Chapter 4

Health Care Management

Unit 4: Denials, *Grievances and* Appeals

In This Unit

4.4 Filing A *Grievance On The Member's Behalf (Act 68)*

Overview

Any Highmark Blue Shield or western region network member has the right to file a grievance or a complaint, as applicable if they are not satisfied with decisions made by Highmark Blue Shield or the western region network regarding medical necessity issues.

What Region Am I?

This process applies to the following Highmark products:

- *Western Region HMO*
- *Western Region POS*
- *adultbasic*
- *CHIP*
- *Central Region PPO*

Denial Decisions

The decision to deny a service, admission or item on the basis of medical necessity is one that can only be made by a physician reviewer.

Definition Of A Member *Grievance /Appeal*

A process by which a member or member's authorized representative (or provider on behalf of member) with the written consent of the member may file a written grievance regarding the denial of payment of a health care service on the basis of medical necessity and appropriateness. A grievance may be filed regarding a decision that:

1. *disapproves full or partial payment for a requested health care service*
2. *approves the provision of a requested health care service for a lesser scope or duration than requested or*
3. *disapproves payment for the provision of a requested health care service but approves payment for the provision of an alternative health care service.*

Provider-Initiated *Grievances* On The Member's Behalf

The grievance must be submitted in writing with supporting documentation regarding the request. A Designation of an Authorized Representative form, that can be found on the Provider Resource Center under the Provider Forms selection, must be completed (including page 3) and include, but not be limited to:

- *the member's name*
- *the member's address*
- *member's identification number*
- *if the member is a minor or legally incompetent, the name, address and relationship to the member of the person who consents for the member;*
- *the name, address and identification number of the provider to whom the member is granting consent;*
- *the name and address of the plan to whom the member is providing consent;*
- *an explanation of the specific service for which coverage was provided and/or denied to which the consent applies.*

4.4 Filing A *Grievance On The Member's Behalf (Act 68),*
Continued

Provider-Initiated *Grievances* On The Member's Behalf, *continued*

The member may not submit a grievance concerning the services listed in the consent form without rescinding the consent in writing. The member may rescind consent at anytime during the process.

The provider, having obtained consent from the member or the member's legal representative to file a grievance, shall have 10 days from receipt of the standard written UR denial and any decision letter from a first, second or external review upholding the plan's decision to notify the enrollee or the enrollee's legal representative of its intention not to pursue a grievance.

The grievance must be filed within one hundred and eighty (180) days from the denial to:

What Region Am I?

In the Western Region: *Member Grievance and Appeals Department*
P.O. Box 2717
Pittsburgh, PA 15230-2717

In the Central Region: *Highmark Blue Shield*
P.O. Box 890174
Camp Hill, PA 17089-0174

**For member appeals and reconsiderations for the Federal Employees Program, please contact FEP Customer Service at 1-866-763-3608.

An acknowledgement letter will be sent to you and to the member within five (5) business days from receipt of the grievance request.

The acknowledgement letter will include the following information:

- *The plan considers the matter to be a grievance rather than a complaint. The enrollee, enrollee's representative, or provider on behalf of member may question the classification of complaints and grievances by contacting the Pennsylvania Department of Health*
- *That the enrollee may appoint a representative to act on the member's behalf at any time during the internal grievance process.*
- *That the enrollee, enrollee's representative, or the provider on behalf of member may review information related to the grievance upon request and submit additional material to be considered by the plan.*
- *That the enrollee or the enrollee's representative may request the aid of a plan employee who has not participated in the utilization management decision to assist in preparing the enrollee's first level grievance.)*

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4.4 Filing A *Grievance On The Member's Behalf (Act 68),*
Continued

Grievance Review Process, – *First Level*

The First Level Grievance Committee will consist of a practitioner in the same or similar specialty that typically treats the medical condition, performs the procedure or provides the treatment. The physician will not be an individual who was involved in any previous adverse benefit determination regarding the grievance or a subordinate of any individual involved. You and the member will be notified of the decision within thirty (30) days from receipt of the grievance request. The decision letter will contain a statement of the issue under review, the basis for the decision, the specific reasons for the decision, the scientific and clinical rational for making the decision applying the terms of the plan to the enrollee's medical circumstances, specific references to the plan provisions on which the decision is based or instructions on how to obtain the specific plan provisions, and an explanation of how to file a request for a second level review of the decision and the time frames for requesting a second level review.

It is not necessary for written consent for each level of the grievance process. The second level grievance request must be submitted within forty-five (45) days from receipt of the first level grievance decision. Upon the plan's receipt of a second level grievance review request, an acknowledgement letter will be sent to the enrollee, enrollee's representative, and the provider, if the provider filed the grievance on behalf of the member. The acknowledgement letter will include an explanation of the procedures to be followed during the second level review, including, how the enrollee or the enrollee's representative may request the aid of a plan employee at no charge, who has not participated in previous decisions to deny coverage for the issue in dispute, in preparing the enrollee's second level grievance; the enrollee, enrollee's representative, and provider if the provider filed the appeal on the enrollee's behalf, have the right to appear before the second level review committee and that the plan will provide the enrollee and the enrollee's representative, and the provider with 15 days advance written notice of the time scheduled for the review. A hearing notification will be sent to you and the member at least fifteen (15) days prior to the hearing explaining that you and/or the member may attend the hearing or participate via phone.

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4.4 Filing A *Grievance On The Member's Behalf (Act 68),*
Continued

Grievance Review Process – *Second Level*

The second level grievance committee will consist of a director/manager of customer service, a customer service supervisor and a medical director who will interpret the written report prepared by the practitioner of the same or similar specialty, who typically treats the medical condition, performs the procedure, or provides the treatment, for consideration by the Committee. You and the member will be notified of the decision within thirty (30) days from receipt of the grievance request.

The decision letter will include the basis for the decision and the procedures and timeframes for the enrollee, enrollee's representative, or the provider on behalf of enrollee to file a request for an external grievance review, a statement of the issue reviewed by the second level review committee, the specific reasons for the decision, references to the specific plan provisions on which the decision is based, instructions on how to obtain the internal rule, guideline, protocol, or criterion used to make the decision, an explanation of the scientific or clinical rationale for the decision, applying the terms of the plan to the enrollee's medical circumstances.

Grievance Review Process – *Third Level*

Third level requests must be submitted to the plan within fifteen (15) days from receipt of the second level grievance decision. Within 5 business days of receiving the external grievance request from the enrollee or the provider on behalf of the member, the plan will notify the Pennsylvania Department of Health (DOH) and request an assignment of an IRO. The plan, within 15 days of request for an external review, forward the case file to the assigned IRO. If the external grievance is being requested by a provider, the plan and the provider must each establish escrow accounts in the amount of half the anticipated cost of the review. The PA Department of Health will randomly select an IRO to review the case and will notify the enrollee, enrollee's representative, and provider on behalf of member of assigned IRO. The plan, within 15 days of the request, will forward the case file to the IRO. The Plan will send the provider or enrollee a listing of all documents forwarded to the IRO.

Additional information must be submitted within fifteen (15) days of receipt of the notice that the external grievance was filed. The IRO will assign a practitioner in the same or similar specialty, who treats the medical condition, performs the procedure, or provides the treatment and who was not involved in the previous decisions. Highmark will implement the IRO's decision within the time frame specified by the IRO.

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4.4 Filing A *Grievance On The Member's Behalf (Act 68),* Continued

Grievance Review Process – *Third Level,* *continued*	*If the IRO's decision in an external grievance review filed by a provider is against the provider in full, the provider shall pay the fees and costs associated with the external grievance. If the IRO's decision is against the plan in full or in part, the plan will pay the fees and costs associated with the external grievance review. The assigned IRO will review and issue a written decision within 60 days of the filing of the request for an external grievance review. The decision will be sent to the enrollee, the enrollee's representative, the provider, the plan, and the DOH.*

4.4 Filing An *Expedited Grievance On The Member's Behalf (Act 68)*

An Expedited Grievance

A request for an expedited review of an initial adverse benefit determination for medical, pharmaceutical, or behavioral health services based on medical necessity and appropriateness when; 1) a delay in decision making might jeopardize the member's life, health or ability to regain maximum functions based on a prudent layperson's judgment and confirmed by the treating practitioner; or 2) in the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request; 3) concerning the admission, continued stay or other health care services for a member who has received emergency services, but has not been discharged from a facility; or 4) concerning a concurrent review.

Requests from providers may be received either verbally or in a written format. Provider requests will be accepted as expedited requests, however if a member submits the same type of request Highmark requires the provider to submit a Physician Certification Form. The form will be sent directly to the member's requesting provider and should be returned to Highmark immediately.

Expedited appeals will follow the second level review process with verbal and written notification of the decision to you and the member within 48 hours from receipt of the request. The hearing may be held telephonically if the enrollee and/or provider on behalf of enrollee cannot be present in the short time frame. All information presented at the hearing is read into the record. If the plan cannot provide a copy of the report of the same or similar specialist to the enrollee/provider prior to the expedited hearing, the plan may read the report into the record at the hearing, and shall provide the member/provider with a copy of the report at that time. It is the responsibility of the enrollee, enrollee's representative, or the provider to provide information to the plan in an expedited manner to allow the plan to conform to the requirements of this section.

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4.4 Filing An *Expedited Grievance On The Member's Behalf (Act 68)*, Continued

An Expedited Grievance, *continued*	*The written decision to the enrollee, enrollee's representative, or provider on behalf of member will state the basis for the decision, including any clinical rationale, and the procedure for obtaining an expedited external review. The enrollee, enrollee's representative, or provider on behalf of member has 2 business days from the receipt of the expedited grievance decision to request an expedited external review. If the Independent Review Organization's (IRO's) decision in an external grievance review filed by a health care provider is against the health care provider in full, the health care provider shall pay the fees and costs associated with the external grievance. If the IRO's decision is against the plan in full or in part, the plan will pay the fees and costs associated with the external grievance review. For expedited external review requests, the plan will submit a request for an expedited external review to the DOH within 24 hours of the receipt of the request. The DOH will assign an IRO within 1 business day of receiving the request for an expedited review. The IRO will have 2 business days following the receipt of the case file to make a decision.*
Services That Are Potentially Cosmetic Or Experimental/ Investigational	A Highmark Blue Shield physician *of the same or similar specialty as the request or who was not previously involved in the denial,* evaluates the medical necessity and appropriateness of services that may potentially be cosmetic or experimental/investigational. If the review indicates that medical necessity or appropriateness does not exist for the service, an experimental/investigational/cosmetic denial will be issued. *The Act 68 appeal process for services that are potentially cosmetic or experimental/investigational are the same. Please review the above language for appeal information related to these services.*

4.4 Filing An Appeal On The Member's Behalf

Overview

Any Highmark Blue Shield member has the right to appeal if they are not satisfied with decisions made by Highmark Blue Shield regarding the coverage of service(s). There are specific regulations in place for handling member appeals.

This process applies to the following Highmark products:

- *Indemnity Products*
- *PPOBlue*
- *EPOBlue*

Definition Of A Member Appeal

A request from a member or member's authorized representative to review an adverse benefit determination. This includes services related to coverage, which includes contract exclusions, non-covered benefits and decisions related to the medical necessity and/or appropriateness of a health care service. This also includes full or partial adverse benefit determinations involving a requested health care service or claim.

Provider-Initiated Appeals On The Member's Behalf

The appeal must be submitted in writing with supporting documentation regarding the request. A Designation of an Authorized Representative form, which can be found on the Provider Resource Center under Provider Forms in the Miscellaneous Forms category or by clicking on the link above must be completed and include:

- *the member's name*
- *the member's address*
- *member's identification number*
- *if the member is a minor or legally incompetent, the name, address and relationship to the member of the person who consents for the member;*
- *the name, address and identification number of the provider to whom the member is granting consent;*
- *the name and address of the plan to whom the member is providing consent;*
- *an explanation of the specific service for which coverage was provided and/or denied to which the consent applies.*

The member may not submit an appeal concerning the services listed in the consent form without rescinding the consent in writing. The member may rescind consent at anytime during the process.

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4.4 Filing An Appeal On The Member's Behalf, Continued

Provider-Initiated Appeals On The Member's Behalf, *continued*

The appeal must be filed within one hundred and eighty (180) days from the denial to:

What Region Am I?

In the Western Region: *Member Grievance and Appeals*
Attention: Review Committee
P.O. Box 535095
Pittsburgh, PA 15253-5095

In the Central Region: *Highmark Blue Shield*
Attention: Review Committee
P.O. Box 890178-0178

***For member appeals and reconsiderations for the Federal Employees Program, please contact FEP Customer Service at 1-866-763-3608.*

An acknowledgement letter will be sent to you and to the member within five (5) business days from receipt of the appeal request.

Any appeals related to medical necessity issues are reviewed by a licensed practitioner in the same or similar specialty that typically treats the medical condition, performs the procedure or provides the treatment of the service being appeals. The practitioner will not have been involved in any previous decision to deny coverage or the subordinate of any individual that was involved in the adverse determination. Appeals related to benefit issues will be reviewed by an Appeals Administrator who was not involved in the initial determination.

For pre and post service appeals, you and the member will be notified of the decision in writing within thirty (30) days from receipt of the request.

Urgent Appeals

A request for an urgent review of a previous adverse benefit determination for medical, pharmaceutical, or behavioral health services based on medical necessity and appropriateness, filed by a member, member's authorized representative or a provider with the members written consent, when: 1) a delay in decision making might jeopardize the member's life, health, or ability to regain maximum function or when supported by a physician with knowledge of the claimants medical condition; 2) concerning the admission, continued stay or other health care services for a member who has received emergency services, but has not been discharged from a facility; or 3) concerning a concurrent review.

Verbal and written notification will be made to you and the member within seventy-two (72) hours from receipt of the request.

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4.4 Filing An Appeal On The Member's Behalf, Continued

Urgent Appeals, *continued*

Requests from providers may be received either verbally or in a written format. Provider requests will be accepted as expedited requests, however if a member submits the same type of request Highmark requires the provider to submit a Physician Certification Form. The form will be sent directly to the member's requesting provider and should be returned to Highmark immediately.

4.4 Provider *Appeals*

Types of Provider Appeals

There are two types of provider appeals to be used under differing circumstances:

*An **expedited** appeal is used when a member is receiving an ongoing service or is scheduled to receive a service for which coverage has been denied and the seriousness of the circumstances require that the appeal be reviewed quickly because the physician believes that the lack of service will adversely affect the member's health. This process may be used when any of the following circumstances exist:*

- *A delay in decision making might jeopardize the member's life, health or ability to regain maximum functions based on a prudent layperson's judgment and confirmed by the treating practitioner; or*
- *In the opinion of the practitioner with knowledge of the member's medical condition would subject the member to sever pain that cannot be adequately managed without the care or treatment that is the subject of the request.*
- *Concerning the admission, continued stay or other health care services for a member who has received emergency services, but has not been discharged from a facility; or*
- *Concerning a concurrent review.*

- *A **standard appeal** is used under all other circumstances, including denials resulting from retrospective reviews of services rendered without the required authorization.*

Explicit directions for filing appeals appear in the written denial notification, which is sent to the member or the member's representative, the physician and the facility, when appropriate. This process involves a telephonic or written request initiated by the provider to review a determination that denied payment of a health care service. A clinical peer reviewer who was not involved in the original denial must conduct the review.

Length Of Time To Request An Appeal

A provider has 180 days from the date of the initial denial of coverage in which to file the appeal.

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4.4 Provider Appeals, Continued

Peer-To-Peer Review

Peer-to-peer contact is a process that offers the member's attending physician the opportunity to present additional pertinent clinical information to support the authorization of a requested service *prior to initiating a formal appeal*. It is provided when a medical necessity denial has been rendered without a peer-to-peer conversation about the request or when additional information has become available. The physician who made the initial denial decision, or a designee, will be available within one Highmark Blue Shield business day to discuss the determination with the requesting physician. To request a Peer-to-Peer contact, call 1-866-634-6468.

Requirements In Processing *Appeals*

Highmark Blue Shield's process for reviewing *appeals* follows all applicable accreditation requirements. These include the following components:

- Review by a clinical peer reviewer who is board certified and holds an unrestricted license and is in the same or similar specialty that typically manages the medical condition, procedure or treatment under review.
- *Are neither the individual who made the original denial decision, nor the subordinate of such an individual*
- Review of the *appeal* within timeframes established by the applicable regulations and standards
- Verbal (as applicable) and written communication of the decision within timeframes established by the applicable regulations and standards.

Responsibility For Medical Treatment And Decisions

Under all circumstances, the member and the physician bear ultimate responsibility for the medical treatment and the decisions made regarding medical care.

Providers and Highmark Blue Shield employees involved in utilization management decisions are not compensated for denying coverage, nor are there any financial incentives to encourage denials of coverage.

4.4 The Expedited Provider *Appeal* Process

Steps To Request An Expedited *Appeal* For A Highmark Member

What Region Am I?

Step	Action
1	Call HMS. In the Central, Eastern and Northeastern Regions call 1-866-731-8080. In the Western Region call 1-800-547-3627, option *2* For Western Region Medicare Advantage HMO, call 1-800-485-9610.
2	An HMS care or case manager will inform the practitioner if additional information is necessary for review. The practitioner gathers the information and forwards it to the HMS care or case manager.
3	A clinical peer reviewer who was not involved in the original decision reviews the case and renders a decision to uphold or reverse the original denial.
4	The appropriate parties will be notified of the determination by telephone. The *written* notification will include, but not be limited to, the following information: • The reason/clinical rationale for the adverse determination. • The source of the screening criteria used to make the determination, if applicable. • The right to file a standard *appeal (except Medicare Advantage).* • The procedure to initiate a standard *appeal.* *Note: This does not apply to provider appeals.*
5	Within one working day of the decision (not to exceed 72 hours of receipt of the *appeal* request), a letter containing the information in step 4 will be sent to the: • *Appealing physician/provider* • Member, member's representative, *if applicable* • Primary care physician and/or specialist • Facility or ancillary provider, if appropriate

4.4 The Standard *Appeal* Process

Steps To Request A Standard *Appeal* For A Highmark Member

Step	Action
1	**In the Western Region, mail information to:** What Region Am I? **Prospective/Concurrent Appeals** Healthcare Management Services 120 Fifth Avenue Place Suite P4301 Pittsburgh, PA 15222 **Retrospective Appeals** Highmark Medical Review P.O. Box 890392 Camp Hill, PA 17089-0392 In all other Western Region cases, call: 1-800-547-3627, Option *2* **In the Central, Eastern and Northeastern Regions mail information to:** Highmark Blue Shield P.O.Box 890035 Camp Hill, PA 17089-0035 Attention: Appeals In all other Central, Eastern and Northeastern Region cases, call 1-866-731-8080.
2	HMS care or case manager communicates any additional information necessary *to conduct the* review. The provider gathers the information and forwards it to the HMS care or case manager.
3	*Within 30 calendar days of receipt of all pertinent information,* a clinical peer reviewer who was not involved in the original decision reviews the case and communicates the decision to the care or case manager by telephone.
4	HMS sends written notification of the decision to the: • Appealing physician or provider • Primary care physician, if appropriate • Facility, if appropriate • Member, member's representative
5	The communication includes: • The decision on the case • Principal reasons and clinical rationale • If applicable, a description of the source of screening criteria used to make the decision.