2016 FINAL RULE 42 CFR 438 Service Authorization and Appeals

Frequently Asked Questions for
Mainstream Medicaid Managed Care (MMC), Health and Recovery Plans (HARP), and HIV Special Needs Plans (HIV SNP)

I. General Questions:

1. Is there an expectation regarding the language that the plans need to use to update plan Policies and Procedures?

   The Department will not be issuing model policy and procedures. Guidance for implementation is posted to the DOH website at: https://www.health.ny.gov/health_care/managed_care/plans/index.htm. In addition, survey tools L-4 and L-10 will be updated and made available to plans.

2. If a drug/medication has been removed from our formulary, which notice should we be sending to the member? Would it be the current letter we have on file that has been approved by the DOH for formulary changes? Or would we need to send the IAD with AC?

   A change in formulary would be noticed to all members as per the current process. A plan decision to deny a medication to a particular member must be noticed as an Initial Adverse Determination. See DOH guidance "New York State Medicaid Managed Care Enrollee Right to Fair Hearing and Aid Continuing for Plan Service Authorization Determinations" for clarification on when the notice with Aid Continuing rights must be provided.

II. Model Notices:

1. In the Approval Letter under {insert for Appeals Resolutions}, are the 4 listed service reasons [a covered benefit], [medically necessary] etc., applicable to initial approval or just intended for use with Appeals?

   These reasons are intended for use for all purposes of the approval model notice. The model notice was adjusted to clarify intent.

2. What are the scenarios where we would use one of these over the other?

   [[Provider Name] is a [participating provider.] [an out of network provider. You are not responsible for any extra payments, but you will still have to pay your regular co-pay or co-insurance if you have any.] *{or}* [This [service] will be provided by [a participating provider.] [an out of network provider. You are not responsible for

any extra payments, but you will still have to pay your regular co-pay or co-insurance if you have any.]]

The first sentence is for use when a specific provider is named or requested, otherwise the latter sentence may be used.

3. During the call we were also advised that for “Coverage Type”, we should add: Medicaid Managed Care, HARP, etc. Is it ok if we use our plan names instead?

   The plan’s product line name may be used if the name is associated with a single coverage type.

4. We are confused regarding the IAD (no AC) letter. There is a section labeled for use of “concurrent review”, but it is our understanding that if no Aid Continuing that concurrent review would not apply. Please advise.

   There are concurrent reviews under NYS PHL 4903 that are not subject to Aid Continuing, for example, a request made prior to expiration of the authorized period for additional hospital inpatient days. See DOH guidance “New York State Medicaid Managed Care Enrollee Right to Fair Hearing and Aid Continuing for Plan Service Authorization Determinations” for clarification on when the notice with Aid Continuing rights must be provided.

5. Do the unique identifiers need to appear on the letters that we send out to the member?

   Yes, once approved, the unique identifier should continue to appear on the template notice as it is utilized.

6. The information below only appears if you move the signature slightly down to the next page on the IAD No AC template. Go to page 7 and use your cursor above the “Sincerely” and hit enter a few times and the information below pops up as a header in the following page. It’s not there if you do not do so. Is this something that needs to be maintained on the template?

   “Important: This notice explains your right to appeal our decision. Read this notice carefully. If you need help, you can call one of the numbers listed on the last page under “To File a Complaint, Get Help or for More Information.” Oral interpretation is available for all languages. Access this service by calling <phone number>.”

   Please disregard this language. This is not a part of the template requirements.

III. Service Authorization Determinations:

1. Are concurrent review letters (letters sent for a denial after services have previously been approved) required to be sent the same day the denial is issued or will verbal notification suffice in this instance?

   Plans must make a determination and send written notice in accordance with the time frames provided in statute, regulation, the Medicaid managed care model contract, and DOH guidance.

2. Are we permitted to have the IAD letters be signed off by one of our Medical Directors, instead of the reviewing nurse?

   Yes, the notice may be signed by a supervisor, contact person, or insert the job title and/or department name. Note NYS PHL 4903(1)(c) requires that all utilization review adverse determinations be made by a clinical peer. Plans must have policies and procedures that clearly document the peer and their decision, which may be by signature on the adverse determination notice, or, for example, an electronic signature of the peer's decision in the plan's records.

3. For partial approvals – is the Health Plan required to send both an IAD and an Approval or is the notation of the approved versus the denied service in the IADs sufficient?

   A partial approval is considered an adverse determination. The plan is required to send an IAD that describes what part of the request has been denied and what has been approved. Plans may issue separate authorization notice in addition to the required IAD.

4. The Initial Adverse Determination (IAD) template notice does not make mention of services denied on reconsideration. Are the plans expected to issue another IAD when a service is denied upon reconsideration? Please advise.

   NYS PHL 4903(6) requires plans issue an IAD if the adverse determination is upheld after reconsideration (peer to peer). Plans may indicate in the IAD clinical rationale that the provider requested reconsideration and provide an explanation as to reason the decision was upheld. Alternatively, plans may submit templates including a placeholder for this information.

5. If there is a new member that was currently receiving a drug from their previous plan, but this drug is not on our formulary, we will allow the member a one-month transition period to receive this non-formulary drug. However, once the one-month transition is over, do we need to issue an IAD? Would this be an IAD with AC or an IAD without AC?

   The requirements for transitioning enrollees under the MMC Model Contract Section 10.32 has not changed and the plan must provide one 30-day supply refill within a 90-day period. A decision to deny continued authorization of a non-

formulary drug or non-participating pharmacy is to be noticed as an Initial Adverse Determination. See DOH guidance "New York State Medicaid Managed Care Enrollee Right to Fair Hearing and Aid Continuing for Plan Service Authorization Determinations" for clarification on when the notice with Aid Continuing rights must be provided.

IV. Appeals:

1. If an enrollee makes a second request for a service that the plan denied while still within the 60-day window to file an appeal, should plans reprocess the denied requests as a new request or direct members/providers to appeal?

   The plan may develop policy and procedures to review a second request as a Plan Appeal or new request. If the second request will be handled as a Plan Appeal, the plan must treat the receipt of the request as the filing date/time of the Plan Appeal for the purposes of complying with determination timeframes.

2. Is written consent from the member or an Appointment of Representative form (AOR) required for standard appeals? Should the plan provide Aid Continuing upon receipt of a Plan Appeal from a provider?

   42 CFR 438.402(c)(1)(ii) requires the enrollee's written consent for the provider or authorized representative to file a Plan Appeal on the enrollee's behalf. Aid Continuing may not be provided when a provider fails to demonstrate an enrollee has authorized the provider as their representative for the Plan Appeal and the Aid Continuing request, as the enrollee may be held responsible for the cost of services provided during the Plan Appeal. Plans should have policies and procedures for processing expedited requests, ensuring recognition of previously designated representatives, and establishing designation of a representative where the enrollee cannot provide written authorization due to an impairment.

V. Fair Hearings:

1. What happens if an enrollee asks for a fair hearing before exhausting the plan's appeal process? Who determines if the plan's appeal process has been exhausted?

   DOH and OTDA are working on process to remind enrollees of the plan appeal exhaustion requirement, but this will not affect the scheduling of the hearing. DOH will provide plans with a clear statement to be included in the evidence packet if plan records indicate the appeal process was not exhausted prior to the request for a fair hearing. Whether the enrollee has exhausted the plan's appeal process will be decided as part of the review of administrative procedures at the hearing.

VI. Aid Continuing:

1. If Aid Continuing is not provided during a Plan Appeal, can an enrollee receive Aid Continuing while a Fair Hearing is pending?

   For decisions subject to Aid Continuing, an enrollee, may receive Aid Continuing upon timely request for a Fair Hearing, whether or not Aid Continuing was provided during review of the Plan Appeal.

2. If an authorization is currently on file for a service, and while still in current the authorization period a request comes in for the same service, to begin after the initial authorization period, in the event of a denial, would AC apply? Our initial thought would be that AC would not apply because we are not terminating, suspending or changing an existing authorized service. Please confirm/advise?

   See DOH guidance "New York State Medicaid Managed Care Enrollee Right to Fair Hearing and Aid Continuing for Plan Service Authorization Determinations" for clarification on when the notice with Aid Continuing rights must be provided.