Section Thirteen

Provider Appeals

Provider Appeals

This section deals with appeals from two kinds of denials: (i) denials for lack of medical necessity, discussed in Part I, and (ii) administrative denials discussed in Part II. If providers disagree with a denial made by Fidelis Care due to lack of medical necessity or an administrative denial, providers shall follow the process set forth in this Section 13.

Part I. Denial of Services For Lack of Medical Necessity

Fidelis Care will not reimburse treatment that is not medically necessary. Decisions denying claims for medical necessity, i.e. clinical denials, are made only by Fidelis Care’s Chief Medical Officer or a Medical Director. Providers, members, or the member’s designee shall appeal Fidelis Care’s decisions regarding the medical necessity of treatment as described below if they disagree with a denial based on lack of medical necessity.

Appealing a Determination Based on Medical Necessity

Standard Appeals

If Fidelis Care denies a request for services based on lack of medical necessity, the provider, member, or member’s designee shall appeal the denial if they disagree with the denial.

The appeal shall be made within sixty (60) business days of the provider receiving the denial. The denial letters are sent to the provider and member, and contain instructions regarding request for appeals. A provider shall file an appeal for a retrospective denial if they disagree with the denial.

An appeal is initiated by contacting Fidelis Care’s Chief Medical Officer or designee either in writing or by telephone. Verbal appeals shall be followed up by written appeal. Fidelis Care strongly urges that all appeals be made in writing and include the following documentation: the member’s medical records for the treatment at issue, an appeal or a summary of that treatment prepared by the provider’s utilization management department, and a copy of the original denial letter from Fidelis Care. All appeals for medical necessity shall be sent to:

Fidelis Care Appeals Department
480 CrossPoint Parkway
Getzville, NY 14068
Phone: 718-896-6500 ext. 13159
Fax: 718-393-6779

If the original denial letter is not available, the appeal should indicate the dates of service at issue, the member’s name, and Fidelis Care member ID number. Although this documentation may be forwarded following the filing of the appeal, Fidelis Care may deny the appeal if such written documentation is not provided and Fidelis Care, in its own discretion, is unable to assess the basis for the appeal.

Fidelis Care will acknowledge the initiation of an appeal in writing within fifteen (15) calendar days after receiving the appeal and will respond to the appeal.

Fidelis Care must make a standard appeal determination within:

a. Thirty (30) calendar days after receipt of the appeal.

b. For Medicaid, as fast as the member’s condition requires, and no later than thirty (30) calendar days from receipt of the appeal. This time may be extended for up to fourteen (14)
calendar days upon member or provider request, or if Fidelis Care concludes that more information is needed and an extension of time is in the best interest of the member and notifies the member accordingly.

Members or a designee may view their case file. The member may also present evidence to support their appeal in person or in writing.

If Fidelis Care requires additional information to conduct a standard internal appeal, then Fidelis Care shall notify the provider, in writing, within five (5) business days of receipt of the appeal, requesting the additional information needed.

Fidelis Care’s written determination regarding the appeal will be mailed to the member, the member’s designee, and the provider within two (2) business days of the determination of the appeal. Fidelis Care will indicate the reasons for its decision and, if the appeal is denied, the clinical rationale for upholding the clinical denial. The written notice of determination includes a notice of the member’s right to an external appeal and a description of the external appeal process, if applicable (see section below on External Appeals), as well as the member’s right to request a fair hearing, if applicable.

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

a. The basis and clinical rationale for the determination.
b. The words “final adverse determination”
c. Fidelis Care contact person and phone number
d. Member 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/manufacturer of service as available.
g. Statement that enrollee may be eligible for external appeal and timeframes for appeal. If health plan offers two levels of appeal, the member cannot be required to exhaust both levels.
h. Clear statement in bold that member has 4 months from the final adverse determination to request an external appeal and that choosing 2nd level of internal appeal may cause time to file external appeal to expire. Providers acting on their own behalf have sixty (60) calendar days to request an external appeal.
i. Standard description of external appeals process attached

For Medicaid, the notice will also include:
j. Summary of appeal and date filed
k. Date appeal process was completed
I. Description of member’s fair hearing rights if not included with initial denial
m. Right of enrollee to complain to the Department of Health at any time via 1-800 number
n. Statement that notice is available in other languages and formats for special needs, as well as an explanation regarding how to access these formats.

Expeditied and standard appeals will be conducted by a clinical peer reviewer, provided that any such appeal shall be reviewed by a clinical peer reviewer other than the clinical peer reviewer who rendered the adverse determination.

The physician reviewing the appeal will be different from the physician or Medical Director who first reviewed and determined that the treatment was not medically necessary. If the appeal determination is adverse (denial upheld) it is considered a final adverse determination (FAD).
If Fidelis Care fails to make a determination within the applicable time periods, it shall be deemed to be a reversal of the original adverse determination.

Fidelis Care and the member may jointly agree to waive the internal appeal process. If this occurs, Fidelis Care will provide a written letter to the member within twenty-four (24) hours of the waiver agreement, setting forth the information necessary for the member to file an external appeal.

If Fidelis Care and the member agree to waive the internal appeal process, no additional internal appeals are available. However, providers may seek to file an external appeal pursuant to the process described below.

**Expedited Appeals**

A provider, member, or member’s designee may seek an expedited appeal in the event of the following:

- If Fidelis Care determines that continued or extended health care services, procedures or treatments, or additional services for a member undergoing a continued course of treatment prescribed by a health care provider are not medically necessary.
- If the provider believes an immediate appeal is necessary, provided that the initial determination regarding a lack of medical necessity was not retrospective (for example, appeals of elective admissions or surgeries).
- For Medicaid provided i) Fidelis Care honors the member’s request for an expedited review; or ii) if Fidelis Care denies the member’s request for an expedited review, Fidelis Care must provide the member with notice by phone immediately, followed by written notice within two (2) calendar days of denying the request.
- Fidelis Care will render a decision for Medicaid as fast as the member’s condition requires and within two (2) business days of receipt of necessary information, but no more than three (3) business days of receipt of the member’s appeal. This time may be extended for up to fourteen (14) calendar days either i) upon the member’s or provider’s request; or ii) if Fidelis Care demonstrates more information is needed, an extension of time is in the best interest of the member, and notifies the member accordingly. If the provider is not satisfied with Fidelis Care’s response to the expedited appeal, the provider or member may further appeal the decision through the standard appeal process described above or the external appeal process as described below.

If Fidelis Care requires information necessary to conduct an expedited appeal, Fidelis Care shall immediately notify the member and provider by telephone or facsimile to identify and request the necessary information, followed by written notification.

Written notice of Fidelis Care’s final adverse determination concerning an expedited UR appeal shall be transmitted to the enrollee within twenty-four (24) hours of Fidelis Care rendering the determination. For Medicaid, Fidelis Care will make reasonable efforts to provide verbal notice to the member and provider at the time the determination is made.

**Expedited appeals not resolved to the satisfaction of the appealing party may be re-appealed via the standard appeal process or through the external appeal process.**

In connection with an expedited appeal, Fidelis Care will make a clinical peer reviewer available within one (1) business day.

In addition, Fidelis Care will render a decision within two (2) business days of receiving all information necessary to process the expedited appeal. If the provider is not satisfied with Fidelis
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Care's response to the expedited appeal, the provider may further appeal the decision through the standard appeal process described above.

Written notice of Fidelis Care’s final adverse determination concerning an expedited appeal shall be transmitted to the member within twenty-four (24) hours of rendering the determination. The notice will include the description of the member's right to further appeal through the standard appeal process. Reasonable efforts will be made to provide verbal notice to the member and the provider at the time the determination is made.

External Appeals
Pursuant to Article 49 of the New York State Public Health Law, an external appeal process is available through the State Department of Financial Services. The time period to file an external appeal is within four (4) months from the receipt of the Final Adverse Determination (FAD) of the first level appeal. Providers acting on their own behalf shall file external appeals within sixty (60) calendar days. The external appeal decision will be rendered in thirty (30) calendar days and within seventy-two (72) hours for an expedited external appeal. External appeal decisions are final, and shall not be subject to arbitration or further review by a court of law. The application to request an external appeal will accompany the FAD.

In order to qualify for an external appeal, the following circumstances must be met:

- The service or treatment was denied as medically unnecessary, experimental/investigational; or out-of-network service or referral;
- The appeal is for a service or procedure that was otherwise covered under the member's contract with Fidelis Care;
- The member has exhausted the internal utilization review process, unless a waiver is signed by the member;
- The appeal must be requested by the member or the member's designee within four (4) months of receiving the final determination of the first level internal appeal or within sixty (60) calendar days if a provider is acting on his / her own behalf.
- To appeal an experimental/investigational, clinical trial, or out-of-network service or out-of-network referral denial, the physician must be a licensed, board-certified or board-eligible physician i) qualified to practice in the area of practice appropriate to treat the patient; and ii) who recommended the patient's treatment. For an appeal involving a rare disease, a physician must meet the above requirements, but need not be the patient's treating physician.
- To appeal to an experimental/investigational denial, the member's attending physician must attest that (i) standard health services or procedures have been ineffective or would be medically inappropriate; or (ii) there does not exist a more beneficial standard health service or procedure covered by the health care plan and the member's physician must have recommended either a health service or procedure (including a pharmaceutical product within the meaning of PHL Section 4900(5)(b)(B), that based on two documents from the available medical and scientific evidence, is likely to be more beneficial to the member than any covered standard health service or procedure.
- To appeal a clinical trial denial for which the member is eligible, the member's physician must attest that i) there exists a clinical trial that is open; ii) the patient is eligible to participate; and iii) the patient has or will likely be accepted. The clinical trial must be a peer-reviewed study plan which has been: (1) reviewed and approved by a qualified institutional review board; and (2) approved by i) one of the National Institutes of Health (NIH), or an NIH cooperative group or center; or ii) the Food and Drug Administration in the form of an investigational new drug exemption; or iii) the federal Department of Veteran Affairs; or iv) a qualified nongovernmental research entity as identified in...
To appeal an out-of-network referral denial, the physician must attest that i) the out-of-network health service is materially different from the alternate in-network service recommended by the health plan; and ii) based on two documents of medical and scientific evidence, is likely to be more clinically beneficial than the alternate in-network health services and the adverse risk of the requested health service would likely not be substantially increased over the alternate in-network health services. The out-of-network provider’s name, address and training and experience must be included.

To appeal an out-of-network denial to a Non-Participating provider, the physician must certify that the Participating Provider recommended by Fidelis Care does not have the appropriate training and experience to meet the member’s health care needs, and recommend a Non-Participating Provider with the appropriate training and experience to meet the member’s particular health care needs who is able to provide the requested health care service.

To appeal a rare disease treatment denial, a physician other than the member’s treating physician must attest that i) the patient has a rare disease for which there is no standard treatment that is likely to be more clinically beneficial to the patient than the requested service; and ii) the requested service is likely to benefit the patient in the treatment of the patient’s rare disease, and such benefit outweighs the risk of service. The physician must also attest he / she does not have a material financial or professional relationship with the provider of the service AND (a) the patient's rare disease currently or previously was subject to a research study by the National Institutes of Health Rare Diseases Clinical Research Network OR (b) the patient's rare disease affects fewer than 200,000 U.S. residents per year. If the provision of the service requires approval of an Institutional Review Board, include or attach the approval.

A member may request an External Appeal in the following ways:

1. Calling the Department of Financial Services at 1-800-400-8882
2. Going to the Department of Financial Services’ website at www.dfs.ny.gov and download the application at http://www.dfs.ny.gov/insurance/extapp/extappl.pdf;
3. Contacting Fidelis Care at 1-888-FIDELIS. Member Services will mail or fax the application to the member.

An application for external appeals can be found in Section 13 B – External Appeal Instructions and Application and is also included in the FAD letter Fidelis Care sends to members.

Medical Necessity Denials from subcontracted Utilization Review (UR) agents (any agent conducting UR services on behalf of Fidelis Care members) are subject to the same appeal rights described above.

**Provider External Appeal Rights**
A provider will be responsible for the full cost of an appeal for a concurrent adverse determination upheld in favor of Fidelis Care.

Fidelis Care is responsible for the full cost of an appeal for a concurrent adverse determination that is overturned.

Fidelis Care and the provider must evenly divide the cost of a concurrent adverse determination that is overturned in-part.
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The fee requirements do not apply to providers who are acting as the member's designee. In such a case, the cost of the external appeal is the responsibility of Fidelis Care. For the provider to claim that the appeal of the final adverse determination is made on behalf of the member, the external appeal application and the designation shall be completed.

External appeal decisions are final, and shall not be subject to arbitration or review by a court of law.

Alternative Dispute Resolution

A facility licensed under Article 28 of the Public Health Law and Fidelis Care may agree to Alternative Dispute Resolution (ADR) in lieu of an external appeal under PHL Section 4906(2) after the internal utilization review process has been exhausted. Any such agreement to ADR in lieu of an external appeal shall be memorialized in a fully executed written agreement between the provider and Fidelis Care. Providers who have contracted to ADR in lieu of an external appeal must request review by ADR within sixty (60) calendar of receiving the final determination of the first level internal appeal. This provision does not impact a member's external appeal rights or right of the member to appoint the provider as their designee. The cost of the ADR in lieu of an external appeal is a matter between Fidelis Care and the provider.

If the member files an external appeal, the external appeal determination takes precedence over the ADR.

Fair Hearings

In some cases, certain members may ask for a Fair Hearing from New York State. A member with Fair Hearing rights may request a Fair Hearing with regard to: i) enrollment/disenrollment decisions made by the Local Department of Social Services; or ii) the denial, suspension, termination, or reduction of a medical treatment or on services covered under the program benefits package. A member with Fair Hearing rights may also request a Fair Hearing if he/she believes that Fidelis Care did not act in a timely manner with regard to services. A member may have any individual he/she selects or designates to represent them at a Fair Hearing.

A member may request a Fair Hearing in the following ways:

1. By phone, call toll-free 1-800-342-3334
2. By fax, 518-473-6735
4. By mail, Fair Hearings, NYS Office of Temporary and Disability Assistance, Office of Administrative Hearings Managed Care Unit P.O. Box 22023, Albany, NY 12201-2023

If the services the member is receiving are scheduled to end, the member may choose to ask to continue the services a provider has ordered while the Fair Hearing case is pending. However, if the member asks for services to be continued, and the Fair Hearing is decided against the member, the member may have to pay the cost for the services received while waiting for a decision. The decision from the Fair Hearing officer and /or Administrative Law Judge will be final. A member always has the right to file a complaint anytime with the New York State Department of Health by calling 1-800-206-8125.

A provider does not have standing to request a Fair Hearing on his / her own behalf. Providers may, however, assist members in asking for a Fair Hearing from New York State.
For additional information on appeals for the Medicare Part D benefit refer to Section 22A of this manual.

Part II. Administrative Denials

An administrative denial is defined as a denied request for authorization of services that is not based on medical necessity, as well as a claim payment denial. Examples include denials based on a lack of member coverage, timely submission of a claim, member eligibility, or the absence of a required authorization.

This section describes how a provider and/or member shall appeal an administrative denial.

Authorization Appeals

If Fidelis Care denies a request for authorization of services and the basis for the denial is not lack of medical necessity, the provider, member, or member's designee shall appeal the denial if they disagree with the denial. Examples include a non-covered benefit, a benefit that has been exhausted, and an eligibility issue.

The appeal must be made within sixty (60) business days of the provider receiving the denial. The denial letters are sent to the provider and member, and contain instructions regarding request for appeals. A provider shall file an appeal for a retrospective denial if he/she disagrees with the denial.

An appeal is initiated by contacting Fidelis Care’s Appeal Department either in writing or by telephone. Verbal appeals shall be followed up by a written appeal. Written appeals shall be mailed to the address below and shall include the justification for the appeal and a copy of the original denial letter from Fidelis Care. If the original denial letter is not available, the appeal should indicate the dates of service(s), the member’s name, and Fidelis Care member ID number. Although this documentation may be forwarded following filing of the appeal, Fidelis Care may deny the appeal if such written documentation is not provided and Fidelis Care, in its own discretion, is unable to assess the basis for the appeal.

Fidelis Care will acknowledge the initiation of an appeal in writing within fifteen (15) calendar days after receiving the appeal.

Fidelis Care must make a standard appeal determination within:

a. Thirty (30) calendar days after receipt of the appeal.

b. For Medicaid, as fast as the member’s condition requires, and no later than thirty (30) calendar days from receipt of the appeal. This time may be extended for up to fourteen (14) calendar days i) upon the member’s or provider’s request; or ii) if Fidelis Care demonstrates more information is needed and the extension of time is in the best interest of the member and Fidelis Care notifies the member accordingly.
If Fidelis Care requires additional information to conduct a standard internal appeal, then Fidelis Care shall notify the provider, in writing, within five (5) business days of receipt of the appeal, requesting the additional information needed.

Fidelis Care’s written determination regarding the appeal will be mailed to the member, the member’s designee and the provider within two (2) business days of the determination of the appeal. Fidelis Care will indicate the reasons for its decision and, if the appeal is denied, the rationale for upholding the denial. The written notice of determination includes notice of the member’s right to request a Fair Hearing, if applicable.

Each notice of the appeal determination will be in writing, dated and include:

- a. The rationale for the determination.
- b. Fidelis Care contact person and phone number
- c. Member coverage type
- d. Name and address of UR agent, contact person and phone number
- e. Health service that was denied, including facility/provider and developer/manufacturer of service as available

For Medicaid, notice will also include:

- f. Summary of appeal and date filed
- g. Date appeal process was completed
- h. Description of member’s fair hearing rights if not included with initial denial
- i. Right of enrollee to complain to the State Department of Health at any time with 1-800 number
- j. Statement that notice available in other languages and formats for special needs and how to access these formats

If Fidelis Care fails to make a determination within the applicable time periods, it shall be deemed to be a reversal of the original adverse determination.

There is only one level of standard appeals on any internal decision.

Following Fidelis Care’s notice of appeal determination, members or a designee may view their case file. The member may also present evidence to support their appeal in person or in writing.

**Expedited Appeals**

A provider, member, or member’s designee may seek an expedited appeal in the event of the following:

- If the provider believes an immediate appeal is necessary

- For Medicaid, i) when Fidelis Care honors the member's request for an expedited review; or ii) if Fidelis Care denies the member's request for an expedited review, Fidelis Care must provide the member with notice by phone immediately, followed by written notice two (2) calendar days thereafter.

- Fidelis Care will render a decision for Medicaid as fast as the member’s condition requires and within two (2) business days of receipt of necessary information, but no more than three (3) business days of receipt of the member’s appeal. Fidelis Care may extend this time for up to fourteen (14) calendar days i) upon the member’s or provider’s request; or ii) if Fidelis Care demonstrates that more information is needed and an extension of time is in the best interest of the member and notifies the member.
accordingly. If the provider is not satisfied with Fidelis Care’s response to the expedited appeal, the provider or member may further appeal the decision through the standard appeal process.

Fidelis Care’s written notice of the appeal determination concerning an expedited appeal shall be transmitted to the enrollee within twenty-four (24) hours of rendering the determination. For Medicaid, Fidelis Care will make a reasonable effort to provide verbal notice to the member and provider at the time the determination is made.

Expedited appeals not resolved to the satisfaction of the appealing party may be re-appealed via the standard appeal process.

Fidelis Care will render a decision within two (2) business days of receiving all information necessary to process the appeal. If the provider is not satisfied with Fidelis Care’s response to the expedited appeal, the provider may further appeal the decision through the standard appeal process described above.

Fidelis Care’s written notice of the appeal determination concerning an expedited appeal shall be transmitted to the member within twenty-four (24) hours of rendering the determination. The notice will include the description of the right to further appeal through the standard appeal process. Reasonable efforts will be made to provide verbal notice to the member and the provider at the time Fidelis Care’s determination is made.

A provider, member, or member’s designee may seek an External Appeal in the event an out-of-network denial. Please see section 13.4 for the External Appeal process.

Claim Appeals

Denial of payment
If a provider disagrees with a claim denial, the provider must attach documentation supporting payment along with a Claim Appeal Form (Section 13A) within sixty (60) days of the remittance advice for the claim. If a provider does not submit a Claims Appeal Form within sixty (60) days of the remittance advice, Fidelis Care’s claim determination is final, and shall not be subject to arbitration or review by a court of law.

Underpayments
If a provider disagrees with the claim payment amount, the provider shall attach documentation supporting additional payment along with a Claims Appeal Form (Section 13A) and submit the request to Fidelis Care within sixty (60) days of the remittance advice for the claim. If a provider does not submit a Claims Appeal Form within sixty (60) days of the remittance advice, Fidelis Care’s claim determination and payment amount is final, and shall not be subject to arbitration or review by a court of law.

Overpayments
If a claim is overpaid, providers shall request an adjustment by submitting to Fidelis Care a Claims Appeal Form (Section 13A) and a copy of the remittance advice that indicates the overpayment. If Fidelis Care agrees with the request for adjustment due to an overpayment, the overpayment will be withdrawn from a future payment. The provider should not return the check containing the overpayment.

If Fidelis Care identifies that an overpayment has been made to a provider, prior to engaging in overpayment recovery efforts Fidelis Care shall furnish the provider with thirty (30) calendar days advance written notice when required by New York State Insurance Law Section 3224-B. Such
notice will state the member name, service date, payment amount, proposed adjustment, and a reasonable explanation supporting the proposed adjustment.

Please send claims appeals to:

**Fidelis Care**  
**Attn: Claims Reconsideration**  
**480 CrossPoint Pkwy**  
**Getzville, NY 14068**

**Claim Denials for Invoice**  
In some cases Fidelis Care may need to deny a claim because a copy of the manufacturer’s invoice is required for claims processing. Providers may send a copy of the invoice via fax or mail to the contact information below. Please be sure to include the member’s name and member ID, as well as the claim number associated with the invoice request:

**By Mail - Fidelis Care**  
**Attn: Claims Reconsideration**  
**480 CrossPoint Parkway**  
**Getzville, NY 14068**

**By Fax - 1-877-247-9187 | Attn: Claims Reconsideration (this fax is for invoice purposes only)**

For Corrected Claims, please see Section 12 Part 1 and Section 12B

Where Fidelis Care does not receive a request for reconsideration within sixty (60) calendar days of the date the claim was paid or denied, the claim determination shall be deemed final and without further recourse, and shall not be subject to arbitration or review by a court of law.