# Section 2
# Members

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# Section 2

## Member Rights and Responsibilities

CDPHP believes that members have the following rights and responsibilities with respect to their health coverage.

### Member Rights:

1. To receive information about CDPHP, its services, practitioners, and providers, and members' rights and responsibilities, and for MMC members, in a manner which does not disclose the member as participating in the MMC program.
2. To be treated with respect and recognition of their dignity and right to privacy.
3. To participate with practitioners in making decisions about their health care.
4. To have a candid discussion of appropriate or medically necessary treatment options for their condition(s), regardless of cost or benefit coverage.
5. To obtain from a practitioner complete, current information concerning their diagnosis, treatment, and prognosis, in terms they reasonably be expected to understand. If appropriate, this information should be made available to another person acting on their behalf.
6. To receive from a practitioner the information they need to give informed consent prior to the start of any procedure or treatment.
7. To refuse treatment to the extent permitted by law and to be informed of the medical consequences of that action.
8. To voice complaints, grievances, or appeals about CDPHP, its providers, or the services CDPHP provides.
9. To make recommendations regarding CDPHP's member rights and responsibilities policies.

### Member Responsibilities:

1. To supply information (to the extent possible) that CDPHP and its practitioners and providers need in order to provide care.
2. To follow plans and instructions for care that they have agreed on with your practitioners.
3. To understand their health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.

### Newsletters:

On a regular basis, the HMO, CDPHP UBI, and CDPHN members receive the *Thrive* publication; CDPHP Medicare Advantage members receive the *Best Life* publication; Medicaid–Select Plan, Medicaid–HARP, and Child Health Plus members receive *Focus on Health*.

## Confidentiality

CDPHP views the protection of member medical insurance information as an issue of paramount importance.

In order to maintain member confidentiality, CDPHP maintains certain procedures. The following statements represent the CDPHP process:

- All employees sign a confidentiality agreement at the time of employment and CDPHP's human resources department maintains all signed employee confidentiality agreements. At hire and on an annual basis, all employees will receive training on the special confidentiality regulations relevant to HIV/AIDS, mental health and substance abuse.
- Access to portions of the building is restricted for unauthorized personnel through the use of an electronic security system.
- All employees are assigned a security level within the claims processing and electronic documentation systems, which restricts them to only those functions needed to perform their job duties.
- Access to all employee protected health information and other employee employment information, i.e., salary, performance evaluation and address, is limited to designated management, human resource department personnel, and payroll department personnel.

- All members of CDPHP committees including, but not limited to, the quality management committee, utilization management committee, credentials committee, joint health services committee, pharmacy and therapeutics committee, and members of the board of directors, sign a confidentiality agreement at each meeting which affirms the confidential nature of both member and provider information shared within those committees.
- Except as permitted by law no protected health information is shared with individuals who are not the subject of the information unless CDPHP receives a written authorization from the individual who is the subject of the information or someone authorized to act on his or her behalf, which identifies that the individual in question is entitled to such information.
- Member services personnel verify member name, address and CDPHP identification number prior to releasing any information to callers. Member services personnel solicit the information from the member to confirm its accuracy.
- CDPHP protects information on its electronic Web site through multiple security levels. Members receive limited access to only member information, and practitioners and providers receive only limited access to practitioner and provider information.
- All member identifiable information is removed prior to initiating an external peer review for clinical decisions.
- CDPHP verifies that legally sufficient authorization is present prior to sharing protected health information with external entities. When this information is shared and includes information about HIV/AIDS, mental health or substance abuse, appropriate disclaimers and additional authorizations related to the release of such information are prominently attached, if necessary.
- CDPHP will obtain a legally sufficient authorization from members participating in case management before providing any protected health information, including medical records, to health care providers or community resource personnel involved in the management of the member's health.
- CDPHP members over the age of 12 years are entitled to consent to the disclosure of certain sensitive information. The member can request that the provider who created the record block its release without obtaining parental request, and the provider who created the record being requested can deny the release of such record if requested.
- CDPHP will assist in obtaining a legally sufficient authorization from a member, if necessary, to receive medical records from a non-participating treating practitioner or provider.
- In the absence of a signed certification from an employer group or as otherwise permitted by HIPAA, CDPHP requires a legally sufficient authorization from the member prior to sharing any individually identifiable protected health information with the member's employer group.
- Information regarding claims payment issues or quality of care issues will be supplied to the New York State Department of Health and the New York State Department of Financial Services upon direct request from the Departments or when the member or provider requests the respective state agency's assistance in resolving such an issue with CDPHP.
- CDPHP will discuss the confidentiality practices of all primary care and other practitioner offices as part of its periodic site evaluations.
- CDPHP does not use or disclose member genetic health information for purposes of enrollment, determining premiums, or underwriting.

# Member Verification

CDPHP has provided each subscriber with two identification cards per family. This card is used to verify some or all of these details:

- CDPHP family ID No. and ID suffix of member
- Group #
- Office visit copayment
- Urgent care
- Emergency room copayment
- Prescription drug benefits, if any
- Dental benefits, if any
- Optical benefits, if any
    - Vision exam only rider—ID cards will indicate "Vision Exam Only."
    - Vision exam and optical hardware rider—ID cards will indicate "Vision."

- Contact telephone number regarding hospital emergency admissions
- Contact telephone number regarding mental health services
- Contact telephone number regarding prior authorizations

Practitioners/providers and their office staff are responsible for verifying each patient's eligibility with CDPHP prior to rendering treatment. Each time a patient presents at your office for services, verify that his/her health insurance information has not changed since the previous visit. Members may have changed jobs and retained CDPHP as their health insurance carrier but have different benefits. Should a member terminate his/her coverage, CDPHP is not responsible for claims with dates-of-service following the termination date.

CDPHP identification cards are similar in design and display the CDPHP logo. Examine the member's card for the previous bulleted information. The following pages contain samples of the various ID cards and important differentiating information.

Verifying eligibility can be accomplished either via internet access to CDPHP's interactive provider website or by calling the CDPHP provider services department at (518) 641-3500 or 1-800-926-7526. (See Section 9, *Claim Submission* or call our IT-EDI Unit at (518) 641-4334 for assistance and information on web access.)

# Collection of Copayments/Coinsurance/Deductibles

Several copayment, coinsurance, and deductible dollar amounts are displayed on the front of each member's CDPHP identification card. Copayments are payable directly to the provider at the time services are rendered. In the event that the member is unable to make payment during the visit, remind the member that in the future, the copayment is the responsibility of the member when services are rendered. If the CDPHP allowed amount is less than the member's copayment, the provider should collect the lesser amount. You may not realize the CDPHP allowed amount is less than the member's copayment until reconciliation of the weekly reimbursement voucher. Please ensure that the member is refunded the overpayment.

**Certain plans require the member to satisfy their deductible and coinsurance prior to receiving reimbursement. Deductible and coinsurance should be collected after receipt of CDPHP payment.**

Copayments, coinsurance, and deductibles may vary within a plan depending upon the contractual benefits and services. For example, the member's copayment for an office visit to his/her PCP may differ from an outpatient hospital facility copayment. Review the member's ID card carefully. If additional information is needed, consult the secure area of www.cdphp.com, or contact the CDPHP provider services department.

# Identification Cards

Once the members/employees select CDPHP, member education starts. CDPHP provides a comprehensive package of contracts, riders, and a member handbook, which fully explain the benefits and policies. Ongoing education occurs with our members through our marketing and member services departments.

Following are sample identification cards issued by CDPHP, separated by line of business.

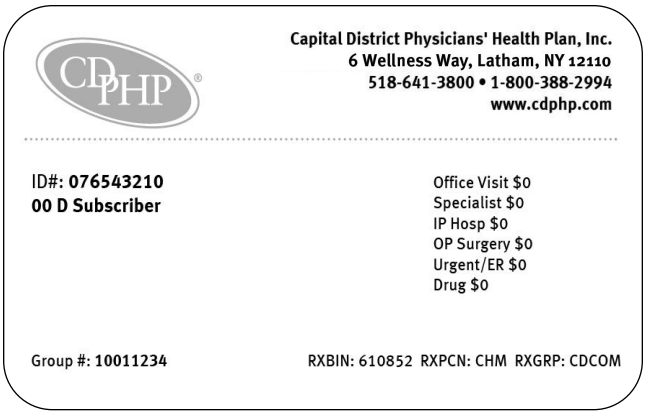
It is very important to verify the current member identification number for all CDPHP members and use the alpha-numeric identification number. It is also important to include your "Patient's Account Number" in field 26 of the CMS 1500 form, to assist you in applying reimbursements.

# Capital District Physicians' Health Plan, Inc.

## CDPHP HMO

CDPHP's HMO plan is designed to provide comprehensive health coverage with no deductibles and no surprises. Each member selects a CDPHP-participating primary care physician (PCP), who acts as a coordinator of care, and manages referrals to specialists and other providers within our network as needed. When referring a member to a specialist, please use the *CDPHP HMO Directory of Participating Practitioners and Providers*. Visits to non-participating practitioners/providers require prior authorization from resource coordination. Women may also choose an OB/GYN to visit without a referral. Groups may also add riders to cover other benefits (such as dental, optical, or extended student coverage).

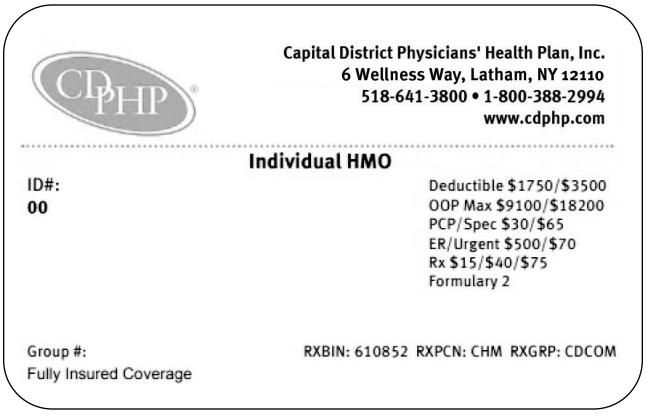
**HMO**




## Individual Plans

Individuals and families who do not have group coverage and wish to purchase health care on a direct-pay basis may join CDPHP through the NY State of Health™ online marketplace or by contacting CDPHP directly. There are a range of Individual plans, all of them HMO plan types. The ID cards will be labeled either "HMO" or "High Deductible HMO," according to the plan chosen. Members joining through the online exchange have member ID's beginning with an "X." When referring a member to a specialist, please use the *CDPHP HMO Directory of Participating Practitioners and Providers*.

**Individual Plans**

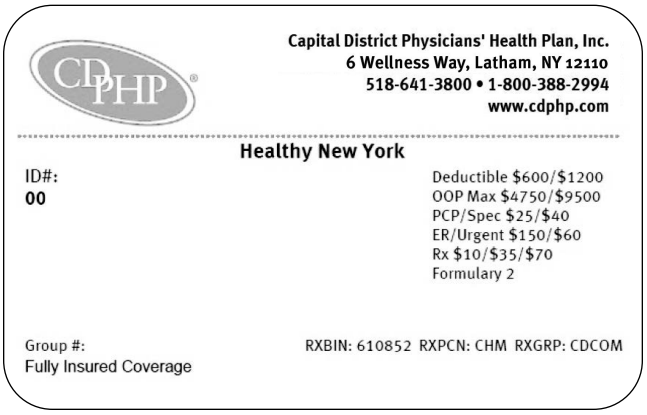



HEALTHY NY

## Healthy New York (HMO and High Deductible)

Healthy New York is a New York state program, available on a direct pay basis to small businesses and subject to PCP and authorization guidelines. When referring a member to a specialist, please use the *CDPHP HMO Directory of Participating Practitioners and Providers*. For members subject to a deductible, the title line on the card will read "Healthy New York High Deductible."

**Healthy New York**



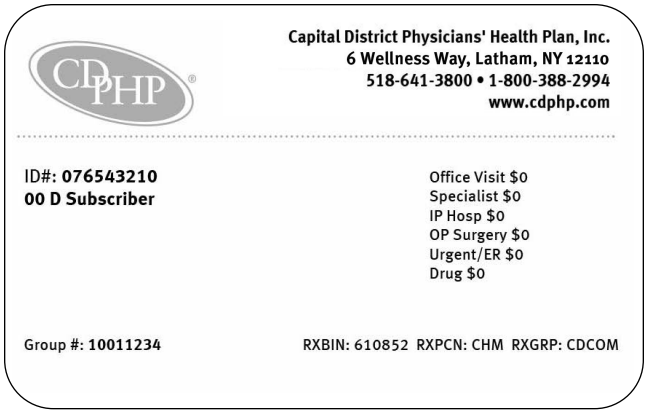
## Child Health Plus (CHP)

Child Health Plus is a New York state program that provides health coverage to uninsured children up to the age of 19. Premiums are on a sliding fee schedule according to family income. Child Health Plus is available throughout CDPHP's service area with the exception of Broome, Clinton, Chenango, Delaware, Dutchess, Essex, Franklin, Hamilton, Herkimer, Madison, Oneida, Orange, Otsego, Tioga, and Ulster Counties. When referring a member to a specialist, please use the *CDPHP Child Health Plus Directory of Participating Practitioners and Providers.* There is no identifier under the logo as with the other cards. Note that the group # for CHP begins with "100." Copayments = $0.

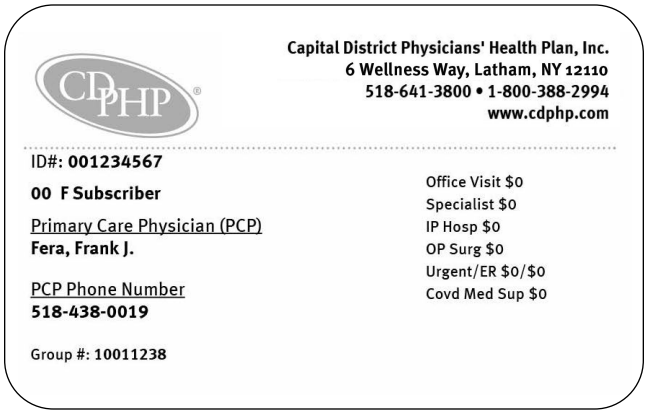
## Select Plan

The CDPHP Select Plan is offered to Medicaid recipients in Albany, Columbia, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, and Washington counties. It provides a full range of both inpatient and outpatient benefits. Each member identification number begins with the letter "D" and ends with "00." Copayments are generally $0 through CDPHP; prescription coverage was carved out to Medicaid Fee For Service effective 4/1/2023. When referring a member to a specialist, please use the *CDPHP Select Plan Directory of Participating Practitioners and Providers.*
Note: A Select Plan member who is considered a restricted recipient will have a card showing "RR" after the member's name.

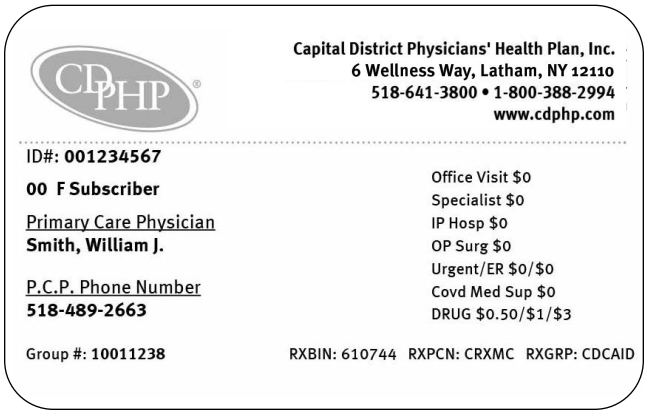
**Child Health Plus**



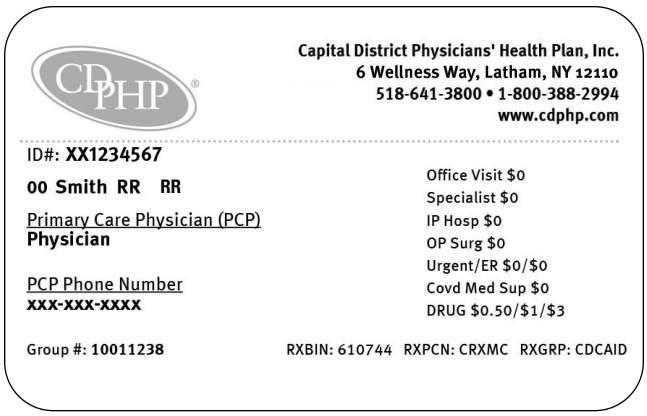

**Medicaid Select Plan**




**Medicaid Select Plan**




**Restricted Recipient**



## Essential Plan

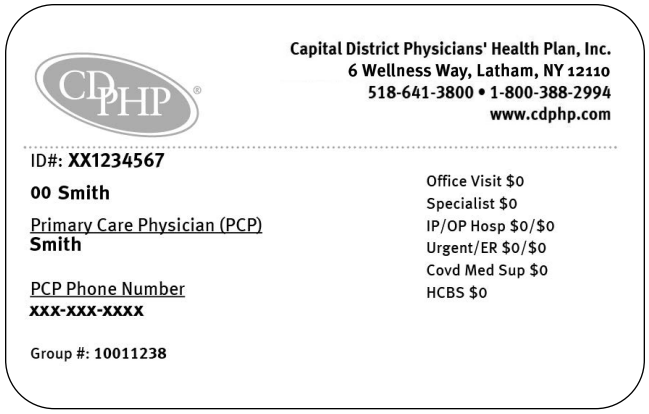
The Essential Plan provides quality health insurance to individuals who do not qualify for Medicaid. There are five types of the Essential Plan, and costs for each plan depend on family size and income. This plan is available in 16 counties within the CDPHP area: Albany, Broome, Clinton, Columbia, Essex, Franklin, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Tioga, Warren, and Washington.

**Essential Plan**

## HARP

HARP is offered to Medicaid recipients in Albany, Columbia, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, and Washington counties. The plan provides a full continuum of mental health, substance use disorder, and physical health services under the Medicaid State Plan as well as the enhanced Home and Community Based Services benefits for adults with serious mental illness (SMI) and/or SUDs who meet eligibility requirements. Each member identification number beings with the letter "D" and ends with "00".

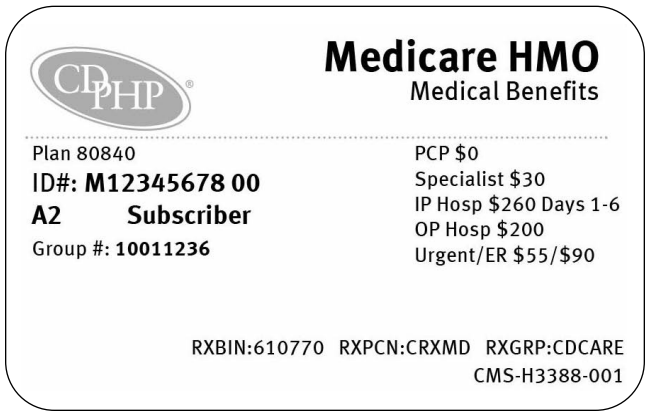
**HARP**




## Medicare Advantage Individual/Group

This is a Medicare Advantage plan contracting with the federal government. Members must have Medicare Part A and Part B in order to be eligible. There are two types of coverage—with and without drug coverage. When referring a member to a specialist, please use the *CDPHP Medicare Advantage Plan Directory of Plan Practitioners and Providers.*

**Medicare Advantage Medical Service Card**

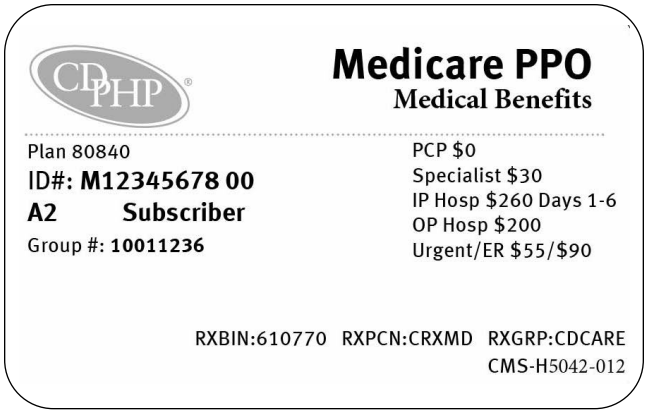



**Medicare Advantage Medical & Pharmacy**

## Medicare PPO Group

This is a Medicare Advantage PPO plan contracting with the federal government. Members must have Part A and Part B in order to be eligible. It is available to individuals and groups. It provides in- and out-of-network options, and most services do not require a referral or prior authorization. No primary care physician is required. When referring a member please use the *CDPHP Medicare PPO Directory of Plan Practitioners and Providers*.

**Medicare PPO Medical Services Card**




**Medicare PPO Medical & Pharmacy**

## CDPHP Care Advantage

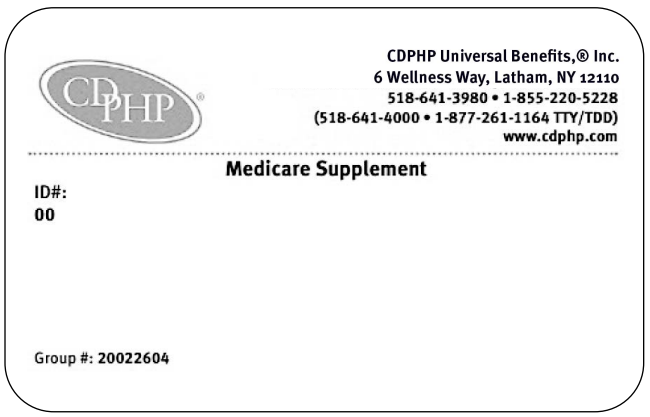
This is a Medicare Advantage plan contracting with the federal government. Members must have Medicare Part A and Part B and a qualifying condition in order to be eligible. This plan includes prescription drug coverage. When referring a member to a specialist, please use the CDPHP Care Advantage HMO C-SNP directory of plan practitioners and providers. This plan is identified by CMS-H3388-018.

**Medicare C-SNP**

## Medicare Supplemental Plans

CDPHP Medicare Advantage offers Medicare Supplemental Plans A, B, F, and N in select areas. These plans typically cover the coinsurance percentage (remaining 20 percent) after the original Medicare payment. Plan N does not require a coinsurance, but instead has a flat dollar copayment ($20 doctor office visits and $50 emergency room). The CDPHP Medicare Supplemental plans will cover everything that Medicare covers. Appeals will be handled directly through Original Medicare. Prior authorization and specialist referral requirement do not apply.

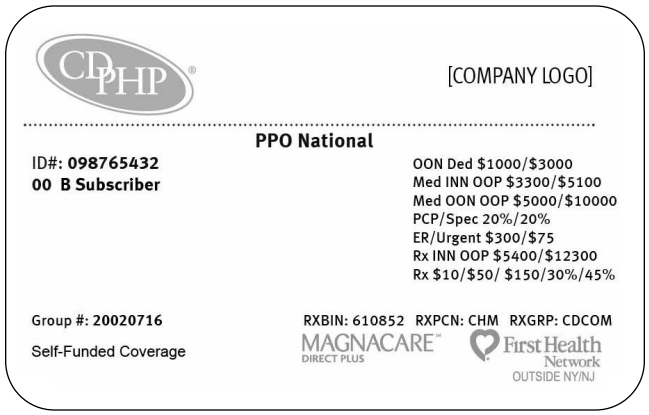
**Medicare Supplement**



# Capital District Physicians' Healthcare Network, Inc.

## Self-Funded Option

An administrative services only (ASO) product is designed for large companies who choose to self-fund their employee benefits program. The company logo will appear on the ID card. In a self-funded plan, the employer designs their own contract and claims are paid by CDPHN, with the employer's funds. Benefits are ***not*** subject to NYS insurance laws; however, they ***are*** subject to ERISA laws. When referring a self-insured plan participant to a specialist, please use the *Capital District Physicians' Healthcare Network, Inc. Directory of Participating Practitioners and Providers.* Self-insured plan participants may have access to our national network as evident from the MagnaCare/FH logo appearing on the front of the card. Employers also have the choice of extending the network nationally, giving their employees outside the region easy access to in-network care as well.




Self-insured groups include: Albany Medical Center Hospital, City School District of Albany, Columbia County, The County of Saratoga, DeCrescente Distributing Co., Fluor, General Electric, Glens Falls Hospital, HealthAlliance of the Hudson Valley, Laborer's Local 157, Lexington Center, National Grid, NYISO, Regeneron, RPI, SABIC Innovative Plastics, Sage Colleges, Saratoga Hospital, Stewart's Shops, UA Local 7, UA Local 773, Union College, and Verizon. Please note that self-insured groups are subject to change. ID cards generally display the group's name or logo along with a CDPHP logo. Samples displayed here.

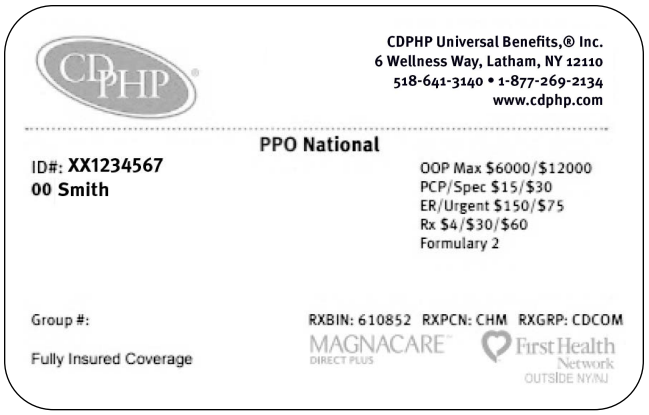
# CDPHP Universal Benefits,® Inc.

## PPO and High Deductible PPO

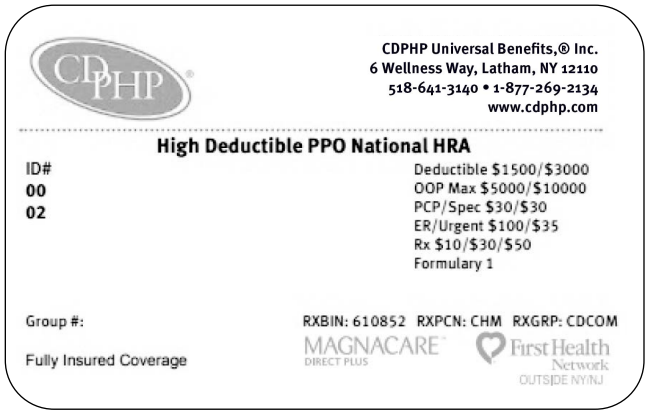
The preferred provider organization (PPO) plans include in- and out-of-network benefits. No primary care physician is required. Members can see any provider without a referral, but their out-of-pocket expenditures will be lower when using CDPHP UBI network providers. If a member chooses to see a non-participating provider, their benefits are provided at the out-of-network level, with higher out-of-pocket costs. The plan is available as a copayment or coinsurance plan design. Groups may also add riders to cover other benefits (such as optical or extended student coverage). Most groups also have the national network, giving their employees outside the region easy access to in-network care as well.

High Deductible PPO members may also be eligible to open a health savings account (HSA).

**PPO**



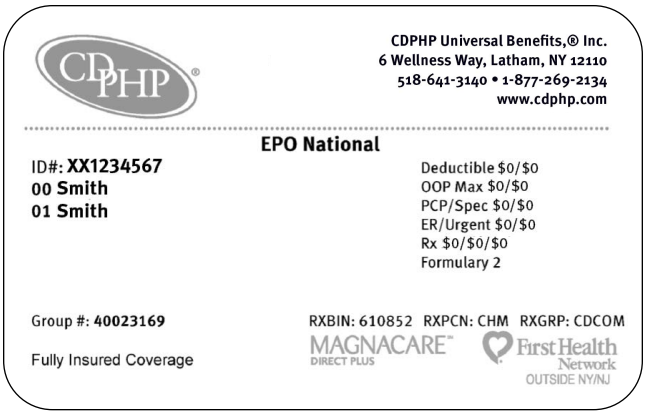

**High Deductible PPO**



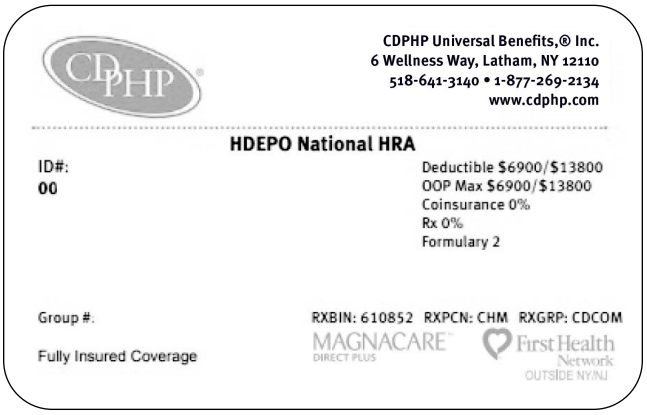
## EPO and High Deductible EPO

The exclusive provider organization (EPO) plans give members the freedom to see providers within the CDPHP Universal Benefits, Inc. (CDPHP UBI) network without a referral. No primary care physician is required. As long as members seek care within the network, they pay only a fixed copayment per visit, with no paperwork or referrals. Groups may also add riders to cover other benefits (such as optical or extended student coverage). Most groups also have the access to a national network.

**EPO**




**High Deductible EPO**



# Member Complaint, Grievance and Appeal Procedures

*Note: Time frames may vary to comply with different requirements for Select Plan, HARP, and Child Health Plus.*

## Complaints

Applies to all Lines of Business Except Medicare (For Medicare, refer to Chapter 3, Government Programs).

A member or his/her designated representative may file a complaint with CDPHP, either verbally or in writing, at the telephone number or address listed in the member identification card and on the cover page of the member's contract. A complaint is a verbal or written expression of dissatisfaction. This section does not apply to complaints which concern a decision made by CDPHP regarding a denial of service or an adverse determination under CDPHP's UR process. For a review of a decision made by CDPHP regarding a denial of service, see the grievances procedure section below. For an appeal of an adverse UR determination, see the Adverse Utilization Review Determination Appeals procedure section.

A designated representative of CDPHP will coordinate the review and investigation of all complaints. The complaint will be reviewed by one or more qualified personnel, provided that when the complaint pertains to clinical matters, the personnel shall include, but not be limited to, one or more licensed, certified or registered health care professionals. CDPHP will provide written acknowledgment of the complaint within 15 days after receipt of the complaint. The acknowledgment will include the name, address, and telephone number of the individual designated to respond to the complaint. CDPHP will request, in writing, within 15 business days from CDPHP's receipt of the member's complaint, any additional information required from the member or provider to resolve the member's complaint. In the event that only a portion of such necessary information is received, CDPHP will request the missing information, in writing, within five business days of receipt of the partial information. CDPHP will provide the member or member's designee a written decision concerning the complaint, and the procedures for requesting an appeal (see the Appeals section below), within 30 business days after receipt of the complaint, or within 30 calendar days after receipt of all necessary information, whichever is sooner. If CDPHP cannot render a decision concerning the complaint due to a lack of necessary information within 30 business days of receipt of the complaint, a letter is sent to the member by the end of the 30th business day explaining the reason for the delay. CDPHP will make a decision based on the information it has and notify the member of the decision within the next 15 business days.

In circumstances where a delay would significantly increase the risk to a member's health, the director of clinical appeals or his/her designee will coordinate all efforts to ensure that the member receives a telephone response within 48 hours after the receipt of all necessary information or 72 hours after the receipt of the complaint, whichever is sooner, with written notice to follow in three business days.

## Claim (Non-Utilization Review) Determinations

A member or his/her designated representative including an attorney may file a claim for benefits, either verbally or in writing, at the telephone number or address listed in the member handbook and on the cover page of the member's contract. This section does not apply to utilization review determinations.

Pre-service claims are claims for a benefit covered under the member's contract, in whole or in part, only with CDPHP's prior approval. Pre-service claim determinations are made within 15 days from receipt of the request for coverage of services. If CDPHP does not have all necessary information by the 15th day, the time period for making a decision may be extended up to 15 additional days, provided CDPHP notifies the member prior to the expiration of the initial 15 day period of what additional information is needed and the date by which CDPHP expects to render a decision. The member will be given 45 days from receipt of the extension notice to provide the necessary information.

The member will receive notice of any decision to reduce or terminate ongoing care previously approved by CDPHP sufficiently in advance of the reduction or termination to allow the member to appeal and receive a determination before the benefit is reduced or terminated.

Urgent care claims are those claims that, if subject to the standard time periods for making determinations, could seriously jeopardize the life or health of the member or the ability of the member to regain maximum function (prudent layperson standard) or, in the opinion of a physician with knowledge of the member's condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Urgent care claims decisions are made as soon as possible, taking into account the medical needs, but no later than 72 hours after the receipt of the request. Notification of the urgent care claim decision will be oral with written or electronic notification to follow within three days of the oral notification. If the member requests to extend a course of treatment for urgent care beyond the previously approved period of time or number of treatments, a decision will be made as soon as possible, taking into account the medical needs, and the member will be notified of the decision within 24 hours after receipt of the claim, provided the claim is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Post-service claims are claims for a benefit under the contract which are not considered pre-service or urgent care claims. Post-service claims decisions are made within 30 days from receipt of the claim. If CDPHP does not have all necessary information by the 30th day, the time period for making a decision may be extended up to 15 additional days, provided CDPHP notifies the member prior to the expiration of the initial 30-day period of what additional information is needed and the date by which CDPHP expects to render a decision. The member will be given 45 days from receipt of the extension notice to provide the necessary information.

All notice of decisions will include the detailed reasons for the decision, including a reference to the specific contract provision, the clinical rationale for the decision, if any, including any internal criteria relied upon, the procedures for requesting a grievance, and any additional information that is necessary to file a grievance.

## Grievances—Pre- and Post-Service

A member or his/her designated representative including an attorney may file a grievance with CDPHP, either verbally or in writing, at the telephone number or address listed on the member identification card and on the cover page of the member's contract. Grievances must be filed within 180 days (60 days for Select Plan and Child Health Plus) after receipt of the adverse determination. A grievance is a verbal or written request to review a determination by CDPHP other than an adverse UR determination. This section does not apply to adverse determinations under CDPHP's UR process. For an appeal of an adverse UR deter-mination, see the Adverse Utilization Review Determination Appeals procedure section below.

A designated representative of CDPHP will coordinate the review and investigation of all grievances. Those involving clinical matters will be reviewed by one or more licensed certified or registered health care professionals who did not make the initial determination, at least one of whom must be a clinical peer reviewer and of the same or similar specialty. The determination of a grievance that is not clinical in nature will be made by qualified personnel at a higher level than the personnel who made the initial determination. CDPHP will provide written acknowledgment of the grievance within fifteen (15) days after receipt of the grievance. The acknowledgment will include the name, address, and telephone number of the individual designated to respond to the grievance.

Upon receipt of the member's grievance, CDPHP will request any other information needed to make a determination to resolve the member's grievance. In the event that only a portion of such necessary information is received, CDPHP will request the missing information, in writing, within five (5) business days of receipt of the partial information. CDPHP will provide the member or member's designee a written decision concerning a pre-service grievance within 15 calendar days after receipt of the grievance (30 calendar days for Select Plan and Child Health Plus) and for a post-service grievance 30 days after receipt of the grievance. All notices of decisions will include the detailed reasons for the decision, the clinical rationale for the decision, if any, and the procedures for requesting an appeal. When applicable, a grievance appeal form will be included with the issuance of an appeal determination notice.

In circumstances where a delay would significantly increase the risk to a member's health, the director of clinical appeals or a clinical appeals specialist or his/her designee will coordinate all efforts to ensure that the member receives notice of the decision via a telephone call within 48 hours after the receipt of all necessary information or 72 hours after the receipt of the grievance. elephone call within 48 hours after the receipt of all necessary information or 72 hours after the receipt of the grievance. Notification of the urgent care grievance decision will be oral with written notice to follow within three (3) days of the oral notification.

*Individual contracts allow for one level grievance. CDPHP will make a determination with regard to the grievance within 15 days for pre-service and 30 days for post-service grievance.

*Large/Small group contracts allow for two levels of appeal. The same time frames as indicated above apply.

## Appeals—Voluntary Level of Appeal

If a member does not agree with the decision made through the grievance or complaint processes, he/she or his/her designee has the right to request an appeal (Individual, Essential Plan, Select Plan, and Child Health Plus products are exempt). This can be done by submitting a verbal or written request to CDPHP within 60 business days of receipt of the decision. CDPHP will provide written acknowledgment of the appeal request within fifteen (15) days after receipt of the request for an appeal. The acknowledgment will include the name, address, and telephone number of the individual designated to respond to the appeal request, as well as any additional information required. An appeal will be reviewed by qualified personnel, including licensed, certified or registered health care professionals, at least one of whom is a clinical peer reviewer if the appeal involves a clinical matter, who did not make the initial decision and who are at a higher level than the personnel who decided the grievance or complaint. CDPHP will make a determination with regard to the appeal within 15 days for pre-service appeals and 30 days for post-service appeals.

If a delay would significantly increase the risk to the member's health, the director of clinical appeals or his/her designee will coordinate all efforts to ensure that the member receives the decision within 48 hours after CDPHP's receipt of all necessary information, or 72 hours from receipt of the appeal, whichever is sooner, with written notification to follow in three (3) business days. All notices of decisions will include the detailed reasons for the decision and the clinical rationale for the decision.

*For Large/Small group contracts, allow for two levels of appeal. CDPHP will make a determination with regard to the appeal within 15 days for pre-service and 30 days for post-service appeals.

## Initial Utilization Review Decisions

Qualified health care professionals make all utilization review decisions. In conformance with state requirements for Medicaid–Select Plan and Medicaid–HARP, a physician who is board certified in general psychiatry reviews all inpatient level of care denials for psychiatric treatment. A physician certified in addiction treatment reviews all inpatient level of care denials for SUD treatment.

Pre-service claims are claims for a benefit covered under the contract, in whole or in part, only with CDPHP's prior approval. Pre-service utilization review claim decisions are made within three business days from receipt of all necessary information,

but in no event later than 15 days from receipt of the request for services. If CDPHP does not have all necessary information by the 15th day, the time period for making a decision may be extended up to 15 additional days, provided CDPHP notifies the member prior to the expiration of the initial 15 day period of what additional information is needed and the date by which CDPHP expects to render a decision. The member will be given 45 days from receipt of the extension notice to provide the necessary information.

In the case of continuing care, utilization review decisions are made and notice is provided to the member in one business day from receipt of all necessary information or 15 days after the member's first request, whichever is first. The member will receive notice of any decision to reduce or terminate ongoing care previously approved by CDPHP sufficiently in advance of the reduction or termination to allow the member to appeal and get a determination before the benefit is reduced or terminated.

Urgent care claims are those claims that, if subject to the standard time periods for making determinations, could seriously jeopardize the life or health of the member or the ability of the member to regain maximum function (prudent layperson standard), or, in the opinion of a physician with knowledge of the member's condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Urgent care utilization review decisions are made as soon as possible, taking into account the medical needs, but no later than 72 hours after receipt of the claim. Notification of the urgent care utilization review decision will be oral with written or electronic notification to follow within three days of the oral notification. If the member requests to extend a course of treatment for urgent care beyond the previously approved period of time or number of treatments, a decision will be made as soon as possible, taking into account the medical needs, and the member will be notified of the decision within 24 hours after receipt of the claim, provided the claim is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Post-service claims are claims for a benefit under the contract which are not considered pre-service or urgent care claims. Post-service utilization review decisions are made within 30 days from receipt of the claim. If CDPHP does not have all necessary information by the 30th day, the time period for making a decision may be extended up to 15 additional days, provided CDPHP notifies the member prior to the expiration of the initial 30 day period of what additional information is needed and the date by which CDPHP expects to render a decision. The member will be given 45 days from receipt of the extension notice to provide the necessary information.

When an adverse determination is made on a pre-service claim review without attempting to discuss such matter with the referring practitioner, the referring practitioner may request a reconsideration of that decision. Reconsideration review is not available for post-service claim review. Such reconsideration will be made in one business day from receipt of all necessary information. CDPHP's failure to make a utilization review decision within these time frames shall be deemed to be an adverse determination (denial) subject to appeal. In addition, all notices of decisions from CDPHP are in writing and include the detailed reasons for the decision, including the clinical rationale, if any, along with references to any applicable specific contract provisions on which the determination was based. It will also include information on how to initiate standard and expedited appeals and an external appeal, and information that the member is entitled to receive, upon request and free of charge, reasonable access to and copies of, all documents, records, and other information relevant to the member's claim.

## Adverse Utilization Review Determination Appeals Procedures

This section applies only to adverse UR appeals. A member or the member's designee may appeal any adverse UR determination. A member's health care provider may appeal a concurrent or retrospective adverse UR determination.

If the adverse UR determination involves any of the following circumstances, the appeal will be considered on an expedited basis : (1) continued or extended health care services, procedures or treatments, or additional services for a member undergoing a course of continued treatment prescribed by a health care provider (the member's coverage is continued under their insurance policy pending the outcome of the appeal for covered services for an ongoing course of treatment); (2) an adverse determination in which the health care provider believes an immediate appeal is warranted (except any retrospective determinations); (3) an appeal of a denial for home health services following a discharge from a hospital admission; or (4) continuous inpatient hospital stay. The provider and member or member's designee will have reasonable access to the clinical peer reviewer within one (1) business day of receiving notice of the taking of an expedited appeal. When additional information is necessary to conduct an expedited appeal, CDPHP will immediately notify the member and the member's health care provider by telephone or facsimile to identify and request the necessary information, followed by written notification. The determination of the expedited appeal will be made by a clinical peer reviewer who did not make the initial adverse UR determination. Expedited appeals will be determined within 48 hours after receipt of necessary information to conduct such appeal, or within 72 hours from receipt of the adverse UR appeal, whichever is sooner, with written notice to follow within 24 hours of rendering the decision. The written notice will include all of the required elements of the notification letter. Expedited appeals that do not result in a resolution satisfactory to the appealing party may be further appealed through the standard appeal process in the following paragraph or the external appeal process noted below. (Select Plan is exempt from a further standard appeal.) For each such appeal step, if the resolution is adverse, the member will be issued a Final Adverse Determination which will include reference to the member's right to external appeal.

All other adverse UR appeals may be filed, either verbally or in writing, at the telephone number or address listed in the *Member Handbook* and on the cover page of the member contract. These appeals must be made within 180 days (60 days for Select Plan and Child Health Plus) after the member's receipt of notification of the initial adverse determination and receipt of all necessary infor-mation to file the appeal from said determination. Adverse determinations that involve experimental or investigational health care services that would otherwise be a covered benefit except for CDPHP's determination that the health care service is experimental or investigational shall be considered as an adverse UR appeal.

CDPHP will provide written acknowledgment of the filing of the appeal to the appealing party within fifteen (15) days of such filing. The acknowledgment will include the name, address, and telephone number of the individual designated to respond to the UR appeal.

Upon receipt of the adverse UR appeal, CDPHP will request, any other information required from the member or provider to resolve the appeal. In the event that only a portion of such necessary information is received, CDPHP will request the missing information, in writing, within five (5) business days of receipt of the partial information.

The determination of the appeal will be made by a clinical peer reviewer who did not make the initial adverse UR determination. CDPHP will make a determination concerning the appeal within 30 days of the receipt of the appeal. CDPHP will notify the member, the member's designee and, where appropriate, the member's health care provider, in writing, of the appeal determination within two business days of the rendering of such determination, but no later than 30 days after receipt of the appeal. If CDPHP fails to make an appeal determination within the above time frames, the disputed service is deemed approved. If CDPHP cannot render a decision concerning the appeal due to a lack of necessary information, and/or viable reason, (from a non-contracted CDPHP provider or when requested by the enrollee),within 30 business days of receipt of the appeal, and if the member contract allows, CDPHP contacts the member via telephone to obtain consent for the extension and after consent is received, an extension letter is sent to the member by the end of the 30th business day explaining the reason for the delay. All notices of decisions will include the detailed reasons for the decision, the clinical rationale for the decision, if any, the procedures, and the New York State Department of Financial Services form for requesting an external review, if applicable (see the External Appeal procedures section below). CDPHP also notifies members of their right to obtain a copy of the appeal file upon request and provides it to members free of charge when requested.

In certain instances, CDPHP and the member may agree to waive CDPHP's adverse UR appeal process so that the member may proceed directly to an external appeal. In those instances, CDPHP will provide written confirmation of such agreement within 24 hours of such agreement. Such written confirmation will include all of the elements of the notification letter.

In conformance with state requirements for Medicaid–Select Plan and Medicaid–HARP, the member and their designee must both sign and date a paper saying the enrollee wants that person to appeal/complaint on their behalf.

## External Appeals—Voluntary Level of Appeal

An external appeal of a final adverse determination by CDPHP (whether issued as a result of a standard UR Appeal, an expedited UR Appeal or a standard UR Appeal following an expedited UR Appeal) is available under the following circumstances:

1. The final adverse determination denied the coverage of a health care service on the grounds that such health care service did not meet the Plan's requirements for medical necessity, appropriateness, healthcare setting, level of care, or effectiveness of a covered benefit and the health care service would otherwise be covered under the member's contract; or
2. The final adverse determination denied the coverage of a health care service as experimental or investigational; and
    a. The member's attending physician has certified that the member has a condition or disease: (i) for which standard health services or procedures have been ineffective or would be medically inappropriate; or (ii) for which there does not exist a more beneficial standard health service or procedure covered by the members contract; or (iii) for which there exists a clinical trial, or rare disease treatment as defined by law; and
    b. The member's attending physician, who must be a licensed, board-certified or board-eligible physician qualified to practice in the area of practice appropriate to treat the member's life-threatening or disabling condition or disease, must have recommended:
        i. A health service or procedure (including a pharmaceutical product within the meaning of New York Public Health Law § 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; or
        ii. A rare disease treatment and, based on the doctor's certification required by New York Insurance Laws 4900 (7-g) and any other evidence presented, indicates the treatment is likely to help treat the member's rare disease and its benefit outweighs the risks; or
        iii. A clinical trial for which the member is eligible. Any physician certification provided under this section shall include a statement of the evidence relied upon by the physician in certifying his/her recommendation, and
    c. The specific health service or procedure recommended by the attending physician would otherwise be covered under the member's contract except for CDPHP's determination that the health service or procedure is experimental or investigational, and
    d. For purposes of this section, the following definitions apply:
        iv. A "life-threatening condition or disease" is one that the attending physician believes has a high probability of death.
        v. A "disabling condition or disease" is a health issue that can be expected to result in death, last for a year or more, or keep a member from working and/or doing any age-appropriate, substantial, gainful activities.

vi. A rare disease is a life-threatening or disabling condition or disease that (1)(a) is currently or has been subject to a research study by the National Institutes of Health Rare Diseases Clinical Research Network; or (b) affects fewer than 200,000 United States residents per year; and (2) for which there does not exist a standard health service or procedure covered by the health care plan that is more clinically beneficial than the requested health service or treatment. A physician, other than the insured's treating physician, shall certify in writing that the condition is a rare disease as defined in this subsection. The certifying physician shall be a licensed, board-certified or board-eligible physician who specializes in the area of practice appropriate to treat the insured's rare disease. The certification shall provide either: (1) that the insured's rare disease is currently or has been subject to a research study by the National Institutes of Health Rare Diseases Clinical Research Network; or (2) that the insured's rare disease affects fewer than 200,000 United States residents per year. The certification shall rely on medical and scientific evidence to support the requested health service or procedure, if such evidence exists, and shall include a statement that, based on the physician's credible experience, there is no standard treatment that is likely to be more clinically beneficial to the insured than the requested health service or procedure and the requested health service or procedure is likely to benefit the insured in the treatment of the insured's rare disease and that such benefit to the insured outweighs the risks of such health service or procedure. The certifying physician shall disclose any material financial or professional relationship with the provider of the requested health service or procedure as part of the application for external appeal of denial of a rare disease treatment. If the provision of the requested health service or procedure at a health care facility requires prior approval of an institutional review board, an insured or insured's designee shall also submit such approval as part of the external appeal application

3. The final adverse determination denied the coverage of a health care service on the grounds that the requested health service is out-of-network and an alternate recommended health service is available in-network.

   For grievances and appeals involving a decision that the out-of-network service requested is materially different from a service that is available in network, the provider must:

   - certify that the out-of-network health service is materially different than the alternate recommended in-network service, and
   - have recommended a healthcare service that, based on two acceptable documents from the available medical and scientific evidence, is likely to be more clinically beneficial than the alternate recommended in network treatment and the adverse risk of the requested service would likely not be substantially increased over the alternate recommended in network health service
   - be licensed and board-certified or board-eligible in the specialty needed for the condition.

4. Out-of-Network Referral Denial will apply when a member is using an out-of-network provider at the in-network level of benefit. If CDPHP denied coverage of a request for a referral to a non-participating provider because it is determined there are participating providers with the appropriate training and experience to meet the member's health care needs and who are able to provide the requested health care service, the member may appeal to an external appeal agent. This out-of-network denial does not constitute an adverse determination as defined in NY Insurance Law section 4900. In addition, the attending physician must certify that the participating provider recommended by the health plan does not have the appropriate training and experience to meet the member's particular 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. For purposes of this section, the attending physician must be a licensed, board-certified, or board-eligible physician qualified to practice in the specialty area appropriate to treat the health need.
5. The Plan has issued a UR Appeal Waiver.
6. The member files an expedited external appeal at the same time they file an expedited internal appeal.
7. The member believes the Plan did not comply with internal appeal requirements for the patients appeal.

The member is not eligible for an external appeal when Medicare is his or her only source of health services. If the member has coverage under Medicare and Medicaid, the external appeal process may only be used to appeal denials of services or treatments covered by Medicaid. Medicaid members may also request a fair hearing, but if the member requests an external appeal and a fair hearing, the determination in the fair hearing will be the one that applies. CDPHP will provide the member, within three (3) business days of a request by the member or the member's designee, a copy of the standard description of the external appeal process as developed jointly by the New York State Departments of Health and Financial Services including a form and instructions for requesting an appeal. CDPHP will also provide, upon request, the member's health care provider with the same information in connection with a concurrent or retrospective adverse determination within three (3) business days of the provider's request.

All external appeals will be conducted by external appeal agents certified by the commissioner of the New York State Department of Health and randomly assigned to conduct external appeals. All external appeals are conducted by clinical peer reviewers.

The member or the member's designee shall have four months after the member receives notice from CDPHP of the final adverse determination to request an external appeal. A healthcare provider, in connection with a concurrent or retrospective Adverse UR determination, shall have 60 days after the provider receives notice from CDPHP of the final adverse determination to request an external appeal. If the member and CDPHP have agreed in writing to waive the UR appeal step, the member shall have 4 months from receipt of such waiver to file a written request for an external appeal. Such request must be in writing on the standard New York State Department of Financial Services form. The election of an external appeal auto-matically waives the member's right to the remainder of CDPHP's grievance process. The member, the member's designee and the member's health care provider, where applicable, will be required to submit relevant medical information concerning the external appeal to the external appeal agent within the above four-month period; provided, however, that when such documentation represents a material change from the documentation upon which CDPHP based its final adverse determination or upon which CDPHP based its initial adverse UR determination, CDPHP shall have three (3) business days to consider such documentation and amend or confirm such final adverse determination.

The external appeal agent shall make a determination with respect to the external appeal within 30 days of the receipt of the member's request thereof. The external appeal agent shall have the opportunity to request additional information from the member, the member's designee, the member's health care provider and CDPHP within such 30-day period, in which case the agent shall have up to five (5) additional business days if necessary to make such determination. The external appeal agent shall notify the member and CDPHP, in writing, of the appeal determination within two (2) business days of the rendering of such determination.

Notwithstanding the above two paragraphs, the enrollee can request an expedited external appeal (1) if the member's attending physician states that a delay in providing the health care service would pose an imminent or serious threat to the member's health or (2) the denial concerns an admission, availability of care, continued stay or health care service for which the enrollee received emergency services and remains hospitalized. The external appeal shall be completed within no more than seventy-two (72) hours of the request and the external appeal agent shall make every reasonable attempt to immediately notify the member and CDPHP of its determination by telephone or facsimile, followed immediately by written notification of such determination. The decision of the external appeal agent is binding to the member and the Plan.

If the external appeal agent overturns CDPHP's decision that a service is not medically necessary or approves coverage of an experimental or investigational treatment, CDPHP will provide coverage subject to the other terms and conditions of the member's contract. If the external appeal agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, CDPHP will only cover the costs of services required to provide treatment to the member according to the design of the trial. CDPHP shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs that would not be covered under the member's contract for non-experimental or non-investigational treatments provided in such clinical trial.

If the external agent upholds a denial for concurrent services that was filed by a provider on behalf of the member, the provider is prohibited from seeking payment from the member other than the copayment, coinsurance, or deductible that would be applicable if the care were approved.

CDPHP does not charge a fee for an external member appeal.

A general communication is sent annually to members announcing the availability of the right to an independent external review.

## Complaint to the Departments of Financial Services and/or Health

The member may submit a complaint to the Departments of Financial Services and/or Health at any time if he/she is not able to resolve a problem with CDPHP. Their addresses are as follows:

New York State Department of Financial Services
1 Commerce Plaza
Albany, NY 12257
www.dfs.ny.gov
1-800-342-3736

New York State Department of Health
Bureau of Managed Care Certification and Surveillance
Corning Tower Building, Rm 1613
Empire State Plaza
Albany, NY 12237
www.health.state.ny.us
1-800-206-8125

## Time Frame for Extensions:

If more time is needed to make a decision about a member's action appeal, as the contract allows, CDPHP will:

- Notify the member in writing what information is needed. If a member's request is in a fast track review, CDPHP will notify the member right away and send a written notice later.
- Tell the member why the delay is in his/her best interest.
- Make a decision no later than 14 days from the day CDPHP asked for more time.

The member, member's provider, or someone the member trusts may also ask CDPHP to take more time to make a decision. This may be because the member may have more information to give the plan to help in the decision of the case. This can be done by calling the CDPHP Member Services Department or writing.

The member or someone the member trusts can file a complaint with the plan if they do not agree with CDPHP's decision to take more time to review the action appeal. The member or someone the member trusts can also file a complaint about the review time with the New York State Department of Health by calling 1-800-206-8125.

If CDPHP does not make a decision about the Adverse UR appeal within the required time frame, the original decision against the member will automatically be reversed, which means the requested service authorization request will be approved.