APPEAL GUIDE

If you need help with the information in this document, including written/ oral translation; or in a different format like large print or as an audio file, we can help you at no cost. Call NHP at 800-541-6870 or State Relay 711 for callers with speech or hearing disabilities.

Si necesita ayuda con la información en este documento, incluyendo traducción escrita u oral, o en un formato diferente como letra grande o archivo de audio, podemos ayudarle sin costo alguno. Llame a NHP al 800-541-6870 o al servicio de retransmisión del estado marcando 711 para personas con discapacidades del habla o auditivas.

Northeast Health Partners (NHP) understands that it may be stressful for Members to have their health services denied. This guide will help you file an Appeal if we make a decision to deny, reduce, or stop any covered behavioral health services that you or your provider requests. There is only one (1) level of an appeal for Members. NHP can only help you appeal denied behavioral health services. To file an appeal for denied behavioral health services, call 800-541- 6870. Our team will guide you through the process and answer your questions.

To file an appeal for denied physical health services, you will need to call the Ombudsman for Health First Colorado at 303-830-3560, toll-free 877-435-7123, or 711 (State Relay). You can also email them at help123@maximus.com.

If you have been told that you do not qualify for Health First Colorado, you may appeal through your county Department of Human Service (DHS) office. You can ask for an informal meeting. You must ask for this meeting within thirty (30) days from being notified that you no longer have coverage. You may find your DHS number at:

https://www.colorado.gov/pacific/cdhs/contact-your-county.

What is an Appeal?

An appeal is a review by NHP of an adverse benefit determination. You can file an appeal if you disagree with a decision about behavioral health services that were not authorized. You will receive a Notice of Adverse Benefit Determination letter from NHP only if treatment was denied. An adverse benefit determination could be:

- A service that is denied or limited that you request. This could be denied based on medical necessity, not being in the right setting, a treatment is not effective, or the type or level of care you ask for.
- A service you get is set to be reduced, suspended or stopped.
- You did not receive a service in a timely manner. This is defined by the State.
- You are not given notice of a decision or a reply to your complaint or appeal within required times
- Your request to get behavioral health care outside your regional organization network is denied, and you live in a rural area where there are no providers.
- You are denied your request to debate the costs you need to pay. This could include cost- sharing, co-payments, premiums, deductibles, coinsurance, or other costs.
- Payment for your health services is denied or limited.

Filing an appeal cannot cause you to lose coverage. That is the law!

Who Can File an Appeal?

You can file an appeal or you can ask someone to file an appeal for you. If you want someone else to file an appeal for you, you must make that person your Designated Client Representative (DCR). This person can be a family member, a service provider, or anyone else you choose to act on your behalf. You must sign a DCR form to name that person as your DCR. If you choose to have your service provider act on your behalf, you can sign a DCR form or give your written consent in a letter. You will also need to sign a Release of Information (ROI) for NHP to share your information with your DCR. Both of these forms can be found on our website, nhprae2.org.

When and How Can I file an Appeal?

You must file your appeal within sixty (60) calendar days from the date of the adverse benefit determination. An Adverse Benefits Determination is a decision made by NHP that denies, reduces or stops a service that you or your provider requested. NHP will send you a Notice of Adverse Benefit Determination letter that explains what services were denied, reduced, or stopped and the reasons for the decision. You can call us to tell us you want to appeal our decision. You can also put the appeal request in writing and send us an

Email or letter.

Our contact information is:

NHP Member Services
(800) 541-6870; State Relay: 711
nhpmembersupport@nhpllc.org
P.O. Box 31364 Salt Lake City UT 84131-0364

Timeframe for Members to Appeal and NHP to Send Letters

Action	Timeframe
When Member, DCR, or Service Provider must Request an Appeal	Within sixty (60) calendar days of notice of adverse benefit determination
NHP sends Member letter stating we received their appeal request	Within two (2) business days of receiving your oral or written appeal request
If Member requests a Standard Appeal, NHP will send an appeal decision letter	Within ten (10) working days of appeal request
If the Request is for a Quick Appeal and the request is approved, NHP will call Member and send Member a letter	Within the same seventy-two (72) hours
If the Request for a Quick Appeal is not approved, NHP will call Member and send Member a letter	Within ten (10) working days of appeal request
If Member/NHP requests more time for a quick or standard appeal decision, NHP will call Member and send Member a letter	Within two (2) calendar days
If the Appeal Decision is extended, NHP will send an appeal decision letter	Within fourteen (14) calendar days from the date the appeal decision was to be made

What Can I Expect When I Call Member Services?

- Be treated with respect
- Help with any forms you may need to file an appeal
- Language assistance, including interpreters, and additional help and support (auxiliary aids)
- Toll-free number and 711 State Relay

- Information about the limited time frames that you have to send us information you want considered in your appeal
- When and where you can send information you want considered in your appeal
- A letter within two (2) business days stating that we received your appeal request
- Pledge that the health professional who reviews and makes a decision on your appeal request was not involved in making the original decision to deny or limit services. The health profession will not by supervised by the person who made the first decision to deny treatment. We will make sure that the reviewer has the necessary clinical training.

What is the Difference between a Quick Appeal and a Standard Appeal?

- The amount of time that a doctor has to review your medical record and make a decision about the denied services. See timeframe chart on pages 2-3.

Quick Appeal

You may ask for a quick appeal if you or your provider believe that waiting for a decision would be harmful to your health. Your provider will not be punished for asking for a quick appeal on your behalf. A quick appeal is also called an expedited appeal. NHP's Medical Director will review your quick appeal request and make a decision to whether to review you appeal quickly. If approved, we will let you know of the limited time we have to receive any records you want to include in the appeal. NHP will make the decision in the timeframe found in the chart on page 2.

If we deny your request for a quick appeal, **we will still process your appeal**. We will process it in the standard appeal time frame. We will call you on the phone to let you know the reason your quick appeal was denied. We will also send you a letter to explain the reason the request was not approved. You have the right to file a grievance if we deny your request for a quick appeal. The time we have to make a standard appeal decision is found in the chart on page 2.

Standard Appeal

You can ask for an appeal verbally or in writing by contacting NHP. We will make an appeal decision within ten (10) business days of your request. You may ask for more time so you can give us information you want included in your appeal or we may decide that we need more time to make a decision. If we need more time, we will tell you why in a letter. If you do not agree with the decision to extend the time frame to make a decision, you may file a grievance. We will mail you a decision letter explaining the results of the appeal and the reasons for our decision. We will do everything we can to make the decision as quickly as possible. See Timeframe chart on Page 3 to learn when you can expect a letter from us.

What Information Can I Provide to Help My Appeal?

NHP wants to give you or your DCR enough time to give us all of the records, documents, or information you think are important to your appeal. This information will be reviewed by the person who will review your appeal. This could include information which was or was not considered in the initial adverse benefit determination. We will let you know the limited time frames that we need to receive these records so that they can be considered in the appeal decision. We can receive this information over the phone, in writing, or in person. You can present your testimony (story) and make legal or factual arguments. You can request your records if there are any new documents which we are considering or have generated relating to your appeal. We will provide these records free of charge and in enough time for the appeal decision. Examples of what may be helpful to include:

- Medical records
- Testing results
- Court documents
- Treatment records
- Personal testimony
- Anything else you think is important

The parties to your appeal are you and your representative. In the case of a Member who has died, the party to the appeal is the legal representative of a deceased Member's estate.

Can I Continue to Receive Services During an Appeal?

Yes, you can continue to receive services during your appeal if already-approved services are going to be stopped or reduced ten days before your authorization ends.

Example:

Your child was approved for residential treatment for thirty (30) days. It is discovered during a clinical review half-way through your child's stay that they no longer need to be treated in twenty-four (24) hour care. We would need to notify you at least ten (10) days before the residential treatment would be stopped.

If you want your services to continue during the appeal process, you must ask that your services continue by contact NHP at 800-541-6870. Your provider cannot make this request. You must make this request within ten (10) days from the date NHP mailed you the Notice of Adverse Benefit Determination letter. There are certain standards that must be met. They include:

- The service must have been ordered by an authorized provider
- The time period for the authorized service must not be over yet
- Your services were denied, reduced, or stopped
- You must ask NHP to continue the service
- You have sixty (60) days from the date of the adverse benefit determination to file your appeal

If you ask for services to continue, services will continue until you withdraw the appeal, an appeal decision is made that is not in your favor, or the time period or service limits of the original authorized services have expired.

What Happens if the Appeal Decision is Not in My Favor?

You can ask for a State Fair Hearing. Your request has to be submitted within 120 days of the adverse appeal decision and you must have exhausted your appeal rights with NHP. Please refer to the State Fair Hearing Guide found on our website, nhprae2.org.