Excellus
165 Court Street
Rochester, NY 14647

A nonprofit independent licensee of the Blue Cross Blue Shield Association

Important Information for Our Health Care Provider Partners

To: **Participating Providers and Facilities**

Date: **June 18, 2018**

Subject: **REMINDERS AND CLARIFICATIONS: Changes to State Requirements Related to Authorizations, Appeals and Grievances Effective June 1, 2018**

As we previously communicated in our bulletin dated May 25, 2018, there have been some recent changes to New York State Department of Health (NYSDOH) regulations as required by the Centers for Medicare & Medicaid Services. These changes are related to service authorizations, appeals and grievances (complaints) for members enrolled in Medicaid managed care (HMOBlue Option, Blue Choice Option, Premier Option) and Health and Recovery Plan, or HARP (Blue Option Plus, Premier Option Plus), and our health plan implemented these changes effective June 1, 2018.

NYSDOH requires that health plans complete the review of service authorization requests under different time frames, issue revised member notices, and, for adverse determinations made on June 1, 2018 and thereafter, follow revised appeal processes. Key provisions for providers assisting members with the appeal process are described below.

- **Federal regulations now require that health plan members sign an agreement* if they wish their provider to represent them during the appeal and complaint processes prior to the provider filing an appeal or complaint with the health plan on the member's behalf.** A copy of the agreement must be signed by the member and included with any appeal/complaint you file with Excellus BlueCross BlueShield on the member's behalf. A copy will also be provided with the initial adverse determination letter. Providers may also contact Customer Care to verbally convey the member's wishes for provider representation, but the member must be present on the phone with the provider and Customer Care advocate to confirm his/her wishes.

- Providers may still request a reconsideration of a medical necessity denial, otherwise known as "peer-to-peer," if such decision was made by the health plan without prior consultation with the provider. Federal rules also limit members to only one level of internal appeal for health plan adverse benefit determinations. Otherwise, the independent external appeal processes for disputing medical necessity decisions as provided by Public Health Law Article 49 remain unchanged.

Continued on the next page

- Beginning with health plan service determinations made on and after June 1 2018, members who want to dispute the health plan's adverse determination regarding their services must exhaust the health plan's internal appeal process **before** requesting a state fair hearing. This means that the member must request an appeal with the health plan, which may be expedited, and receive a final adverse determination upholding the health plan's decision prior to requesting a state fair hearing. Members have 120 days from the final adverse determination to request a state fair hearing. If the health plan does not respond to the appeal or the response is late, the appeal process will be deemed exhausted and the member may request a state fair hearing.

- Upon review, health plans may determine to reduce, suspend or terminate authorized services. The member can have their services continue from the health plan upon filing a plan appeal within 10 days of the initial adverse determination notice, or before the effective date of the decision, whichever is later. If the health plan upholds its decision and issues a final adverse determination, the member may have their services continue by requesting a state fair hearing within 10 days of the final adverse determination notice, or before the effective date of the decision, whichever is later. If the member loses his or her health plan appeal or fair hearing, he or she may have to pay for the services they received while the appeal/fair hearing was being decided.

It is important to note that these changes do not impact the process that a provider uses to file appeals or complaints on his or her own behalf. This information pertains to providers who file appeals on behalf of members.

If you have questions regarding these regulation changes, please send an email to the NYSDOH at 438reg@health.ny.gov. Questions regarding Excellus BlueCross BlueShield's authorization, appeal or complaint procedures should be directed to the health plan.

Please share this important information with anyone within your office who should be aware.

*Visit our website, ExcellusBCBS.com/Provider, to print a copy of the template agreement. Select *Print Forms* from the Quick Links menu and the agreement template is included under the Administration section, titled "Member Consent for Provider Representation During Appeal or Complaint Process."