EmblemHealth

Chapter 32: Dispute Resolution for Commercial and CHP Plans

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Chapter Summary

This chapter contains processes for our Commercial and Child Health Plus (CHP) members and practitioners to dispute a determination that results in a denial of payment and/or covered services.

To see the dispute resolution process for our Medicaid members, view Medicaid plans.

Overview

EmblemHealth provides processes for members and practitioners to dispute a determination that results in a denial of payment and/or covered services. Process, terminology, filing instructions, applicable time frames and additional and/or external review rights vary based on the type of plan in which the member is enrolled. The processes in this section apply to Commercial/CHP plans.

We do not discriminate against practitioners or members, or attempt to terminate a practitioner's agreement or disenroll a member, for filing a request for dispute resolution.

We have interpreter services available to assist members with language and hearing/vision impairments.

Payments for Services in Dispute
EmblemHealth network practitioners may not seek payment from members for either covered services or services determined by EmblemHealth's Care Management program not to be medically necessary unless the member agrees, in writing and in advance of the service, to such payment as a private patient and the written agreement is placed in the member's medical record. Any practitioner attempting to collect such payment from the member in the absence of such a written agreement does so in breach of the contractual provisions with EmblemHealth. Such breach may be grounds for termination of the practitioner's contract.

Key Terminology

The following descriptions provide a general overview of the terminology used with Commercial plans (including Child Health Plus).

Adverse Determination
A notification sent when a health care service, procedure, or treatment is denied.

Appeal
A request to review any aspect of an adverse clinical determination based on medical necessity.

Complaint
A request to review an administrative process, service, or quality-of-care issue that does not pertain to a determination based on claims, benefits, or medical necessity.

Grievance
A request to review any aspect of an adverse benefit or claim determination that is not based on medical necessity.

Certain disputes — whether they are appeals, complaints, or grievances — may be filed as expedited or standard depending on the urgency of the patient's condition.

Certain disputes may also be filed as pre-service or post-service depending on the timing of the determination in question.

Managing Entities
EmblemHealth contracts with separate managing entities to provide care for certain types of medical conditions. In these cases, the designated managing entity will determine the applicable process for filing a dispute. Any aspect of service rendered by EmblemHealth, or any entity designated to perform administrative functions on our behalf, is hereafter jointly referred to as "EmblemHealth."

Appointing a Designee
Members wishing to dispute a determination or claim denial may do so themselves or designate a person or practitioner to act on their behalf. To appoint a designee, members must submit by fax or by mail a signed HIPAA-compliant authorization form or a power of attorney form that specifies the individual as an authorized party. You can find forms at the New York State Department of Health.

Extensions
In certain circumstances, dispute resolution time frames may be extended if permitted by law and requested by the complainant, or if EmblemHealth believes an extension is in the best interest of the member.

Initial Adverse Determinations

EmblemHealth will send a written notice on the date when a health care service, procedure, or treatment is given an adverse determination (denial) on the following grounds:

- Service does not meet, or no longer meets, the criteria for medical necessity, based on the information provided to us.
- Service is considered to be experimental or investigational (rare disease, clinical trial, and out-of-network services).
- Service is approved, but the amount, scope, or duration is less than requested.
- Service is not a covered benefit under the member's benefit plan.
- Service is a covered benefit under the member's benefit plan, but the member has exhausted the benefit for that service.

The written notice will be sent to the member and provider and will include:

- The reasons for the determination, including the clinical rationale, if any.
- Instructions on how to initiate internal appeals (standard and expedited appeals) and eligibility for external appeals.
- Notice of the availability, upon request of the member or the member's designee of the clinical review criteria relied upon to make such determination.
- A description of what additional information, if any, must be provided to, or obtained by, EmblemHealth in order for EmblemHealth to make an appeal determination.
- The description of the action to be taken.
- A statement that EmblemHealth will not retaliate or take any discriminatory action against the member if an appeal is filed.
- The process and time frame for filing/reviewing an appeal with EmblemHealth, including the member's right to file an expedited review.
- The member's right to contact he Department of Health (DOH), with 800 number through which they can file their complaint.

The failure of EmblemHealth to make a utilization review (UR) determination within the time periods prescribed in the Care Management chapter is deemed to be an adverse determination subject to appeal. EmblemHealth must send notice of denial on the date that the utilization review's time frames expire.

Reconsideration
When an adverse determination is rendered without provider input, the provider has the right to reconsideration. The reconsideration shall occur within one business day of receipt of the request (except for retrospective, which is within five days (5) and shall be conducted by the member's health care provider and the clinical peer reviewer making the initial determination. See the Care Management chapter for more information.

Retrospective Review Requests
For retrospective review requests, EmblemHealth must make a decision and provide written notification of the determination. The decision must be made within 30 days of receipt of the necessary information.

Home Health Care Determinations Following an Inpatient Hospital Admission
Once determination is made, EmblemHealth provides written notification to the requesting facility or agency. Initial preauthorization is valid for seven (7) days. During that time, services must be initiated, or a new preauthorization is required.

Final Adverse Determinations

For decisions that uphold or partially uphold a determination made regarding a clinical issue for which no additional internal appeal options are available, EmblemHealth will issue a final adverse determination in writing to the member and provider.

The final adverse determination contains the following information:

- The basis and clinical rationale for the determination.
- The words "final adverse determination."
- EmblemHealth contact person and phone number.
- The member's coverage type.
- EmblemHealth's contact person or UR agent, address and phone number.
- A summary of the appeal.
- The date the appeal was filed.
- The date the appeal process was completed.
- The health service that was denied, including the name of the facility/provider and developer/manufacturer of the health care service as available.

- A statement that the member may be eligible for external appeal and time frames for appeal.
- A standard description of external appeals process, including a clear statement in bold that the member/designee has four (4) months, and the provider has 60 days from the final adverse determination to request an external appeal and choosing a second level of internal appeal may cause the time to file external appeal to expire. This applies to EmblemHealth Plan, Inc. PPO FEHB plan members only.
- Standard description of external appeals process attached.
- The terms "medical necessity," "experimental/investigational," "out-of-network," "clinical trial," or "rare disease treatment."
- Information on available alternative and/or external dispute resolution options.

Notice of Final Appeal Determination
EmblemHealth will notify the member or member's designee in writing of the final appeal determination within two business days of when we make the decision. However, written notice of final adverse determination concerning an expedited utilization review appeal shall be transmitted to the member within 24 hours of rendering the determination.

Practitioner Dispute Resolution Procedures: Complaints and Grievances

View TABLE 21-1, PRACTITIONER COMPLAINT/GRIEVANCE PROCEDURES

Practitioner Complaint Process
If a practitioner is dissatisfied with an administrative process, quality of care issue, and/or any aspect of service rendered by EmblemHealth that does not pertain to a benefit or claim determination, the practitioner may file a complaint on their own behalf. Examples of such dissatisfaction include:

- Long wait times on EmblemHealth's authorization phone lines.
- Difficulty accessing EmblemHealth's systems.
- Quality-of-care issues.

Once a decision is made on a practitioner's complaint, it is considered final and there are no additional internal review rights.

Complaints must be submitted in writing to the EmblemHealth's Grievance and Appeals Department. A complaint should include a detailed explanation of the clinician's request and any documentation to support the practitioner's position.

EmblemHealth will acknowledge receipt of the practitioner's complaint in writing no later than 15 days after its receipt. Practitioner complaints will be reviewed, and a written response will be issued directly to the practitioner no later than 30 days after receipt.

Practitioner Grievance Process
If a practitioner is not satisfied with any aspect of a benefit or claim determination rendered by EmblemHealth (or any entity designated to perform administrative functions on its behalf) which does not pertain to a medical necessity determination, that practitioner may file a claim inquiry with EmblemHealth. If the inquiry does not resolve the issue, the practitioner may then file a grievance.

The practitioner should use the secure provider portal to submit a claim inquiry along with supporting documentation. To initiate an inquiry, sign in to emblemhealth.com/providers and follow these steps:

1. Select the Claims tab and click Search Claims to locate your claim.
2. On the Claims Detail page, click Ask a Question.
3. On the Message Details page, select Claims and Payments category (and a subcategory) to file a claim inquiry.

4. Enter Message Content and upload Attachments (if necessary) and click Submit.

If the practitioner is not satisfied with the outcome of the inquiry, they have the option of filing a grievance via the secure provider portal. To submit a grievance, sign in to emblemhealth.com/providers and follow these steps:

1. Click the User Profile icon and select My Messages.
2. On the My Messages page, search and locate the message you submitted for the initial claim inquiry.
3. Click Follow-up to create a linked message.
4. On the Message Details page, select Grievances & Appeals category (and a subcategory) to file a grievance.
5. Enter Message Content and upload Attachments (if necessary) and click Submit.

See the provider portal training guides and videos for step-by-step instructions on using the Message Center and Claims – Search, View, and Export.

The Grievance and Appeals Department is not involved in determining claim payment or authorizing services, but independently investigates all grievances.

Examples of reasons for filing grievances include dissatisfaction with a decision resulting from a failure to follow a plan policy or procedure, or failure to obtain prior approval for an inpatient admission. A practitioner may also file a grievance regarding how a claim was processed, including issues such as computational errors, interpretation of contract reimbursement terms, or timeliness of payment.

In addition, providers who wish to challenge the recovery of an overpayment or request a reconsideration for commercial claims denied exclusively for untimely filing may follow the grievance procedures in this sub-section.

Note: The right to reconsideration shall not apply to a claim submitted after the time frame outlined in the Timely Submission section of the Claims chapter. If a claim was submitted more than the specified time frame, EmblemHealth may deny the claim in full or in the alternative may agree to reduce payments by up to 25% of the amount that would have been paid had the claim been submitted in a timely manner.

For grievances related to untimely filing, the provider must demonstrate that the late submission was an unusual occurrence and that they have a pattern of submitting claims in a timely manner. Examples of an unusual occurrence include:

- Medicaid Reclamation.
- Member submitted the wrong insurance information to the provider.
- Coordination of Benefits related issues.
- Member retroactively reinstated.

The grievance should be accompanied by a copy of the notice of the standard denial or other documentation of the denial, an explanation outlining the details of the request for a review and all documentation to support a reversal of the decision.

EmblemHealth will acknowledge, in writing, receipt of a grievance that is submitted in writing no later than 15 days after its receipt. The grievance will be reviewed, and a written response will be issued for grievances with a final disposition of partial overturn or upheld, no later than 45 days after receipt. The determination included in the response will be final.

Grievances with a favorable disposition will receive a claims remittance advice in lieu of a written response no later than 45 days after receipt.

Member Dispute Resolution Procedures: Complaints and Grievances

Member Complaint – First Level Process
View Member Complaint – First Level Process Tables here.

A member or designee may file a first level complaint when the member is dissatisfied with any aspect of an EmblemHealth-rendered service that does not pertain to a benefit or claim determination. Examples of such dissatisfaction include:

- Dissatisfaction with treatment received from EmblemHealth, its practitioners, or benefit administrators.
- Quality-of-care complaints.
- Privacy complaints regarding EmblemHealth's practices in using or disclosing protected health information.
- Alleged violation of EmblemHealth's privacy practices and/or state and federal law regarding the privacy of protected health information.
- Fraud and abuse.

Complaints should include a detailed description of the circumstances surrounding the occurrence. EmblemHealth will acknowledge receipt of the complaint and request any necessary information in writing. Complaints will be reviewed, and a response will be issued in writing according to the time frames applicable to the member's benefit plan and detailed in the table linked above.

Member Complaint - Second Level Process
View Member Complaint - Second Level Process Tables here.

If a member or designee is not satisfied with the resolution of a first level complaint, EmblemHealth provides a second level complaint review.

To initiate a second level complaint, a member or designee must submit the second level complaint for review. We will respond within the timeframes noted in the tables linked above. Once we reach a decision, that decision is final and there are no further formal appeals or external mediation opportunities. Please refer to the tables, as in some instances, a member may have the right to complain to the NYS Department of Health.

Second level complaints should include a detailed explanation of the request and any documentation to support the member's position.

Member Grievance - First Level Process
View Member Grievance - First Level Process Tables.

If a member or designee is not satisfied with any aspect of a benefit or claim determination rendered by EmblemHealth that does not pertain to a medical necessity, experimental determination, or investigational determination, they may file a first level grievance.

Grievances should be accompanied by a copy of the adverse determination, an explanation outlining the details of the request for a review and all documentation to support a reversal of the decision. We will acknowledge receipt of the grievance and request any necessary information in writing. Grievances will be reviewed, and a response will be issued according to the time frames detailed in the tables linked above.

Member Grievance - Second Level Process
View Member Grievance - Second Level Process Tables.

If a member or designee is not satisfied with the resolution of a first level grievance, we provide a second level grievance review.

To initiate a second level member grievance, the member or designee must submit the second level grievance with all supporting documentation. We will review the grievance and respond within the time frames noted in the tables linked above.

Provider and Member Clinical Appeal Processes

EmblemHealth may reverse a prior approval decision for a treatment, service, or procedure on retrospective review pursuant to section 4905(5) of PHL when:

- Relevant medical information presented to EmblemHealth or the utilization review agent upon retrospective review is materially different from the information that was presented during the prior approval; and
- The information existed at the time of the prior approval review but was withheld or not made available; and
- EmblemHealth or the utilization review agent was not aware of the existence of the information at the time of the prior approval review; and
- Had they been aware of the information, the treatment, service, or procedure being requested would not have been authorized.

Waiving the Internal Appeal Process
The member or designee and EmblemHealth may jointly agree to waive the internal expedited and standard appeal processes. If this occurs, EmblemHealth must provide a written letter with information regarding filing an External Appeal to the member and the member's health care provider within 24 hours of the agreement to waive EmblemHealth's internal appeal process. For more information, please see the section on New York State External Appeals later in this chapter.

Clinical Appeal - Expedited Process

View Table 21-10, Clinical Appeal - Expedited.

If a member or designee is not satisfied with a service or a determination that was rendered based on issues of medical necessity, an experimental or investigational use, a rare disease, or (in certain instances) out-of-network services, an expedited appeal may be filed if we determine or the provider indicates that a delay would seriously jeopardize the member's life, health or ability to attain, maintain or regain maximum function. The member or designee may request expedited review of a prior approval request or concurrent review request.

An expedited appeal may be filed:

- For continued or extended health care services, procedures, or treatments.
- For additional services for members undergoing a course of continued treatment.
- When the health care provider believes an immediate appeal is warranted.
- When EmblemHealth honors the member's request for an expedited review.

Expedited appeals should be accompanied by a copy of the denial letter, an explanation outlining the details of the request for a review, and all documentation to support a reversal of the decision. The expedited utilization review appeal may be filed in writing or by telephone.

Missing Information
If EmblemHealth requires information necessary to conduct an expedited appeal, EmblemHealth shall immediately notify the member and the member's health care provider by phone or fax to identify and request the necessary information followed by written notification.

Reviewer of Expedited Appeal Requests

The review will be conducted by a qualified EmblemHealth medical director who was neither involved in prior determinations nor the subordinate of any person involved in the initial adverse determination. A clinical peer reviewer will be available to discuss the appeal within one business day.

Denial of Expedited Appeal Process
If we deny the request for expedited review because it does not meet the criteria for an expedited appeal, we will process the request through the standard appeal review time frames and will notify the appellant of this verbally and in writing.

Failure to Render a Decision
If we do not render a decision on the appeal within the applicable timelines, the adverse determination will be reversed automatically, and the requested services or benefits will be approved.

Expedited Appeal Not Resolved to Member's Satisfaction
Expedited appeals not resolved to the satisfaction of the member or designee may be re-appealed through EmblemHealth's process for standard appeals described below. In the alternative, the member or designee may request an external appeal process.

We will review the request and respond within the time frames noted in the table linked above.

Clinical Appeal - Standard Process

Procedures for initiating a standard appeal are outlined in TABLE 21-11, APPEAL - STANDARD.

If a member or designee or provider is not satisfied with a service or a determination that was rendered based on issues of medical necessity, an experimental or investigational use, a clinical trial, a rare disease, or (in certain instances) out-of-network services, an appeal may be filed. The standard Clinical Appeal may be filed in writing or by telephone.

Missing Information
If we require information necessary to conduct a standard internal appeal, we will notify the member and the member's health care provider, in writing, within 15 calendar days of receipt of the appeal (as noted in the tables below), to identify and request the necessary information. In the event that only a portion of such necessary information is received, we shall request the missing information, in writing, within five business days of receipt of the partial information.

Reviewer of Standard Appeal Requests
The review will be conducted by a qualified EmblemHealth medical director who was neither involved in prior determinations nor the subordinate of any person involved in the initial adverse determination. A clinical peer reviewer will be available to discuss the appeal within one business day.

Failure to Render A Decision
If we do not render a decision on the appeal within the applicable timelines, the adverse determination will be reversed automatically, and the requested services or benefits will be approved.

Standard Appeal Not Resolved to Members Satisfaction
Member or designee may request an External Appeal as described in this chapter.

New York State External Appeals

New York State External Appeals
A member has a right to an external appeal of a final adverse determination. New York State's External Appeal Law provides the opportunity for the external review of adverse determinations for members and providers based on lack of medical necessity, experimental or investigational treatment, a clinical trial, or (in certain instances) out-of-network services. Further, a member, the member's designee, and, in conjunction with concurrent and retrospective adverse determinations, a member's health care provider has the right to request an external appeal.

This law also applies to rare diseases, which are defined as any life threatening or disabling condition that is, or was subject to review, by the National Institutes of Health's Rare Disease Council or affects less than 200,000 US residents per year and there is no standard health service or treatment more beneficial than the requested health service or treatment. To qualify as a rare disease, the condition must be certified by an outside physician specialized in an area appropriate to treat the disease in question, the patient should be likely to benefit from the proposed treatment and the benefits must outweigh the risks.

The provider may only file an external review on their own behalf for concurrent and retrospective adverse determinations.

The Circumstances When an External Appeal May Be Filed
1. When the member has had coverage of a health care service, which would otherwise be a covered benefit under a subscriber contract or governmental health benefit program, denied on appeal, in whole or in part, on the grounds that such health care service is not medically necessary; and
2. EmblemHealth has rendered a final adverse determination with respect to such health care service; or
3. both EmblemHealth and the member have jointly agreed to waive any internal appeal.

An External Appeal May Also Be Filed
1. When the member has had coverage of a health care service denied on the basis that such service is experimental or investigational; and
2. The denial has been upheld on appeal or both EmblemHealth and the member have jointly agreed to waive any internal appeal; and
3. The member's attending physician has certified that the member has a life-threatening or disabling condition or disease:
   - For which standard health services or procedures have been ineffective or would be medically inappropriate; or
   - For which there does not exist a more beneficial standard health service or procedure covered by the health care plan; or
   - For which there exists a clinical trial or rare disease treatment; and
4. 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 either:
   - A health service or procedure (including a pharmaceutical product within the meaning of PHL 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 in the case of a rare disease, based on the physician's certification required by Section 4900 (7)(g) of the PHL and such other evidence as the member, the designee, or the attending doctor may present, that the requested health service or procedure is likely to benefit the member in the treatment of the enrollee's rare disease and that the benefit outweighs the risks of such health service or procedure; or
   - 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 or her recommendation; and
5. The specific health service or procedure recommended by the attending physician would otherwise be covered under the policy except for the health care plan's determination that the health service or procedure is experimental or investigational.

External Appeal for Denial of Out-of-Network Service
The member has had coverage of the health service, which would otherwise be a covered benefit under the member's benefit plan, which is denied on appeal, in whole or in part, on the grounds that such health service is out-of-network and an alternate

recommended health service is available in-network, and EmblemHealth has rendered a final adverse determination with respect to an out-of-network denial or both EmblemHealth and the member have jointly agreed to waive any internal appeal; and

The member's attending doctor, who shall be a licensed, board-certified, or eligible physician qualified to practice in the specialty area of practice appropriate to treat the member for the health service sought, certifies that the out-of-network health service is materially different from the alternate recommended in-network service, and recommends a health care service that, based on two 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 health service would likely not be substantially increased over the alternate recommended in-network health service.

EmblemHealth has only one level of internal appeal. It does not require the member to exhaust any second level of internal appeal to be eligible for an external appeal.

How to File an External Clinical Appeal
To file an external clinical appeal, the practitioner appealing on his/her own behalf must complete a New York State External Appeal Application, and send it to the New York State Department of Financial Services within 60 days (45 days before July 1, 2014) from the date of the final adverse determination of the first level appeal.

The member and member's designee (including the provider in the capacity of the member's designee) may submit the same form within four (4) months of the final adverse determination. If the member files on their own behalf, signed applications authorizing the release of medical records must also be sent to the New York State Department of Financial Services along with the application. (Note: Application fees are waived for Child Health Plus members.)

An external appeal must be submitted within the applicable time frame upon receipt of the final adverse determination of the first level appeal, regardless of whether or not a second level appeal is requested. If a member chooses to request a second level internal appeal, the time may expire for the member to request an external appeal. Second level internal appeals are for GHI PPO FEHB plan participating providers only.

The New York State Department of Financial Services screens applications and assigns eligible appeals to state-certified external appeals agents. The Department of Financial Services then notifies both the filer and EmblemHealth whether the request is eligible for appeal, provides explanation thereof, and sends a copy of the signed release form.

EmblemHealth will provide medical and treatment records and an itemization of the clinical standards used to determine medical necessity within three business days of receiving the agent's information and completed release forms. For an expedited appeal, this information will be provided within 24 hours of receipt.

For urgent medical circumstances, an expedited review may be requested which will render a decision within three days.

For standard cases, a determination will be made within 30 days from receipt of the member's request, in accordance with the commissioner's instructions. The external appeal agent shall have the opportunity to request additional information from the member, practitioner and EmblemHealth within the 30-day period, in which case the agent shall have up to five additional business days to make a determination.

The decision of the external appeal agent is final and binding on both the member and EmblemHealth.

To obtain an application or to inquire about external appeals, please contact the New York State Department of Financial Services at 800-400-8882 or email externalappealquestions@dfs.ny.gov.

Note: Practitioners appealing concurrent review determinations cannot pursue reimbursement from members other than copayments from a member for services deemed not medically necessary by the external appeal agent.

Facility Dispute Resolution Procedures

Alternative Dispute Resolution
An Article 28 facility may agree to an alternative dispute resolution in lieu of an external appeal. The alternative dispute process does not affect a member's external appeal rights or the member's right to establish the provider as their designee.

Retrospective Utilization Review Requests
View TABLE 21-12, FACILITY RETROSPECTIVE REVIEW REQUEST.

If an EmblemHealth-contracted facility fails to follow prior approval and/or emergency admittance procedures, payments for such services may be denied and the facility, EmblemHealth or its managing entity may initiate a retrospective utilization review (RUR).

- For Denials Based on "No Prior Approval"
  If the facility fails to obtain prior approval, payment will be denied for "no prior approval." The remittance statement will include information regarding the facility's right to request a retrospective utilization review for medical necessity. See the Care Management chapter.

  If the facility fails to request a retrospective utilization review and submit the medical record within 45 days of receipt of the remittance statement, the claim denial will be upheld and the facility will have no further appeal rights.

  If EmblemHealth or the managing entity fails to render and communicate a decision to the facility within 30 days of receipt of all information, the case will be deemed automatically denied and the facility will have the right to a clinical appeal of the decision.

- For Denials Based on "No E.R. Notification"
  If the facility admits a patient through the emergency room without notifying EmblemHealth or the managing entity and submits a claim for services rendered, EmblemHealth will request medical records to initiate a retrospective utilization review for medical necessity.

  If the facility fails to submit the medical record within the time frame, the facility will receive an adverse determination stating inability to establish medical necessity based on no information received. The facility will then have the opportunity to file a facility clinical appeal.

Facility Clinical Appeals
View TABLE 21-13, FACILITY CLINICAL APPEAL.

If an EmblemHealth-contracted facility is not satisfied with a claim determination regarding denial of payment for inpatient services based on medical necessity, the facility may file a facility clinical appeal.

EmblemHealth provides one internal level of appeal for facilities. Federal Accounts do not have external appeal rights. In cases where the initial adverse determination was made retrospectively or concurrently, the facility has the additional right to file a New York State External Appeal.

EmblemHealth handles all facility clinical appeals, except in the following situations, where the managing entity handles the appeal:

- If the managing entity has a direct contract with the facility.
- The managing entity has denied the case based on medical information.
- The managing entity has denied the case for "no information."

EmblemHealth or the managing entity will render a decision within 30 days of receipt of the appeal request for PPO accounts or

60 days of receipt of the appeal request for all others.

- For members already discharged.
  If the facility provides additional information after the denial is issued and after the member is already discharged, no reconsideration review will be performed. However, the facility may exercise its right to a clinical appeal.

  The appeal request must be filed within 45 days of the initial adverse determination or as stated in the facility contract. If the appeal request is received outside of this time frame, the original denial will be upheld and there will be no further appeal rights. Facilities are not permitted to balance bill members for such denials.

- For denials based on "No Information."
  If the facility fails to provide any clinical information to establish medical necessity for an admission or procedure, the claim will be denied based on "no information" and the facility may file a clinical appeal.