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Overview

This section includes information about the process for Member appeals and Provider billing disputes.

Note: The procedures described in this section may change due to changes in the applicable State and federal laws and regulations, as well as accreditation standards. Also, a decision at any level is not a determination of eligibility or a guarantee of payment. Payment is contingent upon the Member being eligible for coverage at the time of service/treatment and is subject to the terms, limitations, and exclusions of their benefits contract.

Commercial Member appeals

There are two broad types of internal appeals on behalf of Members:

- **Medical Necessity Appeals –** Medical Necessity appeals, or grievances, relate to denials based on Medical Necessity, medical appropriateness, or clinical issues.
- **Administrative Appeals –** Administrative appeals or complaints relate to denials or disputes regarding coverage, including contract exclusions, noncovered services, participating or nonparticipating health care Provider statues, or other contractual terms of the health plan.

Appeals can be pre-service or post-service and may be processed within 48 hours (72 hours for PPO) for an expedited appeal or in a standard time frame. Standards for appeals time frames and processes are established by applicable State and federal laws, as well as by national accrediting organization guidelines adopted by Independence Blue Cross (Independence). Appeals procedures are subject to change.

An expedited appeal may be obtained with validation from the Member's Provider stating that the Member's life, health, or ability to regain maximum function would be placed in jeopardy or the Member would experience severe, unmanageable pain using the standard appeals process. This validation should include clinical rationale and facts to support the opinion. There is only one level of internal review for an expedited appeal.

Self-insured groups

The process for self-insured groups can vary from what is described on the following pages, and the guidelines are not described in this document. Therefore, you should contact the Member's Independence administrator, consult the *Member Handbook*, or ask a Customer Service representative about the appeals process for a self-insured group.

Traditional/CMM Members

Refer to the Member's specific benefits plan regarding the Member appeals process for traditional/CMM plans.

Who may appeal

A Member, a Member's authorized representative, or a Provider authorized to act on behalf of a Member may appeal decisions related to either Medical Necessity or Administrative denials. In most cases, the Member's written consent or authorization is required for a Provider or another person to act as the Member's authorized representative. The defined processes are compliant with regulatory statutes and accreditation standards. A Member who consents to the filing of an appeal by a Provider may not file a separate appeal.

How to file an internal appeal on behalf of the Member

Providers must first obtain written consent from the Member. Upon receipt of a Provider's request for an appeal of an adverse benefit determination, Independence mails the Member a consent form for a Provider to file an appeal on his or her behalf. The *Member Consent for Provider to File an Appeal on my Behalf with Health Insurance Plan* form is also available online at *www.ibx.com/providerforms*. If the Member designates the Provider to represent them in an appeal, the Provider is responsible for submitting supporting documentation, such as a copy of the Provider's office or medical records. Upon receipt of the Member's written consent, both the Provider and Member receive an acknowledgment letter and materials listing the appeal process and applicable time frames. Appeals that do not include a signed Member consent form cannot be processed and will be returned to the Provider to take further action.

A Provider may file an appeal on behalf of a Member within 180 days from notification of the denial by (1) calling the Member Appeals department at 1-888-671-5276, (2) faxing the Member Appeals department at 1-888-671-5274, or (3) writing to:

Member Appeals Department
P.O. Box 41820
Philadelphia, PA 19101-1820

For standard appeals, an acknowledgment letter is sent. It describes the appeals process and applicable time frames for resolution. For expedited appeals, the combined acknowledgment and resolution letter provides the decision and rationale, as well as details on the appeals process and applicable time frames.

If a Member appeal, or Provider appealing on behalf of the Member appeal with the Member's consent, is filed before or during an open Provider appeal for the same issue, the Provider appeal will be closed and addressed under the Member appeal.

HMO/POS (Grievances) and PPO Medical Necessity (i.e., Medical Necessity/clinical issues) External Reviews

A Member, the Member's authorized representative, or the Provider on behalf of the Member, who has exhausted the internal appeal process for an expedited or standard Medical Necessity appeal and continues to be dissatisfied with the decision, may request an external review by an Independent Utilization Review Organization (IURO) by following the instructions described in the final internal appeal decision letter.

Independence is responsible for coordinating the external review. We will forward all of the information presented during the internal appeals processes to the IURO. The Member, the Member's authorized representative, or the Provider on behalf of the Member may submit additional information to us within a specified time frame for submission to the external review entity at the address listed below.

The IRO will review the information and issue a decision. For an external review, the Member, the Member's authorized representative, or the Provider on behalf of the Member is notified of the determination within 72 hours of an expedited request and within 45 calendar days of a standard request, which is binding on the plan.

HMO/POS Administrative appeals (complaints) – (i.e., nonmedical Necessity/administrative issues)

After exhausting the internal Administrative appeals process, the Member, the Member's authorized representative, or Provider on behalf of the Member may file a complaint to the Pennsylvania Insurance Department, as outlined in the final internal appeal decision letter. There is no external administrative appeal option for PPO plans.

Part C and Part D appeals and grievances

Part C Appeals

The Member's appointed representative, or the Provider on behalf of the Member, may request an appeal of any coverage decision about payment, or the failure to arrange, or to continue to arrange for, what the Member believes are Covered Services under Keystone 65 HMO or Personal Choice 65℠ PPO, including noncovered Medicare benefits. Appeals must be filed within 60 calendar days of the original coverage determination, except for good cause.

Pre-service appeals

A decision about medical care that has not already been rendered is called a pre-service appeal.

- **Standard appeal.** Pre-service appeals are resolved as expeditiously as required by the Member's health condition, but in no more than 30 calendar days after the appeal is received.
- **Expedited appeal.** If the Member's health, life, or ability to regain maximum function may be jeopardized by waiting for the standard 30-day initial appeal process, an expedited appeal of a pre-service request may occur at the request of the Member, the Member's appointed representative, or the Member's Provider. Expedited appeals are resolved as expeditiously as required by the Member's health condition, but in no more than 72 hours upon receipt of the appeal request.

Post-service appeals

A decision about payment for care is called a post-service appeal and must be resolved no later than 60 calendar days after the appeal is received.

Part D Appeals

Pre-service appeals

The Member's appointed representative or the prescribing Provider on behalf of the Member may appeal our decision not to cover a drug, vaccine, or other Part D benefits. Appeals must be filed within 60 calendar days of the original coverage determination, except for good cause.

- **Standard appeals.** Pre-service appeals are resolved as expeditiously as the Member's health condition requires, but no later than seven calendar days after we receive the appeal request.
- **Expedited appeals.** An expedited appeal of a pre-service request is resolved within 72 hours upon receipt of the appeal, or sooner if the Member's health condition requires.

Requesting an appeal

For all Part C standard appeals, the Member or his or her authorized representative should mail the written appeal to:

Keystone 65 HMO/Personal Choice 65 PPO Member Appeals Department
P.O. Box 13652
Philadelphia, PA 19101-3652
www.ibxmedicare.com

For all Part D standard appeals, the Member or his or her authorized representative may submit a verbal request and/or a written request via telephone, fax, or online to:

Keystone 65 HMO: 1-800-645-3965
Personal Choice 65 PPO: 1-888-718-3333
TTY/TDD: 711
Fax: 215-988-2001
www.ibxmedicare.com

For all Part C and Part D *expedited* appeals, the Member or his or her authorized representative should contact us by telephone, fax, or online:

Keystone 65 HMO: 1-800-645-3965
Personal Choice 65 PPO: 1-888-718-3333
TTY/TDD: 711
Fax: 215-988-2001
www.ibxmedicare.com

For all Part C Medicare Advantage appeals, if the original denial is upheld after the review by Independence, the case is forwarded for review and determination by an independent review entity (IRE). An IRE is contracted with the Centers for Medicare & Medicaid Services (CMS) to perform second-level independent reviews of Medicare Advantage HMO and PPO Members' appeals.

For all Part D Medicare appeals, if the original denial is upheld after the review by Independence, the member of his or her authorized representative must file a request for further review directly with the IRE.

Grievances process

A Medicare Advantage HMO or PPO grievance is any complaint or dispute raised by a Medicare Advantage HMO or PPO Member or the Member's representative, other than a dispute involving a coverage determination, including coverage of prescription drugs. Medicare Advantage HMO or PPO grievances may include issues with one of our network pharmacies or disputes regarding such issues as office waiting times, Provider behavior, adequacy of facilities, or involuntary disenrollment situations. A decision will be issued no later than 30 calendar days after the grievance is received. An extension of up to 14 calendar days is permitted if the Member requests or if Independence requires more information and the delay is in the best interest of the Member. In certain cases, the Member has the right to ask for an expedited grievance, meaning we must issue a decision within 24 hours. We may extend the time frame by up to 14 calendar days if the Member requests the extension or if we justify a need for additional information and the delay is in the best interest of the Member.

Note: These procedures may change due to changes in the applicable federal laws and regulations.

Timely submission of medical records

As part of the federally mandated Medicare Advantage appeals and grievance process, Independence is required to obtain a Member's medical record in order to make a determination of coverage. If we uphold our determination, we are required to forward the Member's appeal file, which includes medical records, to an IRE. Medical records must be submitted to us in a timely manner. By doing so, we can submit them to an IRE and ensure compliance with mandated appeal deadlines.

CMS also requires that both Independence and an IRE make their determinations within 72 hours for an expedited appeal and within 30 days for a standard appeal. If a Member requests an expedited review, we will immediately send a request to the Provider for medical records. We must receive the records within 24 hours for an expedited appeal and within ten days for a standard appeal. If an appeal is sent to an IRE, the IRE may request additional records, which are required to be sent under the same time frames.

Upon our request, and in accordance with your Professional Provider Agreement (Agreement), you must provide us with copies of a Medicare Advantage HMO or PPO Member's medical records to as requested.

Other reasons we may require the timely submission of medical records include:

- facilitating the delivery of appropriate health care services to Medicare Advantage HMO and PPO Members;
- assisting with utilization review decisions, including those related to disease management programs, quality management, grievances (as discussed above), claims adjudication, and other administrative programs;
- complying with applicable State and federal laws and accrediting body requirements (e.g., National Committee for Quality Assurance);
- facilitating the sharing of such records among health care Providers directly involved with the Member's care.

Skilled nursing facility and home health discharges

Another type of appeal applies only to discharges related to skilled nursing facility, home health, or comprehensive outpatient rehabilitation facility services. Members receive notice two days before coverage ends. If the Member thinks his or her coverage is ending too soon, the Member must appeal no later than noon the day before coverage ends. The appeals should be sent to the following Quality Improvement Organization (QIO) contractor:

Livanta BFCC-QIO Program
108220 Guilford Rd, Suite 202
Annapolis Junction, MD 20701
Phone: 1-866-396-4646
Fax TTY: 1-866-985-2660

If the Member makes this type of appeal, his or her stay may be covered during the time period prior to Livanta making its determination. It is important for the Member to submit the appeal quickly in order to meet the required time frames stated.

Hospital discharges

Another special type of appeal applies only to hospital discharges. If the Member thinks his or her coverage of a hospital stay is ending too soon, the Member can appeal directly and

immediately to Livanta. If the Member makes this type of appeal, his or her stay may be covered during the time period prior to Livanta making its determination.

Discussion about utilization management decisions

Information on utilization management decisions can be found in the *Clinical Services – Utilization Management* section of this manual. Note that peer-to-peer discussion is not part of the Member appeals or Provider appeals processes described in the previous pages.

Provider billing dispute process

Independence offers a two-level post-service billing dispute process for professional Providers. For services provided to any Independence commercial or Medicare Advantage Member, Providers may dispute claim denials related to general coding and the administration of claim payment policy as billing disputes.

Examples of billing disputes include:

- bundling logic (integral, incidental, mutually exclusive claim edits);
- modifier consideration and application;
- claims adjudication settlement not consistent with the law or the terms of the Provider's contract;
- improper administration of an Independence claim payment policy;
- claim coding (i.e., how we processed the codes in the claim vs. the Provider's use of the codes);
- unlisted/not otherwise classified (NOC) service pricing determination.

The Provider billing dispute process does *not* apply to:

- utilization management determinations (e.g., claims for services considered not Medically Necessary, experimental/investigational, cosmetic);
- Preapproval/Precertification/authorization/Referral requirements;
- benefit/eligibility determinations (e.g., claims for noncovered services);
- audit and investigations performed by the Corporate and Financial Investigations Department (CFID);
- fee schedule concerns.

Submission of billing disputes

To facilitate a first- or second-level billing dispute review, submit inquiries to:

Provider Billing Disputes
P.O. Box 7930
Philadelphia, PA 19101-7930

All first-level billing disputes must be filed within 180 days of receiving the Provider Explanation of Benefits (EOB) and should contain a letter explaining the dispute, including the Member's name, identification number, claim number(s), and date(s) of service under dispute. Independence will process first-level disputes within 30 days of receipt of all necessary information. If the determination is to pay the claim, a claim adjustment will be processed, and a new Provider EOB will be sent. If the determination remains denied, a determination letter will be sent to the Provider.

If a Provider disputes the first-level Provider billing dispute determination, he or she may then submit a second-level Provider billing dispute by sending a written request within 60 days of receipt of the decision of the first-level Provider billing dispute. The dispute will be reviewed by an internal Provider Appeals Review Board (PARB) consisting of three members, including at least one Medical Director, a Senior Director of Claim Payment Policy, and a Director of Clinical Services. The decision will then be communicated to the Provider and will include a detailed explanation. The decision of the PARB will be the final decision of Independence.

Provider grievance process

Independence offers a one-level post-service grievance process for professional Providers. For services provided to any Independence commercial or Medicare Advantage Member, Providers may appeal claim denials for Medical Necessity, experimental/investigational, or cosmetic reasons, as a Provider grievance.

The Provider grievance process does *not* apply to:

- lack of Preapproval/Precertification/authorization/Referral;
- benefit/eligibility determinations (e.g., claims for noncovered services);
- audit and investigations performed by the CFID;
- fee schedule concerns;
- billing disputes.

Requests that are unrelated to a medical necessity, experimental/investigational, or cosmetic claim denial will not be processed as a Provider grievance.

Submission of Provider grievances

To facilitate a grievance review, submit to:

Provider Grievances
P.O. Box 7930
Philadelphia, PA 19101-7930

Please ensure that all applicable medical records, notes, and tests are submitted along with a cover letter explaining the grievance. All grievances must be filed within 180 days of receiving the Provider EOB. All grievances will be processed within 60 days of receipt of all necessary information. A preliminary review will be conducted. If the determination is to pay the claim, a claim adjustment will be processed, and a determination letter will be sent to the Provider. All other grievances will be sent to an Independent Review Organization (IRO) for a matched specialty review. A determination letter will be sent to the Provider containing the IRO decision and detailed explanation. The decision of the IRO is final.

If a Member grievance, or Provider filing on behalf of the Member grievance, is filed before or during an open Provider grievance for the same issue, the Provider grievance will be closed and addressed under the Member grievance. Future Provider grievances for the same issue are ineligible for servicing as a Provider grievance.

Other Provider claims review requests

For claims issues excluded from Provider billing dispute or grievance processes, such as a request for additional payment or question on reimbursement amount, please refer to the Billing section, Provider Claims Inquiry, for procedures on requesting a claims review.

ER service appeals

ER claims that do not meet Independence's criteria for an Emergency are automatically processed at the lowest ER payment rate in the fee schedule or as otherwise provided in the Agreement. To appeal an ER determination, complete an Emergency Room Review Form (available at *www.ibx.com/providerforms*), attach the Member's medical record, and submit to:

Claims Medical Review – Emergency Room Review
Independence Blue Cross
1901 Market Street
Philadelphia, PA 19103-1480