cases, the extension reason must be well documented.
 - a. The MLTC Plan must notify enrollee of a plan-initiated extension of the deadline for review of his or her service request. The MLTC Plan must explain the reason for the delay, and how the delay is in the best interest of the Enrollee. The MLTC Plan should request any additional information required to help make a determination or redetermination, and help the enrollee by listing potential sources of the requested information.
4. Enrollee or provider may appeal decision – see Appeal Procedures.
5. If the plan denied the Enrollee's request for an expedited review, the plan will handle as standard review.
 - a. The Contractor must notice the Enrollee if his or her request for expedited review is denied, and that Enrollee's service request will be reviewed in the standard timeframe.

Other Timeframes for Action Notices

1. When the Contractor intends to restrict, reduce, suspend, or terminate a previously authorized service within an authorization period, whether as the result of a Service Authorization Determination or other Action, it must provide the Enrollee with a written notice at least ten (10) days prior to the effective date of the intended Action, except when:
 - a. the period of advance notice is shortened to five (5) days in cases of confirmed Enrollee fraud; or
 - b. the Contractor may mail notice not later than date of the Action for the following:
 - i. the death of the Enrollee;
 - ii. a signed written statement from the Enrollee requesting service termination or giving information requiring termination or reduction of services (where the Enrollee understands that this must be the result of supplying the information);
 - iii. the Enrollee's admission to an institution where the Enrollee is ineligible for further services;

- iv. the Enrollee's address is unknown and mail directed to the Enrollee is returned stating that there is no forwarding address;
 - v. the Enrollee has been accepted for Medicaid services by another jurisdiction; or
 - vi. the Enrollee's physician prescribes a change in the level of medical care.
- c. For CBLTCS and ILTSS, when the Contractor intends to reduce, suspend or terminate a previously authorized service, or issue an authorization for a new period that is less in level or amount than previously authorized, it must provide the Enrollee with a written notice at least ten (10) days prior to the effective date of the intended Action, regardless of the expiration date of the original authorization period, except under the circumstances described in 1(a)-(b).
- i. For CBLTCS and ILTSS, when the Contractor intends to reduce, suspend, or terminate a previously authorized service, or issue an authorization for a new period that is less in level or amount than previously authorized, the Contractor will not set the effective date of the Action to fall on a non-business day, unless the Contractor provides "live" telephone coverage available on a twenty-four (24) hour, seven (7) day a week basis to accept and respond to Complaints, Complaint Appeals and Action Appeals
- d. The Contractor must mail written notice to the Enrollee on the date of the Action when the Action is a denial of payment, in whole or in part,
- e. When the Contractor does not reach a determination within the Service Authorization Determination timeframes described in this Appendix, it is considered an Adverse Determination, and the Contractor must send notice of Action to the Enrollee on the date the timeframes expire.

Contents of Action Notices

1. The Contractor must utilize the model MLTC Initial Adverse Determination notice for all actions, except for actions based on an intent to restrict access to providers under the recipient restriction program.
2. For actions based on an intent to restrict access to providers under the recipient restriction program, the action notice must contain the following as applicable:
 - a. the date the restriction will begin;
 - b. the effect and scope of the restriction;
 - c. the reason for the restriction;
 - d. the recipient's right to an appeal;
 - e. instructions for requesting an appeal including the right to receive aid continuing if the request is made before the effective date of the intended action, or 10 days after the notices was sent, whichever is later;
 - f. the right of Contractor to designate a primary provider for recipient;

- g. the right of the recipient to select a primary provider within two weeks of the date of the notice of intent to restrict, if the Contractor affords the recipient a limited choice of primary providers;
- h. the right of the recipient to request a change of primary provider every three months, or at an earlier time for good cause;
- i. the right to a conference with Contractor to discuss the reason for and effect of the intended restriction;
- j. the right of the recipient to explain and present documentation, either at a conference or by submission, showing the medical necessity of any services cited as misused in the Recipient Information Packet;
- k. the name and telephone number of the person to contact to arrange a conference;
- l. the fact that a conference does not suspend the effective date listed on the notice of intent to restrict;
- m. the fact that the conference does not take the place of or abridge the recipient's right to a fair hearing;
- n. the right of the recipient to examine his/her case record; and
- o. the right of the recipient to examine records maintained by the Contractor which can identify MA services paid for on behalf of the recipient. This information is generally referred to as "claim detail" or "recipient profile" information.