FIDA Integrated Appeal and Grievance Process FAQ

Q1. Do we use the integrated appeal and grievance process that was created for FIDA for appeals and grievances related to Part D benefits?

A1. No, appeals and grievances for Part D benefits should follow the standard Medicare Part D rules and procedures for appeals and grievances.

Q2. Do we use the integrated appeal and grievance process that was created for FIDA for appeals and grievances related to Medicaid prescription drug benefits?

A2. Yes. Medicaid prescription drug determinations follow the integrated process. They are considered standard appeals, however notice of decision must be given within seven (7) days of receipt of the appeal, orally or in writing.

Q3. The Acknowledgment of Appeal notice includes an insert stating that participants will continue to get the disputed service while their appeal is processing. Are plans supposed to automatically continue the benefits or does the participant need to request continuation?

A3. Plans should automatically continue the participant's benefits (and include the referenced text on the Acknowledgement of Appeal notice) if:

1) The action involves a stoppage, reduction, or restriction of a previously authorized benefit, and
2) The appeal was received within ten (10) days of the Integrated Care Denial Notice (ICDN) postmark date or the date the action was intended to take effect, whichever is later.

Q4. If a 14-day decision extension was initiated by the Plan or Participant, can the FIDA Plan make an appeal decision before the new deadline?

A4. No, unless it is in the participant's best interest.

For example, if a Plan extends the deadline and then decides to issue a fully favorable decision, the Plan may issue its decision before the date of the new deadline.

Q5. May Plans extend the level 1 appeal decision timeframe by more than 14 days if the request to do so comes from the Participant (and not the Plan)?

A5. No. Plans may only extend the decision timeframe by up-to 14 additional days, even when the Participant requests the extension (or wants to schedule an in-person review) after this date.

Q6. When should the FIDA Plan send the Appeal Decision Notice to the participant (and their representative, as applicable)?

A6. For Expedited Appeals, barring an extension, FIDA plans must decide the appeal as fast as the Participant's condition requires, but never later than seventy-two (72) hours of receipt of the Appeal (orally or in writing). The FIDA plan must make reasonable efforts to provide prompt oral notice in-person or by phone. After attempting oral notice, whether successful or not, the FIDA Plan has two (2) calendar days to send the Appeal Decision Notice.

For most Standard Appeals, barring an extension, FIDA Plans must send the Appeal Decision Notice as fast as the Participant's condition requires, but never later than thirty (30) calendar days from the date of receipt of the Appeal (orally or in writing).

For Medicaid prescription drug appeals, barring an extension, FIDA Plans must send the Appeal Decision Notice as fast as the Participant's condition requires, but never later than seven (7) calendar days from the date of receipt of the Appeal (orally or in writing).

For appeals on retroactive claims or payment denials, barring an extension, FIDA Plans must send the Appeal Decision Notice as fast as the Participant's condition requires, but never later than sixty (60) calendar days from the date of receipt of the Appeal (orally or in writing).

Q7. Are participants required to follow an oral filing of an appeal with a written filing?

A7. No. The participant may submit supplemental written information for the plan to consider during its review, but is not and may not be required the follow an oral appeal with a written filing.

Q8. Can plans delegate all or part of the Medicaid drug appeal process to their Pharmacy Benefits Manager (PBM)?

A8. Yes, plans can delegate all or part of the Medicaid drug appeal process to their PBM as long as the process is seamless to FIDA participants (e.g. Participants are not burdened with extra steps or multiple phone numbers, address, etc.) and the Plan monitors the PBM to ensure compliance with requirements.

Q9. Can a delegated vendor send out an ICDN (e.g., PBM, behavioral health vendor, etc.)?

A9. Yes. Similar to plans delegating Part B drug functions to PBMs, plans may delegate such functions to vendors as long as the regulatory requirements under 42 CFR 422.504(i) are met. ICDNs sent by delegated vendors must prominently display the FIDA Plan name.

Plans should also note Section IV.F of the IDT Policy: "When decisions are made by the FIDA Plan outside of the IDT meetings, such decisions must be communicated to the Care Manager and recorded in the shared, accessible Participant record (i.e. Comprehensive Participant Health Record) and then must be communicated to all IDT members within one business day of the decision."

Q10. What is the standard for getting an expedited appeal review? Which of these standards applies?

A10. Plans must grant an expedited determination if applying the standard timeframe could seriously jeopardize the life or health of the participant or the participant's ability to attain, maintain, or regain maximum function.

Q11. Are plans required to send the Acknowledgement of Appeal notice for expedited appeals? If so, and if the appeal is resolved on the same day as the request, can it be mailed in the same envelope as the Appeal Decision Notice?

A11. No. Plans are not required to send the Acknowledgement of Appeal notice for expedited appeals, assuming the FIDA Plan resolves the expedited appeal within seventy-two (72) hours of receipt and properly notifies the Participant of the decision. However, if the plan chooses to send the Acknowledgment of Appeal notice, it can be sent in the same envelope as the Appeal Decision Notice.

Q12. The appeal form that is attached to the ICDN calls for an email address for the participant to submit appeals to the FIDA Plan. Is this a requirement for FIDA, or is submission via fax and mail sufficient? Also, can FIDA Plans include a secure portal web address?

A12. Allowing for email submissions of the appeals form is an option, not a requirement. If the secure portal meets HIPAA/HITECH security requirements, then the FIDA Plan may include the address. FIDA Plans using a portal must submit a description of the system capabilities and certify that it meets requisite privacy and security standards.

Q13. Will participating providers be allowed to use the FIDA integrated appeals process? More specifically, can they use the integrated appeals process for retrospective medical necessity reviews?

A13. No. Participating providers may only use the integrated appeals process on behalf of the participant, essentially serving as a representative. They cannot appeal organization determinations through the integrated appeals process on their own behalf. Disputes between a participating provider and a FIDA Plan are generally governed by the contract between them.

Q14. Will non-participating provider appeals regarding claim denials continue to follow the existing CMS process? If yes, will adverse determinations be automatically forwarded to MAXIMUS Federal or OTDA?

A14. Yes, non-participating provider appeals for traditional Medicare services will continue to follow the process described in Chapter 13, Section 60.1.1 of the Medicare Managed Care Manual. This includes automatically forwarding such appeals to MAXIMUS Federal.

Q15. Can a single notice be used to describe multiple reductions/denials if they are all determined within the IDT meeting and accompany a Person Centered Service Plan (PCSP)?

A15. Yes, as stated in the Instructions for the ICDN Models, ICDN Model 2 should be used when the participant had a certain level of care recorded in his or her prior PCSP and then the IDT denies, reduces, or stops at least one of the services in the new PCSP.

Q16. Do Plans have to send an ICDN to participants for retroactive claims denials (*e.g.*, denials for exceeding authorization, medically necessary, wrong code, missing information, etc.)? If so, what does the Plan send to the requesting provider (*e.g.*, the ICDN or an Explanation of Payment [EOP] notice)?

A16. Plans do not send an ICDN if a contracted provider's claim for payment is denied and there is no member liability. Payment disputes between the plan and a contracted provider are governed by the terms of the plan-provider agreement.

Q17. May the Plan's administrative staff who are involved in administrative tasks surrounding the initial coverage determination also be involved in administrative tasks supporting an appeal of the same case?

A17. FIDA Plans must ensure that decision-makers on appeals and grievances are not involved in any previous level of review or decision-making of that case. Decision-makers must be health care professionals with clinical expertise in treating the Participant's condition or disease if:

1) the initial determination was based on medical necessity;
2) the grievance or appeal is regarding the denial of expedited resolution of an appeal; or
3) the grievance or appeal involves clinical issues.

Staff that are only involved in administrative tasks are not decision-makers.

Q18. Do Sections 2.13.1.1.2.3.1 and 2.13.1.1.2.3.2 of the Three-Way Contract require FIDA Plans to allow the Participant to be involved in the review process in person?

A18. These Sections require FIDA Plans to give Participants a reasonable opportunity to present evidence and allegations of fact or law about the issue in dispute. At the Participant's request, this opportunity should be in-person. The FIDA Plan must have a way to schedule these proceedings and to administer the in-person review at a particular time and location.

Q19. What if the participant requests an expedited in-person review? Does the FIDA Plan have to provide the in-person review, decide within 72 hours, or both?

A19. Participants have a right to an in-person review, even in expedited cases. However, in accordance with 42 CFR § 422.586, the Plan should explain to the Participant (or his/her representatives) that if the shortened timeframe will limit the ability to present evidence, the Participant may request a 14-day extension. .

Q20. Who is required to be present at an in-person level 1 appeal review?

A20. The Participant, and/or his or her representative should be present at the in-person review, in addition to the Plan reviewer. Others persons, such as witnesses, caretakers, or providers are permitted to be present.

Q21. What happens if the Participant, and/or his or her representative, does not appear at the in-person review? Has the Participant abandoned the appeal?

A21. No, the Plan is still required to render a decision within the applicable timeframe. The Plan should document its efforts to contact the Participant, and/or his or her representative, and reschedule the in-person review if reasonably possible.

Q22. Does a plan have to pay for transportation to the level 1 appeal in-person review?

A22. Yes, upon request Plans must provide transportation for participants, transportation attendants, representatives, and witnesses as may be medically or financially necessary.

Q23. Are FIDA Plans required to schedule in-person reviews at the Participant's home? If so, then what is the standard for providing a <u>home-based</u> in-person review?

A23. If a participant requests an in-person review and transportation to the Plan's normal review location could seriously jeopardize the life or health of the participant or the participant's ability to attain, maintain, or regain maximum function, then the Plan should conduct the review at the participant's home or current residence.

Q24. If a participant qualifies for a home-based in-person review can the plan send an agent to the home and conference in the reviewer, or have the agent gather information to take back to the reviewer?

A24. No. If a person requests and qualifies for a home-based in-person review, the reviewer must travel to the location of the participant.

Q25. Do plans have to provide transportation to in-person hearings with the Integrated Administrative Hearing Office (IAHO)?

A25. Yes. As with in-person reviews at level 1, Plans are required to provide transportation for participants and transportation attendants to attend IAHO hearings.

Q26. What is the process for Plan participation in the integrated administrative hearings? Are Plans required to attend in person or by phone? Who from the Plan must participate?

A26. As is noted in section 2.13.1.1.2.9 of the Three-Way Contract, "the staff person participating must be knowledgeable in the appeal decision reached by the FIDA plan and the basis for the decision." At the discretion of the Integrated Administrative Hearing Officer, the FIDA plan may waive its right to appear in person, in accordance with and subject to the process outlined in § 358-4.3(c). Plans should contact the IAHO for more information on requirements related to waiving appearance at the hearing.

Q27. What is the timeframe for sending notice to a participant and/or provider of an organization's initial coverage determination?

A27. The timeframes for sending written notice of any decision by the FIDA Plan to deny a Service Authorization Request, or to authorize a service in an amount, duration, or scope that is less than requested, (*i.e.*, ICDN Model 3) are prescribed in section 2.9.4.5 of the Three-way Contract.

The timeframes for sending notice of any authorization decisions by the IDT (*i.e.*, ICDN Models 1 and 2) are prescribed in section 2.9.4.6 of the Three-way Contract.

Q28. Can a participant file an appeal if the FIDA Plan or IDT fails to make a coverage decision within the timeframes under sections 2.9.4.5 or 2.9.4.6 of the Three-Way Contract? Does the FIDA Plan have to notify the participant if this happens?

A28. Yes and yes. The failure to provide items or services in a timely matter is an action than may be appealed to the FIDA Plan using the integrated appeal process. If FIDA Plan or IDT fails to make a timely determination, the FIDA Plan must send the appropriate model ICDN for the action.

Q29. If a FIDA plan fails to make a Level 1 appeal decision within the required timeframe, do they need to forward the case to the IAHO? For example, if an expedited/fast appeal is requested and granted, but the plan doesn't make the decision within the required 72-hour window.

A29. Yes. Failure of the FIDA plan to make a level 1 appeal decision within the required timeframes is deemed an adverse decision which must be auto-forwarded to IAHO. Plans should use the code "F0U – FAILURE TO DECIDE TIMELY" on the Cover Note when auto-forwarding these cases to the IAHO. Please refer to the Cover Note and the FHIS Code Instructions for further details.

Q30. All of the model notices request the "Participant Number." Which number should be used (*e.g.*, HICN)?

A30. Plans should use the Participant Identification Number that the plan has assigned to the Participant upon enrollment.

Q31. What is the review and submission process for the model notices?

A31. The Appeals and Grievances notices and ICDNs are marketing materials but are file and use. If FIDA Plan wish to make changes to the models, they must request prior approval from the NYDOH and CMS.

Please see the marketing codes at the following link: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/NYMMPModelsCodesMemo051514.pdf

Q32. In order to satisfy the need to notify participants that an appeal has been auto-forwarded, can plans send the Appeal Decision Notice (Adverse) and the Acknowledgement of Auto-Forward of Appeal notice together?

A32. Yes, the notices may be sent together.

Q33. The Request for Additional Information notice advises the Participant that they may get more information from his or her provider. Should the FIDA Plan contact the provider instead of putting the onus on the Participant? Also, can a copy of the notice be sent to the provider?

A33. The FIDA Plan is responsible for procuring relevant information and material from network providers, and should make all reasonable attempts to discover and procure such information and material from out-of-network providers as well. The Request for Additional Information notice should not be used unless the FIDA Plan is unable to procure potentially significant, information or material after reasonable attempts to do so.

If the FIDA Plan sends a Request for Additional Information notice to a Participant, a copy should go to any provider that the FIDA Plan is specifically aware of that has or may have the relevant information or material.

Q34. Does a person or entity have to be the Participant's representative in order to file an appeal on their behalf?

A34. No, the Plan must accept and process appeal requests from the Participant, the participant's representative, attorney, family member, provider, or members of the Participant's IDT. These individuals do not need to have a written letter or Form 1696 just to file the appeal on the Participant's behalf.

Q35. Does a person or entity have to be the Participant's representative in order to represent the Participant in appeal proceedings?

A35. Yes. A representative is designated either through a letter from the Participant designated the person he/she wants to have serve as representative or through completion of an Appointment of Representative (form 1696) (http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf).

Q36. Can plans adjust ICDN Model 3 to add a letterhead/plan mailing address field at the top?

A36. Yes.

Q37. According to the FAQ released on 2/13/15, disclaimers must be included on utilization management service approval notices. As such, should the ICDN also have disclaimers?

A37. The disclaimers that are required for the ICDN are already included on the model. The plans do not need to add any additional disclaimers.

Q38. Who is the "specialist" mentioned in ICDN Model 3 under the "Who denied your services" section? Is this a specialist on the IDT?

A38. These are the specialists listed identified in Section 2.9.1.4 of the Three-Way Contract.

Q39. Section 2.13.1.1.2.7.2.3 requires FIDA Plans to list the name of a contact person for use by IAHO. Whose contact information should be used on the Cover Note? Will a contact "group" be accepted?

A39. The Cover Note must indicate the name of an appropriate contact person who has knowledge of the case and basis for decision.

Q40. Will IAHO contact the person listed on the Cover Note during normal business hours or do they have to be available 24 hours a day, 7 days a week?

A40. For expedited appeals forwarded to IAHO, the Plan must make sure that someone with knowledge of the case and basis for decision is available 24 hours per day, 7 days per week.