Helping Beneficiaries Understand the Fully Integrated Dual Advantage (FIDA) Appeals Process
The Medicare Rights Center is a national, nonprofit consumer service organization that works to ensure access to affordable health care for older adults and people with disabilities through:

- Counseling and advocacy
- Educational programs
- Public policy initiatives
What we will learn

- **Background**
  - Evolving landscape

- **FIDA integrated appeals**
  - FIDA rules for hospital discharge

- **FIDA grievances**

- **FIDA drug appeals**
  - Not integrated
  - Exception requests
  - Appeals
    - Common reasons for drug denials
    - Drug appeals process
Medicare and Medicaid coordination

- People who have both Medicare and Medicaid = **dual eligibles**
- Medicare: always pays first
- Medicaid: payer of last resort
  - Medicaid always pays after all other forms of insurance have paid
- Dual eligibles: must have Medicare prescription drug coverage (Part D)
  - Automatically enrolled into Extra Help (aka Low-Income Subsidy or LIS) to help with drug costs
MLTC and FIDA: What’s the difference?

MLTC

- Only covers Medicaid long term care, dental, vision and podiatric services
- Does not affect Medicare coverage
- Is mandatory

FIDA

- Covers all health care services and items, including Medicaid long term care services and prescription drugs
- Provides both Medicare and Medicaid benefits
- Is optional
Who can file an appeal?

- **Beneficiary**
- **Provider**
- **Friend or family member**
  
  - Friends or family members can request an appeal on behalf of a FIDA beneficiary by filing out the sections of the denial notice.
  
  - If a beneficiary needs a friend or family member to represent them at their hearing, representative and beneficiary must sign an Appointment of Representative Form available from the plan.
When to file an appeal

- When beneficiary receives a notice that contains decision/s they disagree with

- For example:
  - Integrated Coverage Determination Notice
    - Issued when the Person-Centered Care Plan (PCSP) is created or updated and changes have been made to the care the beneficiary received under the old PCSP
    - Issued each time care that was requested by the beneficiary or their provider is denied
    - Issued each time care the beneficiary already receives ends or is reduced

- Most drug appeals are handled via separate process (discussed later in training)
Integrated Coverage Determination Notice

- FIDA plan must give the beneficiary written notice of any denials, terminations, reductions
- Notice must be translated for individuals who speak Spanish, Chinese, Russian, Italian, Haitian-Creole, Korean
- Notices must list the Independent Consumer Advocacy Network (ICAN) phone number 844-614-8800 and explain:
  - Denial, reduction, or termination and reasons for decision
  - Citation to the regulations
  - Right to file an appeal
  - How to file an appeal
  - How and when to request an expedited appeal
Standard v. expedited

- Standard appeal: typical appeal timeline
- Expedited appeal: granted where a standard decision would significantly increase the risk to beneficiary’s health
  - Provider must speak to plan to request expedited appeal
  - On the Integrated Coverage Determination Notice, an expedited appeal is called a **fast appeal**
Integrated appeals timeline

Integrated Coverage Determination Notice
10 days to request appeal verbally or in writing if aid continuing* is needed
60 days to request appeal verbally or in writing if aid continuing *is not needed

Standard Request
Answer in 30 days

Automatically forwarded to FIDA Hearing Unit at OTDA

Standard Appeal
Answer in 90 days

Medicare Appeals Council Review
Answer in 90 calendar days

Expeditied Request
Answer in 72 hours

Automatically forwarded to FIDA Hearing Unit at OTDA

Expeditied Appeal
Answer in 72 hours

*Aid continuing defined on next slide
Aid continuing

- Coverage for a service/item being terminated/reduced continues while an appeal is pending = aid continuing
  - Applies through the MAC level of appeal
    - Does not apply to Part D drug appeals
- Beneficiaries or representatives must file an appeal verbally or in writing within 10 days of the postmark date or by the intended effective date of the denial, reduction, termination (whichever is later) to get automatic aid continuing
  - If a beneficiary does not need aid continuing, they or a representative can file an appeal verbally or in writing within 60 calendar days of the postmark date on the denial notice
- Even if denial is upheld, beneficiary should not be charged for aid continuing
Levels of appeal

- Four levels of appeal:
  1) Initial appeal to FIDA plan
  2) Appeal to FIDA Administrative Hearing Unit at the New York State Office for Temporary and Disability Assistance (OTDA)
  3) Appeal to federal Medicare Appeals Council (MAC)
  4) Appeal to federal district court
    - No decision timeframe
1) Initial appeal to FIDA plan

- Can be verbal or written
- Can come from a beneficiary, provider, or caregiver
- FIDA plan has following timeframes to give appeal decisions to beneficiaries:
  - Expedited: verbal decision within 72 hours
    - Plan must make a reasonable effort to tell the beneficiary about the decision verbally in addition to sending written decision
  - Standard: written decision within ~30 days
- Extensions of up to 14 days permitted in certain circumstances:
  - Either a beneficiary or provider requests the delay
  - Plan can extend the deadline up to 14 days if additional appeal documentation is needed to make a decision and the delay is in the best interest of the beneficiary
2) Appeal to FIDA Hearing Unit at OTDA

- Denials and partial denials issued by plan must automatically be forwarded to OTDA within two business days
  - Electronic transfer from plan
- Plan must tell beneficiary in writing that their plan denial was automatically forwarded to the OTDA
- FIDA Hearing Unit must send the beneficiary a notice with their hearing date
  - Notice must be sent at least 10 days before scheduled hearing
- OTDA hearing is either **over the phone or in person**
- FIDA Hearing Unit has
  - 72 hours to issue a verbal decision in expedited appeals
    - Written notice is also required, but not within 72 hours
  - 90 days to issue a written decision for standard appeals in 2015
3) Medicare Appeals Council (MAC)

- Denials or partial denials issued by OTDA may be taken to the MAC
- Beneficiary has 60 days after OTDA issues a denial to ask that appeal be forwarded to the MAC
- The MAC has 90 days to issue a written decision
  - No expedited timelines at MAC level
  - Aid continuing lasts through the MAC level
4) Federal district court

- Denials and partial denials issued by the MAC may be taken to federal district court
- No timeframe for beneficiaries to advance unfavorable MAC decisions to federal district court
- No timeframe for federal district court to issue a written decision
Integrated appeals timeline

Integrated Coverage Determination Notice
10 days to request appeal verbally or in writing if aid continuing is needed
60 days to request appeal verbally or in writing if aid continuing is not needed

Standard Request
Answer in 30 days

Automatically forwarded to FIDA Hearing Unit at OTDA

Standard Appeal
Answer in 90 days

Medicare Appeals Council Review
Answer in 90 calendar days

Expedited Request
Answer in 72 hours

Automatically forwarded to FIDA Hearing Unit at OTDA

Expedited Appeal
Answer in 72 hours

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FIDA grievances

Different from appeal:

- **Grievance**: a complaint against a plan because the beneficiary is dissatisfied with the quality of service received.
- If beneficiaries disagree with their plan’s refusal to cover a service, item, or medication, they should file an appeal.

Grievances must be filed within 60 calendar days of the incident or whenever there is dissatisfaction.

Two types of grievances: internal and external.

- FIDA beneficiary or authorized representative may file an internal grievance with the FIDA plan by calling or writing to plan.
- FIDA plan must inform beneficiaries that they or their authorized representative can file an external grievance through 800-Medicare.
Medicare discharge appeals

- Beneficiaries can appeal if they think hospital is making them leave too soon
  - Steps to ask for review are listed on Important Message from Medicare
  - Hospital discharge appeal goes to Quality Improvement Organization (QIO) – independent body that decides on inpatient discharge appeals
    - Pay close attention to deadline for requesting an appeal

- Most QIO decisions are expedited and QIO must tell beneficiary its decision by close of business the day after appeal is made
  - If appeal is filed on time, hospital cannot charge patient until QIO makes its decision
  - Further levels of review available
FIDA rules for hospital discharge

- FIDA plans must follow Medicare discharge rules
- Hospitals must work with patients and their caregivers to plan for hospital discharge
- Hospitals must provide names of Medicare-certified SNF and home health agencies to beneficiaries before they are discharged
  - To compare the quality of providers: www.medicare.gov or 800-Medicare
- Hospitals must provide the Important Message from Medicare to patients
  - Provided upon admission and again before discharge
  - Explains patient rights
  - Explains rights to appeal an inpatient discharge

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FIDA rules for hospital discharge

- FIDA beneficiaries should follow instructions on their Important Message from Medicare and request review by Quality Improvement Organization (QIO)
  - Request must be made by noon of first business day after receipt of notice
  - QIO has one business day to make decision about hospital discharge
- If they miss deadline, FIDA beneficiary can file oral or written request for expedited, 72-hour FIDA plan appeal
- QIO will make decision within one business day after receipt of request, records, and any other information needed to make decision
- If QIO overturns FIDA plan’s decision, plan must pay for remainder of the hospital stay
Hospital discharge appeals for people with FIDA

- Some dually eligible people whose Medicare-covered services are being terminated or reduced can still receive Medicaid-covered care
  - For example, a beneficiary whose SNF care is being terminated because they no longer have a skilled need can get non-skilled care in the same (or similar) facility covered by the Medicaid piece of their FIDA plan

- Beneficiary may not need to appeal reduction/termination in care
  - Only appeal to continue Medicare-covered services

- Beneficiaries in inpatient settings (or their caregivers) should be in constant contact with their FIDA plan’s care manager
  - Care manager ensures that care transitions for FIDA beneficiaries put minimal stress on beneficiary and caregivers
FIDA Drug Appeals
Medicare and Medicaid drug appeals

- This section covers both Medicare and Medicaid drug appeals under FIDA.

- **Medicaid drug appeals:** process is part of the FIDA integrated appeals process (aid continuing applies).
  - Applies to drugs that are covered by Medicaid but not Medicare.

- **Medicare drug appeals:** process is not part of the FIDA integrated appeals process (aid continuing does not apply).
  - Medicare Part D appeals process applies to Part D drugs.
    - Described in this section.
Medicare Part D drug appeals

- A drug appeal is a challenge to a plan’s decision
  - Not to cover a prescribed medication (not on formulary)
  - To limit the amount of a prescribed medication it will cover (quantity limits)
  - To require approval before the beneficiary can get a drug (prior authorization)
  - To require that the beneficiary try other drugs first (step therapy)
Medicaid drug appeals

1) FIDA plan has following timeframes to give notice of appeal decisions to beneficiaries
   - Standard: decision within 7 days
     - Must mail written notice of decision
   - Expedited: decision within 72 hours
     - Must make a reasonable effort to tell beneficiary verbally in addition to sending a written notice

2) OTDA hearing is either **over the phone or in person**
   - 7 days to issue a written decision in standard appeals

3) MAC has 90 days to issue written decision

4) Federal judge has no timeframe to issue decision
Exception requests (pre-appeal)

- First step of the Part D appeals process
  - Must include doctor’s statement given to the plan via phone, fax or mail
  - Statement says
    - The medication is medically necessary, and why
    - All other drug or dosage alternatives on the plan’s formulary have been ineffective for patient or caused harm (or based on sound clinical evidence and/or knowledge of patient, all other drug or dosage alternatives are likely to be ineffective or cause harm)
Exception requests

- Plan has 72 hours (clock hours) to respond to standard exception request
- If patient’s health is in danger, prescribing physician can request expedited exception
  - Plan must respond within 24 hours
- If denied, plan is required to send written denial to beneficiary detailing how to appeal
Tips for requesting exception

- Clock starts ticking once plan receives both the exception request and the doctor’s statement of medical necessity

- Submit as much supporting evidence as possible
  - Show the whole picture of patient’s health
    - For instance, describe why plan’s preferred drug/quantity may have harmful health effects
  - May shorten appeals process by anticipating and countering plan’s potential reasons for denying coverage
Reasons for denial: quantity limit

- When plan will only cover certain amount of prescription
- If doctor is prescribing more than amount approved on formulary, prescription may be denied
- People choose to appeal quantity limits when they need more of their drug than their plan allows per month
- In an appeal, beneficiary must convey to plan that their health will suffer if they have less of drug than their doctor prescribed
Reasons for denial: prior authorization

- When plan requires beneficiary to ask for special permission before it will consider covering drug
- If individual or their doctor did not get plan’s permission to cover drug before ordering it at pharmacy, prescription may be denied
- In an appeal, beneficiary must ask for an exception to the plan’s prior authorization rule
Reasons for denial: step therapy

- When beneficiary must try another (usually less expensive) drug before plan will cover originally prescribed drug.
- People choose to appeal step therapy when they cannot take the drug/s that plan is requiring them to take because:
  - They have tried another drug and it was harmful or ineffective.
  - Their doctor believes another drug may be harmful or ineffective.
- In an appeal, beneficiary must convey to plan that they cannot take any other drug, and include supporting reasons.
Requesting a drug not on formulary

- Formulary must list approved dosages and any restrictions on coverage.
- Request must demonstrate why beneficiary can’t take similar drugs that are on formulary (i.e. drugs would be harmful/ineffective).
- FIDA plans are not required to process a request for a formulary exception until the prescribing physician provides a supporting statement of medical necessity.
Strengthening an appeal

- Prescribing physician is important to the appeals process
  - Must provide thorough statement of medical necessity and work closely with appeals advocate and/or patient

- Persistence is key
  - Some plans rubber stamp denials (especially if the drug is expensive), and appeals often win at the independent review level without any additional information
Drug appeals timeline

Request an Exception to Plan Formulary
(includes requests to remove coverage restrictions)

**Standard Request**
Answer in 72 clock hours
No Rep form is needed

**Standard Appeal**
Answer in 7 calendar days
Must include Rep form

**Standard Independent Review by Maximus**
Answer in 7 calendar days
Must include Rep form

**Expedited (urgent) Request**
Answer in 24 clock hours
No Rep form is needed

**Expedited Appeal**
Answer in 72 clock hours
No Rep form is needed

**Expedited Independent Review by Maximus**
Answer in 72 clock hours
Must include Rep form

Call plan to find out where to submit a formulary exception request

Submit appeal to plan’s Grievance & Appeals department within 60 days from date on Notice of Denial (look for contact info on notice)

Submit appeal to IRE (Maximus Federal Services) within 60 days from date on denial notice

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Tips if appeal goes beyond exception request

- If beneficiary’s exception request is denied:
  - Tell them to call their plan care manager so s/he can help them with their appeal
  - Tell them to call ICAN at 844-614-8800 for additional help and appeal tips
  - Tell them that ICAN can also help them file a grievance with their plan and/or provide guidance on finding a plan that covers all their drugs
Where to find information

**New York Medicaid Choice**
- 855-600-3432
- Can contact to enroll in or switch FIDA or MLTC plans

**Independent Consumer Advocacy Network (ICAN)**
- 844-614-8800
- [http://www.icannys.org](http://www.icannys.org)
- Can contact with any problems or concerns about MLTC or FIDA