Unit 9 Denials and Appeals

Two types of denials

Hospitals treating Highmark Blue Shield members can experience two types of denials:

- **Benefit denials**, issued when the member's benefit program does not provide the specific benefit needed for a particular admission or service.
- **Medical necessity denials,** issued when the requested admission or service does not meet medical necessity criteria.

Always check member benefits

It is very important for facilities to verify whether the member's benefit program provides the specific benefits required for the service he or she plans to receive. This information is available via the NaviNet Eligibility and Benefits function.

If for any reason NaviNet is unavailable, eligibility and benefits information can be obtained through a number of electronic means, or by contacting Facility Customer Service at (866) 803-3708, option 4, during the hours of 8:00 a.m. to 4:30 p.m., Monday through Friday. ***For information on electronic means of accessing eligibility and benefits data, please see Appendix A.***

Medical Necessity Denial decisions

The decision to deny a service or admission on the basis of medical necessity can only be made by a Highmark Physician Advisor. The decision not to authorize an admission or a service because the benefit is not available can often be determined by a Case Manager.

Appeal of benefit denials

Providers, including facilities, cannot appeal benefit denials **unless** the denial is also based on the determination that the requested service is not medically necessary or appropriate.

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Services potentially cosmetic or experimental/ investigational

A Highmark Blue Shield physician evaluates for medical necessity all determinations related to services, which may potentially be cosmetic or experimental/investigational. If review indicates that a treatment/service is cosmetic or experimental/investigational, a denial decision will be issued. Facilities have the opportunity to appeal all denials related to cosmetic or experimental/investigational services.

When a medical necessity denial has been issued: the physician's right to peer-to-peer discussion

The **Peer-to-Peer discussion** process offers the member's **PCP or attending physician** the opportunity to present additional pertinent clinical information to support authorization of a requested service. 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 initiate a Peer-to-Peer discussion, please contact #(866)-634-6468.

Facility Expedited or Standard Appeals

Facilities have the right to request an **Expedited Appeal** or a **Standard Appeal** of a medical necessity denial or a denial of a cosmetic or experimental/investigational nature.

Expedited Appeals

An **Expedited Appeal** is a request for review of a decision not to authorize an imminent or ongoing service. The request can be initiated by contacting Healthcare Management Services at the telephone number specified in the denial letter. **Because a very short turn-around time applies to these cases, it is imperative that all substantiating materials be supplied to Healthcare Management Services as promptly as possible.**

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Standard Appeal

A Standard Appeal is a request for review of a denial that has been upheld under the Expedited Appeal process or for cases that did not meet the qualifications for an Expedited Appeal. The Standard Appeal process is also used for Retrospective Review of admissions or services rendered without the required pre-certification or authorization.

Explicit directions for filing a standard appeal appear in the denial notification, which is communicated to the member, the physician and the facility. Hospitals filing a standard appeal should send all relevant information to the address specified in the denial letter.

Highmark Blue Shield's requirements in processing appeals

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

- Review by a Clinical Peer Reviewer or Physician Advisor who was not involved in the original denial decision
- Review by a Clinical Peer Reviewer or Physician Advisor 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
- Review of the appeal within timeframes established by all applicable regulations and standards
- Verbal (as applicable) and written communication of the decision within timeframes established by applicable regulations and standards
- To request an appeal please call 1-800-421-4744.