

Chapter 5

Appeals

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Member Appeals and Grievances

Member appeals and grievances for MedicareBlue PPO follow procedures established by the Centers for Medicare & Medicaid Services (CMS).

Member rights and instructions for filing a grievance or an appeal are published in the member contract in the Evidence of Coverage section. Members can also request information about filing a grievance or an appeal by calling Member Services.

Organizational Determinations

An *organizational determination* is any determination (that is, an approval or denial) that MedicareBlue PPO makes for a member regarding:

- Payment for any health care services furnished by a provider that the member believes are covered under Medicare or should have been furnished, arranged for, or reimbursed by MedicareBlue PPO.
- Refusal to prior authorize, provide, or pay for services, in whole or in part, including the type or level of services that a member believes should be furnished or arranged for by MedicareBlue PPO.
- Discontinuation of a service that a member believes to be medically necessary.
- Failure of MedicareBlue PPO to approve, furnish, arrange, or provide payment for health care services in a timely manner, and/or to provide the member with timely notice of adverse determination, such that a delay would adversely affect the health of the member.

Once an organizational determination has been made, the appeals process may be enacted if a member believes that the decision is unfavorable. In the presence of any adverse organization determination, MedicareBlue PPO sends the member a written denial notice that includes appeal rights.

If a member disputes an organizational determination, MedicareBlue PPO follows the procedures outlined in this section.

If a member complains about any other aspect of MedicareBlue PPO (e.g., the manner in which care was provided), the Grievance Procedure will apply. Generally, MedicareBlue PPO will consider complaints about quality of care as a grievance, but such complaints may also be received and acted upon by a quality improvement organization (QIO).

Standard Organizational Determinations

When a member requests a review, MedicareBlue PPO notifies the member of its determination as expeditiously as the member's health condition requires, but no later than 14 calendar days after the date MedicareBlue PPO receives the request for a standard organizational determination. MedicareBlue PPO may extend the time frame up to an additional 14 days if the member requests the extension, or if MedicareBlue PPO justifies and documents the need for additional information. MedicareBlue PPO notifies the member in writing of its decision to extend the time frame, and informs the member of the right to file a grievance if he or she disagrees with the extension.

If MedicareBlue PPO fails to provide the member with a timely notice of an adverse determination, this failure constitutes an adverse organizational determination and may be appealed.

Expedited Organization Determinations

A member of MedicareBlue PPO or any physician may request that MedicareBlue PPO expedite an organizational determination when the member or his/her physician believes that waiting for a decision could place the member's life, health, or ability to regain maximum function in jeopardy.

Expedited determinations may not be requested for cases in which the only issue involves a claim for payment for services that the member has already received. However, if the case includes both a payment denial and a pre-service denial, the member has a right to request an expedited appeal for the pre-service denial.

MedicareBlue PPO will evaluate a request for an expedited determination and decide within 24 hours whether the request will be expedited. If the member's physician initiated the request for an expedited determination, or if the member initiated the request for an expedited determination with the support of their physician, MedicareBlue PPO automatically will expedite the determination.

If MedicareBlue PPO denies a request for an expedited determination, MedicareBlue PPO will provide verbal notice of the denial within 24 hours, with a written notice to follow within two working days. MedicareBlue PPO may take an additional 14 calendar days if the member requests the extension, or if the extension is to the member's benefit. The notice will state that the request will be processed using the timeframe for standard determinations, and that the member has the right to resubmit the request for an expedited determination or file with Member Services an expedited grievance regarding this decision. The notice also will provide instructions on how to file a grievance.

Notification of Adverse Determination by Provider

When a member disagrees with a provider's decision about a service or course of treatment, the provider must notify the member of his or her right to receive a detailed written notice regarding the member's services from MedicareBlue PPO. The provider's notification must include information about how to contact MedicareBlue PPO.

Notification of Adverse Determination by MedicareBlue PPO

When a member asks MedicareBlue PPO to provide a detailed notice of a provider's decision to deny a service in whole or in part, or if MedicareBlue PPO decides to deny in whole or in part services or payment, MedicareBlue PPO must supply the member with a written notice of this determination. This notice must include:

- The specific reason for the denial taking into account the member's presenting medical condition, disabilities, and special language requirements, if any.
- Information regarding the member's right to a standard or expedited determination and the right to appoint a representative to file an appeal on the member's behalf.
- For service denials: a description of both the standard and expedited reconsideration process and time frames, including conditions for obtaining an expedited reconsideration, and the other elements of the appeal process.
- For payment denials: a description of the standard reconsideration process and time frames, and the rest of the appeals process.
- The member's right to submit additional evidence in writing or in person.

Appeal Process

Veridign reconsideration and appeals procedures for MedicareBlue PPO members are consistent with the Centers for Medicare & Medicaid Services (CMS) guidelines. These guidelines ensure that members receive a fair and comprehensive reconsideration of decisions made regarding their health care benefits.

A MedicareBlue PPO member has the right to appeal a denial if he or she believes that the requested service would be Medicare-covered. On behalf of each plan, Veridign has procedures to manage the review of adverse organizational determinations of the health care services a member believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the member), or any amounts the member must pay for services.

The Appeals Procedure applies to:

1. Denial of payment for services the member believes emergency or urgent
2. Refusal by the plan or a network provider to render services the member believes should be furnished, arranged, or paid by the plan
3. Refusal by the plan to pay for any basic benefit for any reason, including medical necessity
4. Termination of the coverage of services by the plan
5. Refusal by a supplier or contracted agent of the plan to deliver services included in the benefit plan

MedicareBlue PPO supports five levels of appeals available to members after an adverse organizational determination has been made. These levels are followed sequentially when the original denial continues to be upheld at each level by the reviewing entity.

Submitting a Request for Reconsideration

Dissatisfied members are instructed to submit an appeal in writing or orally to Member Services within 60 days after the initial determination notice. The member may also file an appeal if she or he believes MedicareBlue PPO neglected to furnish him or her with a written initial organizational determination.

Others May Assist with Members

Members may choose to file their appeals by themselves or with the assistance of a provider or an authorized representative. A provider who is treating the member does not need to be appointed as an authorized representative to request an appeal on behalf of a member. The provider may make the request orally or in writing.

If a provider requests an expedited reconsideration, MedicareBlue PPO expedites the appeal per this policy. Members may also file their appeals with the Social Security office, or for Railroad Retirement Board annuitants, with the Railroad Retirement office. Such appeals are forwarded to MedicareBlue PPO.

All appeals must be received by MedicareBlue PPO within 60 calendar days of an adverse organizational determination or of the event that led to the appeal.

Timeframe Extensions

The initial 60 calendar-day time frame for filing may be extended for good cause.

Opportunity to Present Evidence

All parties are provided a reasonable opportunity to present evidence and allegations of fact or law related to the issue in dispute. All evidence is taken into account when making a decision.

Upon the member's request, Veridign provides the member with a copy of the contents of the case file, including, but not limited to:

- A copy of supporting medical records
- All other pertinent information used to support the decision

Every reasonable effort to accommodate a member's request for case file material will be made.

Appropriate Expertise

Person(s) not involved in the initial decision make reconsideration decisions. All reconsiderations of adverse organizational determinations based on "lack of medical necessity" are made by a physician with appropriate expertise in the field of medicine for the services at issue.

The physician is usually of the same specialty or subspecialty as the treating physician. In all instances, the physician will possess the appropriate level of training and expertise to evaluate the necessity of the service.

Review

The member, provider or another authorized representative may present or submit relevant facts and/or additional evidence for review either verbally or in writing.

Standard pre-service appeal reviews are completed within 30 calendar days of receipt. Post-service appeal reviews are completed within 60 calendar days of receipt.

If the decision is not made completely in the member's favor, the member is notified in writing that the appeals decision was to uphold the denial and the case is forwarded to the CMS Independent Review Entity (IRE).

Level 1: Expedited Appeals

A member or provider may request an expedited appeal in situations where applying the standard procedure could seriously jeopardize the member's life, health, or ability to regain maximum function, including cases in which MedicareBlue PPO makes a less than fully favorable decision to the member.

A provider does not need to be an authorized representative to request an expedited reconsideration on behalf of a member. The physician may make the request orally or in writing. MedicareBlue PPO provides an expedited determination when the physician indicates the member's life, health or ability to regain maximum function could be in jeopardy.

Note: A request for payment of a service already provided to a member *is not* eligible for review as an expedited appeal.

MedicareBlue PPO determines if the standard appeal timeframe for the review of the reconsideration for coverage of a service could seriously jeopardize the life and health of the member or the member's ability to regain maximum functioning.

- Approved requests for expedited appeals are communicated as quickly as the member's health condition requires, but no later than 72 hours after receiving the request. If the request is made or supported by a physician, the expedited reconsideration is granted at the time the physician indicates it is required for the life, health or maximum function of the member. An extension can be granted if the member requests such extension or if MedicareBlue PPO can justify the need for additional information to make an appropriate determination. If the decision is made completely in the member's favor, the member is immediately notified verbally and in writing. The 72-hour timeframe may be extended by up to 14 calendar days upon member request.
- Denied requests for expedited appeals are automatically transferred to the standard reconsideration process and the determination is made as quickly as the member's health condition requires, and within 30 calendar days from the date the request is received. Oral notice of the denial of the request is provided within 3 calendar days of oral notification, followed by a written letter that:
 - Explains the transfer to the standard reconsideration, within 30 days
 - Informs the member of the right to file an expedited grievance if he or she disagrees with the decision to not expedite the appeal
 - Informs the member of the right to file a grievance and provides instructions about the process and timeframes
 - Informs the member of the right to resubmit a request for an expedited appeal with physician's support or if clinical circumstances change

Level 2: Independent Review Entity (IRE) Appeals

Requests for reconsideration are sent to the Independent Review Entity (IRE) for a determination when MedicareBlue PPO has upheld its initial adverse organizational determination in whole or in part.

When submitting a request for review, include a CD with a complete version of the Evidence of Coverage or formulary relevant to the case. Failure to include this information could result in decisions not based on the merits of the case or CMS declining to refer a case for further review.

Follow these instructions when submitting a CD:

- The CD must be properly labeled with the plan name and contract number, formulary ID, enrollee name and HICN.
- The CD must be securely affixed to the paper case file.
- The documents on the CD must be in PDF format and should not be encrypted.
- The CD should include only the documents that are applicable to the specific case.
- Do not include the Evidence of Coverage for Part C cases that are being forwarded to the IRE for dismissal.
- Information should not be mailed, emailed or faxed.

The member is notified that the case has been forwarded to the IRE. The IRE notifies the member in writing of their decision and the reasons for the decision.

- If the IRE upholds MedicareBlue PPO's decision, its notice informs the member of his or her right to a hearing before a Social Security Administration Administrative Law Judge (ALJ).
- If the IRE (or a higher appeal level) decides in the member's favor, MedicareBlue PPO must pay for, provide or authorize the service as quickly as the member's health condition requires, but no later than 14 calendar days from the date MedicareBlue PPO receives notice that the IRE reversed the determination. If it is not appropriate for MedicareBlue PPO to provide the services within 14 calendar days (e.g., because of the member's medical condition or the member is outside of the service area), MedicareBlue PPO authorizes the services within 72 hours from the date it receives notice that the IRE reversed the determination.

When the IRE completes its reconsideration determination, it notifies all parties in understandable language and in a culturally competent manner taking into account the member's presenting medical conditions, disabilities, and special language requirements, if any. The IRE notification must include:

- Specific reasons for its decisions
- The right to an ALJ hearing if the amount in controversy is \$110 or more
- Whether the decision is adverse or does not completely reverse the Plan's previous decision
- A description of procedures that the parties must follow to obtain an ALJ hearing

The IRE determination is final and binding unless an appropriate party requests an ALJ hearing or the case is revised. MedicareBlue PPO does not have the right to request an ALJ hearing.

Level 3: ALJ Appeal

If the amount in controversy is \$110 or greater, the member may further appeal the case by requesting a hearing with an ALJ. To request a hearing, the member must notify the IRE in writing within 60 calendar days of the date of the IRE's letter.

The IRE forwards the case to an ALJ who determines if the amount in controversy is \$110 or greater. Each Plan and Veridign will cooperate with the ALJ to compute the amount in controversy.

The member may combine claims to meet the \$110 limitation, when the following requirements are met:

- Claims belong to the same member
- Claims have each received a determination through the IRE reconsideration process
- 60 calendar-day filing time limit is met for all claims involved
- Hearing request identifies all claims

If the member requests an ALJ hearing, the member's request is forwarded immediately to the IRE. The IRE compiles the reconsideration file and forwards it to the appropriate ALJ hearing office. MedicareBlue PPO will be a party to the ALJ hearing, but cannot initiate a hearing. The ALJ advises all parties in writing of the final ruling.

Level 4: Medicare Appeals Council (MAC)

Any party may request a review of the case from the Medicare Appeals Council (MAC) after the ALJ's ruling. The request must be made in writing within 60 calendar days of the ruling. If a plan requests a MAC review, MedicareBlue PPO sends a copy of the request and accompanying documentation to the member.

The MAC may grant or deny the request for review. If the MAC grants the request, it may either issue a final decision or dismissal, or remand the case to the ALJ with instructions on how to proceed with the case.

The MAC may also initiate a review within 60 days after the date of an ALJ hearing decision or dismissal. If the MAC initiates a review, it mails notice of this action to all parties at their last address of records. The MAC reviews a case under any of the following circumstances:

- There appears to be a discretionary error by the ALJ
- There is a legal error
- The action, findings or conclusions of the ALJ are not supported by substantial evidence
- There is a policy or procedural issue that may affect the general public interest.

The MAC:

- Assumes the ALJ decision was received within five days of the date of the decision, unless evidence indicates otherwise
- May grant an extension for “good cause” for missing the deadline
- May also initiate its own review
- Notifies all parties of its decision

Any party may request a judicial review of the case when:

- The amount in controversy is \$1,090 or more including the same member’s claims that the MAC has acted on and the request is made within the 60 calendar-day filing time limit for all claims
- It is the final decision of CMS
- When the MAC denied the parties request for review.

Judicial review cases are brought before the appropriate Federal District Court of the United States in which the member lives or where the plan has its principal place of business and must be filed within 60 calendar days from the Medicare Appeals Council decision.

Reopening an Appeal

A reopening of an appeal is not an appeal right. It is an administrative procedure under which the entity that made a determination re-examines that decision for a specific reason. The determination of whether or not to reopen a case is at the discretion of the entity that made the determination. If a party requests a reopening while it still has appeal rights, the party should also file for the appeal and ask for a continuance until the reopening is decided. If the reopening is denied or the original determination is not revised, the party retains its appeal rights.

A case may be reopened for good cause after any of the appeal steps but typically the reopening is only requested after the exhaustion of appeal rights. Good cause is demonstrated if:

- New and material evidence becomes known that was not available at the time of the original decision
- There is a clerical error (mathematical or computational mistakes, inaccurate coding and computer errors) in the file
- There is evidence of fraud or an error in the evidence which affects the initial decision

A reopening may be initiated by any party.

Provider Appeals

MedicareBlue PPO participating providers can appeal processed claims. Reasons for disputing a processed claim may include:

- Benefit administration
- Claims processing including reimbursement, methodology and edits
- Services denied due to lack of prior authorization or prior authorization occurring after claims submission
- Timely filing denials
- Medical necessity denials

How to Request a Reconsideration of Claims

Providers are encouraged to contact MedicareBlue PPO service administration to request claim reconsideration either verbally or in writing.

The phone number for a verbal request of reconsideration is:

Service Administration

1-888-457-3009

TTY: 1-888-457-3005

Monday-Friday

8:00 a.m. to 6:00 p.m. Central or Mountain Standard Time

The address for a written request is:

Mail: MedicareBlue PPO Appeals
P.O. Box 13652
Philadelphia, PA 19101-3652

Fax: **215-761-0330**

1st Level Claim Reconsideration

Written requests must be submitted using the Provider Appeal form at the end of this chapter or in the “Forms” section of the MedicareBlue PPO website, www.YourMedicareSolutions.com. If you have not previously requested an adjustment, check the “1st Level Reconsideration” box. Medicare Blue PPO will research the claim in question and work to resolve the claims processing issue. If the outcome of the research is in the provider’s favor, the claim will be reprocessed. If the research results in an adverse decision, the provider will be notified either verbally or in writing. If the provider is not satisfied with the decision, the provider may request a second level appeal.

2nd Level Claim Reconsideration

Providers are encouraged to submit a second level appeal within 60 days of the adverse decision notification. The local Blue Cross and Blue Shield plan’s provider service agreement or contract may allow for a longer period to submit a claims appeal.

Second level appeals must be in writing. Use the Provider Appeal form at the end of this chapter and in the “Forms” section of the MedicareBlue PPO website, www.YourMedicareSolutions.com. Check the “2nd Level Claim Appeal” box and submit the provider remittance/statement, original claim, and any additional documentation for reference. Mail or fax all of the documents to the address on the form.

Providers will be notified of the outcome within 60 days from receipt of the second level appeal. If the outcome is in the provider’s favor, the provider will receive a letter and the claim will be reprocessed. If the outcome upholds the original position, MedicareBlue PPO will send a written response reflecting the final decision.

Appeals for Medical Necessity Denials that Occur Prior to Claim Submission

MedicareBlue PPO participating providers can appeal services that were denied that are believed to be medically necessary. Reasons for requesting a medical necessity appeal may include:

- Denial of payment for services the member/provider believes to be emergent or urgent
- Denial of health care services which the member/provider believes are covered under Medicare or should have been furnished, arranged for or reimbursed by MedicareBlue PPO

- Discontinuation or denial of services that the member/provider believes to be medically necessary
- MedicareBlue PPO neglected to furnish the member with a written initial organizational determination

There are two types of appeals you can file: standard or expedited.

Information Needed on Medical Necessity Appeals

To facilitate appeals, providers should include: member's name, address, ID number, reasons for appealing and evidence to support the appeal. Supporting evidence may include medical records, doctor's letters, or other information that explains why MedicareBlue PPO should provide the service.

Expedited Appeal

You can request an expedited appeal if waiting too long for a determination could seriously harm the member's health. MedicareBlue PPO must provide a determination within 72 hours from receipt of the appeal.

Phone: **1-888-457-3009**
 TTY: 1-888-457-3005
 Monday-Friday
 8:00 a.m. to 6:00 p.m. Central or Mountain Standard Time

Fax: **1-888-289-3008**

The determination time frame for either standard or expedited appeals may be extended by 14 days if the member/provider requests an extension, or if MedicareBlue PPO needs additional information and the extension may benefit the member.