Cherry Blossom PACE®
Program of All-Inclusive Care for the Elderly

How to File An Appeal

ConcertoHealth of Northern Virginia, LLC -DBA-Cherry Blossom PACE (CBP) is committed to ensuring that a participant, a participant's representative or a treating provider has the right to appeal CBP program's decision to deny, defer, terminate or reduce a particular care-related service or its decision not to pay for a service received by a participant.

CBP will handle all appeals in a respectful manner and will maintain the confidentiality of a participant's appeal at all times throughout and after the appeals process is completed. Information pertaining to appeals will not be disclosed to program staff or contract providers, except where appropriate to resolve the appeal.

Contract providers are accountable for all appeal procedures established by CBP. CBP will monitor contracted providers for compliance with this requirement on an annual basis or on an as needed basis.

Definitions:

An **appeal** is defined as a participant's action taken with respect to the PACE organization's noncoverage of, or nonpayment for, a service including denials, reductions or termination of services.

An appeal may be filed verbally, either in person or by telephone or in writing. The appeals process may take one of two following forms:

- A ***standard*** **appeal** means a standard review process for response to, and resolution of, appeals as expeditiously as the participant's health requires, but no later than 30 calendar days after the PACE organization receives an appeal.

- An ***expedited*** **appeal** occurs when a participant believes that his or her life, health or ability to regain or maintain maximum functions would be seriously jeopardized, absent provision of the service in dispute. CBP will respond to the appeal as expeditiously as the participant's health condition requires, but no later than 72 hours after it receives the appeal.
The 72-hour timeframe may be extended by up to 14 calendar days for either of the following reasons:

1. The participant requests the extension.

2. CBP will provide justification to the Virginia Department of Medical Assistance Services (DMAS) the need for additional information and how the delay is in the interest of the participant.

Disputed health care service means any health care service eligible for payment under the enrolled participant's contract with CBP that has been denied, modified, or delayed by a decisionof CBP in whole or in part due to the finding that the service is not necessary.

Necessary or **Necessity** means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.

Representative means a person who is acting on behalf of or assisting a participant, and may include, but is not limited to, a family member, a friend, a CBP employee, or a person legally identified as Power of Attorney for Health Care/Advanced Directive, Conservator, Guardian, etc.

General Information:

1. The CBP program's designee has primary responsibility for maintenance of the procedures, review of operations, and utilization of any patterns of appeals to formulate policy changes and procedural improvements in the administration of the plan.

2. CBP will continue to furnish the participant with all other required services during the appeals process.

3. CBP will not discriminate against a participant solely on the grounds that an appeal has been filed.

4. CBP will ensure that a participant is able to access and participate in the appeals process by addressing the linguistic and cultural needs of its participants, as well as the needs of participants with disabilities. CBP program will ensure the following:

a. If the person filing the appeal does not speak English, a bilingual staff member will be available to facilitate the process. If a staff person is not available, translation services/interpreter will be made available.
b. All written materials describing the appeal process are available in the following languages: **English, Spanish**
c. CBP program maintains a toll-free number **(1-888-524-2060)** for the filing of appeals *[Note: Only applicable in the event that a PACE participant and/or his/her representative would incur long distance charges if calling from within the plan's service area]*.
d. CBP program will maintain a TTY number for hearing impaired. (1-800-905-4147)

5. CBP program will provide written information about the appeal process to a participant and/or his/her representative upon enrollment, at least annually thereafter, and whenever the interdisciplinary team denies, reduces or terminates a service or refuses to pay for a service. Information includes, but is not limited to:

a. Procedures for filing an appeal, including participant's external appeal rights under Medicare and Medicaid.

b. Telephone numbers for the filing of appeals received in person or by telephone: Participants my contact the Executive Director, Center Manager, Medical Director or Clinical

Manager at (toll free) 1-888-524-2060 or TTY for hearing impaired at 1-800-905-4147
8:00 AM to 4:30 PM, Monday through Friday.

c. Location where written appeals may be filed:

CBP Quality Coordinator
1901 N Beauregard,
suite 110
Alexandria, VA, 22311

6. Any method of transmission of appeals information from one CBP staff to another shall be done with strictest confidence, in adherence with HIPAA regulations.

7. CBP program will assist the participant in choosing which external appeals process to pursue if both are applicable and forward the appeal to the appropriate external entity.

To File An Appeal:

A. Receiving Requests to Provide a Service or Pay for a Service

1. A participant or his/her representative may request to initiate, eliminate, or continue a particular service or pay for a service. A participant or his/her representative may submit the request to CBP either verbally, by telephone or in person, or in writing.

2. In the event a participant or his/her representative requests provision of or payment for a particular service, the interdisciplinary team (IDT) will determine whether the requested service is necessary, based on the assessed needs of the participant.

3. CBP will notify the participant or his/her representative its decision to approve, deny, reduce or terminate a service as expeditiously as the participant's condition requires, but no later than 72 hours of receiving the participant's request

a. If the decision is to ***approve*** the requested service, without reducing or terminating provision of the service, or payment for a service the participant or his/her representative will be notified verbally and/or in writing. The service will be furnished to the participant as determined by the interdisciplinary team's revised plan of care.

b. If the decision is to deny, reduce or terminate a service or deny payment of a service, the participant or his/her representative will be notified verbally and in writing. If the participant or his/her representative appeals the denial for reconsideration, CBP will initiate the Appeal Process as outlined in this policy and procedure.

B. Notification of a Decision to Deny, Defer or Modify a Request for Service or Deny Payment of a Service

1. At the time of the decision, CBP will inform the participant, and as appropriate, the treating provider of the reason for denial, deferral or modification of a service or denial of payment for a service.

2. Notification of the denial, reduction or termination of service or denial of payment is made both verbally; either in person or by telephone, *and* in writing, using the Service Denial Letter provided.

3. The CBP designee will document in the medical record that a denial, termination or reduction of service or denial or payment has been made, using “Denial of Service” in the title of the progress note.

4. CBP will notify the participant in writing of their right to appeal the denial for reconsideration by CBP and of their external appeal rights, using the *“Information for Participants about the Appeals Process”* notice (see Attachment 2).

5. If the interdisciplinary team fails to provide the participant with timely notice of the resolution of the request or does not furnish the services required by the revised plan of care, this failure constitutes an adverse decision, and the participant’s request must be automatically processed by CBP as an appeal.

C. Filing an Appeal

1. The appeal process is available to any participant, his/her representative or treating provider who disputes denial of payment for a service or the denial, deferral, or modification of a service by the primary care provider (PCP) or any member of the interdisciplinary team (IDT) who is qualified to make referrals.

2. An appeal for denial, termination, or reduction of a service or payment for a service may be filed verbally or in writing.
a. A participant and/or his/her representative may verbally request an appeal by speaking to the Director, Center Manager, Social Worker, or other IDT member.
b. At the time of denial or at any time upon request, CBP provides a participant and/or his/her representative with an “Appeal for Reconsideration of Denial” form.The participant and/or his/her representative completes the form, which constitutes a written request to appeal CBP Program decision.
c. The CBP Social Worker will assist the CBP participant and/or his/her representative in filing an appeal in the event assistance is required.

3. An appeal may be filed as a **“standard appeal”** or an **“expedited appeal”**, depending on the urgency of the case:

a. A **standard appeal** may be filed verbally or in writing with any CBP staff within 180 calendar days of a denial of service or payment. The 180-day limit may be extended for good cause by CBP.

b. An expedited appeal may be filed verbally or in writing to CBP if the participant or a treating physician believes that participant’s life, health or ability to regain or maintain maximum functions would be seriously jeopardized without provision of the service in dispute.

c. In the case of an expedited appeal, the Quality Assurance Department or designee will immediately contact the Medical Director by telephone at **571-775-0770**

4. The Quality Assurance Department or designee notifies either the CBP Program Director or designee or the CBP Medical Director of the appeal:
a. Appeals related to disputed health care services should be directed to the Medical Director.
b. Appeals related to disputed health care services or payment issues should be directed to the CBP Program Director or designee.

5. For CBP program participants enrolled in Medicaid, CBP will continue to furnish the disputed service if the following conditions are met:

a. CBP program is proposing to terminate or reduce services currently being furnished to the PACE participant.
b. The participant requests continuation of the service with the understanding that he/she may be liable for the cost of the contested service if the determination is not made in his/her favor.

6. If the above conditions are met, CBP will not discontinue the disputed service for which an appeal has been filed until the appeals process has concluded.

D. Acknowledgement of Receipt of Appeal

1. The CBP Medical Director, Program Director or designee will acknowledge a standard appeal in writing within **five** (5) working days of the initial receipt of appeal by CBP program.

2. For an expedited appeal, the **CBP Quality Assurance Coordinator or designee** informs the participant or representative within one (1) business day by telephone or in person that the request for an expedited appeal has been received and explains his/her additional appeal rights, as applicable.

E. Documentation of Receipt of Appeal

1. All appeals expressed either verbally and/or in writing, will be documented on the day that it is received or as soon as possible after the event or events that precipitated the appeal, in an Appeal Log.

2. Appeals are documented on the *"Appeal for Reconsideration of Denial"* form by the participant, his/her representative or by a treating provider, on behalf of the participant. Complete information must be provided so that the appeal can be resolved in a timely manner.

3. In the event of insufficient information, the Social Worker will take all reasonable steps to contact the participant, and/or his/her representative or other appropriate parties to the appeal to obtain missing information in order to resolve the case within the designated timeframes for an expedited and standard appeal.

F. Reconsideration of Decision for Service Request or Payment of a Service

1. An appeal will be reviewed and decided by an appropriately credentialed and impartial third party who was not involved in the original action and who does not have a stake in the outcome of the appeal. At CBP, an impartial third-party reviewer will be selected based on the nature of the appeal. CBP will select the appropriate reviewer from Capital Caring Health, Goodwin House, or another PACE provider in the state.

2. All individuals involved with the appeal, including the participant or their representative, will be given written notice of the appeals process and reasonable opportunity to present evidence or submit relevant facts for review to CBP program, either verbally or in writing.

3. For a "**standard appeal**", the designated CBP Medical Director, Program Director or designee will inform the participant in writing of the decision to reverse or uphold the decision within 30 calendar days of receipt of an appeal, or more quickly if the participant's health condition requires.

4. For an "**expedited appeal**" supported by a physician, the CBP program will make a decision regarding the appeal as promptly as the participant's health condition requires, but no later than 72 hours after receipt of the request for appeal.

a. If a participant's request for expedited appeal is not supported by a PCP, the CBP Medical Director decides if the participant's health situation requires making a decision within 72 hours.
b. If the participant's health does not warrant an expedited appeal process, CBP Medical Directornotifies the participant within 72 hours that the appeal will be treated as a standard appeal.
c. The Medical Director, Program Director or designee will provide the participant and/or his/her representative and the Department of Health Care Services with a written statement of the final disposition or pending status of an expedited appeal within 72 hours of receipt of an appeal.
d. In the event the 72-hour timeframe must be extended, CBP will provide justification to the DMAS for need of the extension. The CBP will notify participant both verbally and in writing of the pending status and reason for the delay in resolving the appeal. The participant will be notified of the anticipated date by which the appeal decision will be determined.

G. Determination of an Appeal

1. When the decision of an appeal is ***in favor of a participant*** that is, the Director's decision to deny, reduce or terminate a service or denies payment of a service is reversed, the following applies:

a. The CBP Medical Director, Program Director or designee provides a written response to the participant and/or representative, sent by mail, within 30 calendar days of receiving a standard appeal or sooner if the participant's health condition requires.
b. CBP will provide authorization to get the disputed service or provide the service as quickly as the participant's health condition requires, but no later than 30 calendar days from the receipt of the request for a standard appeal.
c. For an expedited appeal, CBP will provide the participant permission to obtain the disputed service or provide the service as quickly as the participant's health condition requires, but no later than 72 hours from the receipt of a request for an expedited appeal.
d. If the decision to deny payment for a service is reversed by CBP, then payment will be made within 60 calendar days of receiving the participant's or representative's request for a standard or expedited appeal.

2. When the decision of an appeal is ***not in favor of the participant*** that is the CBP Director's decision to deny, reduce or terminate a service or denies payment of a service is upheld, or if the participant is not notified of the decision within the specified time frame for a standard or expedited appeal, the Quality Assurance Coordinator or designee will do the following:

a. Notify in writing, at the time the decision is made, and within 30 calendar days from the date of the request for a standard appeal and within 72 hours for an expedited appeal:
1. The participant and/or his/her representative
2. Health Plan Management System (HPMS)
3. Department of Medical Assistance Services.
b. Notify the participant and/or his/her representative in writing of his/her appeal rights through the Medicare or Medicaid program, or both, depending on the participant's eligibility.
c. Offer to assist the participant or participant's representative in choosing which external

appeal route to pursue (if desired) and to assist in preparation of appeal.

d. Forward the appeal to appropriate external entity.

H. External Review Options for Appeal

Additional Appeal Rights under Medicaid and Medicare

If we do not decide in your favor on your appeal or fail to provide you a decision within the required time frame, you have additional appeal rights. Your request to file an external appeal can be made either verbally or in writing. The next level of appeal involves a new and impartial review of your appeal request through either the Medicare or Medicaid program.

The **Medicare program** contracts with an "Independent Review Organization" to provide external review on appeals involving PACE programs. This review organization is completely independent of our PACE organization.

The **Medicaid program** conducts their next level of appeal through the Department of Medical Assistance Services.

If you are enrolled in Medicaid, you can appeal if CBP wants to reduce or stop a service you are receiving. Until you receive a final decision, you may choose to continue to receive the disputed service(s). However, you may have to pay for the service(s) if the decision is not in your favor.

You have the right to file an appeal, directly to DMAS, for any decision for denial, reduction, notice to terminate, suspension or refusal to pay for any service. You do not have to exhaust internal PACE review procedures before exercising your right to directly appeal to DMAS. You or your authorized representative must send a written appeal request within thirty (30) days of the receipt of the IDT adverse decision. Your appeal must be postmarked or received by DMAS within 30 days of the adverse decision. If you file an appeal within this time frame, the disputed service may continue during the appeal process. However, if this action is upheld by the Appeals Division, you may be required to reimburse CBP for the cost of the disputed services paid on your behalf during the appeal period.
You may write a letter or complete and Appeal Request Form. Forms are available on the internet at www.dmas.virginia.gov, at your local department of social services, at your PACE Center, or by calling DMAS at (804) 371-8488

Please include a copy of the written adverse decision, sign the appeal request, and mail it to:

Department of Medical Assistance Services
Appeals Division
600 East Broad Street
Richmond, Virginia 23219

Appeal requests may also be faxed to:
(804) 371-8491

Medicare External Appeals Process

If you are a Medicare recipient, you may file your appeal through what is known as the Medicare managed care appeals process. Cherry Blossom PACE staff can help you walk through the process for doing this.

The contracted Medicare appeals entity will contact us with the results of their review. The contracted Medicare appeals entity will either maintain our original decision or change our decision and rule in your favor.

a. If the Administrative Law Judge (ALJ) decision is in favor of the participant's appeal, CBP will follow the judge's instruction as to the timeline for provision of services to the participant or payment for services for a standard or expedited appeal.

b. If the ALJ's decision, adopted by the Director as final, is not in favor of the participant's appeal, the participant may request a re-hearing with the Director within 30 calendar days after receiving the final decision.

c. Within one year after receiving notice of the Director's final decision, the participant may file a petition with the superior court, under the provisions of Section 1094.5 of the Code of Civil Procedure.

2. The following option for external appeal is available to participants enrolled in Medicare, that is, "Medicare only" or "both Medicare and Medicaid":
a. A Medicare enrollee may choose to appeal CBP's decision using Medicare's external appeals process. CBP will send the appeal to the current contracted Medicare appeals entity Maximus Federal Services

Medicare Part A West
3750 Monroe Avenue, Suite 706
Pittsford,NY 14534-1302

b. The contracted Medicare appeals entity maintains a standard and expedited appeal process. Standard appeals will be resolved within 30 calendar days after filing of the appeal; expedited appeals will be resolved with 72 hours (with a possible 14-day extension).
c. The contracted Medicare appeals entity will contact CBP program with the results of the review. The contracted Medicare appeals entity will either maintain CBP program original decision or change CBP program decision and rule in the participant's favor.
d. If the contracted Medicare appeals entity's decision is not in the participant's favor, there are further levels of external appeal, and if requested by the participant and/or representative, the Social Worker will assist a participant in further pursuing the appeal.

I. Documentation, Tracking, Analysis and Reporting

1. All appeals related information shall be marked "confidential".

2. All Appeal-related information and correspondence, including the appeals log will be stored in locked cabinets in the CBP Quality Assurance Department or as designated.

3. The *Appeals Log* will contain, at a minimum, the following information:
a. Name and telephone number of the staff person recording the appeal
b. Date the appeal was filed
c. Participant's and/or her/her representative's name and/or person filing the appeal
d. Description of the appeal
e. Action taken
f. Description and date of the final resolution.

4. Quality Assurance Coordinator or designee is responsible for maintaining, aggregating, and analyzing information related to appeals to identify trends or patterns. On a quarterly basis, this information will be forwarded to Program staff and designated committees. The information will be used in the CBP internal QI program.

5. CBP program will submit a summary of all grievances in the quarterly report to the DMAS, Centers for Medicare and Medicaid Services. The DHCS appeals summary is due 45 calendar days from the date of the end of the reporting quarter.

6. A written summary of appeals including number, type, location, and disposition are reported to the Quality Assurance and Improvement Committee, and the Board of Directors on a quarterly basis.

7. Records of all appeals will be held confidentially and made available as needed to State and Federal agencies upon request.

8. CBP program shall maintain in its files copies of all appeals, the responses and recording of log for ten (10) years from the date the appeal was filed.

9. To ensure timeliness and accuracy in the appeals process, CBP shall perform regular audits of the appeals log and files to ensure they correspond with other data reporting systems (i.e. HPMS reports).

J. Annual Review

1. The appeals process will be reviewed with participants and/or their representative, contract providers and all employees of CBP program on an annual basis as part of the CBP Quality Assurance Program.