



Provider Manual

*Location*  
**Chapter 2**      *Section*  
**Provider Rights and Responsibilities**

*Amendment*

**2.3.1 Provide Quality Care:**

- ▶ Provide care within scope of practice (as defined by Health Plus) and in accordance with Health Plus access, quality and participation standards.
- ▶ Adhere to Health Plus's clinical guidelines.
- ▶ Participate in Health Plus quality improvement initiatives and other activities associated with meeting regulatory requirements and upholding contractual obligations.
- ▶ Provide optimal care to member without regard to age, race, sex, religious background, national origin, disability, sexual orientation, source of payment, veteran Status, claims experience, social status, health status, or marital status.
- ▶ Comply with the American with Disabilities Act (ADA) guidelines set forth by the New York State Department of Health (i.e. wheelchair access).
- ▶ Give members complete an accurate information concerning a diagnosis, treatment plan, or prognosis in terms they can understand (eliminating both language and cultural barriers), and without regard to plan coverage.
- ▶ When it is not advisable to give such information to the enrollee, the information is to be made available to an appropriate person acting on the enrollee's behalf.

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**Chapter 2**

**Provider Rights and Responsibilities**

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**2.3.1 Provide Quality Care: (continued)**

- ▶ If there is no office staff member, friend or relative who speaks the member's language, Health Plus's multi-lingual staff and facilitated connection with the AT&T Language Bank can assist with translation.
- ▶ Provide sufficient information to enable member to give informed consent prior to the initiation of any treatment or
- ▶ Inform members of appropriate follow-up and self-care measures relevant to their condition.
- ▶ Advise members of non-covered treatments or services and their cost prior to rendering them.

**2.6.3 Continuity of Care When Provider Leaves the Network:  
(continued)**

- \*\*For members who have entered the second trimester of pregnancy, the transitional period includes the delivery and postpartum care directly related to the delivery.\*\***
- ▶ Terminating and non-renewing providers are required to continue caring for members for up to ninety (90) days from the date of provider's termination from plan. Health Plus will send a notice of intended termination to all members on the provider's panel with information on obtaining care and service during the transition period thereafter.

<i>Location</i>	<i>Section</i>	<i>Amendment</i>
<i>Chapter 2</i>	<i>Provider Rights and Responsibilities</i>	<p><b>2.6.3 Continuity of Care When Provider Leaves the Network:</b> <i>(continued)**For members who have entered the second trimester of pregnancy, the transitional period includes the delivery and postpartum care directly related to the delivery.**</i></p> <p>Providers offering transitional care must agree to:</p> <ol style="list-style-type: none"><li>1. Continue to accept Health Plus reimbursement rates in effect prior to the transitional period.</li><li>2. Adhere to Health Plus's medical policies and procedures, including referrals, prior authorization requirements a treatment regimen(s) approved by plan.</li></ol>
<i>Chapter 11</i>	<i>Utilization Management</i>	<p><b>11.4.1 Notification of Adverse Determination:</b> An adverse determination occurs when Health Plus denies a service authorization request or decides to reduce the amount, duration, or scope of a requested service. All adverse determination are made by a licensed, certified, or registered health professional an those that are based on failure to meet medical necessity standards must be made by a clinical peer reviewer as defined by PHL 4900(2)(a).</p>

*Amendment*

***11.4.1 Notification of Adverse Determination: (continued)***

- ▶ Notifications of adverse determinations/denials both oral and written are communicated to the member and provider within 24 hours of the decision and must include:
- ▶ The reasons for the determination, including the clinical rationale (if any).
- ▶ Notice of the availability of the clinical review criteria used to make the determination.
- ▶ Specific guidance on what, if any, additional information must be provided to or obtained by Health Plus in order to render a decision on appeal.
- ▶ Information on how to initiate and internal appeal process (standard or expedited).
- ▶ Information on how to initiate an external appeal (if applicable).
- ▶ Information on Fair Hearing request with the additional information needed for the appeal as defined in PHL 4904(3) (for members with Medicaid or FHP coverage only).
- ▶ Copies of relevant forms.
- ▶ Timeframe for appeals determination begins upon the receipt of all necessary information. For Medicaid and FHP the review timeframe begins upon first receipt of appeal, whether filed orally or in writing. Written appeals must be sent to Health Plus, Medical Appeals Department, 335 Adams Street, Suite 2600, Brooklyn, New York 11201 or by calling 800-300-8181.

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**Chapter 11**      *Section*  
**Utilization Management**

*Amendment*

**11.5 Action Appeals:**

▶ Appeals of adverse determinations are conducted in accordance with current New York State Department of Health regulations. Appeals for Medicaid/FHP may be submitted by telephone or by mail. However, oral appeals must be followed up by a signed written appeal.

▶ If health plus determines that an expedited appeal is not justified, the member may file a grievance with the Member Services department. The appeal is then processed as a standard internal appeal.

▶ Determinations are made on expedited appeal within two business days of receipt of the necessary information and no more than three business days after receipt of the appeal. This time may be extended for up to 14 days upon enrollee or provider request; If Health Plus demonstrates more information is needed and the delay is in the best interest of the enrollee and so notifies the enrollee. ▶ Health Plus will provide written notice of the appeal decision along with the clinical rationale in the even of an adverse determination

**11.5.1 Reconsideration Review:**

If Health Plus renders a denial decision for medical necessity without discussing the case with the health care provider recommending the service then that provider is entitled to a reconsideration review (not applicable to retrospective reviews).

**11.5.1 Reconsideration Review: (continued)**

- ▶ A reconsideration review occurs **within one business day** of the request and will be conducted by a Health Plus clinical peer reviewer who made the initial determination, or by a designee if the original peer reviewer is not available.
- ▶ If Health Plus upholds the denial, the provider may appeal the decision through the expedited appeal process (if applicable to retrospective reviews).
- ▶ If Health Plus fails to render a timely determination on a reconsidered review, a notice will be sent to the provider on the day review timeframes expire and this will be treated as an adverse determination, and the provider may proceed to the next level of appeal (Standard or Expedited)

**11.5.2 Standard Action Appeal: (continued)**

- ▶ A Health Plus member or health care provider (acting as the member's designee) may request a standard action appeal if a denial is upheld on reconsideration review or expedited appeal.
- ▶ The member or health care provider has 60 (sixty) business days following the initial utilization review decision to initiate an appeal.

**\*\* Medicaid/FHP member or their designee may request to review their case file. The enrollee may present evidence to support their appeal in person or in writing. \*\***

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**11.5.2 Standard Action Appeal: (continued)**

- ▶ Letters of appeal and supporting clinical documentation should be sent (along with a copy of the denial letter) to: Health Plus, Medical Appeals Department, 335 Adams Street, Suite 2600, Brooklyn, New York 11201.
- ▶ Health plus sends written acknowledgement of the appeal letter (within 15 days). If necessary, a request for additional information needed to conduct the internal review will be made within five (5) business days of receipt of the partial information. The appeal is reviewed by a clinical peer reviewer who was not involved in the previous denial or appeal determination, and who is of the same or similar specialty as the requesting health care provider. Health Plus must make a determination **within 30 days** of receipt of the appeal letter.
- ▶ Once the appeal determination is made, the member (or member's designee) and provider are notified in writing within 2 (two) business days.

**11.5.2 Standard Action Appeal: (continued)**

If the adverse determination is upheld, the notification includes the clinical rationale for the determination, and instructions on how to initiate the external appeal process.

**\*\* If Health Plus fails to render a determination on the appeal within the required time frames, this results in an approval of the services and the reversal of any prior denial determination. \*\***

- ▶ Providers may request an expedited internal appeal when they believe that a delay in rendering an appeal decision could jeopardize the life, health or maximum function of a member (except in any retrospective determination).
- ▶ An expedited internal appeal may also be requested if Health Plus denies a request for continued or extended health care services, procedures or treatments, or for additional services for a member undergoing a prescribed course of treatment.
- ▶ If additional information is required to conduct the expedited appeal Health Plus will notify the member and his or her health care provider immediately by telephone or facsimile, in addition to sending notification by mail.
- ▶ If Health Plus denies enrollees request for expedited appeal Health Plus will notify by phone immediately followed by written notification in two (2) days.

**11.5.3 Expedited Appeals: (continued)**

- ▶ If health plus determines that an expedited appeal is not justified, the member may file a grievance with the Member Services department. The appeal is then processed as a standard internal appeal.
- ▶ Determinations are made on expedited appeal within two business days of receipt of the necessary information and no more than three business days after receipt of the appeal. This time may be extended for up to 14 days upon enrollee or provider request; If Health Plus demonstrates more information is needed and the delay is in the best interest of the enrollee and so notifies the enrollee. Health Plus will provide written notice of the appeal decision along with the clinical rationale in the event of an adverse determination.

**11.5.4 Final Adverse Determination**

Each notice of final adverse determination will be in writing, dated, and include:

- a) The basis and clinical rationale for the determination.
- b) The words " final adverse determination"
- c) Health plus contact person and phone number
- d) Enrollee's coverage type
- e) Name and address of UR agent, contact person and phone number.
- f) Health service that was denied, including facility/provider and developer/manufacture of services as available.
- g) Statement the enrollee may be eligible for an external appeal and the timeframes for appeal.

**11.5.4 Final Adverse Determination (continued)**

h) A notification statement to the enrollee granting 45 days from the date of final adverse determination to request an external appeal. Please note: Choosing the 2nd level of internal appeal may cause time to file external appeal to expire.

i) Standard description of external appeals process.

***For Medicaid/ FHP, notice will also include:***

j) Summary of appeal and date filed

l) Description of enrollee's fair hearing rights if not included with initial denial.

m) Right of enrollee to complain to the Department of Health at any time by calling 1-800-342-3334.

n) Statement that notice available in other languages and formats for

**11.6 Fair Hearings:**

***Health Care Plus (Medicaid) and Family Health Plus*** members have the right to request a Fair Hearing review when Health Plus makes a decision to deny, reduce, suspend or terminate services that have been ordered by a physician, or fails to act with reasonable promptness. ***Members must initiate Fair Hearing requests within 60 days of receiving the notice of intended action from Health Plus.***

